The Advisory Board Company | Health Care Advisory Board

The Final Ruling

Assessing the Impact of the Supreme Court Decision on Health Care Providers

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Executive Summary

Supreme Court (Mostly) Upholds the Affordable Care Act

On June 28, 2012, the Supreme Court of the United States issued its historic ruling in *National Federation of Independent Business et al vs. Sebelius*, upholding the vast majority of the Patient Protection and Affordable Care Act (ACA) by a narrow vote of 5 to 4. In this nationally scrutinized case, 26 states and the National Federation of Independent Business challenged the constitutionality of the national health reform law enacted in March 2009. Chief Justice John Roberts delivered the opinion of the Court, resolving the constitutionality of the ACA.

In the narrowly crafted ruling, the Court upheld the ACA's most controversial provision, the individual mandate. Although the decision rejected the government's initial two arguments supporting the mandate—the Commerce Clause and the Necessary and Proper Clause—the Court agreed that the mandate's penalty functions as a tax.

While upholding the individual mandate, the Court ruled that Congress's Medicaid expansion plan was overly coercive and would violate states' rights if implemented as designed. The Court determined that Medicaid expansion could continue, but that the federal government could not withhold all federal Medicaid funding from states that do not participate in expansion. In essence, the Court excised the Medicaid mandate, making the Medicaid expansion voluntary for states.

Finally, the Court examined the issue of severability, evaluating whether the remainder of the law could stand if a portion were deemed unconstitutional. The Court determined that the invalidated Medicaid mandate was severable, in turn upholding the rest of the ACA.

Providers Face Three Key Implications Following Supreme Court Ruling

Implication #1: Constitutional Challenge Resolved, Political Uncertainty Remains
Although the Supreme Court addressed the constitutionality of the ACA, the justices were careful not to pass judgment on the underlying merits of the health reform law. The Court was clear in its intention to relegate policy judgments to the political arena. As a result, health care reform will continue to play a prominent role in the 2012 elections and the post-election budget debates. To remain in full effect, the ACA must ultimately survive both of these upcoming political tests.

Implication #2: ACA Mostly Intact, Delivery System Reforms Continue Apace
While political candidates debate the merits of the ACA on the campaign trail, the federal government continues to implement the ACA. Even as the justices sat in deliberation, the Centers for Medicare and Medicaid Services (CMS) launched several accountable payment programs: the Medicare Shared Savings Program, the Bundled Payments for Care Improvement Initiative, and the Health Care Innovation Challenge. As CMS implements new payment programs, contingent payment is rapidly becoming the “new normal” for Medicare fee-for-service reimbursement. Further, providers are weighing opportunities to evolve beyond fee-for-service reimbursement. Delivery system reforms continue full steam ahead.

Implication #3: Forgoing Medicaid Expansion Exacerbates Margin Challenge
In the wake of the Court's ruling on Medicaid expansion, providers are questioning whether their state governments will voluntarily engage in Medicaid expansion. If states opt out of the expansion, local providers would face all of the consequences of the ACA, namely the cuts to Medicare reimbursement rate growth, while only partially realizing the anticipated benefits of coverage expansion. Regardless of the Supreme Court ruling or ACA, four forces—shifting payer mix, deteriorating case mix, decelerating price growth, and increasing input costs—will combine to devastate hospital margins across the coming decade. Forgoing Medicaid expansion only exacerbates the underlying margin sustainability challenge.

Ruling in Brief

Supreme Court (Mostly) Upholds the Affordable Care Act

Ruling Preserves Individual Mandate, Makes Medicaid Expansion Voluntary

On June 28, 2012, the Supreme Court of the United States issued its historic ruling in *National Federation of Independent Business et al vs. Sebelius*, upholding the vast majority of the Patient Protection and Affordable Care Act (ACA) by a narrow vote of 5 to 4. In this nationally scrutinized case, 26 states and the National Federation of Independent Business challenged the constitutionality of the national health reform law enacted in March 2009. Chief Justice John Roberts delivered the opinion of the Court, which resolved three constitutional questions about the ACA.

Three Constitutional Questions Resolved

Major Decisions in Supreme Court Ruling

Constitutional Discussion		Supreme Court Decision
Individual Mandate: Can the federal government compel individuals to purchase health insurance?	→	Upheld under Congress's power to impose taxes
Medicaid Expansion: Is the ACA's Medicaid expansion a violation of states' rights?	→	Medicaid expansion upheld; federal government may not withhold all existing Medicaid funds if states forgo expansion
Severability: Should the remainder of the ACA stand if a portion is struck down?	→	The remainder of the law can stand

First, the Court examined the individual mandate, questioning whether Congress could require individuals to purchase health insurance or pay a penalty for failing to maintain insurance. In defending the health reform law, the government proposed three justifications for the individual mandate: the Commerce Clause, the Necessary and Proper Clause, and the Power to Tax and Spend.

The Court rejected the initial two arguments, determining that Congress does not hold the power to compel economic activity. However, the Court ultimately upheld the individual mandate by ruling that the mandate's penalty functions as a tax, which is well within Congress's established powers. In this narrowly crafted decision, the Court concluded that Congress may not require purchase of health insurance—but may impose a tax on individuals without health insurance.

Second, the Court questioned whether the law's path to expand the number of individuals covered through the Medicaid program violates states' rights. As outlined in the ACA, states could risk losing all of their federal Medicaid funding if they fail to adopt the law's Medicaid expansion provisions.

The Court ruled that the Medicaid expansion plan was overly coercive, describing it as "a gun to the head." The Court went on to explain that the Medicaid expansion could continue, but that the federal government could not withhold all federal Medicaid funding from states that do not participate in expansion. In essence, the Court excised the Medicaid mandate, making the Medicaid expansion voluntary for states.

Finally, the Court examined the issue of severability, evaluating whether the remainder of the law could stand if a portion were deemed unconstitutional. The Court determined that the invalidated Medicaid expansion provisions were severable, in turn upholding the rest of the health reform law.

The Supreme Court ruling ultimately leaves almost all of the ACA's provisions untouched. Across the law's many programs to expand health insurance coverage, finance coverage expansion, and promote delivery system reform, only one provision—the Medicaid mandate—was struck down. Apart from determining that Medicaid expansion must be optional, the Supreme Court ruling leaves the remainder of the ACA fully intact.

Major Provisions of the Affordable Care Act

Only Medicaid Expansion Affected by Supreme Court Ruling

Year	Coverage Expansion	Financing	Delivery System Reform
2010	• Coverage for non-dependent children through age 26 • Prohibition on denying coverage for children with pre-existing conditions • Small business subsidies to provide coverage to employees • High-risk pools for those denied coverage	• Tanning salon tax takes effect • Market basket adjustment to DRG updates	• Patient-centered outcomes research • Community transformation grants • Gainsharing, global payment demonstrations • Hospital Value-Based Purchasing Program
2011	• Five-year opt-in long-term care program begins	• Medicare Advantage payment restructuring	• Center for Medicare and Medicaid Innovation launches
2012		• First industry fees take effect • Medicare Advantage bonuses take effect • Hospital productivity adjustment	• Medicare Shared Savings Program (ACOs) • Hospital Readmission Reduction Program • Independence at Home demonstration
2013	• Increased payments to primary care physicians take effect	• New Medicare tax takes effect • Passive income tax takes effect • Excise tax on medical devices takes effect	• National Pilot Program on Payment Bundling
2014	• Health Benefit Exchanges created • Individual, employer mandates take effect • Medicaid expanded to 133% of the Federal Poverty Level	• Individual, employer penalties take effect • DSH payment adjustments take effect	• Independent Payment Advisory Board begins submitting recommendations
2015			• Payment adjustment for hospital-acquired conditions takes effect
2016		• Individual, employer penalties rise	
2018		• Excise tax on "Cadillac" health plans	

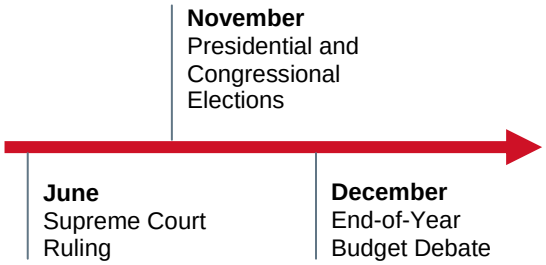
Key Implications for Providers

Implication #1: Constitutional Challenge Resolved, Political Uncertainty Remains

Health Care to Remain Front and Center in Elections, Year-End Budget Debates

Although the Supreme Court addressed the constitutionality of the ACA, the justices were careful not to pass judgment on the underlying public policy or wisdom of the health reform law. As the Chief Justice explained, "Those decisions are entrusted to our Nation's elected leaders, who can be thrown out of office if the people disagree with them. It is not our job to protect the people from the consequences of their political choices." The Supreme Court was clear in its intention to relegate policy judgments to the political arena. As a result, health care reform will continue to play a prominent role in the 2012 elections and the post-election budget debates. While the law's constitutional challenges have been fully resolved, the ACA must survive both of these future political tests.

Three Flashpoints in Health Care Policy
2012



Key Issues in End-of-Year Budget Debate

- **Bush Tax Cuts Set to Expire**
  Congress set to determine renewal or alternative distributions
- **Sequester**
  House Republicans have proposed replacing defense cuts with greater discretionary spending reductions
- **Sustainable Growth Rate**
  Decision looming to replace provision or extend temporary "fix"
- **Debt Ceiling Approaching (Again)**
  Federal government likely to reach debt ceiling by December; Congressional sessions focused on additional cuts

Implication #2: ACA Mostly Intact, Delivery System Reforms Continue Apace

CMS Leading the Transition Toward Accountable Care

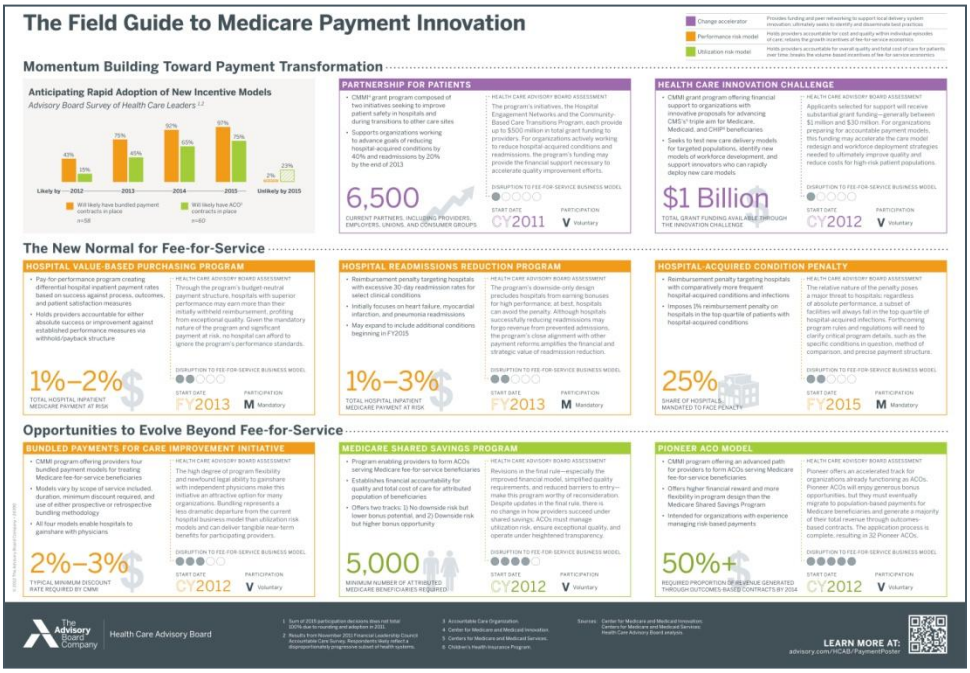
While political candidates on the campaign trail will almost certainly debate the merits of the ACA across the coming months, the federal government will continue to implement the health reform law, especially provisions designed to reduce health care spending growth through reimbursement rate cuts and the transition to new payment models. Even as the justices sat in deliberation, the Centers for Medicare and Medicaid Services (CMS) launched several accountable payment programs: the Medicare Shared Savings Program, the Bundled Payments for Care Improvement Initiative, and the Health Care Innovation Challenge. The federal government is rapidly advancing down the path toward accountable care.

As CMS implements new payment programs, contingent payment is rapidly becoming the "new normal" for Medicare fee-for-service reimbursement. All hospitals reimbursed through the prospective payment system face the heightened accountability of mandatory pay-for-performance programs, including the Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Condition Penalty. Furthermore, providers are eying opportunities to evolve beyond fee-for-service reimbursement, particularly the Medicare Shared Savings Program and Bundled Payments for Care Improvement Initiative.

The Health Care Advisory Board's "Field Guide to Medicare Payment Innovation" provides a detailed analysis of the major Medicare accountable payment programs. The "Field Guide" is available for download or order at **advisory.com/PaymentFieldGuide**.

The Field Guide to Medicare Payment Innovation

Delivery System Reforms Continue Full Steam Ahead



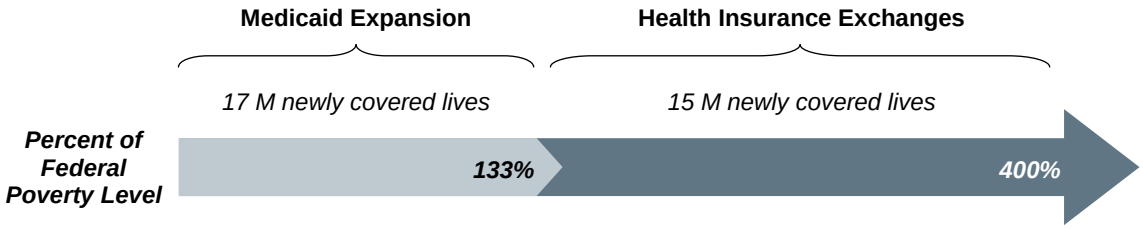
Implication #3: Forgoing Medicaid Expansion Exacerbates Margin Challenge

Coverage Expansion Proceeds—Perhaps Not As Originally Envisioned

The coverage expansion elements of the ACA are also continuing to roll out, although potentially not as Congress originally intended. The ACA combines several strategies, largely based on individuals' income levels, to achieve near-universal coverage. Congress initially intended for individuals with incomes below 133 percent of the Federal Poverty Level (FPL) to gain coverage through state Medicaid expansion. Next, individuals with incomes between 133 percent and 400 percent of the FPL would gain access to subsidized commercial coverage via the health insurance exchanges. Taken together, Medicaid expansion and the health insurance exchanges would offer coverage to approximately 32 million previously uninsured individuals.

ACA's Original Coverage Expansion Plan

32 Million Newly Covered Lives through Medicaid Expansion and Exchanges



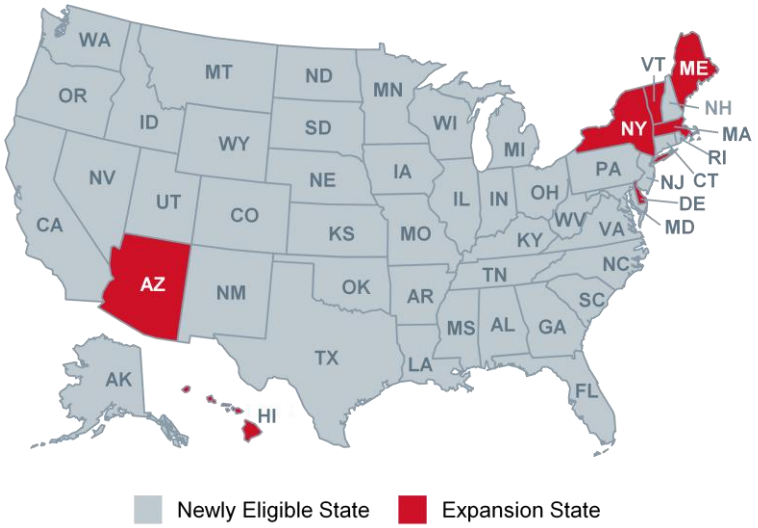
But the Supreme Court's ruling calls the Medicaid expansion into question. The decision now gives each state government the choice of whether or not to expand Medicaid eligibility and provide the essential benefits needed to qualify for new federal funding.

Because each state's Medicaid program varies widely, each also approaches the Medicaid expansion question from a different starting place. The law's provisions recognize this. Some states already meet the Medicaid expansion standards, and these "expansion states" would qualify for increased federal matching rates for a portion of their population. The ACA also includes Maintenance of Effort (MOE) provisions that generally prevent states from scaling back Medicaid eligibility prior to 2014.

The vast majority of states, however, currently fail to meet the Medicaid expansion standards; these "newly eligible" states will receive substantial federal funding to support expansion. The federal government will fund 100 percent of "newly eligible" states' Medicaid expansion costs between 2014 and 2017 and then gradually scale back until reaching the long-term federal funding rate of 90 percent in 2020.

Two Paths to Medicaid Expansion

Seven "Expansion States," Remaining States "Newly Eligible"



Medicaid Expansion Definitions

Newly Eligible State:

- Currently no coverage for childless adults
- Typically low income eligibility threshold
- Qualifies for high federal match for newly eligible enrollees

Expansion State:

- Currently covers both parents and childless adults
- Qualifies for enhanced federal matching rate for population below 133 percent of the FPL

States Face a Complex Calculus

Regardless of whether a state falls into the "expansion state" or "newly eligible state" category, state-level officials face a complex calculus surrounding Medicaid expansion. Several factors influence state Medicaid expansion decisions, with access to coverage for approximately 17 million individuals hanging in the balance.

Supporting Medicaid expansion, some state officials will highlight the public benefit of having fewer uninsured residents at a relatively low cost to the state. And given the dollars at stake, providers and employers may lobby their state lawmakers to expand access. Without the Medicaid expansion, providers would continue to face the financial burden of uncompensated care and bad debt from uninsured residents (not to mention the cuts to Medicare reimbursement growth already included in the ACA). Further, employers of low-wage workers—who previously assumed their employees would gain Medicaid coverage—would bear the costs associated with the employer mandate absent Medicaid expansion.

Other state-level officials, however, will argue against Medicaid expansion, citing the long-term costs of expansion or ideological objection. Furthermore, some leaders will point to concerns that Medicaid expansion efforts will increase enrollment among the currently eligible population in addition to the newly eligible. Increased enrollment of currently eligible residents would increase states' financial exposure, as the states would receive their current federal matching rates for these individuals rather than the elevated matching rates which are dedicated to newly eligible individuals.

Factors Influencing State Medicaid Expansion Decisions

Undergoing Medicaid Expansion

- **Public Benefit:** Would largely reduce uninsured population among legal residents
- **Cost Shifting:** Over 90 percent of expanded Medicaid coverage paid for by federal government
- **Provider Pressure:** Pressure from providers seeking relief from uncompensated care and bad debt
- **Employer Pressure:** Pressure from employers of low-wage workers seeking to avoid cost of coverage

Declining Medicaid Expansion

- **Increased Long-Term Cost:** Financial burden of funding state's share of Medicaid expansion costs
- **Ideological Objections:** Political views that may influence Medicaid expansion decision
- **Financial Exposure from Currently Eligible but Not Enrolled Residents:** Concerns about Medicaid expansion capturing currently eligible but not enrolled residents for whom state would receive current, less generous federal matching rate

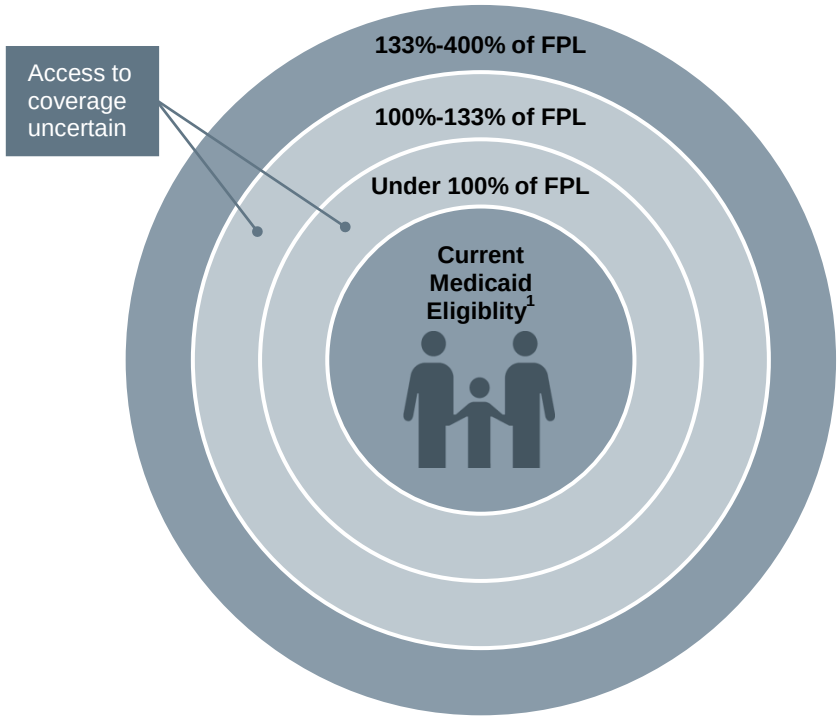
Beneficiaries (Potentially) Facing Another Doughnut Hole

If a state government decides to opt out of the voluntary Medicaid expansion, the decision would likely create a "doughnut hole" for health insurance beneficiaries based on income levels. Under this scenario, two segments of the state's population would have clear access to coverage: individuals currently eligible for Medicaid benefits and those with income between 133 and 400 percent of the FPL who will have access to the subsidized exchanges.

The fate of individuals with incomes above current Medicaid eligibility levels but below 133 percent of the FPL would be far less certain. The federal government has not indicated if states will have the option to enroll individuals and families between 100 and 133 percent of the FPL in state health insurance exchanges in lieu of the Medicaid expansion. In states where current Medicaid eligibility is less than 100 percent of the FPL, individuals with incomes above the Medicaid threshold but below 100 percent of the FPL face the most daunting scenario, gaining neither subsidies nor access to affordable health insurance.

Access to Health Insurance Coverage After Ruling

By Income Level



Four Key Questions

For individuals with incomes below 133 percent of the FPL:

- Are they subject to the mandate?
- Are they exempt from the penalties?
- Are they eligible for subsidies in the health insurance exchanges?
- Do they have access to employer-based coverage?

[1] Medicaid eligibility levels vary widely by state.

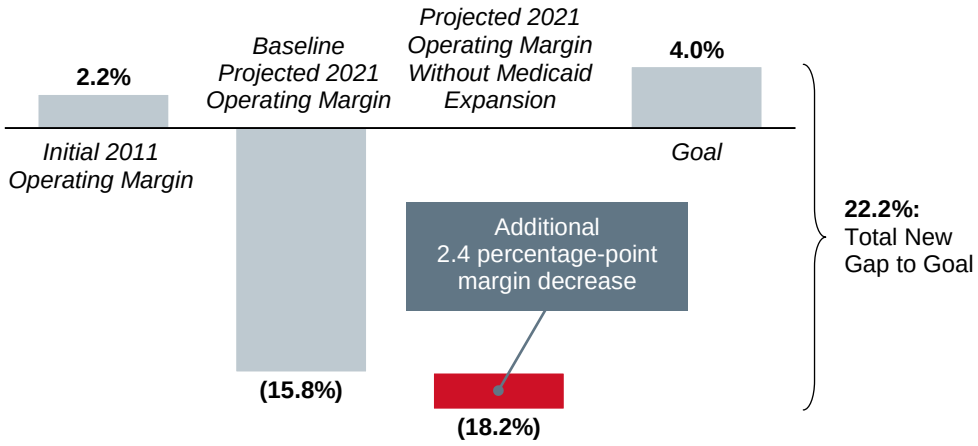
Forgoing Medicaid Expansion a Costly Proposition for Providers

Even before factoring in the impact of the Supreme Court ruling, providers face substantial margin sustainability challenges. The aging of the population remains the single biggest threat to hospitals' long-term financial stability. Across the next decade, Baby Boomers will transition from commercial insurance to the Medicare program at a rapid pace, resulting in a payer mix evermore weighted toward publicly insured patients. Medicare beneficiaries also tend to disproportionately use poorly reimbursed medical care, eroding hospitals' overall case mix. Further, providers can expect to see both slowing payment rate growth and escalating input costs. Left unfettered, these four forces—shifting payer mix, deteriorating case mix, decelerating price growth, and increasing input costs—will combine to devastate hospital margins across the coming decade.

Any state-level decision to forgo Medicaid expansion only exacerbates local hospitals' long-term margin sustainability challenge. According to the Health Care Advisory Board's Pleasantville Hospital model, the decision to forgo Medicaid expansion would directly result in an additional 2.4 percentage-point decrease in Pleasantville's 10-year margin projection—an amount larger than Pleasantville's entire margin in 2011. Regardless of ideology, providers have a significant financial stake in Medicaid expansion to reduce the burden of uncompensated care and partially offset the Medicare rate growth reductions included in the ACA.

Impact of Forgoing Medicaid Expansion at Pleasantville Hospital[2]

2011 - 2021



Case in Brief: Pleasantville Hospital

- Health Care Advisory Board model hospital designed to project 10-year margins
- Revenue, cost, and operational inputs based on national averages
- Inputs adjusted to forecast impact on future financial performance
- Offers insight into relative opportunity of pulling various margin improvement levers

[2] The Pleasantville Hospital model is designed to project the potential impact of demographic, pricing, cost, and case mix changes on an average hospital's operating margin. The model is intended to illuminate the potential results of unchecked market forces and should not be considered a prediction of future margins.

Health Care Advisory Board Resources

Supreme Court Ruling Margin Impact Analysis

Assessing the Impact of the Supreme Court Ruling on Your Institution

Now that the Supreme Court has released its ruling on the constitutionality of the ACA, providers across the country are weighing the ruling's impact on operations and future strategy. The Supreme Court Ruling Margin Impact Analysis tool enables organizations to evaluate how potential state Medicaid expansion decisions—along with the economic forces of price deceleration, cost growth, and shifts in payer and case mix—are likely to affect future profitability. Combining market projections, Advisory Board forecasts, and user inputs, this tool calculates institution-specific estimates of future payer mix, case mix, volumes, and margins both with and without Medicaid expansion.

Learn more and access the tool at **advisory.com/SCOTUSMarginAnalysis**.

The Medicare Breakeven Project

Advancing Toward Long-Term Margin Sustainability

The Medicare Breakeven Project is a peer working group for providers looking to strengthen margins in the face of demographic, pricing, cost, and case mix pressures. Supported by senior Advisory Board staff, the Project offers ongoing guidance to hospitals and health systems preparing for the challenges of a market characterized by ever-greater reliance on publicly insured volumes. The Project offers a suite of best practice research, webconferences, and ongoing analysis through *The Medicare Breakeven Blog*.

Join the Project, access resources, and read the Project blog at **advisory.com/MedicareBreakeven**.

The Medicare Payment Innovation Project

Navigating the Transition to Accountable Care

The Medicare Payment Innovation Project is an ongoing initiative to study provider payment innovation and support providers preparing for, or participating in, Medicare's accountable care programs. Led by senior Advisory Board staff, the Project's research focuses on the details and strategic implications of emerging payment methodologies, especially bundled payments and shared savings/ACO models. Project participants gain priority access to new Advisory Board resources, enjoy special webconferences and networking opportunities, and remain current on major developments through the Project's *Toward Accountable Payment* blog.

Join the Project, access resources, and read the Project blog at **advisory.com/hcab/PaymentInnovation**.

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