

Federalism, the Affordable Care Act, and Health Reform in the 2020 Election

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ABSTRACT

ISSUE: Under the U.S. federalist system, governing responsibility is allocated between the federal and state governments. The Affordable Care Act (ACA), which expanded Americans' coverage options, among other health system changes, reflects this structure. While the federal government provides most of the financing for subsidized coverage and sets a federal floor for insurance market regulations, states have flexibility to implement the law. Current health reform proposals from the political right aim to give greater responsibility to states; proposals from the left expand the federal role.

GOALS: To review the federal–state governance balance regarding health care, assess how Republican and Democratic proposals might alter that balance, and assess the potential impact on insurance coverage and access to care.

METHODS: Evaluation of federal and state governing responsibilities under the ACA and in emerging reform proposals, along with assessment of regional differences in coverage and access using state-level federal data.

KEY FINDINGS AND CONCLUSIONS: The ACA's blend of federal standards and subsidies combined with state regulatory authority significantly improved coverage and access nationally and narrowed regional differences. However, the law's federalist structure, established in statute and altered through regulations and court decisions, resulted in disparities in coverage and access across states. These differences would likely widen under proposals that expand state authority and narrow under those that reduce it.

TOPLINES

- ▶ States' flexibility in how they implement the Affordable Care Act has resulted in pronounced geographic variations in health insurance coverage and access to care.
- ▶ Republican health reform proposals would give greater responsibility to states, while proposals from Democrats would expand the federal government's role.



BACKGROUND

The U.S. health system is characterized by considerable geographic variation in insurance coverage, access to care, health status, quality of care, and cost of care. As shown in Exhibit 1, 2017 uninsured rates among nonelderly adults with incomes below 200 percent of the federal poverty level (FPL) varied sixfold across states (from 7% in Massachusetts and Vermont to 43% in Texas).¹ Of the eight states with uninsured rates of 30 percent or higher in this income group, seven are in the South.²

Cost-related access problems closely track regional uninsured rates (Exhibit 2). All but two of the seven states where a third or more of adults with low incomes reported forgoing care because of cost are in the South.³

Geographic variation on health indicators also occurs at the substate level — the county and metropolitan statistical area (MSA) level, even within the same states.⁴ These regional disparities mean that parts of the United States lag even further behind other economically advanced countries than national averages suggest.⁵ This

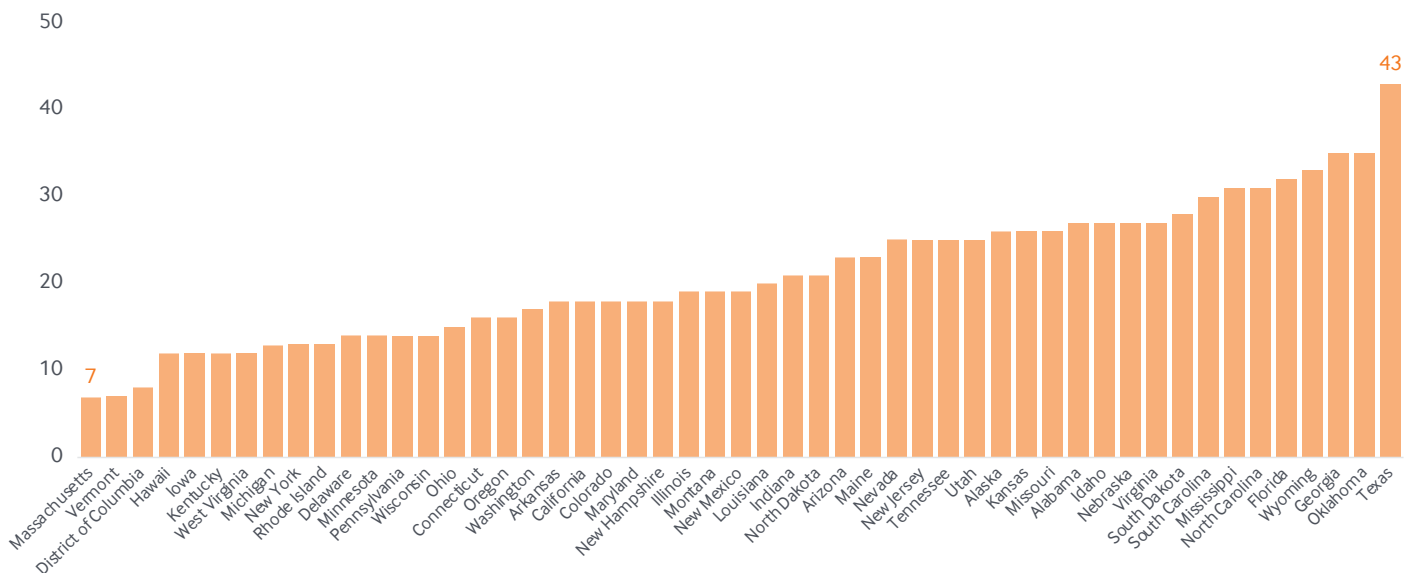
matters not only for people living in low-performing regions but also for the U.S. economy more broadly. Such divisions will, ultimately, undermine the nation's long-term economic growth potential.

The Affordable Care Act (ACA) both reduced the nation's uninsured rate and narrowed the geographic variation in health insurance coverage. An estimated 20 million people gained coverage, and the difference in the adult uninsured rates between the highest and lowest states (Texas and Massachusetts) narrowed by 5 percentage points.⁶ Improvements in coverage stemmed from both from the law's federal regulations and subsidies and the flexibility granted to states in implementing the law.

California provides one example of state-influenced improvements. California expanded eligibility for Medicaid, established its own marketplace, and adopted state-specific policies and operational approaches. By 2017, California had reduced its uninsured rate by 14 percentage points — more than may have occurred had the state just used the federal marketplace platform.

Exhibit 1. In 2017, uninsured rates among nonelderly adults with incomes below 200 percent of the federal poverty level varied sixfold across states, from 7 percent to 43 percent.

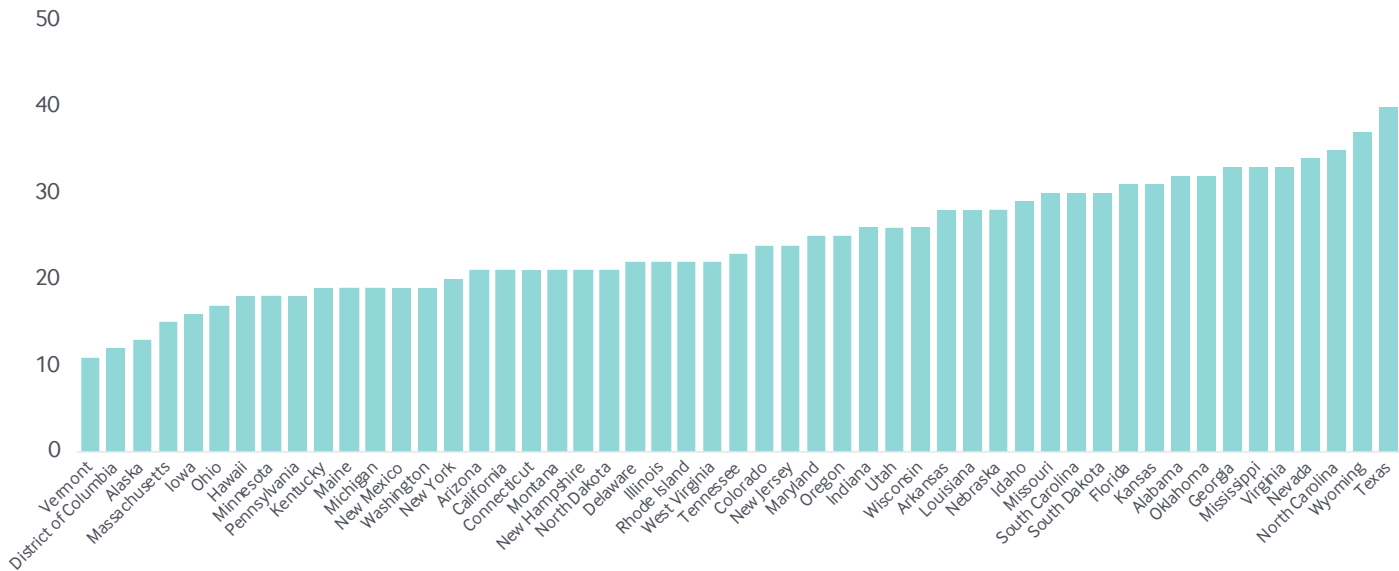
*Percentage of uninsured adults ages 19–64 with incomes below 200 percent of federal poverty level**



* In 2017, income of less than \$24,120 for a single person was below 200 percent of the federal poverty level. Data: U.S. Census Bureau, 2017 1-Year American Community Survey, Public Use Microdata Sample (PUMS).

Exhibit 2. In 2017, the states with the highest rates of forgone health care because of cost among nonelderly adults were concentrated in the South.

Percentage of adults ages 18–64 with incomes below 200 percent of the federal poverty level who went without care because of cost*



* In 2017, income of less than \$24,120 for a single person was below 200 percent of the federal poverty level.
Data: Behavioral Risk Factor Surveillance System (BRFSS), 2017.

At the same time, the ACA's uniform federal policies also meant that people living in states that did not set up their own marketplaces or expand Medicaid, like Mississippi, also made gains. The law improved performance and reduced state differences on indicators most directly linked to coverage, such as access to care and consumer financial problems stemming from uncovered health care encounters.⁷

However, state discretion on key aspects of coverage expansion also limited the extent to which regional differences narrowed and tempered national gains. State decisions not to expand Medicaid has left more than 2 million people without coverage in 2019.⁸ Negative downstream effects were also triggered in states that didn't expand Medicaid, including higher marketplace premiums, which affect people with incomes above the premium subsidy threshold.⁹ Rural hospital closures have also been higher in states that did not expand Medicaid.¹⁰ Research has also shown that states that made aggressive efforts to inform and enroll eligible people in Medicaid and marketplace coverage had higher enrollment.¹¹

The debate over whether federal or state governments can make needed improvements in coverage and access and reduce regional disparities in health system outcomes will be prominent in the 2020 presidential campaign.¹² Coverage gains resulting from the ACA have stalled since 2015 and are reversing in some states.¹³ An estimated 44 million people now have health plans that leave them underinsured, with cost protections deteriorating fastest in employer plans, the source of coverage for the majority of Americans (which was least affected by the ACA).¹⁴ With health care costs outpacing growth in median incomes nationally, it's not surprising that recent polls show the cost of health care to be a top concern of voters.¹⁵

Leading Republican and Democratic health reform proposals to address these interrelated problems differ, in part, over the relative emphasis they give to federal versus state government authority.¹⁶ In this report, we assess the balance of federal and state governance over health care in these proposals and discuss how that balance might affect key indicators of insurance coverage and access.

U.S. FEDERALISM AND THE ACA

U.S. federalism, or the allocation of governing responsibility between federal and state governments, has evolved and changed over the course of U.S. history. States had significantly greater autonomy in governance prior to the 1930s.¹⁷ After the Great Depression, the federal government assumed greater responsibility, perhaps because of a recognition that poor conditions in one state can affect the country's overall growth and the need to ensure the rights of African Americans and other minorities who had suffered devastating discrimination and terror across the South and Great Plains. In health care, the federal government's increasing role was most significantly manifested in the creation of Medicare and Medicaid in 1965.

By the 1970s, there was a backlash to federal decision-making, and a new form of federalism emerged that emphasizes a greater role for states in policy.¹⁸ For example, after the failure of comprehensive health reform in 1994, Congress created the state-based Children's Health Insurance Program in 1997. Abbe Gluck describes this new federalism approach as "national federalism": the allocation of implementation authority to states from federal statutes.¹⁹

The ACA built on this tradition, granting states a significant role in implementing the law's coverage expansion, subject to a strong federal floor (see box).

States' role in implementing the ACA has increased even further under various regulations, guidance, and court decisions:

- The Obama administration, through executive actions, gave states choices, such as defining the essential health benefit package within federal parameters and allowing the renewal of plans that do not comply with all ACA insurance reforms.
- In 2012, the Supreme Court's decision in *NFIB v. Sebelius* made optional the requirement that states extend Medicaid to all adults with incomes below 138 percent of FPL.
- Beginning in 2017, Congress and the Trump administration reduced the federal government's role in setting standards and operations; for example, they reduced efforts to encourage people to enroll, including zeroing out the tax penalty for not having coverage.
- The Trump administration has let states have even more flexibility in designing the essential health benefit package and alternatives to the ACA under the 1332 waiver program.²¹
- The Trump administration loosened restrictions on non-ACA-compliant plans.
- In Medicaid, the Trump administration has encouraged states to use the section 1115 waiver program to test work requirements and other policies not previously approved.

Federal Rules and State Authorities Under the ACA

The federal government provides:

- Protections for people with preexisting health conditions
- Uniform financial assistance for people with incomes below 400 percent of the federal poverty level
- Individual and employer mandates to ensure people gain and keep coverage.

States have authority to:

- Oversee their individual, small-, and large-group insurance markets

- Manage their Medicaid program
- Run their own insurance marketplace
- Create a Basic Health Plan for people earning between 138 percent and 200 percent of FPL
- Set up risk adjustment and rate review programs
- Make significant changes to their individual markets (through a Section 1332 state innovation waiver) so long as the coverage offered is affordable, comprehensive, and available to the same number of people as under current law (without raising federal costs).²⁰

States have responded to these options and actions in different ways:

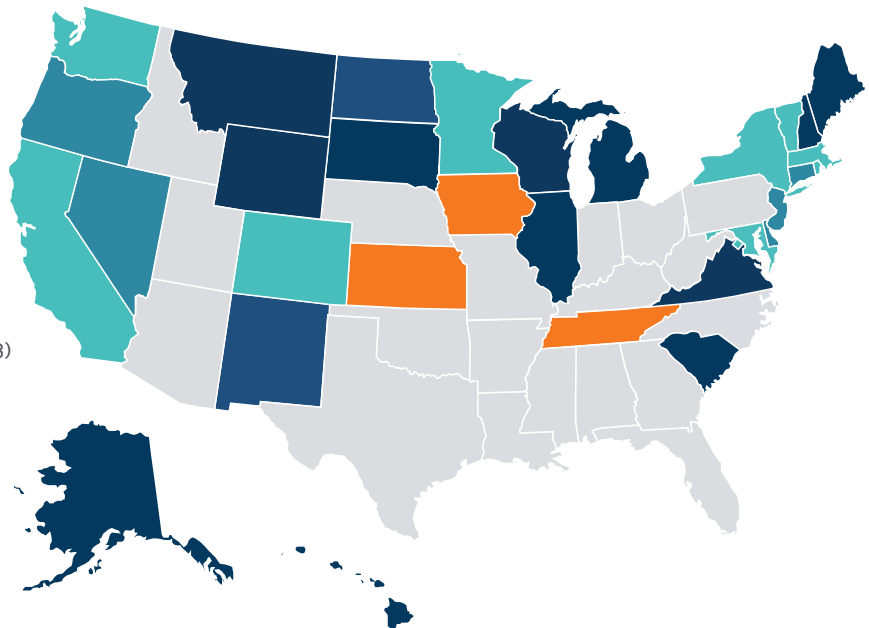
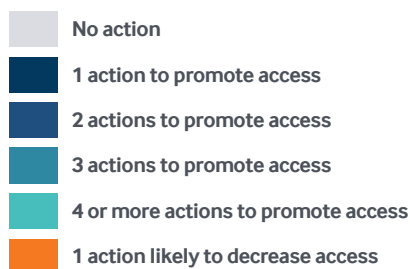
- Twelve states fully run their own marketplaces and another five have their own marketplaces but use the federal website to enroll people;²² evidence suggests that enrollment and issuer participation are higher and premiums are lower in such states compared to states that use the federal government's marketplace.²³
- In the individual market, 27 states have taken regulatory actions aimed at stabilizing and improving their markets, some of which predate the Trump administration, including establishing a reinsurance program and banning or placing limits on non-ACA-compliant policies (Exhibit 3).
- Three states have exempted health plans sold by the state farm bureau from the ACA's consumer protections, an approach consistent with the Trump administration's goals of loosening regulations.
- In Medicaid, 33 states and the District of Columbia have adopted the ACA expansion. Voters in three states approved ballot initiatives to expand Medicaid in the 2018 midterm elections, but those states have yet to expand (Exhibit 4).

From a geographic variation perspective, what is notable is the concentration of states along the coasts and in the Upper Midwest that have sought to increase coverage and access. On Medicaid expansion, Deep South states stand out as doing the least to expand coverage options. This, in part, reflects politics: these states have had Republican legislatures or governors that opposed implementing the ACA. However, this partisan opposition to the law stands in contrast to a traditional conservative preference for state rather than federal government control of public policy. It also may reflect other factors, such as differences in the size and structure of state governments, historical state coverage policy, local public opinion, stakeholder engagement, concerns over long-term costs to the state, and leadership.²⁴

Exhibit 3. State Action on Their Individual Markets

Type of action (number of states):

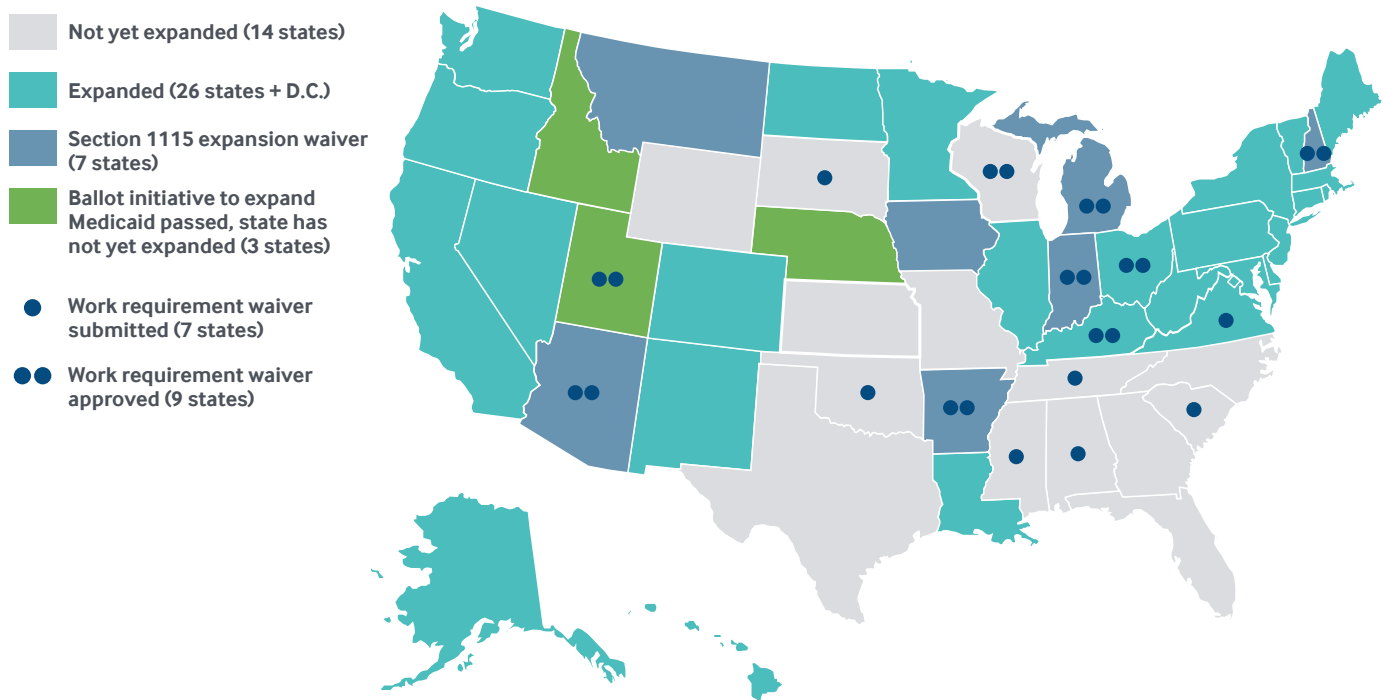
1. Reinsurance (7)
2. Individual mandate requiring health coverage (5 + D.C.)
3. Health coverage subsidies (3)
4. Short-term health plan regulation (23 + D.C.)
5. Annual open enrollment period extensions (7 + D.C.)
6. Promotion of ACA marketplace competition (6 + D.C.)
7. Prohibition of noncompliant transitional health plans (14 + D.C.)
8. Exemption of farm bureau plans from insurance rules (3)
9. Public plan option (1)



Note: Extension of open enrollment is for 2019 coverage.

Data: Commonwealth Fund, "What Is Your State Doing to Affect Access to Adequate Health Insurance?" (Commonwealth Fund, last updated July 2019).

Exhibit 4. Status of Medicaid Expansion Across the States



Note: Adults in Wisconsin are eligible for Medicaid up to 100 percent of the federal poverty level.

Data: Commonwealth Fund, "Status of Medicaid Expansion and Work Requirement Waivers," (Commonwealth Fund, last updated July 2019).

HEALTH REFORM APPROACHES: FROM GREATER STATE AUTHORITY TO GREATER FEDERAL AUTHORITY

In the past year, several Democratic members of Congress introduced significant health reform bills. Republicans' last major health reform proposal was the final repeal-and-replace bill introduced by Senators Graham and Cassidy in September 2017. As illustrated in Exhibit 5, these bills can be placed on a continuum of governmental authority. On the left are those bills that give the federal government greater authority. On the right are those bills that allocate more authority to the states.

Republicans: State Innovation Approaches

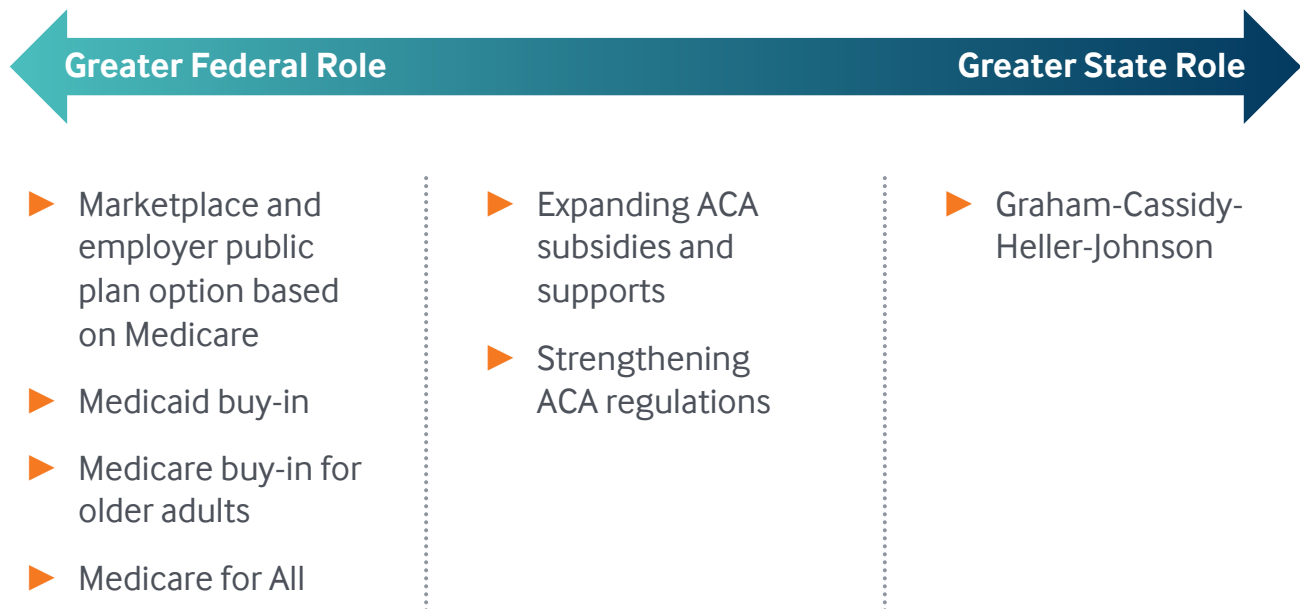
The Graham, Cassidy, Heller, and Johnson (GCHJ) amendment, named for the Republican senators that sponsored it, was the last of the 2017 ACA repeal-and-replace bills. It has been embraced by President Trump and could be adopted in the 2020 Republican platform.²⁵ GCHJ repeals the ACA marketplace subsidies

and Medicaid expansion funding and replaces them with block grants that states can use for a wide range of purposes. It also places per capita spending limits on the traditional Medicaid program.

GCHJ would significantly reduce and reallocate federal funding. The Congressional Budget Office (CBO) estimated that it would reduce net federal subsidies for health insurance by at least \$133 billion over 10 years and shift funding away from states that expanded Medicaid eligibility toward those that did not.²⁶ It also would allow states discretion in setting rules for their individual market, consistent with similar block-grant proposals that trade reduced federal funding for increased state control over insurance markets and programs.

GCHJ would give states extraordinary flexibility in the use of federal funds. States could use the block grant funding to expand coverage, pay providers, or lower premiums and consumer out-of-pocket costs in the individual market. However, as the CBO notes in its analysis of the bill, states also could use these funds to patch holes in

Exhibit 5. Health Reform Approaches Left to Right



state budgets or finance uncompensated care. In addition, unlike most federal grants, the GCHJ block grants wouldn't require states to maintain funding for their existing Medicaid programs or CHIP, in similar areas (i.e., so-called maintenance-of-effort requirements). The only restriction is that states must use half of the funds for assistance for people with incomes between 50 percent and 300 percent of poverty.

The lower funding level would constrain states' choices. Most states with Medicaid expansions would likely find it challenging, for example, to maintain coverage with less funding. Likewise, fewer federal funds would make it difficult for states to sustain the preexisting condition protections in the individual market. This is because without sufficient premium tax credits, young people and individuals in good health might drop out of the market. To prevent a so-called death spiral, states might allow insurers to rate based on health, undermining protections for people with preexisting conditions.

Despite this shift toward state control, Republicans would preserve a federal role in significant parts of the health system. GCHJ would not change the federally run Medicare program for seniors and certain people with disabilities. Nor would it modify federal rules and

tax breaks for employer-based coverage except for its expansion of federally defined health savings accounts. In 2018, the tax exclusion for employer benefits amounted to \$280 billion, the largest single federal tax expenditure.²⁷

Democrats: Public Plan Expansions

There are considerably more Democratic proposals that aim to expand coverage, improve affordability, and/or lower the rate of health care cost growth.²⁸ Several bills, such as those introduced by Sen. Elizabeth Warren and Rep. Frank Pallone, would add more federal financing and authority to the ACA's coverage provisions, including enhanced subsidies and market regulations.

Others introduce public insurance plan options based on Medicare, which range in scope from plans that would only be available to people with limited coverage options in state marketplaces (such as the bill sponsored by Sens. Michael Bennet and Tim Kaine) to expanding the public option to employers and employees. Medicare buy-in bills would offer public insurance plans based on Medicare through the marketplaces to people age 50 and older (Sen. Debbie Stabenow and Rep. Brian Higgins) and state options to expand Medicaid to people buying coverage on their own (Sen. Brian Schatz).

Most Medicare for All proposals, including those sponsored by Sen. Bernie Sanders, Rep. Pramila Jayapal, and Rep. Keith Ellison, would make a single public plan the sole source of major medical coverage. However, Rep. Rosa DeLauro's bill would preserve a highly regulated role for employer coverage.

These proposals would generally expand the federal role in the health system in one of two ways:

- by adding more federal standards and subsidies to private plans
- by offering a federally run public plan alongside or instead of private insurance plans.

Raising federal minimum standards for insurance markets and increasing subsidies, as the Warren and Pallone bills propose, builds on the ACA framework. Doing so would limit some of the flexibility states are given under the ACA (e.g., by tightening network adequacy and rate review rules) and leverage other federal programs like Medicare Advantage and Medicaid managed care to ensure a choice of insurers in the individual market. Other proposals would inject Medicare payment rates into private plans in certain circumstances. For instance, a bill proposed by Sen. Jeanne Shaheen limits costs for out-of-network health care. These proposals would shrink the role of states relative to the ACA.

Alternatively, bills that would give people a choice of a public plan or insure everyone through a single public plan would use a government-managed health plan to improve access to and affordability of insurance. Generally, eligibility rules would be set for the nation. The Medicare for All proposals would introduce uniform, Medicare-like benefits and pay providers at Medicare rates. The public-plan options would allow geographic adjustment of features, such as premiums and benefits to place the public plan on a level playing field with state-regulated private plans. The proposals that give people a choice of a public plan aim to address local disparities in the number of plan choices by offering people a federally defined alternative to private plans that would either fill a local gap or incent local private plans to become more

affordable as they compete for enrollees. They also seek to lower payments to providers, one of the key drivers of health care spending in private insurance markets.²⁹

In general, these public plan proposals would vest authority in the federal government, but they could give states decision-making authority. The version of the ACA that the Senate brought to the floor in November 2009 would have allowed states to opt out of having a public plan offered to their residents.³⁰ The Medicaid buy-in proposal, as proposed in the Schatz bill, would be purely at states' discretion, subject to federal rules and accompanied by federal funding. While a state interested in a Medicaid buy-in could theoretically implement it under GCHJ, the fixed (and likely limited) amount of federal funding might make it a practical impossibility.

The Medicare for All proposals would eliminate state-run and state-regulated health plans. Two House versions of Medicare for All would create regional and state budgets for hospitals and other institutional providers, along with regional directors. The shift in responsibility for health insurance coverage from the states to the federal government is demonstrated vividly in the shift in financing of health care spending. While overall health care spending is estimated to either fall or increase by less than the overall rise in demand from insuring everyone with no cost-sharing, the responsibility for paying for health care moves from states, employers, and households to the federal government.³¹ Liu and Eibner estimate that a Medicare for All approach if implemented in 2019 would reduce employer and household spending by about \$1.7 trillion, lower state health care expenditures by \$638 billion, and increase federal spending by \$2.4 trillion.³²

HOW MORE AND LESS FEDERALISM AFFECTS REGIONAL DIFFERENCES IN COVERAGE AND ACCESS

How would different degrees of state versus federal authority, which characterize these conservative and progressive reform approaches, reduce differences in insurance coverage and access to care?

GCHJ. The approach represented by the Graham, Cassidy, Heller, and Johnson Senate amendment would likely lower overall insurance coverage nationwide by reducing federal financing and allowing funding to be used for noncoverage purposes. An estimated 21 million Americans could lose coverage.³³

States could use their block grant to target geographic areas with the greatest coverage and access issues. However, given the fixed (and, in most states, reduced) funding available under GCHJ, this approach would reduce coverage in other parts of the state. Assuming that past is prologue, many states along the coasts and in the Upper Midwest (as shown in Exhibits 3 and 4) would respond to the enhanced flexibility in GCHJ by maximizing coverage subject to resource limits. States in the South and Central Midwest, meanwhile, might be expected to loosen insurance market regulations and use some block-grant funds for purposes other than coverage expansion.

Republicans could modify GCHJ to ensure that states use greater amounts of funds for coverage or provide the same level of current federal funding (with no federal savings). Both modifications would improve coverage-related outcomes relative to the GCHJ legislation in some states.³⁴ However, block-grant funding is, by design, preset by a formula; it lacks automatic adjustments for local cost trends, the demographic makeup of states, and unexpected events like hurricanes or disease outbreaks, which may leave states with insufficient funding to continue current programs.³⁵ Such adjustments could be built into the formula.

Building on the ACA. The bills that seek to build on the ACA would preserve the current division of authority between federal and state government, but the different goals and details of each bill would impact the legislation's potential for increasing coverage nationally and reducing state variation on coverage and access measures. For instance, adding a public plan option to the marketplaces might improve the affordability of plans for people without subsidies and ensure markets have at least one insurer. But its primary effect on coverage would come from having a reduced-cost and potentially more trusted health plan. By itself, such an approach may not have the same coverage impact as increasing subsidies,

closing the Medicaid gap, or reinstating the tax penalty for not having health insurance.

Medicare for All. At the other end of the federalism spectrum, a Medicare for All approach, which would leave virtually no discretion to states, would be expected to increase coverage nationally and significantly reduce state variation in coverage and access. Given its near-automatic enrollment of all residents, it would go the farthest in moving states like Texas closer to the front of the pack.

However, its uniform approach might not eliminate regional differences in access to care, which persist under Medicare.³⁶ Additionally, it would stifle innovation in states like California, which have been performance leaders in marketplace and Medicaid expansion implementation.

CONCLUSION

The ACA and related regulations and court decisions have given states considerable flexibility in how they implement the federal law. This has resulted in geographic variation on key performance indicators related to insurance coverage and access to care.

Several states have emerged as performance leaders, creating innovative approaches to their marketplaces, investing in enrollment outreach and education, and smoothing enrollment and reenrollment in state Medicaid programs. Other states have achieved fewer gains in coverage because they did not expand Medicaid or undertake aggressive efforts to inform and enroll people who are eligible for marketplace coverage. As such, expanding state control of the health system may enable deregulation or advance other goals, but will likely do little to reduce geographic disparities in access and coverage.

More broadly, policy decisions about the allocation of state versus federal governing responsibility in health care have implications for the relative performance of states as well as the overall health of the U.S. population. Since human capital is key to the nation's long-term economic growth — and health is a critical component of human capital — declining health status in any state can have national implications for the ability of the U.S. workforce to rise to the challenges of an evolving global economy.³⁷

NOTES

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Editorial support was provided by Maggie Van Dyke.

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