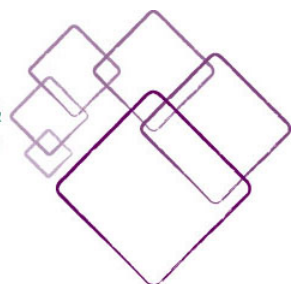


# **A Guide to the Affordable Care Act**

**TASC** Training &  
Advocacy  
Support  
Center



**The Affordable Care Act on the Practical Level:  
What Are the Key Programs of Significance to People with Disabilities?  
What Disability Focused Advocacy is Needed Right Now?**

On June 28, 2012, in *National Federation of Independent Business v. Sebelius*<sup>1</sup>, the U.S. Supreme Court upheld the constitutionality of all portions of the Affordable Care Act (ACA), except for one provision that allowed the federal government to take away a state's Medicaid funding if it failed to expand Medicaid coverage in the state as the ACA had required. This summary provides practical information about the decision that can help advocates respond to questions from people with disabilities, the media, and state officials.<sup>2</sup> This summary will address four questions:

- 1) What programs and requirements of the ACA might people with disabilities find of particular value?
- 2) What limits did the Court place on the ACA requirement that states expand Medicaid coverage to all individuals under age 65, with incomes between 100% and 133% of the federal poverty level (FPL)?
- 3) What information can Advocates offer to state officials and the public to explain why extending Medicaid coverage to a greater number of poor individuals and families makes good economic and political sense?
- 4) What are some of the open questions concerning ACA implementation likely to be clarified in federal policy over the next few months?

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<sup>1</sup> \_\_ S.Ct. \_\_, 2012 WL 2427810 (U.S.).

<sup>2</sup> This paper does not provide an in-depth analysis of the Anti-Injunction, Spending, or Commerce clause holdings in the decision. A good legal analysis of these provisions, and the entire decision, is *The Supreme Court's Decision and its Implications for Medicaid*, by the National Health Law Program, available for download at: [http://www.healthlaw.org/images/stories/ACA\\_July\\_2012\\_Fact\\_Sheet.pdf](http://www.healthlaw.org/images/stories/ACA_July_2012_Fact_Sheet.pdf).

## **A. ACA Disability Programs and Requirements of Particular Significance to People with Disabilities**

It is important to spread the word that in upholding the ACA, all of its programs enacted by Congress remain in place. Below are a few worth highlighting, because they are likely to be of great benefit to people with disabilities, their families, and support providers.

### **1. Anti-Discrimination Provisions**

- Insurance companies are prohibited from denying coverage or charging more to any person based on their medical history.
- Ensures accessible examination and diagnostic equipment.

### **2. Enhanced Beneficiary Protections**

- The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as “essential health benefits”. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services by 2014.
- Health plan enrollees have enhanced rights to appeal insurance company decisions, including the: right to information about why a claim for coverage has been denied; right to appeal; and right to an independent review.
- No lifetime or annual dollar limit “caps” on insurance benefits (except for certain individual policies that were in existence on March 23, 2010).

- No cost sharing, (e.g. co-payments, deductibles) on preventative services.
- Greater limits on cost sharing (co-payments, deductibles, etc.) For a set package of “essential health benefits.”

### **3. Funding for Home and Community Based Services and Supports**

- Funding to maintain and expand the Money Follows the Person (MFP) Program through 2016. Under this program Medicaid funds that supported an individual to live in a nursing facility can now “follow” the person and support the provision of long term services in their home.
- Funding for The Community First Choice (CFC) Program, which gives states an increased six (6) percent federal Medicaid match for providing community-based attendant supports as an alternative to institutional services.
- Funding for The Balancing Incentives Program, which gives a higher federal Medicaid match to heavily institutionalized states who shift to community based services as an alternative to Institutions.
- Enhanced Funding for Aging and Disability Resource Centers, which are designed to assist seniors and people with disabilities in a variety of tasks, including choosing among long term care options.
- Maintenance of the CLASS Act which is a federally administered national long term care insurance program allowing individuals who are at least 18 years old and actively employed, to voluntarily pay into the plan through payroll deduction. If the individual later develops limitations of daily life activities, and has paid into the program for at least 5 years and meets certain earning requirements, he or she is eligible to receive a lifetime cash payment, intended to be spent on long term care to help the individual stay employed and off Medicaid. Currently, the Secretary of HHS has halted implementation of the CLASS Act, however the Program remains in the ACA.

### **4. Quality Improvements**

- Improves data collection and provider training on health disparities.

- Continues demonstration projects to support care coordination for Medicare-Medicaid Enrollees (known as “dual eligibles”).
- Increases payments to providers.
- Continues Medicaid Health Homes Option: This option started in January 2012 and allows States to develop “health homes,” which are person-centered systems of care that facilitate access to, and coordination of, supports for certain people with chronic conditions. States receive a temporary 90% federal Medicaid match for payments to home health providers for care coordination.

## **B. What Did the Court Rule Related to the “Medicaid Expansion” Requirement**

To understand the Medicaid expansion requirement, it is helpful to put it in the context of other provisions in the ACA related to health coverage expansion. Essentially, the ACA relies on three methods, which taken together, will ensure health coverage for most all Americans:

1. The Employer Mandate: The ACA mandates that employees with 50 or more employees offer health insurance that provides at least the statutorily defined “essential health benefits.” To support employers to comply with this mandate the federal government will offer tax benefits to assist with coverage costs. In addition, the federal government will offer tax incentives to encourage employers with fewer than 50 employees to also offer health insurance to their employees;
2. The Individual Mandate: The ACA requires all Americans to have health insurance. Coverage could come from Medicaid, Medicare or veterans benefits, if eligible; employer coverage; or through individual policies purchased through state based health benefit “exchange” programs.

The purpose of the “exchange” is to provide individuals a low cost option(s) for purchasing health insurance that will still provide a package of statutorily defined “essential health benefits.” By 2014, each state is required to establish exchanges or allow their residents to purchase health insurance through a federally

established exchange. Individuals who do not obtain health insurance by 2014 will be required to pay a modest penalty. The penalty will increase in the second and third years and remain the same thereafter. However, to assist individuals to purchase health insurance, the federal government will offer individuals with income between 100% and 400% of the federal poverty level, premium assistance in the form of a tax credit, or an “advanced tax credit” to help individuals pay for monthly health insurance premiums, co-payments and deductibles.

3. Medicaid Expansion: The ACA requires states, as a condition of receiving federal Medicaid funds, to expand Medicaid coverage to individuals under 65, whose incomes are no more than 133%<sup>3</sup> of the federal poverty level, and who are not already eligible under a mandatory categorically needy group. To help states finance this Medicaid expansion the federal government agrees to provide states with an increased federal match for the medical assistance furnished to the newly-eligible individuals. Specifically, from 2014 to 2016, the federal government will cover 100% of the costs. In 2017, the federal match will begin to phase down until it reaches 90% in 2020, where it will remain. As enacted, if a state chose not to expand coverage to this new population, it would be penalized by losing *all* of their existing federal Medicaid dollars. This one provision was overturned by the Court.

### **What the Court Ruled:**

- The Medicaid Act obtains its authority under the spending clause of the U.S. Constitution which grants Congress the power “to pay the Debts and provide for the . . . general Welfare of the United States.” [U.S. Const., Art. I, § 8, cl. 1](#). Congress uses the spending clause to address issues of national concern by offering federal funds to states. As a condition of receiving the funding states agree to abide by the standards set by the federal government.. In the case of the Medicaid Act, states agree to provide certain mandatory services and comply with certain

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<sup>3</sup> You may hear that the ACA actually requires coverage of individuals under 65 who make up to 138% of the federal poverty level. This percentage reflects Medicaid’s standard 5% of income disregard that effectively raises the latest limit to 138% of federal poverty level.

beneficiary protections, in order to receive a federal match of funds spent pursuant to the Medicaid program.

- In this case the 26 states, and the private individuals and organization of independent businesses, who brought this case challenging the ACA, argued that the penalty for not complying with the Medicaid expansion was so great that it constituted not just coercion, but in fact, compelled them to expand the Medicaid program. They cited a 1992 Supreme Court decision in which the Court held that: "states should not be compelled into administering a federal program". Chief Justice Roberts who authored the Supreme Court's ACA decision, determined that the requested expansion, coupled with the penalty for non-compliance, constitutes undue coercion, beyond the scope of what the spending clause permits. The Court's determination relies on two points:

- 1) the required expansion could not have been anticipated by states because it essentially "transforms Medicaid" into a program that no longer cares "for the neediest among us, but rather [is] an element of a comprehensive national plan to provide universal health insurance coverage."
- 2) Medicaid spending is a large portion of most states budgets, and loss of federal matching dollars would be so harmful that states have no choice but to comply with the expansion.

- Fortunately, rather than throw out the whole Medicaid expansion provision as unconstitutional, Chief Justice Roberts declared that the spending clause Constitutionality problem can be "fully remedied by prohibiting the Secretary of HHS from terminating all federal Medicaid funding to a state that does not want to undertake the expansion." He clarifies that:

"Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding."

- The bottom line is that the entire ACA remains intact, including the Medicaid expansion requirements. However, without a penalty several governors have announced they do not plan to expand Medicaid to these new populations<sup>4</sup>. The majority of states have not indicated whether they plan to expand or not.

### **C. Reasons Why Medicaid Expansion Makes Good Economic and Political Sense**

Without delay advocates are urged to communicate information to the public, policy makers, and other state officials about how important Medicaid is for people with disabilities. Related to Medicaid expansion specifically:

1. Clarify for policy makers that Medicaid expansion comes with a 100% federal match through 2016, at which time it will gradually diminish, until in 2020 it reaches a 90% federal match where it remains permanently. Because of this high match, the cost of Medicaid expansion to states is anticipated to be only a 2.8 % increase over what states otherwise would have spent on Medicaid.
2. Point out that states that choose not to expand Medicaid coverage will still have to serve the uninsured in hospital emergency rooms. In 2014, and beyond, these costs will be higher for states. This is because the ACA calls for a reduction in “disproportionate share hospital” (DSH) payments. These are payments the federal government offers hospitals to help them defray the costs of caring for the uninsured. The ACA envisions that by 2024, fewer people will be uninsured, in part because of Medicaid expansion. Thus, the ACA reduces DSH to hospitals<sup>5</sup>.


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<sup>4</sup> These include: Florida, Louisiana, Mississippi, South Carolina, and Texas. Other states that are leaning toward not expanding include: Iowa, Missouri, Nebraska, Nevada and New Jersey. Steve Gold, a private disability rights attorney, has compiled statistics about the anticipated (minimal) costs of Medicaid expansion in states whose Governors’ have so far announced that they will NOT expand Medicaid. To access this data go to [www.stevegoldada.com](http://www.stevegoldada.com) and look for the article, “States Reluctant to Expand the Affordable Care Act's Medicaid” or Information Bulletin # 362 (7/2012).

<sup>5</sup> For more detailed information about the effect loss of DSH payments will likely have on states that fail to comply with Medicaid expansion requirements, read the National Health Law Program paper, *DSH Payments and Medicaid Expansion*, July 2012 at: [http://www.healthlaw.org/images/stories/DSH\\_QA\\_final.pdf](http://www.healthlaw.org/images/stories/DSH_QA_final.pdf)



3. Explain to the public that failure to expand Medicaid hurts families and individuals below the federal poverty level (FPL) the most. This is because the ACA does not provide for individuals earning below the FPL to receive any federal subsidies to help them purchase insurance (since these individuals are covered under Medicaid expansion requirements). Now, however, if a state chooses not to comply with the expansion requirements, it could mean that individuals and families earning less than %100 of FPL must purchase insurance without any federal assistance, while individual earning %100 to %400 percent above the FPL will qualify to receive federal subsidies to help pay for coverage.
4. States will also reduce spending on individuals with mental illness. Currently, state and local governments use general fund dollars to pay for a large portion of state mental health costs. The ACA will extend Medicaid to many low-income people with mental illness who previously were uninsured, increasing state mental Health programs' federal funding.
5. Share data about how much the health care industry relies on Medicaid payments, and the number of health care jobs that would likely be created as a result of the Medicaid expansion. Families USA has a website that calculates the economic stimulus value of Medicaid state-by-state at:  
<http://www.familiesusa.org/resources/publications/reports/medicaid/essential-for-hospitals.html>.
6. An expansion of coverage for people with disabilities in the private market, with an essential benefits plan which now must include habilitative services, means many individuals who rely on the state to provide a minimum amount of specialty care to maintain function may now be able to get that support in the private market. This means these individuals can expand their employment, receive the quality of care they need through private means, and free up scarce Medicaid



Many individuals who rely on the state to provide a minimum amount of specialty care to maintain function may now be able to get that support

dollars to be used for the more expansive habilitative care required by people with the most significant disabilities.

7. Over time, Americans will see the benefits of the ACA. More acceptance of the ACA will raise the political pressure to explain why federal matching funds were left on the table. This pressure will mount once government and advocacy groups start releasing national ACA progress reports listing specific dollar amounts lost to states that did not expand.

#### **D. Open Questions Concerning ACA Implementation Likely To Be Clarified In Federal Policy Over The Next Few Months**

In weeks since the Supreme Court issued its decision, states and advocates have sought federal clarification on several issues. On July 10<sup>th</sup> the National Republican Governor's Association sent a letter to President Obama, seeking answers to 30 questions regarding health benefit exchange and Medicaid expansion requirements in the wake of the Supreme Court's decision in *National Federation of Independent Business vs. Sebelius*<sup>6</sup>. Just two days later, Marilyn Tavenner, Acting Director of the Center for Medicare and Medicaid Services (CMS), sent a letter in response<sup>7</sup>. The letter is short and does not set out to answer all the questions posed by the National Republican Governor's Association letter. However, it does include some important policy statements, which indicate that HHS will give states flexibility as they determine whether or not to comply with Medicaid eligibility expansion requirements, including:

- "the Court's decision keeps in place all aspects of the law, affecting Medicaid,... with one exception, a state may not, as a consequence of not participating in [Medicaid] expansion, lose federal funding for its existing Medicaid program. The Court's decision did not affect other provisions of the law." This statement will hopefully end the question a few Governors have asked as to whether the Medicaid "maintenance of effort" requirements remain in place until 2014.
- There is no deadline by when states must tell HHS whether they are going to comply with Medicaid expansion requirements;

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<sup>6</sup> The letter can be downloaded at: <http://rgppc.com/medicaid-and-exchange-letter-2/>

<sup>7</sup> This letter can be downloaded at:

[http://nasuad.org/documentation/newsroom/CMS\\_Response\\_VA.pdf](http://nasuad.org/documentation/newsroom/CMS_Response_VA.pdf)

- States will still be held to the November 2012 deadline for notifying CMS whether they plan to set up their own exchange or use the federal exchange option.
- “the state can receive extra funding for Medicaid IT costs and exchange implementation costs even if it has not yet decided whether to expand Medicaid eligibility requirements or run its own exchange; and if a state ultimately decides not to do so, it will not have to pay these resources back.”

A few other questions P&As are anxious to know include: (1) Can States implement a partial expansion to, as example, 75% of the federal poverty level and still receive the 100% federal match? (2) What happens in a State that implements the expansion with 100% federal funding but decides to end the coverage when the federal match drops to 90%? And, a question sure to be litigated eventually, (3) How does the Court’s ruling on the Commerce and Spending Clauses affect other civil rights laws?

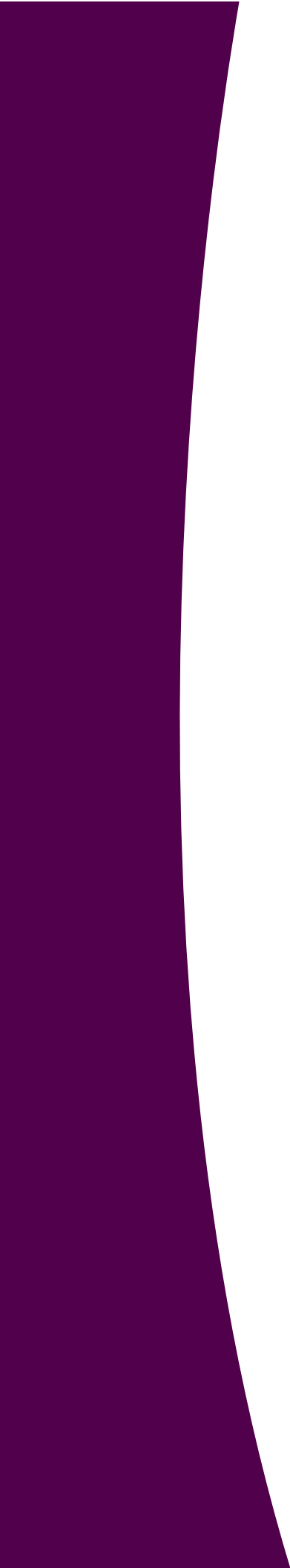
Through policy issuances, legislative change, and the Court’s many of these questions will be clarified. Since the vast majority of ACA policies and programs must be in place by 2014, it is likely policy clarifications will come out quickly.

## **E. Conclusion**

ACA resources and policy clarifications are coming out daily. Individuals with questions about the ruling and its impact; or who seek ideas for sharing information about the ACA are encouraged to contact Elizabeth Priaulx at NDRN at 202-408-9514 x113 or [Elizabeth.priaulx@ndrn.org](mailto:Elizabeth.priaulx@ndrn.org).

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