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State Implementation of the Affordable Care Act

Alexander H. Sommer, JD

Three years ago, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA). Until June 28, 2012, much of the health care reform debate was consumed by the pending Supreme Court review of whether the law was constitutional. The Court's decision to uphold key provisions of the ACA, coupled with President Obama's reelection in November, shifted the debate from repealing the law to effectively implementing it. That debate largely revolves around the various roles states must play in instituting the law and the division of financial responsibility between states and the federal government. The negotiation of states' participation in and responsibility for ACA programs will shape the form the requirements ultimately take. This article discusses recent developments in the ongoing implementation of the ACA, with focus on the role of the states in shaping these developments.

State-Based Health Insurance Exchanges

The states were intended to have one of the most important roles in implementing the Affordable Care Act through the establishment of state-run health insurance exchanges. Beginning January 1, 2014, the Health Insurance Marketplace, through each state's health insurance exchange, will be open to the American public [1]. Health insurance exchanges will create a competitive marketplace of qualified health plans for individuals and small businesses [2]. In response to the mandate that all individuals carry minimum coverage for essential health care, the health insurance exchanges aim to ensure that all American citizens can access quality and affordable health care coverage, through increased competition and price transparency.

But state resistance to the exchanges has complicated the process and altered the exchanges' form [3]. The Health Insurance Marketplace will still be opened by January 1, 2014 [1], but the federal government will play a larger role in starting the exchanges than it originally anticipated. Only 17 states will be initiating and running their own exchanges in 2014 [4]. Twenty-six states declined entirely to operate health insurance exchanges, thus leaving the federal government to do so [4]. The remaining 7 states are pursuing partnerships with the federal government, in which oversight and funding will be shared between the federal government and state government [4]. The final format of this partnership remains unclear, as the cost of running the exchanges is still largely unknown.

Medicaid Expansion

Originally, the ACA would have withheld all federal Medicaid funds from states that failed or declined to extend Medicaid eligibility to those earning up to 133 percent of

the federal poverty level [5]. The idea was to increase the pool of Medicaid recipients to cover some of those who would have difficulty paying for insurance under the individual mandate. The Supreme Court, though, struck down that provision as an unconstitutional withholding of federal funds [6]. The federal government, in an effort to retain the expansion of Medicaid, has offered to pay 100 percent of the costs incurred by a state as a result of the expanded Medicaid eligibility for the first three years and 90 percent of those costs in subsequent years [7].

Many states, however, are using the federal government's Medicaid expansion offer as their newest stand against the ACA. A number of states that had previously passed legislation, constitutional amendments, and resolutions declaring the federal government's mandate of the purchase of health insurance unconstitutional are now standing against what they deem to be further encroachment upon states' rights [8]. As of June 14, 2013, 13 states had declared that they will not participate in the Medicaid expansion and another six are leaning toward not participating [9]. Political differences largely account for the unwillingness [10]. In Florida, Republican Governor Rick Scott endorsed the Medicaid expansion, despite previously speaking out against the ACA. The Republican-led Florida legislature, though, ultimately opposed the move [10].

Arkansas, a conservative state with a Democratic governor that previously declined to participate in the Medicaid expansion, adopted what looks like a hopeful bipartisan solution [10]—allowing low-income citizens to shop for and purchase private insurance with federal Medicaid funds [9]. This appears to be a model that conservative states could adopt to appease legislative concerns about the growth of the federal government and make wider health care coverage appealing to those who favor market solutions to social problems.

Access to Care

An oft-ignored provision of the ACA is an attempt to promote Medicaid recipients' access to care; as of January 1, 2013, states were required to pay no less than 100 percent of the Medicare rates for primary care services [12]. Previously, Medicaid reimbursement rates, which were set by individual states, averaged only 66 percent of the federal Medicare reimbursement rate [12]. Additionally, the federal government is providing more funding to state Medicaid programs that cover preventive services [12]. The hope is that increasing reimbursement rates will make more physicians available to Medicaid beneficiaries for preventive care, reducing the need for expensive interventions for advanced conditions.

Conclusion

The ACA as originally signed will look much different than the ACA as implemented. The relationship between federal and state governments will ultimately mean a patchwork of related but not identical strategies, solutions, and regulations to unfold in the coming years.

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Alexander H. Sommer, JD, graduated from the DePaul University School of Law in Chicago, where he was an editor of the DePaul Journal of Health Care Law. His academic interests focus on health information technology and government involvement in health care coverage.

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