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The *NAELA Journal* Editorial Board invites the submission of manuscripts year-round with the following guidelines:

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INTRODUCTION TO HEALTH CARE REFORM

By William J. Brisk, CELA

This issue of NAELA Journal represents one of the most ambitious projects we have undertaken. In spring 2009, we decided, under former Editor-in-Chief, A. Frank Johns, to ask some of the nation’s health law experts to contribute original articles on different aspects of the health care reform. Since then, it must be admitted, we have had some doubts as to whether we could carry out our goal. Would the authors we sought be available to write for NAELA Journal? Even if they were, would they prepare manuscripts in time for editing? Did we have sufficient space in our journal to allow all 10 articles we solicited to treat in detail their separate subjects? Would 10 distinct articles deal comprehensively with such complex legislation — without descending into the partisan political debates centering on “death panels,” abortion funding, “unconstitutional mandates,” and “socialistic” public plans, and without undue repetition? That you are reading this now suggests that we could answer all of those questions positively.

Another set of challenges soon arose as our work proceeded. We anticipated, even prior to the November 2010 elections, that opponents would seek to repeal the laws in Congress and would also, as some 20 Governors have since announced, test the constitutionality of the Health Law Reform in the courts. Would we be guilty of the same

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1 The reform consists of two laws, the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), respectively referred to as the PPACA and the HCERA. The two acts are collectively referred to as the Affordable Care Act or ACA. As this is written they are about to be codified in 42 U.S.C. sections 201, 300gg, 1320a-3, 1395-w, 3602, and elsewhere. The CLASS Act is a separate part of the PPACA amending 42 U.S.C. sections 201 ff (Title VIII, CLASS Act).

2 The Congressional Budget Office, Jan. 6, 2011 letter to John Boehner, Speaker of the House however, estimates that repealing the reforms “would probably increase federal budget deficits over the 2012-2019 period by a total of roughly $145 billion ….” Id. at 4 and would result in “about 32 million fewer nonelderly people [who] would have health insurance in 2019 ….” Id. at 8.

3 John Schwartz, The Supreme Court and Obama’s Health Care Law, N.Y. Times. Dec. 18, 2010, recognizes that at least the question of requiring Americans to obtain health insurance is likely to require a Supreme Court decision. His polling of Constitutional scholars suggests that it is too early to tell how the Court will vote.
lack of foresight that led, apocryphally, to publication of the ill-fated masterpiece, “The Federal Common Law” just weeks before the Supreme Court issued its decision in *Erie v. Tompkins*?

Why, then, did we proceed? First, we recognized early on that the health care reform is too significant to ignore. The reforms are the most far-reaching social legislation enacted in the United States since the 1960s, when the federal government finally enforced Civil Rights and enacted (in 1965) both Medicaid and Medicare. Even if these reforms are revised or whittled down in appropriations and, indeed, even if their mandatory insurance provisions are declared unconstitutional, Elder and Special Needs Law attorneys need to understand how the laws might change how medical care in the United States will be financed in the future. A full understanding begins by discerning what the laws change and what they don’t.

Let us start with negatives. *The reform is certainly not the universal health program many of its proponents had hoped and worked for and many of its opponents feared.* Moreover, it is certainly not the single-payor plan which reformists had anticipated when it was first discussed. *This reform is neither simple nor coherent* and as a surprise to many who began this journey in the early Clinton years, what emerged from Congress is remarkably similar to what had been implemented in Massachusetts two years ago than it is to the comprehensive national health services that were launched more than three decades ago throughout Europe.

The goals of the national reform are, nevertheless, ambitious — to enroll at least 30 of the 40 million Americans who currently have no health insurance coverage and to rescue millions of Americans from disastrous medical bills which plunge them into bankruptcy because they did not obtain insurance or were unable to renew policies due to “pre-existing conditions.” The implementation of these reforms depends upon existing government programs (Medicaid and Medicare) and private health insurance companies and health maintenance organizations which will continue to play a critical role in American health policy. To expand insurance coverage of medical expenses, the reforms compel some employers to cover employees while by 2014, those not enrolled in such company plans or in Medicare will need to purchase their own insurance or face monetary

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4 304 U.S. 64 (1938) which held that “... there is no federal common law.” *Id.* at 78.
5 Bill Frist, a former Republican Senate majority leader and a heart surgeon, explained his opposition to repeal of the ACA in the following words: “It’s not the bill that I would have drafted. But it is the law of the land, and it is the platform, the fundamental platform, upon which all future efforts to make this system better for that patient, for that family, for that community, will be based.” (emphasis added) Speech presented with another former Senate Majority leader, Tom Daschle, Bipartisan Policy Center, Jan. 18, 2011.
6 See Jonathan T. Kolstad & Amanda E. Kowalski, *The Impact of Health Care Reform on Hospital and Preventative Care: Evidence From Massachusetts*, National Bureau of Economic Research, working paper 16012, May 2010. The 43-page report, plus statistical tables, is available at www.nber.org/papers/w16012 The report that the Massachusetts reform did, in fact, decrease the number of uninsured persons in the Commonwealth by 36 percent and, even more significantly, save money by “decreasing length of stay and the number of inpatient admissions originating from the emergency room.” Preliminary analysis also suggests that it has reduced the number of “hospitalizations for preventable conditions....” *Id.* Abstract.
7 In Britain, and elsewhere, the role of private health insurance has been relegated to a narrow function, to pay for care provided by concierge physicians and private clinics to people (mostly well-to-do) who don’t want to rely on national standards of care or are concerned about delays in the national health services.
penalties. The reform subsidizes insurance for those whom the law defines as incapable of paying the full cost of insurance.

The laws, at least, initially, do not directly control the rising cost of care in the United States. American medicine absorbs twice the percentage of our gross national product\(^8\) as compared with European economies and is a major cause of both inflation and poverty in the United States. Sadly, the opportunity for a “teaching moment” on curbing such costs was lost in the administration’s desire to cobble an alliance among physicians, hospitals, insurers, and consumers, something the Clintons failed to achieve. Postponing a concerted effort to cut costs is likely to require even more serious cost controls in the future. Added funding for Medicaid, initially at the federal level but eventually also at the state level, to cover the poor will put even greater pressure on Medicaid programs to skim when it comes to long-term care.

To complicate matters further, the laws feature:

- Different effective dates partly due to political considerations but also to allow for creating administrative tools to administer these new initiatives.
- Attempts to reduce some of the financial burdens on the Medicaid program in order to enroll more needy Americans.
- Coercion of the young and comfortable and inducements to the poor to obtain health insurance, hoping to enroll most of the 40-plus million Americans not presently covered by private or public health insurance.
- Greater emphasis on preventative medicine to reduce per capita health costs — especially with the aging of Baby Boomers.

The articles that follow reveal the very complexity of these reforms that grant new benefits and impose new burdens on businesses and individuals.

The introductory article by Kathryn Hayes traces the immediate origins of the Affordable Care Act to proposals raised by then Senate Finance Committee Chairman Max Baucus before President Obama’s inauguration. Ms. Hayes sagely predicts that “the future of the ACA will likely provide as much drama as its passage.”

Vicki Gottlich, Patricia Nemore, and Alfred Chiplin focus on how Medicare is likely to meet the challenges posed by the Affordable Care Act. While closing the “donut hole” in Medicare’s Part D (prescription medication) benefit has received a great deal of popular attention, the authors burrow deeper into the new law to describe changes in reimbursements to and incentives for health care providers as well as new approaches to health delivery systems.

Morris Klein analyzes the Community Living Assistance Services and Supports Act, thankfully shortened to the mnemonic CLASS Act, which is a bold attempt to provide

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\(^8\) See, e.g., Council of Economic Advisers, Executive Office of the President, *The Economic Case for Health Care Reform*, issued June 2, 2009, which states that “Health care expenditures in the United States are currently about 18 percent of GDP, and this share is projected to rise sharply. If health care costs continue to grow at historical rates, the share of GDP devoted to health care in the United States [will] reach 34 percent by 2040. For households with employer-sponsored health insurance, this trends implies that a progressively smaller fraction of their total compensation will be in the form of take-home pay and a progressively larger fraction will take the form of employer-provided health insurance.” This apocalyptic vision of what might occur if health care costs cannot be contained has not received the attention it merits in either the debate or the political commentaries.
alternatives to institutionalization of long-term care patients. Recognizing that the long-term care “problem” can’t be solved by commercial insurance products alone, CLASS was designed to reduce nursing home populations precisely at the time that Boomers are reaching their 60s.

In an analysis of a very different approach to a similar concern (institutionalization of long-term care patients), Charles Perez Golbert considers intensified monitoring of nursing homes and new ways to report and correct deficiencies that will add to the administrative burden borne by state governments. The new legislation requires facilities to conduct background checks for most employees, and also provides explicit protections for nursing home residents when their facilities close.

Ben Neiburger tackles the highly complex way that the new laws, in order to cover a far greater percentage of Americans, will require businesses with more than 50 employees to provide health insurance to their employees and how individuals who work for smaller companies or are self-employed will need to obtain insurance or face significant penalties. These mandates have set off a political storm.\footnote{The non-partisan Congressional Budget Office, however, estimates that the penalty in 2016 for those the government considers capable of paying for health insurance would be the greater of $695 or 2.5 percent of their household’s income. \textit{Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act}, Revised report, April 30, 2010.}

In the strange politics that surrounded reform, what the public was led to believe was one of its most controversial measures (a new, national approach to end-of-life decisions, and, in particular, what some saw as a way to legitimize ways to shorten the end of life) grabbed headlines but detracted analysis of the actual reforms. Fay Blix’s fascinating article distinguishes the rhetoric from the law. Her analysis of what was actually proposed as opposed to what was debated is instructive. Her conclusion is, simply, that the reforms accept individual determination of such issues and that opponents ignored what most ethicists and medical personnel believe: that patient autonomy requires knowledgeable counseling as to choices.

Gene Coffey’s predictions on how the Affordable Care Act will impact long-term care services begin with a disclaimer. The new laws, he observes, won’t affect Elder Law nearly as much as the Deficit Reduction Act of 2005 did (by changing fundamental qualification for long-term care assistance). The reform will, however, give a boost to caring for frail elders outside of nursing homes — adding to their options. Overcoming the “institutional bias” (i.e., funding care in nursing homes but not at home) will mean that coverage (whether public or private) will eventually provide for expanded case management and the monitoring of less formal ways to provide good care. The Affordable Care Act builds on several existing programs (Real Choice created in 2003 and the Community Living Program which had been funded since 2007) and extends several pilot projects such as the Money Follows the Person, which seek to return nursing home residents to their homes or less institutional settings. Only a few states opted for such programs in the past, but Coffey believes that many more will offer such programs as a way to lessen their contributions to Medicaid.

Brian Lindberg, Charles P. Sabatino, and Robert B. Blancato trace the history of the Elder Justice Act (EJA), introduced nearly a decade ago, specifically to protect elders
from abuse, neglect, and exploitation. They refer to one study that estimated (in 1996) that “at least half-a-million older persons in domestic settings were newly abused, neglected, and/or exploited, or experienced self-neglect.” They cite a recent study that estimates financial losses due to elder financial abuse amount to $2.6 billion a year. The EJA is an integral feature of the Affordable Care Act thanks to a coalition formed in 2003 that included NAELA. While the EJA commits $757 million to protective and other services over the next four years, Congressional annual appropriations will determine the actual extent of the commitment to deepen and extend research on abuse and neglect, strengthening the means to combat them, promoting forensic expertise, strengthening adult protective services, and improving their capacities to prevent and respond to abuse, neglect, and exploitation in long-term care settings.

Lucinda E. Jesson writes about the much-discussed but not nearly as well-understood reforms mandated for the private health insurance industry. Key changes designed to “spread the risk” among more insureds, include elimination of lifetime coverage limits, prohibition of rescissions except in cases of fraud, and barring pre-existing conditions as grounds for denying coverage or raising premiums. Previous protections of insured were mandated, piecemeal, in programs governed by ERISA (as regulated employer-sponsored programs) and HIPAA (which required health plans to be uniformly available to all similarly situated employees) but neither prohibited raising premiums for companies (or their employees) with good claims histories. Moreover, neither ERISA nor HIPAA protects the 14 million individuals who purchase non-group policies. These tasks, under the reform, will be undertaken by “Exchanges” which will certify “qualified health plans” to operate “virtually” like Expedia or Orbitz. Jesson describes several significant insurance market reforms: all Americans will qualify for coverage and renewal regardless of health or other status, premiums will be uniform except they may take into account regional costs, age, and use of tobacco, explicit bans on excluding coverage for those with “preexisting conditions,” and waiting periods for group coverage will be limited to 90 days.

The issue concludes with an article by Renée M. Landers and Patrick A. Leeman on how the reform legislation is likely to expand Medicaid. They first note that Medicaid coverage is not likely to expand greatly until 2014 at which point Medicaid will cover individuals whose adjusted gross income does not exceed 133 percent of the federal poverty level. While Medicaid previously covered families with children, the new laws will be far more generous to adults without dependent children. Regulations will have to be promulgated to implement what the Affordable Care Act defines as “benchmarks” for coverage of “essential health benefits.” Landers and Leeman realistically assess political and judicial impediments to full implementation of the reforms as well as growing disenchantment among health providers with Medicare and, especially, Medicaid reimbursements. Implementation of the ACA’s Medicaid reforms will require unprecedented state administration of the increasingly complicated programs. The authors conclude by observing that American laws provide “support for the poor only in a grudging and re-

10 Jesson points out that in the United States, “the health expenditures of 5 percent of the population account for almost half of all health care costs, a quarter of health spending went towards the treatment of 1 percent of the population” citing an article by Berk and Monheit that appeared in a 2001 issue of Health Affairs and a recent Kaiser Family Foundation “Primer” on health care costs.
sentful manner.” That notwithstanding, the time has come for substantial reform of the American health care system.

After assessing the articles, we hope our readers will have a more complete, nuanced, and, dare we say it, “fair and balanced” sense of this major legislation.
OVERVIEW OF POLICY, PROCEDURE, AND LEGISLATIVE HISTORY OF THE AFFORDABLE CARE ACT

By Katherine Hayes, JD

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I. INTRODUCTION

Those who are seeking insight into the meaning of provisions of the Patient Protection and Affordable Care Act of 2010 (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA)\(^1\) (hereinafter collectively referred to as the Affordable Care Act or ACA) will not find ready answers in the ACA’s legislative history. Enactment of the ACA was far from typical. A sequence of political, historical, and procedural events shaped its passage. Regardless of whether one supports or opposes the law as finally enacted, those who are subject to regulation by the federal agencies implementing it must understand the provisions.

This introduction is intended to provide a broad overview of the substance and structure of the law, as well as the political and legislative history that shaped the ACA. Subsequent articles will examine various aspects of the law, but in trying to discern its meaning, one must understand that the law’s authors never intended the Senate-passed bill to be the version signed into law by the President. Lawmakers believed at the time of its passage in December 2009, that they would have the opportunity to improve and refine the language as differences between the House and Senate-passed versions were resolved. Although the House and Senate did ultimately pass a few limited amendments to the Senate bill, there is considerable ambiguity in the language and gaps in Congressional intent that will be filled in by the federal agencies as the law is implemented in the coming years.

II. SUBSTANCE AND STRUCTURE

The key to understanding the structure of the ACA is to understand the key prob-

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\(^1\) Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) [hereinafter PPACA] as amended by the Health Care and Education Reconciliation Act, Pub. L. 111-152 (2010) [hereinafter HCERA]. These two laws are collectively referred to as the Affordable Care Act or ACA.
lems that Congress was attempting to address. One Senator’s views of the problems were laid out in a white paper released by Senate Finance Committee Chairman Max Baucus (D-Mont.) in spring 2009.\(^2\) His goal was to improve access to quality, affordable health care and to control costs in the United States health care system.\(^3\) Both political parties have shared these goals and have tried to address them for decades. As outlined below, given the complexity of the United States health care system, once a policymaker decides to require insurers to accept all applicants, a series of additional decisions must be made to avoid disruption of coverage.

**Insurance market reforms and exchanges.** Guaranteeing that more Americans have access to private health insurance requires a series of insurance market reforms designed to end practices that deny or limit coverage to those with pre-existing conditions. Guaranteeing access also requires policies to prohibit rescissions of health insurance policies without cause, limit price variation of health insurance premiums based on an individual’s health status, limit lifetime and annual coverage caps, and other practices designed to limit losses or to avoid high risk individuals.\(^4\) The ACA built on the portability provisions of the Health Insurance Portability and Accountability Act of 1996,\(^5\) by amending the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act (PHSA) to strengthen minimum federal insurance market standards and to broaden their application.\(^6\) As under the current regulatory structure, states may enact more stringent standards. Small group and non-group (individual) policies that meet these and other standards will be permitted to offer policies through state-level health benefit Exchanges, through which small businesses and individuals may choose from an array of insurance plans.\(^7\)

**Shared responsibility.** Requiring private insurance plans to offer coverage to individuals and small employer groups, regardless of individual health status, led to the shared responsibility provisions. Guaranteed issue of health insurance without a requirement to purchase coverage would encourage individuals to wait until they are sick or injured to purchase coverage, leading to increased enrollment of high-risk individuals without a corresponding increase in healthy individuals to offset their costs.\(^8\) The ACA requires individuals to purchase coverage, but exempts: 1) those with qualified employer-provided coverage; 2) those who are eligible for coverage through federal programs, such as Medicare, Medicaid, or the Indian Health Service program, 3) those who receive coverage through the Department of Veterans Affairs or the Department of Defense; and 4) those with religious objections.\(^9\)

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\(^3\) *Id.*

\(^4\) PPACA § 1001.

\(^5\) Pub. L. 104-191, Title I.

\(^6\) PPACA, amending 42 U.S.C. 300gg.

\(^7\) PPACA §§ 1301-1304, 1311-1313.


\(^9\) PPACA §§ 1501-1513.
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- **Tax credits and Medicaid expansion.** Requiring individuals to maintain coverage led to federal tax credits and Medicaid expansions to assist individuals who could not otherwise afford insurance coverage.\(^\text{10}\) The law provides refundable tax credits to individuals who are not eligible for Medicaid, with incomes between 100 percent and 400 percent of the federal poverty level. Individuals at the lower end of the spectrum, about $22,000 for a family of four, would receive higher subsidies than those at the higher end, who earn about $55,000 for a family of four.\(^\text{11}\) Those uninsured citizens with incomes below 138 percent of the federal poverty level would be eligible for coverage under Medicaid.\(^\text{12}\)

- **Public health and workforce investments.** Expanded coverage led to a necessary investment in public health and in the nation’s health care workforce to assure access to qualified providers and services for the existing and newly insured populations, as well as for those who will remain uninsured.\(^\text{13}\) The ACA provides funding for a public health trust fund to help provide adequate state and local resources to be spent on prevention activities, as well as investments in health care workforce initiatives designed to expand patient access to medical professionals and community health centers.\(^\text{14}\)

- **Lowering cost and improving quality.** Data on skyrocketing health care costs to businesses, families, and the government and the added costs of tax credits and Medicaid expansions, as well as reports that our health care system invests in care that is unnecessary, duplicative, and even harmful, led to delivery system reforms and provider payment reductions to promote new and more efficient payments to providers.\(^\text{15}\) The ACA includes changes in federal programs and increased revenues to assure that the law does not add to the federal deficit, as well as a series of pilots and demonstrations in federal programs designed to test new payment models and delivery systems to improve quality and lower costs. If proven successful, policy makers expect these models to be adopted by private sector insurers.

### III. Political Influence Shaping the Affordable Care Act

Media coverage of the debate provided few details of the legislation’s provisions, other than incomplete sound-bite summaries of the most high-profile and controversial among them. Even avid television viewers would be hard pressed to know which side to believe by watching the House and Senate floor debate. Does the law reduce the deficit or add to it? Will Medicare reductions extend the life of the Medicare Trust Fund or threaten its solvency? Will Americans be able to keep their insurance or lose the coverage they now enjoy? Will health insurance premiums go up or down as a result of the law? Opponents of the ACA cite polls suggesting that Americans overwhelmingly oppose health

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10 Id. at § 1401.
11 Id.
12 Id. at § 2001(A)(1) and § 2002(a) as amended by § 1004(b)(1)(A) and § 1004(e) of the HCERA. This figure reflects the coverage standard of 133 percent of the federal poverty level plus a disregard in the amount of 5 percent of the poverty line, included as part of a new federal definition of “modified adjusted gross income.”
13 Id. at §§ 3101-3114.
14 Id. at §§ 3001-3027, 4001-4102.
15 Id. at §§ 3131-3602.
reform, while a closer look by at least one poll indicates that the majority believes Congress did not reform the system enough.\(^{16}\)

Cynical observers may conclude that talk of bipartisanship in fall 2008, was no more than political lip service given to the messages that pollsters tell politicians that swing voters want to hear going into an election. Early in 2009, there was evidence that a bipartisan bill was possible. A bipartisan group of Senators worked through the spring and into the early summer to develop a consensus on health reform.\(^{17}\)

Former Senate Majority Leaders Howard Baker (R-Tenn.), Tom Daschle (D-S.D.), and Bob Dole (R-Kan.) released the outlines of a bipartisan health reform proposal in June 2009, under the auspices of the Bipartisan Policy Center (BPC).\(^{18}\) That proposal included many of the same provisions enacted as part of the ACA, such as insurance market reforms, state-based insurance Exchanges, Medicaid expansions, tax credits, delivery system reforms, and payment reductions in federal health programs.\(^{19}\)

Not surprisingly, given the members of the BPC, recommendations were similar to prominent Republican and bipartisan proposals considered during the 1993–1994 health reform debate, including the Senate Republican Health Care Task Force legislation (Health Equity and Access Reform Today Act of 1993).\(^{20}\) That legislation included insurance market reforms, an individual requirement to purchase health insurance coverage, tax credits to help Americans afford health insurance coverage, and incentives to states to establish insurance purchasing groups or co-ops through which individuals and small businesses would have a choice of private health insurance plans. Key differences then and now, included whether employers should be required to contribute to the cost of employee health insurance and the level of federal spending on tax credits to assist in the purchase of insurance coverage. The individual mandate, however, which is now the subject of consternation and litigation, was then widely accepted as necessary to assure stabilization of a reformed private insurance market.

By the August 2009 Congressional recess, however, voter frustration over the economy, federal spending on the financial and auto-industry bailouts, and federal deficits, combined with political rhetoric about provisions in the health reform bill, including so-called “death panels,” resulted in angry town hall meetings that threatened any chance of bipartisanship, regardless of the substance of the legislation.\(^{21}\) After the election of Scott Brown to the late Sen. Kennedy’s seat in the Senate, depriving Senate

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\(^{19}\) Id.


Democrats of a filibuster-proof majority, many on both sides of the aisle predicted that health reform was dead. When Speaker Nancy Pelosi announced that the Democratic Congress would move forward with health reform, Minority Leader John Boehner predicted that it would cost her the majority in the House. Whether or not health reform was the cause of the Democratic losses, few would argue that it was not at least a factor in the November 2010 elections, which resulted in the loss of Democratic seats in Congress.

While progressive Democrats preferred a public plan option and believed the law did not go far enough, Republicans (many of whom were energized by the Tea Party movement) would have preferred a more incremental approach or nothing at all. Whether scaling back provisions of the ACA to reduce its cost or regulatory structure would have garnered any Republican votes when the bill came to the floor in December 2009, is a question that may be debated for decades. What is clear, however, is that including a public plan option in the Senate would have cost the votes of Democratic conservatives in the Senate, assuring the bill’s failure.

IV. LEGISLATIVE HISTORY OF THE AFFORDABLE CARE ACT

To understand the legislative history of the ACA, or more accurately the lack of legislative history, it is helpful to understand how legislation generally moves through Congress, and how passage of the ACA deviated from that process. Typically, a bill is introduced in Congress, is referred to committee, is the subject of hearings, is marked up or amended by the committee, and is then reported. In the House of Representatives, the bill is referred to the Rules Committee, which determines the rules for floor consideration (i.e., the amount of time allocated for debate and which amendments, if any, will be in order). The bill is then taken up and passed on the House floor. A similar process occurs in the Senate, although there, a bill proceeds directly to the Senate floor once the bill is reported by a committee, and is considered pursuant to a time agreement negotiated between the Senate Majority and Minority Leaders. Once legislation has passed both houses of Congress, each chamber appoints members to an ad hoc conference committee to resolve the differences. To become law, each House must pass the identical conference report prior to presentment to the President for his signature. Along the way, committees

26 Another means of resolving House and Senate differences is for one House to take up legislation passed in the other House, and amend the legislation, sending it back to the other body for passage or further amendment, and under both House and Senate Rules, there are procedures for expedited consideration of measures, particularly those that are non-controversial.
issue reports, Senators and Members of Congress make floor statements, and finally the conference report explains how differences were ultimately resolved, thus providing a fairly extensive legislative history.

Health reform, however, was a procedural challenge from the start. Given the breadth of issues and laws touched by the legislation, multiple committees in each House and Senate had jurisdiction over the legislation. Because the legislation affected the tax code, under the Constitution, it was required to originate in the House of Representatives.\(^{27}\)

### A. Health Reform in the House of Representatives

Three major committees in the House of Representatives are responsible for the regulation of health care. First, the House Education and Labor Committee (renamed the House Education and Workforce Committee in the 112th Congress), chaired by Rep. George Miller (D-Calif.) during the 111th Congress, has jurisdiction over employer-sponsored health insurance, including single and multiple employer plans, as well as certain types of trusts.\(^{28}\) The majority of these plans are self-funded, meaning that the employer or trust bears the risk of costs, rather than purchasing coverage from private insurers. These plans are regulated by the Department of Labor under ERISA. Employer-sponsored plans that are fully or partially insured are subject to both state insurance laws and federal regulation under ERISA.

Second, the House Energy and Commerce Committee, chaired by Rep. Henry Waxman (D-Calif.) during the 111th Congress, has jurisdiction over most major federal health programs, with the exception of Medicare Part A. This Committee has jurisdiction over Medicaid, the Child Health Insurance Program (CHIP), and the Public Health Service Act, which includes rules governing insured health plans. In addition, Energy and Commerce has jurisdiction over the Food and Drug Administration and shares jurisdiction with the Ways and Means Committee over Medicare Part B (outpatient services), Part C (managed care plans), and Part D (coverage of out-patient prescription drugs).\(^{29}\)

Third, the Ways and Means Committee has jurisdiction on health care issues through the Internal Revenue Code, which governs the tax treatment of health benefits and the tax status of health care providers. Ways and Means also has jurisdiction over Medicare Part A (inpatient services) and shares jurisdiction with Energy and Commerce over Medicare Parts B, C and D.\(^{30}\) The Ways and Means Committee was chaired by Rep. Charlie Rangel (D-N.Y.) during markup of the health reform legislation.

During consideration of the House version of the health reform legislation, the three Committees worked together to produce a single bill, the America’s Affordable Health Choices Act of 2009, better known as the Tri-Committee bill.\(^{31}\) Each of the respective

\(^{27}\) U.S. Cont. art. I, § 7, cl. 1.


\(^{31}\) H.R. Res. 3200, 111th Cong. (July 14, 2009).
HEALTH CARE CHANGES: CHALLENGES TO MEDICARE

By Vicki Gottlich, Esq., Patricia Nemore, Esq., and Alfred J. Chiplin Jr., Esq.

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VIII. CONCLUSION

I. INTRODUCTION

President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (PPACA) on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA) on March 30, 2010. These two laws, collectively referred to as the Affordable Care Act (ACA), will change both the availability of health insurance and how health care is delivered in America. They include substantial changes for Medicare and Medicaid. This article focuses on Medicare and will include Medicaid changes only to the extent they intersect with Medicare.

Much of the discussion surrounding the implications of health care reform for older people and people with disabilities centered on changes in Medicare funding, including funding for Medicare Advantage (MA) plans. Opponents of the legislation cite as cause for alarm the projected $533 billion in savings or cuts to Medicare funding over 10 years, about $130 billion of which is attributable to reductions in funding for MA plans.

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3 Technical Explanation of The Revenue Provisions of The “Reconciliation Act Of 2010,” As Amended, In
attention is paid to other provisions in the legislation that provide needed protections for Medicare beneficiaries who enroll in private plans. Some of the changes have been under consideration for many years.

Proponents of the ACA cite the closing of the Part D donut hole or coverage gap as one of the most important changes for Medicare beneficiaries. The donut hole is that period of time between the initial coverage limit and catastrophic coverage when Medicare beneficiaries must pay full cost for their prescriptions while continuing to pay premiums for their drug coverage. On August 30, 2010, the Department of Health and Human Services (HHS) announced that one million older people and people with disabilities had already benefitted from the donut hole changes for 2010.4

Of most significance, the changes made to Medicare by the ACA extend the solvency of the Medicare Part A (hospital insurance) trust fund. The Medicare trustees now project that the trust fund will remain solvent through 2029 rather than through 2017, providing an extension of 12 years.5 According to the Center on Budget and Policy Priorities, the most recent projection by the trustees is among the most favorable projections within the last 21 years.6

The law is in the early stages of implementation. Some provisions, including some Medicare provisions, were effective upon enactment. Others are phased in over a number of years, and still others become effective in 2014. This article describes provisions of the ACA that most directly affect Medicare beneficiaries, providing as much information about implementation as is available at the time of this writing and raising questions that will be important for beneficiaries and for practitioners who advise them.

II. Payment Reforms

A. Changes in Payment to Providers

The ACA achieves savings in the Medicare program through a series of payment reforms, service delivery innovations, and increased efforts to reduce fraud, waste, and abuse. The actual projected reduction in Medicare spending is $428 billion over 10 years, after $105 billion in new Medicare spending is taken into consideration.7 It is important to stress that none of the payment reforms affects the guaranteed benefit package under
Medicare Part A and Part B. The law specifically states that these guaranteed benefits will not be reduced or eliminated as a result of changes to the Medicare program.\(^8\)

The majority of the payment reforms consist of changes in the methodology used to calculate payment updates for hospitals, skilled nursing facilities, home health agencies, and ambulance services, among others. Payment updates for these providers are based on an update to the “market basket” specific to the provider type that reflects the increased cost in doing business. In general terms, the ACA reduces the annual market basket increase by a specific productivity adjustment that is phased in over a set statutory time frame.\(^9\) Thus, the new law does not reduce payments from the 2010 level, but only reduces the amount of payment increases.\(^10\) Furthermore, as discussed below, the ACA added new payment schemes to reward high quality care and increased efficiency.\(^11\)

\textbf{B. Changes in Payment to Physicians}

Payments to physicians are based on a formula (the sustainable growth rate or SGR), which was enacted as part of the Balanced Budget Act of 1997.\(^12\) Because application of the formula would have resulted in negative updates to physician payments, Congress has enacted delays to its implementation since 2003. The ACA did not make any revisions to the SGR. Unless Congress continues its practice of enacting a temporary “doc fix” or, more unlikely, reforms the method for calculating doctor reimbursement, reduction in payment to physicians remains a potential threat to access to doctors for Medicare beneficiaries. A reduction in physician payments may result in fewer physicians accepting Medicare as a source of payment, which results in less access to care.

\textbf{C. Changes in Payment to Medicare Advantage Plans}

As noted above, the greatest amount of savings in Medicare will be achieved from changes in payment to MA plans. These are the private insurance plans that contract with the Centers for Medicare & Medicaid Services (CMS) under Medicare Part C to provide benefits to those who voluntarily enroll in the plans. MA plans must provide all of the guaranteed benefits under Part A and Part B and may provide additional benefits with monies they receive in excess of the cost of providing the guaranteed benefits. Under the funding mechanism in effect before enactment of the ACA, MA plans paid, on average, 109 percent–113 percent of the cost of providing the same services to beneficiaries enrolled in the traditional Medicare program. The extra payments resulted in Medicare Part B premiums being $3.35 higher per month for all beneficiaries in 2009, and resulted in the federal government expending $14 billion more than it would have spent had MA plan enrollees remained in the traditional Medicare program.\(^13\)

\(^8\) PPACA § 3602.

\(^9\) PPACA §§ 3401, 10319; HCERA § 1105.

\(^10\) New methods of calculating reimbursement that are separate from changes made by the ACA may have the effect of reducing 2011 reimbursement levels to some providers, however. Alex Wayne, \textit{Providers to See Lower Medicare Payments}, Wash. Post, (Nov. 5, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/11/04/AR2010110407506.html.

\(^11\) PPACA § II.D., \textit{infra}.


\(^13\) Report to Congress, \textit{Medicare Payment Policy} (March 2010); www.medpac.gov/documents/Mar_10Ch04.
The ACA phases in changes to the MA plan payment structure, starting with a freeze in payments to MA plans for 2011. When the new system is phased in, all of the counties in the United States will be ranked according to the average of traditional Medicare costs in each county. Counties will then be grouped into four categories, designating high cost and low cost counties, with plans being paid a fixed percentage of traditional Medicare costs depending on the category into which they are placed. As a result of the payment scheme, plans in some lower-paid counties, generally rural and suburban areas, will continue to receive payments that exceed the traditional Medicare amount, while plans in higher paid counties, many of them large cities, may see substantial reductions. Rebates (an amount plans receive if they bid less than the county benchmark) will also be reduced. The new payment structure also provides for an increase in payments by up to 5 percent for plans that receive four or more stars on the CMS star rating system.

Many people in the health care industry predicted that the change in MA payments would result in fewer MA plans contracting with CMS, higher premiums, and reduced benefit packages. CMS announced at the end of September 2010, however, that these predictions were not accurate. According to CMS, MA plan premiums for 2011 will be, on average, $1 less than in 2010, and most beneficiaries will have a choice of MA plans. Many MA plans that chose to leave the Medicare market effective in 2011 did so as a result of changes made by the Medicare Improvement for Patients and Providers Act of 2008 and not because of the ACA.


HCERA § 1102. CMS compiles the quality and performance data it receives about all Medicare Advantage plans and then ranks the health plans. The information is made available on www.medicare.gov in the form of a star system, with five stars being the highest rating and one star being the lowest rating. See Quality Ratings of Medicare Advantage Plans: Key Changes in the Health Reform Law and 2010 Enrollment Data, Kaiser Family Foundation, www.kff.org/Medicare/upload/8097.pdf (accessed Sept. 20, 2010).


Section 162 of the Medicare Improvements for Patients and Providers Act of 2008 Pub. L. 110-225, required private fee for service (PFFS) Medicare Advantage plans to have provider networks in most areas of the country, effective January 1, 2011. These plans generally did not have provider networks, and many operated in parts of the country where developing and maintaining a network of providers would be difficult. Also, it might be difficult for consumers to distinguish between a PFFS plan with a network of providers and a Preferred Provider Organization.
D. Linking Payment to Quality Outcomes

The ACA moves in the direction of linking payment to quality outcomes for entities providing services to Medicare beneficiaries. Congress has placed emphasis on efforts to measure quality and to provide payment for only those services and procedures that meet certain quality-of-care standards. As stated above, MA plans may be entitled to bonus payments if they score highly on quality measures. Hospitals will be given incentives to reduce hospital-acquired conditions with respect to hospital discharges starting in 2015.\(^{18}\)

The new law creates a value-based purchasing program under which value-based incentive payments are made to hospitals that meet performance standards for that fiscal year.\(^{19}\) The program is to begin for payments made for hospital discharges occurring on or after October 1, 2012. The Secretary of the Department of Health and Human Services (Secretary of HHS) is also directed to develop plans for a value-based purchasing program for skilled nursing facilities and home health agencies,\(^{20}\) as well as a value-based modifier that provides differential payment to a physician or group of physicians based upon quality of care compared to cost.\(^{21}\) These new purchasing programs are to be in effect by 2014 and 2015, respectively.

Payments also may be reduced to certain providers in the future if they do not provide high quality health care. For example, beginning in 2012, hospital payments may be reduced if a hospital is determined to have excessive re-admissions for identified conditions or procedures that are high volume or high cost and for which the re-admission rate is high. A re-admission is defined as a return to the same or a different hospital for the same condition within a time frame to be specified by the Secretary of HHS.\(^{22}\) Beneficiary advocates will watch implementation of this provision closely to ensure that hospitals do not try to avoid payment cuts and quality improvement standards by placing patients in “observation status” rather than admitting them as inpatients.\(^{23}\)

Finally, the ACA promotes quality measure development,\(^{24}\) improved data collection, and increased reporting requirements.\(^{25}\) As the provisions indicate, measuring quality and obtaining agreement on standards and norms of treatment for quality measurement is a complex and emerging activity. Of concern to advocates is that Medicare myths such

\(^{18}\) PPACA § 3008, amending 42 U.S.C. § 1395ww.
\(^{19}\) PPACA § 3001, amending 42 U.S.C. § 1395ww.
\(^{20}\) PPACA § 3006.
\(^{21}\) PPACA § 3007, amending 42 U.S.C. § 1395-w.
\(^{22}\) PPACA § 3025.
\(^{23}\) Beneficiaries in hospital beds receiving physician and nursing services, tests, medications, food, and supplies, are in many instances identified as outpatients in “observation status” rather than inpatients. Despite Medicare guidance limiting observation status to 24-48 hours, some beneficiaries remain in the hospital in observation status for many days, even weeks. Beneficiaries receiving outpatient observation services, which are covered under Medicare Part B, are not eligible for Medicare coverage of a subsequent skilled nursing facility stay and are billed for services such as prescription drugs that would ordinarily be covered under Medicare Part A during an inpatient hospital stay. See Observation Services: What Can Beneficiaries and Advocates Do?, Center for Medicare Advocacy, Inc., http://www.medicareadvocacy.org/InfoByTopic/ObservationStatus/ObservationMain.htm (accessed Mar. 4, 2011).
THE NEW CLASS ACT

By Morris Klein, CELA, CAP

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I. INTRODUCTION

This article discusses the basics of the new Community Living Assistance Services and Supports Act (CLASS Act).\(^1\) The article first discusses the need for the law, and then provides a broad overview of its significant features and how the government will implement it. Finally, the article raises some questions and concerns about the law.

The gap between the need for long-term care and the ability of persons to pay for such services is well known. The problem is that long-term care services are expensive, people do not have personal resources to pay for the services, and public and private support are lacking. The Administration on Aging estimates that about 70 percent of Americans over age 65 will need long-term care support.\(^2\) Currently, the provision for long-

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term care services is fragmented. Medicare provides little assistance.\(^3\) Medicaid requires impoverishment and in many states it favors institutionalization rather than home and community-based services.\(^4\) Sales of long-term care insurance have been difficult.\(^5\) Only about 10 percent of persons over the age of 65 have private long-term care insurance, and long-term care insurance is reported to account for only about 7 percent of all long-term care expenditures.\(^6\) Worse yet, about 42 percent of Americans age 45 and over have saved less than $25,000 for retirement;\(^7\) an amount that indicates many people will not be able to afford long-term care insurance, let alone the cost of long-term care services.\(^8\) The Deficit Reduction Act of 2005 permitted states to offer a long-term care insurance Medicaid partnership program to encourage persons to purchase long-term care insurance, but participation has been lackluster.\(^9\)

The CLASS Act is a unique experiment that attempts to offer an alternative ap-

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\(^3\) Medicare will only pay for up to 100 days of skilled nursing care. All but 20 days require a co-pay of $141.50 per day.

\(^4\) For example, in medically needy states, Medicaid eligibility for home and community-based services is subject to an income cap. Compare 42 U.S.C. § 1396a(a)(10)(C) (2010) with § 1396a(a)(10)(C).

\(^5\) *Wall Street Journal* reported on Nov. 12, 2010, that MetLife will halt new sales of long-term care insurance. The paper reports that MetLife is among the bigger sellers of the coverage, with about 600,000 policyholders, or about 8 percent, among the eight million who have long-term care insurance in the U.S. “MetLife joins a parade of insurers that have exited the business rather than try to fight for customers in the small market... Customer have held on to the policies at a rate many insurers didn’t expect. Those lower lapse rates in the first years of the policy translate into more people filing claims years later.” Erik Holm & Anne Tergeson, *MetLife Steps Back From Long-Term Care Market*, Wall St. J. (Nov. 12, 2010), http://online.wsj.com/article/SB10001424052748704756804575608472482348634.html.


\(^7\) Id.

\(^8\) The national average daily rate in 2010 for a private room in a nursing home is $229, while a semi-private room is $205, up from $219 and $198 respectively in 2009. The national average monthly base rate in an assisted living community rose from $3,131 in 2009 to $3,293 in 2010. The 2010 *MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*, MetLife (Oct. 2010), http://www.metlife.com/mmi/research/2010-market-survey-ltcc.html#findings.

\(^9\) In 1987, the Robert-Wood Johnston Foundation offered financial support to states to create a program that would reduce Medicaid long-term care costs by encouraging the purchase of long-term care insurance. Dubbed the “partnership program,” participants could keep exempt more assets then Medicaid would otherwise allow if they purchased long-term care insurance. The amount exempted would equal the amount of long-term care insurance purchased. For example, a $200,000 long-term care insurance policy could exempt $200,000 worth of assets. By 1993, California, Connecticut, Indiana, and New York had established variations of this program. The Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, § 13612, 107 Stat. 312, (1993). Congress in effect prevented additional states from establishing partnership programs by requiring states to recover such protected assets from the estates of Medicaid beneficiaries, (the law permitted the four states that had already established programs to continue unaffected). The Deficit Reduction Act of 2005, Pub. L. 109-171, § 6012, 116 Stat. 716, (2005) reversed the 1993 law and permitted states to establish partnership programs. In a report to Congress, the federal General Accounting Office reviewed whether state partnership programs are in fact saving Medicaid money. It reported that as of 2006, the four states had only 190,000 active partnership policies. *Long-term Care Insurance — Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings*, U.S. General Accounting Office, GAO-07-231, May 2007, 18.
approach to help people pay for long-term care services. A hybrid of a public benefit program and long-term care insurance, it establishes a voluntary government-administered long-term care service program whereby individuals who enroll in the program and pay the requisite premiums are eligible to receive modest cash payments for their long-term care needs in the community. Enrollees will not need to undergo medical underwriting and could be eligible for life-long benefits in as little as five years.

If successful, the program will allow persons with care needs to live in the community longer, help establish an infrastructure to provide community living assistance, alleviate burdens on family caregivers, and address institutional bias by supporting personal choice and independence to live in the community.

The CLASS Act is found in Title VIII (§§ 8001-8002) of the Patient Protection and Affordable Care Act (PPACA), creating §§ 3201 et seq. of the Public Health Service Act (PHSA) and codified at 42 U.S.C. §§300ll et seq.

The effective date of the CLASS Act is January 1, 2011, but it is unlikely that the program will start to enroll participants until 2012 or later. In fact, the statute allows the Secretary of the Department of Health and Human Services (Secretary of HHS) until October 1, 2012, to determine benefit plans and promulgate necessary regulations.

II. PROGRAM MECHANICS

A. Financing CLASS

Although a “public” program, Congress explicitly mandated CLASS to be voluntary and funded without government expense. Premiums must be actuarially sound for the first 75 years solely through the payment of premiums. The premium charged to enrollees may include a 3 percent administrative expense (presumably a maximum). The program cannot use general federal revenues to subsidize the program.

B. Enrollment

Persons 18 years of age and older who are “actively employed” may participate in the CLASS program. “Actively employed” includes employees, the self-employed, mem-

10 The law is one of the last legislative efforts of the late Sen. Edward Kennedy (D-Mass.).
13 The CLASS Act is not affected by the amendments to the PPACA, found in the Health Care and Education Reconciliation Act, Pub. L. 111-152 (2010) [hereinafter HCERA], 124 Stat. 1029.
14 PPACA § 8002(e), 42 U.S.C. § 300ll.
15 42 U.S.C. § 300ll-2(a)(3), PHSA § 3203(a). The Dept. of Health and Human Services has published a few notices in the Federal Register relating to start-up issues. HHS has solicited requests for membership in a Personal Care Attendants Workforce Advisory Panel, 75 FR 34140 (June 16, 2010) and has solicited requests for membership in the CLASS Independent Advisory Council, 75 FR 70005 (Nov. 16, 2010).
16 42 U.S.C. § 300ll-2(a), PHSA § 3203(a).
19 42 U.S.C. § 300ll-7(b), PHSA § 3208(b).
bers of the military, and working students.\textsuperscript{20} The statute defines employment as earning enough to be credited with a quarter of coverage under the Social Security Act.\textsuperscript{21} Persons who are not “actively employed,” such as stay-at-home spouses and persons whose disabilities preclude them from working, are not eligible. The statute does not permit family members of an eligible participant to enroll. Persons institutionalized in a nursing home, intermediate care facility, hospital, or prison are also excluded.\textsuperscript{22}

Employment is the sole eligibility standard. Unlike long-term care insurance, past or present health care needs do not directly affect eligibility. Presumably this is based on the notion that a person who is healthy enough to work does not have major health problems.

Employees of employers who elect to participate in the CLASS program are required to enroll unless they take action to “opt out.”\textsuperscript{23} Employees will have funds withheld from their payroll checks similar to deductions for retirement plans.\textsuperscript{24} Employers, however, have the option whether or not to participate, and only employees of employers who “opt-in” are automatically enrolled and must take action not to have premiums withheld from their paychecks.\textsuperscript{25} The statute does not offer any explicit incentives to employers to participate in the program or disincentives if they do not participate. Employees of employers who do not opt-in, along with the self-employed and working students, must take action to participate in the program.\textsuperscript{26} Thus, the opt-out feature of the program will only work if sufficient numbers of employers opt-in.

C. Re-enrollment and Penalties

To further encourage early participation, employees who opt out after enrolling may be subject to a penalty premium payment if they re-enroll later. The law does not appear to impose any adverse impact if a person drops out and re-enrolls within three months. For persons with a three-month to five-year lapse in paying premiums, the premium will be based on age of re-enrollment, with a credit for premiums previously paid.\textsuperscript{27} For lapses exceeding five years, the premium will be based on the age of re-enrollment with an additional penalty that is the greater of 1 percent or an amount determined by the Secretary of HHS to be actuarially sound.\textsuperscript{28} The Secretary of HHS may establish an “open season” for persons who want to re-enroll.\textsuperscript{29}

\begin{footnotesize}
\begin{enumerate}
\item[20] 42 U.S.C. §§ 300ll-3(c) and 300ll-1(2), PHSA §§ 3204(c) and 3202(3).
\item[22] 42 U.S.C. § 300ll-3(c)(4), PHSA § 3204(c)(4).
\item[23] 42 U.S.C. § 300ll-3(a), PHSA § 3204(a).
\item[24] 42 U.S.C. § 300ll-3(e)(1), PHSA § 3204(e)(1).
\item[25] 42 U.S.C. § 300ll-3(b), PHSA § 3204(b).
\item[26] 42 U.S.C. § 300ll-3(e)(2), PHSA § 3204(e)(2).
\item[29] 42 U.S.C. § 300ll-3(g)(1), PHSA § 3204(g)(1).
\end{enumerate}
\end{footnotesize}
D. Eligibility for Benefits

An enrollee may be eligible for benefits in as little as 60 months after enrolling in the program.30 The enrollee must pay premiums for at least 60 months and have been employed for three calendar years of the first 60 months of paying premiums.31 If a lapse of premium payments exceeds three months, then the enrollee must have paid premiums for at least 24 consecutive months to qualify for benefits.32 An enrollee is eligible for benefits upon certification by a licensed health care practitioner that, for at least 90 days, the enrollee:

1. Cannot perform at least “two or three” activities of daily living33 “without substantial assistance” (eating, toileting, transferring, bathing, dressing, or continence), or
2. Requires substantial supervision to protect from threats to health and safety due to substantial cognitive impairment, or
3. Has a level of functional limitations similar to the first two criteria.34

The Secretary of HHS is to establish an Eligibility Assessment System, using state disability assessment agencies, and eligibility is to be redetermined annually.35 This may be similar to the way an individual is evaluated for medical eligibility for Medicaid. The Secretary of HHS may promulgate regulations to develop expedited determinations, appeals, and redeterminations.36

The statute states that an enrollee is presumed to be eligible for benefits if the enrollee is a patient in a hospital provided the hospitalization is for long-term care, a nursing facility, an ICF, or an institution for mental diseases, and is in the process of, or about to begin the process of, planning to discharge from the facility or within 60 days of discharge.

E. Determining the Premium

The law requires the Secretary of HHS to determine premiums by October 1, 2012.37 Premiums will be set based on the age of the applicant and will not change as long as the enrollee continues in the program.38 Although premiums may increase “across the board” if the Secretary of HHS determines that the premiums to fund the program are insufficient,39 neither the cost of premiums nor the determination of eligibility take into consideration the enrollee’s current or past health.40
Persons with income below the poverty level and students younger than 22 years old who enroll will pay only a nominal premium of $5 a month, adjusted annually for inflation. The Secretary of HHS is tasked with developing procedures “similar to the procedures used by the Commissioner of Social Security” to verify that individuals qualify for the nominal premium. An enrollee who is at least 65 years old, paid premiums for 20 years, and is no longer actively employed cannot have premiums increased.

The cost of premiums and the range of benefit payments cannot be accurately predicted at this time. The law requires a minimum average benefit of $50 a day, with the specific amount scaled to the beneficiary’s care needs. It is thought that a monthly premium of $75 a month will provide a future benefit of $120 a month. A CLASS Independent Advisory Council, subject to the various constraints imposed by the law, is to advise the Secretary of HHS on the setting of premiums. The Independent Advisory Council is to be composed of not more than 15 individuals appointed by the President who are representative of program beneficiaries. All premiums that are collected are to be managed by a CLASS Board of Trustees, consisting of the Secretaries of HHS, Labor and Treasury and four individuals and two members of the public from different political parties.

F. The Benefit

The Secretary of HHS is to determine a cash benefit, called the CLASS Independence Benefit Plan, which is expected to average $50 a day. The actual benefit a person receives will vary based on his or her care needs, ranging from two and six deficiencies in activities of daily living. Coordination with supplemental coverage purchased through the health care exchanges is anticipated. The beneficiary can use benefit funds to purchase various care services or nonmedical services and supports, including services the beneficiary needs to maintain independence at home or a residential setting in the community, as well as for health care decision making and advance directives. It appears from the wording of the statute that it does not include nursing home expenses as allowable services. In addition, the Preamble to the

42 42 U.S.C. § 300ll-2(c)(2), PHSA § 3203(c)(2).
43 42 U.S.C. § 300ll-2(b)(1)(B)(ii), PHSA § 3203(b)(1)(B)(ii). The law is silent as to when premiums end for other enrollees. Most long-term care insurance programs do not require payment of premiums once benefits begin to be paid out.
44 42 U.S.C. §§ 300ll-2(a)(1)(D)(i) and (ii), PHSA §§ 3203(a)(1)(D)(i) and (ii).
46 42 U.S.C. §§ 300ll-2(a)(2) and (3), PHSA §§ 3203(a)(2) and (3).
47 42 U.S.C. § 300ll-6, PHSA § 3207.
48 42 U.S.C. § 300ll-5(c), PHSA § 3206(c).
49 42 U.S.C. § 300ll-4(b)(1) referring to § 300ll-2(a)(1)(D), PHSA §§ 3205(b)(1) referring to § 3202(a)(1)(D). To arrive at the appropriate amount, the Secretary is to develop at least three actuarially sound benefits plans as alternatives for consideration. 42 U.S.C. § 300ll-2(a)(1), PHSA § 3203(a)(1).
51 42 U.S.C. §§ 300ll-4(c)(1) and (2), PHSA §§ 3205(c)(1) and (2).
52 42 U.S.C. §§ 300ll-4(c)(1) and (2), PHSA §§ 3205(c)(1) and (2).
I. INTRODUCTION

“Nursing Homes Mix Felons, Seniors,” blares a headline in Chicago.¹ According to the article, an elderly woman was raped in her nursing home room by another resident who was an ex-convict. The article cites, among other problems, inappropriate resident mix, low staff levels, inadequate supervision, failure to report abuse to appropriate authorities, and poor state tracking of abuse incidents.²

“State Fines Nursing Homes More Than $200,000 in Deaths,” screams the headline

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¹ David Jackson & Gary Marx, Illinois Nursing Homes Mix Felons, Seniors, Chicago Tribune, B1 (Sept. 29, 2009).
² Id.
in Orange County, Calif. The article reports that two nursing homes were fined for inadequate care that led to the deaths of two residents. In one case, an 82-year-old woman died on Christmas Day of dehydration and acute kidney failure when the nursing home failed to monitor and document her medical condition. In Boston, the headline yells “Shafting Our Seniors.” The article alleges poor staff training, low staffing levels, lack of oversight, unsanitary living conditions, and overall neglect in some Boston-area nursing homes.

A barrage of recent articles from across the country cites similar problems that have resulted in injury or death to nursing home residents, who are some of our most vulnerable citizens. These problems have also been documented by national government studies and academic scholarship.

The Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), hereinafter collectively referred to as the Affordable Care Act or ACA, contains new nursing home regulations designed to address these problems. The regulations are intended to significantly improve the standard of care in nursing homes nationwide. Congress included the reforms as part of the ACA in recognition that improving nursing home care is “one piece of the puzzle to comprehensively reform our health care system.” Moreover, for many elderly persons, much of their health care takes place in nursing homes.

 Unless indicated otherwise, the new requirements apply both to nursing facilities as defined in § 1919(a) of the Social Security Act, and to skilled nursing facilities as

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3 Courtney Perkes, *State Fines O.C. Nursing Homes More Than $200,000 in Deaths*, Orange Co. Register, Local Section, B (June 10, 2009).
4 Id.
10 Id.
12 42 U.S.C. § 1396r(a).
defined in § 1819(a) of the Social Security Act\textsuperscript{13} (hereinafter collectively referred to as nursing homes or facilities).

The new regulations fall into five categories:
1. Reforms to promote transparency and accountability;
2. Data collection to compare facilities;
3. Provider screening, which includes background checks for certain employees;
4. Resident protections when a facility closes; and
5. National demonstration projects on culture change and the use of information technology in nursing homes.

Each of these areas is discussed below.

II. TRANSPARENCY AND ACCOUNTABILITY

The ACA imposes new requirements on nursing homes to promote transparency and accountability. The reforms include:

• Reporting governance and staffing information;
• Standardized complaint resolution procedures;
• Making investigative reports available to the public;
• Expenditure reporting for skilled nursing facilities;
• Changes in civil monetary penalties to encourage self-reporting and deficiency correction;
• A compliance and ethics program for nursing homes; and
• A national independent monitor demonstration project for nursing home chains.

A. Information Regarding Governance

When Congress was debating the ACA, it heard testimony that some nursing home chains develop subsidiaries to insulate themselves from liability.\textsuperscript{14} The Byzantine structures make it difficult for families to obtain accurate information.\textsuperscript{15} These structures also challenge regulators and prosecutors seeking to identify the actual owners to hold the owners accountable for abuse or fraud.\textsuperscript{16} Witnesses cited several examples of the foregoing problem, including fatal fires at two different nursing homes in Michigan. Only long after the second fire did authorities discover that both facilities were under the same ownership.\textsuperscript{17}

To address these problems, the ACA requires nursing homes to maintain and re-

\textsuperscript{13} 42 U.S.C. § 1395i-3(a). The primary difference between nursing facilities and skilled nursing facilities is that the former may not admit mentally ill or mentally retarded individuals unless the state mental health authority has determined that such admission is appropriate. See 42 U.S.C. § 1396r(b)(3)(F).


\textsuperscript{15} Id.

\textsuperscript{16} Id.

\textsuperscript{17} Hearing on How the Senate Health Care Reform Bill Will Affect Seniors, supra n. 11.
port to the Secretary of the Department of Health and Human Services (Secretary of HHS) information about their governance. Effective as of the ACA’s enactment, homes must maintain information about their officers, directors, members, partners, trustees, and managing employees (including their names, titles, and periods of service).\textsuperscript{18} Nursing homes must also maintain information about any “additional disclosable party”\textsuperscript{19} (including its identity, organizational structure,\textsuperscript{20} and the relationship of each additional disclosable party to one another).\textsuperscript{21}

Within two years of the ACA’s enactment, the Secretary of HHS must promulgate regulations requiring facilities to report the information to the Secretary of HHS in a standardized format.\textsuperscript{22} The regulations must require that the facility certify that the information is accurate and current.\textsuperscript{23} The new reporting requirements are in addition to, and do not reduce or alter, existing reporting requirements.\textsuperscript{24} Within one year after promulgation of the new regulations, the Secretary of HHS is required to make the information available to the public.\textsuperscript{25}

B. Reporting Staffing Information

Within two years of the ACA’s enactment, the Secretary of HHS will require nursing homes to electronically submit direct care staffing information, including information about agency and contract staff.\textsuperscript{26} The Secretary of HHS must do so in consultation with state long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary of HHS deems appropriate.\textsuperscript{27}

The information will be based on payroll and other verifiable data, and provided in a uniform format according to specifications established by the Secretary of HHS.\textsuperscript{28} The staffing information must include:

\begin{itemize}
  \item \textsuperscript{18} PPACA § 6101(a), amending § 1124 of the Social Security Act (42 U.S.C. § 1320a-3) by adding a new subsection (c)(2)(A)(ii)(I) and (II).
  \item \textsuperscript{19} The Act defines this term as any person or entity who: 1) exercises operational, financial, or managerial control or provides policies or procedures for any part of the facility, or financial or cash management services; 2) leases or subleases real property to the facility or has an ownership of 5 percent or more in the real property; or 3) provides management, administrative, consulting, accounting or financial services. PPACA § 6101(a), amending § 1124 of the Social Security Act (42 U.S.C. § 1320a-3) by adding a new subsection (c)(5)(A).
  \item \textsuperscript{20} Organizational structure is defined in PPACA § 6101(a), amending § 1124 of the Social Security Act (42 U.S.C. § 1320a-3) by adding a new subsection (c)(5)(D).
  \item \textsuperscript{21} PPACA § 6101(a), amending § 1124 of the Social Security Act (42 U.S.C. § 1320a-3) by adding a new subsection (c)(2)(A)(ii)(III) and (c)(A)(iii).
  \item \textsuperscript{22} PPACA § 6101(a), amending § 1124 of the Social Security Act (42 U.S.C. § 1320a-3) by adding a new subsection (c)(3)(A).
  \item \textsuperscript{23} Id.
  \item \textsuperscript{24} PPACA § 6101(a), amending § 1124 of the Social Security Act (42 U.S.C. § 1320a-3) by adding a new subsection (c)(4).
  \item \textsuperscript{25} PPACA § 6101(b).
  \item \textsuperscript{26} PPACA § 6106, amending § 1128l of the Social Security Act as added and amended by the PPACA by adding a new subsection (g).
  \item \textsuperscript{27} Id.
  \item \textsuperscript{28} Id.
\end{itemize}
• A description of the category of work a certified employee performs, such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel;
• Information on employee turnover and tenure, as well as the hours of care provided by each category of certified employees;
• Resident census data and information on resident case mix; and
• A regular reporting schedule.\(^{29}\)

C. Standardized Complaint Form and Complaint Resolution Procedures

Within one year of the ACA’s enactment, the Secretary of HHS must develop a standardized form for residents, or persons acting on a resident’s behalf, to file a complaint with a state survey and certification agency and a state long-term care ombudsman program.\(^{30}\) The states must make the standardized complaint form available upon request to residents, and to any person acting on a resident’s behalf.\(^{31}\) However, these new requirements do not prevent a resident, or a person acting on behalf of a resident, from submitting a complaint in any other manner, including orally.\(^{32}\)

The states must also establish a complaint resolution process within one year of the ACA’s enactment. The process must ensure that a facility does not retaliate against the resident’s legal representative or other responsible party if he or she has a complaint.\(^{33}\) The resolution process must also include:
• Procedures to assure accurate tracking of complaints, including notification to the complainant that a complaint has been received;
• Procedures for determining the likely severity of a complaint and for investigating the complaint; and
• Deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.\(^{34}\)

D. Availability of Reports on Surveys, Certifications, and Complaint Investigations

Within one year after the ACA’s enactment, nursing homes must maintain for three years reports with respect to any surveys, certifications, and complaint investigations.\(^{35}\) The reports must be available for any individual to review upon request.\(^{36}\) However, the

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\(^{29}\) Id.

\(^{30}\) PPACA § 6105, amending § 1128I of the Social Security Act as added and amended by the PPACA by adding a new subsection (f)(1).

\(^{31}\) PPACA § 6105, amending § 1128I of the Social Security Act as added and amended by the PPACA by adding a new subsection (f)(2)(A).

\(^{32}\) PPACA § 6105, amending § 1128I of the Social Security Act as added and amended by the PPACA by adding a new subsection (f)(3).

\(^{33}\) PPACA § 6105, amending § 1128I of the Social Security Act as added and amended by the PPACA by adding a new subsection (f)(2)(B).

\(^{34}\) Id.

\(^{35}\) PPACA § 6103(c), amending § 1819(d)(1) of the Social Security Act (42 U.S.C. § 1395i-3(d)(1)), as amended by PPACA § 6101, by adding a new subsection (C)(i), and amending § 1919(d)(1) of the Social Security Act (42 U.S.C. § 1396r(d)(1)), as amended by PPACA § 6101, by adding a new subsection (V)(i).

\(^{36}\) Id.
nursing home shall not make available identifying information about the complainants or residents.\textsuperscript{37} The facility must post notice of the availability of such reports in areas that are prominent and accessible to the public.\textsuperscript{38}

\textbf{E. Reporting of Expenditures for Skilled Nursing Facilities}

The ACA imposes on skilled nursing facilities more stringent reporting of expenses to the Department of Health and Human Services (HHS). The new expense reporting requirements apply only to skilled nursing facilities, not to nursing facilities.

For cost reports submitted to HHS for reporting periods beginning two years after the ACA’s enactment, skilled nursing facilities must separately report expenditures for wages and benefits for direct-care staff.\textsuperscript{39} This separate report must break out, at a minimum, registered nurses, licensed professional nurses, certified nurse assistants, and other medical therapy staff.\textsuperscript{40}

Within 30 months after the ACA’s enactment, the Secretary of HHS will categorize the expenditures listed on the cost reports into the following functional accounts on an annual basis:

- Spending on direct care, including nursing, therapy, and medical services;
- Spending on indirect care, including housekeeping and dietary services;
- Capital assets, including land costs; and
- Administrative service costs.\textsuperscript{41}

In categorizing the expenditures, the Secretary of HHS will work with the Medicare Payment Advisory Commission, the Medicaid and Children’s Health Insurance Program (CHIP) Payment and Access Commission, the HHS Inspector General, and such other expert parties as the Secretary of HHS deems appropriate.\textsuperscript{42} The Secretary of HHS will establish procedures to make information on expenditures readily available to interested parties.\textsuperscript{43}

\textbf{F. Changes in Civil Monetary Penalties to Encourage Self-Reporting and Deficiency Correction}

The ACA changes the civil monetary penalty system to encourage providers to self-report and correct deficiencies. These changes become effective one year after the Act’s enactment.\textsuperscript{44}

\textsuperscript{37} \textit{Id.}
\textsuperscript{38} PPACA § 6103, amending § 1819(d)(1) of the Social Security Act (42 U.S.C. § 1395i-3(d)(1)), as amended by PPACA § 6101, by adding a new subsection (C)(ii), and amending § 1919(d)(1) of the Social Security Act (42 U.S.C. § 1396r(d)(1)), as amended by PPACA § 6101, by adding a new subsection (V)(ii).
\textsuperscript{39} PPACA § 6104, amending § 1888 of the Social Security Act (42 U.S.C. § 1395yy) by adding a new § (f) (1).
\textsuperscript{40} \textit{Id.}
\textsuperscript{41} PPACA § 6104, amending § 1888 of the Social Security Act (42 U.S.C. § 1395yy) by adding a new subsection (f)(3).
\textsuperscript{42} \textit{Id.}
\textsuperscript{43} PPACA § 6104, amending § 1888 of the Social Security Act (42 U.S.C. § 1395yy) by adding a new subsection (f)(4).
\textsuperscript{44} PPACA § 6111(c).
HEALTH CARE REFORM’S IMPACT ON SMALL BUSINESSES AND INDIVIDUALS

By Ben A. Neiburger, Esq.

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I. Introduction

In early 2010, overcoming nearly 70 years of Congressional resistance, President Obama signed legislation that created the greatest single expansion of health care access and coverage in American history. The Patient Protection and Affordable Care Act of 2010 (PPCA)\(^1\) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA)\(^2\) (hereinafter collectively referred to as the Affordable Care Act or ACA) represents a major effort to enroll nearly all Americans in comprehensive health insurance programs.

Many sections of the ACA indirectly affect small businesses and individuals, while several directly affect them by providing tax incentives for business owners, taxing certain employers who fail to provide health insurance for their workers, and establishing wellness incentives for individuals. To make the ACA more workable, given its scope, some provisions were effective immediately, some in September 2010, and the most complex will not take effect until 2014.

The ACA contains incentives and penalties to expand coverage for employees and individuals, generally by requiring all individuals to have health insurance (paid for by companies with more than 50 employees, or by requiring individuals who are not so covered to purchase their own insurance). Individuals purchasing their own insurance will obtain tax credits and those who cannot afford to maintain policies will receive subsidies. Companies and individuals who fail to comply will be subject to new taxes collected by the Internal Revenue Service (IRS).

As can be easily imagined, because the ACA creates a new regimen for reporting to the federal government, it will create new work for tax attorneys and CPAs. Computing penalties as well as deductions and credits under the ACA will not be easy. The law is likely to increase taxes on many taxpayers by reducing both medical deductions and the amounts that individuals can place in tax deferred accounts for medical expenses. Reporting provisions will, of course, increase operating costs for most businesses.

This article assesses how the ACA is likely to affect small business owners and individuals. The first two sections of this article discuss how the ACA expands and subsidizes health insurance coverage. The third section discusses tax penalties on individuals and employers for noncompliance. The fourth section discusses changes in the Internal Revenue Code (IRC) that will place additional tax and administrative burdens on individuals and businesses.

II. The Expansion of Health Insurance Coverage

Congress sought to expand the availability, affordability, coverage, and portability of health insurance coverage by eliminating certain coverage limits, by covering children up to age 27 on their parents’ policies, by establishing wellness pilot programs designed to reduce overall health expenses, and by subsidizing credits for those who cannot afford coverage. It also created a voucher program to facilitate portability of existing coverage.

\(^1\) Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) [hereinafter PPACA].
\(^2\) Health Care and Education Reconciliation Act, Pub. L. 111-152 (2010) [hereinafter HCERA].
A. Prohibition of Lifetime or Annual Insurance Coverage Limits in Health Plans

The ACA prohibits health insurers from imposing lifetime or annual benefit limits on individuals for “essential health benefits.”³ This prohibition became effective for plans whose anniversary fell after September 23, 2010, but it is subject to transition rules for lifetime and annual limits prior to 2014. For plan years beginning before January 1, 2014, insurers may establish a restricted annual limit on the dollar value of essential health benefits. This restricted annual limit will be further defined by the Secretary of the Department of Health and Human Services (Secretary of HHS).⁴ However, insurers may impose an annual or lifetime limit per beneficiary on goods or services that are not considered “essential health benefits.” “Essential health benefits” include all of the following: ambulance services, emergency services, hospitalization, maternity and new born care, mental health services, prescription drugs, rehabilitation and habitation services and devices, laboratory services, preventative and wellness services, chronic disease management, and pediatric services (including vision and oral care).⁵ The ACA authorizes the Secretary of HHS to define “essential health benefits” beyond that minimum.⁶

In addition to prohibiting lifetime limits, the ACA prohibits insurers from rescinding coverage once offered unless there is fraud or misrepresentation by the insured.⁷ This has the effect of guaranteeing renewability of policies (people can no longer be “dropped” by their insurers because of ill health or other reasons). Regulations are likely to spell out grounds for “fraud or intentional misrepresentation of material fact” by the insured.

Prior to the enactment of the ACA, many individual and group health plans imposed lifetime benefit limits and sometimes annual benefit limits on individuals, typically set at $1 million or $2 million. Now, insurance companies cannot impose these limits or drop coverage if the insured’s health care costs increase after the insurance company issues the policy.

B. Prohibitions Against Pre-Existing Condition Exclusions and Discrimination Based on Health Status

The ACA prohibits a group health plan or a health insurance issuer offering group or individual health insurance coverage from imposing any pre-existing exclusion with respect to such plan or coverage.⁸ This rule became effective on September 23, 2010, for children under age 19. For everyone else, it will become effective when their plan begins on or after January 1, 2014. In addition, the ACA prohibits a group health plan or an insurer offering group or individual health insurance coverage from establishing eligibility rules for any individual or dependent to enroll in the plan based on the following: health status, medical condition (including both physical and mental illness), claim experience, receipt of health care, medical history, genetic information, evidence of insurability (in-
cluding conditions arising out of acts of domestic violence), or disability.⁹

This provision means that virtually all Americans will be guaranteed health insurance coverage even if they do not participate in a group plan offered by an employer. Previously, many individuals could not obtain coverage due to the exclusion of pre-existing conditions and sometimes the refusal of the insurance company to provide coverage at all.

C. Tax Deduction for Providing Health Insurance Coverage to Children Under Age 27

The ACA requires health insurers¹⁰ to make available health insurance to insureds’ children under age 27 by mid-September 2010.¹¹ They also amend IRC § 105(b) to exclude from an individual’s income health benefits provided to children under age 27. Before this change, the income exclusion only applied to unmarried children up to age 24. While the child’s marital status is no longer a bar to parental coverage, the new law does not extend coverage to the children or spouses of those children ages 24–26. If the ACA did not modify the IRC for this change, the health care benefits for children over age 24 would have been subject to income tax.

D. Free Choice Vouchers

Free choice vouchers give a small number of employees the right to have their employers pay for coverage for them outside of the employer’s own health plan. The amount that an employer pays is equal to what the employer would have paid under its own plan if the employee did not elect coverage from elsewhere.¹² The mechanism for this is the “free choice voucher” that an employer issues to an employee. Only certain employees, however, may obtain a free choice voucher from their employer — provided the employer also provides minimum essential coverage¹³ to its employees and pays for any part of that coverage.

Employees eligible for free choice vouchers are those who: 1) make contributions to their health insurance premiums of between 8 percent and 9.8 percent of their household income,¹⁴ 2) have household income equal to 400 percent of the federal poverty line or less, and 3) choose not to participate in their employer’s plan.¹⁵ Only a small subset of employees qualify for these benefits since, according to the Congressional Budget Office, this provision is designed to cover the estimated 100,000 employees nationwide who fall between two separate mandates: 1) the requirement that individuals must maintain health

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⁹ By adding new § 2705 to the PHSA.
¹⁰ The term “insurers” here refers to a group health plan or a health insurance issuer offering group or individual insurance that provided dependent coverage of children.
¹¹ PPACA §§ 1001, 1004; HCERA § 2301.
¹² PPACA § 10108(d).
¹³ PPACA § 1501(b) (as defined in the new Code Section 5000A(f)). Minimum essential coverage is coverage that provides minimum essential benefits which include ambulance services, emergency services, hospitalization, maternity and new born care, mental health, prescription drugs, rehabilitation and habilitation services and devices, laboratory services, preventative and wellness services, chronic disease management, and pediatric services (including vision and oral care).
¹⁴ The CCH Editorial Staff, CCH’s Law, Explanation and Analysis of the Patient Protection and Affordable Care Act, CCH, 281, Paragraph 350.
¹⁵ PPACA § 10108(c).
coverage unless the coverage premium exceeds 8 percent of a person’s household income and 2) employees who would not be eligible for premium subsidies because their premium contributions are less than 9.8 percent of their household income.\textsuperscript{16} Persons whose household income exceeds 9.8 percent would qualify for premium subsidies.

If a qualified employee requests this benefit, his or her employer must issue a voucher that the employee can use in any Health Insurance Exchange.\textsuperscript{17} The Health Insurance Exchange must credit the amount of the free choice voucher to the premium cost for any Exchange health plan in which the employee enrolls. The value of the voucher is not included in the employee’s gross income (up to the amount actually paid under the voucher for a qualified plan),\textsuperscript{18} but employers can deduct as a compensation expense the value of the voucher it provides to its employee.\textsuperscript{19} From the employer’s perspective, the voucher is treated as any other health insurance benefit that an employer provides to an employee other than the costs of administering, reporting, and tracking the voucher.

\textbf{E. Simple Cafeteria Plans for Small Businesses}

A “cafeteria plan” is a type of employee benefit plan under which an employee may choose among several different nontaxable benefits. Cafeteria plans may offer a variety of benefits, which may include health insurance, dental insurance, life insurance, flexible medical spending reimbursements, and child care reimbursements. IRC § 125, which governs cafeteria plans, requires that the benefits granted under the plan not discriminate in favor of so-called “highly compensated employees.” In other words, if the value of benefits offered to highly compensated employees significantly exceeds the value of benefits offered to non-highly compensated employees, the plan may lose its tax qualified status. Administering “non-discriminatory” tests are likely to be highly complex, complicated even further because the actual comparisons may not be available until the end of the tax year.

Effective for plan years beginning after December 31, 2010, there is a new classification of cafeteria plan.\textsuperscript{20} “Simple” cafeteria plans will help employers who employ 100 or fewer employees to offer a uniform plan that will avoid the non-discrimination rules. To satisfy “safe harbor” requirements the employer must meet both contribution and participation requirements. By following the safe harbor, an employer may safely retain certain discriminatory benefits for their highly compensated employees without running afoul of the non-discrimination requirements. To meet the contributory safe harbor, the employer must contribute to the plan on behalf of each employee (regardless of an employee’s actual contribution) an amount that is at least 1) 2 percent of an employee’s compensation or 2) the lesser of 6 percent of an employee’s compensation or twice the amount of salary reduction contributions of each employee. The participation safe harbor requirements are met if all employees who have worked at least 1,000 hours of service during the prior plan year participate under the plan and if all those employees participat-

\textsuperscript{16} PPACA § 1501(b) (which adds Code Section 5000aa(e)(1)).
\textsuperscript{17} PPACA § 10108.
\textsuperscript{18} PPACA § 10108(d) (adding I.R.C. § 139D).
\textsuperscript{19} PPACA § 10108(d) (modifying I.R.C. § 162(a)).
\textsuperscript{20} PPACA § 9022.
ing under the plan are able to elect all benefits that the plan offers. The plan may exclude employees under age 21 and those who have less than one year of service. Of course, it may be difficult for an employer’s cafeteria plan to use this safe harbor if the refusal of even one eligible employee disqualifies it.

F. Protection Against Premium Discrimination for Gun Owners

As an obvious sop to the National Rifle Association and other Second Amendment advocates, the ACA protects gun owners from being required to bear the costs of any increased health risk arising from gun ownership. The ACA prohibits insurers from inquiring about or collecting information about whether an insured owns a firearm or ammunition or stores a firearm or ammunition on his or her property. Group health plans and insurers cannot collect that information or use it to increase health coverage premium rates, deny health insurance, or reduce or withhold wellness program discounts or rewards.21

G. Wellness Incentives

The ACA requires the Secretary of HHS to create a demonstration pilot program for Individualized Wellness Plans22 to test the impact of providing at-risk populations who use community health centers with an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment. The legislation funds 10 community health centers to conduct activities under the pilot program. The plans under the program may include one or more of the following as appropriate to the individual’s risk factors: nutritional counseling, physical activity plan, alcohol and smoking cessation counseling and services, stress management, certain dietary supplements, and compliance assistance. Wellness plans will be designed to lessen risk factors such as obesity, tobacco and alcohol use and concentrate on healthy exercise, nutrition, and lowering blood pressure.

III. The Subsidization of Health Insurance Coverage

A. Health Insurance Premium Assistance Refundable Credit

As part of its plan to require all citizens to pay for health insurance, the ACA subsidizes lower income taxpayers via a tax credit — a dollar-for-dollar reduction in income tax liability — to pay some or all of the cost of insurance when the taxpayer purchases “silver” 23 or better coverage on a state Exchange.24 Beginning in 2014, every “applicable taxpayer” who buys a “qualified health plan” will receive a tax credit equal to the “premium assistance credit amount.”25 Each of these terms will require some explanation — some more than others. The credit is a refundable tax credit, i.e., a tax credit that can

21 PPACA § 1001(5).
22 PPACA § 4206 (amending § 330 of the PHSA [42 U.S.C. 245b]).
23 The ACA defines four levels of plans: bronze, silver, gold, and platinum.
24 See Section III. B, Other Income-Based Benefits, of this article for more information on plans available on state Exchanges.
25 PPACA § 1401(e) (adding § 36B to the I.R.C.).
HEALTH CARE REFORM AND END-OF-LIFE ISSUES

By Fay Blix, CELA, CAP

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I. INTRODUCTION

While very little about end-of-life issues remained in the final health care reform
bill when it ultimately passed, it was these very end-of-life concerns that almost derailed
the entire reform enterprise. This article will briefly summarize the end-of-life provisions
contained in the various versions of the House and Senate bills. It will also provide a short
history of the political firestorm surrounding the debate over these issues. Finally, it will
address the impact of this debate on our senior and special needs clients as well as some
of the ways in which the Elder and Special Needs Law community can allay our clients’
concerns and turn this crisis into an opportunity for growth.

II. SUMMARY OF HEALTH CARE LAW CONCERNING END-OF-LIFE DECISIONS

The original House bill contained two provisions that promoted the discussion and
use of advance directives. The first provision required entities that offered health benefit
plans to disseminate information about advance directives and “end-of-life planning” to

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1 The reform consists of two laws, the Patient Protection and Affordable Care Act (Pub. L. 111-148) and
the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), respectively referred to as
the PPACA and the HCERA. The two acts are collectively referred to as the Affordable Care Act or ACA.
those enrolling in their plans.\textsuperscript{2} The section provided that the decision to execute an advance directive was to be completely voluntary and that the directives provided by the plans comply with “the laws of the state in which the individual resides.”\textsuperscript{3} The information presented to enrollees was not to “presume the withdrawal of treatment” but was mandated to include particulars about options to “maintain all or most medical interventions.” In fact, twice in this provision, it was stated that these informational efforts were not to “promote suicide, assisted suicide, euthanasia, or mercy killing.”\textsuperscript{4}

In addition, the provision stated that the “advance directives and other planning tools” were prohibited from including options concerning assisted suicide, euthanasia, or mercy killing, “regardless of legality.”\textsuperscript{5} The final clause declared that nothing in this provision may be construed to “preempt or otherwise have any effect on [s]tate laws regarding advance care planning, palliative care, or end-of-life decision-making.”\textsuperscript{6}

The House bill also provided for the development of new quality measures for the delivery of health care services by qualified entities that allow the assessment of “the continuity and coordination of care and care transitions for patients across providers and health care settings, including end of life care.”\textsuperscript{7}

The second House bill provision regarding advance directives allowed for federal reimbursement for “voluntary advance care planning consultations” between Medicare patients and their physicians.\textsuperscript{8} Such consultations were to be optional and to be paid for only every five years. Further, this section provided that nothing in this provision was to “encourage the promotion of suicide or assisted suicide.”\textsuperscript{9}

The original Senate bill included none of these provisions, but instead included a provision forbidding discrimination against an institutional or individual health care provider who “does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.”\textsuperscript{10} However, withholding or withdrawal of medical treatment, nutrition or hydration or the use of any pain relief that may increase the risk of death, but is not provided for the purpose of causing death are specifically excluded from the definition of lethal medical procedures.\textsuperscript{11} These Senate provisions appear to be taken directly from the Assisted Suicide Funding Restriction Act of 1997,\textsuperscript{12} which excludes assisted suicide from all federal health care funding, including federal-state programs such as Medicaid.

Both original bills included the issue of advance directives as part of the Community Living Assistance Services and Supports (CLASS) Act, creating a new Title XXXII

\begin{enumerate}
\item H.R. 3962, § 240.
\item H.R. 3962, § 240 (a)(2)(A).
\item H.R. 3962, §§ 240 (a)(3), 240 (b)(3).
\item H.R. 3962, § 240 (d)(1).
\item H.R. 3962, § 240 (d)(3).
\item H.R.3962, §1192(c)(1)(B).
\item H.R. 3962, § 1233.
\item H.R. 3962, § 1233 (b)(3).
\item H.R. 3590, § 1533.
\item H.R. 3590, § 1533 (c).
\item Pub. L. No. 105-12.
\end{enumerate}
Health Care Reform and End-of-Life Issues

of the Public Health Services Act for this program.\textsuperscript{13} The bills provided that a beneficiary who paid into a Life Independence Account could use these cash benefits to procure “assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under [s]tate [l]aw.”\textsuperscript{14} Under this plan a beneficiary could ask to be assigned an “advice and assistance counselor,” who could provide additional information on such decision making.\textsuperscript{15}

In the end, the advance care planning provisions were dropped and all that remained in the final bill were 1) the CLASS Act provisions which authorized that cash benefits in a Life Independence Account could be used to obtain assistance with medical decision making and the formulation of advance directives,\textsuperscript{16} and 2) the Section 1553 provisions which clarified that the prohibition against discrimination on assisted suicide does not apply to withholding or withdrawing medical care, nutrition or hydration, or items or services that increase risk of death if furnished for the purpose of alleviating pain and not to cause death.\textsuperscript{17}

III. THE POLITICAL FIRESTORM — ACCUSATIONS OF DEATH PANELS AND EUTHANASIA

“I didn’t mean to kill Grandma. I didn’t even mean to create death panels,” confessed Rep. Earl Blumenauer (D-Ore.). His statement appeared in a November 2009 op-ed piece for \textit{The New York Times}\textsuperscript{18} in which he defended himself from attacks that the proposed health care legislation instituted death panels which would be responsible for making end-of-life decisions based on a cost/benefit analysis.

When the health care reform act was in its initial drafting phase, it appeared that both Republicans and Democrats agreed that end-of-life planning would be an integral part of the plan. Rep. Blumenauer stated that he specifically included the end-of-life planning issue as part of health care reform because it was a “rare common denominator of health care politics.” In fact, Reps. Charles Boustany (R-La.), Geoff Davis (R-Ky.) and Patrick Tiberi (R-Ohio) joined Blumenauer as co-sponsors of the counseling bill when it was first introduced.\textsuperscript{19} On the Senate side, Sen. Jay Rockefeller (D-W.Va.) was joined by Sen. Susan Collins (R-Maine) in co-sponsoring a similar bill in the Senate (S.1150). Upon introducing the bill, Rockefeller stated in his opening remarks that “[i]n preparation for the impending health reform debate, Sen. Collins and I decided last year that it was time to update our Advance Planning and Compassionate Care Act to incorporate all of the best ideas out there on improving end-of-life care.”\textsuperscript{20} A precursor bill, The Medicare End-Of-Life Care Planning Act, (S.466) had been introduced by Rockefeller in 2007 with

\begin{itemize}
\item \textsuperscript{13} H.R. 3962, § 2581 (a), H.R. 3590, § 8002 (a)(1).
\item \textsuperscript{14} H.R. 3590, § 3205 (c)(1)(B).
\item \textsuperscript{15} H.R. 3590, § 3205 (e)(5).
\item \textsuperscript{16} H.R. 3590, § 8002.
\item \textsuperscript{17} H.R. 3590, § 1553.
\end{itemize}
bipartisan co-sponsorship support from Sens. Collins, Richard Luger (R-Ind.) and John Isakson (R-Ga.).

On July 16, 2009, at the House Ways and Means Committee mark-up session, which lasted well into the night, not one word was spoken in opposition to this advance care planning proposal. However, on July 23, 2009, House Republican Leader John Boehner (R-Ohio) and Republican Policy Committee Chairman Thaddeus McCotter (R-Mich.) issued a press release stating:

Section 1233 of the House-drafted legislation encourages health care providers to provide their Medicare patients with counseling on “the use of artificially administered nutrition and hydration” and other end of life directives they would not otherwise sign. This provision may start us down a treacherous path toward government-encouraged euthanasia if enacted into law. At a minimum, this legislative language deserves a full and open public debate — the sort of debate that is impossible to have under the politically-driven deadlines Democratic leaders have arbitrarily set for enactment of a health care bill. . . . With three states having legalized physician-assisted suicide, this provision could create a slippery slope for a more permissive environment for euthanasia, mercy-killing and physician-assisted suicide because it does not clearly exclude counseling about the supposed benefits of killing oneself.

Betsy McCaughey, former Republican Lieutenant Governor for the State of New York (famous for her role in defeating the Clinton health care plan in 1994), reinforced the GOP leaders’ position with an opinion piece in the Wall Street Journal by firmly stating that the House bill “ensures that seniors are counseled on end-of-life options, including refusing nutrition where state law allows it,” and then she linked the counseling to assisted suicide by adding, “In Oregon some cancer patients are being denied care by the state that could extend their lives and instead are afforded the benefit of physician-assisted suicide.” Her opinion piece followed comments she had made during a July 16, 2009, appearance on former Sen. Fred Thompson’s radio show, when she emphatically stated, “Congress would make it mandatory — absolutely require — that every five years people in Medicare have a required counseling session that will tell them how to end their life sooner.”

Troubled by McCaughey’s misrepresentation of the provision, Jim Dau, national spokesperson for AARP commented, “The only thing mandatory is that Medicare will have to pay for the counseling.” He characterized McCaughey’s comments as “not just wrong, they are cruel. We want to make sure people are making the right decision. If someone wants to take every life-saving measure, that’s their call. Others will decide it’s not worth going through the trauma just for themselves and their families, and that’s their

22 Blumenauer, supra n. 17.  
decision, too.”

Nevertheless, radio celebrity, Rush Limbaugh, echoed McCaughey’s refrain on his July 21, 2009, radio show, commenting, “Mandatory counseling for all seniors at a minimum of every five years, more often if the senior citizen is sick or in a nursing home. . . We can’t have counseling for mothers who are thinking about terminating their pregnancy, but we can go in there and counsel people about to die. I’m sure you could get some counselors from the Hemlock Society to go in and do this. Kevorkian might want to come back to life and handle this. End-of-life counselors, end-of-life treatment for senior citizens, mandatory [sic].”

When Sarah Palin entered the fray by posting a comment on her Facebook page on August 7, 2009, the rumor went viral. “The America I know and love is not one in which my parents or my baby with Down syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their ‘level of productivity in society’ whether they are worthy of health care.”

Although the “death panel” phrase appeared nowhere in the bill, it somehow captured the imagination of the country, generating high octane fear. Town halls became shrill shouting matches, with citizens spurred to unruly disruption fueled by the steady drumbeat of right wing pundits and incendiary blogs. Unreasoned fear was so rampant that Rep. Frank Kratovil (D-Md.) was hung in effigy outside his Maryland office.

President Obama finally addressed the issue at a town hall meeting in Portsmouth, N.H. on August 11, 2009, stating, “The rumor that’s been circulating a lot lately is this idea that somehow the House of Representatives voted for ‘death panels’ that will basically pull the plug on grandma . . . [T]his arose out of [a] provision in one of the House bills that allowed Medicare to reimburse people for consultations about end-of-life care, setting up living wills, the availability of hospice, etc. So the intention of the members of Congress was to give people more information so that they could handle issues of end-of-life care when they’re ready, on their own terms. It wasn’t forcing anybody to do anything. This is I guess where the rumor came from.”

Despite President Obama’s reassurances, Sen. Charles Grassley (R-Iowa) told a crowd in Winterset, Iowa, “In the House bill, there is counseling for end of life. You have every right to fear. You shouldn’t have counseling at the end of life; you should have done

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that 20 years before. [You] should not have a government-run plan to decide when to pull the plug on grandma.”

Others, like John Isakson (R-Ga.), a cosponsor of an earlier similar measure, told Ezra Klein of the Washington Post, “I just had a phone call where someone said Sarah Palin’s website had talked about the House Bill having death panels on it where people would be euthanized. How someone could take an end-of-life directive or a living will as that is nuts. You’re putting the authority in the individual rather than the government. I don’t know how that got so mixed up.”

Meanwhile, Rep. Mike Ross (D-Ark.), a moderate Democrat, had reached an agreement with Rep. Henry Waxman (D-Calif.), chair of the House Energy and Commerce Committee, to insert an amendment, which was adopted by the committee late Friday, July 31, 2009. His amendment prohibited the promotion of assisted suicide and provided that the information given to consumers regarding their end-of-life choices would not presume the withdrawal of treatment. The House bill, with the Ross amendment, specifically prevented health care providers from even discussing euthanasia.

However, even some who debunked the death panel interpretation of the far right still expressed concern that Section 1233 was in “disconcerting proximity” to cost-saving fiscal provisions and that the mandated content of the advance planning counseling sessions and the fact that the doctors were allowed to initiate the discussion rather than waiting for a patient request presented the danger that patients “will bow to white-coated authority.” Picking up on that theme, bioethicist Francis Beckwith opined that Section 1233 “includes conditions and financial incentives for physicians and other health providers that create a setting in which an elderly patient’s decision to appropriate this option is likely to be less than voluntary.” He added that any “special health court” to which patients could present their grievances would be “one likely informed by a youth-worshipping culture and a utilitarian bioethics philosophy that sees the elderly … as burdens that are siphoning away valuable resources that could be put to better use in support of society’s ‘real persons’ and more productive contributors.”

Finally, Sen. Charles Grassley (R-Iowa), the ranking Republican on the Senate Finance Committee that was trying to produce a bipartisan bill, issued a press release stating, “We dropped end-of-life provisions from consideration entirely because of the way...


THE AFFORDABLE CARE ACT’S CHANGES TO MEDICAID’S COVERAGE FOR LONG-TERM SERVICES AND SUPPORTS

By Gene Coffey, Esq.

I. INTRODUCTION

Despite the historic and comprehensive character of the Affordable Care Act (ACA), the law’s immediate impact on the practices of lawyers counseling Medicaid applicants pales in comparison to what was experienced in the aftermath of the Deficit Reduction Act of 2005 (DRA). In contrast to the DRA, the ACA contains no major changes to Medicaid’s eligibility rules or methodologies for coverage of long-term services and supports (LTSS), nor were the Medicaid LTSS provisions in the ACA created to reduce coverage for persons with chronic needs.

But the ACA was designed to be comprehensive, and given that Medicaid is the nation’s single largest purchaser of LTSS, there was no doubt that Medicaid’s LTSS coverage required attention. Congress itself actually identified in the ACA why such attention was necessary, by including in the law the declaration that:

In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. … This disparity con-

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1 Two different laws encompass the health reform legislation passed by Congress: The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) [hereinafter PPACA], and the Health Care Education Affordability Reconciliation Act, Pub. L. No. 111-152 (2010) [hereinafter HCERA], collectively referred to as the Affordable Care Act or ACA. The two are distinguished herein where specific citations are made.

tinues even though, on average, it is estimated that Medicaid dollars can support nearly three elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.3

What Congress therefore did in the ACA was confront this imbalance in Medicaid’s delivery of LTSS coverage by authorizing new programs and enhancing existing ones that are designed to help Medicaid applicants and beneficiaries with chronic needs access services in the community. The effort, however, is not unique, as Congress has been making piecemeal changes to the Medicaid statute since its inception to expand the program’s community-based options. But even with these additions, Medicaid’s institutional bias has persisted, and the ACA left intact some of the more salient aspects of the statute that make Medicaid coverage easier to attain in an institution than outside of one. Still, the percentage of Medicaid LTSS recipients who receive community-based services has increased, as has the percentage of Medicaid spending for these services.4

This article provides an overview of the ACA’s Medicaid LTSS provisions, and to give these provisions context, it also provides background on the historical framework of Medicaid’s LTSS coverage and identification of past efforts to expand community-based service options for people with chronic needs.

II. ROOTS OF THE IMBALANCE IN MEDICAID LTSS SPENDING

A person with a moderate-to-high level of need for daily or regular assistance who cannot afford the cost of necessary services will stand a much better chance of receiving Medicaid’s support for those services by entering a nursing facility (NF). This is because the federal law requires that state Medicaid programs offer NF coverage to all older adults and persons with disabilities who meet the program’s financial eligibility requirements and have long-term needs, but the law does not similarly require that states offer a comparable package of services in the community to the same persons if they refuse to enter institutions.5

The institutional bias that stems from this framework was conceded by Congress immediately after the program’s enactment, when in 1967 Congress revisited the Medicaid statute to make home health services a mandatory benefit for all beneficiaries who are “entitled to nursing facility services.”6 But the mandatory home health benefit, even

3 PPACA, § 2406.
4 For example, the percentage of Medicaid spending for LTSS increased from 17 percent to 41 percent between 1995 and 2007. Enid Kassner, Susan Reinhard, Wendy Fox-Grage, Ari Houser & Jean Accius, AARP Public Policy Institute, A Balancing Act: State Long-Term Care Reform 5 (2008), http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf (2008).
6 “Federal medical assistance programs have been criticized … for emphasizing institutional services to the extent that a bias is produced tending to promote the institutional confinement of public assistance clientele. Sometimes needed services can be provided and paid for only if the person is placed in a nursing home.” Statement of Sen. Frank Moss, introducing S. 1611, 113 Cong. Rec. 11,416-17 (1967). The requirement that states provide coverage for home health services is codified at 42 U.S.C. § 1396a(a)(10)(D).
when coupled with the optional personal care services benefit, generally cannot compete with the level of care available in an NF.

Additionally, the Medicaid financial eligibility rules are more flexible for NF coverage. Historically, Medicaid has permitted a “special income level” for NF coverage, under which individuals who have incomes up to 300 percent of the Supplemental Security Income (SSI) federal benefit rate can automatically qualify for Medicaid,7 whereas a Medicaid applicant with comparable income who is not institutionalized will only qualify if his state has a medically needy category. Even if his state does, he will have to “spend down” to the state’s medically needy income level, which in most states is an amount lower than the SSI benefit rate.8

In 1981, Congress acted again to address the inherent tilt toward institutional coverage in Medicaid, after determining “that many elderly, disabled and chronically ill persons live in institutions not for medical reasons, but because of the paucity of health and social services available to them in their homes or communities, and the individual’s inability to pay for those services or to have them covered by Medicaid when they do exist.”9 Thus, Congress created the Medicaid home and community-based services (HCBS) waiver program, which authorized a more comprehensive package of community-based services for Medicaid beneficiaries and introduced some parity into the financial eligibility rules for Medicaid LTSS coverage.10

Specifically, the waiver program granted states the authority to offer Medicaid applicants who meet a state’s clinical eligibility standard for NF a comparable package of services in the community.11 It also permitted states to apply the same financial eligibility rules applicable in the NF context (i.e., a Medicaid applicant in the community with income up to 300 percent of the SSI rate can also automatically qualify for a waiver, instead of having to spend down).12

Virtually every state is operating at least one HCBS waiver. However, the HCBS waiver program contains some crucial limitations. First, waiver programs are entirely at a state’s option to adopt, and states may cap enrollment in the waiver.13 Second, even if a state does not want to cap enrollment, it must impose a cap if spending on the population served by the waiver would exceed the cost the state would incur if the enrollees were institutionalized instead (whereas there is no spending limitation for NF services).14 Third, enrollment in a waiver is only available to an individual who meets this state’s Medicaid NF clinical eligibility standard,15 which means an individual looking to offset or delay the need for an NF level of care cannot access the waiver program for assistance.

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13 42 U.S.C. § 1396n(c)(3).
14 42 U.S.C. § 1396n(c)(2)(D).
15 42 U.S.C. § 1396n(c)(2)(C).
III. The Supreme Court’s Olmstead Decision and Federal Initiatives to Expand HCBS

By 1999, 18 years after the introduction of the HCBS waiver program, almost twice the number of Medicaid LTSS beneficiaries 65 or older or with physical disabilities were in institutions rather than in the community. The persistence of the program’s institutional bias, coupled with the overall lack of enthusiasm on the part of many states to embrace the waiver concept (even though most states had adopted them), limited the potential of the Medicaid program to preserve the community integration of persons with chronic needs.

That same year, however, the Supreme Court ruled in *Olmstead v. L.C.* that the unnecessary institutionalization of people with disabilities is a type of discrimination prohibited by the Americans with Disabilities Act (ADA). This meant that states operating programs serving people with disabilities would be under increased pressure to explore, if not adopt, the full range of community-based alternatives. Given Medicaid’s central role in providing coverage to NF residents, state operation of their Medicaid programs would come under greater scrutiny.

The *Olmstead* decision was not matched with a concomitant change in the framework of the Medicaid statute, so the Health Care Financing Administration (HCFA) reviewed its own Medicaid policies in order to identify changes that could help states maximize their HCBS options, and thereby comply with their *Olmstead* mandates. HCFA transmitted its policy changes and recommendations through a series of “Olmstead” letters to state Medicaid agencies beginning almost immediately after the decision.

For example, in *Olmstead* Update No. 3, HCFA informed states that they could make “retainer” payments to personal care providers when Medicaid HCBS recipients are temporarily institutionalized. The agency also extended the scope of coverage for case management services that may be provided to an institutionalized Medicaid enrollee trying to return to the community, and authorized federal reimbursement for services necessary for a transition (e.g., moving expenses, security deposits on leases).

At the same time, Congress began authorizing annual funding for a separate program, the Real Choice Systems Change Grants Program (Real Choice). The initiative

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18 42 U.S.C. § 12101 et seq.
19 HCFA was the designation for the federal agency charged with oversight of the Medicare and Medicaid programs. The agency’s name was changed to the Centers for Medicare & Medicaid Services (CMS) in 2001.
21 Id., at 13-17. The Olmstead letters can be found on CMS’s website in a search of the State Medicaid Director Letters, https://www.cms.gov/SMDL/SMD/list.asp#TopOfPage.
was designed to “assist [s]tates to partner with their disability and aging communities in designing or implementing effective and enduring improvements in customer-responsive long-term service systems that support people of all ages who have a disability or chronic illness to … live in the most integrated community setting appropriate to their needs and strengths.”

Between the years 2001 and 2009, CMS awarded 352 Real Choice grants to states, for a total of approximately $284 million. The grants were primarily aimed at assisting states divert individuals from, or transition them out of, institutions.

An outgrowth of the Real Choice program was a partnership between CMS and the Administration on Aging (AoA) to create in 2003 the Aging and Disability Resource Center (ADRC) program. A central purpose of the ADRC program is to provide a one-stop shop for consumer information on long-term services in order to reduce institutionalizations that result from a lack of information on available community-based options. ADRCs currently operate in all 50 states and Washington, D.C., and more than 200 sites operate across the nation.

The role of the AoA in administering the ADRC program is now part of its new mission to help establish “comprehensive, coordinated systems at federal, state, and local levels that enable older individuals to receive long-term care in home and community-based settings.” While the Older Americans Act has for more than 30 years included the general mandate for the AoA to “assist older persons in avoiding institutionalization,” Congress raised the obligation to priority level in its 2006 amendments. One of the products of the AoA’s new mission is the Community Living Program, which is “designed to assist individuals who are at risk of nursing home placement and spend down to Medicaid to enable them to continue to live in their communities.” Since 2007, many states have been receiving grants of up to $1 million a year for their Community Living Programs.

IV. THE DEFICIT REDUCTION ACT OF 2005

This concentrated push toward HCBS has certainly made a difference. Looking specifically at Medicaid, the number of beneficiaries at least 65 years old or with physical disabilities receiving coverage for HCBS increased between the years 1999 and 2004 by...
43 percent, compared to a 6 percent increase in the number of people in the same populations receiving Medicaid NF coverage.\textsuperscript{32}

However, states were still primarily relying on NFs for the delivery of coverage to older people and persons with physical disabilities. Indeed, in 2006, 35 states were devoting at least 75 percent of their Medicaid LTSS dollars toward NF coverage for these populations.\textsuperscript{33} Thus, in the DRA, Congress made another attempt to modify the Medicaid statute in order to facilitate the “rebalancing” of LTSS spending from institutions to the community.

While generally notorious for its radical changes to Medicaid’s transfer-of-asset rules and other Medicaid-related changes (including the imposition of citizenship documentation requirements), the DRA also included important new programs specifically tailored to increase Medicaid’s coverage for HCBS.

First, Congress authorized $1.7 billion through fiscal year 2011 for the Money Follows the Person program (MFP).\textsuperscript{34} MFP offers states enhanced federal reimbursement for the Medicaid HCBS services provided to Medicaid enrollees who transition to the community after being institutionalized for at least six months (the DRA authorized states to impose a longer minimum residency of up to two years\textsuperscript{35}). States can only receive the enhanced federal reimbursement when MFP participants transition to “qualified residences,” which generally excludes assisted living facilities as an option.\textsuperscript{36} Thirty states and Washington, D.C., were awarded grants, which ranged from $5 million to $140 million.\textsuperscript{37}

Second, Congress authorized a new Medicaid benefit, the HCBS state plan benefit, otherwise known as the “1915(i)” benefit.\textsuperscript{38} The 1915(i) benefit addressed the feature of the HCBS waiver program that limits coverage to individuals who meet the NF clinical eligibility standard. States adopting the 1915(i) benefit must apply a standard of medical need for the benefit that is less restrictive than the state’s NF eligibility standard.\textsuperscript{39} Additionally, states are not limited in how much they may spend for the benefit as they are for services delivered under HCBS waivers.

The original DRA provision limited eligibility to Medicaid beneficiaries whose incomes are at or below 150 percent of the federal poverty level (FPL), without creating a new categorical eligibility population.\textsuperscript{40} This is in contrast to the HCBS waiver program, which authorizes states to make a separate categorical population of all individuals who meet both the state’s special income limit for NF coverage and NF clinical eligibility stan-

\begin{itemize}
  \item [32] Kassner et al., supra n. 16.
  \item [33] Id., at 127-128.
  \item [34] Pub. L. No. 109-171, § 6071(h).
  \item [35] Id., at § 6071(b)(2)(A)(i).
  \item [36] Id., at § 6071(b)(6). This provision defines a “qualified residence” as a home owned or leased by the program participant, or an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual’s family has domain and control, and a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.
  \item [37] CMS website page, Money Follows the Person, https://www.cms.gov/CommunityServices/20_MFP.asp.
  \item [38] Id., at § 6086, codified at 42 U.S.C. § 1396n(i).
  \item [39] 42 U.S.C. § 1396n(i)(1).
  \item [40] Id. See also 73 Fed. Reg. 18676, 18678 (April 4, 2008).
\end{itemize}
Bringing National Action to a National Disgrace: The History of the Elder Justice Act

By Brian W. Lindberg, Charles P. Sabatino, Esq., and Robert B. Blancato

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I. INTRODUCTION

With the signing of the Elder Justice Act (EJA) as part of the landmark Affordable Care Act on March 23, 2010, President Obama culminated a decades-long effort to bring national action to a national disgrace: the abuse, neglect, and exploitation of America’s most vulnerable citizens. The EJA is the first federal law “to specifically state that it is the right of older adults to be free of abuse, neglect, and exploitation.” With the adoption

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3 Pamela B. Teaster, Tenzin Wangmo & Georgia J. Anetzberger, A Glass Half Full: The Dubious History of
of the EJA, we hope that a cohesive, comprehensive, and sustained national campaign to prevent and treat elder abuse, neglect, and exploitation will be set in motion.

Congress defined “elder abuse” in 1987 as the domestic and institutional abuse of persons over age 60 involving physical, sexual, and emotional/psychological harm, as well as neglect, self-neglect, abandonment, and financial exploitation. Throughout history, older individuals who have outlived their “usefulness” have been treated much like society treats the mentally ill — as different, a burden. One theory suggests that the Salem witch trials were evidence of elder abuse since many of the individuals prosecuted, tortured, or burned at the stake were old. Not until the early 1960s, when the plight of disenfranchised populations (women, minorities, older persons) became part of the public discourse, did the issues of elder abuse and neglect become recognized as a problem as well.

“Domestic” elder abuse is a form of domestic violence and, as such, it cuts across income, race, socioeconomic, religious, ability, and cultural lines. It has unique dimensions, however, because of the vulnerability of old age. It can be exacerbated by age-related circumstances, such as retirement, disability, and the changing roles of partners. An older person’s isolation, dependence, and impairments in mobility and cognitive function and medication may contribute to his or her risk of being abused, neglected, and exploited by family members physically or financially. Issues related to financial abuse cover theft, scams, financial manipulation, and fraud. Institutional abuse can encompass neglect (e.g., subpar care leading to bed sores), human rights violations (e.g., using unnecessary physical restraints, misusing medication, imposing involuntary seclusion) and sexual, verbal, and physical abuse by employees, contract workers, other residents, and visitors. Abduction and abandonment are also forms of elder abuse.

Intervention and prevention requires a wide system of community involvement, from family members, to social workers, to health care, legal and financial professionals, to concerned neighbors. Most states have mandatory reporting laws and most provide protection for all family or household members threatened with physical harm. To date, the ability to provide services to victims and prosecute perpetrators has been hampered by conflicting mandates, differing definitions and disparate funding streams.

Eminent scholar and aging advocate Rose Dobrof recounts an illustrative moment in the long life of the elder justice movement.

I … was reminded of congressional hearings years and years ago, at which an official (who shall remain nameless) reported to the House of Representatives Committee that the problem was less widespread than many advocates reported… Congressman Mario Biaggi, who was chairing the hearings, thundered, “Even one case of elder abuse is too many!”

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4 Id. at 9.
5 Id. at 7.
8 Dubble, supra n. 6, at xxi.
As with most forms of abuse hidden behind closed doors, the quality of elder abuse data is severely limited. Studies consistently show that elder abuse is far more widespread than the number of cases actually reported. The National Elder Abuse Incidence Study estimated that at least half-a-million older persons in domestic settings were newly abused, neglected, and/or exploited, or experienced self-neglect in 1996. The study also found that for every reported incident of elder abuse, neglect, exploitation, or self-neglect, approximately five go unreported.\(^9\) A 2009 report estimated the annual financial loss by victims of elder financial abuse to be at least $2.6 billion.\(^10\) The extent of elder abuse is of such epidemic proportions that a national strategy is sorely needed. Unfortunately, efforts to galvanize national leadership to address elder abuse have been on a tortuous path of slow progress for more than 60 years. The EJA itself, took more than eight years to become law.

## II. History of National Efforts to Address Elder Abuse

President Harry Truman called for the first National Conference on Aging in 1950. The origins of the EJA can be traced to the 1950s when demonstration projects for “protective service units” were awarded by the Department of Health, Education and Welfare. The next national conference, the White House Conference on Aging (WHCoA), was held 11 years later.\(^11\) The 1961 WHCoA stimulated national discussion and congressional attempts aimed at preventing elder abuse.\(^12\)

In 1962, the Public Welfare amendments to the Social Security Act\(^13\) “authorized payments to states for establishing protective services” and funded demonstration projects.\(^14\) Building from this momentum, the 1965 Older Americans Act\(^15\) represented “the watershed of … new awareness and activism” around the rights and needs of older adults.\(^16\) The law provided assistance to states to develop programs to help older persons but did not specifically address elder abuse.\(^17\) Regardless, as a result of the 1962 and 1965 national legislation, many states mobilized to enact laws providing protective services to older adults.\(^18\)

The White House hosted the second WHCoA in 1971, a decade after the first confer-

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\(^11\) Teaster et al., *supra* n. 3, at 18.

\(^12\) Dubble, *supra* n. 6, at 40.


\(^14\) Teaster et al., *supra* n. 3, at 8.

\(^15\) The Older Americans Act, Pub. L. 89-73 (1965).

\(^16\) Dubble, *supra* n. 6, at 40.

\(^17\) Teaster et al., *supra* n. 3, at 9.

\(^18\) Dubble, *supra* n. 6, at 40.
In 1974, the Social Security Act authorized Adult Protective Services (APS)\(^\text{19}\) under Title XX, which prompted some states to create their own APS units and some states to go so far as to require mandatory reporting of elder abuse.\(^\text{20}\) Title XX authorized funding of more demonstration projects. In 1981, the third WHCoA looked at the issue, followed in the same year by a House Select Committee on Aging report entitled *Elder Abuse: An Examination of a Hidden Problem.*\(^\text{21}\)

Responding to these events, Congresswoman Mary Rose Oakar (D-Ohio) sponsored the Prevention, Identification, and Treatment of Adult Abuse Bill of 1981, which proposed funding incentives to the states for APS. The legislation was not enacted. One observer noted: “Absent federal direction on this issue, many states continued to adopt their own statutes providing adult protective services which were usually delivered by state or local social service agencies.”\(^\text{22}\)

In 1984, Congress passed the Victims of Crime Act,\(^\text{23}\) which provides financial compensation to cover such costs as health care and lost wages resulting from the crime. The law applied to crime victims in all age groups but helped boost services to victims of elder abuse.\(^\text{24}\)

Rep. Claude Pepper (D-Fla.) was a tenacious champion of the elderly for more than a decade, hosting public hearings on the issue of elder abuse as early as the late 1970s. In his capacity as Chairman of the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, Pepper issued a report in 1985: *Elder Abuse: A National Disgrace.*\(^\text{25}\)

### A. Funding for Elder Abuse

After a decade of reports and hearings, Congress inched the agenda forward in 1987 with the Omnibus Budget Reconciliation Act of 1987.\(^\text{26}\) The Act “mandated that nursing homes protect and preserve the quality of life of the residents.” This broad statute resulted in regulations that specifically defined elder abuse in the context of long-term care (LTC) facilities, mandated that it was the state’s responsibility to investigate abuse allegations against facilities, and instructed those facilities to train staff to prevent elder abuse.\(^\text{27}\)

The 1987 reauthorization of the 1965 Older Americans Act\(^\text{28}\) made the first strong national foray into elder abuse protection by defining and describing elder abuse and providing for Elder Abuse Prevention Services to “address elder abuse through public

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20 Teaster et al., *supra* n. 3, at 8.
21 *Id.*
24 Dubble, *supra* n. 6, at 42.
27 Teaster et al., *supra* n. 3, at 11.
28 The Older Americans Act, Pub. L. 100-175 (1987).
education, identification of abuse, and methods for receiving reports of abuse.” Congress never appropriated funds for those services, however. (See Appendix A for selected definitions of “elder abuse” in the EJA.)

Sadly, for several decades, lack of funding for abuse prevention was the primary barrier to establishing and expanding elder justice services. To date, the majority of funding for APS comes from Social Services Block Grants, through which funding for elder justice has steadily declined since the early 1980s. It was not until 1990 that Congress set aside funds specifically for elder abuse: a mere $2.9 million shared by 50 states, the District of Columbia, and the U.S. Territories. Older victims received short shrift. “States were spending an average of $45.03 per child and only $3.80 per adult on protective services (U.S. Congress, 1990).”

However, the Administration on Aging had laid the groundwork for continued action. In 1988, it launched the National Center on Elder Abuse, which was made permanent in the 1992 reauthorization of the Older Americans Act. Title VII of the same legislation, entitled “Allotments for Vulnerable Elder Rights Protection Activities,” strengthened three programs: the Long-Term Care Ombudsman Program, Programs for the Prevention of Abuse and Exploitation, and State Legal Assistance Development Programs. In the early 1990s, the Congressional Subcommittee on Health and Long-Term Care was also active in issuing two back-to-back reports on elder abuse: Elder Abuse: A Decade of Shame and Inaction (1990) and Protecting America’s Abused Elderly: The Need For Congressional Action (1991). In 1992, The Family Violence Prevention Services Act funded a major study, the National Elder Abuse Incidence Study, conducted by the Administration for Children and Families and the Administration on Aging. The data from the study “is the political benchmark for data on elder victimization” and validated the belief that very few cases of elder abuse are ever reported to APS (Adult Protective Services) or local authorities. In 1995, President Clinton announced the launch of a fourth White House Conference on Aging, the first WHCoA in 14 years. Under the leadership of Executive Director Robert Blancato, the 1995 WHCoA devoted unprecedented attention to elder abuse. Of the 50 resolutions the conference produced, two were devoted solely to the protection of vulnerable older adults.

B. The Elder Justice Act — The Evolution of a Law

Seven years after the fourth WHCoA, on September 12, 2002, the EJA (Elder Jus-

29 Dubble, supra n. 6, at 41.
30 Teaster et al., supra n. 3, at 9.
31 Id. at 8.
32 Otto, supra n., at 22.
34 Smith, supra n. 7, at 1.
35 U.S. House Select Committee on Aging, Subcommittee on Health and Long-Term Care, Elder Abuse: A Decade of Shame and Inaction (1990).
37 42 U.S.C. 10401 et seq.
38 Dubble, supra n. 6, at 41.
tice Act) was introduced by Sen. John Breaux (D-La.) and Sen. Orrin Hatch (R-Utah). Born of decades of elder justice work, the EJA took nearly another decade to become law. The legislation was introduced in the 107th Congress and each Congress thereafter until it was finally passed in the 111th Congress as part of the Affordable Care Act.

For the advocates, congressional staff, and bill sponsors working toward passage, it seemed that each Congress offered excellent opportunities for passage. Hearings and press conferences were held to gain support and draw attention to the issue. Grassroots advocacy campaigns and Hill lobbying efforts increased co-sponsorship of the legislation. A steady flow of news articles on abuse cases around the country, including the high profile case accusing the son of philanthropist and socialite Brooke Astor of abuse and exploitation, provided ammunition for supporters of the bill. And there was no public opposition to the bill. Yet each chapter of the bill’s story ended just short of legislative success.

Why the EJA took eight years to become law is the result of a combination of factors, with different factors predominant at different times. In at least two Congresses, in-

**Legislative Timeline**


HEALTH INSURANCE REFORMS: 
ONCE IN A LIFETIME CHANGE OR SAME AS IT EVER WAS?

By Lucinda E. Jesson

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I. INTRODUCTION

Health insurers played the role of villain in the health reform debate that consumed the United States in 2009–2010. In an attempt to demonstrate how reform would help the 160 million Americans with insurance, “health care reform” became “health insurance reform.” The President warned Congress that if it did not pass his plan, “the insurance industry will continue to run amok.” This pattern of what the Washington Post referred to as the “near-daily demonization of the insurance industry” meant that while the White House cut “deals” with other major stakeholders, health insurers were met with a barrage of criticism rather than a “Rose Garden Invitation.” In short, while insurers entered

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1 Chris Frates, Obama’s new term: ‘Insurance Reform’, Politico (July 22, 2009), http://www.politico.com/news/stories/0709/25312.html. As the article notes, “the term also has distinctive political advantages. Insurance reform, insiders say, likely polls better than a more general reform message because it targets something voters know, understand, and don’t particularly like. And, it has the added bonus of setting up the insurance industry as a political punching bag.”
3 Amy Goldstein & Scott Wilson, Obama launches attack on health insurance companies, Wash. Post (March 9, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/03/08/AR2010030801703.html.
4 Drug Industry OKs $80 billion Medicare deal, MSNBC (June 20, 2009), http://www.msnbc.msn.com/id/31464689/; Carrie Budoff Brown & Chris Frates, Hospitals nearing a deal with White House, Politico (July 3, 2009), http://www.politico.com/news/stories/0709/24477.htm. There was an $80 billion initial pledge by the Pharmaceutical Research and Manufacturers of America (PhRMA) and the $155 billion reduction accepted by the leading hospital groups. In short, these stakeholders promised billions of dollars in product discounts and reduced payments across 10 years and to promote reform — a reform plan that would bring each industry millions of new insured customers.
the reform debate with proposals and words of support, they quickly became President Obama’s foil.

In the end, health insurers served not only as the catalysts for passage of health reform, but as central actors in implementation. Villains, it turns out, can play lead roles. Indeed, in 2010, Congress reconstructed a health care system that relies on their expertise. Given the lack of public trust, insurers face a myriad of new regulations—no more lifetime coverage limits, rescissions prohibited except in cases of fraud, pre-existing condition exclusions barred, premiums increases reviewed and medical loss ratios imposed. With the restrictions come new customers and with the new customers come new opportunities.

This article considers how the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (hereinafter collectively referred to as the Affordable Care Act or ACA) will change the nature of health insurance. To do so, it begins with a discussion of private health insurance basics: what is insurance and how is it regulated today? The overall health reform package is then considered, with particular emphasis on the role insurers play in the quest to expand access to quality care while controlling costs. The article then examines the game-change that looms in 2014: the institution of Insurance Exchanges combined with promises of guaranteed issue and an individual mandate. Next, it reviews the underwriting and consumer protection reforms built into ACA. With this backdrop, the author looks into her crystal ball to consider whether health reform will, indeed, change the nature of insurance.

II. THE BACKDROP: THE PROVISION AND REGULATION OF PRIVATE INSURANCE

Employer-based insurance is the primary source of health care in the United States today, covering approximately 159 million nonelderly Americans. Sixty percent of Americans under age 65 are covered by employer-sponsored insurance, while 17 percent are uninsured, 18 percent receive coverage under a public plan such as Medicaid and 5 percent have insurance through the private non-group market. Those lucky enough to have private insurance, however, live in two very different regulatory worlds: the laws governing the group insurance provided by most large organizations and those governing the non-group (individual) insurance.

A. Employer-Sponsored Group Insurance

While the rules and realities of group insurance are in stark contrast to those governing the individual market, employer-sponsored insurance, itself, is divided into two worlds: the fully insured and the self-insured. The distinctions begin when employers, embarking on the road to purchase health insurance, answer the following question: who will bear

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7 Id. If all Americans are included, employer-sponsored insurance covers 52 percent of the population. The major difference, of course, is Medicare, which provides coverage to 14 percent of Americans, primarily the elderly population.
Health Insurance Reforms:
Once In a Lifetime Change or Same as It Ever Was?

the risk? After all, insurance is founded on the principle that unpredictable events can be shifted to budgeted, predictable ones by pooling risks within a sizable group of people. If the employer is small, it normally will purchase insurance and, in doing so, shift the risk to a traditional insurer. A larger employer may choose to self-insure, retaining the risk and hiring a third-party administrator (typically an insurer or a managed care organization) to manage the claims process. While the choice is an invisible one to most employees, it has significant ramifications for benefit design and plan regulation purposes.

If an employer purchases insurance, that product is highly regulated by the state government. For example, the state will monitor the insurer’s financial solvency and will review premium rates and policies. The state may have an “any willing provider” law which requires a Managed Care Organization (MCO) to contract with any provider that agrees to abide by the MCO’s rules of participation. Most states require group insurance plans to include specific kinds of health services, the most common of which are mandated benefits related to HIV/AIDS, bone marrow transplants, newborn benefits, breast reconstruction surgery, mental health care, fertility treatments, hospice and hearing care, chiropractic treatments, and alcoholism and drug treatment. Many states grant enrollees a right to demand an independent external review of coverage denials.

If an employer decides to self-insure, the plan is largely governed by the Employee Retirement Income Security Act of 1974 (ERISA) rather than state insurance law. ERISA was enacted to provide federal oversight of all employer-sponsored fringe benefit plans. In 1974, the focus of the ERISA drafters was the need to curb abuses of private pension funds, not health insurance. Even so, ERISA dramatically changed health care benefits over the next 20 years by federalizing employee benefits laws for self-insured employers. This allowed large employers to self-insure and only concern themselves with the federal mandates, which were few, rather than provide insurance that had to comply with a myriad of state laws. For example, while ERISA regulates plans for solvency, it does not require employers to provide any particular minimum benefit set. ERISA also does

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9 Id.
14 Furrow et al., supra, n. 12, at 688-689.
15 Id.
16 Id.; 29 U.S.C.A. § 1144. Most — but not all — state regulation does not apply to self-insured plans. Compare Blue Cross Hosp. Service, Inc. of Missouri v. Frappier, 698 S.W.2d 326 (Mo. 1985) (holding that law mandating inclusion of chiropractors and psychologist is not preempted by ERISA) with Hayden v. Blue Cross and Blue Shield of Alabama, 843 F. Supp. 1427 (M.D. Ala. 1994) (concluding that ERISA preempts state law requiring self-insured plans to pay for services of nurse anesthetists directly to nurses).
not regulate “medical necessity” or dictate which providers are part of a network. Moreover, it largely preempts state laws regulating MCOs and the right of enrollees to challenge benefit decisions (such as decisions to deny or delay health care) in state courts.  

Group health plans governed by ERISA are largely free from the dictates of state law, but all health plans, whether public or private, must comply with the nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires that if a health plan provides a benefit it must be uniformly available to all similarly situated individuals. HIPAA prohibits health plans from discriminating with respect to eligibility, benefits, premiums, or contributions based on the health factors of employees or their dependants. In short, it prohibits group health plans from excluding individuals from a group or from charging them higher premiums because of their health status. Similarly, a group health plan may not, based on any health factor, require individuals to pay a premium or other contribution that is greater than the payment required for a similarly situated individual enrolled in the plan.

HIPAA’s nondiscrimination rule does not bar a health insurance issuer from reviewing the claims data of an employer, however, and based on the claims experience of one employee with a chronic condition, quote a higher per-participant rate to the employer. While this blending of rates is permissible under HIPAA, the issuer may not quote, and the health plan may not require, a higher participant contribution for the employee with the chronic condition. In addition to forbidding premium discounts, the rules also generally prohibit a plan or issuer from requiring similarly situated individuals to pay different co-pays, deductibles or other cost-sharing arrangements based upon a health factor.

18 ERISA does contain very limited mandates. For example, under the Newborns’ and Mothers’ Health Protection Act of 1996, a health plan or issuer cannot restrict the hospital stay in connection with child birth for a mother or child to less than 48 hours. Pub. L. No. 104-2049, Title VI, 110 Stat. 2874, 2936 (1996).

19 See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996), 29 U.S.C. 1181 et seq. HIPAA amended ERISA and the Public Health Service Act. HIPAA defines a “health plan” to mean “an individual or group plan that provides, or pays the cost of, medical care.” 45 C.F.R. § 160.103. “Group health plans” are explicitly defined to include both “insured and self-insured plans” with the only exception for health plans that have fewer than 50 participants and are administered by the employer. Id. “Health Plans” as defined by HIPAA includes Medicare and Medicaid plans as well as government health plans. Id.

20 45 C.F.R. § 146.121(b)(2)(i)(B). The governing regulation states as follows: “Thus, for example, a plan or issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.” Id.

21 Id. § 146.121(b)(1).

22 29 C.F.R. § 2590.702(c). “Health factors,” for purposes of prohibiting discrimination against beneficiaries, means any of the following: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. 29 C.F.R. § 2590.702(a).

23 Id.

24 29 C.F.R. § 2590.702(c) (2007). A health insurance issuer is one type of health plan which is defined to mean “an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a [s]tate and that is subject to [s]tate law that regulates insurance.” 29 C.F.R. § 2590.701-2 (2007).
B. Non-Group (Individual) Insurance

While HIPAA provides protection from individual health discrimination for those 160 million Americans covered by employer-sponsored insurance, it does little to protect the 14 million individuals who purchase insurance on the individual, or non-group, market. Moreover, there is less regulation of private insurance by states, most of which permit insurers on the individual market to exclude people or impose high premiums based on a person’s medical history and pre-existing health conditions. It is in the insurer’s self interest to make such exclusions, since the health expenditures of 5 percent of the American population account for almost half of all health care costs, and a quarter of health spending goes towards the treatment of 1 percent of the population. When expenditures are measured by disease, we learn that 80 percent of health care dollars are attributable to treating chronic conditions such as hypertension, arthritis, heart disease, asthma, mental conditions and diabetes. As a result, the insurer that seeks to match premiums to predicted costs of an enrollee or small group of enrollees will ask about individual health status to predict whether the applicants will be in the small group of people responsible for the vast majority of costs. The insurer will seek to find out if the applicant has a chronic condition that will serve as a cost-driver. In insurance terms, this risk assessment of applicants and the subsequent determination whether or not to accept that risk is known as “underwriting.”

The net result of this underwriting process is that Americans insured through the individual market are often denied insurance or quoted high premiums if they have a pre-existing condition. People who buy their own insurance report insurers recently requested premium increases averaging 20 percent, according to a 2010 Kaiser Survey. Another concern for the individual market has been “post claims underwriting,” which results in rescission. This is the practice of accepting applications for insurance, collecting the premiums for a period of time, but then reviewing the application and health status again after a substantial claim is filed to see if the insured misrepresented health status on the application. If misrepresentation can be found, the health plan “rescinds” coverage.

Small groups have more protections under HIPAA and they typically have better insurance rates than individuals. However, because they have fewer individuals among whom to “spread the risk” they, too, have premiums generally higher than those of large

26 Kaiser Family Foundation, Survey of People Who Purchase their Own Insurance, (June, 2010) [hereinafter Survey of People Who Purchase their Own Insurance], http://www.kff.org/kaiserpolls/upload/8077-R.pdf. Some state attempts to regulate the individual market include rating bands, provision for voluntary or mandatory participation in reinsurance pools, and some preexisting conditions limitations. Furrow et al., supra n. 12, at 657-659.
29 Survey of People Who Purchase their Own Insurance, supra, n. 26.
groups. As a result, while 60 percent of all employers offer health benefits, less than half of employers with fewer than 10 employees provide coverage, compared to 72 percent of firms with 10 to 24 employees and over 95 percent of firms with 50 or more workers.

The realities behind the group and individual markets described above drove much of the health reform discussion. Premiums continued to rise, causing many small employers — unable to either self-insure or spread the risk — to eliminate health insurance as an employee benefit. Self-employed individuals or those working without access to employer-based insurance faced stiff premiums in the individual market, particularly if they had pre-existing conditions. Even those who had individual insurance found that after they became ill, their premiums for the following year dramatically increased. Some even saw their current insurance rescinded. On the other hand, many Americans were satisfied with their health coverage, particularly those in large group plans. As is discussed below, this played out in the insurance reforms adopted in ACA. Overall, the bill set out to “fix” the small group and individual markets through a variety of interventions, while attempting to hold harmless the large group plans.

III. The Affordable Care Act Changes the Landscape for Health Insurers

The Affordable Care Act requires most U.S. citizens and legal residents to have health insurance by 2014. This individual mandate to maintain “minimum essential coverage” provides for exceptions for religious objectors, undocumented individuals, and those who are incarcerated. Failure to maintain coverage for more than three months of the year will result in a penalty of $95 in 2014; $350 in 2015; and $750 in 2016, or up to 2 percent of income subject to a cap related to the cost of average premiums. Exemptions from the penalty will be available to those who cannot afford coverage (hardship waivers), as well as to members of American Indian tribes.

Of course, the mandate is meaningless unless Americans have access to affordable insurance. To address the plight of those who struggle to pay for insurance, ACA takes two dramatic steps beyond penalty hardship waivers. First, it provides premium subsidies for individuals with incomes up to 400 percent of the federal poverty level (approximately $88,200 for a family of four in 2010). Second, it provides for “cost-sharing reduction payments” from the government to insurers. These are payments from the government on behalf of “eligible individuals” in order to lower the cost-sharing obligations for those with household incomes between 100 percent and 400 percent of the poverty level.

Some Americans simply cannot afford insurance. To assist these individuals, ACA made fundamental changes to the Medicaid program. Medicaid is the nation’s public health insurance program for low income Americans. Medicaid provides health care to nearly 60 million individuals. Unlike Medicare, which is solely federally funded and

31 Furrow et al., supra, n. 12, at 658.
33 PPACA §§ 1501 & 10106.
34 PPACA § 1402.
35 Id.
36 PPACA § 1415.
37 Kaiser Commission on Medicaid and the Uninsured, Medicaid: A Primer 2010, 4 (June 22, 2010), http://
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I. INTRODUCTION

The Medicaid program,¹ created at the same time as the Medicare program as part of President Lyndon B. Johnson’s “Great Society,” has evolved to become the “primary

¹ 42 U.S.C § 1396 (West 2010).
source of health and long-term care assistance” for nearly 60 million people and the “cornerstone of the nation’s health care safety net.” With President Barack Obama’s signature in March 2010, the landmark health reform legislation became the most significant social legislation enacted in the United States since the creation of the Medicare and Medicaid programs in 1965. A major goal of this transformative enactment is to reach near universal health insurance coverage in the United States by improving access to affordable insurance coverage and requiring individuals to obtain coverage by 2014. Given the central role Medicaid plays in providing health care and long-term care coverage, that “a dramatic expansion of the Medicaid program” is an integral component of achieving this goal is no surprise. Half the expected gains in health insurance coverage resulting from health reform will be achieved through the provisions in the legislation expanding the Medicaid program.

The changes the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (hereinafter collectively referred to as the Affordable Care Act or ACA) brings to the Medicaid program, in addition to expanding the range of low-income people eligible for benefits, eliminate the historical limitations on Medicaid eligibility that attempted to reserve Medicaid coverage for certain categories of the “deserving” poor and exclude “unworthy” individuals from this form of public assistance. In contrast, everyone meeting the age and participation
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criteria was eligible for the Medicare program. As a result, the Medicare program has enjoyed a high level of public support while public acceptance of the Medicaid program has been much more tenuous. The expansion of the Medicaid program to provide coverage for all low-income individuals meeting the income eligibility criteria has the potential to make it possible for future policies to transcend the value judgments inherent in the categorical approach to Medicaid eligibility, and, perhaps, to mitigate public distrust for the program. This article will focus on how the ACA expands Medicaid coverage and the challenges, both administrative and legal, that the federal government and states will face in implementing such provisions.

Beginning in 2014, nearly all Americans will be required to have basic health insurance coverage or face paying a penalty. To achieve this goal, the ACA contains provisions aimed at enhancing access and protections for individuals covered by employersponsored health plans. The ACA also restructures the market for individual purchase of insurance to make access more transparent and affordable for individuals not covered by employer-sponsored insurance by requiring states to establish purchasing “exchanges.” For those individuals unable to afford private insurance, the ACA expands Medicaid coverage to certain categories of individuals. This expansion of Medicaid coverage will account for approximately 45 percent of the overall cost of health reform, thus, making this Medicaid expansion one of the most ambitious aspects of health care reform.

II. MEDICAID AND MEDICAID ELIGIBILITY BEFORE REFORMS

While the states and the federal government jointly fund the costs of Medicaid ser-

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12 Furrow et al., supra n. 10, at 470-471.
13 PPACA § 1501; Lawrence R. Jacobs & Theda Skocpol, Health Care Reform and American Politics: What Everyone Needs To Know 5 (Oxford Univ. Press, 2010). Individuals with income below the Internal Revenue Code’s filing threshold for a taxable year, however, are exempt from the mandate of basic health insurance coverage. I.R.C. § 5000A(e)(2). In 2009, for most people, the threshold for filing was $9,350 for an individual and $18,700 for a couple. Internal Revenue Service, 1040EZ Instructions 2010, http://www.irs.gov/pub/irs-pdf/i1040gi.pdf. Unfortunately, limiting the insurance mandate to those individuals who meet this threshold may result in a lack of coverage for certain low-income individuals who are most at-risk for not having insurance coverage. Benjamin D. Sommers & Sara Rosenbaum, Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges, 30, Health Affairs, 228, 233, 235; see discussion infra of the effects of income fluctuation.
14 See e.g. PPACA §§ 1001-1004 (describing immediate improvements to coverage); PPACA §§ 1101-1105 (detailing immediate actions to preserve and expand coverage). Jacobs & Skolpol, supra n. 13, at 3.
15 See e.g. PPACA § 1311 (establishing voluntary exchanges). PPACA requires that an Exchange be “a governmental agency or nonprofit entity” that facilitates the purchase of health insurance. In addition, PPACA also contains provisions to grant subsidies to small businesses and certain individuals to buy coverage from private health plans on these state-based insurance exchanges. Jacobs & Skocpol, supra n. 13, at 4.
16 PPACA § 2001 (expanding Medicaid coverage to the lowest income populations); Jacobs & Skocpol, supra n. 13, at 4; Renée M. Landers, “Tomorrow” May Finally Have Arrived—The Patient Protection and Affordable Care Act: A Necessary First Step Toward Health Care Equity in the United States, 6, J. Health & Biomedical L., 65, 69 (2010).
17 See Jacobs & Skocpol, supra n. 13, at 132.
vices, the states develop and administer Medicaid programs under broad federal standards. As a result, Medicaid programs across the country reflect tremendous variation. This section describes the basic structure of the Medicaid program before the enactment of ACA and identifies permissible areas of state variation.

A. Populations Covered

Medicaid covers health care services for the nation’s poorest populations. The federal Medicaid guidelines mandate state program coverage of certain groups as a condition of participation in the Medicaid program and prohibits states from offering Medicaid coverage to individuals unless they met certain financial criteria and also fall into a specific eligibility group or “category.” Prior to ACA reforms, coverage was mandatory for the following categorically eligible groups determined to be the “deserving” poor:

- pregnant women and children under age 6 with family incomes below 133 percent of the Federal Poverty Level (FPL), currently $29,327 for a family of four;
- children ages 6 to 18 below 100 percent of the FPL;
- parents with dependent children with incomes below a state’s welfare eligibility levels (often below 50 percent of the FPL); and
- severely and permanently disabled individuals and seniors with incomes at or below 75 percent of the FPL.

States also could receive federal contributions to cover individuals and families with higher incomes if the state elected to make such coverage available. Most states cover all children below 200 percent of the FPL because of the special provisions for children

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21 Furrow et al., supra n. 18, at 587.
22 Id. at 587; The Medicaid Program at a Glance, supra n.18; Kaiser Family Foundation: Focus on Health Reform, Expanding Medicaid: Coverage for Low-Income Adults under Health Reform (Feb. 2010), http://www.kff.org/healthreform/upload/8052.pdf; Medicaid: A Primer, supra n. 3, at 8. Among the “seniors” eligible for coverage are 39 million people who are also covered by Medicare, known as “dual eligibles” who need assistance with Medicare premiums and cost-sharing. Medicaid: A Primer, supra n. 3, at 10. In addition, Medicaid covers services for this population that Medicare does not cover, most prominently long-term care services. Id.
23 Furrow et al., supra n. 18, at 587. The most significant optional group is the “medically needy.” Id. The medically needy meet financial criteria for Medicaid only after “spending down” their income on medical expenses. Centers for Medicare & Medicaid Services, Medically Needy, http://www.cms.gov/MedicaidEligibility/06_Medically_Needy.asp (accessed Dec. 3, 2010).
and the Children’s Health Insurance Program (CHIP).\textsuperscript{24} Expansion of coverage to adult groups is much less widely adopted, and as a result, Medicaid eligibility for adults with incomes above the federal minimum levels varies greatly.\textsuperscript{25} Medicaid eligibility extends only to United States citizens and lawful residing immigrants who have resided in the country for longer than five years, except for emergency treatment. States have the option to cover legal immigrants without the five-year wait and to receive federal contributions. Eighteen states and the District of Columbia adopted this option.\textsuperscript{26}

\textbf{B. Funding for the Medicaid Program}

In general, Medicaid provides open-ended financing for state programs; the federal government pays a share of the costs of the Medicaid program for both administrative and service expenditures to each state through a matching system.\textsuperscript{27} For service expenditures, the matching rate or federal medical assistance percentage (FMAP) is determined by a formula comparing a state’s per capita income with the national per capita income, so states with higher per capita incomes usually have a lower FMAP.\textsuperscript{28} Normally, the federal share of Medicaid spending in individual states ranges from the minimum of 50 percent to 76 percent, with the federal share of spending averaging about 57 percent of total Medicaid expenditures.\textsuperscript{29} As part of the American Recovery and Reinvestment Act (ARRA), enacted in 2009 to stimulate the struggling economy, Congress temporarily increased the federal share of Medicaid spending.\textsuperscript{30} This adjustment recognizes that Medicaid enrollment typically increases during difficult economic times and that this increased demand places burdens on states when revenues to support the increased spending on Medicaid also decline.\textsuperscript{31} For fiscal year 2010, the range of the federal share increased to between 56 percent and 85 percent, with the total federal share increasing from 57 percent to 66 percent for that period.\textsuperscript{32} The enhanced FMAP adjustment was set to end on December 31, 2010, but the Education, Jobs and Medicaid Assistance Act, which was signed into law in August 2010, extended this period through June 30, 2011.\textsuperscript{33} To receive these increased

\textsuperscript{24} Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured, Challenges Of Providing Health Coverage For Children And Parents In A Recession: A 50-State Update On Eligibility Rules, Enrollment And Renewal Procedures, And Cost-Sharing Practices In Medicaid And SCHIP In 2009, 6. In 2009, 43 states provided coverage to children in families up to 200 percent FPL or at a higher level. \textit{Id.}
\textsuperscript{25} \textit{Id.} To cover groups beyond the federally required categories, a state needed to obtain a waiver of the federal rules or use only state funds. Furrow et al., \textit{supra n. 13}, at 587, 607 (explaining how waivers can be used by states to expand eligibility for Medicaid as well as the types of services state programs may cover); \textit{The Medicaid Program at a Glance, supra n. 18.}
\textsuperscript{26} \textit{Medicaid: A Primer, supra n. 3}, at 8 (citing Personal Responsibility and Work Opportunity Reconciliation Act (Pub. L. 104-193) and Children’s Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3)).
\textsuperscript{27} Furrow et al., \textit{supra n. 13}, at 617.
\textsuperscript{28} \textit{Id.; Medicaid: A Primer, supra n. 3}, at 27.
\textsuperscript{29} \textit{Medicaid: A Primer, supra n. 3}, at 27.
\textsuperscript{30} \textit{Id.}
\textsuperscript{31} \textit{Id.} at 29.
\textsuperscript{32} \textit{Id.} at 27. ARRA also provided funding to encourage health care providers serving Medicaid populations to use electronic health records. \textit{Id.}
\textsuperscript{33} Education, Jobs and Medicaid Assistance Act, Pub. L. No. 111-226; Bulletin from Cindy Mann, Director,
funds, states must ensure that Medicaid eligibility levels are not reduced, and states may not use more restrictive methods to determine Medicaid eligibility.\footnote{Id.}

The federal contribution toward state Medicaid expenditures includes a component directed toward state spending for program administration as well as spending for health care services.\footnote{April Grady, \textit{State Medicaid Program Administration: A Brief Overview}, Congressional Research Service 2-3 (May 14, 2008).} This contribution toward administrative expenditures “does not vary by state and is generally 50 percent, but certain administrative functions have a higher federal match.”\footnote{Id. at 2-3 (listing administrative functions with federal contributions of 75 percent or 100 percent).} A 2008 Congressional Research Service report states that administrative functions represent about 5 percent of total Medicaid program expenditures.\footnote{Id. at 3.} Other sources place the percentage at around 7 percent.\footnote{See, e.g., Phil Galewitz, \textit{Medicaid: True or False?}, Kaiser Health News, (July 1, 2009), http://www.kaiserhealthnews.org/Stories/2009/July/01/Medicaid-True-or-False (accessed Jan. 4, 2011).} By comparison, private insurers have average administrative costs of 14 percent to 20 percent, and most sources place administrative expenditures at 2 percent of Medicare costs.\footnote{Thomas S. Bodenheimer & Kevin Grumbach, \textit{Understanding Health Policy: A Clinical Approach} 182 (3d ed., Appleton & Lange, 2002). But see, Robert A. Book, \textit{Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance}, The Heritage Foundation (June 25, 2009) (arguing that Medicare’s administrative costs are higher on a per-person basis than the administrative costs of private insurance), www.heritage.org/Research/HealthCare/wm2505.cfm (accessed Jan. 4, 2011).} To the extent that Medicaid’s administrative expenses derive from the cost of eligibility determinations, by eliminating the categorical criteria for eligibility, adoption of the ACA should result in reduced administrative costs. On the other hand, the ongoing need to make income-based eligibility determinations will probably mean that Medicaid’s administrative costs will continue to exceed Medicare administrative costs because such determinations are not required for most aspects of the Medicare program.\footnote{The ACA has added, however, provisions for means-testing for premium structures under the Medicare prescription drug benefit program. For example, effective January 1, 2011, reductions in premium subsidies for Medicare Part D participants with incomes above $85,000 for individuals and $170,000 for couples took effect. \textit{PPACA} § 3308.} III. \textbf{MEDICAID ELIGIBILITY EXPANSIONS UNDER THE NEW LAW}

Despite its conception as a public insurance program for the poor, Medicaid currently only covers about two out of five “poor” Americans, as defined by federal poverty standards, due to the categorical restrictions.\footnote{John K. Iglehart, \textit{Medicaid Expansion Offers Solutions, Challenges}, 29, Health Affairs, 230, 230 (Feb. 2010), http://content.healthaffairs.org/cgi/reprint/29/2/230 (accessed Dec. 3, 2010).} The ACA expands Medicaid coverage to many low-income Americans by establishing a new mandatory eligibility group that ends the “historic exclusion of individuals from Medicaid coverage based on family status, a lingering vestige of the program’s early ties to Welfare, which is inconsistent with Med-
ONLINE RESOURCES AVAILABLE TO SUPPLEMENT HEALTH CARE REFORM DISCUSSION

Prepared by Claire DeMarco, Esq.

When the concept for this issue of NAELA Journal was initially presented, the Editorial Board discussed how to provide supplementary materials for the reader that would build on the tremendous research efforts of the individual writers, allowing the reader to directly access relevant portions of both the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. After publishing my review of the CCH Analysis of both laws, the editors suggested that I begin compiling relevant sections of the law and determining how the reader should be presented with the material. As the reader can imagine, this task resulted in hundreds of pages of text that could not reasonably be incorporated in the Journal’s print edition. In this digital age, therefore, it seemed appropriate to utilize the seemingly boundless online resources on the subject. What follows is a broad-strokes guide to what sections of the law are referenced by each author.

On the following page you will find links to online copies of the Patient Protection and Affordable Care and the Health Care and Reconciliation Act and a list of relevant sections used by the authors. The reader can use these links to access the text of each law as passed in .pdf form. One can then use the search function of the viewing program (most likely Adobe Reader) to find the section numbers outlined below.

continued on next page
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Health Care and Education Reconciliation Act

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Amendments

On February 1, 2011, Senator Debbie Stabenow (D-MI) introduced Amendment S.A. 9 (to S. 223) to repeal what were considered by both parties to be burdensome recordkeeping requirements for small businesses. The legislative action was drafted to relieve small businesses from having to file a 1099 on any transaction that exceeded $600. The following day, the amendment was approved by a vote of 81-17.

Constitutional Challenges

Readers will also be interested in several Federal District Court cases challenging the constitutionality of PPACA:

*Thomas More Law Center v. Obama*, Case No. 10-CV-11156, US District Court for the Eastern District of Michigan, Southern Division (October 7, 2010). Judge Steeh ruled that Congressional action was authorized by the Commerce Clause.

*Liberty University v. U.S.*, Case No. 6:10-cv-00015-nkm, US District Court for the Western District of Virginia (November 30, 2010). Judge Moon held that the “employer and individual coverage provisions are a regulation of interstate commerce authorized by the Commerce Clause.”

*Virginia v. Sebelius*, Civil Action No. 3:10CV188-HEH, US District Court for the Eastern District of Virginia (December 13, 2010). Judge Hudson ruled that the law’s individual mandate exceeded the regulatory authority granted to Congress under the Commerce Clause.

*Mead v. Holder*, Civil Action No. 10-950 (GK), US District Court for the District of Columbia (February 22, 2011). Judge Kessler ruled that the individual mandate “is the least restrictive means of serving a compelling governmental interest.”


Experts predict that we will have a Supreme Court ruling stemming from one or more of these rulings in short order, although perhaps not in time to resolve these issues prior to the 2012 election. At the appellate level, a three-judge panel may hear the case, which could then result in an appeal to the full complement of judges on that circuit before it heads to the Supreme Court. One thing is certain, health care reform generally, as well as the specific provisions of the Patient Protection and Affordable Care Act will continue to dominate the national dialogue and will be of special interest to attorneys representing the interests of elders and their families.