Getting Back to Reality: The Election, the Fiscal Cliff, and the ACA

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President Obama’s victory in November resolves whether the Affordable Care Act (ACA) will be implemented. In general terms, it will. Although the Republican-controlled House of Representatives may pass another resolution to abolish the ACA, that threat is not credible, with Democrats in charge in the Senate. But that does not settle what will actually become of the law. Action or inaction by the states, reaction from insurers and healthcare providers, responses from consumers, and budget-cutting policies adopted by Congress to ease the country off the fiscal cliff will determine the future shape of reform and its impact on the health sector.

States in the Driver’s Seat

The biggest challenge facing the second-term Obama White House comes from the states. Perhaps surprisingly, the federal government does not have the power to reshape the healthcare sector on its own. The ACA relies on the states to act as Washington’s agent in implementing the health insurance exchanges, enforcing new insurance regulations, and expanding eligibility for Medicaid. The ACA’s drafters recognized that not all states shared their vision of healthcare reform. Consequently, the legislation includes a combination of steep penalties to force state compliance and federal fallbacks in the event that some states do not comply.

Those provisions are unlikely to be effective in obtaining full state cooperation. The Supreme Court decision in June restored the states’ ability to manage their Medicaid programs by declaring unconstitutional the threat that states failing to expand eligibility would lose all of their federal Medicaid funding. Republican governors continue to question whether it is in their best interest to create their own insurance exchanges. The fallback federal exchange that is supposed to fill in when states have not acted has yet to show signs of life, and there is an ongoing debate over whether the federal insurance exchange can distribute insurance subsidies. Even when states are willing to take on the complex new tasks laid out by the ACA, many are unlikely to meet the deadlines set forth in the law. For the most part, this is not a case of political recalcitrance.

Insurance Exchanges

Creating an insurance exchange is a complex task that only a few states have previously attempted. A top executive with Maryland Health Benefit Exchange, which has been under active development for 2 years, doubts that states beginning now to implement an exchange will be ready to start enrolling beneficiaries by October 2013. Even Massachusetts faces challenges, because its exchange system was developed before enactment of the ACA. To comply with the new federal requirements, Massachusetts will have to disassemble parts of its current system. That may prove as difficult as starting from scratch.

With 30 Republican state governors next year, as well as some Democratic governors questioning the wisdom of proceeding with full implementation of the ACA, the Obama administration is beginning to show signs that it will accommodate state concerns to some extent. On November 9, Health and Human Services (HHS) Secretary Kathleen Sebelius sent a letter to all governors, extending the deadline for submitting a plan for a state exchange (known as a “blueprint”) from November 16 to December 14, 2012. On November 15, HHS Secretary Sebelius moved the deadline for states’ declaring their intention to establish an exchange to December 14, 2012, as well, responding to a request from the Republican Governors Association.

These are the first of many compromises to come as states—including those governed by Democrats—recognize that they are in the driver’s seat of healthcare reform. States that fail to meet the federal deadlines for implementing insurance exchanges face no penalty other than a possible delay by the HHS in approving their plans. States that implement exchanges late, or not at all, risk losing insurance subsidies for some of their currently uninsured citizens, but even that is uncertain.

The Obama administration insists that the federally facilitated exchange will distribute subsidies, despite clear language in the ACA to the contrary. Having created a new entitlement program, the administration intends to spend the money.

That raises some interesting possibilities. Could a state create its own insurance exchange but not implement all
of the insurance market regulations imposed by Washington. If so, would individuals purchasing coverage in such an exchange still be eligible for the subsidies? What punitive actions could the administration take against states that do not vigorously enforce ACA rules?

Considering the political consequences of withholding financial support from otherwise deserving families who need health insurance, the federal government probably would seek some avenue other than the insurance subsidies to rein in contrary states. That assumes the administration thinks this is a fight it could win.

The alternative approach—not establishing an exchange and leaving it to the federal government—will be attractive to some states, because it avoids any implicit alignment between the state and Washington politics. It also eliminates the need to resolve technical problems that are inevitable with such an enterprise, does not prevent a state from creating an exchange later, and blame for any problems can be shifted to the federal government. This wait-and-see approach is likely how a dozen or more states will proceed.

**Medicaid**

Thanks to the Supreme Court’s decision, the states are more clearly in control with regard to expanding Medicaid eligibility. Faced with fiscal problems, many states are likely to seek ways to maximize federal contributions for health insurance—or at least minimize their own.

Although expanding Medicaid to everyone with incomes up to 138% of the federal poverty line will ensure full federal payments for the expansion population for several years, the matching rate eventually drops to 90% of the cost of benefits. There is no guarantee that Congress would not reduce that matching rate in the future. States will also bear additional costs as individuals “come out of the woodwork” to enroll in Medicaid. The federal matching rate does not increase for anyone newly enrolling in Medicaid if they were previously eligible.

Given the risks, states would be better off financially to take advantage of the subsidies in the exchanges that are available to persons with a household income between 100% and 400% of the federal poverty line. One approach would be to limit the Medicaid expansion to incomes up to 100% of the federal poverty line and encourage those with higher incomes to enroll in the exchanges. As an added inducement, states could supplement the exchange subsidies with a few hundred dollars of their own funds for each person who would otherwise have enrolled in Medicaid, reducing their premium cost to zero.

States have flexibility in setting eligibility, and the administration has gone out of its way to make that point. In an August meeting of the National Conference of State Legislatures, federal Medicaid director Cindy Mann said that states could expand Medicaid to new populations under the ACA and later drop the coverage.

This gesture of acceptance (if not support) raises the possibility that the Obama administration may be willing to negotiate more favorable terms with states that choose to expand coverage. States want more discretion in how they operate their Medicaid programs. This was a central issue in the Republican proposal to provide states with block grants for Medicaid rather than continuing to require them to seek federal permission for even modest changes in states’ policies and management procedures.

States will make their “best deal” with the federal government on exchanges, Medicaid, and other aspects of the ACA rather than simply falling into line with the administration’s policies. Even if a Republican House blocks changes that could make the rules easier to live with, the administration will use the ample authority of the ACA to grant waivers, make exceptions, and otherwise look the other way when circumstances and politics dictate. As a result, the dream of some Democrats for a nationally uniform health insurance system will be replaced with the reality of a multitude of systems with varying degrees of regulatory control, much as we see today.

**The Budget Knife Comes Out**

A second major threat to the ACA is purely a product of Washington politics. Unless the lame duck Congress acts by the end of the year, we will fall off the fiscal cliff. That means starting in January 2013 with a large increase in tax rates, large across-the-board reductions in federal spending through a sequester, and a cap on federal borrowing that limits the government’s ability to run up larger deficits.

Three months later, the federal government’s authorization to spend money for discretionary programs expires. Funding could grind to a halt for education, infrastructure development, defense, and other activities but would continue largely unrestrained for the major entitlements—Social Security, Medicare, and Medicaid.

The Congressional Budget Office warns that without legislative action, the combination of abruptly higher taxes and abruptly lower spending will trigger another recession. That message seems to have gotten through to both political parties, and negotiations are under way between congressional leaders and the president. The bargain that will eventually be struck will probably be a combination of tax increases focused on those with high incomes and an agreement in principle to reform entitlement spending.

The bad news for the healthcare sector is that the
sequester imposes a much gentler cut in federal payments than is likely under the deal that is expected to ease us off the fiscal cliff. Medicare is scheduled for a 2% reduction under the sequester, and Medicaid spending would not be cut. The president’s 2013 budget that was released in February 2012 gives a good indication of where the administration stands on this issue. That document proposed to double the Medicare cuts, with $292 billion in savings through 2022, and cut federal Medicaid payments by $52 billion.19

Those figures ignore the impending 27% cut in Medicare physician fees under the sustainable growth rate formula. The 10-year cost of replacing the scheduled reductions with a freeze amounts to $271 billion.17 Congress will almost certainly delay any cut in physician fees for next year, pushing that cost forward to 2014.

Filling the larger budget hole that includes a physician payment fix will force Congress to accept a mix of Medicare fee reductions (other than for physicians) and increases in beneficiary costs. Rather than inventing new ways to cut provider payments, the fiscal compromise will probably accelerate implementation of the “productivity adjustments” and other fee-reduction provisions imposed by the ACA. Medicare premiums are likely to rise (perhaps to an average of 35% of the cost of Part B and Part D), with more of the cost paid by higher income beneficiaries.19

Other initiatives are more speculative, but possible. Medicare could shed its historical division into Part A and Part B, which no longer has any usefulness (if it ever did). Combining Medicare’s parts into a single comprehensive health benefit would allow restructuring the current and complex cost-sharing requirements that make no sense. A single, all-encompassing deductible, a simple uniform copayment or coinsurance structure across all services, and the addition of a cap on catastrophic expenses would convert the program into modern insurance. Medicare Part B premium would become a premium for the entire benefit, with appropriate adjustment to the rate to avoid overburdening beneficiaries.

These are stopgap measures at best. Structural reforms are needed that shift Medicare from an open-ended entitlement program to a budgeted approach. Premium support remains a viable but dormant political idea. Scare stories about “vouchers” during the campaign did not create a wave of senior backlash against Republicans, but there is also no wave of senior enthusiasm for major program reforms. For the time being, Congress is likely to adopt more modest reforms intended to improve the competitive bidding process for Medicare Advantage and to give accountable care organizations more control over and accountability for the delivery and cost of their services.

Another target for budget cutting is the ACA’s subsidy for insurance offered on the exchanges, totaling $1 trillion through 2022.19 The Obama administration will be reluctant to modify the subsidy structure, particularly if they believe that the Supreme Court’s decision to make the health insurance mandate a tax significantly weakens the pressure on individuals to purchase coverage. They may reason that a generous subsidy is needed under that circumstance to maintain a stable insurance market.

Nonetheless, reducing the subsidy (perhaps by cutting its generosity and limiting its availability to individuals with incomes below 250% of the poverty line rather than the current 400%) offers substantial budget savings. Those savings may be easier for the public to accept than cuts in existing programs that already have well-established and politically vocal constituents.

There is also a chance that the deficit fighters could reduce the tax subsidy for employer-sponsored health insurance. The ACA includes a “Cadillac tax” on employer coverage that is deemed too expensive. The Obama administration has agreed that our current tax subsidy is inefficient, even though it endorsed an inefficient way to address this problem. The tax is imposed on insurers, but obviously most of it will be passed on, in the form of higher premiums, to workers, who will receive a tax subsidy on the higher amount. The political objective was to avoid admitting that the tax would be paid by those who will, in fact, pay it. Broad tax reform could make sense out of this by directly limiting the amount of insurance premium that can be excluded from personal income tax.

Will It Work? The Healthcare Sector and Consumers React

Passage of the ACA in 2010 triggered the adoption of massive changes in the practices of health insurers and, to a lesser extent, healthcare providers. Despite the uncertainty of the election, the healthcare industry has taken as given that the basic structure of the ACA would remain intact. With the reelection of President Obama, and the torrent of proposed regulations and other guidance that has ensued in recent weeks, implementation efforts continue with renewed urgency.

The question is—will it work?

The third threat to the ACA is the response of the market to the policy ambitions of the Obama administration. Although their criticism has been muted, insurers and health plans have warned that the overlapping requirements that are meant to protect consumers will drive up costs, drive away customers, and destabilize the individual insurance market.

The self-imposed problems are numerous. For example, partial community rating limits the premiums charged to
older people to no more than 3 times the rate charged young purchasers. In most states, the variation in age rating is 5 or 6 to 1. The result is lower premiums for older consumers, offset by higher premiums for the young. The mandate to buy health insurance was added to force young people to purchase high-priced coverage, but the ACA explicitly limits enforcement to a slap on the wrist. The essential benefits package was intended to ensure good coverage, but that will drive up premiums further, making insurance unaffordable for many and increasing the cost of federal subsidies.

The political desire to halt what one federal official calls “some of the worst insurance industry practices” will collide with the real-world challenges of operating an insurance market. Older people use more healthcare. Consumers decide to purchase insurance based on their assessment of their own need for healthcare services. Medical underwriting (which sets premiums and benefit restrictions based on the person’s health) was instituted to avoid disastrous losses that could result from enrolling high users, without charging commensurately high rates. The ACA eliminates these mechanisms, which are subject to abuse, but does not adequately address the underlying problem of market incentives and risk selection.

Health insurers will do their best to succeed in the new environment. Millions of people seek to purchase health insurance through the exchanges. But insurance costs will rise, and the exchanges will not provide that easy one-stop-shopping experience that proponents of the ACA imagined. Those most eager to find coverage they can afford are likely to be disappointed.

The next years are critical to the president’s healthcare legislation. Although there is general agreement that the ACA, like all major legislation, has flaws that should be fixed, no fixes are likely in 2013.

The president is already viewed with suspicion by his liberal supporters, who are disappointed that healthcare reform did not produce national health insurance, and who fear that he may be ready to lay a heavy hand on their favorite social insurance programs. Republicans will not support legislation that corrects errors in the ACA, which they would view as capitulation. Unless the 2 sides can agree on structural reforms in Medicare and substantial reductions in federal spending, the ACA will limp into 2014 unchanged.

Shortly after the election, Speaker John Boehner said that “Obamacare is the law of the land.” That was not just a statement of the obvious. The ACA with all its warts has set the government’s healthcare agenda, and citizens, states, employers, and the healthcare sector will have to deal with it. That will be much harder if we fail to reenergize the American economy and rein in our burgeoning federal debt. Unless President Obama’s successor is extraordinarily fortunate, he or she will revisit these thorny issues 4 years from now.

References