NHeLP
NATIONAL HEALTH LAW PROGRAM

Fact Sheet
Federal Health Reform: The Patient Protection and Affordable Care Act of 2010[1]

produced by the National Health Law Program
Contact: Sarah Somers
with a grant from the Training and Advocacy Support Center (TASC)

June 2010

I. Introduction

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), which makes extensive changes to the American public and private health care systems.[2] The PPACA was amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), which was signed by the President on March 30, 2010.[3] Together, the laws are referred to as the Affordable Care Act (ACA).

The ACA will dramatically affect the financing, delivery, quality, and availability of health care services for all Americans. It will reform publicly funded programs like Medicaid, Medicare, and CHIP, revamp the private insurance market, and even make changes to the income tax system. Some provisions are effective immediately; others will be phased in over the coming years.

In this Fact Sheet, we will provide an overview of the ACA and will highlight selected provisions, particularly those related to disability and Medicaid. This represents NHeLP's initial interpretation of the law. This legislation is lengthy and complex and some ambiguities have already been identified. Many details will need to be fleshed out by regulations. Thus, the conclusions in this Fact Sheet are subject to refinement and adjustment as regulations and interpretive federal guidance are issued.

---

[1] Produced by the National Health Law Program with a grant from the Nathan Cummings Foundation, NC IOLTA, and the Training Advocacy Support Center (TASC), which is sponsored by the Administration on Developmental Disabilities, the Center for Mental Health Services, the Rehabilitation Services Administration, the Social Security Administration, and the HealthResources Services Administration. TASC is a division of the National Disabilities Rights Network (NDRN).
[2] Pub. L. No. 111-148 (March 23, 2010).
[3] Pub. L. No. 111-152 (March 30, 2010).

NHeLP will be releasing its in-depth analysis of the ACA in June 2010.

II. Health Insurance System Reform

Perhaps the most complicated and controversial features of the ACA are the changes it makes to private and public insurance markets. The fundamental underpinning of the legislation is the mandate that nearly all Americans have "minimum essential coverage." There are several different pathways that individuals may follow to obtain that coverage, depending on their household income and which options their states choose. These pathways are described below.

Minimum Essential Coverage is coverage provided through:

- Government programs including Medicaid, Medicare Part A, CHIP, TRICARE, Veteran's programs, and health care for peace corps volunteers;
- Most employer-sponsored health insurance plans;
- Plans purchased through the individual market
- Coverage through existing plans retained through the "grandfathering" requirement (PPACA § 1251)
- Other coverage recognized by the Secretaries of HHS and Treasury, such as high risk pools.

PPACA § 1501

A. Health Insurance "Exchanges" and Qualified Health Plans

The ACA requires American Health Benefit Insurance Exchanges ("Exchanges") to be established by January 1, 2014. Exchanges will be entities administered by government agencies or non-profit entities, through which individuals may purchase "qualified health plans."[4] Among other functions, Exchanges must implement procedures for certifying and assigning ratings to health plans and inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program. If it is determined that individuals are eligible for one of these public programs, they must be enrolled in it.[5]

Only qualified health plans will be offered through the Exchange. These are plans that are certified and:

- Cover certain essential benefits (see below);
- Are offered by licensed insurance issuers that (1) provide at least one qualified health plan at silver and gold levels and (2) agree to charge the same premium rate for the qualified health plan

[4] PPACA § 1311 (as amended by §§ 10104, 10203) (PPACA).
[5] *Id.* § 1311(d)(4).

regardless of whether the plan is offered through an Exchange, directly from the insurance issuer, or through an agent; and

- Comply with regulations designated by the Secretary of the Department of Health and Human Services (Secretary) and any other requirements imposed by the Exchange.[6]

Four different types of qualified health plans – platinum, gold, silver, and bronze - will be available through the Exchange. Each type of plan has a different level of cost sharing. Platinum plans will cover 90 percent of health care costs and individuals will be responsible for the remaining 10 percent. Gold plans cover 80 percent of health care costs; silver plans, 70 percent, and bronze plans, 60 percent, with enrolled individuals responsible for the remaining costs.[7]

Cost Sharing Definition

Deductibles, coinsurance, copayments and similar charges and other qualified medical expenses as defined by § 223(d)(2) of the IRS Code of 1986.

Premiums, balance billing for services provided by non-network providers, or spending on non-covered services are specifically excluded.

PPACA § 1302(c)(3).

All plans offered through the Exchange must cover certain essential benefits: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder services, including behavioral health services; (6) prescription drugs; (7) rehabilitation and habilitation services; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[8] This list of benefits will be defined and periodically updated by the Secretary, subject to notice and an opportunity for public comment.[9]

Lawfully present immigrants may purchase insurance through the Exchange and, as discussed below, are eligible for premium tax credits and service reductions.[10]

B. Optional Basic Health Programs and Standard Health Plans

States are also given the option of operating basic health programs

[6] PPACA § 1301.
[7] *Id.* § 1302(d).
[8] *Id.* § 1302(b)(1).
[9] *Id.* § 1302(b)(3), (4)(H).
[10] *Id.* § 1312(f)(3).

through which they may offer coverage to people who have household incomes of 134 percent to 200 percent of the Federal Poverty Level (FPL) and are not eligible for Medicaid. This is an alternative to offering coverage for such individuals through an Exchange. The "standard health plans" offered through this program must provide at least the essential health benefits provided in qualified health plans offered through the Exchange and have a medical loss ratio of at least 85 percent. The term medical loss ratio is not defined but, generally, it is the amount that a health plan collects in premiums that is expended on medical services, as opposed to profits, administration, marketing or other costs.[11]

The Secretary must certify that the monthly premiums required under standard plans are no greater than those required for the second lowest cost silver level qualified health plan offered under the Exchange. This is determined after reduction for any premium tax credits and reduction for cost sharing for which the individual is also eligible. And, any required cost sharing may not exceed the amount required in a platinum plan for individuals under 150 percent of FPL or the gold plan for all others.[12]

Standard health plans must provide at least the essential health benefits provided through qualified health plans. The state must establish a competitive process for entering into contracts to offer such plans that includes negotiating benefit packages, premiums, and cost sharing.[13]

States must, to the greatest extent possible, make multiple standard health plans available to ensure that potential enrollees have a choice of plans. States may negotiate regional compacts with other states to include coverage of eligible individuals in all participating states.[14] States must also seek to coordinate administration of this program with other programs including Medicaid, CHIP, and any other state-administered health programs.[15]

Immigrants who are lawfully present and have incomes no greater than 133 percent of FPL but are not eligible for Medicaid because of immigration status may also obtain coverage through standard health plans. To qualify, they cannot be eligible for "minimum essential coverage" or be eligible for an employer-sponsored plan that is not "affordable coverage."[16]

C. Removing Barriers to Obtaining Insurance

1. Affordability – Premium Tax Credits and Cost Sharing limits

[11] PPACA § 1331(a)(1), (b), (e).
[12] PPACA § 1331(a)(2). Cost sharing and premium protections are addressed below.
[13] *Id.* § 1331(c)(1), (2); *see also* § 1302(b).
[14] *Id.* § 1331(c)(3).
[15] *Id.* § 1331(c)(4).
[16] *Id.* § 1331(e).

Premium Tax Credits. The ACA makes significant revisions to the tax code. Tax credits are the mechanism by which individuals and families enrolled in qualified insurance programs through the Exchange will obtain financial assistance for payment of the monthly premiums. The idea is that the tax credit should pay for most of a monthly premium, with the individual being responsible for contributing the remainder. This credit will be paid directly to the insurer. This is a particularly complicated area of the health reform legislation and will require clarification through regulations and guidance.

Premium tax credits are available for citizens with incomes up to 400 percent of the federal poverty level (FPL) and lawfully present immigrants with incomes below 100 percent of FPL.[17] Individuals and families with incomes up to 133 percent of FPL are responsible for 2 percent of the premium. The percentage for which individuals and families are responsible increases on a linear sliding scale up to 9.5 percent for individuals and households at 400 percent of FPL. This means that they will be entitled to a tax credit to cover the remaining amount of the premium.[18] The formula to be used for determining the amount of the premium is described in detail in NHeLP's complete analysis.

Reduced Cost-Sharing. Individuals participating in qualified health plans or standard health plans at the silver level (meaning that they are responsible for 30 percent of all cost sharing) entitled to certain cost sharing reductions. Those eligible for gold, platinum, or bronze are not.[19] Citizens must also have incomes between 100 and 400 percent of FPL and immigrants must have incomes below 100 percent and not be eligible for Medicaid.

The responsibility of eligible individuals for payment of cost sharing will range from 6 percent of the value of the plan to 30 percent of the value of the plan, depending on the household income. The formula to be used for determining the amount of cost sharing for which individuals are responsible is described in detail in NHeLP's complete analysis.

Cost sharing reductions may only be given for a coverage month in which an individual is receiving a premium assistance tax credit.[20]

2. Protection against discrimination based on health status

Immediate action to assist individuals who have pre-existing conditions. By June 30, 2010, the Secretary must create a temporary high risk

[17] For the remainder of 2010, in the contiguous 48 states and D.C., 400 percent of FPL is $73,240 for a family of three, and 100 percent is $18,310 for a family of the same size. 75 Fed. Reg. 45628 (Tuesday, Aug. 3, 2010).
[18] PPACA § 1402(a) (as amended by Recon. Act. § 1001).
[19] *Id.* § 1402(b).
[20] *Id.* § 1402(d).

insurance pool program to cover uninsured individuals with pre-existing conditions. This program will only last until the state insurance Exchanges begin on January 1, 2014. The pools will be open to citizens, nationals, and others lawfully present in the U.S. who have pre-existing conditions. Insurers participating in the pool must cover at least 65 percent of the cost of the covered benefits. The insured individual's out of pocket limits (including deductibles and co-pays, but excluding premiums) are capped at $5 thousand annually for an individual and $10,000 for a family.[21]

Prohibition of discrimination in insurance. Discriminatory insurance rates in the individual or small group market are restricted by the ACA. Premiums may only vary based on certain factors: (1) geography/rating area; (2) age; (3) tobacco use; and (4) family structure. [22] Health insurance issuers must accept every employer and individual in the state that applies during open enrollment or special enrollment periods.[23] In addition, insurers may not exclude individuals based on pre-existing conditions or a history of illness.[24] These provisions become effective for plan years beginning after January 1, 2014.[25]

Group health plans and insurers that offer group or individual coverage may not establish eligibility requirements based on: (1) health status; (2) medical condition (including both physical and mental illness); (3) claims experience; (4) receipt of health care; (5) genetic information; (6) evidence of insurability (including conditions arising out of domestic violence); (7) any other health related status factor deemed appropriate by the Secretary.[26] This section is effective for plan years beginning after January 1, 2014.[27]

In addition, health insurance must be renewable regardless of health status.[28] This provision is also effective for plan years beginning after January 1, 2014, except for enrollees under age 19, for whom it becomes effective for plan years beginning on or after August 23, 2010.[29]

III. Changes to Medicaid

A. Expansion of Medicaid Eligibility

Individuals newly eligible. Since the Medicaid program's inception in

---

[21] PPACA § 1101. *See also* Dep't Health & Human Servs., "Pre-existing Condition Insurance Plan Program," 75 Fed. Reg. 45014 (Friday, July 30, 2010) (interim final rule with comment period).
[22] PPACA § 1201 (adding § 2701 of the Public Health Services Act (PHSA)).
[23] *Id.* (adding § 2702 of the PHSA).
[24] *Id.* (adding § 2704 of the PHSA).
[25] *Id.* (adding § 1255 of the PHSA).
[26] *Id.* § 1201 (adding § 2705 of the PHSA).
[27] *Id.* (adding § 1255 of the PHSA).
[28] *Id.* (adding § 2703 of the PHSA).
[29] *Id.* (adding § 1255 of the PHSA).

1965, to qualify for Medicaid, individuals must not only have low incomes but must also fit into particular categories based on age, disability, or being a parent. As a result, many low income people, particularly childless adults without disabilities, are not eligible for Medicaid. The ACA changes this and significantly expands Medicaid eligibility to include all people under 133 percent of FPL.

Beginning January 1, 2014, states must extend Medicaid eligibility to certain individuals whose incomes are no more than 133 percent of FPL. To qualify, individuals may not be over age 65; pregnant; entitled to or enrolled in Medicare Part A; enrolled in Medicare Part B; or described in any of the previously existing mandatory categorically needy groups set forth in 42 U.S.C. § 1396a(a)(10)(A)(i). The state may phase in eligibility, but may not cover individuals with higher incomes before it covers those with lower incomes.[30] The income eligibility threshold for children aged 6-19 is increased from 100 percent of FPL to 133 percent of FPL.[31]

In addition, as of April 1, 2010, states may provide early coverage to individuals in this new category by submitting a state plan amendment. CMS has already issued guidance on how to do this.[32]

Also beginning January 1, 2014, states may elect to cover individuals under age 65 who are not included in any previous optional categorically needy coverage groups and whose incomes exceed 133 percent of FPL. If the individual is a parent or caretaker relative, the individual cannot be enrolled unless the individual's child is also enrolled. As with the group with incomes below 133 percent of FPL, the state may phase in eligibility, but may not cover individuals with higher incomes before it covers those with lower incomes.[33]

When determining income, the ACA's newly enacted modified adjusted gross income (MAGI) rules will be used. There will be no resource tests and a standard income disregard must be used.[34]

MAGI is based on adjusted gross income, which is defined under the IRS code gross income minus certain deductions, including: (1) trade and business deductions; (2) losses from the sale or exchange of property; (3) alimony; (4) retirement savings; (5) moving expenses; (6) interest on educational loans; (7) higher education expenses; and (8) health savings accounts. [35] Adjusted gross income is then increased by:

- Foreign income earned outside the U.S. that is excluded from gross

[30] PPACA § 2001(a)(1) (as amended by Recon. Act. § 1201).
[31] *Id.* § 2001(a)(5).
[32] *See* CMS, *Letter to State Medicaid Director* (Apr. 9, 2010).
[33] PPACA § 2001(e).
[34] PPACA § 2001(e).
[35] *See* 26 U.S.C. § 62. MAGI is defined differently for various programs. The definition set forth in this Fact Sheet is the one used in the PPACA and Reconciliation Act.

income by Internal Revenue Code (IRC) § 911;
- Housing costs for individuals living outside the U.S., which are also excluded from gross income pursuant to IRC § 911;
- Any amount of interest received or accrued by a taxpayer that is tax exempt.[36]

States may also use presumptive eligibility for this new category of eligibility, if the state has already elected this option for pregnant women or children.[37] States may also extend presumptive eligibility for individuals eligible for Medicaid as caretaker relatives.[38]

The benefit package. In recent years, states have had the option of providing benchmark or benchmark-equivalent coverage to Medicaid beneficiaries. Benchmark coverage is the standard Blue Cross/Blue Shield preferred provider option for federal employees in the state; coverage offered by the largest commercial, non-Medicaid HMO in the state; or Secretary-approved coverage. Benchmark-equivalent coverage consists of certain basic services (e.g. hospital, physician, lab, and preventive services) with an actuarial value equal to at least 75 percent of the actuarial value of that additional service in the benchmark plan. Some populations are exempted from mandatory enrollment in benchmark equivalent plans, including individuals who quality based upon disability, such as SSI beneficiaries, dual eligibles, and institutionalized individuals.[39]

Medicaid coverage for most individuals eligible through the new eligibility category will consist of benchmark or benchmark-equivalent coverage unless the individuals is exempt from mandatory enrollment pursuant to § 1396u-7.

Benchmark-equivalent coverage is expanded to include coverage of prescription drugs and mental health services. In addition, mental health benefits are updated to include parity requirements. Benchmark or benchmark-equivalent coverage offered by an entity that is not a Medicaid managed care organization must comply with the Mental Health Parity Act requirements of § 2705(a) of the Public Health Service Act. Thus, if the entity provides both medical/surgical benefits and mental health or substance use disorder benefits, it must ensure that the mental health or substance disorder benefits are subject to the same financial requirements and treatment limitations as the medical/surgical benefits.[40] Coverage provided to mandatory and optional categorically needy children under the state plan (those covered under 42 U.S.C. § 1396a(a)(10)(A)) will be deemed to be in compliance with the mental health services parity requirements

[36] PPACA § 1401(a) (as amended by Recon. Act. § 1004).

[37] 42 U.S.C. § 1396r-1(k).
[38] *Id.,* § 1396u-1.
[39] 42 U.S.C. § 1396u-7(a)(2)(B).
[40] PPACA § 2001(c)(6) (adding 42 U.S.C. § 1396u-7(a)(2)(6)).

if that coverage is the EPSDT services described in §§ 1396d(a)(4)(B) and 1396d(r) and provided is accordance with § 1396a(a)(43). [41]

Finally, effective January 1, 2014, all benchmark and benchmark-equivalent coverage must provide at least the essential health benefits that will be available through Exchanges, discussed above.[42]

Federal matching funds. The federal government reimburses states participating in Medicaid for at least half of all of their Medicaid costs.[43] The percentage paid by federal dollars, known as the federal medical assistance percentage (FMAP), ranges from 50 percent up to 83 percent.[44]

The ACA temporarily increases the FMAP for certain newly eligible populations: those between the ages of 19 (or a higher state-set age) and 65 who were not previously eligible for or enrolled in a health plan through Medicaid. The increased rates and manner in which they are applied are discussed in detail in NHeLP's complete analysis.

Maintenance of effort. The ACA includes a maintenance of effort (MOE) requirement to prevent states from dropping individuals from Medicaid before the new eligibility category comes into effect in January 2014. States are not allowed to implement eligibility standards, methodologies or procedures under the state plan or a waiver that are more restrictive than the eligibility standards, methodologies or procedures in effect on March 23, 2010, the date of the PPACA enactment. For adult populations, this MOE requirement lasts until the date the Secretary determines that a "fully operational" Exchange has been established in the state. For children under age 19, the MOE is extended through September 30, 2019.[45]

There is an exception to the MOE requirement for states in budget crisis. A state must certify to the Secretary that it has a budget deficit for the current fiscal year or that it is projected to have one in the succeeding year. This certification lifts the MOE requirement for nonpregnant, nondisabled adults whose incomes exceed 133 percent of FPL. This exception is available January 1, 2011 and ends on December 31, 2013.[46]

Income determination for Medicaid programs The ACA changes the method used for determining income in Medicaid state plan and waiver programs.[47] States will no longer use resource tests and must use MAGI to determine individual and family income. All current income disregards will be

[41] PPACA § 2001(a)(2).
[42] *See* § 2001(c) (adding 42 U.S.C. § 1396u-7(a)(5)).
[43] 42 U.S.C. § 1396b(a), 1396d(a).
[44] 42 U.S.C. § 1301(a)(8); 73 Fed. Reg. 72051 (Nov. 26, 2008).
[45] PPACA § 2001(b).
[46] *Id.* § 2001(b).
[47] *Id.* § 2002.

replaced by a standard five percent income disregard. Use of these income rules will not be applied to certain populations and services, unless the state obtains a waiver: (1) individuals eligible on a basis unrelated to income, such as status as a child in foster care; (2) individuals age 65 and over; (3) individuals who qualify for Medicaid on the basis of blindness or disability; (4) medically needy individuals; and (5) individuals for whom Medicaid is paying Medicare cost sharing. [48]

Individuals who are enrolled in Medicaid as of January 1, 2014 and who would be ineligible as a result of the application of the new income rules will remain eligible, with the same premiums and cost sharing through *either* March 31, 2014 or the date of the next regularly scheduled date for redetermination of eligibility.[49]

B. Dual Eligibles

There is no cost sharing for Medicare Part D for dual eligible beneficiaries who are institutionalized. The ACA extends this prohibition to include dual eligibles who are receiving home and community based services under an 1115 waiver, a 1915(c) or (d) waiver, or a state plan amendment to provide services under 42 U.S.C. § 1396n(i). This is effective on a date determined by the Secretary that is no earlier than January 1, 2012.[50]

C. Medicaid Improvements

The ACA includes numerous other provisions intended to improve access to Medicaid, including:

- providing an option for states to extend premium assistance for employer-sponsored insurance to all Medicaid recipients and parents of recipients under age 19;[51]
- expanding coverage for former foster care children up to the age of 26;[52]
- special adjustments to FMAP for states recovering from major disasters;[53]
- simplification of enrollment and coordination with the Exchanges;[54] and
- extending authority to hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.[55]

---

[48] *Id.* § 2002(a).
[49] PPACA § 2002(a). This provision has generated some confusion because the ACA repeatedly instructs states to develop eligibility standards that will not cause individuals who would be eligible on March 23, 2010 to lose eligibility. Clarification from CMS is needed.
[50] PPACA § 3309.
[51] *Id.* § 2003.
[52] *Id.* § 2004 (as amended by Recon. Act § 10201).
[53] *Id.* § 2006 (as amended by Recon. Act § 10201).
[54] *Id.* § 2201.
[55] *Id.* § 2002.

There are also improvements to Medicaid services, including:

- clarifying that the definition of Medicaid includes services and not merely payment for services (PPACA § 2304);[56]
- creating a state option to provide coordinated care through "health homes" for eligible individuals with chronic conditions. To be eligible, a person must be eligible for Medicaid through the state plan or a waiver and have two chronic conditions, one chronic condition and be at risk of developing a second, or one serious and persistent mental health disorder. Chronic conditions will be defined through regulations, but must include a mental health condition, substance abuse disorder, asthma, diabetes, health disease, or being overweight with a BMI over 25;[57]
- Creating incentives for chronic care and prevention by appropriating $100 million for grants to states for programs to help Medicaid beneficiaries to improve their health and avoid certain chronic conditions;[58]
- authorization for a demonstration project for covering emergency psychiatric services in institutions for mental diseases for adults ages 18-64;[59]
- adding language making explicit the requirement that free standing birth centers are covered Medicaid services;[60] and
- specifying that the election of hospice care for a terminally ill child does not waive the child's right to any treatment for the child's terminal condition.[61]

IV. Application of Federal Civil Rights Laws

This provision extends the application of some existing federal civil rights laws to the programs and activities administered, funded, or created by this law.[62] The relevant laws are Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), and § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794).[63] The provision prohibits any individual from being excluded from participation in, being denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by

---

[56] PPACA § 2304. For further analysis of this provision, *see* Jane Perkins and Gene Coffey, "Patient Protection Act clarifies the meaning of medical assistance," (March 31, 2010), available at www.healthlaw.org.
[57] *Id.* § 2703.
[58] *Id.* § 4108.
[59] *Id* § 2707.
[60] *Id.* § 2301.
[61] *Id.* § 2302.
[62] PPACA § 1557.
[63] Earlier drafts of this provision also included reference to the Americans with Disabilities Act but the final legislation did not include this reference.

an Executive Agency or any entity established under this title. This provision extends the protections to "contracts of insurance" which generally have been exempted from civil rights protections.[64]

Further, the provision allows the use of the same enforcement mechanisms provided for and available under Title VI, Title IX, § 504, or such Age Discrimination Act. The Secretary is authorized to promulgate regulations to implement this section. Nothing in this section will preempt a state law that provides greater protections to employees than those provided under this section.[65]

V. Disability-Related Provisions

A. Community First Choices

This provision authorizes states to provide home and community based attendant care and support services through a state plan amendment.[66] These services may be made available to Medicaid-eligible individuals with incomes up to either 150 percent FPL or the state income limit for eligibility for nursing facility services under the state plan, whichever is greater. Effectively, all states will have the option to receive Federal match for these services when provided for individuals with incomes up to 150 percent FPL, and some states may go as high as roughly 225 percent of FPL.[67]

Definitions Applicable to the Community First Choices Option

Activities of Daily Living: tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

Instrumental Activities of Daily Living: tasks much as meal planning and preparation, managing finances, shopping for food and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

Health-related tasks: specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health care professionals.

PPACA § 2401 (adding 42 U.S.C. § 1396n(k)(6))

States may adopt the Community First Choice (CFC) option after October 1, 2011. Individuals are eligible if they need assistance with activities of daily living

[64] PPACA § 1557, *see e.g.,* 42 U.S.C. § 4000d-4.
[65] PPACA § 1557.
[66] PPACA § 2401 (as amended by Recon. Act § 1205, adding 42 U.S.C. § 1396n(k)).
[67] *Id.* States are allowed to cover nursing facility or HCB services for individuals with incomes at 300 percent of the SSI level (currently equal to about 225 percent of FPL). *See* 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(V), 1396b(f)(4)(C).

(ADLs), instrumental activities of daily living (IADLs), or health related tasks and with respect to whom there has been a determination that the individual would otherwise require the level of care provided in a nursing facility, intermediate care facility for people with intellectual disabilities, or an institute for mental diseases.[68]

Services must be provided according to a person-centered plan of care and in a home or community setting. They may be provided through an agency model or other model, such as provision of vouchers, direct cash payments, or use of a fiscal agent. The consumer (or her representative) must control the services to a significant degree and have the right to select, manage, and dismiss a provider. Consumers must also have access to services provided by qualified family members, as defined by the Secretary. [69]

In addition to actual attendant services, the following must be provided:

- the acquisition, maintenance, and enhancement of skills necessary to accomplish ADLS, IADLs, and health related tasks;
- back up systems and mechanisms to maintain continuity of services, such as beepers or other electronic devices;
- voluntary training on how to select, manage, and dismiss attendants.

States may also include the following services:

- expenditures for transition costs such as rent and utility deposits or first months' rent and utilities;
- bedding, basic kitchen supplies, or other necessities required to transition from an institutional setting; or
- expenditures that will increase independence or substitute for human assistance that would otherwise be provided.

Services that are specifically excluded are:

- room and board costs (other than the transition services listed above);
- special education and related services;
- assistive technology devices and services other than those specifically listed in the available services;
- medical supplies and equipment;
- home modifications.[70]

The state gets an additional 6 percent in federal matching funds for services through this option.[71]

---

[68] PPACA § 2401.
[69] *Id.*
[70] *Id.*
[71] *Id.*

States must fulfill certain requirements in order to implement this option. States must provide CFC services in the most integrated setting appropriate to an individual's needs, without regard to the individual's age, type or nature or severity of disability, or the form of services and supports necessary to meet an individual's needs. The state must also make CFC services available statewide.[72]

The option must be implemented in collaboration with a Development and Implementation Council in the state that includes individuals with disabilities and elderly individuals. The provision also requires implementation of a quality assurance system that provides for monitoring the health and welfare of individuals receiving services, ensuring adequate state spending and quality, and reporting to the Secretary. The Secretary is required to conduct an evaluation of services under this provision, collect data from state reports, and make interim and final public reports to Congress.[73]

B. Expanded State Plan Option to Offer Home and Community-Based Services (HCBS)

The Deficit Reduction Act of 2005 added a new section to the Medicaid Act that authorizes states to provide home and community-based services through a state plan option – that is, without a waiver – to certain individuals whose household incomes do not exceed 150 percent of FPL.[74] Previously, such home and community-based services could be offered only pursuant to an 1115 or 1915(c) waiver.[75] In order to offer this option, states had to establish criteria for determining an individual's need for supportive services covered under this state plan option.

The ACA amends § 1396n(i) to enable states to expand eligibility for the state plan option to individuals whose incomes do not exceed 300 percent of the SSI benefit rate, as long as they meet criteria established for determining the need for supportive services.[76] These services include case management, homemaker/home health aide and personal care, adult day health, habilitation, respite care, and such other services requested by the state as the Secretary may approve, as well as day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.[77]

---

[72] *Id.*
[73] *Id.*
[74] 42 U.S.C. § 1396n(i).
[75] *See* 42 U.S.C. § 1315 (authorizing waivers to enable states to run pilot programs to test innovative methods of service delivery); § 1396n(c), (d), (e) (authorizing home and community based waivers to serve individuals who would otherwise need the level of services provided in an institution).
[76] PPACA § 2402(b).
[77] 42 U.S.C. § 1396n(c)(4)(B).

States may choose to offer home and community-based services through this state plan option to specific, targeted populations and offer different amount, duration, and scope of services to different groups. States are, however, no longer allowed to waive the requirement that services be available statewide nor to place caps on enrollment. [78] This section also removes the limitation on the scope of services that may be covered. Previously, states could only cover the services listed in the statute. Now, states may, with permission from CMS, offer other services not specifically listed.[79]

States may authorize these programs for a period of five years. States may also phase in eligible individuals and covered services, so long as all are enrolled and all services provided by the end of that five year period. States may renew for an additional a five year term if Secretary determines that the state had complied with the requirements of the subsection and met quality and outcome improvement goals.[80]

The PPACA also adds an optional category of eligibility for individuals who would be eligible for home and community-based services through § 1396n(i), which will allow states to offer them full scope Medicaid benefits.[81]

States retain their ability to modify entrance criteria if enrollment exceeds projections, but any individuals who are eligible for services will remain so until they no longer meet the criteria for eligibility.[82] The effective date of §§ 2402(b)-(f) is April 1, 2010.[83]

Finally, the ACA requires the Secretary to promulgate regulations ensuring that states develop service systems that are responsive to the needs and choices of beneficiaries receiving state and Medicaid-funded community-based long-term care services. These systems must also: (1) enable beneficiaries to receive services in a way that maximizes their independence, including through the use of client-employed providers; (2) provide the support and coordination needed to design a self-directed, community-supported life; (3) improve coordination, consistency, and regulation of federally and state-funded services, including development of effective eligibility determination and assessments, complaint, management and monitoring systems; and (4) assure an adequate number of qualified direct care workers to provide self-directed personal assistance services. The effective date of this subsection is March 23, 2010.[84]

C. Money Follows the Person

[78] PPACA § 2402(e), (f).
[79] *Id.* § 2402(c).
[80] *Id.* § 2402(b).
[81] *Id.* § 2402(d).
[82] PPACA § 2402(e), amending 42 U.S.C. § 1396n(i)(1)(D)(ii)(I).
[83] *Id.* § 2402(g).

[84] PPACA § 2402(a).

The DRA of 2005 directed the Secretary to award Money Follows the Person (MFP) Rebalancing Demonstration grants to states to increase the use the home and community-based services offered under a state's waiver or regular Medicaid program. Participating states could waive comparability, income, and statewideness requirements. To be eligible, individuals were required to be living in an inpatient facility for 6 months to two years. A determination must also have been made that the individual requires home and community-based services in order to remain safely in the community. The program provided grants of up to five years.[85]

The PPACA extends the demonstration for five additional years.[86] It also reduces the amount of time an individual must reside in an institution before becoming eligible to only 90 days. Days of residency that are solely for the purpose of receiving short-term rehabilitative services during Medicare's waiting period will not be counted toward the 90 days. The effective date of this section is April 22, 2010.[87]

D. Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes, PPACA § 10202

This section creates the State Balancing Incentive Payments Program (SBIPP) to offer states the incentive of an increase of 2 or 5 percent to a State's FMAP for covering community-based long-term care services and supports (LTCSS).

Definitions Applicable to the State Balancing Incentives Program

Long-Term Care Services and Supports: the term has the meaning given by the Secretary and may include any of the following (as defined for the purpose of the state Medicaid program):

- *Institutionally Based Long-Term Services and Supports:* services provided in an institution, including nursing facility and ICF-MR services
- *Non-Institutionally Based Long Term Services and Supports:* includes (1) home and community based services provided under a waiver pursuant to 1915(c), (d), or (i) or 1115; (2) home health care services; (3) personal care services; (4) services provided pursuant to Programs of All Inclusive Care for the Elderly (PACE); and (5) self-directed personal assistance services

PPACA § 10202(f)

The SBIPP is open to any state that currently devotes less than half of its Medicaid long term care expenditures to non-institutional services.[88] In 2007,

[85] Deficit Reduction Act of 2005, Pub. L. No. 109-171 § 6071, *codified at* § 1396a (note
[86] *Id.* § 2403(a).
[87] § 2403(b).
[88] PPACA § 10202(b)(1).

this described all except six states.[89] A State may seek to participate in SBIPP either through a state plan amendment or through a federal waiver.[90] A maximum of $3 billion in total aggregate payments will be available under this program.[91]

To be eligible for participation, a state must submit an application that includes a budget detailing the state's plans to expand and diversify medical assistance for non-institutionally based LTCSS in order to achieve the targeted percentage rate. If a state chooses to provide services to individuals with incomes up to three times the federal SSI rate, it must indicate so in the application. [92]

The FMAP for which a participating state qualifies is determined based on its proportion of Medicaid expenditures for HCBS. If in fiscal year 2009, the State spent less than 25 percent of its long-term care and support services money on HCBS, the State may receive a 5 percent increase in its federal matching rate for any non-institutionally based LTCSS it provides by adopting a target of increasing the amount spent on HCBS to 25 percent.[93] States that spent more than 25 percent and less than 50 percent may adopt a target of 50 percent and receive a 2 percent increase in the State's FMAP for non-institutionally based LTCSS.[94]

Illustration

State A has a current FMAP of 60%. It devoted 15% of its Medicaid LTCSS expenditures to HCBS in 2009. If it adopts a target of devoting 25% of its LTCSS expenditures to HCBS, it will receive an FMAP of 65% for the non-institutionally based services it provides.

For all participating states, there is a maintenance of effort (MOE) requirement: the State may not apply eligibility standards, methodologies, or procedures for determining eligibility for non-institutionally-based long-term care and support services provided pursuant to the SBIPP that are more restrictive than the eligibility standards, methodologies, or procedures that are in effect as of December 31, 2010.[95] Any additional funding that the State receives under this program must be used to provide new or expanded non-institutionally-based services in the State's Medicaid program.[96]

---

[89] *Id.* § 2406(a)(4).
[90] *Id.* § 10202(f)(4).
[91] *Id.* § 10202(e)(2).
[92] *Id.* § 10202(c)(1)(B); *see also* § 2402, discussed above.
[93] *Id.* § 10202(c)(2)(A), (d)(1).
[94] *Id.* § 10202(c)(2)(B), (d)(2).
[95] *Id.* § 10202(c)(3).
[96] *Id.* § 10202(c)(4).

To be eligible for this program and the additional funding, the State must agree to make certain structural changes within six months of applying for the program.[97] The required structural changes are:

- The State must develop a "**No Wrong Door—Single Entry Point System"** for individuals to access all long-term services and supports, not only the non-institutionally-based services and supports available through SBIPP. The access point may be through an agency, organization, coordinated network, or portal. The system must provide availability information, application information, referral services, and financial and functional eligibility determinations or assistance with assessment processes for financial and functional eligibility.[98]

- Creation of **conflict-free case management services** to develop a service plan, arrange for services and supports, support the beneficiary (and the caregiver, if appropriate) in directing the provision of services and supports, and monitoring to assure that the beneficiary's needs and outcomes are met.[99]

- Development of **core standardized assessment instruments** to determine eligibility for the non-institutionally-based services and supports. These assessment instruments must be used uniformly throughout the State and would also be used to determine the beneficiary's need for training, support services, medical care, transportation, and other services. The instruments must also be used to develop an individual service plan to address these needs.[100]

Participating states must also agree to do the following:

- **Collect services data on a per-beneficiary basis** from all providers of non-institutionally-based services and supports.[101]

- **Collect core quality data** that are based on population-specific outcome measures and accessible to providers.[102]

- **Develop outcome measures** that are population-specific and accessible to providers. The outcomes measures must include beneficiary and family caregiver experience with providers, satisfaction with services, and

---

[97] *Id.* § 10202(c)(5). While an earlier section seems to imply that States have flexibility in choosing which changes to make, this later section clearly requires States to implement six structural changes in order to qualify for the program. *Compare* § 10202(c)(1)(A)*with* (c)(5) and (c)(6).
[98] PPACA § 10202(c)(5)(A).
[99] *Id.* § 10202(c)(5)(B).
[100] *Id.* § 10202(c)(5)(C).
[101] PPACA § 10202(c)(6)(A).
[102] *Id.* § 10202(c)(6)(B).

beneficiary-specific measures which indicate whether desired outcomes are achieved in the individual case.[103]

States that participate in this program may receive the additional FMAP payments for expenses for non-institutionally based LTCSS incurred during the "balancing incentive period," which runs from October 1, 2011 through September 30, 2015.[104] There is an upper limit on the amount that can be paid to a state; no state may receive $3 billion during the balancing period. States must meet the target percentages of non-institutionally-based services and supports by October 1, 2015.[105] However, the structural changes must be made within six months of application.[106]

The CLASS Act

The Community Living Assistance Services and Supports (CLASS) Act establishes a voluntary, national insurance program to cover the costs of purchasing community based services and supports. The program is primarily funded by wages withheld before taxes, similar to a 401(k) or medical savings account. The legislation expressly provides that taxpayer funds cannot be used to fund the program. To ensure solvency and protect against waste, the law provides for an Independence Advisory Council (IAC) and for reports by the Inspector General of HHS.[107]

Individuals are eligible to participate if:

- they have paid premiums for at least 60 months before enrollment (with 24 of those months being consecutive); and
- have earned, during at least 3 calendar years, at least the amount of income that would credit the individual for a quarter of coverage under the Federal Old Age, Survivors, and Disability Insurance Act.[108]

Eligibility for benefits is triggered once an individual is certified to have a functional limitation that is expected to last for a continuous period of more than 90 days.[109] A functional limitation is defined as the inability to perform a minimum number of activities of daily living without substantial assistance, substantial cognitive impairments that necessitate substantial supervision to protect from health and safety, or a level of functional limitation similar to either.

---

[103] *Id.* § 10202(c)(6)(C).
[104] § 10202(e), (f)(2).
[105] § 10202(c)(2).
[106] § 10202(c)(5).
[107] PPACA § 8002(a) (adding § 3209 to the Public Health Services Act(PHSA)). The entire CLASS Act is added by § 8002(a) which adds numerous sections to the PHSA. Accordingly, to make reference easier, this section will refer to the PHSA section containing the requirement that is being discussed.
[108] PHSA § 3202(6).
[109] PHSA § 3202(6).

This definition will be fleshed out by regulations.[110]

The Secretary must create at least three actuarially sound benefits plans from which eligible individuals may choose. Premiums must be based on an actuarial analysis to ensure that the program is solvent for a 75 year period but cannot exceed $5 per month for individuals with incomes below the poverty line or full-time students under age 22 who are actively employed.[111] Program premiums may be recalculated to preserve program solvency but must remain at a nominal level for low-income beneficiaries. Premiums for particular individuals must remain the same, with certain exceptions. Individuals age 65 or older, who have paid premiums into the plan for at least 20 years or who are not actively employed are exempt from any premium increase.[112]

The following benefits are available through the program:

- cash to be used to purchase non-medical services and supports needed to maintain independence,
- advocacy services, and
- advice and assistance counseling.

The cash benefits paid through the program cannot be less than an average of $50 per day, determined based on the level of functional limitation, and may not be subject to lifetime limits. They are to be paid into a "Life Independence Account" for each individual beneficiary and must be coordinated with any benefits eligible through a qualified health plan.[113]

Services that may be purchased include, but are not limited to:

- home modifications,
- assistive technology,
- accessible transportation,
- homemaker services,
- respite care,
- personal assistance services,
- home care aides, and
- respite.[114]

Benefits must be disregarded when determining eligibility for federal, state, or local benefits programs, including Medicaid, Medicare, Social Security Disability, SSI or CHIP.[115]

---

[110] PHSA §§ 3203(a)(1)(C).
[111] PHSA § 3203.
[112] PHSA § 3203(a)(1)(D).
[113] PHSA §§ 3203(a)(1)(D), 3205(c)(1).
[114] PHSA § 3205(c)(1).
[115] PHSA § 3205(f).

For most individuals, premiums will be paid through payroll deductions, but special provisions are made for people who do not earn wages or whose employers will not participate. The Secretary must coordinate with the Treasury Secretary and establish procedures for employers to enroll individuals in the CLASS program, similar to those governing enrollment in a 401(k) or similar plan. They must also establish procedures to enable individuals who are self-employed, have more than one employer, or whose employer does not choose to participate.[116] The Secretaries must create procedures through which employers may make payroll deductions for individuals who are not subject to automatic enrollment. Alternative procedures must be created for people whose employers do not elect to deduct and withhold and for those who earn no wages.[117]

States are also required to enter into agreements with each state's Protection and Advocacy System to provide advocacy services.[118] Pursuant to these agreements, the P & As will be required to assign an advocacy counselor for each eligible beneficiary to:

- provide information about accessing the appeals process for the program,
- assist with recertification, and
- provide other assistance obtaining CLASS Act services that the Secretary may require through regulations.[119]

States must also enter agreements with private or public entities to provide advice and assistance counseling.[120] The agreements must require provision of information to beneficiaries about:

- coordination of long term services and supports in the most integrated setting,
- possible eligibility for other benefits,
- development of a service and support plan,
- information about services provided under the Assistive Technology Act of 1998;
- resources to assist with decision making concerning medical care, including the right to refuse or accept medical treatment; and
- other services required by the Secretary.[121]

Special payor rules apply for individuals enrolled in Medicaid. Institutionalized individuals (residing in a hospital, nursing facility, intermediate

[116] PHSA § 3204(a).
[117] PHSA § 3204(a).
[118] PHSA § 3205(a)(2)(A)(ii).
[119] PHSA § 3205(d).
[120] PHSA § 3205(a)(2)(A)(iii).
[121] PHSA § 3205(e).

care facility for the mentally retarded, or an institution for mental diseases) may retain 5 percent of their cash benefit, while the remainder goes to the Medicaid agency to cover the cost of services provided. Medicaid will then provide secondary coverage for remaining costs care. Individuals will still receive the personal needs allowance provided under Medicaid. [122]

Beneficiaries receiving home and community-based services will be allowed to retain fifty percent of their cash benefit. Medicaid will provide secondary coverage for any additional costs incurred in covering services. The remaining 50 percent of the cash benefit will be paid to the state only if the waiver in which the enrollee is participating does not include waivers of statewideness and comparability. Individuals enrolled in Programs of All-inclusive Care for the Elderly are subject to the 50-50 split if living in the community and the 95-5 split if living in an institution.[123]

The Secretary must establish a process for application and eligibility determination and must promulgate regulations governing an expedited national eligibility determination process. The process must include the capacity to determine presumptive eligibility. The legislation specifies that a person is presumptively eligible if he has applied for and attests to be eligible for the maximum cash benefit and:

- is a patient in an institutional setting (nursing facility, intermediate care facility for the mentally retarded, institution for mental diseases, or hospital on a long-term basis); and
- is about to be, or in the process of planning to be, discharged from an institutional setting, or is within 60 days from the discharge from the hospital.[124]

The CLASS Act will fill a significant gap in our insurance system. Long term care services, particularly nursing homes, are extremely expensive. Yet, only the most limited coverage for these services is available through Medicare and private health insurance. Private insurance is prohibitively expensive and generally excludes people with certain disabling conditions. Medicaid covers nursing home and community-based services but only for those with very low incomes. Thus, people with middle and higher incomes are ineligible or must spend themselves into poverty to qualify. The CLASS Act is intended to provide a realistic, accessible, and affordable option for aging individuals or those with disabilities.

D. Miscellaneous

[122] PHSA § 3205(c)(1)(D).
[123] *Id.*
[124] PHSA § 3205(a).

- **Sense of the Senate.** Makes findings rejecting states' continued dependence on institutional care instead of home and community-based services and pledges to address the imbalance between these two approaches during the current legislative session.[125]

- **Protection against spousal impoverishment .** Provides that spousal impoverishment protections apply not only to individuals with a spouse in an institution, but also to those with a spouse receiving home and community-based services pursuant to a waiver. This provision is effective only from January 1, 2014 through December 31, 2008.[126]

- **Accessibility of diagnostic equipment.** Requires that, within 24 months after enactment of the PPACA, the Architectural and Transportation Barriers Compliance Board (ATBCB), in consultation with the Commissioner of the FDA, must promulgate regulations establishing minimum physical accessibility requirements for medical diagnostic equipment used in hospitals, clinics, physician's offices, emergency departments, and other medical settings. Equipment covered includes examination tables and chairs, weight scales, mammography equipment, x-ray machines, and other radiological equipment. ATCBA and the FDA must periodically review and amend these standards. This provision addresses a significant gap in current law, as access to this equipment has not previously been regulated by federal laws such as the Rehabilitation or Americans with Disabilities Acts. The regulations will affect both publicly funded and private health care providers.[127]

- **Expansion of Aging and Disability Resource centers** Authorizes an additional $10 million annually for FY 2010 through 2014 to augment the services provided by State Aging and Disability Resource Centers, which assist seniors and people with disabilities in a variety of tasks, including choosing among long term care options.[128]

VI. The Indian Health Care Improvement Act

The Indian Health Care Improvement Reauthorization and Extension Act (IHCIREA) reauthorizes and amends the existing Indian Health Care Improvement Act (IHCIA).[129] The law contains provisions addressing: (1) recruitment, education, training and retention of health care providers to serve

[125] PPACA § 2406(b).
[126] *Id.* § 2402.
[127] *Id.* § 4203.
[128] *Id.* § 2405.
[129] 25 U.S.C. §§ 1601-1680o.

Indian communities; (2) provision of and funding for specific health services, including dental, behavioral health, and chronic disease care; and health facilities operated by the Indian Health Service (IHS) or tribes; (3) organizational improvements to IHS; (4) behavioral health prevention and treatment services; (5) Indian youth suicide prevention; and (6) miscellaneous health-related issues. The law is intended to ensure maximum participation by tribes themselves in directing and providing health care services, in order to establish a system that is more responsive to the needs of Native American communities.

This is a permanent reauthorization of the current IHCIA, meaning that it no longer needs to be reauthorized annually.[130]

Provisions of ICHIA address the following issues:

- Training, education, recruitment, and certification of Indian health care providers;
- Funding for health services and education;
- Expanded prevention services, including those aimed at diabetes;
- Payment for Indian Health Services (IHS), including services covered by Medicaid;
- Health services for Urban Indians;
- Organizational improvements to IHS;
- Shared authority for long term care.

The Act also authorizes the development of a comprehensive behavioral health and substance abuse treatment program. The Secretary will not only encourage tribal entities to develop their own plans, but also develop a federal program consisting of:

- community-based prevention, intervention, outpatient, and behavioral health aftercare;
- detoxification;
- acute hospitalization;
- intensive outpatient/day treatment;
- residential treatment;
- transition living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;
- emergency shelter;
- intensive case management;
- diagnostic services; and
- promotion of healthy approaches to risk and safety issues, including injury prevention.

[130] § 10221, enacting § 101 of IHCIREA, amending § 42 U.S.C. § 1680o.

Programs must also provide behavioral health treatment and prevention services especially for individuals from birth through age 17, and for adults age 18 through 55, for elders over age 56, and families.[131]

VII. Conclusion

There are many more provisions in the ACA that are not discussed in this Fact Sheet. And, some that are included here are analyzed in greater detail in NHeLP's complete analysis. Advocates will be informed through the Community Integration and ADAPA listservs when it is completed

Further, the changes made by the ACA are extensive and complicated. Even so, many more details will be fleshed out by regulations. Some provisions, including those governing the Exchange and establishing the Community First Choice program, the extended state plan option for HCBS, and the State Balancing Incentives Program, expressly require the Secretary to promulgate regulations. Other measures, such as the expansion of Medicaid eligibility, will necessarily require regulations for implementation. Thus, many crucial details are yet to worked out. Proposed regulations will need to be monitored closely to assure that covered benefits include services that are essential to disabled and low income populations. NHeLP will be closely monitoring these developments, will send out alerts and will post analysis on our website at www.healthlaw.org.

[131] Pub. L. No. 111-148 § 10221, enacting § 181 of IHCIREA, amending 25 U.S.C. §§ 1665 *et seq.*