Advocate's Guide to Reproductive Health in the Medicaid Program: *Updated Information Following the Passage of the Patient Protection and Affordable Care Act*

About this Patient Protection and Affordable Care Act Update

On March 23, 2010, President Obama signed major health care reform legislation, the Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA).[1] The *Advocate's Guide to Reproductive Health in the Medicaid Program* was written prior to the passage of the ACA, and this update incorporates new changes to Medicaid triggered by the ACA that are important for reproductive health.

The ACA changes the landscape of the health care system in a number of ways, including:

- Expands Medicaid starting January 1, 2014, covering 16 million uninsured people, although states have the option to begin the expansion immediately;
- Creates state-based insurance "exchanges" in 2014, which will cover another 16 million uninsured people, many of whom will get subsidies to purchase health insurance;
- Creates many new options for state administration of the Medicaid program – for example, a new State Plan Option to cover family planning services and supplies;
- Creates new initiatives in the Children's Health Insurance Program (CHIP), Medicare and other publicly funded health care programs; and
- Creates a wide array of consumer health insurance protections.

Many of these initiatives, and others, impact the Medicaid program and access to reproductive health services. As millions of additional low-income people will be eligible for Medicaid, it is more critical than ever that advocates understand the Medicaid program. This *Update* will describe the changes as they relate to the material in this *Guide*.

The ACA significantly changes how most people in the U.S. will access health insurance coverage, and creates new health insurance Exchanges through which low-income people whose incomes are too high to qualify for Medicaid can obtain subsidized health coverage. Many of these newly covered individuals will transition between the health Exchange and Medicaid as their income and circumstances fluctuate. While Medicaid is the focus of this *Guide*, advocates will also need to understand how the Exchanges operate.

IMPORTANT NOTE: As the Administration and states begin issuing regulations and policies to implement the ACA, NHeLP will provide periodic updates to keep advocates apprised of the current state of law and policy, and the advocacy opportunities at the state and federal level. Check our website at www.healthlaw.org.

National Health Law Program
1444 I Street NW, Suite 1105 · Washington, DC 20005 · (202) 289-7661 · Fax (202) 289-7724
3701 Wilshire Boulevard, Suite 750 · Los Angeles, CA 90010 · (310) 204-6010 · Fax (213) 368-0774
101 E. Weaver Street, Suite G-7 · Carrboro, NC 27510 · (919) 968-6308 · Fax (919) 968-8855
www.healthlaw.org

How to Use This ACA Update

When reading content in the *Advocate's Guide to Reproductive Health in the Medicaid Program* (the *Guide*), refer to this *ACA Update* to find any relevant changes. This *Update* is organized with page number headings that match the page numbers in the *Advocate's Guide*. Simply note the page number of the content in the *Advocate's Guide*, and find the corresponding section in the *Update*.

Index to the Advocate's Guide

Page 5, "III. Overview of the Medicaid Program"

Health reform will change the landscape of Medicaid eligibility in 2014. Currently, and up until 2014, Medicaid does not cover all poor people. Starting January 1, 2014, however, Medicaid will cover nearly all people with incomes below 133 percent FPL.[2] As described in detail below, the ACA created a new category of eligibility, referred to as "newly eligible," consisting of people with incomes below 133 percent FPL who do not fit into any of the traditional categories of eligibility. The ACA maintains existing Medicaid rules on immigration status including the five-year bar for legal immigrants and the state residency requirement. In addition, states have optional authority to expand Medicaid before 2014. Millions of previously ineligible single women, in particular, including young adult women, older women under age 65, and childless lesbians, will have access to comprehensive health coverage and care. Note that the previously existing Medicaid programs will continue to operate with the same financial and other eligibility criteria.

Page 5, "A. Administration"

Under the ACA, Medicaid participation remains optional for states. Once a state chooses to participate in Medicaid, it is required to cover a number of populations – including the new Medicaid expansion group.

There is a new non-discrimination provision, which explicitly prohibits any health program that receives federal funding from discriminating on the basis of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Rehabilitation Act of 1973. These civil rights laws explicitly apply to "contracts of insurance." [3]

Page 6, "4. Federal Financial Participation (FFP)"

The ACA added new federal financial participation (FFP) rates (commonly called federal matching rates) for "newly eligible" populations under the Medicaid expansion. The newly

eligible matching rate will be 100 percent in 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.[4] States that already cover some part of the newly eligible population will not receive the full matching rate for these populations from 2014-2019 but will gradually have their current matching rate adjusted upwards to ultimately correspond to the 90 percent match rate in 2019.[5] Existing Medicaid categories will retain their traditional matching rates.

Page 6, "5. Service Delivery"

The ACA expands authority for a number of alternative delivery systems in Medicaid in addition to fee-for-service and Medicaid managed care, including medical homes,[6] accountable care organizations,[7] global payment,[8] bundled payment,[9] and others.

Page 7, "B. Medicaid Eligibility"

The ACA makes significant changes to the Medicaid eligibility framework. Medicaid is available to everyone under age 65 whose income is under 133 percent FPL and who meets basic residency and immigration requirements, making coverage available for millions of people who do not currently fit into any of the eligibility categories. Additionally, there are several new optional categories and services in Medicaid, as described in further detail below.

Page 7, "1. Eligibility Categories, a. Mandatory Categorically Needy"

The Medicaid expansion creates a new mandatory category for individuals under age 65 with incomes up to 133 percent FPL who are not eligible for one of the traditional categories. This category is referred to as "newly eligible." All states participating in Medicaid must cover this group as of January 1, 2014 or sooner at a state's option. Note that the long-standing categories of Medicaid are preserved. For example, a pregnant woman at 100 percent FPL is still eligible through the state's pregnancy category.

As of January 1, 2014, the mandatory Medicaid income eligibility level for children ages 6 to 19 changes from 100 percent FPL to 133 percent FPL.[10]

Starting January 1, 2014, states must provide Medicaid coverage to individuals under the age of 26 who are in foster care, and who are not eligible for Medicaid in previously existing categories or are over the income limit for those categories. [11]

Page 8, "1. Eligibility Categories, b. Optional Categorically Needy"

The ACA creates several new optional categories of Medicaid:

- States have the option to implement the Medicaid expansion for individuals up to 133 percent FPL prior to the mandatory effective date in 2014.[12] States have flexibility to phase-in the expansion year-by-year if they choose.
- States have the option, starting 2014, to implement an expansion for non-elderly adult populations above 133 percent FPL.[13]

- States have the option to create a new category for individuals in need of family planning services.[14]
- States have the option to create a new category of eligibility for individuals in need of home and community-based services.[15]

Page 8, "3. Financial Eligibility: Income and Resources"

Beginning January 1, 2014, states will use different income rules to determine Medicaid eligibility for most applicants (including but not limited to many people in the newly eligible category). Income eligibility will be determined by using the Modified Adjusted Gross Income (MAGI) of an individual and household income of a family.[16] This income counting method is a significant change from the way income eligibility is currently determined. The MAGI rules will track the income counting method used by IRS tax forms. It will apply different rules for factors such as the type of income counted and the household composition, and it will not include numerous traditional Medicaid income deductions. The large Medicaid expansion up to 133 percent FPL starting in 2014 will include an automatic five percentage point income disregard (effectively making the limit 138 percent FPL), and it will have no asset test. Note, however, that some Medicaid enrollees will continue to use the traditional Medicaid income counting methods detailed in the *Guide,*[17] so there will be in fact two different income methodologies in use.

Page 13, "6. Medicaid Eligibility Expansion Programs"

The ACA does not eliminate the option for states to conduct Medicaid family planning demonstration programs. However, the ACA creates a new optional Medicaid category to expand eligibility for family planning services and supplies that can replace an existing family planning waiver. (See comments below for page 21 for more details).

CORRECTION: The content discussing the Breast and Cervical Cancer Prevention and Treatment Act of 2000 should be under "b. Optional Categorically Needy" on page 8. The BCCPT program is an Optional Category of Medicaid for states and not a Section 1115 demonstration program.

Page 13, "C. Applying for Medicaid"

The ACA does not change the basic rules of applying for Medicaid. However, it does require states to design more integrated application systems for Medicaid and other public health programs including the new health insurance exchanges, and it requires the availability of web-based unified portals for application.[18] If well implemented, these new systems may make it easier for people to apply for and qualify for Medicaid.

Advocacy tip: Well-designed application systems are essential to ensure that people are enrolled in the most comprehensive coverage at the lowest out of pocket costs for which they are eligible.

Page 14, "5. Presumptive Eligibility"

e. Presumptive Eligibility for Family Planning State Option (new section added after "d. Presumptive Eligibility for Children")

States now have the option to use a presumptive eligibility process for the new Medicaid category of eligibility for family planning services and supplies.[19] (See section for "Page 21" below for more details about new category.) The presumptive eligibility process must be made by a "qualified entity" that is authorized by the state and participates in Medicaid. The process is essentially the same as for pregnant women, children, and the Breast and Cervical Cancer Treatment Program as detailed in the *Guide*.

Page 17, "IV. Services, A. Services Categories"

As discussed below in the update to "Page 21," the ACA creates a new optional category for family planning services and supplies. Consistent with existing Medicaid law, the ACA does not include a definition of family planning services and supplies; however, it explicitly expands covered services in the new category to include "medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting."[20] The latter, described in CMS guidance as family planning-*related* services, represents a new and potentially broad set of services provided in the family planning context, including follow-up treatments provided outside of the family planning visit but which are "identified or diagnosed" at a family planning visit.[21]

Page 18, "4. Benchmark Benefits" (new section added after "3. Services for Medically Needy Beneficiaries")

The Deficit Reduction Act (DRA) of 2005 gave states the option to apply "benchmark" (or "benchmark equivalent") benefits packages to certain eligibility groups.[22] This benchmark benefits standard is important because it is the basis of benefits packages for: 1) some existing Medicaid populations, as initially provided in the DRA of 2005; 2) the new Medicaid expansion population created in health reform starting 2014; and 3) the new state exchange health insurance plans that will start in 2014.

These benchmark plans can have a defined set of benefits that is less than what the state is offering in its Medicaid program so long as the coverage is at least equal to the coverage in certain plans offered in the state (the "benchmarks") such as a plan generally offered to state employees, or the standard Blue Cross/Blue Shield plan for federal employees in the state.[23] Benchmark plans are generally allowed to impose premiums and cost sharing. Benchmark plans and benchmark-equivalent coverage are required to cover family planning services and supplies without cost sharing.[24]

Page 21, "V. Women's Health Services"

The ACA significantly expands access to family planning services through the Medicaid expansion and the optional family planning expansions. Millions of previously uninsured women will have access to comprehensive health care (except abortion care as discussed on "Page 27" below) including reproductive health services.

A note about preventive services for women: The ACA requires that all preventive services designated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) be covered without cost-sharing. This includes services such as vaccinations, breast and cervical cancer screening, healthy diet counseling, and screening for chronic conditions such as diabetes, hypertension, and obesity.[25] Notably, the "A" and "B" designations do not include contraceptives. The ACA directed the Health Resources and Services Administration (HRSA) to recommend to the Secretary of HHS which women's preventive health services should be required to be covered without cost-sharing, and HHS commissioned the Institute of Medicine (IOM) to study this question. The IOM recommended the addition of eight preventive services, and HHS issued regulations requiring that the following services be included in individual and group health insurance plans without cost sharing in new plans beginning on or after August 1, 2013.[26]

- Screening for gestational diabetes
- Testing for HPV
- Counseling for sexually transmitted infections
- Counseling and screening for HIV
- The full range of FDA-approved contraceptive methods and counseling
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence
- Annual well-woman visits

Page 21, "1. Eligibility for Family Planning Services"

Eligibility for family planning expansions:

In addition to mandatory coverage of a range of family planning and women's health services for people with incomes below 133 percent FPL who qualify for Medicaid, the ACA creates a new optional category of eligibility for states to provide family planning services and supplies to individuals based solely on income through a State Plan Amendment (SPA).[27]

States can set eligibility levels up to the higher of the maximum income eligibility for pregnant women in the state Medicaid program or in the state Children's Health Insurance Program. Pregnant women are counted as a family of two. States also have the option to count only the income of the applicant. The language of the statute is gender neutral, and services can also be provided to men.[28] There is no age limit on eligibility. Therefore, with the new state plan option, states have a choice of mechanisms through which they can expand family planning

services. States that currently have a family planning waiver in effect can convert the existing waiver to a SPA. States without a waiver can initiate a SPA. Last, the ACA does not limit the ability of states to expand family planning through a waiver. If states move enrollees from an existing waiver to a new State Plan category, they must provide the individual with notice. [29] Moreover, states have the option to grandparent in women who would have been eligible through the state's Section 1115 waiver based on the eligibility criteria in place on January 1, 2007.[30]

Advocacy tip: Advocates should gauge the political and administrative climate in their state to determine which option is most achievable.

For individuals who are eligible through the new optional family planning eligibility category, states will receive the same traditional 90 percent matching rate – except that family planning-*related* services (described previously at "Page 17") will only be reimbursed at the state's lower standard matching rate. As noted above, states can also offer presumptive eligibility for family planning services.

Page 22, "2. Access to Family Planning Providers"

If a state with a Section 1115 family planning waiver converts that waiver to a State Plan Amendment through the new option described above, any network restrictions allowed by the waiver would no longer be permissible, and the enrolled women would gain the full Freedom of Choice rights to go out of network.

Page 22, "3. Covered Services"

"Family planning services and supplies" continue to be a required Medicaid service, but the term is not defined, leading to great variability among state programs. For states that select the new family planning State Plan Option, the ACA specifically allows states to cover not only family planning services, but also "diagnosis and treatment services provided during a family planning service visit in a family planning setting,"[31] (which CMS refers to as "family planning-*related* services") and enables advocates to press for more expansive service packages through the new eligibility category. CMS has issued guidance on the new State Plan Option that includes examples of family planning-related services such as: STD treatment when the STD is identified during a routine family planning visit including follow-up visits and rescreening, annual visits for men, treatment of urinary tract infections, major complications related to contraceptive methods such as IUDs and Depo-Provera injections, and cervical cancer vaccinations.[32]

As mentioned earlier, the ACA also requires benchmark or benchmark-equivalent plans to cover family planning services and supplies without co-payment.[33]

Page 23, "b. Sterilization Services"

Family planning-*related* services coverable under family planning SPA expansions, discussed previously, may include major complications related to sterilization services such as surgical or anesthesia-related complications.[34]

CORRECTION: The citation for footnote 159 should be: 42 U.S.C. § 1396d(a)(xvii)(4).

Page 25, "B. Family Planning Demonstration Projects"

As discussed previously, states that currently expand access to family planning services using a Section 1115 demonstration project can now do so using a new optional category of Medicaid available through a State Plan Amendment (SPA). Using the SPA process has several advantages as compared to the demonstration program, including: no regular renewals of authority, no budget neutrality requirement (and thus no limits on number of enrollees), option to use presumptive eligibility, permanence in the state Medicaid program, and authority for more expansive benefits. However, health reform also allows states to continue using the demonstration authority to conduct their family planning expansions if they so choose.

Page 26, "C. Services for Pregnant Women"

The ACA includes a new requirement mandating coverage for services provided at freestanding birth centers. Freestanding birth centers are facilities separate from hospitals that are licensed by the state to provide prenatal, labor and delivery, and post-partum care. So long as the freestanding birth centers are recognized and licensed under state law and are operating within their authorized scope of practice, health professionals such as nurse midwives, birth attendants and other professionals can provide covered services and are not required to be supervised by a physician.[35] This creates another option, effective immediately,[36] for pregnant women to receive high-quality services in the Medicaid program.

The ACA also includes a provision raising the rate of payment for Certified Nurse-Midwives to align their payment more closely with that of physicians.[37]

In addition, the ACA requires coverage of smoking cessation drugs and services for pregnant women, including diagnostic services, therapy and counseling, and over-the-counter and prescription drugs and devices.[38]

Page 27, "D. Abortion Under Medicaid"

The ACA did not alter the ban on abortion funding in the Medicaid program; however, the Medicaid expansion means that millions more women will now face abortion restrictions. In addition, the ACA added new restrictions on abortion access in the new health insurance exchanges.[39] States are explicitly allowed to entirely prohibit abortion coverage in their state exchanges.[40] Federal subsidy funding cannot be used for abortion coverage except for

pregnancies due to rape or incest, or pregnancies that endanger the life of the woman. Enrollees in plans that cover abortion service must make a separate payment of a minimum of $1 per month, and insurers must segregate those funds from other premium payments. HHS will issue regulations on how these abortion provisions will operate.[41]

Page 28, "E. Refusal Clauses"

The ACA specifically states that it will not affect existing federal laws on refusals;[42] however, it prohibits discrimination against individual providers and facilities that refuse to provide, pay for, cover, or refer for abortion, but does not extend that protection to those who are willing to provide those abortion services. [43]

In February 2010, HHS issued final regulations titled, *Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws*. The final regulations substantially rescind and revise the 2009 HHS regulations issued under President Bush. The new regulations affirm underlying existing law, remove the certification requirements, and designate the Office of Civil Rights to receive complaints of violations of existing conscience laws. [44]

Page 31, "G. Mental Health Services"

The ACA improves access to mental health and substance abuse services in at least two critical ways. First, the coverage of about 32 million uninsured individuals will dramatically and broadly expand access to these services. Second, the minimum benefit requirements in both Medicaid[45] and private insurance in the exchange[46] include parity for mental health and substance abuse services. Numerous additional provisions improve access to mental health services.

Prior to passage of the ACA, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (effective July 2010) was enacted, requiring parity among private and self-insured insurance products that cover mental health and substance abuse services.[47]

Page 32, "H. Language Services Limited English Proficient Patients"

The anti-discrimination language in the ACA explicitly extends the protections of Title VI to the health insurance exchanges.[48] Discrimination under Title VI has been interpreted to include preventing meaningful access to federally funded services for "national origin minorities" with limited English proficiency.[49]

Page 34, "J. Prescription Drug Coverage"

Medicaid programs will no longer be able to exclude smoking cessation agents, barbiturates, and benzodiazepines (psychotropic drugs) from coverage under Medicaid.[50]

VI. Appendix A: Other Reproductive Health Programs

Page 36, "A. Title X Family Planning Clinics"

The impact of the ACA on Title X clinics is difficult to predict. Title X clinics are the regular source of care for many low-income women, and they feel safe and believe their confidentiality is protected in the Title X system of care. The ACA requires health plans in the exchanges to contract with "essential community providers," and it is not yet clear if all or most Title X clinics will be able to contract with health plans and managed care entities in the new system.

Advocacy tip: Get involved with the development of the health insurance exchange in your state to ensure that family planning providers are included in the state systems of care.

Page 37, "D. Sexuality Education"

The ACA allocates $75 million per year for five years for medically accurate, evidence-based sexuality and relationship education referenced as "personal responsibility education," [51] including $10 million for new initiatives on pregnancy prevention for at-risk youth. However, $50 million per year is also allocated to abstinence-only education. [52]

Page 37, "E. Children's Health Insurance Program (CHIP)"

The ACA creates a Maintenance of Effort requirement for state enrollment of children in CHIP (and Medicaid) programs until October 1, 2019, and provides for the funding of CHIP until October 1, 2015. [53] States that are unable to cover all eligible children under CHIP (for example, if they run out of federal funding) can enroll children in comparable exchange-based insurance.

Page 38, "G. Maternal and Child Health Block Grants"

HHS is authorized to issue grants for new prenatal, early childhood and childhood home visitation programs. [54] Furthermore, as a condition of receiving Title V funding in 2011, states must conduct a needs assessment to identify important problem trends (such as low birth weights, infant mortality and domestic violence) in at-risk communities. [55] States are subsequently required to analyze and report on the capacity to address these problems. In addition, a new provision in the Maternal and Child Health Services Block Grant allows the Secretary to make grants to public and nonprofit entities to fund projects that develop, operate, or coordinate the provision of direct services to people with or at risk for postpartum depression. [56]

The chart on the following page provides a brief outline of the changes made to the health care law as a result of the ACA and the new benefits afforded to women

Title I – Improvements in Health Care Coverage for All Americans			
Section	Title	Primary Scope	Effective
Subtitle A – Amendments to the Public Health Service Act			
Sec. 1001	Coverage of preventive health services under PHSA Sec. 2713	New group or individual health plans must provide, at a minimum, certain preventive health services with no cost-sharing including breast and cervical cancer screening, breastfeeding promotion, and STI screening and counseling. These services must also include folic acid supplements and counseling for smoking cessation for pregnant women.	Sept. 23, 2010
Subtitle B – Immediate Actions to Preserve and Expand Coverage			
Sec. 1101	Immediate access to insurance for uninsured individuals with a pre-existing condition	Temporary high-risk health insurance program to provide coverage for individuals with a pre-existing condition until state exchanges are established in 2014. Coverage under these new plans is to include essential health benefits, which initially include a requirement to pro-vide at least maternity and newborn care, prescription drugs, and preventive and wellness services. Contraceptive services are not included (to date). This provision will benefit many women who currently lack insurance due to a pre-existing condition, including those previously unable to obtain private insurance that treated pregnancy as a pre-existing condition, thus requiring higher premiums for pregnant women or refusing to cover the cost of childbirth.	July 1, 2010 (ending Jan. 1, 2014)
Subtitle D – Available Coverage Choices for All Americans			
Sec. 1303	Special rules [for establishment of qualified health plans]	States may prohibit abortion coverage in qualified health plans in the exchanges. Qualified health plans in the exchange can choose to cover abortion services, and if covered, women must pay premiums in two separate checks. Health plans will be required to cover maternity and childbirth services for pregnant women as part of the "essential health benefits" package offered by health plans in the exchange. The requirement to provide maternity care is critical for women, as health insurance coverage increases the likelihood that pregnant women will receive screening and diagnostic tests to identify potential problems; services to manage and treat developing or existing problems; as well as the educational, counseling, and referral services necessary to ensure a healthy pregnancy and reduce risky behaviors.	Jan. 1, 2014

Title II – Role of Public Programs			
Subtitle A – Improved Access to Medicaid			
Sec. 2001	Medicaid coverage for the lowest income populations	Mandatory eligibility expansion for individuals with incomes up to 133 percent of FPL. Many women who previously couldn't get into Medicaid, or could only access family planning options, will be included in the health program as a result of this expansion (for example, lesbians, women aged 55-64, single women of all ages, and women with HIV). Pregnant women who are covered by Medicaid often lack health insurance before they become pregnant or become ineligible for continued Medicaid coverage shortly after giving birth (60 days postpartum). This expansion will increase the likelihood that more women have health insurance coverage prior to becoming pregnant, thus increasing the overall health of the woman and the likelihood of a successful pregnancy.	Jan. 1, 2014
Subtitle C – Medicaid and CHIP Enrollment Simplification			
Sec. 2201	Enrollment simplification and coordination with state health insurance exchanges	To receive any federal financial assistance for Medicaid after January 1, 2014, states must establish several procedures to simplify and coordinate enrollment with the state exchange. One such procedure includes outreach and enrollment of Medicaid/CHIP to vulnerable and underserved populations, including pregnant women.	Jan. 1, 2014
Sec. 2202	Permitting hospitals to make presumptive eligibility determinations for all Medicaid-eligible populations	Medicaid-participating hospitals may make presumptive eligibility determinations. This provision greatly expands the out-stationing function of many hospitals, and will give many low-income individuals, including women, access to Medicaid-covered services at the point of service.	Jan. 1, 2014
Subtitle D – Improvements to Medicaid Services			
Sec. 2301	Coverage for freestanding birth center services	This provision explicitly includes services provided in freestanding birth centers as part of the care and services covered as "medical assistance" in the Medicaid program. This provision will improve the range of choices available to pregnant women in the Medicaid program. Birthing centers will benefit from the additional federal funding, and more pregnant women will have easier access to high-quality maternity care.	March 23, 2010

Sec. 2303	State eligibility option for family planning services	Creates a new state option to extend family planning services and supplies to individuals solely based on income, through a state plan amendment rather than a waiver. "Family planning services and supplies" applies to both men and women, with no age restriction, and services can include "diagnosis and treatment services provided during a family planning service visit in a family planning setting."	March 23, 2010
Subtitle F – Medicaid Prescription Drug Coverage			
Sec. 2502	Elimination of exclusion of coverage of certain drugs	Over-the-counter smoking cessation drugs; barbiturates; and benzodiazepines will no longer be excluded from drug coverage under Medicaid.	Jan. 1, 2014
Subtitle L – Maternal and Child Health Services			
Sec. 2951	Maternal, infant and early childhood home visiting programs	Within six months of enactment, states must conduct a needs assessment to receive their fiscal year 2011 Title V allotment. The assessment must identify communities with concentrations of premature birth, low birth-weight infants and infant mortality; poverty; crime; domestic violence; high rates of high school drop-outs; substance abuse; unemployment; or child maltreatment. States must also assess existing programs for early child-hood home visitation in the state, and create a plan for addressing the needs identified. Additional federal funding will be dedicated to the expansion of home-visiting programs in which nurses and providers visit and provide support and counseling to pregnant teenagers and young mothers.	March 23, 2010
Sec. 2952	Services to individuals with a postpartum condition and their families	This provision "encourages" HHS to expand research into the causes and treatment of postpartum depression and psychosis. It will also allow HHS to provide grants for direct services to people with or at risk for postpartum depression and their families.	March 23, 2010
Sec. 2953	Personal responsibility education	HHS Secretary is to allocate funding to the states for programs aimed at reducing teen pregnancy and birth rates by educating adolescents aged 10-19 on abstinence and contraception, prevention of pregnancy and STIs and HIV, and preparation for adulthood. States must apply for this funding, and to be eligible the programs must be evidence-based, medically accurate, complete, age appropriate, culturally competent, and include skills development (for example, healthy relationships, healthy marriages, financial literacy, career skills, and healthy living skills).	March 23, 2010
Sec. 2954	Restoration of funding for abstinence education	The ACA restores funding for abstinence education, allocating $50 million per year for fiscal years 2010-2014 for abstinence-only-until-marriage education.	March 23, 2010

Title IV – Prevention of Chronic Disease and Improving Public Health			
Subtitle B – Increasing Access to Clinical Preventive Services			
Sec. 4101	School-based health centers	Authorizes the HHS Secretary to award grants to support the operation of school-based health centers. Preference may be given to schools serving large populations of Medicaid- or CHIP-eligible children.	March 23, 2010
Sec. 4102	Oral healthcare prevention activities	Establishes a five-year national, public education campaign focusing on oral health prevention and education, to be targeted to specific populations, including pregnant women and parents.	March 23, 2010
Sec. 4106	Improving access to preventive services for eligible adults in Medicaid	The ACA expands the definition of preventive services that can be covered by a state as optional services under Medicaid. While contraceptive services are not on this list (yet), other services including breast and cervical cancer screening, breastfeeding promotion, STI screening and counseling, and tobacco-use counseling and intervention are included as preventive services for purposes of this provision.	Jan. 1, 2013
Sec. 4107	Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid	The ACA requires coverage of products, drugs and therapies to help pregnant women stop smoking. Services include diagnostic, therapy and counseling services, as well as prescription and non-prescription drugs and products approved by the FDA for smoking cessation. Smoking cessation products are added to the list of services for pregnant women that are exempt from cost-sharing. This provision is critical as studies have found that pregnant women in Medicaid are 2.5 times more likely than other pregnant women to smoke.	Oct. 1, 2010
Sec. 4108	Incentives for prevention of chronic diseases in Medicaid	Appropriates $100 million to HHS to award grants to states for innovative programs that will create incentives for Medicaid beneficiaries to improve their health and avoid certain chronic conditions.	Jan. 1, 2011

Subtitle C – Creating Healthier Communities			
Sec. 4201	Community transformation grants	Competitive grants are to be issued to state and local governments and community-based organizations, to implement and evaluate community preventive programs to promote healthy living and reduce health disparities.	March 23, 2010
Sec. 4203	Removing barriers and improving access to wellness for individuals with disabilities	Within 24 months of enactment of the ACA, the Architectural and Transportation Barriers Compliance Board (ATBCB) must promulgate regulations establishing minimum physical accessibility requirements for medical diagnostic equipment used in various health care settings.	March 23, 2010
Sec. 4207	Reasonable break time for nursing mothers	Employers are required to provide a reasonable break time for employees to express breast milk for nursing children when the need arises, and they must provide a private area (other than a bathroom) for employees to express breast milk that is free from intrusion. Employers with fewer than 50 employees are exempt from these provisions if it would impose an undue hardship.	March 23, 2010
Subtitle D – Support for Prevention and Public Health Innovation			
Sec. 4302	Understanding health disparities: data collection and analysis	Several deficiencies in federal data collection are targeted by this provision as a way to improve identification and analysis of health disparities. This is meant to allow ongoing, accurate, and timely collection and evaluation of data on disparities in health care services, and performance on the basis of race, ethnicity, sex, primary language and disability status.	March 23, 2010

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act (Pub. L. No 111-152, 124 Stat. 1029 (2010). This law is cited in this *Update* as PPACA and Recon.

[2] The notable exception is that Medicaid will continue to offer only emergency coverage for undocumented immigrants and others without satisfactory immigration status.

[3] PPACA § 1557.

[4] Recon Act § 1201 adding 42 U.S.C. § 1396b(y)(1).

[5] Recon Act § 1201.

[6] PPACA § 2703 and § 3021(a) creating new Social Security Act § 1115A(b)(2)(B)(i) and (viii).

[7] PPACA § 2706.

[8] PPACA § 2705 and § 3021(a) creating new Social Security Act § 1115A(b)(2)(B)(ii), and (xi).

[9] PPACA § 2704.
[10] PPACA § 2001(a)(5).
[11] PPACA §§ 2004(a), 10201(a) adding a new section IX to 42 U.S.C. § 1396a(a)(10)(A)(i).
[12] PPACA § 2001(a)(4) as amended by § 10201.
[13] PPACA § 2001(e).
[14] PPACA § 2303.
[15] PPACA § 2402(b).
[16] PACA § 2002(a) as amended by Recon Act § 1004.
[17] Populations and services that will be subject to the current income rules include: Individuals eligible on a basis that requires state determination of income (e.g. SSI recipients or foster child who is a ward of the state); Individuals who have attained age 65; Individuals who qualify on the basis of being blind or disabled or treated as such (without regard for SSI eligibility), including individuals eligible under the Katie Beckett option; Medically needy individuals; and Individuals for whom Medicaid is paying Medicare cost-sharing amounts, including Qualified Medicare Beneficiaries.
[18] PPACA § 2201.
[19] PPACA § 2303(b).
[20] PPACA § 2303(a)(3)(B).
[21] Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 5 (July 2, 2010).
[22] 42 CFR § 440.335 and Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 5 (July 2, 2010).
[23] 42 U.S.C. § 1396u-7; PPACA § 2001(a)(2).
[24] PPACA § 2303(c); CMS State Medicaid Director Letter SMDL #06-015 (June 16, 2006); 42 CFR § 440.335 (Benchmark plans must cover family planning); Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 5 (July 2, 2010) (Benchmark plans cannot charge co-payment for family planning services and supplies).
[25] ACA § 1001, 42 U.S.C.A. 300gg-13 (a)(1)(West 2011)(adding § 2713(a)(1) to the Public Health Service Act). The USPSTF designation "A" is for services that are likely to provide a substantial benefit to patients; "B" is for services that are substantially likely to provide a moderate benefit to patients or the service is moderately likely to provide a substantial benefit to patients. See generally http://www.uspreventiveservicestaskforce.org.
[26] ACA § 1001, 42 U.S.C.A. 300gg-13(a)(4) (West 2011)(adding § 2713(a)(4) to the Public Health Service Act. For the IOM recommendations, see Institute of Medicine Committee on Preventive Services for Women, *Clinical Preventive Services for Women: Closing the Gaps* (July 11, 2011) (prepublication copy) available at http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. For the final interim rule, see Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46,621 (Aug. 3, 2011) (to be codified at 45 CFR Part 147). These interim final regulations also include an exemption to the requirement to

provide contraceptive coverage for certain religious employers, such as churches, synagogues or mosques.

[27] PPACA § 2303, Recon Act § 1202.

[28] 42 U.S.C. § 1396a(ii)(1); *see also* Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 3 (July 2, 2010) (stating that men's annual visits would also cover comprehensive patient history, physical, laboratory tests and contraceptive counseling when conducted through a family-planning program).

[29] Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 5 (July 2, 2010).

[30] 42 U.S.C. § 1396a(ii)(2) as amended by PPACA § 2303(a)(2) (''At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.").

[31] 42 U.S.C. § 1396a(a)(10)(XVI) as amended by PPACA § 2303(a)(3)(B).

[32] Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 3 (July 2, 2010).

[33] 42 U.S.C. § 1396u-7 as amended by PPACA § 2303(c). *See also* Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 6 (July 2, 2010).

[34] Centers for Medicare & Medicaid Services, SMDL# 10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans 3 (July 2, 2010).

[35] PPACA § 2301(a)(2) adding 42 U.S.C. § 1396d(l)(3)(B), (C).

[36] In states where legislation is required to implement this section, states will not be considered out of compliance until the first quarter following the close of the state's next legislative session. PPACA § 2301(c)(2).

[37] PPACA § 3114.

[38] PPACA § 4107.

[39] PPACA § 1303.

[40] PPACA § 1303(a)(2).

[41] PPACA § 1303(b).

[42] PPACA § 1303(c)(2).

[43] PPACA § 1303(b)(4).

[44] 45 CFR Part 88, http://www.ofr.gov/OFRUpload/OFRData/2011-03993_PI.pdf.

[45] Benchmark benefits, which affect newly eligible Medicaid enrollees and many existing enrollees, will include parity for mental health and substance abuse services. See PPACA § 2001(c)(2) and (c)(3).

[46] PPACA § 1301(b)(1)(E) and § 1311(j).

[47] P.L. 110-343, § 512 (2008).

[48] PPACA § 1557.

[49] For more information about Title VI and the Affordable Care Act, see M Youdelman, The ACA and Application of § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges, National Health Law Program (Jan. 2011), http://www.healthlaw.org/images/stories/Short_Paper_6_The_ACA_and_Application_of_Section_1557_and_Title_VI.pdf.
[50] PPACA § 2502.
[51] PPACA § 2953 amending 42 U.S.C. § 713 (allotting states funding for personal responsibility education programs (based on population and state programs) to educate teens on "abstinence and contraception for the prevention of pregnancy and sexually transmitted infections" as well as "adulthood preparation subjects.").
[52] PPACA § 2955 amending 42 U.S.C. § 710 (extending funding until 2014).
[53] *See* PPACA § 2101.
[54] PPACA § 2951(c) amending 42 U.S.C. § 711.
[55] PPACA § 2951(b) amending 42 U.S.C. § 711.
[56] PPACA § 2951(b) amending 42 U.S.C. § 711.

Contact Us

NOTE: Please be advised that NHeLP cannot provide legal advice to individuals. We are not a direct service agency. The following websites may assist you in locating legal resources in your community:

Lawhelp.org: legal help for people with low and moderate incomes (and their lawyers)

LSC Directory: legal help in civil (not criminal) matters for low-income people.

Protection & Advocacy System: provides protection of the rights of persons with disabilities through legally based advocacy

The American Bar Association website provides useful links to lawyer referral services and pro bono legal help for the poor.

Washington, DC Office
1444 I Street NW, Suite 1105
Washington, DC 20005
ph: (202) 289-7661
fx: (202) 289-7724
nhelpdc@healthlaw.org

Los Angeles Office
3701 Wilshire Boulevard, Suite 750
Los Angeles, CA 90010
ph: (310) 736-1653
fx: (213) 368-0774
nhelp@healthlaw.org

North Carolina Office
101 East Weaver Street, Suite G-7
Carrboro, NC 27510
ph: (919) 968-6308
fx: (919) 968-8855
nhelpnc@healthlaw.org

Health Consumer Alliance

hca@healthlaw.org