The Supreme Court upheld most of the Affordable Care Act (ACA), giving the White House cause to breathe a sigh of relief. The Court ruled the individual mandate to buy insurance constitutional, requiring only that we call the penalty for noncompliance a tax. The only real setback was in Medicaid. The federal government’s threat to take away all Medicaid funding from a state that did not expand eligibility to everyone with incomes below 133% of the poverty level was declared coercive and unconstitutional. With that caveat, proponents claim that the Obama healthcare reform will proceed as scheduled.

Don’t bet on it. The Supreme Court may have settled some issues, but its decision opened up new areas of uncertainty. Will the renamed individual mandate penalty/tax be effective in leading both healthy and unhealthy people to buy insurance? Will states, facing serious fiscal problems, expand eligibility for Medicaid? More fundamentally, will the myriad changes called for by the ACA be implemented on time and with the impact promised by the White House?

We have already seen a major component of the ACA fail because it promised more than it could deliver. The Community Living Assistance Services and Supports Act (better known as the CLASS Act) was a government long-term care insurance program that could not be made financially solvent and was eventually shelved.1,2 Other elements of the ACA are facing substantial challenges in implementation. Regardless of who is elected president in November, healthcare reform will be recast to fit political, economic, and practical realities that largely have been ignored for the past 4 years.

The Broccoli Question

The individual mandate is constitutional, but the penalty is not—unless we call it a tax. That semantic issue consumed several days of political debate, but that merely splits hairs. The issue is not what you call it, but whether the mandate will be sufficient to avoid meltdown in the individual insurance market.

The ACA imposes new federal regulations on health insurance, including guaranteed issue, no exclusions for preexisting conditions, and community rating. “Guaranteed issue” means that insurers cannot turn an applicant away, regardless of their state of health. The cost of treating any preexisting condition must be covered under the new rules, and insurers cannot charge higher premiums based on the applicant’s state of health. Unless some way is found to induce people to purchase health insurance while they are young and healthy, premiums will soar as the sick buy coverage and the healthy wait to buy it until they really need it.

The combination of a mandate and generous subsidies in the insurance exchanges is supposed to be sufficient to avoid a collapse of the individual insurance market. But Congress defanged the mandate threat. The penalty for noncompliance is small, and the ACA limits the ability of the Internal Revenue Service (IRS) to collect the penalty. In 2014, the penalty is $95, or 1% of a person’s income. It grows to $695, or 2.5% of a person’s income, by 2016. However, premiums charged on the insurance exchanges will be higher than the penalty for most people. Those with incomes above 133% of the poverty level will be charged between 3% and 9% of their income for insurance if they are eligible for exchange subsidies. As a simple matter of arithmetic, delaying an insurance purchase is money in the bank if you do not need healthcare. A young person struggling to cover the rent and pay a student loan—in other words, the prime target of the mandate—is likely to take the risk.

Not that the penalty/tax is likely to be collected. Under the ACA, the IRS can hold back an amount from income tax refunds owed to someone who owes the mandate tax. Scofflaws will be asked to turn themselves in by checking a box on their tax form admitting to not buying insurance. If they overwithheld, and if the IRS can verify that they were, in fact, liable, then the gov-

Dr Antos is Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute, Washington, DC.

The Broccoli Question

The individual mandate is constitutional, but the penalty is not—unless we call it a tax. That semantic issue consumed several days of political debate, but that merely splits hairs. The issue is not what you call it, but whether the mandate will be sufficient to avoid meltdown in the individual insurance market.

The ACA imposes new federal regulations on health insurance, including guaranteed issue, no exclusions for preexisting conditions, and community rating. “Guaranteed issue” means that insurers cannot turn an applicant away, regardless of their state of health. The cost of treating any preexisting condition must be covered under the new rules, and insurers cannot charge higher premiums based on the applicant’s state of health. Unless some way is found to induce people to purchase health insurance while they are young and healthy, premiums will soar as the sick buy coverage and the healthy wait to buy it until they really need it.

The combination of a mandate and generous subsidies in the insurance exchanges is supposed to be sufficient to avoid a collapse of the individual insurance market. But Congress defanged the mandate threat. The penalty for noncompliance is small, and the ACA limits the ability of the Internal Revenue Service (IRS) to collect the penalty. In 2014, the penalty is $95, or 1% of a person’s income. It grows to $695, or 2.5% of a person’s income, by 2016. However, premiums charged on the insurance exchanges will be higher than the penalty for most people. Those with incomes above 133% of the poverty level will be charged between 3% and 9% of their income for insurance if they are eligible for exchange subsidies. As a simple matter of arithmetic, delaying an insurance purchase is money in the bank if you do not need healthcare. A young person struggling to cover the rent and pay a student loan—in other words, the prime target of the mandate—is likely to take the risk.

Not that the penalty/tax is likely to be collected. Under the ACA, the IRS can hold back an amount from income tax refunds owed to someone who owes the mandate tax. Scofflaws will be asked to turn themselves in by checking a box on their tax form admitting to not buying insurance. If they overwithheld, and if the IRS can verify that they were, in fact, liable, then the gov-

Dr Antos is Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute, Washington, DC.
Creating an exchange involves extremely complex tasks, requiring careful deliberation and consultation with insurers and others to ensure that actions taken do not have unforeseen adverse consequences.

As of mid-July, only 16 states have taken formal action (either through state legislation or an executive order) to establish an exchange, and 1 state will partner with the US Department of Health and Human Services (HHS) in creating an exchange. Seven states—Alaska, Florida, Louisiana, Maine, New Hampshire, South Carolina, and Texas—have decided not to establish an exchange, and another 10 states have taken no action over the past 2 years. The remaining states are studying the matter.

It is not surprising that the states have not rushed into implementing the ACA. Some governors will not move forward as a matter of politics. Some states are cautious, waiting for the fall election before deciding whether to commit significant resources to exchange development. But almost all states have concerns about the complex requirements and their capacity to implement, operate, and finance the health insurance exchange over the long-term.

New processes and standards must be established for functions that have never been needed before. Exchanges must certify qualifying health plans, which have to satisfy requirements for adequate provider networks, access to essential community providers, essential benefits, actuarial value standards, marketing, and other performance standards. Exchanges must also facilitate enrollment in health plans, which requires creating “navigators” to provide consumer education, determining whether individuals are eligible for Medicaid or for exchange subsidies, and determining whether individuals are exempt from the health insurance mandate, among other duties.

To do this, states must interpret thousands of pages of federal regulations, create their own implementing regulations (which may require enactment of new state laws), and translate all of that into concrete actions. Information on income, citizenship, and other personal data must be obtained from federal agencies before subsidies can be paid. In some critical areas, the federal government has avoided the formal regulatory process, opting to issue “guidance” that does not have the full force of law. This throws particularly sensitive issues, such as the definition of essential benefits, into the laps of the states.

There is a current tempest over whether the federal exchange can fill in for states that do not create their own entity. Some argue that states should leave it to the federal exchange, both as a political matter and because they believe that this would protect employers in those states from fines if their health plans do not satisfy federal requirements. The argument is that federal exchanges lack the authority to provide subsidies, which negates other provisions of the ACA. Others assert that a drafting error, not congressional intent, caused this result. Although the courts are likely to side with the White House on this issue, it remains a concern at least in the red states.

Creating an exchange involves extremely complex tasks, requiring careful deliberation and consultation with insurers and others to ensure that actions taken do not have unforeseen adverse consequences.
Despite vague claims to the contrary, it is doubtful that the federal government—which carefully describes its role as facilitating the state’s exchange rather than running a federal exchange—will be capable of stepping in. The task is too large, and the time is too short.

The Medicaid Expansion

The Supreme Court has given the states another difficult decision to make. They now can decide for themselves whether to expand their Medicaid programs without the potential loss of billions of dollars in federal support. Although the lure of full funding for newly eligible enrollees remains for the first 3 years, eventually states would be responsible for 10% of the cost of services, and they also would have to cover 50% of all additional administrative costs.

For states facing serious financial difficulties, that does not look like free money. Most state budgets are in crisis, in large part because of underfunded public employee pensions. Governor Mitt Daniels pointed out that the full Medicaid expansion would cost Indiana $2 billion over 10 years, and other governors have expressed similar concerns. With the Court’s decision, there are new options. Even states that favor expanding Medicaid are likely to think twice before proceeding.

If states expand Medicaid eligibility to include everyone with incomes below 133% of the poverty level, state funds will begin to cover an increasing share of the cost beginning in 2018. If states expand Medicaid eligibility to those at or below the poverty line, those between 100% and 133% of the poverty level could receive subsidized coverage through the exchanges. Instead of using state funds for that coverage, the cost would shift completely to the federal budget.

Coverage in the exchanges will be more expensive than Medicaid because private insurers pay providers more for their services, which provides better access and potentially higher quality care. The additional federal cost is likely to run between $50 billion and $90 billion over 10 years. States would incur no cost for health services, would save on their administrative costs, and would gain political points for providing a better healthcare alternative to many of their low-income residents.

It is too early to tell whether states will expand Medicaid coverage, and if so, to what extent. Higher-income states already have more lenient enrollment requirements, but low-income states are likely to be hard-pressed to expand Medicaid significantly, even on the generous terms offered by the ACA. One thing will not change, however. Medicaid will remain the insurer of last resort for patients and providers because of low payment rates and limited access to services.

Wait Until Next Year

Despite enthusiastic claims that the Supreme Court resolved the uncertainty surrounding the ACA, much uncertainty remains. As discussed above, there are many uncertainties about how specific provisions will be implemented. But the biggest unknown is the most basic. Will the ACA be implemented at all?

Despite enthusiastic claims that the Supreme Court resolved the uncertainty surrounding the ACA, much uncertainty remains.

If Mitt Romney is elected president, he has promised to repeal the ACA. Like all campaign promises, that is not exactly true. Mr Romney could repeal the spending and revenue provisions through the reconciliation process if Republicans hold the House and gain 50 votes in the Senate. Other provisions, including the insurance regulations, would remain, but would likely be modified in subsequent legislation. Some health sector changes that were triggered by passage of the ACA will continue regardless of any government action, and other provisions of the law will be kept in some form under a Republican health reform.

Insurers announced that they will continue to allow children up to the age of 26 years to remain on their parents’ policy, even without the ACA requirement. Accountable care organizations are here to stay, although not necessarily the way the Medicare program wants them. The ACA has accelerated the trend toward greater provider consolidation, with hospitals buying up physician practices and other business arrangements that will increase their market power and drive up prices to private payers. Employers, who have been cutting back their employee health benefits, redoubled their efforts to keep benefit costs down to avoid incurring the “Cadillac” tax on high-cost coverage. These and other trends will continue regardless of who is in office.

Whoever is president next year will face stubbornly high unemployment rates, slow economic growth, and the possibility of a double-dip recession. The federal government will once again be in a debt crisis, reaching the $16.4-trillion debt limit in early 2014. Unlike last year’s
The confluence of a debt crisis, an economic crisis, and a healthcare sector crisis is our best chance yet for policymakers to take those problems seriously and to not simply kick them down the road.

Substantial spending reductions would be necessary as part of a debt ceiling increase, and that is likely to mean sharp reductions in exchange subsidies and Medicaid matching rates for the newly eligible population. New reductions in Medicare payments to providers are virtually certain, but they could be accompanied by restructuring that would begin to look like the premium support model that Mr Romney supports.

The options are limited and politically difficult, but necessary. Healthcare spending at all levels—federal, state, local, and individual—is growing faster than we are willing and able to accommodate over the long-term. The confluence of a debt crisis, an economic crisis, and a healthcare sector crisis is our best chance yet for policymakers to take those problems seriously and to not simply kick them down the road.

Author Disclosure Statement

Dr Antos reported no conflicts of interest.

References