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TOWARD HEALTH INSURANCE COVERAGE FOR ALL AMERICANS

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The Affordable Care Act: A Giant Step Toward Insurance Coverage for All Americans

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The Affordable Care Act, signed into law in March 2010, promises to bring about the most significant reforms to our health care system in more than a generation. The law affects the financing, delivery, quality, and availability of health care services for all Americans not only by amending publicly funded programs such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Indian Health Services but also by substantially reforming the private insurance market. The Act prohibits discrimination in the provision of health care services and seeks to reduce racial health disparities. Once implemented, it will significantly increase federal funding for preventive care, expand the health care workforce, make more home- and community-based services available, and speed development of health information technology.

Yet, before many of its provisions are implemented—even before they become effective—the Act is under attack. To date, eighteen lawsuits are challenging the law's constitutionality, with elected officials in more than half the states involved. Despite early hope that these suits would be viewed as political theater, the first judge to issue a ruling denied the federal government's motion to dismiss an attack, filed by Virginia's attorney general, on the Act. Thus there is reason for concern that, after decades of fighting for universal health care, it may be delayed—or even snatched away—before becoming a reality.

Here we offer an overview of the Affordable Care Act, highlight selected provisions and discuss them in greater detail, and describe the lawsuits that are challenging the Act.[1]

[1]For an in-depth analysis of many Affordable Care Act provisions, see National Health Law Program, Analysis of the Health Care Reform Law: PPACA and the Reconciliation Act (n.d.), http://bit.ly/ajvcrT.

I. Overview of the Health Care Reform Statutes

President Obama signed, on March 23, 2010, the Patient Protection and Affordable Care Act; this law was immediately amended by the Health Care and Education Reconciliation Act, which the president signed on March 30.[2] The resulting combined legislation is referred to as the Affordable Care Act.[3]

The Patient Protection and Affordable Care Act is divided into ten titles.

- Title I reforms the private insurance market and, among other provisions, creates state-based health insurance "exchanges" through which consumers may purchase qualified health insurance plans. Title I also prohibits insurers from excluding individuals based on preexisting conditions or rescinding insurance coverage for reasons other than fraud; it requires individuals to maintain health insurance coverage and many large employers to offer coverage. It establishes tax credits to offset the cost of insurance premiums and cost sharing for many individuals.[4]
- Title II makes changes in public programs, particularly Medicaid, as well as in the CHIP and federal maternal and child health programs.[5]
- Title III is intended to improve the quality and efficiency of health care and links payment to "quality outcomes" in Medicare; Title III requires the development of a national strategy to improve health care quality and encourages development of new patient care models.[6] Other provisions in the title are intended to ensure beneficiary access to physician care and other services, protect residents of rural areas, improve payment accuracy, and improve the Medicare program.[7]
- Title IV, entitled "Prevention of Chronic Disease and Improving Public Health," is intended to modernize public health systems, increase access to clinical preventive services, spur the creation of healthier communities, and support innovation in public health.[8]
- Title V seeks to increase the primary health care workforce, enhance education and training of that workforce, and improve overall access to primary and other health care.[9] It specifically provides for workforce expansion in public health, primary care, dentistry, nursing, mental health, and long-term care.[10]
- Title VI will improve transparency and program integrity of health care, including Medicare and Medicaid.
- Title VII will improve access to innovative medical therapies.[11]
- Title VIII establishes the Community Living Assistance Services and Supports Act, a national voluntary insurance program through which

[2]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), http://bit.ly/aqyYTa; Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), http://bit.ly/cPlNPG.

[3]The Congressional debate over health care reform lasted more than a year, during which the House and Senate each passed their own comprehensive reform bill. Ultimately the House approved the Senate's bill, with minor revisions. For a more detailed discussion, see, e.g., C. Stephen Redhead & Erin D. Williams, Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148) 1 (March 24, 2010), http://bit.ly/b342rU.

[4]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, §§ 1001–1563.

[5]*Id.* §§ 2001–2955.

[6]*Id.* §§ 3001–3027.

[7]*Id.* §§ 3101–3602.

[8]*Id.* §§ 4001–4402.

[9]*Id.* §§ 5001–5606.

[10]*Id.*

[11]*Id.* §§ 6001–7103.

beneficiaries will be able to purchase community-based assistance services and supports.[12]

- Title IX contains tax and penalty provisions.[13]
- Title X amends and repeals some provisions in the previous nine titles and adds new provisions.[14] Notably it also permanently reauthorizes the Indian Health Care Improvement Act, which has long languished in Congress.[15]

Title I of the Health Care Education and Reconciliation Act, which amends the Patient Protection and Affordable Care Act, contains provisions related to private insurance, Medicaid, and Medicare coverage, as well as health care related taxes.[16] Title II consists primarily of measures related to education, but it also deals with insurance, prescription drugs, and community health centers.[17]

II. Selected Provisions of the Affordable Care Act

We describe reforms of the private insurance system and of the Medicaid program as well as miscellaneous provisions: those prohibiting discrimination, emphasizing preventive care, and establishing options for states to offer home- and community-based services for individuals with disabilities.

A. Reform of Private Health Insurance

The most complicated and controversial features of the Affordable Care Act may well be the Act's changes in private insurance markets. The fundamental underpinning of the legislation is the mandate that all Americans have "minimum essential coverage" or pay a penalty.[18] Minimum essential coverage is defined as

- government programs, such as Medicare Part A, Medicaid, CHIP, TRICARE (the health care program for service members, retirees, and their families), veterans' programs, and coverage for Peace Corps volunteers;
- most employer-sponsored health insurance plans;
- plans purchased through the individual market;
- coverage through existing plans that are "grandfathered" in; and
- other coverage, such as high-risk pools, recognized by the secretary of health and human services (HHS) and the secretary of the treasury.[19]

Thus individuals may choose among a number of ways to obtain the requisite coverage, depending on their household income and which options their states choose. For most insured individuals, the Act will not represent a change in their insurance.

The Affordable Care Act improves the private insurance market in ways some of which take effect in 2010. For plan years beginning on or after September 23, 2010, group health plans and insurance issuers may not impose lifetime or annual limits on the monetary value of most health benefits, nor may they rescind coverage for individuals for reasons other than fraud or intentional misrepresentation.[20] For those same plan years,

[12] *Id.* §§ 8001-8002.

[13] *Id.* §§ 9001-9023.

[14] *Id.* tit. X §§ 10101–10909; see Redhead & Williams, *supra* note 3, at 2.

[15] Patient Protection and Affordable Care Act § 10221; see also Sarah Somers, *Health Care Reform for Native Americans: The Long-Awaited Permanent Reauthorization of the Indian Health Care Improvement Act*, in this issue.

[16] Patient Protection and Affordable Care Act §§ 1001–1501.

[17] *Id.* §§ 2001–2303.

[18] *Id.* §§ 1501(b), 10106; Health Care Education and Reconciliation Act §§ 1002, 1004.

[19] Patient Protection and Affordable Care Act §§ 1501(b).

[20] *Id.* §§ 1001, 10101; Health Care Education and Reconciliation Act § 2301 (adding §§ 2711–2712 of the Public Health Services Act, to be codified following 42 U.S.C. §§ 300gg).

group health plans and insurance issuers are also prohibited from excluding individuals based on preexisting conditions or a history of illness.[21]

Beginning January 1, 2014, a number of other reforms become effective. Discriminatory rate setting in the individual and small group market will be prohibited. Premiums may vary only with specific factors: geography-rating area, age, tobacco use, and family structure.[22] Health insurance issuers will have to accept every employer or individual who applies for coverage, subject to open or special enrollment periods.[23] Most health insurance policies must be renewable regardless of health status.[24]

B. The Exchanges and Qualified Health Plans

These heightened protections for participants in the private insurance market are relatively easy to understand. Comprehending the provisions governing the manner in which many currently uninsured individuals will purchase private insurance is more difficult. Not only are the requirements complex and detailed, but also many specifics are not yet established. Regulations and federal guidance will flesh out the requirements and, it is hoped, make clearer the specific services covered and the out-of-pocket costs for individuals and employers.

By January 1, 2014, each state must establish an American Health Benefit Insurance Exchange.[25] "Qualified health plans" may be purchased through these bodies, which are to be administered by government agencies or nonprofit entities.[26] The exchanges will primarily serve individuals or small-business employers purchasing coverage.

Exchanges must implement procedures for certifying and assigning ratings to health plans and must inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program. If the exchange determines that individuals are eligible for one of these public programs, they must be enrolled in it.[27]

As noted, only "qualified" health plans will be offered through the exchange. These plans must

- be certified as eligible to be offered through the exchange;
- cover certain essential benefits (see below);
- be offered by licensed insurance issuers that (1) provide at least one qualified health plan at "silver" and "gold" levels and (2) agree to charge the same premium whether the plan is offered through an exchange, directly from the insurance issuer, or through an agent; and
- comply with regulations designated by the HHS secretary and any other requirements that the exchange imposes.[28]

Four types of qualified health plans—platinum, gold, silver, and bronze—will be available through the exchange, with each type covering a different percentage of the cost of health benefits. Platinum plans will cover 90 percent of the actuarial value of benefit costs, gold plans 80 percent, silver plans 70 percent, and bronze plans 60 percent.[29] This means,

[21]Patient Protection and Affordable Care Act § 1201 (adding Public Health Services Act § 2704).

[22]*Id.* (adding Public Health Services Act § 2701).

[23]*Id.* (adding Public Health Services Act § 2702).

[24]*Id.* (adding Public Health Services Act § 2703).

[25]*Id.* § 1311(b).

[26]*Id.* §§ 1301, 1311, 10203; Health Care Education and Reconciliation Act §§ 10104, 10203.

[27]Patient Protection and Affordable Care Act § 1311(d)(4)(F).

[28]*Id.* § 1301(a)(1).

[29]*Id.* § 1302(d)(1). "Actuarial value" is the estimated percentage of medical expenses that an insurer will pay for a standard population and basic set of charges. For further discussion, see Chris L. Peterson, Congressional Research Service, Setting and Valuing Health Insurance Benefits 1–2 (April 6, 2009), http://bit.ly/dhe8Ri.

for example, that an individual enrolled in a gold plan will have to pay no more than 20 percent out of pocket in cost sharing or other charges.

All qualified plans offered through the exchange must cover "essential" benefits: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder services, such as behavioral health services; (6) prescription drugs; (7) rehabilitation and habilitation services; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, such as oral and vision care.[30] The HHS secretary will define and periodically update this list of benefits, subject to an opportunity for public comment.[31]

Lawfully present immigrants may purchase insurance through the exchange and, as discussed below, are eligible for premium tax credits and cost-sharing reductions.[32]

C. Premium Assistance and Cost-Sharing Protections

To enable individuals to purchase the required insurance, the Affordable Care Act establishes tax credits, with an underlying premise that the credit should cover most of a monthly premium and the individual be responsible for the remainder. This is a particularly complicated area of the health care reform legislation and will require clarification through regulations and guidance from the federal government.

Premium tax credits essentially are available for citizens whose incomes are under 400 percent of the federal poverty level and for lawfully present immigrants whose incomes are below 100 percent of that level.[33] Individuals and families with incomes up to 133 percent of the poverty level are responsible for 2 percent of the premium; the percentage increases on a linear sliding scale until it reaches 9.5 percent for individuals and households at 400 percent of the federal poverty level.[34] To cover the remaining amount of the premium this group will be entitled to a tax credit for months in which a taxpayer is covered by a qualified health plan and pays the monthly premium for that coverage.[35]

The Affordable Care Act also reduces cost sharing for some individuals.[36] Those who participate in qualified health plans or standard health plans at the silver level are entitled to certain cost-sharing reductions, while those eligible for gold, platinum, or bronze are not.[37] Citizens must have incomes between 100 percent and 400 percent of the federal poverty level, and immigrants must have incomes below 100 percent (and not be eligible for Medicaid).[38] Cost sharing is defined as deductibles, coinsurance, co-

[30]Patient Protection and Affordable Care Act § 1302(b)(1).

[31]*Id.* § 1302(b)(3), (4)(H).

[32]*Id.* § 1312(f)(3).

[33]*Id.* § 1401(c)(1)(A), (B); Health Care Education and Reconciliation Act § 1001(a). For the remainder of 2010, in the contiguous forty-eight states and the District of Columbia, 400 percent of the federal poverty level is $73,240 for a family of three, and 100 percent is $18,310 for a family of the same size (75 Fed. Reg. 45628 (Aug. 3, 2010).

[34]Patient Protection and Affordable Care Act § 1401(b), Health Care Education and Reconciliation Act § 1001(a) (amending Section 280C of the Internal Revenue Service Code of 1986). For an in-depth discussion of this sliding scale, see National Health Law Program, *supra* note 1, pt. I, at 39–40. See also Hinda Chaikand et al., Congressional Research Service, Private Health Insurance Provisions in PPACA (P.L. 111-148), at 21 (April 15, 2010), http://bit.ly/atzRZb.

[35]Patient Protection and Affordable Care Act § 1401(a), Health Care Education and Reconciliation Act § 1001 (to be codified at I.R.C. §§ 36B(a), (c)(2) (1986)).

[36]Patient Protection and Affordable Care Act § 1402; Health Care Education and Reconciliation Act § 1001.

[37]Patient Protection and Affordable Care Act § 1402(b). Bronze, silver, gold, and platinum plans reflect different levels of cost sharing, not different levels of generosity of benefit packages. The plans will likely have different premium levels as well. E.g., a bronze plan covers 60 percent of the value of the benefits of the plan, and the individual is responsible for the remaining 40 percent of the value of the benefits of the plan. A bronze plan may have a less expensive monthly premium than the higher tiered plans (see *infra* for more on "standard" plans).

[38]Patient Protection and Affordable Care Act § 1402(c)(1)(A), (2); Health Care Education and Reconciliation Act § 1001(b).

payments and similar charges, and other qualified medical expenses as defined by the Internal Revenue Code; cost sharing does not include premiums, balance billing for services from nonnetwork providers, or spending on noncovered services.[39]

Cost sharing will range from 6 percent to 30 percent of the value of the plan, depending on household income.[40] Cost-sharing reductions may be given only for a coverage month in which an individual receives a premium assistance tax credit.[41]

D. Basic Health Programs

States may, as an alternative to coverage through an exchange, operate basic health programs through which they offer coverage to individuals who have household incomes of 134 percent to 200 percent of the federal poverty level and lack an affordable option for minimum essential coverage.[42] These "standard health plans" must provide at least the essential health benefits in qualified health plans offered through the exchange and, for most, have a medical loss ratio of at least 85 percent.[43] "Medical loss ratio" is not defined, but generally the term refers to the portion of premiums collected that a health plan expends on medical services, as opposed to profit, administration, marketing, or other costs.[44]

The HHS secretary must certify that, after any reduction for premium tax credits and cost sharing, standard-plan monthly premiums are no greater than those for the second lowest-cost silver-level qualified health plan offered under the exchange.[45] Cost sharing may not exceed the amount required in a platinum plan for individuals below 150 percent of the federal poverty level or the gold plan for all others.[46]

In contracting to offer standard health plans the state must establish a competitive process that features negotiating over benefit packages, premiums, and cost sharing.[47] States must also, to the greatest extent possible, make multiple standard health plans available to enhance potential enrollees' choice.[48] States may join in regional compacts to cover eligible individuals in all participating states.[49] States must coordinate the administration of this program with Medicaid, CHIP, and any other state-administered health programs.[50]

Lawfully present immigrants may obtain coverage through standard health plans if they have incomes no greater than 133 percent of the federal poverty level and are ineligible for affordable minimum essential coverage (including Medicaid).[51]

E. Waiver

Beginning in 2017, states may request waivers to enable them to offer coverage, subsidies, and tax credits in an alternative system to the exchange. To grant a

[39]Patient Protection and Affordable Care Act § 1302(c)(3); see 26 U.S.C. § 223(d)(2) (defining qualified medical expenses).

[40]Patient Protection and Affordable Care Act § 1402(b); Health Care Education and Reconciliation Act § 1001(b). The amount of cost sharing for an individual or family is determined through a complex two-tiered formula (for further detail, see National Health Law Program, *supra* note 1, pt. I, at 45; see also Chaikand et al., *supra* note 34, at 23).

[41]Patient Protection and Affordable Care Act § 1402(f)(2).

[42]*Id.* § 1331(e).

[43]*Id.* § 1331(a)(1), (b)(3), (e).

[44]See generally Families USA, *Medical Loss Ratios: Making Sure Premium Dollars Go to Health Care—Not Profits* (Feb. 2010), http://bit.ly/azlKph.

[45]Patient Protection and Affordable Care Act § 1331(a)(2).

[46]*Id.*

[47]*Id.* § 1331(c)(1), (2); see also *id.* § 1302(b).

[48]*Id.* § 1331(c)(3)(A).

[49]*Id.* § 1331(c)(3)(B).

[50]*Id.* § 1331(c)(4).

[51]*Id.* § 1331(e).

waiver request the HHS secretary must determine that the state waiver plan will

- provide coverage at least as comprehensive as that from qualified health plans through an exchange, as certified by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary;
- provide coverage and cost-sharing protection at least as affordable as other types of Affordable Care Act coverage; and
- not increase the federal deficit.[52]

F. Medicaid

The Affordable Care Act will expand Medicaid eligibility. Since Medicaid began in 1965, adults, despite low income, were ineligible unless they also fit into particular categories based on age, disability, or being a parent. Under the Act, beginning January 1, 2014, Medicaid eligibility will encompass most people whose incomes are under 133 percent of the federal poverty level.[53]

To qualify, individuals may not be over 65, pregnant, entitled to or enrolled in Medicare Part A, enrolled in Medicare Part B, or described in any of the mandatory categorically needy groups previously set forth in the Medicaid Act.[54] The state may phase in eligibility but must cover lower-income individuals before those with higher incomes.[55]

As of April 1, 2010, states were authorized to provide early coverage to individuals in this new category by submitting a state-plan amendment. Guidance on how to do so has come from CMS.[56]

Beginning January 1, 2014, states may cover individuals who are under 65 and are not part of previous optional categorically needy coverage groups and whose incomes exceed 133 percent of the federal poverty level. The individual, if a parent or caretaker relative, may not be enrolled unless the individual's child is also enrolled. As with those whose incomes are below 133 percent of the federal poverty level, the state may phase in eligibility but must cover those with lower incomes first.[57]

The Affordable Care Act changes the method used to determine income in Medicaid state-plan and waiver programs.[58] For most individuals, states will no longer use resource tests and must use modified adjusted gross income (known as MAGI) to determine individual and family income. [59] A standard 5 percent disregard will replace current income disregards.[60] These income and resource rules will not apply to individuals (1) who are eligible on a basis unrelated to income, such as being a child in foster care; (2) who are 65 or over; (3) who qualify for Medicaid on the basis of blindness or disability; (4) who are medically needy; or (5) for whom Medicaid is

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[52]*Id.* § 1332(b).

[53]*Id.* §§ 2001, 10201; Health Care Education and Reconciliation Act § 1201.

[54]Patient Protection and Affordable Care Act § 2001(a) (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)). Medicaid covers certain categories of individuals—children and pregnant women, individuals who receive Supplemental Security Income (SSI), or low-income Medicare beneficiaries. For some of these categories, coverage is mandatory (see 42 U.S.C. § 1396a(a)(10)(A)(i) and the groups listed therein; for further details, see Jane Perkins & Sarah Somers, National Health Law Program, An Advocate's Guide to the Medicaid Program (2001)).

[55]Patient Protection and Affordable Care Act §§ 2001(a)(1), 10201 (to be codified at 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XX), 1396a(k)(2)).

[56]See Cindy Mann, Director, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Letter to State Health Officials and Medicaid Directors (April 9, 2010), http://bit.ly/cX5uO7.

[57]Patient Protection and Affordable Care Act § 2001(e) (to be codified at 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XX), 1396a(hh)).

[58]*Id.* § 2002(a); Health Care Education and Reconciliation Act § 1004 (to be codified at 42 U.S.C. § 1396a(e)(14)).

[59]Patient Protection and Affordable Care Act § 2002(a). For purposes of the Affordable Care Act, modified adjusted gross income is based on adjusted gross income, defined under the Internal Revenue Code as gross income minus certain deductions (see 26 U.S.C. § 62). Adjusted gross income is then increased by certain other factors (see Patient Protection and Affordable Care Act § 1401(a); Health Care Education and Reconciliation Act § 1004).

[60]Health Care Education and Reconciliation Act § 1004(e).

paying Medicare cost sharing.[61] The state may, however, obtain a waiver from the federal government and subject these populations to these requirements.

Individuals who are enrolled in Medicaid as of January 1, 2014, and who would be ineligible as a result of new income rules will remain eligible, with the same premiums and cost sharing through *either* March 31, 2014, or the date of the next regularly scheduled redetermination of eligibility.[62]

The Affordable Care Act changes the Medicaid benefit package for most people who are eligible through the expanded coverage category. Their coverage will likely consist of benchmark or benchmark-equivalent coverage, which is a more limited package of services than that currently available under traditional Medicaid rules.[63] Effective January 1, 2014, benchmark and benchmark-equivalent coverage must provide at least the essential health benefits that will also be available through exchanges, discussed above.[64] Mental health parity requirements will also apply for most beneficiaries.[65]

G. Federal Reimbursement

The federal government reimburses participating states for at least half of their Medicaid costs.[66] The percentage paid by federal dollars, known as the federal medical assistance percentage, normally ranges from 50 percent to 83 percent.[67] The Affordable Care Act temporarily increases the percentage for certain newly eligible populations: those who are between 19 (or a higher state-set age) and 65 who were not eligible for or enrolled in a health plan through Medicaid.[68]

The Patient Protection and Affordable Care Act requires maintenance of effort to prevent states from dropping individuals from Medicaid before the new eligibility category comes into effect by January 1, 2014. States may not, under the state Medicaid plan or a waiver, implement eligibility standards, methodologies, or procedures more restrictive than those in effect on March 23, 2010. For adult populations, this requirement lasts until the HHS secretary determines that a "fully operational" exchange has been established in the state. For children under 19, the maintenance-of-effort requirement extends through September 30, 2019.[69]

Between January 1, 2011, and December 31, 2013, if a state faces a budget crisis and certifies to the HHS secretary that it has a budget deficit for the current fiscal year or is projected to have one for the next year, the maintenance-of-effort requirement is lifted for nonpregnant, nondisabled

[61]Patient Protection and Affordable Care Act § 2002(a).

[62]*Id.* This provision has generated confusion because the Patient Protection and Affordable Care Act repeatedly instructs states to develop eligibility standards that will not cause individuals who would be eligible on March 23, 2010, to lose eligibility. Clarification from CMS is needed.

[63]*Id.* § 2001(a)(2) (to be codified at 42 U.S.C. § 1396a(k)(1)). Benchmark coverage is the standard Blue Cross/Blue Shield preferred provider option for federal employees in the state; a benefits package generally available to state employees; coverage offered by the largest commercial, non-Medicaid health maintenance organization in the state; or coverage approved by the U.S. Department of Health and Human Services secretary. Benchmark-equivalent coverage consists of certain basic services (e.g., hospital, physician, laboratory, and preventive services) with an actuarial value equal to at least 75 percent of the actuarial value of that additional service in the benchmark plan. Some populations—those who qualify based on disability, such as SSI beneficiaries; people eligible for both Medicare and Medicaid (known as dual eligibles); and institutionalized individuals—are exempted from mandatory enrollment in benchmark-equivalent plans (42 U.S.C. § 1396u-7(a)(2)(B)).

[64]See Patient Protection and Affordable Care Act § 2001(c) (to be codified at 42 U.S.C. § 1396u-7(a)(5)).

[65]*Id.* § 2001(c)(6) (to be codified at 42 U.S.C. § 1396u-7(a)(2)(6)).

[66]*Id.* § 1396b(a), 1396d(a).

[67]*Id.* § 1301(a)(8); 73 Fed. Reg. 72051 (Nov. 26, 2008).

[68]Health Care Education and Reconciliation Act § 1201 (to be codified at 42 U.S.C. § 1396b(y)(1)). The question of who is "newly eligible" and the benefit package for which they qualify will be an important implementation issue. Advocates interested in this issue should look to NHeLP's in-depth analysis and further guidance from NHeLP.

[69]Patient Protection and Affordable Care Act § 2001(b) (adding 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)).

adults whose incomes exceed 133 percent of the federal poverty level.[70]

Other Affordable Care Act provisions intended to improve access to Medicaid are those that

- give states the option to extend premium assistance for employer-sponsored insurance to all Medicaid recipients and parents of recipients under 19;[71]
- expand coverage for former foster care children up to age 26;[72]
- simplify enrollment and coordination with the exchanges;[73] and
- give hospitals authority to make presumptive eligibility determinations for Medicaid-eligible populations.[74]

Among Affordable Care Act provisions to improve Medicaid services are those that

- clarify the definition of Medicaid as including services, not merely payment for services;[75]
- create a state option to coordinate care through "health homes" for eligible individuals with chronic illnesses such as mental health conditions, substance abuse disorders, asthma, diabetes, heart disease, or body mass index of more than 25;[76]
- appropriate $100 million for grants to states to help Medicaid beneficiaries improve their health and avoid certain chronic conditions;[77]
- authorize a demonstration project covering emergency psychiatric services in institutions for mental diseases for adults 18–64;[78] and
- create a new state option to extend family planning services and supplies to individuals based solely on income through a state-plan amendment rather than a waiver.[79]

H. Antidiscrimination

The Patient Protection and Affordable Care Act extends the application of federal civil rights laws—Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973—to the programs and activities that the Act administers, funds, or creates.[80] No individual may be excluded from participation in, denied the benefits of, or subjected to discrimination under any health program or activity that, in whole or in part, receives specified forms of federal financial assistance. This provision extends the protections to "contracts of insurance," which generally have been exempted from civil rights protections.[81]

Further, the antidiscrimination provision states explicitly that the enforcement

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[70]*Id.*

[71]*Id.* §§ 2003, 10203 (to be codified at 42 U.S.C. § 1396e-1).

[72]*Id.* §§ 2004(a), 10201(a) (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(IX)).

[73]*Id.* § 2201(b) (to be codified at 42 U.S.C. § 1397a).

[74]*Id.* § 2202(a) (to be codified at 42 U.S.C. § 1396a(a)(47)).

[75]Patient Protection and Affordable Care Act § 2304 (to be codified at 42 U.S.C. § 1396d(a)). For further analysis of this provision and its implications for Medicaid litigation, see Jane Perkins & Gene Coffey, National Health Law Program and National Senior Citizens Law Center, Patient Protection Act Clarifies the Meaning of "Medical Assistance" (March 31, 2010), http://bit.ly/alZsyY.

[76]Patient Protection and Affordable Care Act § 2703 (to be codified at 42 U.S.C. § 1396w-4).

[77]*Id.* § 4108.

[78]*Id.* § 2707.

[79]*Id.* § 2303, Health Care Education and Reconciliation Act § 1202 (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXI).

[80]Patient Protection and Affordable Care Act § 1557. Earlier drafts of this provision notably also referred to the Americans with Disabilities Act, but the final legislation did not refer to it.

[81]*Id*; see, e.g., 42 U.S.C. § 4000d-4.

mechanisms available under the identified civil rights laws "shall apply" and that the provision does not preempt state laws that confer greater protection.[82]

I. Other Provisions

Of interest to poverty advocates may be these other provisions:

- Additional state options to cover services for people with disabilities in the community, rather than in institutions. Most of these options come with more federal matching funds and become effective in 2011.[83]
- Options to create health homes through which individuals who have chronic diseases can obtain coordinated care;[84]
- Additional protections for individuals eligible for Medicare and Medicaid, with cost-sharing limits.

III. Litigation Filed to Stop Health Care Reform

Within minutes after President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010, attorneys general from Florida and twelve other states challenged the law's constitutionality in federal court. Later that day Virginia's attorney general also filed suit. Since then, sixteen additional federal court cases have been filed.[85]

In *Florida v. Sebelius* Florida Attorney General Bill McCollum raised a number of constitutional challenges to the individual mandate and to the Affordable Care Act's requirement that participating states expand Medicaid to individuals with incomes below 133 percent of the poverty line.[86] Amended on May 14, the complaint now names as plaintiffs attorneys general and governors from twenty states.[87] The federal government filed a motion to dismiss the case. In October that motion was denied in part, and claims challenging the constitutionality of the individual mandate to carry insurance and the expansion of the Medicaid program will be heard on the merits. Motions for summary judgment will be filed in November 2010.

In *Virginia ex rel. Cuccinelli v. Sebelius* the Virginia attorney general argues, among other assertions, that the Affordable Care Act conflicts directly with the recently enacted Virginia Health Care Freedom Act, which prohibits requiring any Virginian to obtain or maintain an individual insurance policy.[88] The federal government moved to dismiss, arguing that the case was not ripe for review because the Affordable Care Act's insurance mandate does not take effect until 2014. On August 2, 2010, however, Judge Henry Hudson decisively denied the motion.[89] He will hear cross-motions for summary judgment in the fall of 2010. Cases in Michigan and California are also active, with motions for preliminary injunction pending in both.[90]

While the claims differ somewhat, all eighteen cases focus on the Affordable Care Act's so-called individual-mandate provision—the requirement that most individuals either have qualified health

[82]Patient Protection and Affordable Care Act § 1557.

[83]See *id.* § 2401 (Community First Choices); § 2402 (Expanded State Plan Option to Offer Home- and Community-Based Services); § 2403 (Money Follows the Person Demonstration Grant); and § 10202 (State Balancing Incentives Program).

[84]*Id.* § 2703.

[85]See Jane Perkins, National Health Law Program, Health Reform Litigation Case Scheduling (updated weekly), http://bit.ly/ePsGfO.

[86]Amended Complaint, *McCollum v. U.S. Department of Health and Human Services*, No. 3:10-cv-91 (N.D. Fla. filed May 14, 2010), ECF No. 42.

[87]In addition to Florida the states are Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington.

[88]Complaint for Declaratory and Injunctive Relief, *Virginia ex rel. Cuccinelli v. Sebelius*, No. 3:10cv188 (E.D. Va. filed March 23, 2010), ECF No. 1; see Va. Code Ann. § 38.2-3430.1 (2010).

[89]*Virginia ex rel. Cuccinelli v. Sebelius*, 2010 WL 2991385 (E.D. Va. Aug. 2, 2010).

[90]See Complaint, *Thomas More Law Center v. Obama*, No. 2:10-cv-11156 (E.D. Mich. filed March 23, 2010); Complaint, *Baldwin v. Sebelius*, No. 3:10-cv-01033 (S.D. Cal. filed May 14, 2010).

insurance or pay a penalty as part of their income tax filing. According to the complaints, the individual mandate exceeds the scope of authority that the Constitution gives to Congress.[91]

The Affordable Care Act is enacted pursuant to the commerce clause.[92] Not surprisingly, then, the antireform cases focus on congressional authority under that clause "to regulate Commerce … among the several States."[93] The antireform plaintiffs claim that the Constitution does not authorize Congress to impose an "individual mandate" and that the Affordable Care Act does not regulate interstate commerce but rather regulates noneconomic inactivity, that is, individuals not obtaining qualified health insurance. In their briefs the plaintiffs argue that the logical extension of the individual mandate is the government's authority to require individuals to do almost anything. The *Thomas More* plaintiffs, for example, complain that the government's reading of the commerce clause would produce a "nanny state," capable of "ordering private citizens to engage in affirmative acts, under penalty of law, such as taking vitamins, losing weight, joining health clubs, buying a GMC truck, or purchasing an AIG insurance policy."[94] The federal government challenges the cases as premature and responds that health care, on which Americans spent $2.5 trillion in 2009, is serious commerce.[95] As the federal government points out, regardless of health insurance status, almost everyone participates in the stream of health care commerce at some point—e.g., "[w]hen accidents and illnesses inevitably occur, the uninsured still receive medical assistance, even if they cannot pay."[96]

Notably, to succeed on their claims the plaintiffs must distinguish decades of U.S. Supreme Court precedent. Dating back at least to 1944, the Supreme Court has recognized that the business of insurance falls within Congress' authority under the commerce clause.[97] Moreover, the Court recently affirmed Congress' broad authority to regulate under the commerce clause. For example, in *Gonzales v. Raich* the Court upheld federal regulation of marijuana grown for home use as part of a national scheme for banning controlled substances.[98] In *Gonzales* Justice Scalia noted that "Congress may regulate even noneconomic local activ-

[91]The Virginia case raises an additional constitutional issue. As noted, Virginia has enacted state legislation designed to block, or nullify, enforcement of the federal reform law. The question arises, then, whether the Virginia law violates the supremacy clause, which makes federal law the "supreme Law of the Land … any Laws of any State to the Contrary notwithstanding" (U.S. Const. art. IV). A number of U.S. Supreme Court cases have affirmed the supremacy of federal law (see, e.g., *Cooper v. Aaron*, 358 U.S. 1 (1958) (affirming supremacy of federal supreme court decision requiring school desegregation over an Arkansas constitutional amendment that prohibited integration); see Timothy S. Jost, *Can the States Nullify Health Care Reform?*, 362 New England Journal of Medicine 869 (2010).

[92]See Patient Protection and Affordable Care Act §§ 1501, 10106.

[93]U.S. Const. art. I, § 8. The plaintiffs also charge that the Patient Protection and Affordable Care Act does not fall within Congress' authority to "lay and collect Taxes, Duties, Imposts, and Excises, to … provide for the common Defense and general Welfare of the United States" (U.S. Const. art. I, § 8; see U.S. Const. amend. XVI). They argue that the insurance mandate provision is a "direct" tax prohibited by Article I, Section 9. This argument is difficult given the wording of the Patient Protection and Affordable Care Act, which clearly structures the payment as a tax. Some of the complaints also claim that the Act violates the Tenth Amendment and the equal protection clause and the due process clause of the U.S. Constitution.

[94]Plaintiffs' Motion for a Preliminary Injunction and Brief in Support at 18, *Thomas More Law Center v. Obama*, No. 2:10-cv-11156 (E.D. Mich. filed April 6, 2010), ECF No. 7.

[95]Defendant's Response to Plaintiffs' Motion for Preliminary Injunction and Brief in Support at 2, *Thomas More Law Center*, No. 2:10-cv-11156 (E.D. Mich. filed May 11, 2010), ECF No. 12.

[96]*Id.* at 3.

[97]See, e.g., *United States v. South-Eastern Underwriters Association*, 322 U.S. 533, 540 (1944) ("Perhaps no modern commercial enterprise directly affects so many persons in all walks of life as does the insurance business. Insurance touches the home, the family, and the occupation or the business of almost every person in the United States.").

[98]*Gonzales v. Raich*, 545 U.S. 1 (2005).

ity if that regulation is a necessary part of a more general regulation of interstate commerce."[99]

■ ■ ■

The Affordable Care Act will make profound and lasting changes in the way that Americans obtain health care. The legislation, however, forms only the outline of many of these changes. The details—vital matters such as the services in qualified health plans—will be shaped by regulations and federal guidance. If health care reform is to achieve its goal of near universal, quality coverage, continued engagement by health and poverty advocates is crucial.

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[99]*Id.* at 37. But compare *United States v. Morrison*, 529 U.S. 598 (2000), and *United States v. Lopez*, 514 U.S. 549 (1995) (limiting Congress' authority under commerce clause when activity is noneconomic), with *Gonzales*, 545 U.S. 1.

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