alert Health Practice
Updates on Affordable Care Act
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# The Supreme Court Ruled on Health Reform – What's Next for Medicaid and Medicare Managed Care Plans

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**SUMMARY**

**The Affordable Care Act will present significant challenges and opportunities for Medicaid and Medicare managed care organizations.**

The Affordable Care Act ("ACA") is the single biggest overhaul of the United States health care delivery system since the 1965 Amendments to the Social Security Act that created the Medicare and Medicaid programs. The Supreme Court's historic ruling in ***National Federation of Independent Business et al. v. Sebelius*** strikes the penalty imposed by ACA on states that fail to expand their Medicaid programs to cover adults whose incomes are up to 133 percent of the poverty level and upholds the remaining provisions of ACA. These developments present significant challenges and opportunities for Medicaid and Medicare managed care organizations.

## Medicaid Expansion

ACA requires each state, beginning in 2014, to expand its Medicaid program to cover adults under the age of 65 with incomes up to 133 percent of the federal poverty level, who were previously ineligible for Medicaid, and penalizes states that do not comply with the loss of all federal matching dollars for the state's Medicaid program. Under ACA, a state that complies with the Medicaid expansion requirement will have 100 percent of the cost of its Medicaid expansion covered by the federal government through 2016, thereafter phasing down to 90 percent of its costs in 2020.

The Supreme Court's decision holds that the penalty imposed on a state for failure to expand its Medicaid program to cover adults with incomes up to 133 percent of the poverty level violates the Spending Clause of the United States Constitution. As a result, states that choose not to expand their Medicaid programs will no longer risk losing all federal Medicaid funds.

To date, fifteen governors have announced that they will opt out of ACA's Medicaid expansion requirement while governors of other states remain undecided. In response, the Centers for Medicare and Medicaid Services ("CMS") has stated that there is no deadline for states to make a decision and the Obama Administration has taken the position that low income individuals in states that opt out of Medicaid expansion will not be at risk for incurring federal penalties. Whether states decide to comply with ACA's Medicaid expansion requirement is expected to have an impact on the state's Medicaid managed care organizations from the standpoint of enrollment, reimbursement and accessibility of health providers.

## Medicare and Medicaid Dual Eligibles

Still alive are provisions of ACA which empower the Secretary of Health and Human Services to establish demonstration projects and innovative programs to cut costs while preserving or enhancing the quality of care delivered to Medicare and Medicare beneficiaries. For example, one demonstration project enables states to assign individuals eligible for Medicare and Medicaid ("Dual Eligible Individuals") to health plans in order to test two types of integrated care programs: a capitated model and managed fee-for-service model. According to CMS, twenty six states applied to be part of the demonstration project and fifteen states were awarded $1 million grants to design managed care initiatives to eliminate duplication of services and improve the quality of care for Dual Eligible Individuals while lowering costs. This pilot project is expected to result in better care coordination and a reduction in Medicare costs.

## Medicare Advantage and Prescription Drug Plans

A few examples of provisions of ACA that present opportunities for Medicare Advantage ("MA") Plans and Prescription Drug Plans ("PDP") are (i) the expansion of the Annual Enrollment Period ("AEP") and (ii) the payment of bonuses to MA Plans based upon a quality rating system. Beginning with enrollment for the 2012 plan year, the AEP for MA and PDP Plans was changed from beginning on November 15 and ending on December 31 to beginning on October 15 and ending on December 7. The extra week gives Medicare beneficiaries more time to review their options and change plans, and gives MA and PDP plans time to process enrollment paperwork prior to the beginning of the new plan year.

The quality rating system is not new to MA Plans. MA plans are rated on a scale of 1 to 5 stars with 5 stars representing the highest rating for excellent performance. Commencing on December 8, 2011, ACA allows Medicare beneficiaries to switch to a 5 star geographically available MA Plan at any time during the year, provided that this special enrollment option is only used one time per year. Beginning in 2012, ACA also provides for bonus payments to qualifying MA Plans and plans that were not rated because they had too few enrollees or were too new. Qualifying MA Plans are plans that receive 4 or more stars based upon measures such as preventive care, managing chronic conditions, health plan responsiveness and care and customer service.

Saul Ewing can assist Medicare and Medicaid managed care organizations (i) keep apprised of state and federal health reform developments, (ii) comply with the multitude of regulations that have been issued pursuant to ACA, (iii) and take advantage of the opportunities presented by health reform.

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