Coates' Canons Blog: Two Implications of the Supreme Court's Health Care Decision for North Carolina

By Jill Moore

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UPDATE: In March 2013, North Carolina enacted legislation declining Medicaid expansion and directing state agencies and institutions not to participate in the implementation of a health benefits exchange in North Carolina. SeeS.L. 2013-5, summarizedhere.

Readers of this blog are no doubt well aware that the Supreme Court upheld the Patient Protection and Affordable Care Act (ACA) yesterday. *National Federation of Independent Business v. Sebelius* has already been summarized and analyzed in dozens of forums and I won't repeat that. If you're looking for a quick summary, SCOTUSblog offers a "Plain English" wrap-up **here**. Chief Justice Roberts wrote the majority opinion, Justice Ginsburg authored a concurrence, four Justices (Scalia, Kennedy, Thomas, and Alito) issued a joint dissent, and Justice Thomas wrote a separate dissent. The **Supreme Court's website** has the opinions – all 187 pages – for you to read at your leisure.

States have a significant role in implementing the ACA provisions that are intended to extend insurance coverage to individuals who are presently uninsured. This post describes two aspects of that role and the steps North Carolina has taken or may take to carry them out. Before I write about that, I want to acknowledge that a great deal of background work on state implementation has already been undertaken by the North Carolina Institute of Medicine (NCIOM). In 2010, the state Departments of Insurance and Health & Human Services asked the NCIOM to convene several workgroups to study ACA implementation and make recommendations. Eight workgroups on several matters, including the two discussed in this post, were convened and developed recommendations that were published in **this report**.

Health Benefits Exchanges

The ACA calls for states to set up health benefits exchanges for individuals who are not insured through other means, such as employer-provided insurance. The idea of the exchanges is to create an insurance pool so that uninsured people may purchase health insurance at lower rates than are typically available to individuals in the present market. If a state does not set up a health benefits exchange, the federal government will provide an exchange for residents of the state. The Court's decision yesterday left unchanged the ACA's provisions regarding health benefits exchanges.

The NCIOM workgroup on health benefits exchanges recommended that North Carolina develop a state exchange. In 2011, the North Carolina legislature stated its intent to do so in the budget technical corrections act (**S.L. 2011-391**, sec. 49), and legislation that would create a state exchange passed the North Carolina House (**H 115**). However, H 115 has not yet been considered in the Senate. A state that wishes to create its own exchange must demonstrate operational readiness by mid-2013 and begin operating in 2014. If North Carolina does not meet these target dates, the federal government is required to provide an exchange for the state's citizens and legal immigrants. (Under the ACA, unauthorized immigrants are not permitted to purchase insurance through a health benefits exchange.)

Medicaid Expansion

The ACA included an expansion of Medicaid, the health insurance program for low-income individuals. Medicaid is a voluntary program, but states receive large amounts of federal funding to support it and no state declines to participate in it. To receive federal Medicaid funds, a state must have a state plan that complies with federal laws and is approved by the U.S. Department of Health and Human Services. At present, Medicaid coverage extends only to people who fit into particular categories, such as pregnant women, families with children, or individuals with disabilities.

The ACA extends Medicaid eligibility to individuals with incomes up to 133% of the federal poverty level regardless of

whether they fit within a category. The chief impact of this provision is to extend Medicaid to low-income adults who are under age 65 and do not have minor children. The federal government will pay 100% of the cost of the expansion during the first three years of its implementation, which is slated to begin January 1, 2014. Then states begin picking up part of the cost, beginning at 5% in 2017 and increasing each year until 2020 when the cost-sharing would stabilize at 90% federal and 10% state. Under the ACA as written, a state that did not comply with this expansion of Medicaid would have been at risk of losing all its federal Medicaid funding – not just funding for the expansion, but also federal funds that are used to support current programs.

In yesterday's decision, the Court held that the Medicaid expansion exceeded Congress' authority under the spending clause. While Congress may use its spending power to create and regulate voluntary state-federal programs such as Medicaid, it may not coerce states into participating in them. Chief Justice Roberts described the threat of loss of very large amounts of federal funding as "economic dragooning" that left states with no choice but to go along with the Medicaid expansion – in other words, it amounts to the coercion that is not constitutionally permitted. However, the Court prescribed a remedy: The constitutional violation is cured by prohibiting the federal government from withholding all Medicaid funds from a state that declines participating in the expansion. Instead, it may withhold only those funds necessary to pay for the expansion.

Each state will need to decide whether to put the Medicaid expansion into effect. To do this in North Carolina, the state's Medicaid plan would need to be amended. The federal agency that is responsible for Medicaid—the Centers for Medicare and Medicaid Services (CMS)—has adopted **rules** for states to follow in implementing the expansion. The state agency that is responsible for preparing and modifying the plan is the Division of Medical Assistance (DMA) of the state Department of Health and Human Services. DMA is required to take several steps before amending the plan, including consulting with stakeholder groups, allowing the public to review the proposed changes and provide comments, and submitting the amended plan to CMS for approval. The NCIOM workgroup on Medicaid reported that DMA estimated that the expansion would result in an additional 525,000 individuals enrolling in either Medicaid or North Carolina Health Choice (the state children's health insurance plan) in 2014. New enrollees must be citizens or legal immigrants who are eligible for Medicaid under existing federal immigrant benefit eligibility laws.

Conclusion

Now that the ACA has been upheld, North Carolina has some decisions to make regarding how to proceed with implementation. The two issues discussed in this post present decisions that will probably need to be made sooner rather than later in order to meet the ACA's deadlines.

Links

- www.ncleg.net/EnactedLegislation/SessionLaws/PDF/2013-2014/SL2013-5.pdf
- www.sog.unc.edu/resources/legal-summaries/sl-2013-5-s-4-no-nc-exchangeno-medicaid-expansion
- www.scotusblog.com/2012/06/todays-health-care-decision-in-plain-english/
- www.supremecourt.gov/
- www.nciom.org/wp-content/uploads/2012/05/Full-Report-Online-Pending.pdf
- www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2011-2012/SL2011-391.html
- www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2011&BillID=h115&submitButton=Go
- www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm