In July 2012, the Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act (PPACA). The Court thus ended one phase in the political and legal battle over health reform. Yet in doing so, it opened a new front. In a notable departure from post–New Deal commerce clause jurisprudence, the Court ruled that the federal government could not require states that receive federal funds under the Medicaid program to participate in the PPACA’s Medicaid expansion. In effect, the Court made states’ participation in the PPACA’s Medicaid expansion voluntary—a possibility that neither the act’s supporters nor its opponents seriously entertained during the long legislative battle of 2009 and 2010.

The full implications of these changes in federal-state relations remain to be seen. For states, the ruling brings both new flexibility and new accountability. Conservative legislators who have traditionally railed against Medicaid while accepting large subsidies will now have to actively accept or reject billions of dollars in federal resources made possible through this program. For the federal government, the ruling brings new uncertainties and complication, as states decide whether and when to participate in the PPACA’s Medicaid expansion. For millions of citizens, this decision likely delays the path to near-universal coverage envisioned under the new law.

This issue’s Point-Counterpoint essays underscore the difference in perspective among informed participants regarding what may be the most complex and contested measure in the history of American social policy.
Austin Frakt and Aaron Carroll note that states have powerful reasons to participate in the PPACA's Medicaid expansion. Under current law, the federal government will initially finance 100 percent of the costs of coverage for newly eligible Medicaid recipients. That federal support will taper off to 90 percent by 2020 and in subsequent years. This is still a tremendous fiscal opportunity for states, localities, safety-net providers, and for an estimated sixteen million otherwise-uninsured individuals who would be covered by Medicaid under the new law. Frakt and Carroll emphasize recent findings that the public health impact of the PPACA's Medicaid expansion could be substantial.

As a matter of policy substance, then, Frakt and Carroll make a strong case that states should—and eventually will—participate in the PPACA's Medicaid expansion. Their arguments bear similarity to the early days of Medicare and Medicaid, in which providers and conservative state governments bitterly opposed key aspects of these programs, yet eventually found the financial inducements too lucrative to pass up.

In the counterpoint, Joseph Antos offers several critiques of Frakt and Carroll's analysis. He notes important shortcomings in Medicaid, such as limited provider payment and associated patient access barriers.

To my eye, Antos's most intriguing comments concern the complicated strategic choices states will now face regarding the new law. States have strong incentives to at least delay implementation until after the 2012 election. If Governor Romney wins, the PPACA will be drastically altered. If President Obama is reelected, the Supreme Court decision may still provide states with new leverage to strike better deals with the federal government.

Whereas Frakt and Carroll emphasize the generous financial terms states are slated to receive, Antos notes that future congresses and presidential administrations might shift greater burdens on states. States already face significant fiscal challenges arising from Medicaid and public employee retirement benefits. Governors may regard the PPACA as creating other immediate—if admittedly limited—costs and long-term fiscal risks.

More to the point, states may have new opportunities for bargaining or for modified Medicaid policies that were not envisioned by the framers of health reform. For example, states might expand Medicaid to 100 percent (rather than 133 percent) of the federal poverty line and then seek to enroll eligible individuals and families above this income threshold into the new health insurance exchanges. This policy would reduce state Medicaid enrollment and would require low-income individuals to pay
(modest) premiums for an exchange plan. Although such a policy would increase federal expenditures, along with increased out-of-pocket costs for near-poor households, it potentially offers certain advantages, too. If provider reimbursement rates prove higher within the new exchanges than in Medicaid, patients may have access to a broader set of specialty services.

The current moment—I write this on August 1, 2012—encourages observers of health policy to view state-federal burden-sharing through a partisan-political lens. The PPACA is most emphatically resisted by conservative Republican governors. Yet in the long run, efforts by states to shift burdens onto the federal government could serve liberal ends, as well. Meanwhile, proposed federal policy changes such as the bloc granting of Medicaid embraced by opponents of the new law are likely to impose major costs and risks on states and local government.

Individuals and families with incomes below the poverty line may be well served by Medicaid, which is linked to important social services and which is specifically designed for people with little or no financial resources. Private plans available to low-income people often display shortcomings commonly associated with Medicaid. It remains unclear that health insurance exchanges would serve this population well. Yet the situation may be different for families with slightly higher incomes. Many health reform advocates would welcome greater participation among near-poor recipients in health insurance exchanges. The politics of federal budget policy constrained these possibilities.

By weakening federal power to compel states through Medicaid, a surprise Supreme Court ruling further complicates and delays an already-troubled implementation of health reform. Yet the decision may also open new channels of federal financing and ultimate influence unforeseen during the long legislative debate that resulted in health reform.