THE EFFECTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON MEDICAID: WILL SENIORS HAVE MORE LONG-TERM CARE OPTIONS AND AN EASIER APPLICATION PROCESS?

I. INTRODUCTION

After decades of indecision over health care reform, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010. This comment analyzes the effects of the PPACA on the elderly, especially those who reside in nursing homes. Although some seniors will face higher taxes under the Act, the legislation will provide more benefit options with an emphasis on non-institutionalized care. This comment examines the background of Medicare and Medicaid, the Medicaid application process, changes under the Act, application facilitation, and concludes that while some of the ramifications are unknown overall, the Act will benefit the elderly needing long-term care.

During the contentious debates regarding the health care reform legislation, I took my dog Beau to a nursing home to spend time with the residents. I was sitting to the side watching my dog do all the entertaining, when a talkative eighty-seven-year old lady introduced herself to me. "My name is Dorothy," she remarked. After some small talk, I told her I was on my first break from law school, and Dorothy's eyes started to sparkle. Unlike myself, Dorothy followed cable news daily and had many opinions on health care reform. Because she was in the nursing home only for mobility reasons, she yearned for another sound mind to talk to and wanted my opinion on the issue.

Dorothy was born in the 1920s, right after the invention of the band-aid, in a time before Social Security and Medicaid. Dorothy said the current system of health care does not need another band-aid, and she believes with the input of the elderly and caretakers, the health care system can improve. What Dorothy thought would be a ninety-day stay in the nursing home to recover from a broken hip turned into four years, but her motivation to return home and to her husband of over fifty years has never waned. Notwithstanding four years of rehabilitation, Dorothy is still relegated to a wheelchair, and her mobility is no better than when she arrived. During her first year in the nursing home, she went to rehabilitation several times a week, but now her visits to the trainer are marked with irony. She remains optimistic that one day she will be able to walk so she can go home and eat dinner with her husband. Even though her motivation has never faded, Dorothy is pragmatic and knows that she has lived in the nursing home twice as long as the average resident and, despite her efforts, there is still no end in sight. As roommates have come and gone, time has slowly started to fade away the memories of her home—her one motivation for leaving.

Traditionally, the United States left health care up to the individual, but in 2010, that philosophy changed.[1] In 2010, President Obama signed the PPACA and the Health Care and Education Reconciliation Act (HCERA) into law. This legislation will extend health coverage to millions of individuals and tie payments to better health care outcomes instead of to the number of treatments.[2] The PPACA provides more options for the elderly when it comes to choosing long-term care benefits.[3] Additionally, the government reinvigorated the dialogue on how to affordably care for seniors with programs that will make them happier and healthier instead of the current one-size-fits-all solution.[4]

Generally, seniors rely on using the equity in their home to pay for medical care later in life, but with home prices at all-time lows, seniors are forced to find other sources to fund their care.[5] Today, seniors that saved and paid into Social Security for their lifetimes are using all their fixed savings and even going into debt to pay for health care needed in the last

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1. *See* MARSHALL B. KAPP, LEGAL ASPECTS OF ELDER CARE 101 (Jones and Bartlett Publishers 2010).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

3. *See Fact Sheet: What the Health Care Law Does Now for People 65+*, AARP (Jan. 2011), http://www.aarp.org/health/health-care-reform/info-01-2011/the_new_health_care_law_what_it_does_now_for_people_65.html.

4. § 2406, 124 Stat. at 305 (Senate Findings).

5. *See* Victoria E. Knight, *How to Fund Retirement Living*, WALL ST. J., Dec. 23, 2008, at D4, *available at* http://online.wsj.com/article/SB122999501532228873.html (stating that a reverse mortgage is one option that seniors who own their own home can utilize to pay for long-term care costs).

years of their lives.[6] The PPACA will reduce the burdens on seniors by making it easier for them to qualify for Medicaid assisted Medicare thanks to improved "coordination of eligibility . . . determinations and individual assessments."[7] Seniors attempting to qualify for long-term care benefits should anticipate changes in the enrollment process and the administration of care.[8] Along with the improvements and more long-term care options, the PPACA amended several provisions of the Tax Code, which will enable the Centers for Medicare and Medicaid Services (CMS) to better coordinate with the Tax Service.[9] The PPACA focuses on better coordination of existing programs and the people that utilize those programs, which will make it easier for the elderly by reducing the amount of paperwork.[10] With patient input and innovative-care options, the elderly, their families, and their communities will benefit from a system moving away from institutionalized care.[11]

This comment will address the effects of the PPACA on the long-term health care system. Part II of this comment will briefly discuss the background of Medicaid and the different parts of Medicare. However, the social and policy issues of who should be responsible for long-term care costs are beyond the scope of this comment. Part III will outline the standard application process to qualify for Medicaid and the difficulties with this system. Several examples from the Texas application process are included; Medicaid, however, is a "joint" federal-state program, in which the states and counties serve as "laboratories" for innovation to the system, making a national comparison impossible.[12] Part IV lists several parts of the PPACA that are relevant to seniors either living in long-term care facilities or about to apply for Medicaid. Part V illustrates the amendments to the Tax Code and the process to close the Medicare Part D "doughnut hole." Part VI discusses several approaches to implementing systems that will streamline the application process currently used in other states. Finally, Part VII concludes with the positive and negative implications of the health reform bill.

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6. *Id.*

7. § 2402, 124 Stat. at 302.

8. Rebecca C. Morgan et al., *What Elder Law Attorneys Need to Know About PPACA and Health Care Reform*, 2010 EMERGING ISSUES 5170 (2010).

9. *See id.*

10. *See* § 2402(a)(1)–(3), 124 Stat. at 119.

11. *See id.*

12. Keith B. Gallant, *Long-Term Care Insurance: Planning and Paying for "Long-Term Care"*, at 7 (Oct. 2006), http://files.ali-aba.org/thumbs/datastorage/lacidoirep/articles/EPCMJ_EPCMJ0610-Gallant_thumb.pdf.

II. BACKGROUND OF MEDICAID AND MEDICARE

When Congress first enacted Medicaid in 1965 it did not cover payments to nursing homes.[13] Congress later amended the Social Security Act with the Boren Amendment to require states to cover long-term care under the Medicaid Act.[14] The Amendment allowed the states discretion in administration of Medicaid and the ability to enact their own standard rates.[15] However, this flexibility and the emphasis on nursing homes—instead of home or community based care—has not necessarily contributed to better outcomes concerning the overall well-being of the elderly.[16] People like Dorothy, who are mentally sharp but lack mobility, would prefer more options under Medicare instead of using Medicaid and going to the hospital or the nursing home.

States partially fund Medicaid but "[Medicare is] exclusively federal, unlike . . . Medicaid."[17] Today, Medicare consists of several parts, which vary in coverage and premiums.[18] For example, "Part A covers: Inpatient care in hospitals (such as critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals)[;] [i]npatient care in a skilled nursing facility (not custodial or long term care)[;] [h]ospice care services[;] [h]ome health care services[;] [i]npatient care in a Religious Nonmedical Health Care Institution."[19] Part A covers costs in a skilled nursing facility (SNF) for up to 100 days only. During the first twenty days, the patient pays nothing; during the 21st to 100th day the patient pays $133.50 per day.[20] For terminally ill patients, Part A covers up to two periods of ninety days and an "unlimited number of subsequent periods of 60 days each."[21] Thus, Medicare does not cover the average two-year stay in a nursing home, let alone Dorothy's four-year stay.[22]

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13. *See* Thomas C. Fox, ed., *Long Term Care and the Law*, THE NAT'L HEALTH LAWYERS ASSN., 3 (Rynd Communications 1986) (stating Congress enacted the Boren Amendment because the prior reimbursement program "had unduly restrained the states' fiscal and administrative discretion").

14. *See id.* at 4.

15. *See id.*

16. *See id.* at 39.

17. DAVID A. PRATT, SOCIAL SECURITY AND MEDICARE ANSWER BOOK 1-2 (Aspen Publishers, 3rd ed. 2003).

18. *See, e.g.*, *Medicare Benefits*, MEDICARE, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/medicare-benefits-overview.aspx (last visited Oct. 28, 2011).

19. *Medicare Part A (Hospital Benefits)*, MEDICARE.GOV, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-a.aspx (last visited Oct. 28, 2011).

20. *See* 42 U.S.C. §§ 1395d(a)(2), 1395e(a)(3) (2006). *See also* PRATT, *supra* note 17, at 15-2.

21. 42 U.S.C. § 1395d(a)(4).

22. Stephanie AuWerter, *Insurance, The Basics*, WALL ST. J., Mar. 14, 2005, *available at* http://www.smartmoney.com/personal-finance/insurance/the-basics-17373/ (stating that the average stay in a nursing home is 2.4 years, but 68% of people 65 or older discharged from a nursing home stay less than ninety days).

Generally, beneficiaries do not pay a monthly premium for Part A coverage if the beneficiary or their spouse paid Medicare taxes while working.[23] If a beneficiary receives Part A coverage, then he or she automatically receives Part B coverage unless the beneficiary specifically opts out.[24] Part B is optional and covers "medically-necessary services like doctors' services, outpatient care, home health services, and other medical services."[25] Hence, most residents in nursing homes do not qualify for Part A because Medicare limits coverage to patients that require skilled nursing or skilled rehabilitation services on a daily basis.[26]

Currently Medicaid, not Medicare, covers the cost for approximately sixty percent of nursing-home residents.[27] Medicaid provides coverage for nine million seniors.[28]

> Although the law requires Medicaid beneficiaries to contribute or spend down their income and assets, critics contend that "impoverishment is a fallacy" and that Medicaid pays for the care of most nursing home residents because people with the resources to afford their own care—middle-income and wealthier people, even "millionaires"—transfer their assets to qualify for public subsidies intended for the poor.[29]

For example, an applicant who otherwise would meet the income and medical necessity requirements can begin receiving Medicaid benefits as soon as she "spent down" her assets to the $2,000 limit.[30] Critics of middle- and upper-income Medicaid enrollees argue the elderly "artificially impoverish" themselves by hiring an estate-planning attorney.[31] However, most of the disabled elderly have limited assets, lack the means to hire an attorney, and pay for their own care.[32]

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23. *See generally*, *Medicare Part A (Hospital Benefits)*, *supra* note 19.

24. *See id.*; PRATT, *supra* note 17, at 12-2.

25. *Medicare Part B (Medical Insurance)*, MEDICARE, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-b.aspx (last visited Oct. 28, 2011).

26. *See* PRATT, *supra* note 17, at 15–16.

27. *See* Press Release, Kristen Knapp, Florida Healthcare Ass'n, Nursing Home Care Threatened by Medicaid Spending Cut (Mar. 22, 2010), *available at* http://www.fhca.org/presscenter/NewsRelease-NHCareThreatenedbyMedicaidFundingCuts-0310.pdf.

28. *See* DAVID NATHER, THE NEW HEALTH CARE SYSTEM 119–20 (Thomas Dunne Books, 2010).

29. Ellen O'Brien, *Medicaid's coverage of nursing home costs: Asset shelter for the wealthy or essential safety net?*, GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT (May 2005), http://ltc.georgetown.edu/pdfs/nursinghomecosts.pdf (quoting Stephen Moses, *The Fallacy of Impoverishment*, 30(1) The Gerontologist 21, 21–25 (1990); *Medicaid for Millions*, WALL. ST. J., Feb. 24, 2005, at A14).

30. *Id.* at 2. *See also* Michael B. Cohen, *Medicaid: The Basics*, *in* FUNDAMENTAL ISSUES IN ELDER LAW 13, 28–29 (Nat'l Bus. Inst. 2006).

31. O'Brien, *supra* note 29, at 2–3 (stating that the critics arguments "are supported only by anecdotal accounts of abuses by the rich[]").

32. *See id.* at 3.

Before Dorothy's fall, she only received Medicare because her assets and income made her ineligible for Medicaid. While being treated in the hospital for several weeks, Dorothy and her family thought about what was important—her health—and not about the avalanche of forms that were coming. Although Dorothy had "excess" assets, those assets would not come close to covering the costs of nursing home care. Once her family realized that she would require an extended recovery in a nursing facility, her family enlisted the help of a consultant to begin the process of spending down her assets and start the Medicaid application process.

III. THE CURRENT APPLICATION PROCESS

Aging is a fact of life, and Medicare and Medicaid are methods individuals may use to lessen the impact on their pocket books. However, while the costs are well known, few people seek financial and estate planning for long-term care before moving into a nursing home.[33] While Medicare, like any insurance policy, does not require applicants to spend down assets or have a certain income, it does not cover the average stay in a nursing home.[34] By comparison, Medicaid, a "poverty program," pays for health care only if the person meets certain income and health requirements.[35] Since upwards of seventy percent of people over sixty-five-years-old will require care in a long-term nursing facility, the lack of planning to meet the numerous state requirements can have a significant financial and emotional impact.[36]

In order to apply for Medicaid, an individual must go to the local Medicaid or welfare office.[37] "Approximately 20 states (including Arizona, Colorado, Florida and Texas) either deny assistance to an applicant whose income exceeds a certain mandatory cap or impose expenditure restrictions that have almost the same effect."[38] Other states, however, allow an otherwise eligible individual with either a high or low income to pay part of the cost while the state subsidizes the shortfall.[39]

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33. Michelle Andrews, *4 Ways to Cover the Cost of Long-Term Care*, U.S. NEWS, Mar. 11, 2009, *available at* http://health.usnews.com/health-news/best-nursing-homes/articles/2009/03/11/4-ways-to-cover-the-cost-of-long-term-care.

34. Monica Franklin, *So the Patient is in a skilled care facility, what's next?*, GREY MATTERS: NOTES, NEWS & MUSINGS ON ELDER CARE (Aug. 25, 2010), http://elderlawblogtn.com/articles-by-monica-franklin/so-the-patient-is-in-a-skilled-care-facility-whats-next.html.

35. *Id.*

36. *See* Andrews, *supra* note 33 (stating that "[e]ven if they did, the cold fact is that the options available to pay for long-term care, whether it's a nursing home, an assisted living facility, or home care, are limited and too often unaffordable").

37. *See* NATHER, *supra* note 28, at 123.

38. Gallant, *supra* note 12, at 8 n.7.

39. *Id.*

In Texas, an applicant for Medicaid must satisfy numerous requirements to qualify to reside in nursing facilities.[40] The basic requirements are that the recipient be a United States citizen or legal alien, and a Texas resident.[41] Additionally, an applicant must meet an Income Test, Resource Test, Medical Necessity requirement, and contribute towards at least thirty days of costs in a Medicaid qualified facility.[42]

Under the Income Test, an applicant is ineligible for the program if her gross income exceeds $1,869 per month for a single taxpayer or gross income of $3,738 for a married couple filing a joint tax return.[43] Another type of problem arises when the applicant's gross income exceeds the limit for eligibility but is not enough to cover the cost of living in a nursing facility.[44] The cost of nursing home care in Texas, for example, can be $3,000 to $5,000 per month.[45] An individual with income less than $5,000 per month but more than $1,869 would have to find collateral sources to cover the costs.[46]

The Resource Test—in which total assets must not exceed $2,000 for an individual or $3,000 for a couple—requires more planning to qualify.[47] Certain assets are included in the countable resources while other assets are excludable.[48] Most importantly, the Resource Test excludes the family home if owned by the applicant or their spouse.[49] Because Medicaid regulations include or exclude certain types of assets, or because the applicant's resources are too great, the process may be time intensive for an elderly person in a hospital or already in a nursing home.[50]

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40. *See generally* Michael B. Cohen, *Medicaid: The Basics*, *in* FUNDAMENTAL ISSUES IN ELDER LAW 13, 14–49 (Nat'l Bus. Inst. ed. 2006).

41. *See* 40 TEX. ADMIN. CODE § 15.300(a) (2003); (Tex. Health and Human Servs. Comm'n, United States Citizenship and Residence Requirements). *See also*, Sandra S. Moore-Duarte, *Estate Planning and Recovery for Elderly Clients*, *in* ESTATE PLANNING AND RECOVERY FOR ELDERLY CLIENTS 140, 141–42 (Nat'l Bus. Inst. ed., Dec. 2007).

42. *See* Sandra S. Moore-Duarte, *Estate Planning and Recovery for Elderly Clients*, *in* ESTATE PLANNING AND RECOVERY FOR ELDERLY CLIENTS 140, 141–42 (Nat'l Bus. Inst. ed., 2007).

43. *See id.* at 141.

44. *See id.* at 143.

45. *See id*.

46. *See id*. *See, e.g.*, Victoria E. Knight, *How to Fund Retirement Living*, WALL ST. J., Dec. 23, 2008, at D4, *available at* http://online.wsj.com/article/SB122999501532228873.html ("The average cost of a private room at a nursing home runs $76,500 per person annually, while a one-year stay in a one-bedroom unit in an assisted living facility costs $36,000 and periodic care from a home health assistant at $18,000 or more.").

47. *See* Moore-Duarte, *supra* note 42, at 142.

48. *See* 1 TEX. ADMIN. CODE § 358.401 (2003); (Tex. Health and Human Servs. Comm'n, Transfer of Assets before February 8, 2006); Cohen, *supra* note 40, at 28–34.

49. *See* Cohen, *supra* note 40, at 28.

50. *See* Monica Franklin, *How Does a Tennessee Nursing Home Patient Qualify for Medicaid?*, GREY MATTERS (Sep. 10, 2010), http://elderlawblogtn.com/articles-by-monica-franklin/how-does-a-tennessee-nursing-home-patient-qualify-for-medicaid.html ("Often, a nursing home business office staff member will submit an application for the patient without speaking with the family . . . [b]ecause the

To meet the Income and Resource Tests, an ineligible applicant should consult with an estate planner.[51] The planner can create a "Miller's Trust" or "Qualified Income Trust," which are both irrevocable and "shelter the income out of the control of the applicant."[52] An individual with excess assets sometimes receives advice to give the assets to children or other family members, but generally these transfers are improper and result in a penalty.[53] Alternatively, the Medicaid estate exempts certain annuities if the annuity meets the following five requirements:

> (A) Is irrevocable; (B) [p]ays out principal in equal monthly installments and pays out interest in either equal monthly installments or in amounts that result in increases of the monthly installments at least annually; (C) [i]s guaranteed to return within the person's life expectancy at least the person's principal investment plus a reasonable amount of interest . . . ; (D) Names the State of Texas or the [Texas] Department [of Health and Human Resources] as the residual beneficiary of amounts payable under the annuity contract, not to exceed any Medicaid funds expended on the person during his lifetime; and (E) [i]s issued by an insurance company licensed and approved to do business in the State of Texas.[54]

However, the Texas Departments of Health and Human Services (Department) examines the applicant's assets during the prior thirty-six months or even sixty months in some cases involving conveyances to trusts.[55] The Department penalizes uncompensated transfers and transfers that are less than the fair market value of the assets.[56] Hence, the applicant should go through this complex process well in advance to avoid stress and penalties.

Moreover, the Income Test, Resource Test, and Medical Necessity requirement are only preliminary concerns and do not finish the long-term care puzzle. If an elderly client does not want to enroll in Medicaid, "[t]hree alternatives to Medicaid appear viable: be **healthy** enough not to require long term care (the best); be **wealthy** enough not to worry about the cost of long term care (a good second); or be **wise** enough to plan in advance for the possibility of long term care . . . ."[57] Like any type of

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nursing home needs payment as soon as Medicare ends. While submitting a Medicaid application may ultimately create eligibility problems for the patient, nursing home staff is merely trying to make sure the patient's medical bills will be paid.").

51. *See* Moore-Duarte, *supra* note 42. *See also* Franklin, *supra* note 34.

52. *See* Moore-Duarte, *supra* note 42, at 143.

53. Gallant, *supra* note 12, at 8.

54. MICHAEL B. COHEN, *Addressing the Conflicting Interest Between Tax and Medicaid Planning*, UNDERSTANDING MEDICAID AND ESTATE RECOVERY, 7, 10 (Nat'l Bus. Inst. ed. Sept. 2006).

55. *See* Moore-Duarte, *supra* note 42, at 142.

56. *See* COHEN, *supra* note 54, at 12–13.

57. Gallant, *supra* note 12, at 9.

family estate planning, "financial considerations are only a part of the total picture."[58] These questions should take a back seat to what the individual wants and if their desires are reasonable based on their personal health issues.[59] Nevertheless, financial considerations play a vital role in the application process and whether the individual can receive the desired care.[60]

IV. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

The Act makes big changes and provides for more options throughout the health-care system.[61] Some changes went into effect immediately while the government will not implement other programs until 2014.[62] First, "[t]he Affordable Care Act will bring down costs, improve the quality of health care delivered to all Americans and expand coverage to 32 million Americans."[63] The Act provides incentives for patients' outcomes rather than for the number of tests a doctor can perform.[64] To achieve the goal of making the person healthy as a whole, for example, elderly individuals will no longer have to pay for preventative check-ups and yearly screenings.[65]

Second, the Act will extend primary Medicaid coverage to an estimated 18 million people by easing the eligibility requirements.[66] An example of a new group of eligible individuals are disabled adults who meet current eligibility requirements for Medicaid and earn less than the

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58. *Id.*

59. *See id*. at 7.

60. *See id*. at 8 ("Not unlike the use of discounts in transfer tax planning, Medicaid transfers offer tremendous opportunities for the knowledgeable and terrible pitfalls for the unwary. Unlike most transfer tax planning, however, federal laws and regulations are only the beginning of Medicaid planning, which is largely a function of state laws, regulations, and practice.").

61. Richard L. Kaplan, *Analyzing The Impact of The New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 213–14 (2011) (stating that the PPACA is also named "The Affordable Care Act" or informally "ObamaCare").

62. *See* Morgan, *supra* note 8.

63. *The Affordable Care Act*, WHITEHOUSE, http://www.whitehouse.gov/healthreform/healthcare-overview#healthcare-menu (last visited Oct. 28, 2011). *See* Janet Adamy, *Judge Allows Challenge to Health-Coverage Mandate*, WALL ST. J., Oct. 15, 2010, at A3 (stating that critics of the legislation argue that expanding the Medicaid program to cover millions of additional people while simultaneously cutting Medicaid expenditures is unconstitutional because it imposes an unaffordable liability on the states).

64. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3004, 124 Stat. 119, 368 (2010) (imposing a 2% reduction in payments if long-term care hospitals do not start to compile and report data to the Secretary).

65. *See* Kimberly Lankford, *Health-Care Reform Provisions Kicking In*, AARP (Sept. 23, 2010), http://www.aarp.org/money/insurance/info-09-2010/kip_healthcare_reform_provisions_kicking_in.html.

66. *See* Memorandum from Richard S. Foster, Chief Actuary, Ctr. for Medicare and Medicaid Servs., Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended, at 3 (Apr. 22, 2010), https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf [hereinafter Foster].

FPL but have incomes greater than the state's eligibility requirements.[67] In addition, Medicaid coverage would extend to households who earn less than the FPL but have no other qualifying factors that would make them eligible under prior law.[68] While the opponents of the PPACA warned seniors that additional people in the program would lead to rationing and even "death panels," these arguments are inaccurate.[69] Thus, instead of rationing health coverage, the Act will cover two new groups of individuals, and some new benefits will be available at no cost.[70]

Before the enactment of the PPACA, the Congressional Budget Office initially estimated that the reform would reduce the federal deficit by $143 billion; the Act, however, will cost more than initially predicted.[71] The Act will require an additional $115 billion over ten years due to underestimated implementation costs for federal agencies.[72] Financing for the Act will primarily come from employer taxes, cuts to Medicaid, and "[c]ost saving measures, including provisions that will make our system more efficient."[73] In 2010, the PPACA will increase payments to institutional providers of long-term care services.[74] The Community First Choice Option, which adds incentives to encourage home and community-based services instead of institutionalization, would cost $29 billion over ten years. These incentive programs could have the potential of greatly reducing the total Medicaid expenditures to nursing facilities.[75]

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67. *See id.*

68. *See id.*

69. *See Patient's Bill of Rights*, HEALTHCARE.GOV (July 1, 2010), http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html (noting that under the private run health insurance system, private companies rationed care for people with preexisting conditions). *See, e.g.*, *The Affordable Care Act's New Patient's Bill of Rights*, HEALTHCARE.GOV (June 22, 2010) http://www.healthcare.gov/news/factsheets/2010/06/aca-new-patients-bill-of-rights.html ("A Texas insurance company denied coverage for a baby born with a heart defect that required surgery. Friends and neighbors rallied around the family to raise the thousands of dollars needed to pay for the surgery and put pressure on the insurer to pay for the needed treatment. A week later the insurer backed off and covered the baby.").

70. *See* Foster, *supra* note 66.

71. *See Health Care*, CONGRESSIONAL BUDGET OFFICE, http://www.cbo.gov/publications/collections/health.cfm.

72. *See* Letter from Douglas W. Elmendorf, Director of Congressional Budget Office, to Congressman Jerry Lewis (May 11, 2010), *available at* http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf (stating that the upward budget revision is due to "[c]osts to the Internal Revenue Service (IRS) of implementing the eligibility determination, documentation, and verification processes for premium and cost-sharing credits . . . will probably total between $5 billion and $10 billion over 10 years. Costs to HHS, especially the Centers for Medicare and Medicaid Services, and the Office of Personnel Management for implementing the changes in Medicare, Medicaid . . . will probably total at least $5 billion to $10 billion over 10 years").

73. *The Affordable Care Act*, WHITEHOUSE, http://www.whitehouse.gov/healthreform/healthcare-overview#healthcare-menu.

74. *See* NATHER, *supra* note 28, at 180 (stating that the government will save $157 billion of projected cost increases by spending less than before).

75. *See* Foster, *supra* note 66, at 12.

A study by Richard S. Foster, chief actuary for the Centers of Medicare and Medicaid Services (CMS), reports that the savings to Medicare could total $577 billion over the next decade.[76] "The PPACA introduces permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a ten-year moving average of economy-wide private, non-farm productivity gains."[77] Because payments to Medicare and Medicaid are compared to the productivity gains of the economy at large, health care cost increases will more closely match inflation and productivity gains of the overall economy.[78] Theoretically, payments to health care providers should no longer rise at an exponential rate, which will save money over the long term.[79]

Payments for nursing home care account for three-fourths of the nation's long-term care costs, and Medicaid accounts for the bulk of the reimbursements.[80] Even though approximately eighty percent of all care provided to the elderly is "'informal,' that is, provided by family members or other unpaid volunteer caregivers in the home rather than by care giving professionals or institutions," Medicaid and Medicare do not reimburse informal care.[81] Applying the Americans with Disabilities Act to the issues in *Olmstead v. L.C. ex rel. Zimring*, the Supreme Court held that individuals with mental disabilities have the right to choose between community and home care rather than institutionalization.[82] In the PPACA, the Senate noted in its findings that twenty years after the Pepper Commission, and a decade after the *Olmstead* decision, long-term care "for many . . . has gotten far worse."[83] The Act incorporates the elderly into the decision making process and the Court's patient-centered reasoning.[84] Hence, with input

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76. *See id.* at 2.

77. *See id.* at 9.

78. *See id.* at 12.

79. *See id.*

80. *See* O'Brien, *supra* note 29. *See also* Press Release, Steve Tokar, University of California Medical Center, *Social support is key to nursing home length of stay before death*, (Aug. 24 2010), http://www.ucsf.edu/news/2010/08/4447/social-support-key-nursing-home-length-stay-death (quoting Alexander K. Smith, MD, MS, MPH, a palliative medicine physician at SFVAMC and an assistant professor of medicine in the Division of Geriatrics at the University of California, San Francisco: "One quarter of all deaths in the United States occur in nursing homes, and that figure is expected to rise to 40 percent by the year 2020").

81. *Caring Today, Planning for Tomorrow*, NAT'L ALLIANCE FOR CAREGIVING (1999), http://www.caregiving.org/data/archives/nacguide.pdf (last visited Oct. 25, 2011).

82. Olmstead v. L. C. ex rel. by Zimring, 527 U.S. 581, 589 (1999).

83. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 306, 2406 (2010) (Sense of the Senate Regarding Long-Term Care). *See also*, S. REP. NO. 101-114 (1990) (agreeing unanimously that "all Americans should have access to affordable health and long-term care coverage in an efficient and effective system"). Other Resources, THE ALLIANCE FOR HEALTH REFORM, http://www.allhealth.org/pubs_otherpublications.asp (last visited Oct. 25, 2011).

84. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 301, 2402(a)(1)–(3) (2010).

from seniors, the PPACA would provide different options for more seniors to remain happily in their homes or communities, which will reduce the cost of Medicaid payments to nursing homes.[85]

Due to the aging population and high spending on nursing home care, "[t]he PPACA contains a number of provisions directed toward keeping patients in the community and out of nursing homes, including the Community First Choice Option, the Removing Barriers to Providing Home and Community-based Services program, and the extension of the Money Follows the Person Rebalancing demonstration program."[86] For some senior citizens, institutionalization in a nursing home is essential; however, for many others, "informal" home care provides the optimal amount of services at a significantly lower cost.[87]

A. Extensions of Existing Programs

The Act extends funding for the Money Follows the Person Program (MFP), which provides assistance to Medicaid-enrolled nursing facility residents.[88] Congress enacted the MFP program in 2005 under the Deficit Reduction Act and authorized up to $1.75 billion in federal funding through 2011.[89] "The MFP Demonstration Program reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to person-centered consumer directed and community-based."[90] In the spring of 2008, states began transitioning the elderly from institutionalized care back into community settings.[91]

Approximately thirty states have implemented the program, and "the number of participants transitioning has increased as solutions to barriers were identified and significant technical assistance is continuing to be provided to help States [sic] meet transition benchmarks they set."[92] The original MFP program required institutional residency for six months.[93] Congress identified this barrier to the program, and the Act reduces the period from six months to ninety days and prohibits states from establishing

85. *See id.*

86. Timothy Stoltzfus Jost, *Introduction to the PPACA and HCERA of 2010*, 2010 Emerging Issues 5106, http://www.lexisnexis.com/community/emergingissues/blogs/spotlightonhealthcarereform/archive/2010/09/13/introduction-to-the-patient-protection-and-affordable-care-act-and-the-health-care-ppaca-and-education-reconciliation-act-of-2010.aspx (2011).

87. *See* Fox, *supra* note 13, at 39.

88. *See Money Follows the Person*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (July 12, 2011), http://www.cms.gov/CommunityServices/20_MFP.asp.

89. *Id.*

90. *Id.*

91. *See id.*

92. *Id.*

93. S. Res. 1932, 109th Cong. (2006) (enacted).

a longer period.[94] To date, the program has successfully allowed over 6,000 individuals to return to the community.[95] With the extension of the MFP Program under the PPACA, states receive additional funding to help individuals transition back into their homes or other community-based centers.[96] Through 2016, the PPACA will provide $2.25 billion in additional funding, and fourteen states intend to join the program.[97]

Another improvement extended under the Act protects spouses of people receiving Medicaid from impoverishment.[98] Before the PPACA, spouses of beneficiaries in community property states were forced into poverty before their spouse could receive Medicaid benefits.[99] Beginning in 2014, the Act provides the same protection against impoverishment for spouses of beneficiaries receiving institutionalized care.[100] The Act expands Medicaid's spousal impoverishment protections by requiring all states to extend the protections to the spouses of all Medicaid beneficiaries.[101] The rationale for the mandate is to ensure that spouses of individuals in nursing homes are not left penniless by having to sell the family home and other assets to pay for their spouse's care.[102] In addition, the spouse will have sufficient income to live and enjoy being at home in the community.[103]

Thanks to these programs, people residing in nursing homes could potentially move back home, or to a community center, without spending their lives' savings. Even if a resident cannot be relocated, the protections against spousal impoverishment will benefit both spouses. Hence both spouses, with more options and resources, will be happier and healthier.

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94. *Health Care Reform and Low-Income Older Adults: An Overview*, NAT'L SENIOR CITIZENS L. CTR., Apr. 2010, *available at* http://www.nsclc.org/index.php/health-care-reform-low-income-older-adults-an-overview/.

95. *See Money Follows the Person*, *supra* note 88.

96. *See Health Care Reform and Low-Income Older Adults: An Overview*, *supra* note 94.

97. *See Money Follows the Person*, *supra* note 88.

98. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 2404 (2010) amending the Deficit Reduction Act of 2005 § 6071(h). *See also*, Medicare Catastrophic Coverage Act of 1988, 42 U.S.C.A. § 1369r-5 (West 2008).

99. *Medicare and the New Health Care Law - What It Means for You: A Message from Kathleen Sebelius, Secretary of Health & Human Services*, MEDICARE, Centers for Medicare and Medicaid Services, ADMINISTRATION ON AGING, (May 2010), *available at* http://www.aoa.gov/Aging_Statistics /doc/medicare_English.pdf.

100. 42 U.S.C.A. § 1396(a) (West 2010); Patient Protection and Affordable Care Act, 124 Stat. 119 at 2404.

101. *See Health Care Reform and Low-Income Older Adults: An Overview*, *supra* note 94.

102. *See Paying for Nursing Home Care-Protecting Assets*, THE ELDER LAW FIRM OF ROBERT CLOFINE (Jan. 17, 2010), http://www.estateattorney.com/elderlaw-articles/nursingcare-assetprotection .html.

103. *See id.*

B. New Options Under the PPACA

The Act creates a new Medicaid benefit beginning in October 2011 named the Community-Based Attendant Service Option.[104] However, the benefit will vary from state to state.[105] States that choose to make the benefit part of their state's Medicaid plan will receive a six percent increase in federal Medicaid reimbursements.[106] The option allows individuals with an institutional level of need for care to remain in their homes or another community-based setting instead of a nursing home.[107] Also, if a state opts for the program, the PPACA allows states to extend the new Medicaid benefit to people with higher incomes.[108]

Beginning in October 2011, another new option is the Community First Choice (CFC) option.[109] The CFC option covers home and community based services (HCBS) for individuals who require an institutional level of care.[110] States must meet a number of requirements to participate in the program.[111] First, if a state chooses to participate in this program, "[t]he State shall make available home and community-based attendant services . . . under a person-centered plan of services and supports that is based on an assessment of functional need . . . ."[112] Second, states must maintain or exceed expenditures for HCBS during the first full year the program is implemented.[113] Third, states must offer the services state-wide without requiring individuals to sit on a waiting list.[114] Under the CFC program, the beneficiary or the beneficiary's representative would be allowed to reasonably control the amount of assistance needed and even appoint their own caregiver–-possibly a family member who is qualified.[115] Hence, funding from the CFC program would assist families providing "informal care," which consists of approximately 80% of all care provided to the elderly.[116]

The program would provide assistance to the elderly "in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks . . . ."[117] The CFC offers the following

104. *See Health Care Reform and Low-Income Older Adults: An Overview*, *supra* note 94.
105. *See id.*
106. *See id.*
107. *See id.*
108. *See* NATHER, *supra* note 28, at 139.
109. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2401, 124 Stat. 297 (2010).
110. *See Money Follows the Person*, *supra* note 88.
111. Patient Protection and Affordable Care Act § 2401.
112. *Id.*
113. *See Money Follows the Person*, *supra* note 88.
114. *See id.*
115. Patient Protection and Affordable Care Act § 2401.
116. *See Caring Today, Planning for Tomorrow*, *supra* note 81.
117. Patient Protection and Affordable Care Act § 2401.

benefits, training to acquire and enhance the skills necessary for independent daily living, beepers or other electronic devices for care or to use during an emergency, and optional training on how to manage and dismiss caregivers.[118] Because of the prevalence of informal care by a relative, the CFC would provide useful benefits by giving the individual autonomy over his or her caregiver.[119] Thus, the Act provides needed assistance to related caregivers and other trusted nursing aides to continue to treat the elderly by alleviating the financial burdens associated with informal care.[120]

Another incentive created by the Act is the "Balancing Incentive Payment Program" that provides additional funds to the states that "commit to shift more of their Medicaid Long-Term Services and Support spending toward noninstitutionalized [sic] care."[121] The grant will vary from state to state based on the state's spending for institutionalized verses non-institutionalized care.[122] The Act grants the Secretary of Health and Human Services broad discretion to enact different criteria for HCBS.[123] With aggressive use of the MFP program, a state could reduce its Medicaid reimbursements to nursing homes and potentially receive a double windfall from the Balancing Incentive Payment Program.[124]

C. The "Community Living Assistance Services and Supports" Insurance Program

Although not a part of Medicaid or Medicare, the "Community Living Assistance Services and Supports" (CLASS) is a new insurance program that supplements the costs of long-term care.[125] In 2011, individuals will begin to participate in this voluntary insurance program.[126] The individual or the individual's spouse must be employed and pay into the system for

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118. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2401, 124 Stat. 119 (2010). However, room and board and home modifications are not a covered cost. *Id.*

119. *See generally id.*

120. *See id.*

121. Morgan, *supra* note 8. *See Money Follows the Person*, *supra* note 88. "The Balancing Incentive Payments Program provides a five-year grant to states that spent less than 50 percent of their Medicaid LTC dollars on non-institutional services and supports." *Health Care Reform Improves Access to Medicaid Home and Community-Based Services*, AARP, http://www.aarp.org/health/health-care-reform/info-06-2010/FS-192.html (last visited Oct. 31, 2011).

122. *See Money Follows the Person*, *supra* note 88.

123. *See id.*

124. *See id.*

125. Morgan, *supra* note 8.

126. Kate Pickert, *Should Long-Term Care Insurance Be Part of Health Reform?*, TIME MAGAZINE, Dec. 8, 2009, *available at* http://www.time.com/time/politics/article/0,8599,1946431,00.html. *See* Morgan, *supra* note 8 (stating that the CLASS program will likely take longer to implement and enrollment may not start until after January 2011).

five years before receiving any benefits.[127] Individuals could begin receiving benefits from the CLASS program as early as 2016.[128]

Once an individual becomes eligible, he or she could receive fifty dollars per day or more.[129] Unlike current Medicare and Medicaid benefits, which in effect forces the elderly to go to a nursing home or forgo care altogether, this insurance program provides seniors with more options on how to allocate the benefits.[130] For example, "[t]he cash benefits could be applied to nursing-home care, but in an effort to encourage enrollees to stay in their own homes, payouts could cover such things as wheelchair ramps and wages for home health care aides."[131] Also, a beneficiary could apply her CLASS benefits toward legal fees for creating a durable power of attorney for health care or a living will.[132] Although the amount of the premiums is unknown, premiums could be as high as $180 per month.[133] The program, however, will not cover the full cost of health care expenses.[134] The best way to utilize the program is as a way to offset some expenses, and an additional private insurance policy may be needed.[135] Hence, the decision to purchase CLASS insurance should encompass the cost of the premiums and the likelihood that an individual will require long-term care, plus additional costs not covered by the insurance versus the uninsured cost of long-term care without CLASS.[136]

Because only 8 million individuals have long-term care insurance and private long-term care insurers are reducing or rethinking sales of long-term care insurance, elder law attorneys should be cognizant of this alternative insurance option for their clients.[137]

Unlike private long-term care insurance, CLASS does not have medical insurability requirements, a lifetime limit, or a medical history examination.[138] Therefore, anyone, even someone with preexisting medical

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127. *See id*.

128. *See id.*; *Health Care Reform and the CLASS Act*, KAISER FAMILY FOUND. (Apr. 2010), http://www.kff.org/healthreform/8069.cfm (stating that CLASS payments are not expected to start until 2017).

129. *See* Pickert, *supra* note 126.

130. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 8002(a)(1), 124 Stat. at 837–38 (to be codified at 42 U.S.C. § 300*ll*-4(c)(1)(B) (final sentence)). *See also* Fox, *supra* note 13.

131. Pickert, *supra* note 126.

132. Patient Protection and Affordable Care Act, § 8002(a)(1).

133. *See* Pickert, *supra* note 126.

134. *See* NATHER, *supra* note 28, at 123.

135. *See id*.

136. Gallant, *supra* note 12.

137. Jilian Mincer & Annie Gasparro, *News for Brokers, Wealth Managers and Their Clients*, WALL ST. J., Nov. 1, 2010, *available at* http://online.http://online.wsj.com/article/SB10001424052748704300604575554620832164134.html. *See* Morgan, *supra* note 8.

138. Kaplan, *supra* note 61, at 233.

problems, may qualify for CLASS insurance, unlike the restrictive luxury insurance programs offered on the private market.[139]

Each of the aforementioned programs is centered on improving quality by providing more options while simultaneously reducing costs. Pursuant to the Act, quality of care will improve with collaboration from a Development and Implementation Counsel established by each state that is composed of a majority of elderly individuals and other beneficiaries that can voice their suggestions and opinions.[140] The strategy to accomplish these goals focuses on better coordination between the different departments of government with the input from the beneficiaries using the programs.[141]

V. PPACA'S EFFECT ON THE TAX CODE

The Act also amended several portions of the Internal Revenue Code, which will foster cooperation and coordination between the Service and other departments of government. Additionally, the Act will raise taxes for some high-income earners; however, only a few of the tax provisions specifically apply to the elderly.[142] For example, section 2002 of the PPACA requires states to use modified adjusted gross income (AGI) to determine whether an individual qualifies for Medicaid.[143] This provision will significantly reduce the administrative burden for some applicants; however, the Act prohibits states from using AGI for persons over sixty-five to determine eligibility for Medicaid or long-term care nursing homes.[144]

Beginning in 2013, "[t]he Reconciliation Act amendments [will introduce] a new 3.8-percent 'unearned income Medicare contribution' on income from interest, dividends, annuities, and other non-earnings sources for individual taxpayers with incomes above $200,000 and couples filing joint returns with incomes above $250,000."[145] However, the title "unearned income Medicare contribution" is a misnomer, because monies

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139. *Id.* at 234.

140. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2401, 124 Stat. 119 (2010).

141. *Id.*

142. *See* Morgan, *supra* note 8.

143. Patient Protection and Affordable Care Act § 2002. *See* Jost, *supra* note 86.

144. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119; H.R. Res. 3590, 111th Cong. (2010) (enacted), "(iv) Long-Term Care. Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services . . . ." Patient Protection and Affordable Care Act § 2002.

145. Memorandum from the Chief Actuary, Dep't of Health and Human Servs., Centers from the Medicare and Medicaid Service, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended 1, 9 (Apr. 22, 2010), *available at* https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

generated by the tax do not go into the Medicare trust.[146] Also effective for the 2013 taxable year, the minimum deduction allowed for medical expenses will rise from 7.5% to 10%.[147] While not specifically directed at seniors, the deduction allows seniors to owe less tax relative to the general population because seniors have a smaller fixed income and a higher portion of that income goes to medical treatments, prescriptions, and health care.[148]

As stated in the PPACA, after ten years Medicare Part D—the program that provides prescription drug plans for seniors—will no longer have a gap in coverage.[149] In 2010, the Act slowly phases out the gap (also known as the "doughnut hole").[150] Medicare Part D beneficiaries cite the "doughnut hole" as the biggest drawback of the program.[151] A beneficiary falls in the gap if the total cost of his prescription drugs reaches over $2,840 in 2011.[152] The total cost "includes the amount you've [sic] spent yourself—your deductible, if your Part D plan has one, and copayments—and the amount your plan has contributed."[153] After spending $2,840, the beneficiary would be responsible for 100% of the cost of the drugs in the gap, and Medicare would only reimburse the additional cost when the beneficiary spends over $4,550 (in 2010).[154] Once the beneficiary spends a certain amount, he or she "get[s] out of the gap and qualif[ies] for low-cost catastrophic coverage until the end of the year."[155]

Pursuant to the PPACA, a Medicare Part D beneficiary who reached the gap in 2010 automatically received a one-time, tax-free $250 rebate check.[156] Over the next ten years additional provisions in the PPACA will go into force to gradually remove the gap in coverage, which will close in 2020.[157] In 2011, the Act requires drug manufacturers to reduce the cost of brand-name and biologic drugs by 50%.[158] Before the enactment of the PPACA, seniors in the coverage gap were responsible for 100% of the cost

146. *Id.*

147. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9013, 124 Stat. 119 (2010), *amending* I.R.C. §§ 213, 56 (West 2010). For example, under the 7.5% floor, a senior with an AGI of $50,000 with $20,000 in medical expenses could deduct $16,250. *See id.* In 2013, a senior with the same AGI and amount of medical expenses could only deduct $15,000. *See id*.

148. *See* O'Brien, *supra* note 29, at 3.

149. *See* Morgan, *supra* note 8.

150. *Id.*

151. Patricia Barry, *Paying Less for Drugs in the Part D 'Doughnut Hole'*, AARP (Jan. 13, 2011), http://www.aarp.org/health/medicare-insurance/info-01-2011/ask_ms_medicare_question_92.html.

152. *See id*.

153. *See id*.

154. *See id*.

155. *Id.*

156. *See* Morgan, *supra* note 8.

157. *See id*.

158. *See id*.

of generic prescriptions.[159] Today, with the help of a government subsidy, seniors will "receive a 7[%] discount on generic drugs.[160] Over the next [ten] years these discounts will get larger," and by 2020 a Part D beneficiary "will pay no more than 25[%] of the cost of any Part D" prescriptions in the coverage gap.[161] Even though higher-income beneficiaries already pay a higher premium for their Medicare coverage, in 2011 these individuals will also pay higher Part D premiums.[162]

Upper-income beneficiaries will pay more—or receive a reduced government subsidy—for Part D coverage based on "means-testing Medicare . . . ."[163] Individual premiums are determined by computing the person's AGI from the second preceding calendar year.[164] For example, a beneficiary's 2015 premium is based on his AGI from 2013. The Act, however, freezes the applicable dollar parameters that qualify a person for additional premiums for ten years, which could require even more beneficiaries to pay higher costs than expected.[165]

As noted above, the CLASS Act is not part of Medicare or Medicaid. If an individual chooses to participate in the CLASS Act, their employer will deduct the premiums from the employee's paycheck.[166] The employer will automatically enroll his employees in the program, but employers must provide employees an opportunity to opt out.[167] The CLASS program also requires older employees to contribute higher premiums than younger employees.[168] Congress intends that the CLASS Act will pay for itself, but critics think the program will become just another expensive government entitlement.[169] However, the Act explicitly restricts taxpayer funds from going towards CLASS benefits.[170] A trust fund consisting of employees' premiums and the interest earned on the trust will provide funding for CLASS benefits.[171] Even though the insurance will cover higher risk

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159. *See* Barry, *supra* note 151.

160. *See id.*

161. *See id.*

162. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3308(a)(1), 124 Stat. 119, 472–73 (2010) (codified at 42 U.S.C. § 1395w-113(a)(7)).

163. Kaplan, *supra* note 61, at 227.

164. 42 U.S.C. § 1395r(i)(4)(A)(i), (ii) (2006); 42 U.S.C. § 1395r(i)(4)(B)(i) (2006).

165. Patient Protection and Affordable Care Act, § 3402(4), 124 Stat. at 489 (to be codified at 42 U.S.C. § 1395r(i)(6)). *See also* Kaplan, *supra* note 61, at 227.

166. *See* NATHER, *supra* note 28, at 131.

167. *See id.*

168. *See Health Care Reform and the CLASS Act*, *supra* note 128.

169. *See* NATHER, *supra* note 28, at 132. *See also Health Care Reform and the CLASS Act*, *supra* note 128 ("The CBO estimates that the CLASS Act will reduce the federal deficit by $70.2 billion over the course of a ten year period. These estimates are based on an average monthly premium of $123 and a cash daily benefit of $75 for life, with no underwriting.").

170. *See Health Care Reform and the CLASS Act*, *supra* note 128.

171. *See id.*

groups without linking premiums to existing health problems, the Act expressly prohibits additional federal monies for the CLASS program.[172]

Increased costs will adversely affect relatively few Medicare and Medicaid beneficiaries.[173] Moreover, closing the doughnut hole benefits the integrity of the Medicare program overall.[174] Nonetheless, Congress, by raising the floor on the medical expense deduction to ten percent, backhandedly raised taxes on seniors who spend the most on prescription drugs.[175]

VI. POSSIBLE STATE APPROACHES TO COMPLY WITH THE PPACA

Implementing systems that will streamline the healthcare industry is a foundational plank of the PPACA.[176] Instead of an eligible individual foregoing benefits because she is unaware the benefits exist or that she qualifies, "the intended enrollment facilitation under the PPACA—i.e., that the Health Benefits Exchanges help people determine which insurance plans are available and identify whether individuals qualify for Medicaid coverage, premium subsidies, etc.—would result in a high percentage of eligible persons becoming enrolled in Medicaid."[177] The government projects that enrollment facilitation will notify at least fifteen million people of their eligibility and benefits, and enroll them in a program by 2014.[178]

Since not all states have the same health care policy goals, states may decide to operate an insurance exchange rather than use an exchange operated by the federal government.[179] "A critical feature of PPACA's exchange provisions is that a state can either (a) permit all qualified plans to offer coverage or (b) exclude qualified plans based on the state's view of the best interests of individuals and firms using the exchange."[180] Under a state program, the individual state has control over health plan choices and eligibility requirements, which a state can lower to include more of its

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172. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. 845 (to be codified at 42 U.S.C. § 300*ll*-7(a)).

173. *See* Kaplan, *supra* note 61, at 227.

174. *See* Barry, *supra* note 151.

175. *See* The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9013, 124 Stat. 119 (Mar. 23, 2010), *amending* I.R.C. § 213 (West 2005).

176. *See Western Maryland Health System Sponsoring Dell/eClinicalWorks EMR Solution for Physicians to Improve Quality and Efficiency of Patient Care*, WALL ST. J. (Sept. 29, 2010, 7:30 PM), http://in.reuters.com/article/2010/09/29/idUS145603+29-Sep-2010+BW20100929 [hereinafter *EMR*].

177. Foster, *supra* note 66, at 6.

178. *See id.*

179. Stan Dorn, *State Implementation of National Health Reform: Harnessing State Resources to Meet State Policy Goals*, THE URBAN INST., at 3 (July 2010), *available at* http://www.rwjf.org/files/research/66488.pdf.

180. *Id.*

residents.[181] For example, section 1332 of the PPACA provides a waiver for state innovation.[182] In the exchange, a consumer can choose an individual health insurance plan that best suits their needs.[183]

Moreover, state policy makers seeking to cover all individuals that are eligible and to provide more care "can take advantage of PPACA's new options to establish eligibility for Medicaid . . . ."[184] The new options will reduce a state's administrative costs while allowing more uninsured people to receive health care.[185] Also, the PPACA requires states to have a single application form "for all three need-based health-coverage programs—Medicaid, CHIP, and subsidies in the exchange."[186] In addition to a single form, a state must implement data-matching systems that would allow all health agencies to use the form to determine eligibility for Medicaid.[187] Therefore, streamlining the healthcare system with one form for multiple programs and data-matching systems would further states' policy goals of caring for the elderly.

For example, Massachusetts implemented a data matching system and a public education campaign in 2006.[188] Less than two years after its introduction, the state insured more than ninety-seven percent of its residents.[189] During President Obama's campaign, his advisors studied the Massachusetts system, and the PPACA attempts to replicate parts of the Massachusetts system in the rest of the country.[190] In Massachusetts, a single statewide office determines eligibility for all programs "on a computerized, logic-driven decision tree, rather than the state's previous, traditional approach, which required local public welfare staff to manually determine each applicant's eligibility case-by-case."[191] In other states, applicants filled out form after form with each health agency until they found a program that they qualified for.[192] Under the well-integrated

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181. See id.

182. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1332, 124 Stat. 119 (2010).

183. *See* Dorn, *supra* note 179, at 9 (noting that "[c]onsumers pay all of the increased premiums when a more expensive plan is selected, thus furnishing an incentive for cost-conscious choice of coverage").

184. *Id.*

185. *See id.*

186. *See id.*

187. *See id.* at 10 ("These systems also gather information from a broad range of external sources to establish and to confirm eligibility, including the data currently used to verify income eligibility for Medicaid, federal income tax data, and information from eligibility files of need-based public benefit programs.").

188. *See id.* at 11.

189. Stan Dorn, J.D., Ian Hill, M.P.A., M.S.W. & Sara Hogan, M.H.S., *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, THE URBAN INSTITUTE, ii (Nov. 2009), http://www.rwjf.org/files/research/51368fullreport.pdf.

190. *See* NATHER, *supra* note 28, at 73.

191. *See* Dorn, Hill, & Hogan, *supra* note 189, at 5.

192. *See id.* at 9.

Massachusetts system, an applicant completes less paperwork while applying for more programs.[193]

Although many individuals are hesitant about having all their medical records stored on a computer, Electronic Medical Records (EMR) would save lives, improve care, reduce costs, and streamline the administration of the health care system. The American Recovery and Reinvestment Act (ARRA) provides incentives including financial plans and bonus payments to health care providers who adopt EMR from 2011 to 2015.[194] Additionally, under the ARRA, providers may qualify for financing to switch to EMR.[195] Once EMR are widely available, hospitals and nursing facilities can better coordinate care and quickly prepare individualized intake procedures for hospital patients transitioning to the nursing facility.

Furthermore, the Act mandates stringent disclosures by nursing home operators.[196] The most important aspect of nursing home care is simply finding the *right* nursing home. The Act requires that nursing home facilities provide specific information: ownership of the facilities and direct and indirect ownership interests; organizational structure; data on staffing turnover and retention; and "[s]ummary information on the number, type, severity, and outcome of substantiated complaints."[197] The Secretary of Health and Human Services compiles this vital information in the "Nursing Home Compare" feature on Medicare's website, and each state must provide information on its websites regarding the certification of facilities.[198]

Because the drafters of the Act were conscientious in accounting for the technological skills of the website's users, a person with any amount of computer skill can easily navigate the site and quickly compare several different nursing homes' statistics side-by-side.[199] Even though states are afforded wide discretion in implementing their own health-care systems, the Act requires enrollment facilitation and the development of standardized

193. *See id.* at 5.

194. *EMR*, *supra* note 176.

195. See id.

196. Patient Protection and Affordable Care Act, § 6101, 124 Stat. 119. *See also*, Kaplan, *supra* note 61, at 235 (stating that "[t]he principal contribution of Obama Care is expanding the quantity of information about such facilities that is available to Medicare beneficiaries").

197. Patient Protection and Affordable Care Act, § 6101-03, 124 Stat. 119 (to be codified at 42 U.S.C. § 1395i-3(i)(1)(A)(iv)).

198. *See Nursing Home Compare*, MEDICARE, http://www.medicare.gov (place cursor over the "Resource Locator" link and select "Nursing Homes" from the pull-down menu) (last visited Oct. 15, 2010). *See* Patient Protection and Affordable Care Act, § 6103(a), 124 Stat. 119 (to be codified at 42 U.S.C. § 1395i-3(i)(1)(A)(v)(III)) (requiring the site to provide the information to the user "in a manner that is prominent . . . easily accessible, [and] readily understandable to consumers of long-term care services . . .").

199. *But cf.* Kaplan, *supra* note 61, at 236 (stating that the information "often is not sufficiently standardized to enable a prospective resident to easily evaluate potential residential facilities").

forms.[200] Thus, states have the framework to streamline and simplify the Medicaid assisted nursing-home application process for individuals in Dorothy's position.

VII. CONCLUSION

Millions of families like that of Dorothy know the financial, physical, and emotional burdens of caring for relatives that need intensive care—a World War II veteran with Alzheimer's disease, a great-grandmother paralyzed from a fall, or even a spouse with Lou Gehrig's disease to name a few. Under the antiquated health care system, Medicare has stagnated since its inception in 1965 by providing too many one-size-fits-all benefits rather than innovative care programs.[201] Until recently, Congress had accomplished little to alleviate these burdens for the elderly and their loved ones.[202] In the future, the enrollment and application process to select different benefits may be drastically simpler, and the states may have the necessary framework to coordinate care and create innovative strategies to evolve the health care system.[203]

In Texas, to qualify for Medicaid benefits for nursing home costs, the applicant must meet several requirements.[204] However, some of the application information is duplicative and unnecessary. For example, the IRS could provide information for the Income Requirement to the state without the input of the applicant. However, the Act provides this shortcut for the nonelderly by using AGI.[205] Notably, the group of people that should have the least paperwork burden does not have this eligibility shortcut.

Additionally, an applicant must have a Medical Necessity.[206] A well-coordinated state health care program could use EMR from the hospital to alert the state Department of Health and Human Services about potential nursing home patients. Rather than requiring a family member to obtain the necessary documents from the primary physician of the applicant, the hospital could forward the diagnosis requiring long-term care to the state. While the AGI shortcut to eligibility expressly excludes the elderly, other techniques are available to reduce some of the paperwork burden.[207]

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200. Patient Protection and Affordable Care Act, § 2201, 124 Stat. 119 (to be codified at 42 U.S.C. § 1396W-3). *See also*, Patient Protection and Affordable Care Act, § 6103(a), 124 Stat. 119 (to be codified at 42 U.S.C. § 1395i-3(i)(1)(A)(v)(III)).

201. *See supra* Introduction.

202. *See supra* Introduction.

203. *See supra* Part VI.

204. *See supra* Part III.

205. Patient Protection and Affordable Care Act, § 2002, 124 Stat. 119.

206. *See supra* Part III.

207. *See supra* Part VI.

A problem with requiring Medicare providers to streamline processes across the board is the fact that some providers will not be capable of doing so.[208] Health care services, especially nursing home care, are very labor-intensive relative to manufacturing or other services sectors of the economy.[209] Therefore, a comparison to the economy as a whole could provide an unrealistic benchmark for the industry.[210] This creates the risk for the health-care industry that "some of them might just stop seeing Medicare patients altogether."[211] Thus, if providers leave the system, the elderly would not have as many care options as before the reform even with the legislative focus on improved access to benefits.[212]

Increased options and better access to care are the solutions that people like Dorothy wanted.[213] Succinctly, Dorothy wants to go back to her home.[214] Given the budgetary cuts to Medicare and Medicaid, informal care for someone like Dorothy would cost a fraction of the cost of her nursing home stay. With the MFP program, Community-Based Attendant Service Option, Balancing Incentive Payment Program, and the CLASS program, there is no viable reason why someone like Dorothy or anyone in a nursing home with a low level of need for care should not be able to return home.

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208. *See* NATHER, *supra* note 28, at 123.
209. *See* Foster, *supra* note 66, at 9.
210. *See id.*
211. *See* NATHER, *supra* note 28, at 115.
212. *See supra* Part IV.
213. *See supra* Introduction.
214. *See supra* Introduction.