MACPAC

Medicaid 101

Medicaid and CHIP Payment and Access Commission

Anne L. Schwartz, PhD

Executive Director

March 6, 2020

What is MACPAC?

- Non-partisan (as opposed to bipartisan)
- Provide analyses and advice to Congress and HHS on Medicaid and CHIP policy issues
  - Report annually on March 15 and June 15
  - Provide technical assistance to Congress
  - Serve as an information resource to the broader health policy community
- 17 commissioners appointed by GAO to three-year terms
  - Meet 6–8 times per year in public
  - Permanent staff of 30 based in DC

Medicaid according to the experts

- "among the most intricate ever drafted by Congress"
- "byzantine construction"
- "virtually impenetrable thicket of legalese and gobbledygook"
- "an aggravated assault on the English language, resistant to attempts to understand it"

The basics

- 96.1 million people
- 17.2 percent of national health expenditures
- 9.5 percent of federal budget; 16 percent of state budgets
- Pays for:
  - 42 percent of all births
  - 26 percent of spending on mental health, substance use disorder (SUD) treatment
  - 61 percent of spending on long-term services and supports (LTSS)

Program design

- Entitlement to individuals (some federally mandated, others at state option)
- Entitlement to states (based on spending for covered services for covered individuals)
- States run day-to-day operations and make policy decisions within federal parameters
- Administered at federal level by Centers for Medicare & Medicaid Services (CMS)

Split of responsibilities

Federal

- Mandatory populations
- Mandatory benefits
- Provide matching funds
- Approve state plan amendments, waivers of federal rules
- Oversight

State

- Optional populations
- Optional benefits
- Raise non-federal share of funds (at least 40% from state)
- Design of delivery system
- Payment methods and rates

Variat trans provinciarium

Populations covered

- Children
- Pregnant women
- Parents and caretakers
- People with disabilities
- Elderly
- New adult group

More than medical Insurance

- EPSDT
- Non-emergency medical transportation
- Wraps around Medicare and employer-sponsored coverage
- Long-term services and supports
  - Nursing facility services
  - Home- and community-based services

Financing

- Shared federal-state responsibility
- State spending on allowable expenses is matched by federal government so that states with lower capita income get higher match
- Federal medical assistance percentage (FMAP) for services ranges from 50 percent to 77 percent
- Administration matched at 50 percent; special FMAPs for certain activities, populations

Delivery system

- Managed care is primary delivery system for acute care
  - About 2/3 of beneficiaries; about half of benefit spending
  - Growing use for long-term services and supports
- Reasons for using managed care
  - Predictability for future costs
  - Improved potential for care management and coordination, accountability for outcomes
  - Evidence on cost savings is mixed

Payment

- States set payment rates consistent with efficiency, economy, access, and quality
- Managed care rates must be actuarially sound
- Statutory rebates for prescription drugs
- Specific rules apply to:
  - Disproportionate share hospital (DSH) payments
  - Upper payment limit (UPL) supplemental payments
  - Federally qualified health centers

Waivers

- Refers to CMS action to waive federal rules; different parameters in statute and regulation
- Examples include:
  - 1915(b) freedom of choice
  - 1915 (c) home- and community-based services
  - Family planning
- Section 1115 demonstration waivers:
  - Budget neutrality
  - Transparency
  - Evaluations

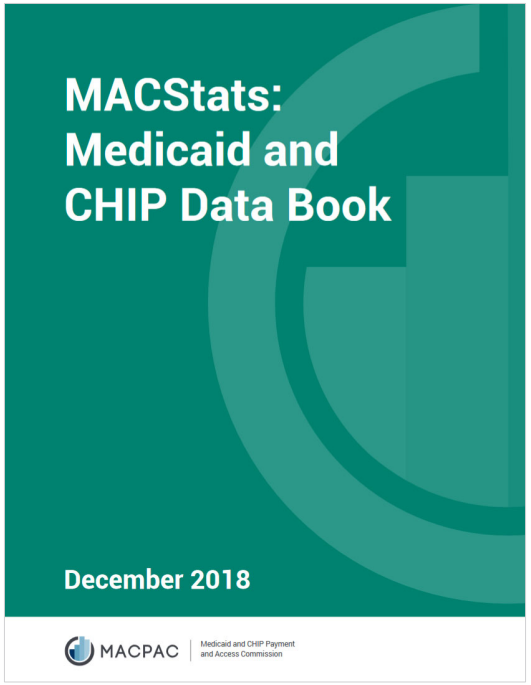
Short-term federal policy issues

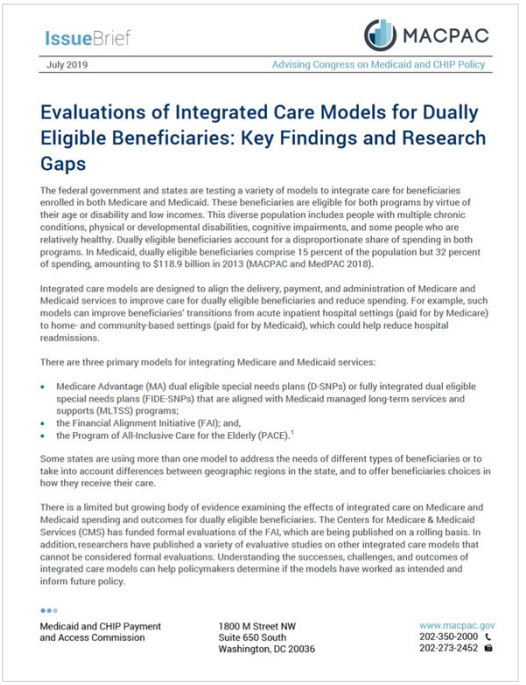
- Legislative
  - Cuts to DSH payments
  - Extenders (e.g., Money Follows the Person)
  - Medicaid generally not affected by pending legislation affecting Rx drugs, surprise billing
- Regulatory
  - Supplemental payments and financing rule
  - Work and community engagement waivers
  - Healthy adult opportunity waivers
  - Eligibility determination rule

Perennial federal policy issues

- Size of the program
- Balance between state flexibility and federal requirements
- Conditions of eligibility
- Program design

MACPAC resources





IssueBrief MACPAC

July 2019 Advising Congress on Medicaid and CHIP Policy

Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps

The federal government and states are testing a variety of models to integrate care for beneficiaries enrolled in both Medicare and Medicaid. These beneficiaries are eligible for both programs by virtue of their age or disability and low incomes. This diverse population includes people with multiple chronic conditions, physical or developmental disabilities, cognitive impairments, and some people who are relatively healthy. Dually eligible beneficiaries account for a disproportionate share of spending in both programs. In Medicaid, dually eligible beneficiaries comprise 15 percent of the population but 32 percent of spending, amounting to $118.9 billion in 2013 (MACPAC and MedPAC 2018).

Integrated care models are designed to align the delivery, payment, and administration of Medicare and Medicaid services to improve care for dually eligible beneficiaries and reduce spending. For example, such models can improve beneficiaries' transitions from acute inpatient hospital settings (paid for by Medicare) to home- and community-based settings (paid for by Medicaid), which could help reduce hospital readmissions.

There are three primary models for integrating Medicare and Medicaid services:

- Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) or fully integrated dual eligible special needs plans (FIDE-SNPs) that are aligned with Medicaid managed long-term services and supports (MLTSS) programs;
- the Financial Alignment Initiative (FAI); and,
- the Program of All-Inclusive Care for the Elderly (PACE).[1]

Some states are using more than one model to address the needs of different types of beneficiaries or to take into account differences between geographic regions in the state, and to offer beneficiaries choices in how they receive their care.

There is a limited but growing body of evidence examining the effects of integrated care on Medicare and Medicaid spending and outcomes for dually eligible beneficiaries. The Centers for Medicare & Medicaid Services (CMS) has funded formal evaluations of the FAI, which are being published on a rolling basis. In addition, researchers have published a variety of evaluative studies on other integrated care models that cannot be considered formal evaluations. Understanding the successes, challenges, and outcomes of integrated care models can help policymakers determine if the models have worked as intended and inform future policy.

Medicaid and CHIP Payment
and Access Commission

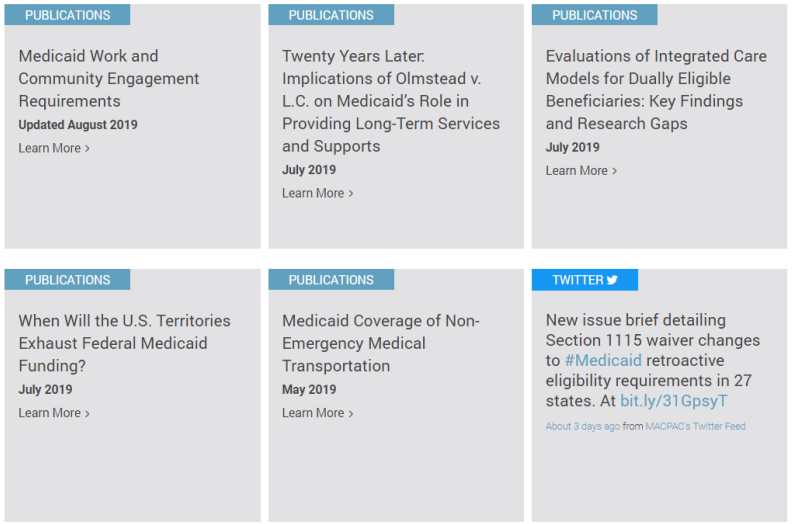
1800 M Street NW
Suite 650 South
Washington, DC 20036

www.macpac.gov
202-350-2000
202-273-2452

MACPAC.gov

Twitter

@macpacgov



Medicaid 101

Medicaid and CHIP Payment and Access Commission

Anne L. Schwartz, PhD

Executive Director

March 6, 2020

Medicare 101

Jack Hoadley, Ph.D.
Research Professor Emeritus
Health Policy Institute
Georgetown University

Health Policy Academy
Alliance for Health Policy
March 6, 2020

Medicare Past and Present

- Established in 1965 to provide health and economic security to seniors age 65 and older
- Expanded in 1972 to cover younger beneficiaries with permanent disabilities (and later to those with end-stage renal disease or ALS)
- Part D coverage for outpatient drugs effective in 2006
- Covers people regardless of income or medical history
- Private plans play an increasing role in Medicare

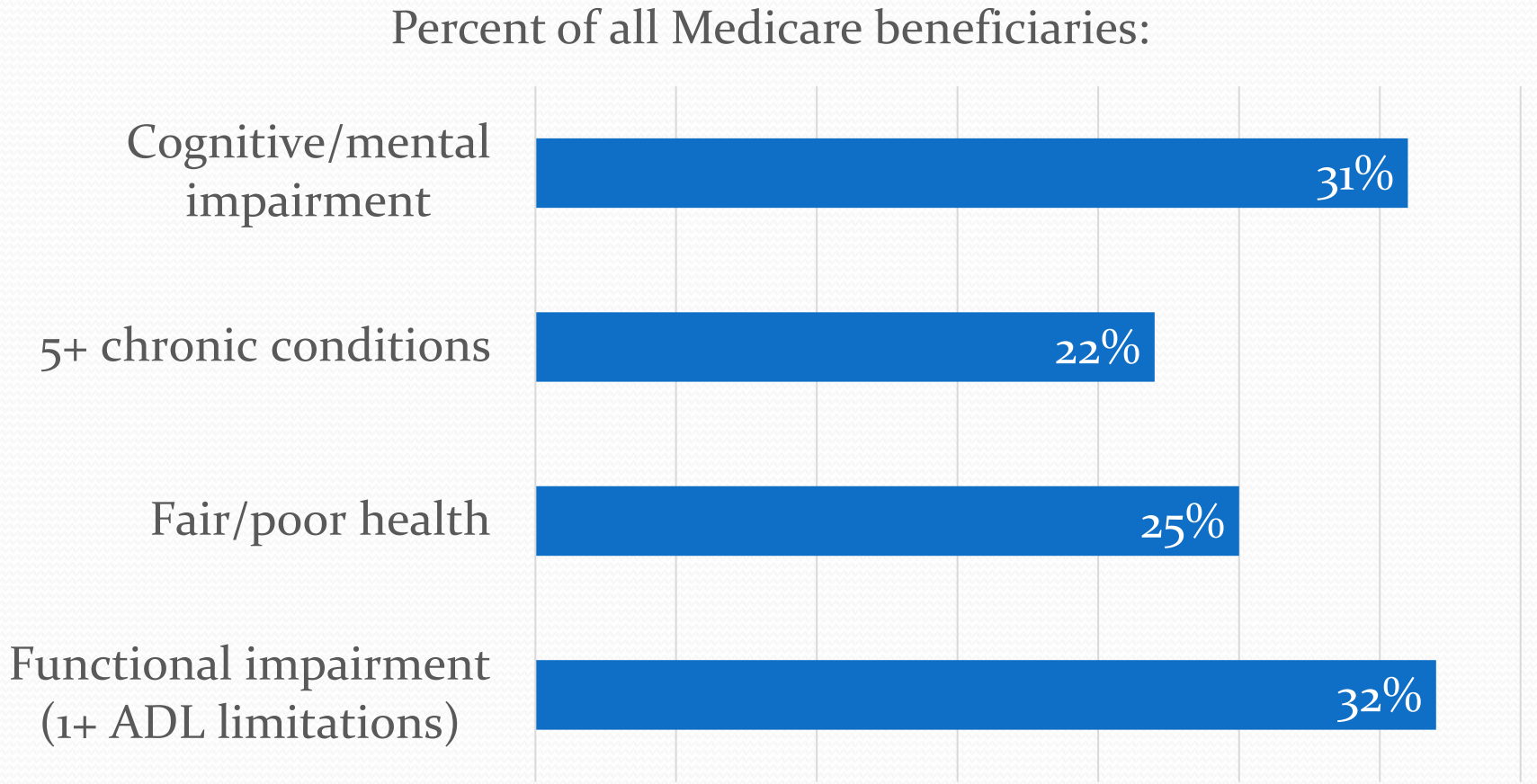
Medicare: Basic Facts

- Medicare covered 61.2 million people in 2019
  - Beneficiaries age 65 and over: 52.6 million
  - Beneficiaries under age 65, with disabilities: 8.6 million
- Estimated federal outlays in 2019: $772 billion
  - Net federal outlays in 2019: 637 billion

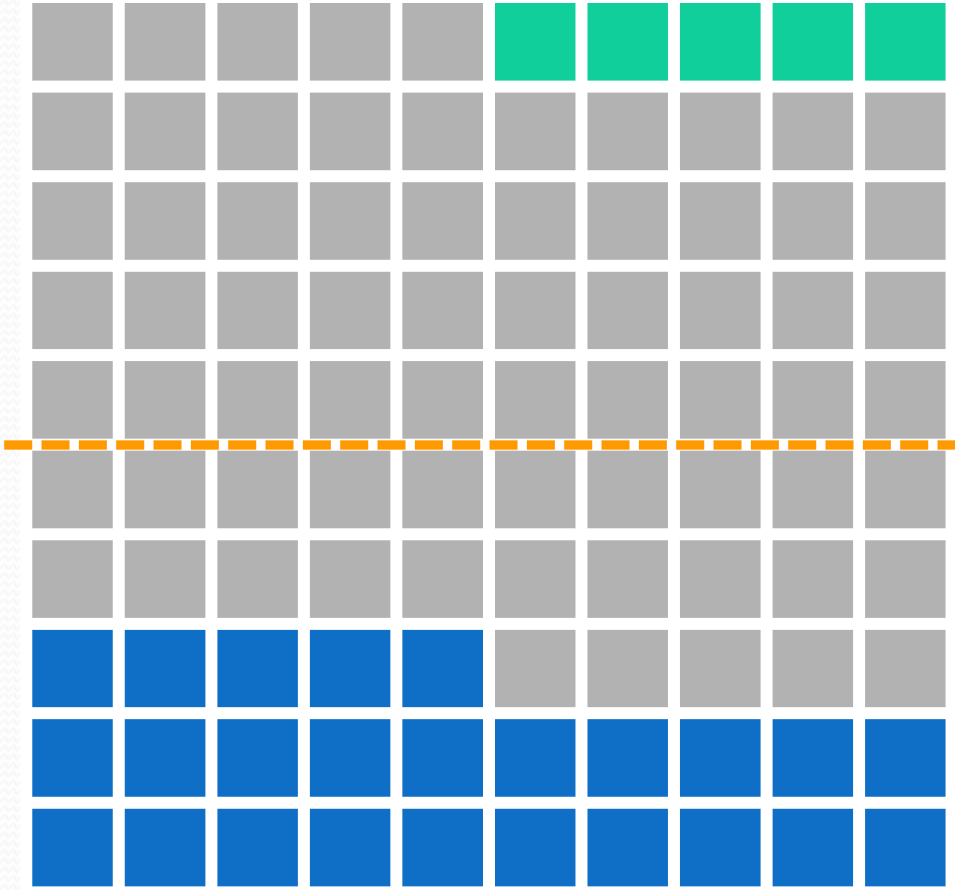
Gaps in Medicare Coverage

- No long-term care benefit
  - Only covers post-acute skilled nursing facility care and home health services
- No routine eye exams or eyeglasses
- No dental services or dentures
- No hearing aids
- No limit on out-of-pocket expenses

Health Status of Beneficiaries, 2016



Beneficiaries By Income, 2016



5%: incomes above **$103,450**

50%: incomes below **$26,200**

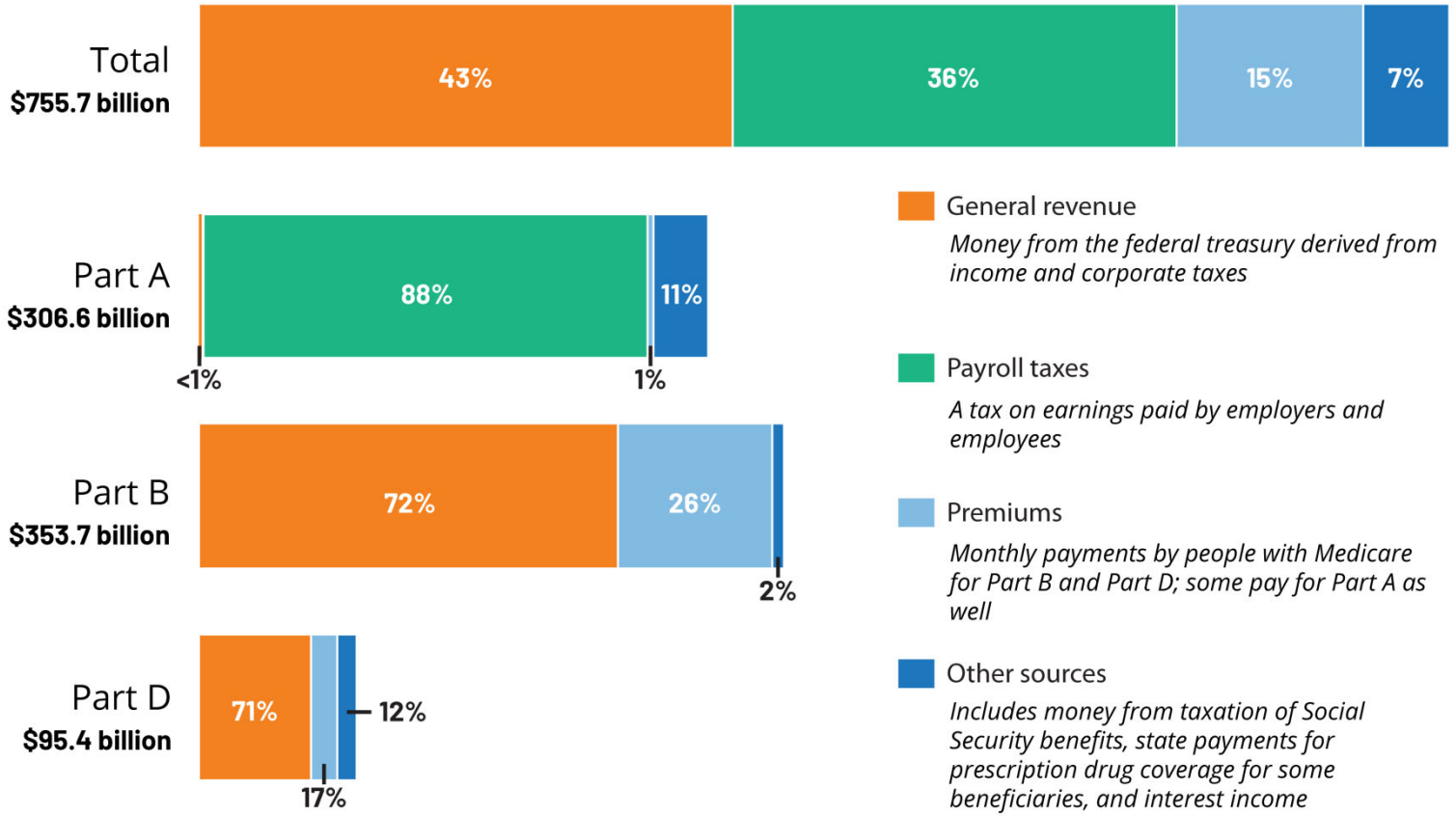
25%: incomes below **$15,250**

NOTE: Total household income for couples is split equally between husbands and wives to estimate income for married beneficiaries.
SOURCE: Urban Institute analysis of DYNASIM for the Kaiser Family Foundation.

Components of Medicare

- Traditional Medicare
  - Part A: Inpatient hospital, post-acute care
  - Part B: Physician services, outpatient hospital, ambulatory care
- Medicare Advantage (Part C)
  - Private health plans that contract with the government to administer A & B benefits
- Part D: Prescription Drug Coverage
  - Private plans that contract with the government

Sources of Medicare Funding

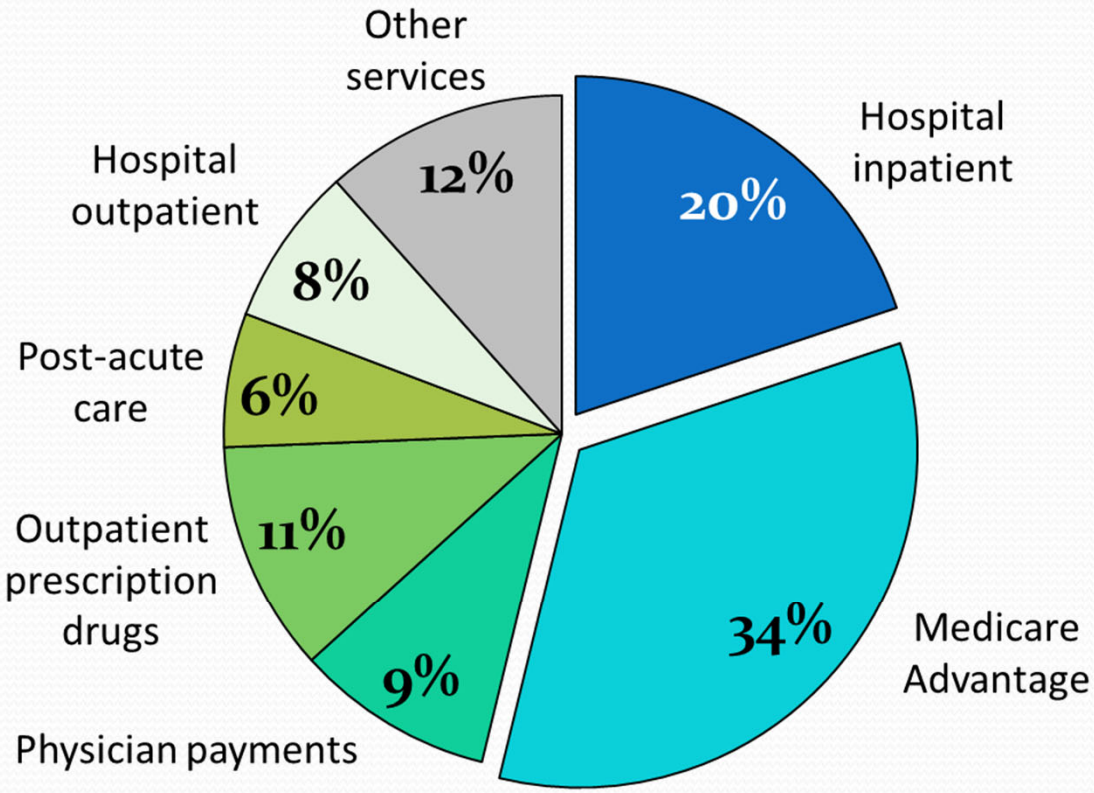


NOTE: Data are for the calendar year.
SOURCE: KFF analysis of Medicare spending data from 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.

KFF
HENRY J KAISER FAMILY FOUNDATION

Shares of Medicare Spending

Total Medicare Benefit Payments in 2019: $749 billion



NOTE: Other services consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

SOURCE: Congressional Budget Office, 2019 Medicare Baseline (May 2019).

Part A: Hospital Insurance

	Part A
Services Covered	Inpatient hospital services Post-acute care services: skilled nursing facility, (some) home health care, inpatient rehabilitation facility Hospice care
Premiums	$0 for most beneficiaries, based on entitlement after 10+ years of paying payroll taxes
Deductible	$1,408 per benefit period
Cost Sharing	Daily copayments for some inpatient hospital stays and skilled nursing facility stays
Financing	2.9% tax on earnings, paid by employers and employees (1.45% each). Additional tax for taxpayers with wages above $200,000 for individuals or $250,000 for couples
Payment	Prospective payment systems for hospitals, post-acute care providers

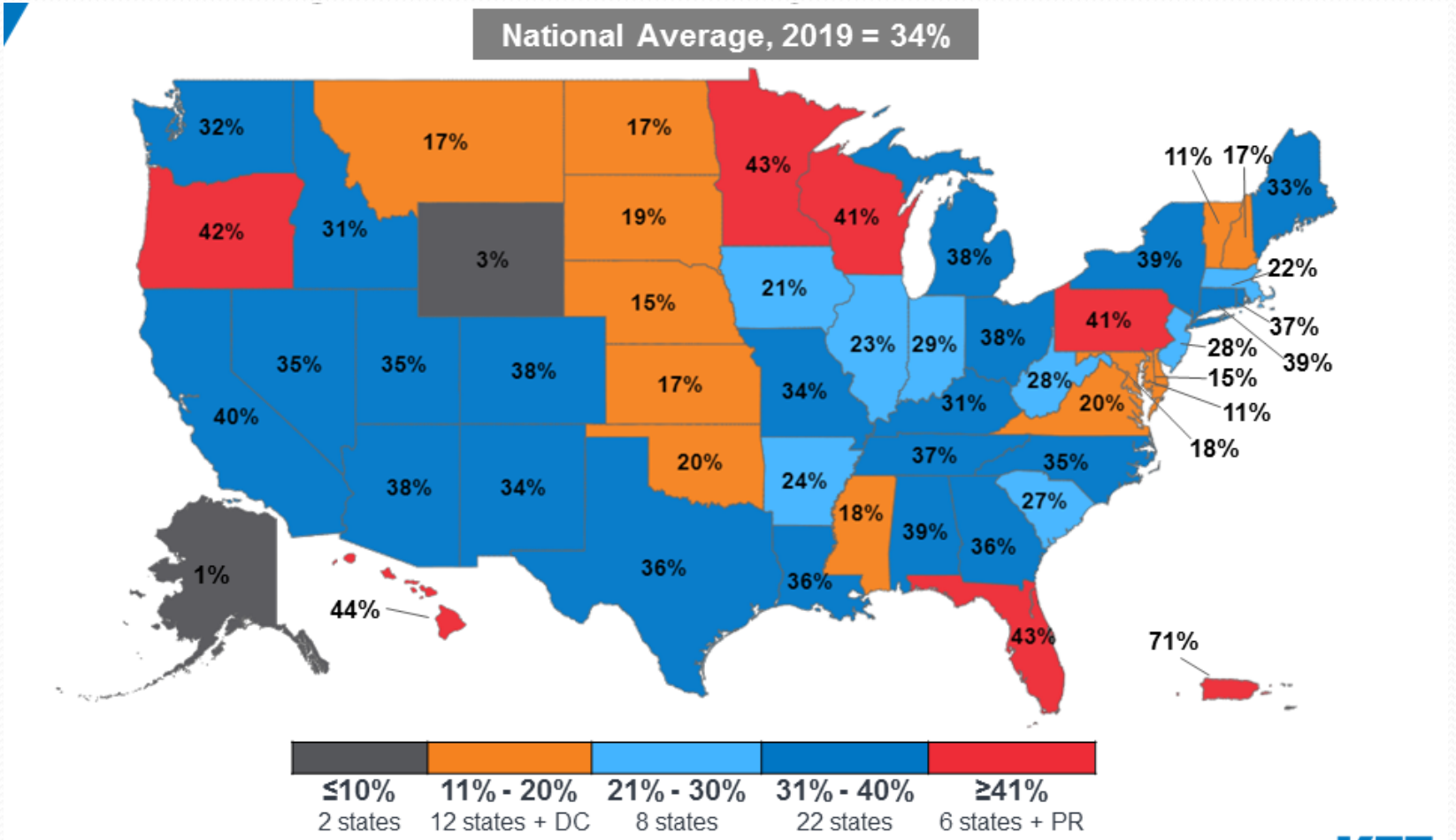
Part B: Supplementary Medical Insurance

	Part B
Services covered	Physician visits, outpatient hospital service, preventive services, (some) home health care, and drugs administered in hospital outpatient departments or physician offices
Monthly Premiums	$144.60 for most beneficiaries Income-related premium of $202.40 to $491.60 per person if income >$87,000 for individuals or >$174,000 for couples
Deductible	$198 per year
Cost sharing	20% coinsurance (generally) for most covered services, except preventive services which are free
Financing	Beneficiary premiums pay for 25% of program costs General revenues pay for the remainder
Payment	Physician services: Medicare fee schedule Hospital outpatient services: prospective payment system Physician-administered drugs: average sales price

Part C: Medicare Advantage

- Alternative to traditional Medicare where beneficiaries enroll in a private plan with restricted network
- Enrollees receive all covered Part A & Part B benefits
  - Typically also receive drug coverage (Part D)
  - Often receive extra benefits (e.g., dental, eyeglasses)
  - Special supplemental benefits for the chronically ill
    - Home-delivered meals, pest control, transport for non-medical needs
- 34% of beneficiaries enrolled in MA in 2019
- Medicare pays plans a fixed amount per enrollee
- Spending on MA, 2019: $254 billion
- Enrollees generally pay Part B premium and an additional MA plan premium (some MA plans are zero premium)

Medicare Advantage, by State, 2019



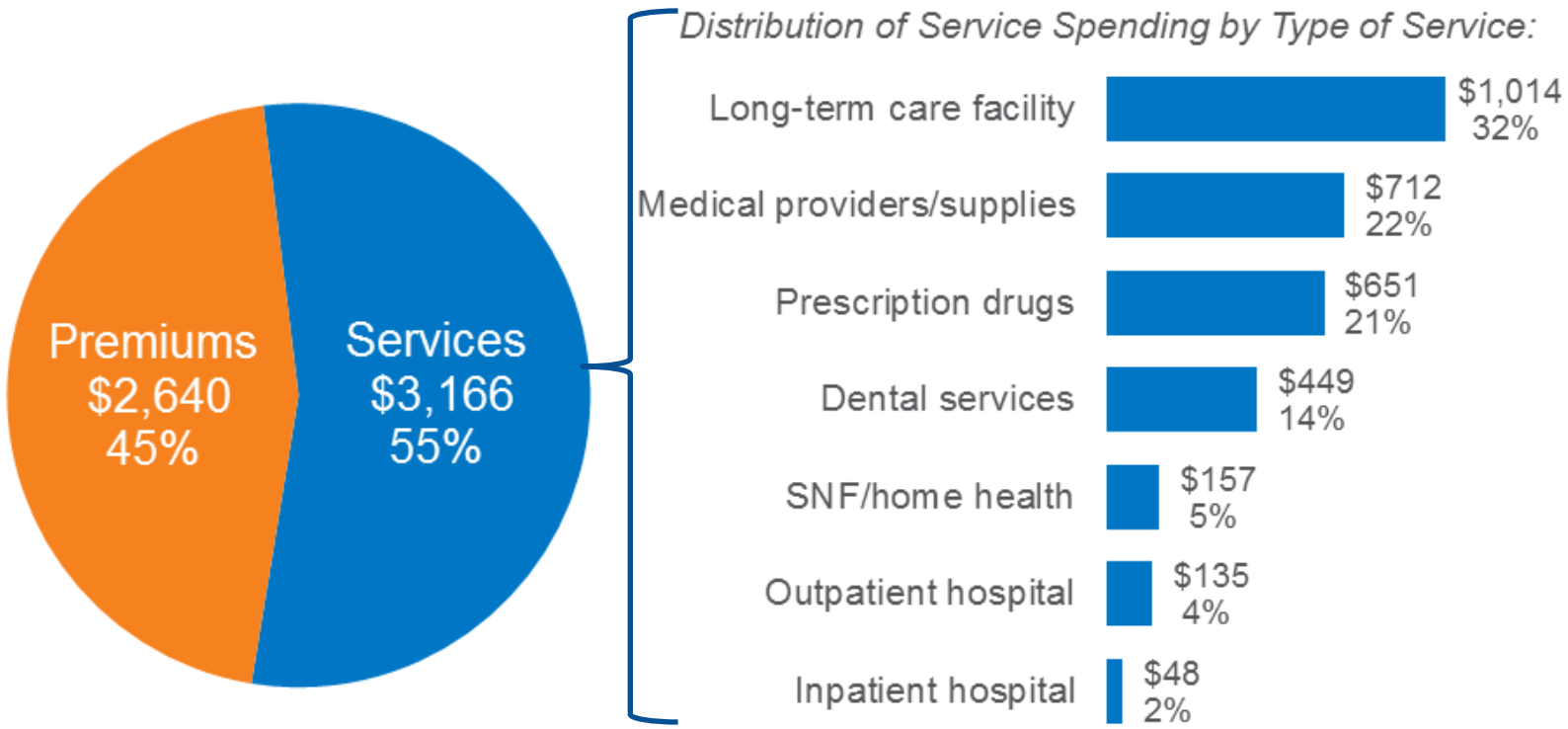
NOTE: Includes cost plans, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2019.

KFF
HENRY J KAISER FAMILY FOUNDATION

Part D: Prescription Drug Benefit

- Voluntary outpatient drug benefit offered through private stand-alone drug plans (PDPs) or Medicare Advantage drug plans
- 75% of beneficiaries enrolled in Part D plans in 2019
- Program spending: $88 billion in 2020
- Medicare pays ~75% of basic benefits, enrollees pay ~25%
- Plans vary widely: premiums, drugs covered, costs
- Additional subsidies for enrollees with low incomes and resources

Out-of-Pocket Spending, 2016

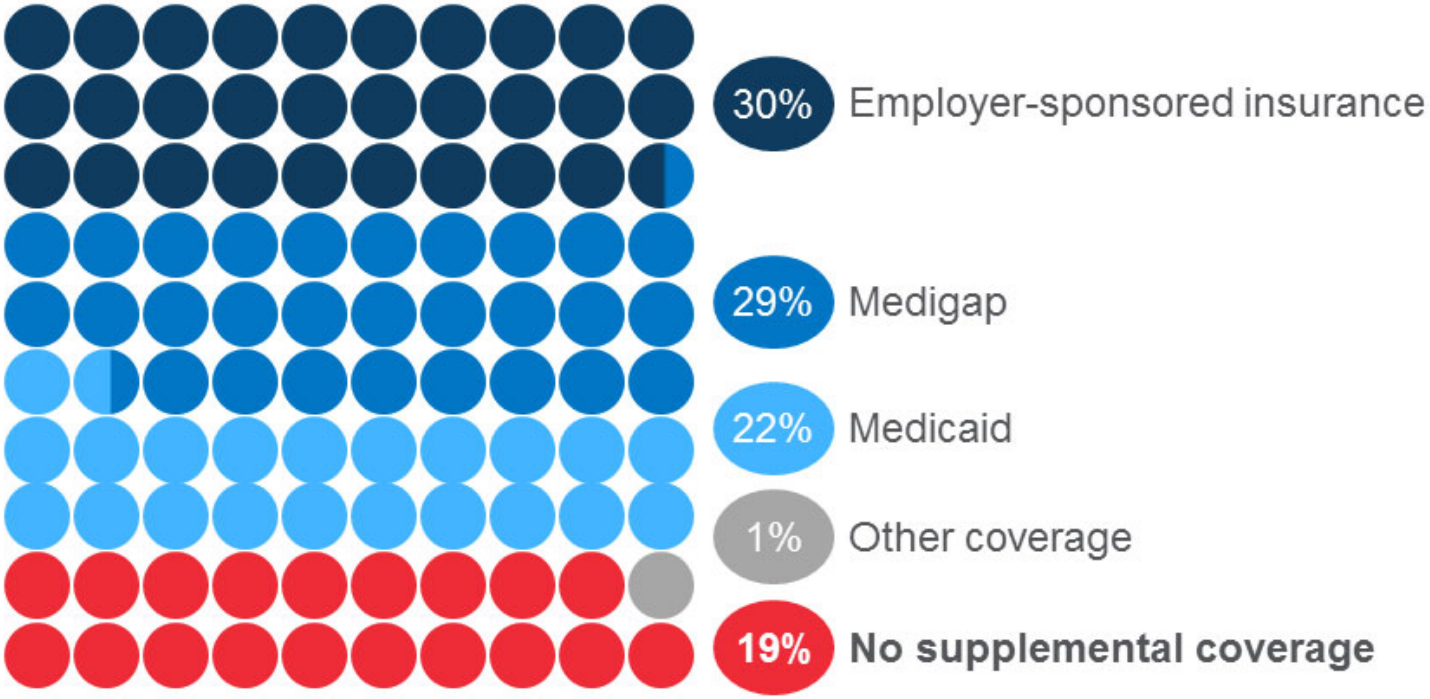


Average Total Out-of-Pocket Spending, 2016: $5,806

NOTE: SNF is skilled nursing facility. Analysis excludes beneficiaries with Part A only or Part B only for most of the year or Medicare as a Secondary Payer, and beneficiaries in Medicare Advantage.
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2016 Medicare Current Beneficiary Survey.

KFF HENRY J KAISER FAMILY FOUNDATION

Supplemental Coverage, 2016



2016 Total = 32.4 million traditional Medicare beneficiaries

NOTE: Total excludes beneficiaries with Part A only or Part B only for most of the year (n=4.4 million) or Medicare as a Secondary Payer (n=2.0 million), and beneficiaries in Medicare Advantage.
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2016 Medicare Current Beneficiary Survey.

KFF
HENRY J KAISER FAMILY FOUNDATION

Medicare Payment Advisory Commission (MedPAC)

- Provides independent, nonpartisan policy and technical advice to the Congress on Medicare issues
- Make recommendations to Congress
- 17 national experts selected by the Comptroller General for expertise
  - Includes providers, payers, academics, beneficiary-focused experts
  - Serve 3-year terms, can be reappointed
  - Meets in public 7 times a year, votes in public
- Commissioners supported by staff of 25-30 analysts

Medicare's Long-Term Challenges

- Spending
  - Medicare is 14% of the federal budget – and growing
  - Medicare faces long-term financing challenges with more beneficiaries, an aging population, and rising costs
- Beneficiaries
  - Beneficiaries incur relatively high out-of-pocket costs as a share of income and household budgets
  - Coverage is complex, with many private plan choices
- Providers
  - Are payments adequate?
  - Navigate new payment approaches, delivery system reforms
  - How to improve care management and target interventions to those with the greatest needs

Current Medicare Issues

- Restructuring the Medicare Part D benefit, including a cap on out-of-pocket costs
- Restructuring payment systems for post-acute care
- Addressing the physician payment system to include more quality-based incentives
- Continue on path to delivery system reforms
- Simplify enrollment process for new beneficiaries
- Improving access to Medicare supplemental (Medigap) coverage

Health Coverage Fundamentals

Karen Pollitz, Senior Fellow, KFF

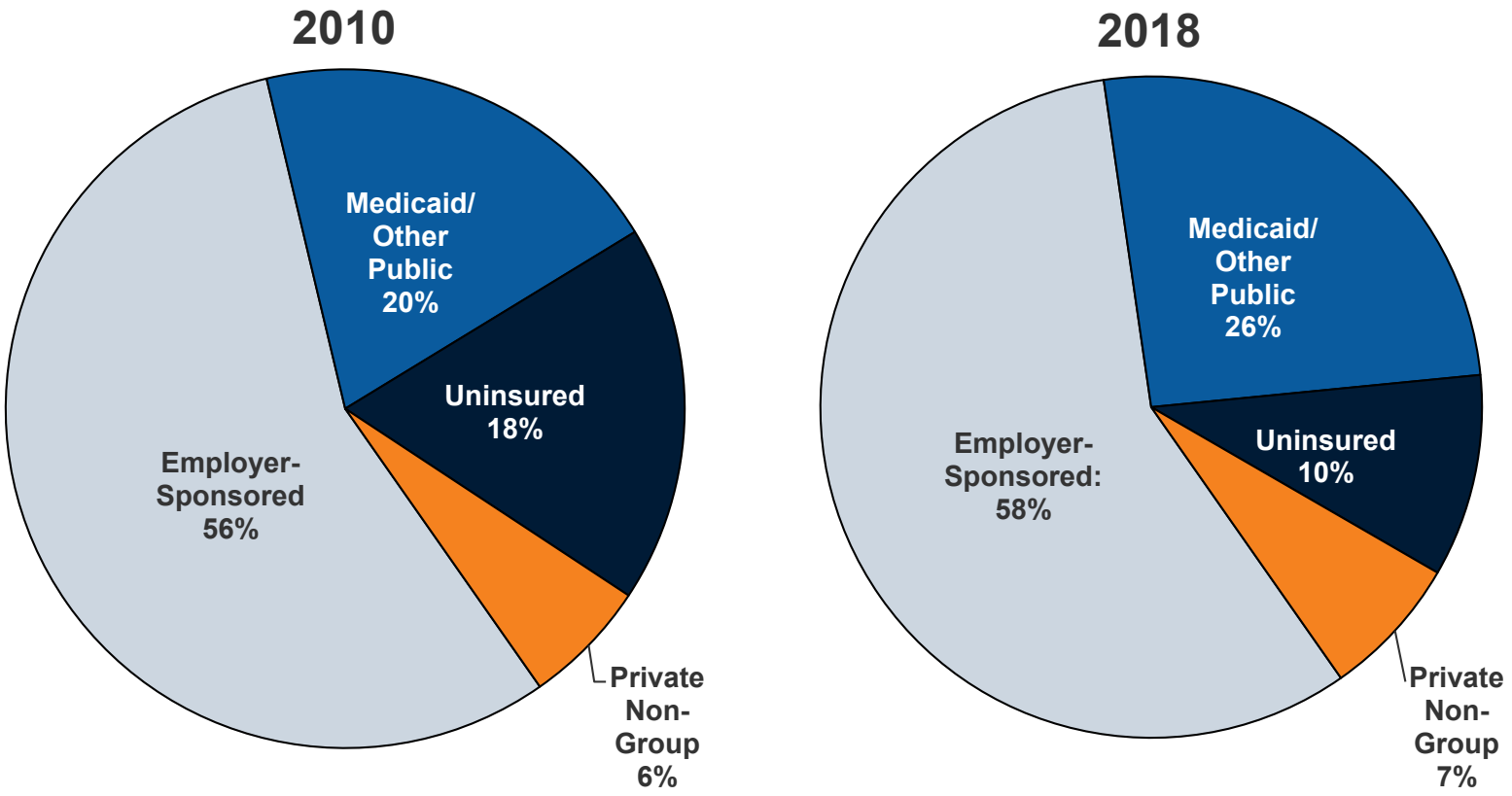
Alliance Health Policy Academy
March 6, 2020

KFF
HENRY J KAISER
FAMILY FOUNDATION

Filling the need for trusted information on national health issues.

Figure 1

Sources of Health Coverage for Non-Elderly, 2010-2018

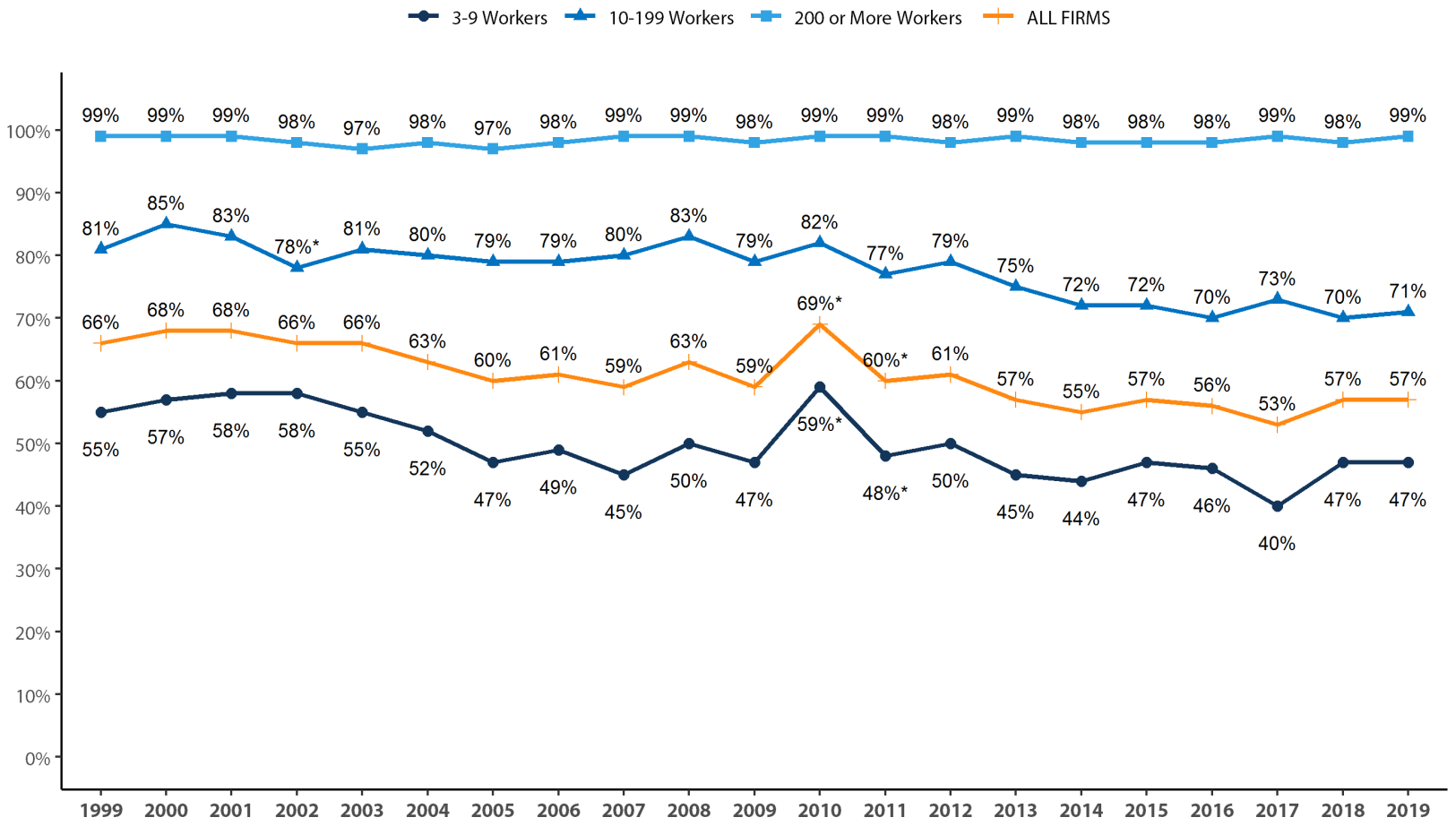


SOURCE: KFF analysis of the 2011, 2019 American Community Survey, US Census Bureau.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 2

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

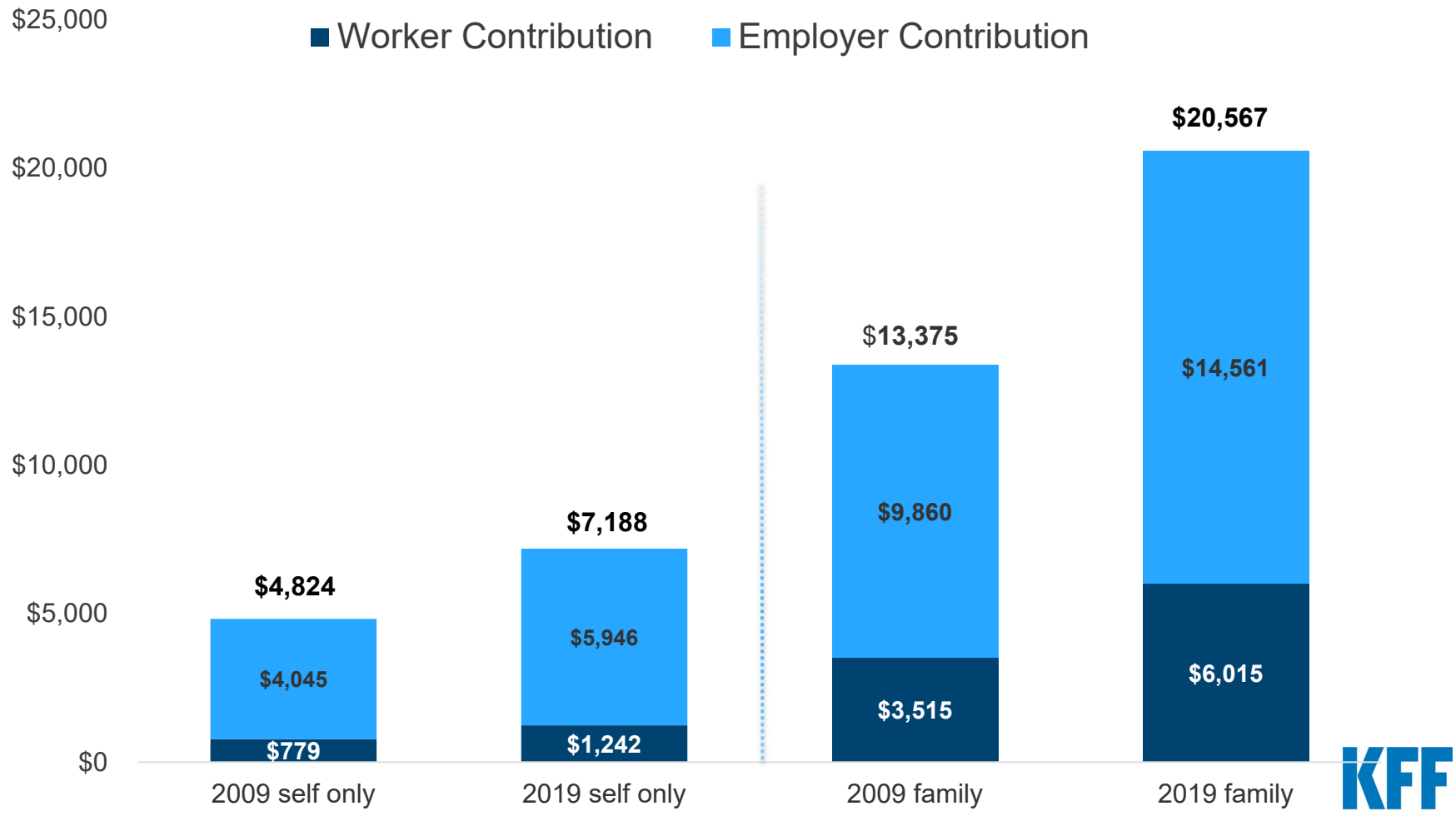
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 3

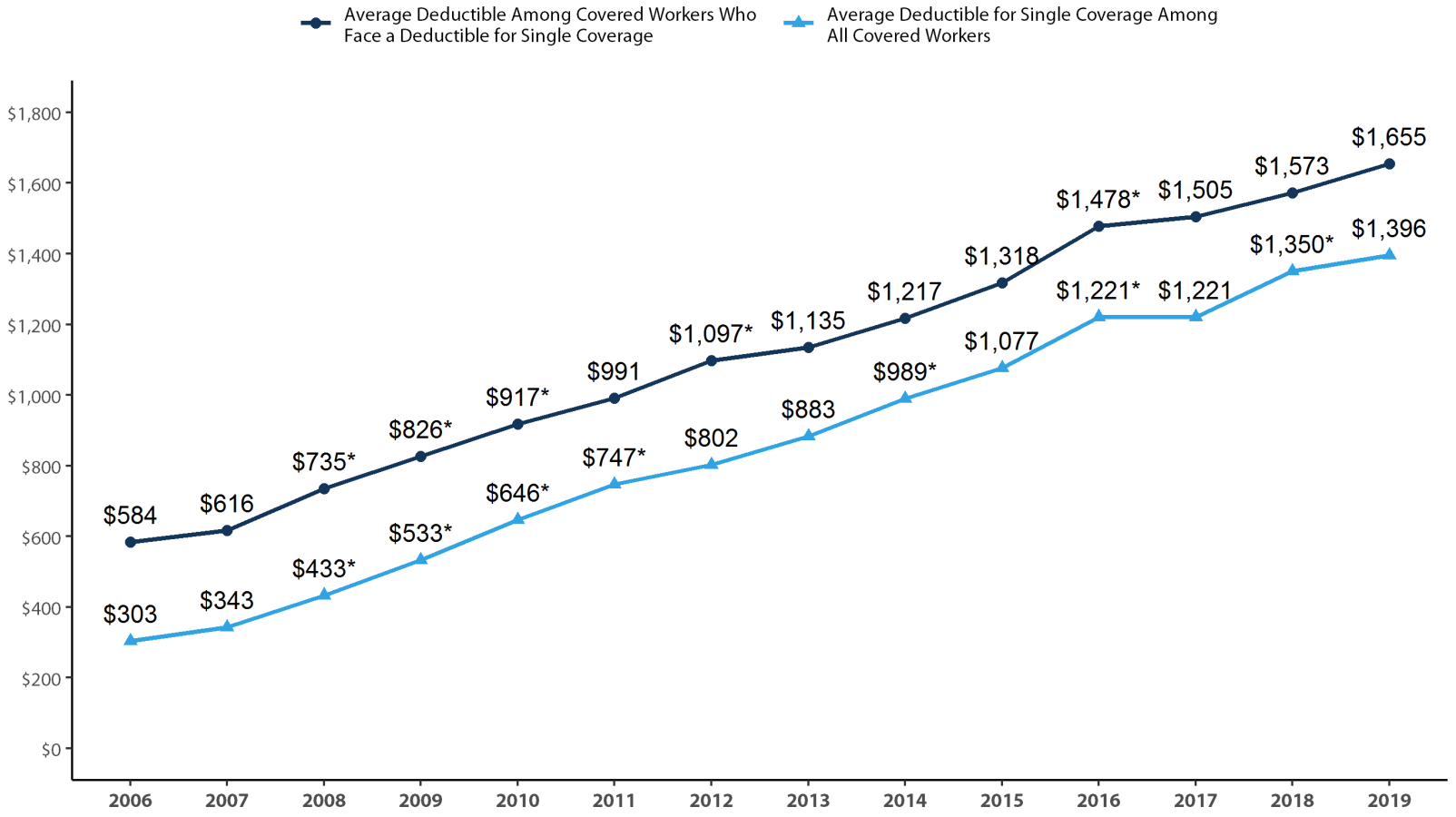
Average Annual Worker and Employer Premium Contributions and Total Premiums for Self-Only and Family Coverage, 2009 and 2019



SOURCE: KFF Employer Health Benefits Survey, 2019; Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2009

Figure 4

Average General Annual Deductibles for Single Coverage, 2006-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

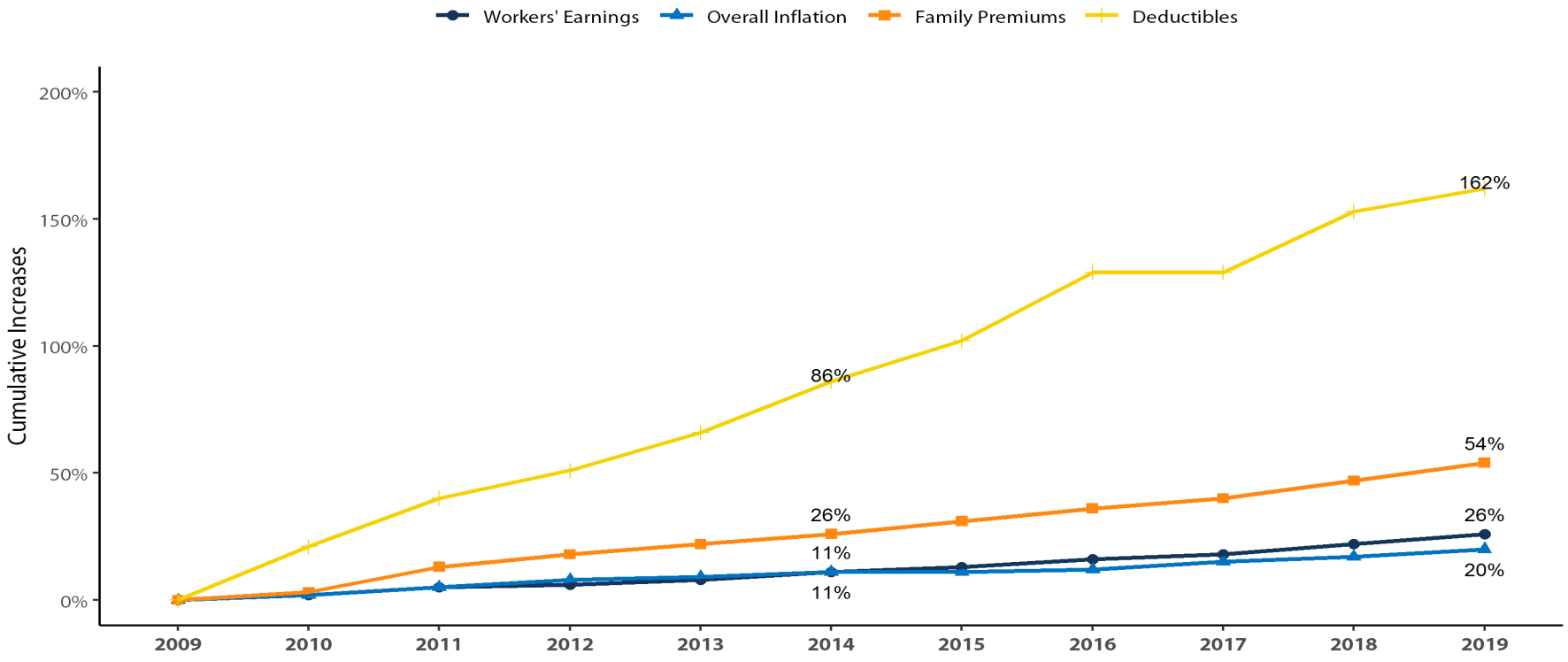
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 5

Cumulative Increases in Family Coverage Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2009-2019



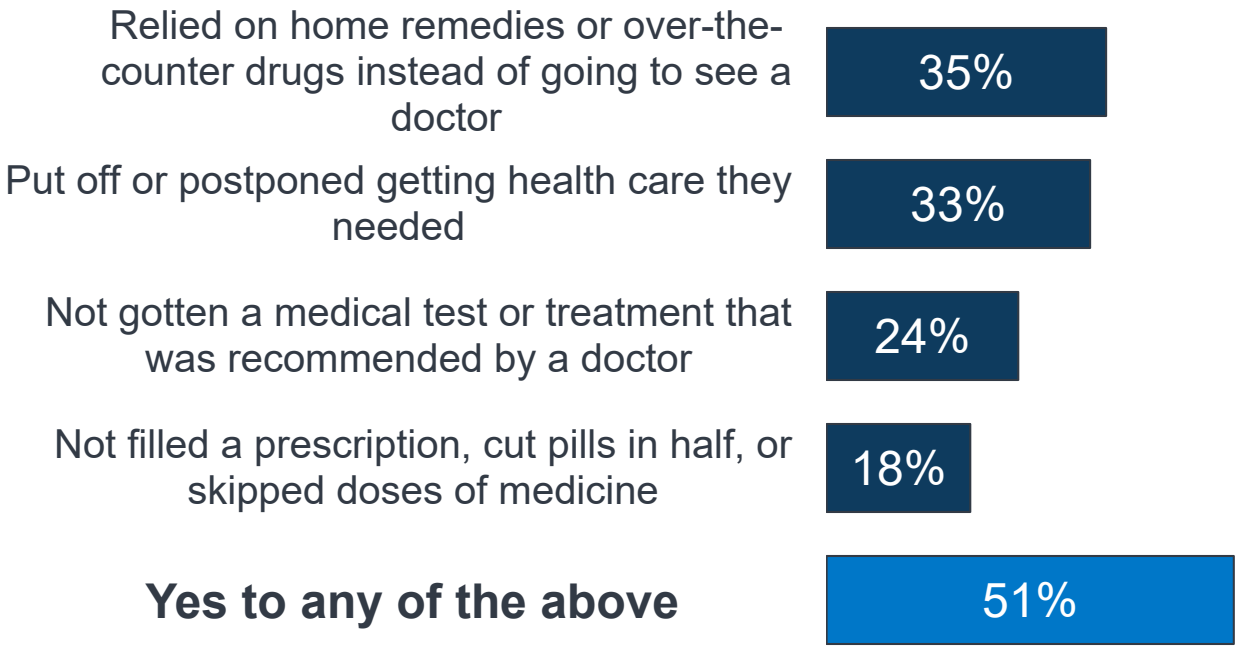
NOTE: Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2009-2019; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2009-2019 (April to April).

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 6

Half of Those With ESI Say Someone in Family Skipped or Postponed Needed Care or Rx Because of The Cost

Percent who say they or another family member living in their household have done each of the following in the past 12 months because of the cost:

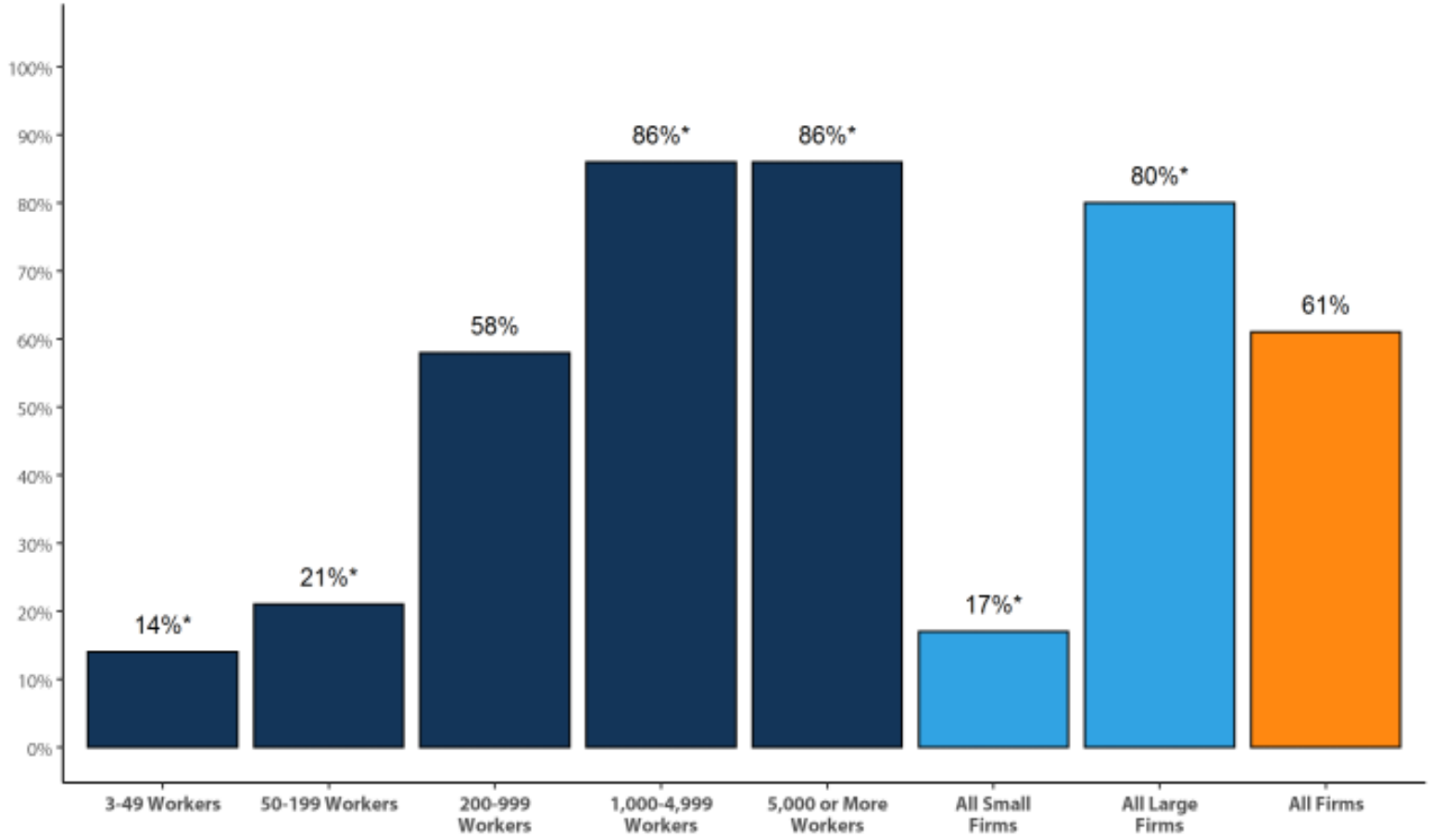


SOURCE: KFF/LA Times Survey of Adults with Employer-Sponsored Health Insurance (Sept. 25-Oct. 9, 2018). See topline for full question wording.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 7

Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2019



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

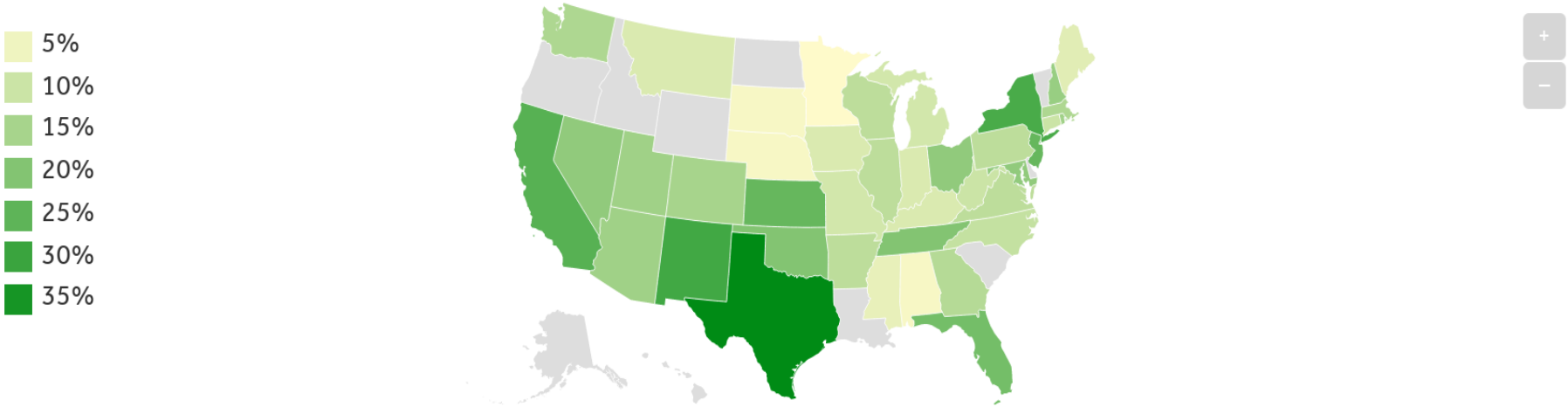
NOTE: Figure includes covered workers enrolled in partially or completely self-funded plans. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2019

Figure 8

On Average, 18% of Emergency Visits Result in at Least One Out-of-Network Charge, but the Rate Varied by State

Among people with large employer coverage, the share of emergency visits with at least one out-of-network charge, 2017



States shaded gray have insufficient data

Source: KFF analysis of IBM Marketscan 2017 data

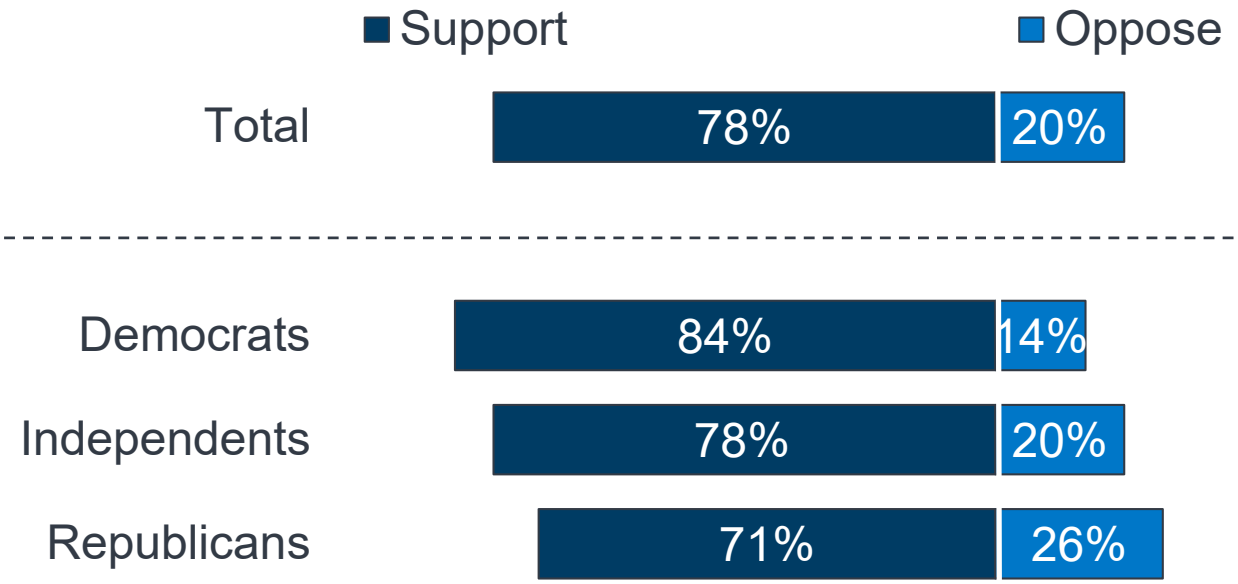
Peterson-KFF Health System Tracker

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 9

Majorities Across Parties Support Surprise Medical Bill Legislation

Do you support or oppose legislation protecting patients from paying the cost not covered by their insurance when they receive care from a provider or hospital who is not in their network?



SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 10

Affordable Care Act Substantially Changed Private, Non-Group Health Insurance

- Require guaranteed issue (insurers can't deny applicants) * *
- Require modified community rating (premiums vary only by family size, age (3:1) geography, tobacco use) *
- Prohibit pre-existing condition exclusions * * *
- Require policies to cover essential health benefits *
- Prohibit lifetime and annual dollar limits on covered benefits * * *
- Require maximum out-of-pocket (OOP) cap on cost sharing, in-network * * *
- Establish cost sharing tiers (bronze, silver, gold, platinum) *
- Dependent coverage up to age 26 * * *
- Require minimum medical loss ratios * *
- Establish premium tax credit subsidies for those with income 100% - 400% FPL
- Establish cost sharing reduction subsidies (CSR) for those with income 100% - 250% FPL
- Establish marketplace to certify plans meet ACA requirements, administer subsidies, foster competition *

* **Also applies to fully-insured small group insurance market**

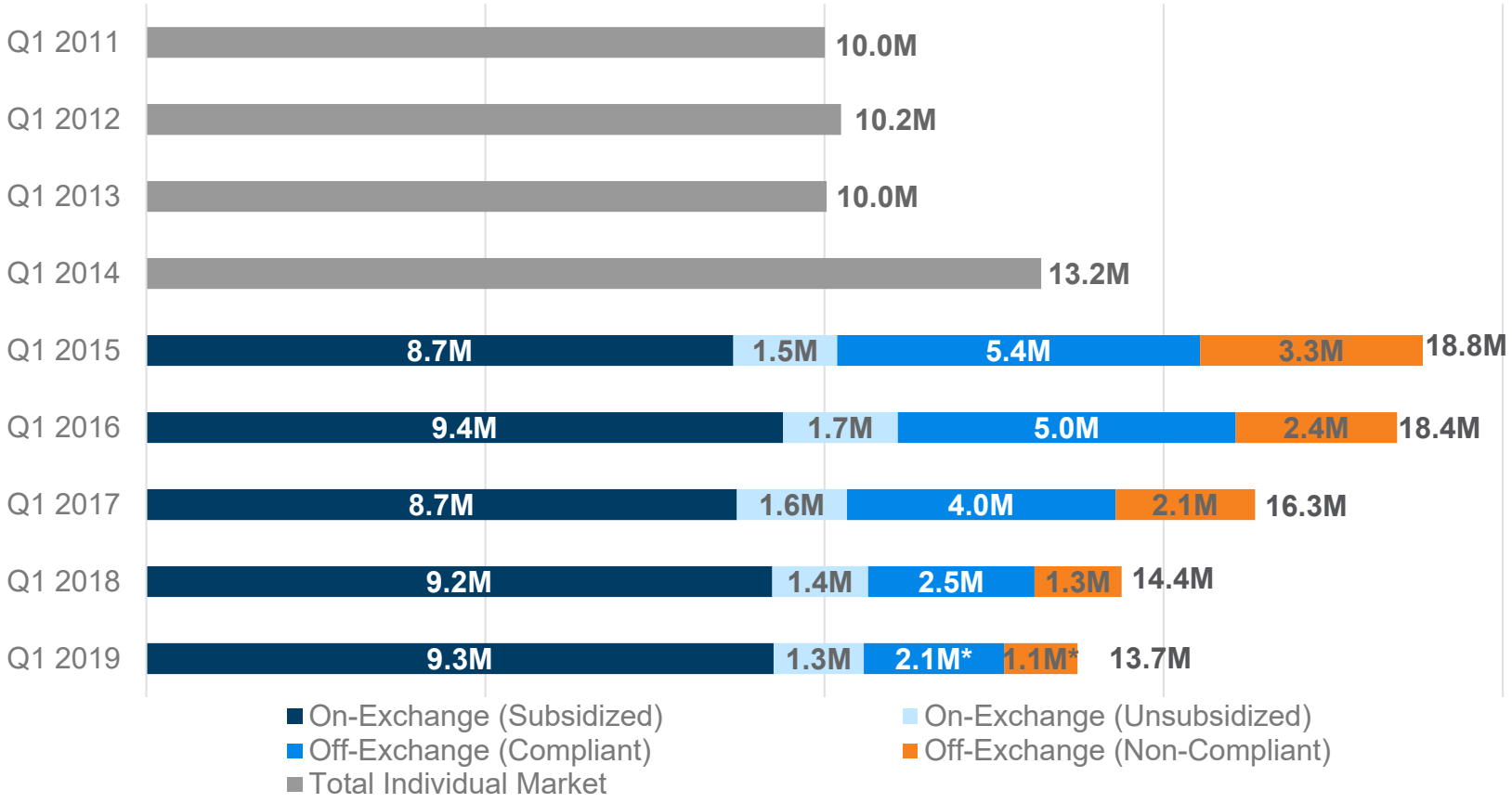
* **Also applies to fully-insured large group insurance market**

* **Also applies to self-insured group plans**

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 11

Q1 Individual Market Enrollment, 2011 - 2019



Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM and Centers for Medicare and Medicaid Services (CMS)

Note: First quarter (Q1) enrollment is measured in average members per month. For 2015 through 2018, we assume the share of off-exchange enrollment in compliant plans in Q1 is the same as the share of annual enrollment in off-exchange compliant coverage.

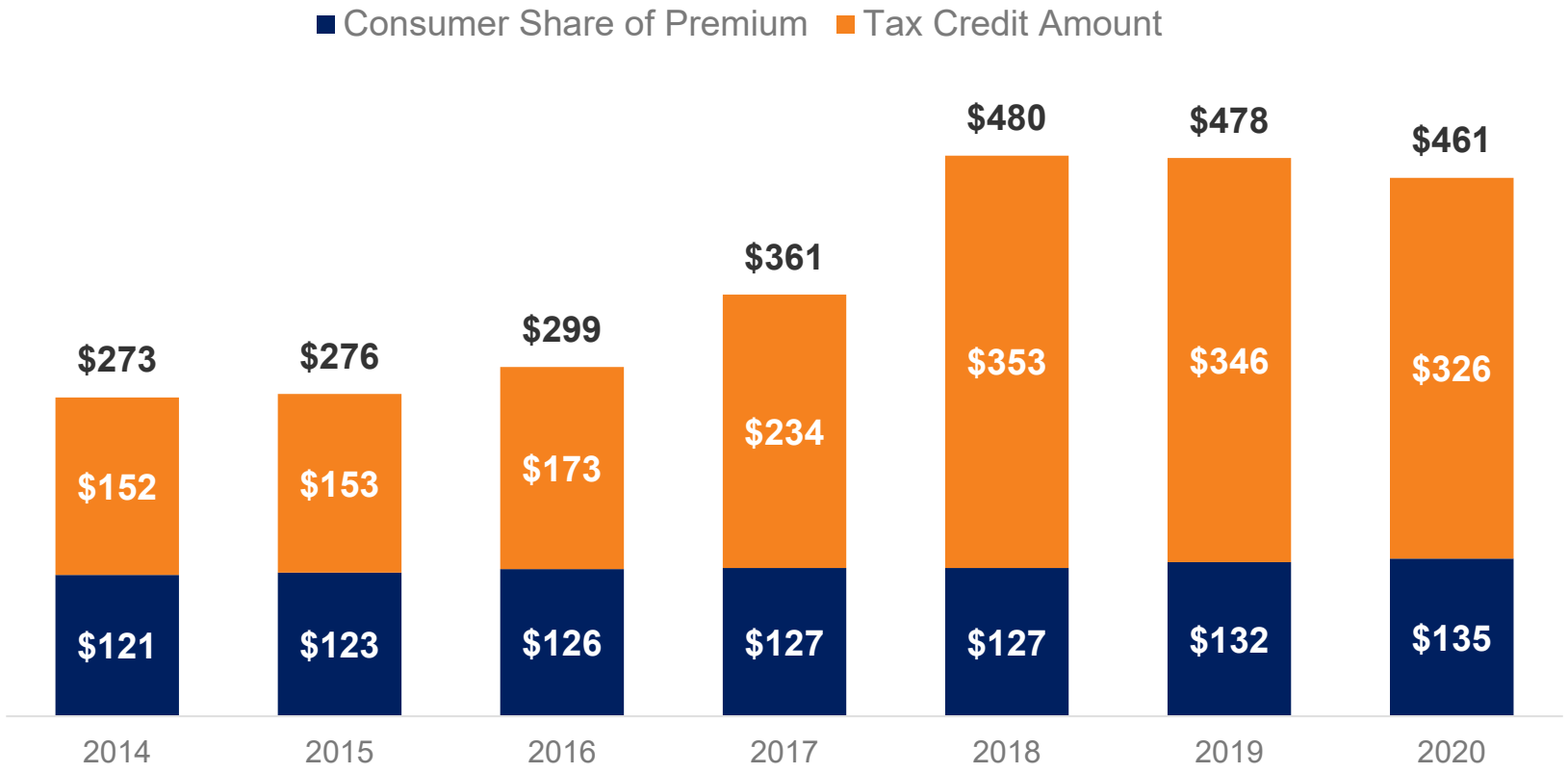
* Data on the share of off-exchange enrollment in compliant plans in 2019 are not available, so it is assumed to be the same as the share in 2018.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 12

Marketplace Trends: Benchmark Plan Premiums, With and Without Subsidies

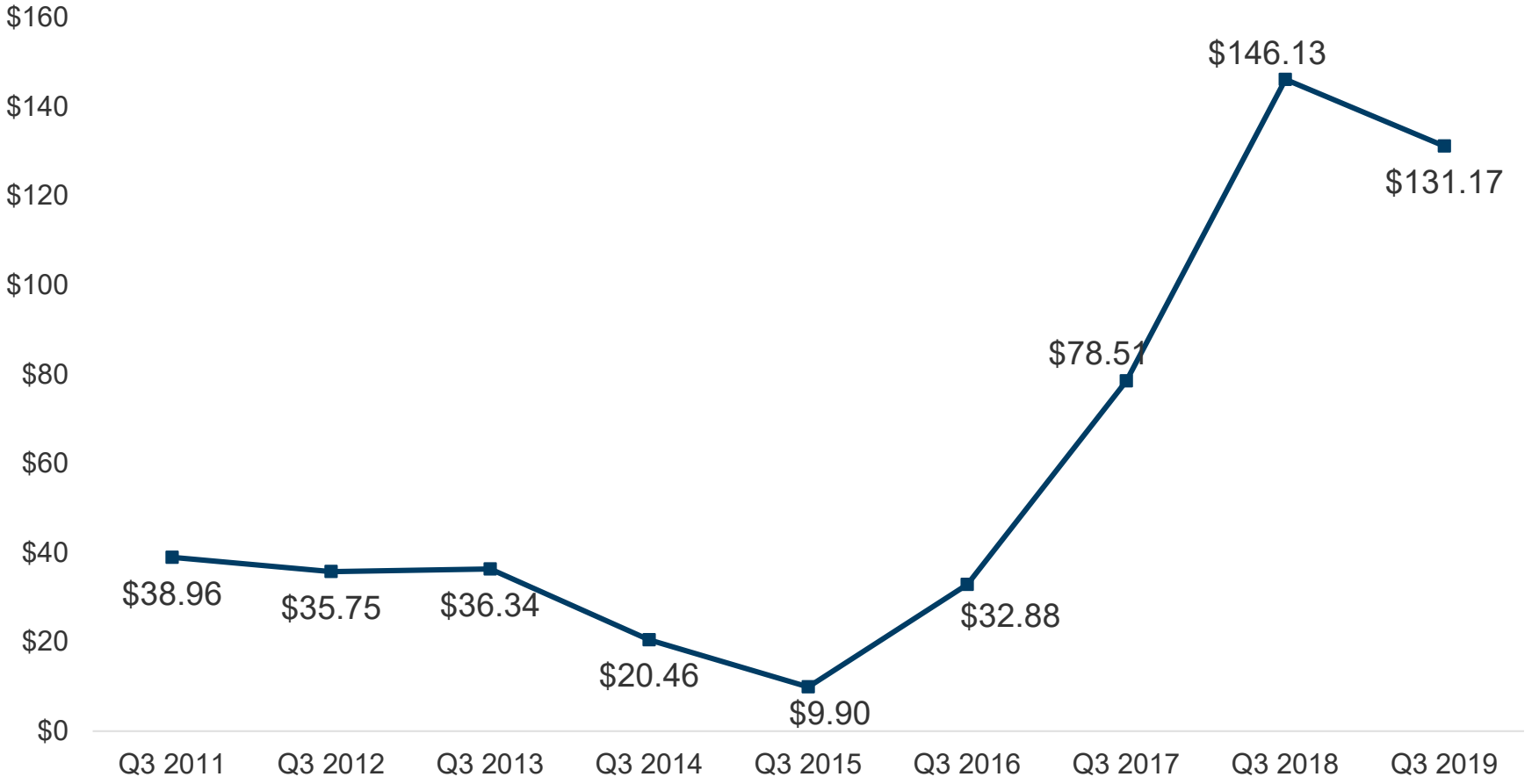
National average monthly premiums, tax credit amounts, and individual contributions for the benchmark Silver plan for a 40-year old consumer with income at 200% FPL, 2014-2020



SOURCE: Kaiser Family Foundation Health Insurance Marketplace Calculator

Figure 13

Average Third Quarter Individual Market Gross Margins Per Member Per Month, 2011 - 2019



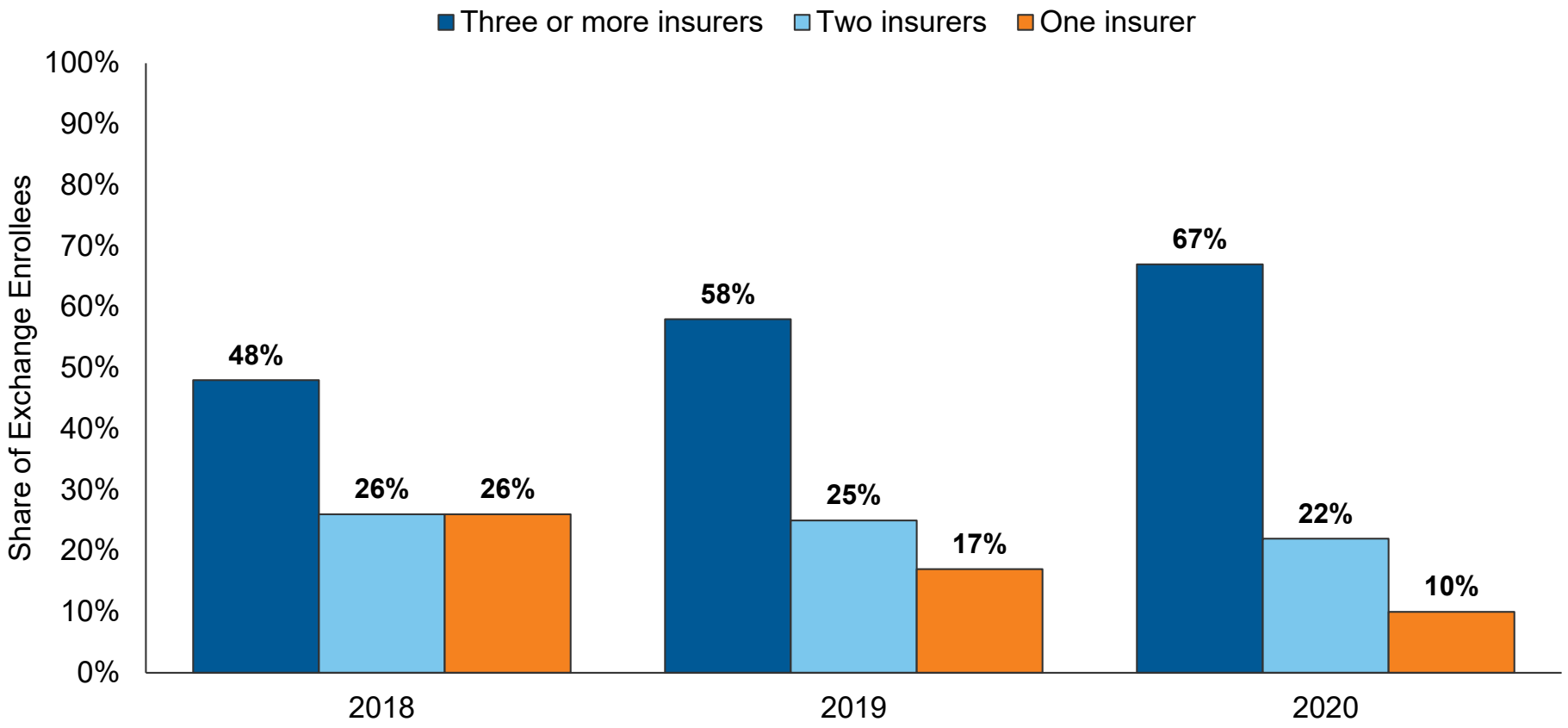
NOTE: Q3 data is year-to-date from January 1 – September 30

SOURCE: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 14

Two-thirds of Exchange Enrollees Have a Choice of Three or More Insurers in 2020

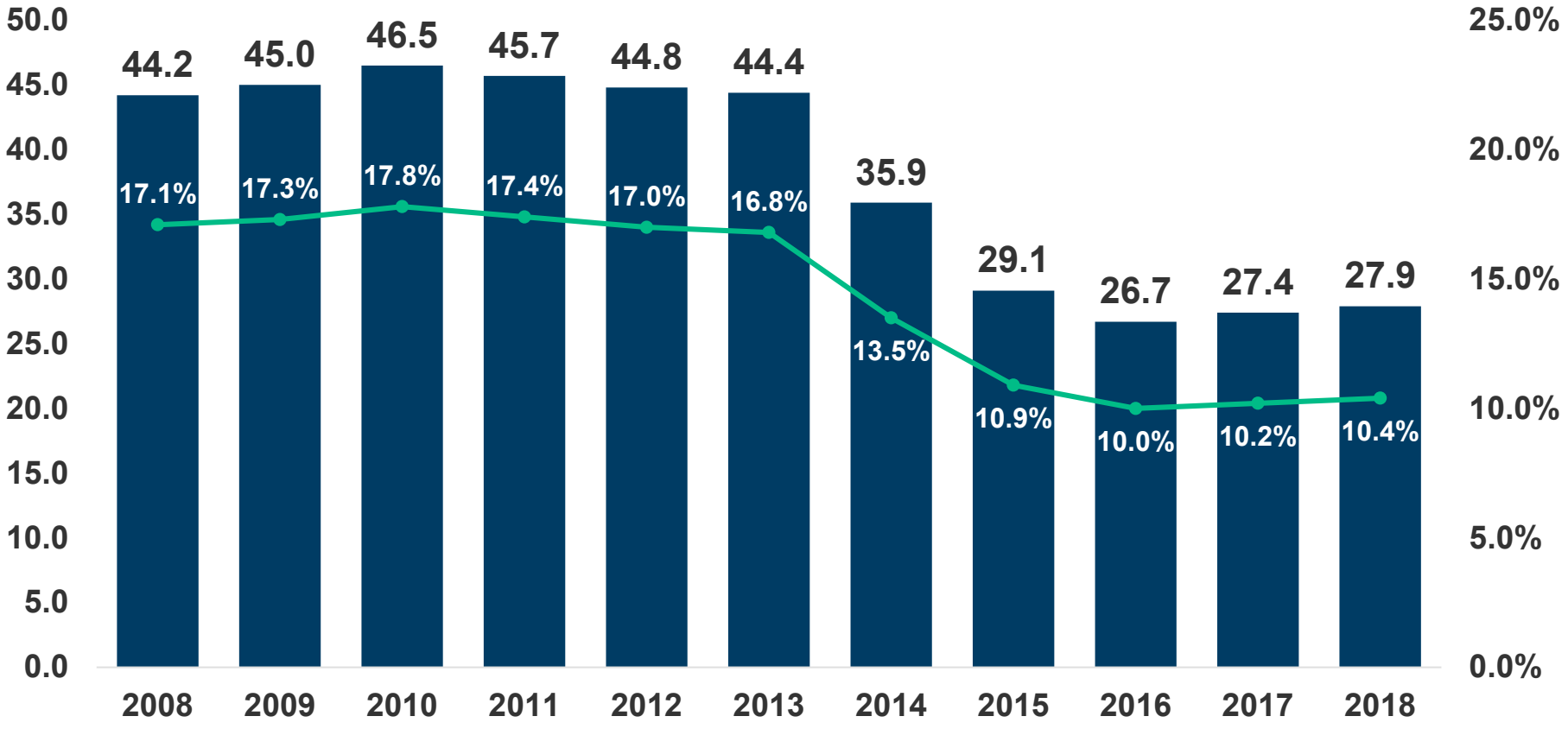


SOURCE: Kaiser Family Foundation analysis of data from Healthcare.gov and a review of state rate filings.
NOTE: Enrollment in 2020 is based on 2019 plan selections. Percentages may not sum to 100 due to rounding.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 15

Number of Uninsured and Uninsured Rate Among the Nonelderly Population, 2008-2018

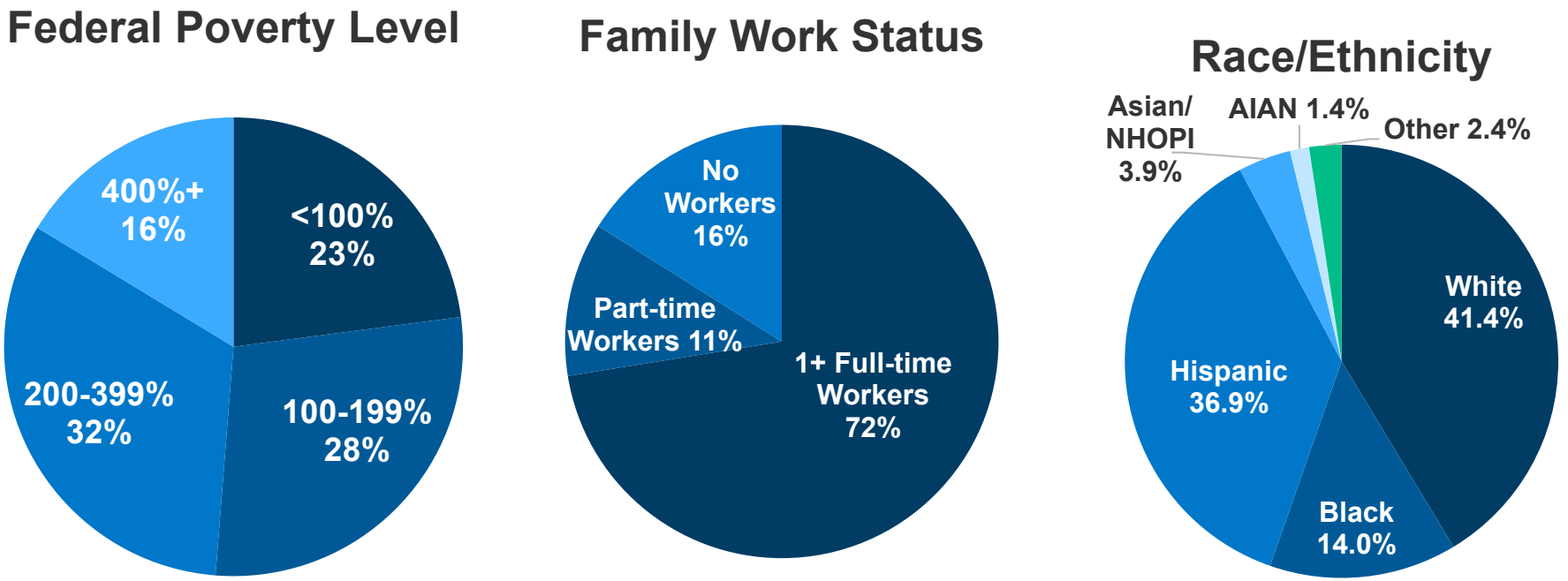


NOTE: Includes nonelderly individuals ages 0 to 64.
SOURCE: KFF analysis of 2008-2018 American Community Survey (ACS), 1-Year Estimates.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 16

Share of Nonelderly Uninsured by Selected Characteristics, 2018



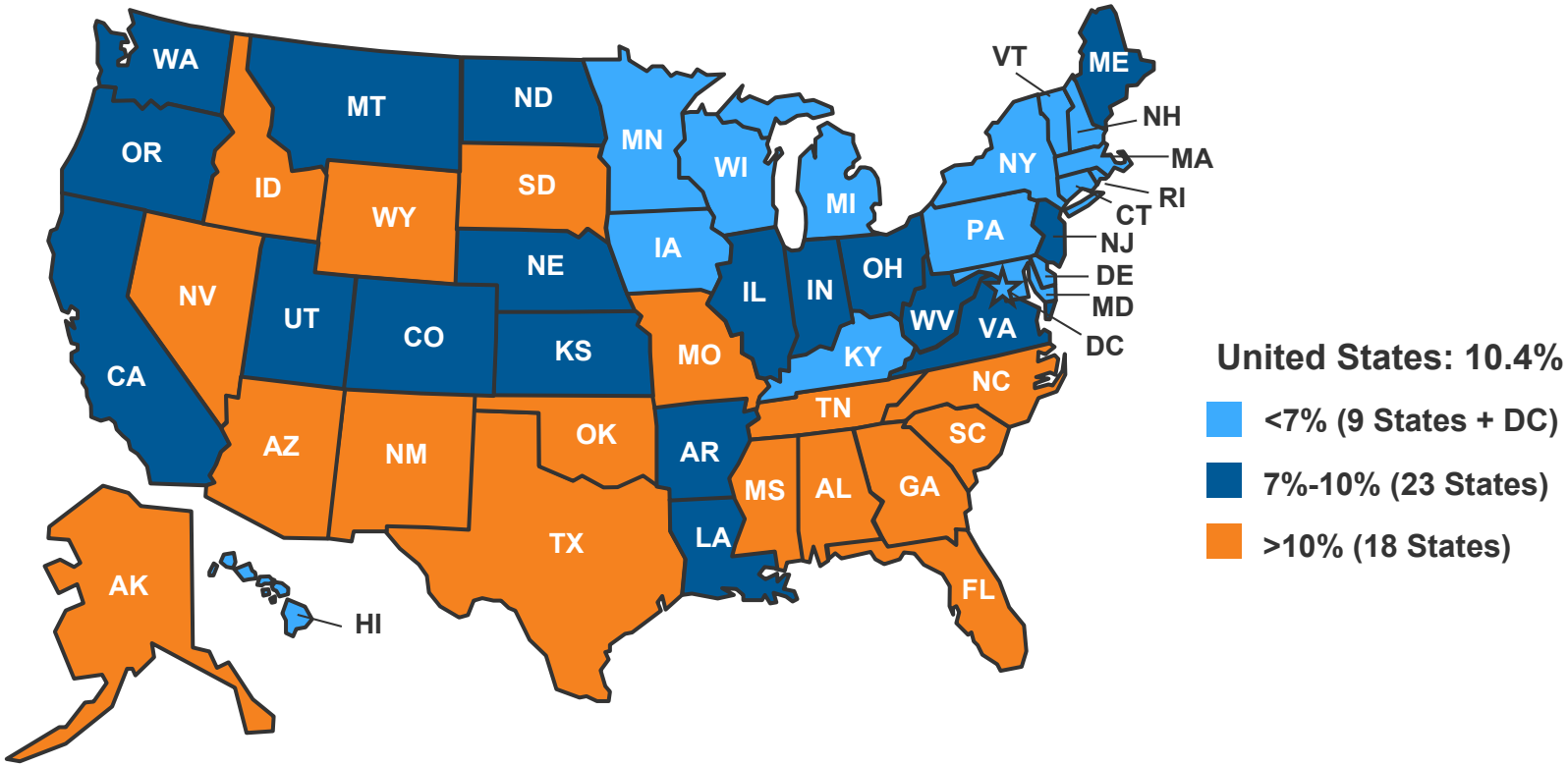
Total Nonelderly Uninsured = 27.9 Million

NOTE: Includes nonelderly individuals ages 0 to 64.
SOURCE: KFF analysis of 2018 American Community Survey, 1-Year Estimates.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 17

Uninsured Rates Among the Nonelderly by State, 2018

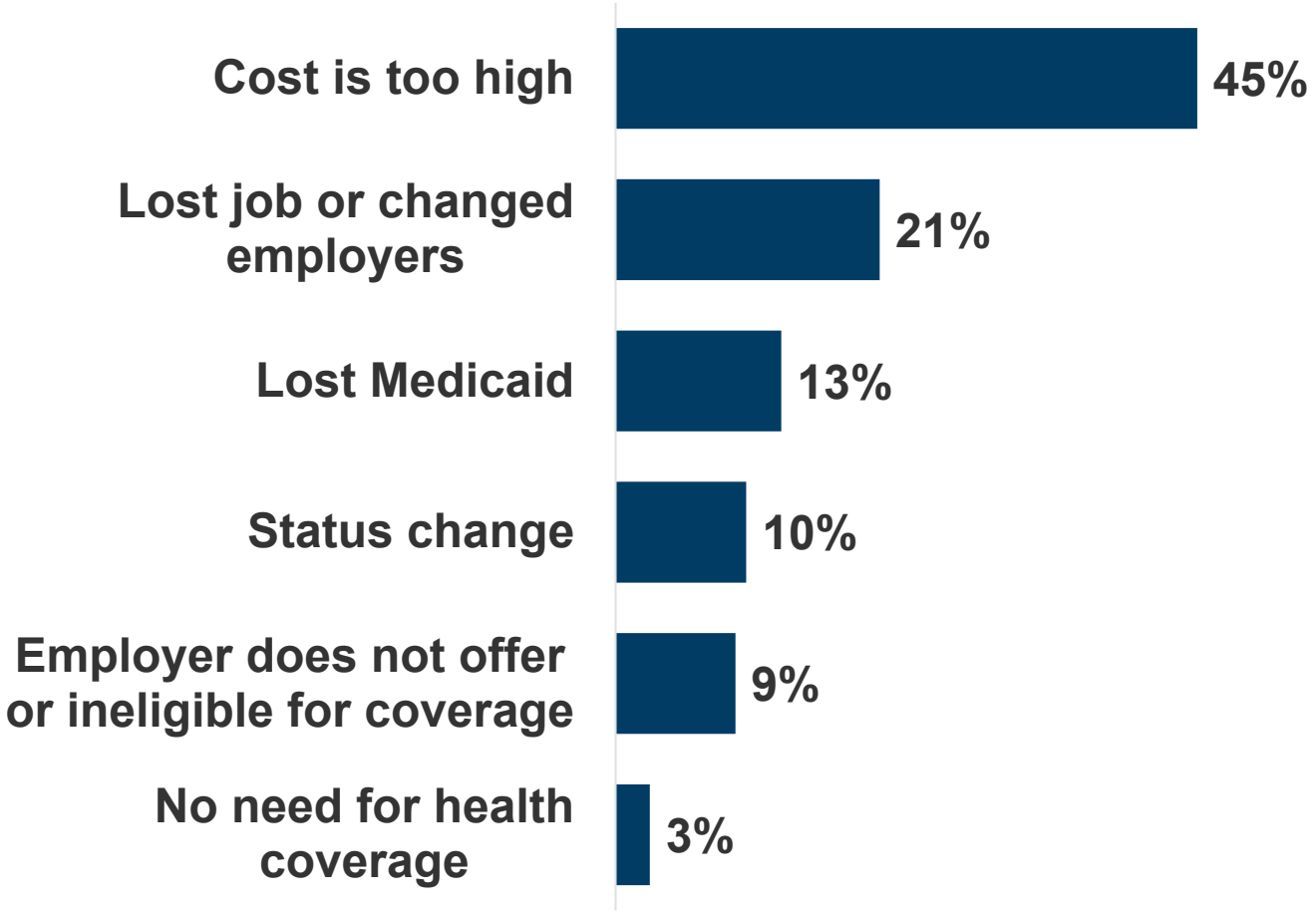


NOTE: Includes nonelderly individuals ages 0 to 64.
SOURCE: KFF analysis of 2018 American Community Survey, 1-Year Estimates.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 18

Reasons for Being Uninsured Among Uninsured Nonelderly Adults, 2018

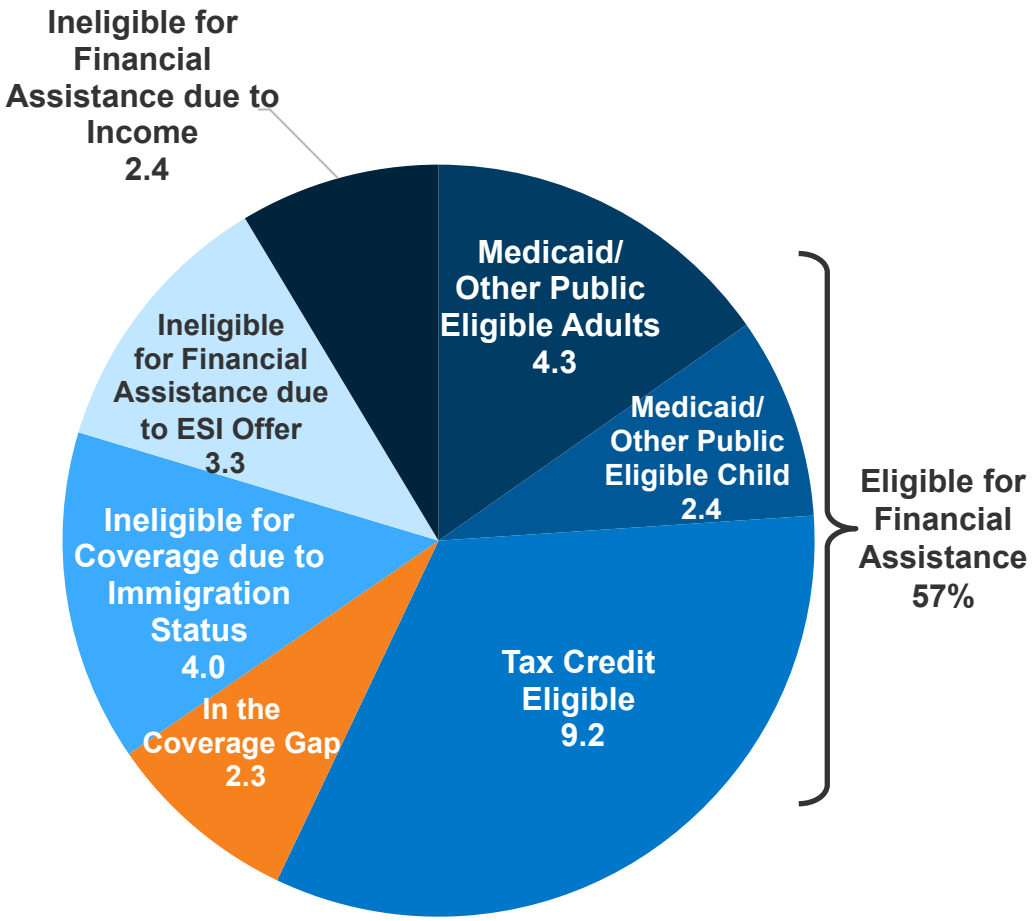


NOTE: Includes nonelderly adults ages 18 to 64.
SOURCE: KFF analysis of 2018 National Health Interview Survey.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 19

Eligibility for ACA Coverage among Nonelderly Uninsured, 2018



NOTE: Numbers may not sum to totals due to rounding. Tax Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan. Medicaid/Other Public also includes CHIP and some state-funded programs for immigrants otherwise ineligible for Medicaid.

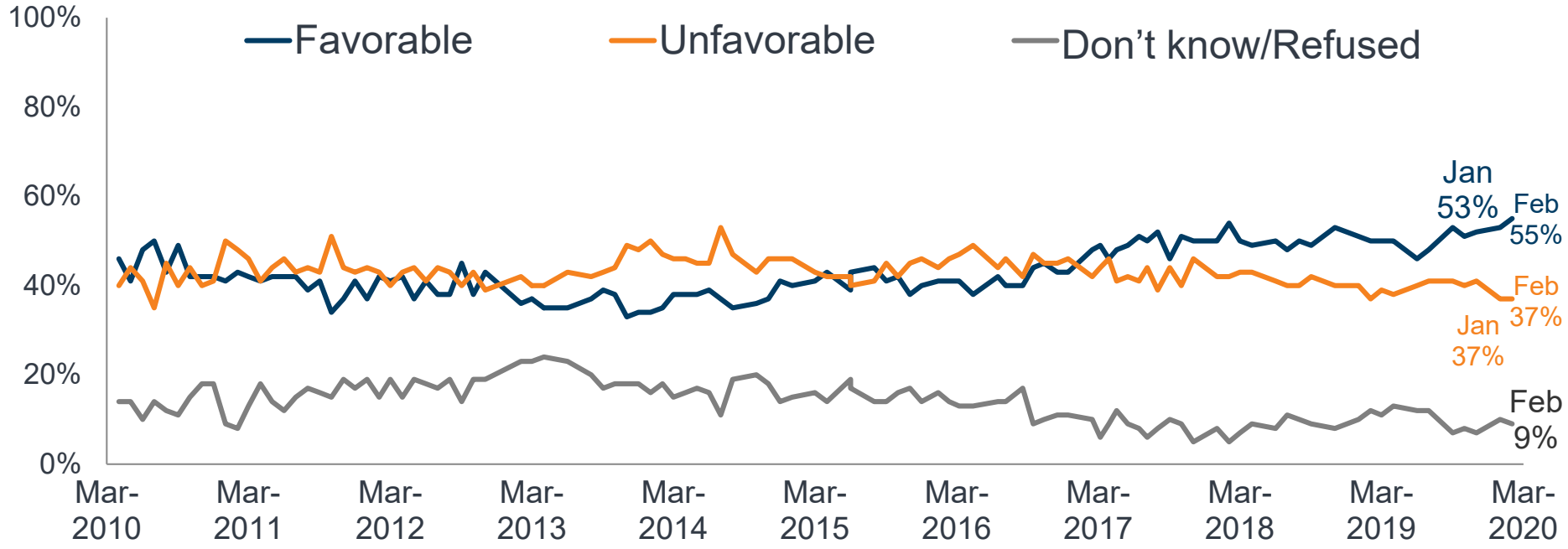
SOURCE: Kaiser Family Foundation analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 20

Clear Majority Of The Public Now Favor 2010 Affordable Care Act

Do you have a generally favorable or generally unfavorable opinion of the 2010 heath reform law?



SOURCE: KFF Health Tracking Polls. See topline for full question wording and response options.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 21

Republicans Are Now Prioritizing Other Health Care Issues Over Repealing The ACA

AMONG REPUBLICAN VOTERS: When you say health care is one of the most important issues in making your decision about who to vote for this year, what specifically do you mean *(open-ended)?*

RANK	MARCH 2016	OCTOBER 2018	FEBRUARY 2020
1	Opposition to/Repealing the ACA 29%	Health care costs 21%	Health care costs 24%
2	Health care costs 20%	Opposition to/Repealing the ACA 18%	Opposition to single-payer/Medicare-for-all 19%
3	Increasing access to health care 10%	Concern about quality of coverage 7%	Increasing access to health care 15%
4	Medicare/Senior concerns 4%	Medicare/Senior concerns 7%	Opposition to/Repealing the ACA 3%

NOTE: February 2020 question asked of those who say health care is very or somewhat important to their vote (79%). Percentages reported based on total registered voters. Open-ended responses, top four shown
SOURCE: KFF Health Tracking Poll (conducted March 7-14, 2016, September 19-October 2, 2018 and February 13-18, 2020). See toplines for full question wording.

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 22

Texas v. US Lawsuit Challenges Constitutionality of ACA

- 16 Republican state attorneys general, led by Texas, filed suit in 2018 arguing that the ACA in its entirety is unconstitutional because the individual mandate without a tax penalty is unconstitutional (Congress repealed tax penalty for the ACA individual mandate in 2017)
- The Trump administration supports this lawsuit and has argued that nearly all of the ACA, including protections for people with pre-existing conditions, should be overturned. Pending a final decision on the case, the Administration continues to enforce the ACA
- 21 Democratic state attorneys general, led by California, intervened in the case to defend the ACA. The House of Representatives joined as a party in support of the defending states
- In 2018, a federal district court agreed with plaintiffs that the entire law is unconstitutional
- In 2019, the 5th Circuit Court of Appeals affirmed the individual mandate is unconstitutional, but sent case back to trial court to analyze which ACA provisions are "severable" and can be preserved
- Supreme Court will hear appeal. Case may be argued this fall, prior to the 2020 election, but will most likely be decided later in the next term, after the 2020 election

Figure 23

KFF Resources

- ACA/Marketplace Frequently Asked Questions https://www.kff.org/health-reform/faq/health-reform-frequently-asked-questions/
- Marketplace Subsidy Calculator https://www.kff.org/interactive/subsidy-calculator/
- ACA Analyses and Data, *Texas vs. US* case https://www.kff.org/health-reform/
- Private Insurance Analyses and Data https://www.kff.org/private-insurance/
- Employer Health Benefits Survey https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/
- Uninsured https://www.kff.org/uninsured/
- State Health Facts https://www.kff.org/statedata

KFF
HENRY J KAISER FAMILY FOUNDATION

Figure 24

Contact Information

Karen Pollitz
Senior Fellow
Email: **karenp@kff.org**
Phone: 202-654-1307

KFF
HENRY J KAISER FAMILY FOUNDATION