

Elder Law Year in Review July 2010

Legislative and Regulatory Update

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1. Recent Federal Laws Enacted

1.1. Health Care Reform

1.1.1. Overview

The biggest news of the past year was the enactment of health care reform legislation. The legislation was passed in two stages: the “[Patient Protection and Affordable Care Act](#)”¹ and the “[Health Care and Education Reconciliation Act of 2010](#).”² In order to simplify the following discussion, the provisions resulting from these separate enactments will be referred to jointly as provisions of the Affordable Care Act (or “ACA”).

Although many seniors were frightened by the often disingenuous political debate surrounding the reform legislation, the law includes many provisions of benefit to older Americans. Some of

1 P.L. 111-148 (March 23, 2010).

2 P.L. 111-152 (March 30, 2010). A summary of the changes made to the Affordable Care Act by the Reconciliation Act is available at the following link: <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>. A compilation of the two Acts is available at <http://docs.house.gov/energycommerce/ppacacon.pdf>.

these provisions will take effect within the first year, while others will be phased in over longer periods.

Among the early changes of significance to older adults are:

1. **States are barred from imposing new eligibility barriers for Medicaid.** So-called “maintenance-of-effort” (MOE) provisions in the new law prohibit states from making it more difficult for people to become eligible for Medicaid. These MOE requirements will apply until the major components of health reform go into effect on January 1, 2014. They will help assure that budget-strapped states do not try to save money by imposing new eligibility limitations on Medicaid.
2. **Provisions to close the Medicare prescription drug donut hole.** A \$250 rebate will be paid to Medicare beneficiaries who hit the donut hole in 2010. In 2011 there will be a 50% discount on brand-name drugs in the donut hole. The donut hole is to be completely eliminated by 2020.
3. **Expanded coverage of preventive care under Medicare.** Effective January 1, 2011, co-payments for many preventive services are eliminated and preventive services are exempted from deductibles under the Medicare program.
4. **Help for Some Early Retirees.** The law creates a temporary re-insurance program (until health insurance exchanges become available) to help offset the costs of health claims for employers that provide health benefits for retirees age 55-64. This provision is already effective.
5. **Health plans may not drop people from coverage when they get sick** (effective 6 months after enactment – Sept 23, 2010). Faced with this upcoming mandate, many health plans have already agreed to end the practice of rescinding coverage.
6. **Health plans are prohibited from placing lifetime limits on coverage and are restricted in the use of annual limits that impede access to needed care** (effective 6 months after enactment). In 2014, the use of any annual limits will be prohibited.

The ACA is far-reaching legislation that will change how millions of Pennsylvanians access and pay for their health care coverage. The law includes provisions expanding Medicaid eligibility, providing incentives and mandates for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, supporting medical research, and encouraging coordinated care and an increase in primary care physicians.

Included in the new law are extensive changes to the Medicare and Medicaid programs that will touch almost all seniors. It will take years for the ramifications of the ACA to be fully felt.

White House summaries of the Key Elements of Health Reform:³

- [Title I: Quality, Affordable Health Care for All Americans](#)
- [Title II: The Role of Public Programs](#)
- [Title III: Improving the Quality and Efficiency of Health Care](#)
- [Title IV: Prevention of Chronic Disease and Improving Public Health](#)
- [Title V: Health Care Workforce](#)
- [Title VI: Transparency and Program Integrity](#)

³ <http://www.whitehouse.gov/health-care-meeting/proposal>

- [Title VII: Improving Access to Innovative Medical Therapies](#)
- [Title VIII: Community Living Assistance Services and Supports Act \(CLASS Act\)](#)
- [Title IX: Revenue Provisions](#)
- [Title X: Reauthorization of the Indian Health Care Improvement Act](#)

While seniors, as the biggest users of health care, will be dramatically affected by the new law, the impact on younger Americans may be even more significant. The ACA's signature and most controversial provisions seek to achieve near universal health insurance coverage beginning in 2014.⁴

While the ACA represents the beginning of a massive reformation of the American Health Care system it pretty much retains our current private structure of health care financing and delivery. America's has the most privatized health care system in the developed world. It is also the most expensive. The multi-trillion dollar question is whether reform can be implemented in a fashion that makes our health system more responsive to cost and quality concerns while maintaining its privatized free market based design. The ultimate success or failure of the ACA is largely dependent on whether the law will help the US bring its health care costs under better control.

The following materials are limited to a brief summary of just a few of the provisions of the law that are of particular significance to seniors.⁵

1.1.2. **Medicare Impacts**⁶

1.1.2.1. **Closing the Donut Hole- Reforms to Medicare Prescription Drug (Part D) Benefit**

Medicare Part D provides prescription drug benefits to Americans on Medicare. This benefit comes with a \$310 deductible. In 2010, after the beneficiary has spent \$310, he pays 25 percent

4 The ACA imposes an individual mandate requiring most U.S. citizens and legal residents to have health insurance coverage or pay a penalty. There are exceptions to this requirement for financial hardship, religious objections, those without coverage for less than three months, certain low-income individuals, and others. Beginning January 1, 2014, a penalty for not having coverage will be phased in over three years and will be calculated based on a specified percentage of a person's taxable income. Shortly after the Act was signed into law on March 23, thirteen states, including Pennsylvania, filed a lawsuit challenging the law. A copy of the complaint is available at [http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/\\$file/HealthCareReformLawsuit.pdf](http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/$file/HealthCareReformLawsuit.pdf). See "Health Care Reform Law is unconstitutional" by Pennsylvania Attorney General Tom Corbett, <http://www.attorneygeneral.gov/press.aspx?id=5202>.

5 For a general summary of the law see, <http://www.kff.org/healthreform/8061.cfm>

6 Materials in this Section are drawn largely from the following sources: "The Patient Protection and Affordable Care Act, Section-by-Section Analysis with Changes Made by Title X and Reconciliation included within Titles I – IX" <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>; U.S. House of Representatives Energy and Commerce Committee, http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1931:health-care-reform&catid=169:legislation&Itemid=55; [Summary of Key Changes to Medicare in 2010 Health Reform Law](#). Kaiser Family Foundation, May, 2010, <http://www.kff.org/healthreform/upload/7948-02.pdf>; [Health Care Reform and Low-Income Older Adults: An Overview](#), National Senior Citizens Law Center, April 2010, http://www.nslc.org/areas/medicare-part-d/health-reform-overview/at_download/attachment; Medicare Rights Center, [Health Reform and Medicare](#), <http://www.medicarerights.org/issues-actions/health-reform-and-medicare.php>; CMS, [Medicare and the New Health Care Law — What it Means for You](#), <http://www.medicare.gov/Publications/Pubs/pdf/11467.pdf>; and the CMS Health Reform website, www.healthreform.gov.

of the cost of prescriptions until the total cost of all the covered medicine hits \$2,830. (The \$2,830 represents the total cost of the medication including the amount paid by insurance, not just the amount the Medicare beneficiary pays.)

At that point, the beneficiary is stuck with 100 percent of the bill until the total cost of medicines hits the catastrophic threshold of \$6,440.⁷ This coverage gap is known as the “donut hole.” In 2010 the donut hole totals \$3,610 in drug costs that have to be paid solely by the beneficiary. Without reform, congressional estimates projected the gap would have risen from \$3,610 this year to \$6,000 by 2019.

The ACA phases in the elimination of the donut hole. In 2010, enrollees who hit the donut hole will receive a \$250 rebate from the government. That check will be sent directly to the beneficiary from Medicare. Your clients should note that there is no application process and no private company can be involved in getting them their rebate check. If anyone tries to charge them for help in getting their rebate, it is a scam.

The rebate checks started going out in June to individuals who hit the donut hole earlier this year. The checks will continue to be sent out on a rolling basis over the remainder of the year as people hit the coverage gap. Checks will be sent to the beneficiary’s mailbox. Overall, it is anticipated that some 4 million seniors and disabled people will get checks this year.

Low income Medicare beneficiaries who get “extra help” through the low income subsidy program and are not subject to the donut hole will not receive a rebate check. However, PACE/PACNET members are eligible for rebates so long as they don’t receive a low income subsidy. Consumers can make sure Social Security has their correct home mailing address by calling 1-800-772-1213.

The 2010 rebate is only the first step toward closing the Medicare prescription drug coverage gap. Beginning in 2011, enrollees who hit the donut hole will receive a 50 percent discount on brand-name drugs and a phase in of Medicare coverage in the gap for generic drugs begins. Partial donut hole coverage for brand-name drugs begins in 2013. By 2020, Part D enrollees will be responsible for only the standard 25 percent of the cost of both brand name drugs and generics until they reach the catastrophic limit where their co-pay is dramatically reduced.

For further information on closing the donut hole: “Health Reform and Medicare: Closing the Doughnut Hole,” Medicare Rights Center, <http://www.medicarerights.org/pdf/Closing-the-Doughnut-Hole-Chart.pdf>

Eventually Part D co-payments will be eliminated for individuals receiving Medicaid funded home and community based services. The ACA also makes a number of changes in regard to dual-eligibles and the low income subsidy programs

1.1.2.2 Changes to Medicare Advantage Plans

Most Medicare beneficiaries must choose between two distinct paths for coverage: traditional

⁷ Thus, an enrollee reaches the catastrophic threshold once they have paid \$4,550 in out of pocket costs. <http://www.medicare.gov/Publications/Pubs/pdf/11213.pdf>

(original) fee-for-service Medicare, or a federally subsidized private Medicare Advantage (MA) plan. MA plans typically operate like HMO or PPO managed care plans by placing some limitations on the beneficiary's access to health care providers.

The political philosophy underlying the Medicare Modernization Act of 2003 was to encourage enrollees to shift from traditional public Medicare to private MA Plans. To accomplish this political goal, the government began paying MA plans a premium over what beneficiaries would cost if they had remained in the original Medicare program. Medicare currently pays Medicare Advantage plans an average of 13% more than the cost would be if the same beneficiaries were enrolled in traditional Medicare. These extra payments averaged \$1,138 per plan enrollee in 2009.⁸ This financial advantage allows Advantage Plans to cover their higher administrative costs and still be able to offer enrollees attractive extra benefits, such as health club memberships, not included in traditional Medicare.

The Affordable Care Act will eventually return the two Medicare pathways to a more level competition by reducing most of the excess reimbursements currently paid to Advantage Plans. Over the next several years the extra payments to MA plans will be reduced until the average differential is reduced to 1%. Actual payments to individual MA plans will vary depending on Medicare costs in the geographic location and the plan's performance ratings.

Like many of the ACA provisions, the MA plan cuts and other changes will be phased in over time. In 2010, no cuts will be made. In 2011, payments will be frozen at current levels. Starting in 2012, the cuts will phase in over two to six years.

MA plans that rate well on certain quality measures will receive bonuses. (MA plan ratings are available on the Medicare.gov website under "Find & Compare Health Plans.") Plans receiving 4 to 5 stars will be rewarded with bonus payments of 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later years. The Affordable Care Act also requires the suspension of MA plan enrollment for 3 years if a plan's medical loss ratio is less than 85% for 2 consecutive years and the termination of the plan contract if the medical loss ratio is less than 85% for 5 consecutive years (effective beginning in 2011).

The Congressional Budget Office has estimated that the MA plan changes will reduce Medicare payments by \$132 billion over the next 10 years. This reduction in payments has raised concerns that MA plans may reduce benefits, raise premiums, or both. However, MA plans must provide mandated benefits. This means that any benefit reductions due to the payment cuts can only be made to extra, optional benefits such as health club memberships, vision and dental.

A report by Kaiser Health News found that there is some truth to concerns that MA plans will reduce benefits and raise premiums. It recommends that MA enrollees stick with an Advantage plan that's been around for at least five years and, if available, earns four or five stars from the government.

1.1.2.3

Creation of Independent Advisory Board

⁸ Biles and Arnold, [Medicare Advantage Payment Provisions: Health Care and Education Affordability Reconciliation Act of 2010 HR 4872](#), George Washington University School of Public Health, April 2010,

The ACA establishes an Independent Payment Advisory Board which is tasked with recommending ways to reduce Medicare spending if Medicare per capita growth rates exceed targets. Beginning in 2014, The Secretary of HHS is required to implement the Board's recommendations unless Congress enacts alternative proposals that achieve the same level of savings. The Board is prohibited from recommending changes that would ration care or modify premiums or benefits. Congress is required to reexamine the board in 2017 and will have the option to terminate it.

1.1.2.4 Free Prevention Services

Medicare already provides some coverage for a number of preventive services. The coverage is usually subject to some form of beneficiary cost sharing. Starting January 1, 2011, beneficiaries will have access to the same preventive services as previously provided by Medicare but with no cost sharing for most. The health reform law specifies that any Medicare-covered service recommended with a grade A or B by the [United States Preventive Services Task Force](#) will be free from cost sharing.

Also beginning on January 1, 2011, Medicare will cover an annual wellness visit and accompanying personalized prevention plan for all beneficiaries. (This is in addition to the current one time wellness visit provided within 12 months of a beneficiary signing up for Part B services.) Personalized prevention plan services means the creation of an individual health plan that includes a health risk assessment and may include other elements, such as updating family history, listing providers that regularly provide medical care to the individuals, body mass index measurement, and screenings for other risk factors. The Part B deductible, 20 percent physician copayment, and applicable hospital copayment (if you have the test at a hospital or a hospital-owned clinic) will be waived.

Proposed rules were issued by CMS on June 25, 2010.

http://www.federalregister.gov/OFRUpload/OFRData/2010-15900_PI.pdf

1.1.3 Medicaid Impacts for Seniors

1.1.3.1 Expansion of Coverage for those under 65

The ACA balances the requirement for individuals to maintain health insurance with a commitment by the government to make coverage available and affordable for low- and moderate-income people who otherwise could not afford it. Starting in 2014, the Affordable Care Act expands Medicaid to cover individuals age 64 and under who have incomes at or below 133 percent of the federal poverty level even if they do not fit into a disability or other coverage category. In addition, the government will provide health insurance subsidies for individuals earning up to 400% FPL (\$43,320 for an individual and \$88,200 for a family of four in 2010). The federal government will pay all of the costs of covering newly eligible enrollees through 2016; in subsequent years, the share of federal spending (FMAP) will vary somewhat from year to year but ultimately would average about 90 percent.

1.1.3.2 Maintenance of Effort

New “maintenance-of-effort” (MOE) provisions in the ACA prohibit states from making it more difficult for people to become eligible for Medicaid. (Pennsylvania was already subject to a Medicaid MOE as a condition of receiving enhanced Federal Medicaid Funding through the American Recovery and Reinvestment Act (ARRA)). The idea is to prevent budget strapped states from trying to save money by imposing new eligibility limitations on Medicaid. The ACA MOE requirements will apply until the major components of health reform go into effect no later than January 1, 2014 (and longer for children’s Medicaid).

The MOE prevents states from implementing cuts to eligibility levels, increases in premiums or enrollment fees, and more restrictive enrollment policies (for example, requiring more frequent re-certifications, more documentary proof of income or assets than is currently required, or freezing enrollment in a program). Under the MOE, Pennsylvania and other States must maintain the eligibility and enrollment policies and procedures that were in effect on **March 23, 2010**. If a state violates the MOE provisions it will lose all federal matching funding for its entire Medicaid program until the violation is corrected.

The complex MOE provisions are found at Title II, Section 2001(b) of the PPACA. They amend Section 1902 of the Social Security Act by adding a new Section 1902(a)(74) [42 U.S.C. 1396(a)(74)(gg)]. The relevant provisions are as follows:

Section 2001 (b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—

Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting “; and”; and

(C) by inserting after paragraph (73) the following new paragraph:

“(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg).”;

(2) by adding at the end the following new subsection:

“(gg) MAINTENANCE OF EFFORT.—

“(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—

Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility

standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

“(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

“(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

“(4) DETERMINATION OF COMPLIANCE.—

“(A) STATES SHALL APPLY MODIFIED GROSS INCOME.—

A State’s determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

“(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—

With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver

of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).”

1.1.3.3 Home & Community Based Services

“Currently, we spend approximately 73% of Medicaid long-term care resources for seniors and people with physical disabilities on institutional care, even though most individuals prefer the often less expensive and more cost-effective HCBS. According to AARP’s Public Policy Institute, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based settings for every person in a nursing facility. According to a study by Stephen Kaye published in a 2009 *Health Affairs* article, states that invested in HCBS, over a relatively short period of time, were able to slow their rate of Medicaid spending on long-term care.”⁹

There are a number of provisions in the ACA which are designed to increase access to and utilization of Home and Community Based Services (HCBS).

1.1.3.2.1 Community First Choice Option¹⁰

The ACA creates a new state plan option, available beginning October 1, 2011, to provide comprehensive home and community-based attendant services and supports for individuals who are eligible for an institutional level of care. States adopting the option are prohibited from placing caps on the number of individuals served or waiting lists for applicable services. Services provided under the option must be made available statewide in the most integrated setting appropriate for the individual. As an incentive to participate, states that adopt this “Community First Choice” option will be eligible for an additional six percent federal match rate (FMAP) for included services.

1.1.3.2.2 Removal of Barriers to HCBS

The existing HCBS state plan option under Sec. 1915(i) of the Social Security Act allows states to provide HCBS services without a waiver, but states must establish eligibility criteria that are less strict than that for institutional and HCBS waiver services. Pennsylvania has not taken up this option. The ACA removes a number of limitations in an effort to encourage states to adopt the HCBS state plan option and make more people eligible for services.¹¹

1.1.3.2.3 Money Follows the Person Rebalancing Demonstration

The ACA extends the Money Follows the Person Rebalancing Demonstration program through

9 National Council on Aging Issue Brief “Long-Term Services and Supports Provisions in Health Reform,” <http://www.ncoa.org/assets/files/pdf/Conference-2010-LTSS-2-pager.pdf>

10 ACA § 2401. See discussion in “Health Care Reform Improves Access to Medicaid Home and Community-Based Services,” AARP Public Policy Fact Sheet (June 2010) at <http://assets.aarp.org/rgcenter/ppi/ltr/fs192-hcbs.pdf>.

11 See discussion in AUCD, [Patient Protection and Affordable Care Act New Options for Long-Term Services and Supports](#), May 28, 2010.

2016 and allows states to cover people who are institutionalized for over 90 days.¹² The Money Follows the Person program provides incentives for states to move Medicaid beneficiaries out of nursing homes into home and community-based services.

1.1.3.2.4 Protection for Recipients of HCBS against Spousal Impoverishment

Federal law mandates that states extend spousal impoverishment rules to the spouses of nursing facility residents. However, states have the option as to whether extend these rules to the spouses of recipients of Home and Community Based (HCBS) waiver services like those provided through the Aging Waiver.¹³

Prior to 2005, it was frequently easier to qualify for Medicaid for Aging Waiver services than for institutional care, because the spousal rules were not applied to HCBS. At that time, DPW disregarded the assets of the spouse of the applicant. This meant that excess resources could be transferred without penalty to the non-applicant spouse where they would not bar eligibility.

While the resource rules favored HCBS for married couples, the income rules were biased on the side of institutional care. In Pennsylvania, the normal financial eligibility pathway for Aging Waiver services is based on the special income rule – which requires the applicant to have income no greater than 300% of the federal benefit rate (FBR). This income ceiling is a primary financial impediment for Aging Waiver services. Institutional applicants can have income well in excess of 300% of the FBR and still qualify for Medicaid due to the liberal spend-down rules. But due to its reliance on the special income rule path to Medicaid, higher income applicants are typically barred from the Aging Waiver program.

The resource methodology changed with the enactment of Act 42 of 2005.¹⁴ Under Act 42, Pennsylvania applied the federal financial eligibility rules of 42 U.S.C. §§1396p and 1396r-5 to the Aging Waiver program. §1396r-5 contains the spousal income and asset impoverishment rules.

The real world effect of the Act 42 change was to advance the bias in favor of institutional care over the Aging Waiver. The easier resource rules for married applicants for HCBS were removed. But the more restrictive income rules were retained.

The purpose of Section 2404 of the ACA is to encourage HCBS through requiring states to provide spousal impoverishment protections in the HCBS setting, but it is not clear whether it will ameliorate the above described institutional bias that currently exists in Pennsylvania. As discussed above, Pennsylvania needs to be able lift the 300% of FBR barrier in order to tilt the income eligibility bias away from institutional care.

One of the most significant spousal impoverishment protections is that the income of a community spouse is not deemed to be available to an institutionalized spouse. 1396r-5 reads as follow:

¹² ACA § 2403.

¹³ 42 U.S.C. §1396r-5(h)(1)

¹⁴ 62 P.S. § 441.8.

(b) Rules for treatment of income.

(1) Separate treatment of income. During any month in which an institutionalized spouse **is in the institution**, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.¹⁵ (emphasis added).

An applicant is income eligible for the Aging Waiver HCBS program if his total gross countable income is equal to or less than 300% of the current Federal Benefit rate (current rate = \$674 which means that the Aging Waiver income limit in 2010 is \$2,022)). This is the typical pathway to eligibility for the Aging Waiver. Under this pathway the income of the community spouse is deemed to be unavailable to the applicant spouse just as if the applicant spouse was “in the institution.”

The problem is that an otherwise eligible applicant will be denied Aging Waiver benefits if his income is over \$2,022. Under this eligibility pathway, the applicant is not allowed to utilize any medical expense deductions to spend down to this limit. An NFCE individual who could appropriately remain home may be forced into undesirable and more expensive institutional care simply because his income is over this inflexible limit.

There are alternative paths to Medicaid eligibility that do allow income spend down. The most viable in this context is the mandatory categorically needy NMP pathway. The income standard under the NMP eligibility pathway is the current federal benefit rate plus the state SSI supplement (For a married couple the standard this year is \$1044.30).

There are a number of differences in the rules for qualification under the NMP Medicaid pathway vs. qualification under the 300% of FBR rules. Notable differences are that under NMP rules

- C Spend Down (deductions to reduce countable income) are allowed.
- C A married applicant and spouse are considered as part of a group for purposes of qualification.¹⁶
- C The resource limit for an individual is \$2,000 and \$3,000 for a couple.
- C Spousal impoverishment protections are not applicable under the NMP spend-down route.

Spend down eligibility exists when the applicant/recipient group's total monthly net income, after allowable spend down deductions, is equal to or less than the NMP limit. In 2010, the limit for

¹⁵ 42 U.S.C. §§1396r-5(b).

¹⁶ The ACAO will determine NMP eligibility by using the countable actual and/or anticipated income and resources available to the members of the applicant/recipient group. @ MEDICAID ELIGIBILITY HANDBOOK Section 368.11 NMP PROGRAMS, citing 55 Pa. Code § 181.1(a).

an individual is \$696.10 and the limit for two persons is \$1044.30.¹⁷

Because the spousal protections rules do not apply to a married applicant for HCBS through the NMP pathway, it has been an unrealistic alternative for most married couples. The financial security of the community spouse is typically much better protected if the MA applicant spouse is institutionalized so that the spousal impoverishment protections become applicable. By institutionalizing the spouse in need of MA, the married couple will avoid the income cap of \$1,044.30 and the resource cap of \$3,000.00. The rules are strongly biased in favor of institutionalization where the spouse in need of MA has income in excess of 300% of FBR because it is so difficult to qualify under the alternate NMP pathway. To its credit, DPW recognizes this problem and has been discussing it with CMS.

Beginning in 2014, Section 2404 of the ACA extends Medicaid's spousal impoverishment protections to the spouses of all Medicaid enrollees receiving HCBS coverage through waivers or certain state plan benefits.¹⁸ The protections become mandatory rather than elective.

Since Pennsylvania has already elected to apply the spousal impoverishment rules to the 300% of FBR special income pathway, it would appear at first glance that this section of the ACA will have no relevance here. However, Section 2404 could turn out to have major significance if it is interpreted to apply the spousal income protections to applicants for Aging Waiver services through the NMP pathway. This could allow the community spouse to retain more income and resources under NMP eligibility for Waiver.

At least one commentator has suggested that spousal protections under Section 2404 should apply to all HCBS waiver participants including those who qualify under a spend down path.¹⁹ This argument is bolstered by Section 2406 of the ACA which specifies the "Sense of the Senate" that long term services and supports should be made available in the community in addition to in institutions.

However, as noted above, §1396r-5(b) requires the applicant spouse to be "in the institution" before the income of the community spouse is deemed to be unavailable. Is a recipient of HCBS "in the institution?" Section 2404 of the ACA does not change §1396r-5(b). But it does change the definition of the term "institutionalized spouse." Under ACA effective for 5 years beginning January 1, 2014, the definition of that term will be modified to read as follows:

42 USC §1396f-5(h) Definitions.

In this section:

- (1) The term "institutionalized spouse" means an individual who--
—(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI) [~~42 USCS § 1396a(a)(10)(A)(ii)(VI)~~];
(A) is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved

¹⁷ <http://www.dpw.state.pa.us/ServicesPrograms/MedicalAssistance/003670300.htm>

¹⁸ ACA § 2404.

¹⁹ National Senior Citizens Law Center, "The Medicaid Long-Term Services and Supports Provisions in the Health Care Reform Law," April 2010, http://www.nslc.org/areas/medicaid/health-reform-ltss/at_download/attachment

under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k), and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

If CMS interprets this new definition of “institutionalized spouse” to mean that a recipient of HCBS meets the “in the institution” requirement, the ACA will help remove the institutional bias that exists where the applicant has income higher than 300% of FBR. There are some early indications that CMS will interpret the section in a manner that will encourage the expansion of HCBS.

CMS has some time to consider the implications of Section 2404. The spousal impoverishment protections of the Section 2404 do not become effective until January 1, 2014 and sunset on December 31, 2019.

Here is the text of Section 2404.

SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r– 5(h)(1)(A)) shall be applied as though “is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)” were substituted in such section for “(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)”.

1.1.3.2.4 Funding to Expand State Aging and Disability Resource Centers (ADRCs)

Section 2405 of the ACA appropriates \$10 million each year from 2010 to 2014 to the Aging and Disability Resource Centers (ADRC) program. The ADRC program is intended to facilitate access to long-term care services and supports and improve the ability of States to effectively manage the system, monitor program quality, and measure the responsiveness of State and local

systems of care. ADRCs now operate in at least one community in each of the 50 States. There are currently over 200 ADRC sites across the Nation.²⁰

1.1.3.2.5 State Balancing Incentive Program.

The ACA offers financial incentives to states that are spending less than 50% of their Medicaid Long Term Services and Support dollars on community-based services to shift more Medicaid spending toward the community.

1.1.4 Other Provisions of Significance to Seniors

The Affordable Care Act enacts several initiatives intended to deal with long term care and limit abuse of the elderly. Included in the law are the Nursing Home Transparency and Improvement Act, the Elder Justice Act, and the Patient Safety and Abuse Prevention Act. Also included are provisions to improve training of the long-term care workforce and expand public coverage of long-term care outside nursing homes.

Many seniors will also be affected by revenue producers included in the law.

1.1.4.1 Nursing Home Transparency and Improvement Act

The nursing home transparency provisions are the first comprehensive improvements in the regulation of nursing home quality since the Nursing Home Reform Act in OBRA '87. When fully implemented, the law will give consumers access to a substantial amount of new information about individual facilities. The Nursing Home Transparency and Improvement Act will require disclosure of the individuals and entities that own, operate, and finance nursing homes, and it will require nursing homes to escrow fines if they appeal violations. It also will provide consumers with more ready access to information that is now unavailable or hard to obtain, such as accurate information about staffing levels and turnover rates; sanctions against facilities; and inspection reports. As described by NCCNHR, the law includes provisions for:²¹

- Public disclosure of nursing home owners, operators, and other entities and individuals that provide management, financing, and services to nursing homes.
- Establishment of internal procedures by nursing homes ("compliance and ethics programs") to reduce civil and criminal violations and improve quality assurance.
- Collection of staffing data electronically from payroll records and other verifiable sources and public reporting of hours per resident day of care and turnover and retention rates.
- Improved public information on [Nursing Home Compare](#), including staffing data for each facility that includes hours of care per resident day, turnover, and retention rates; links to facilities' survey reports and plans of correction on state websites; summaries of complaints against facilities, including number, type, severity and outcome; a standardized complaint form; and adjudicated criminal violations by facilities and their employees inside the facility, including civil monetary penalties levied against the facility, its employees, contractors, and other agents.

20 CMS SMDL# 10-008, Re: Community Living Initiative, May 20, 2010.

21 The following list is quoted from a NCCNHR summary of Health Care Reform which is available online at <http://www.nccnhr.org/advocate/health-care-reform>.

- Establishment of a consumer rights information page on Nursing Home Compare, including services available from the long-term care ombudsman.
- A review of Nursing Home Compare's accuracy, clarity, timeliness, and comprehensiveness and modifications of the site based on the review.
- A Government Accountability Office study of the Five Star Quality Rating System.
- Improved timeliness of survey information made available to the public.
- A requirement for nursing homes to make surveys and complaint investigations for three years available on request and to post a notice that they are available.
- A requirement that states maintain a website with information on all nursing homes in the state, including survey reports, complaint investigation reports, plans of correction, and other information that the state or CMS considers useful.
- A statutory requirement for a special focus facility program.
- Establishment of a methodology for categorization and public reporting of facilities' expenditures, regardless of source of payment, for direct care (including nursing, therapy, and medical services); indirect care (including housekeeping and dietary services); capital assets; and administrative services.
- Improved complaint handling, including a voluntary standardized form for filing complaints with the survey agency and ombudsman; and protection of residents' legal representatives and other responsible parties from retaliation when they complain about quality of care.
- Escrowing of civil monetary penalties after an independent informal dispute resolution process and pending resolution of further appeals. (Allows for reduction of CMP amounts for self-reported, non-repeat violations.)
- Sixty-day advance notification of facility closure and authorization to continue Medicaid payments pending relocation of all residents.
- Dementia care and abuse prevention in nurse aide training programs.
- Demonstration projects to identify best practices in culture change and information technology.
- Demonstration program to develop, test, and implement federal oversight of interstate and large intrastate chains. (Chains apply to participate in the demonstrations.)

1.1.4.2 Class Act

The controversial Class Act creates a voluntary payroll deduction plan that will pay cash benefits to adults who enroll and later become functionally disabled. Employees who pay into the program for at least five years will be entitled to a daily cash benefit that they can use for long-term care at home or in a community-based setting. Medicaid beneficiaries in nursing homes would retain 5 percent of their cash benefit; and Medicaid beneficiaries receiving home and community-based services would keep 50 percent.

Coverage will be available only to those working people who enroll. Participants must pay premiums for a vesting period of five years before they can receive benefits, and they have to continue working for three of those years. This means that the Act is not relevant to seniors who are already out of the work-force. Nonworking spouses are not covered. Part-time workers are eligible, if they earn enough each year to pay Social Security taxes. The self-employed will also be able to sign up.

Many of the implementation details remain unclear. Experts expect enrollment to begin in 2013.

The Class Act is not intended to pay the full cost of 24-hour home care or a nursing home, but to allow individuals to stay out of an institution or delay admission, with moderate levels of assistance that will supplement family care.

Strongly opposed by some in the long term care insurance industry, the Class Act is an experiment in encouraging people to take personal responsibility through a public program that allows them to save for long term care. It can be anticipated that people whom no private insurer would accept — for example those who already have diagnoses but can work part-time for three years — are most likely to enroll. This type of “adverse selection” could destroy the long term financial viability of the program if too few young and healthy workers also sign up.

1.1.4.3 The Elder Justice Act

The ACA includes the Elder Justice Act (EJA), which establishes an Elder Justice Coordinating Council tasked with making recommendations on the coordination of activities of federal, state, local and private agencies and entities relating to elder abuse, neglect, and exploitation. Recommendations are due in two years. The Act also provides funding for various adult protective services related programs.

1.1.4.4 Patient Safety and Abuse Prevention Act

The Patient Safety and Abuse Prevention Act creates a national program of criminal background checks on employees of long-term care providers who have access to residents of facilities or people receiving care in their own homes.

1.1.4.5 Increases in Taxes and Fees

Title IX of the Affordable Care Act includes over \$400 billion in revenue raisers including new taxes. The new law:

1. Imposes a 40% surtax on high-end employer-sponsored health plans;
2. Increases the Medicare tax to 2.35% for couples with adjusted gross incomes (AGI) over \$250,000 a year and individuals with AGI over \$200,000;
3. Imposes new fees on certain health-related industries;
4. Increases the threshold for the deduction of eligible unreimbursed medical expenses from 7.5% to 10% of AGI starting in 2013.

1.1.6 Resources

Here are some links to additional resources and information on the new health reform law:

[Compilation of the Patient Protection and Affordable Care Act including the provisions of the Health Care and Education Reconciliation Act](#)

<http://docs.house.gov/energycommerce/ppacacon.pdf>

[Full Text of the Patient Protection and Affordable Care Act \(P.L. 111-148\)](#)

<http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>

[Full Text of the Health Care and Education Reconciliation Act of 2010](#)

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872enr.txt.pdf

[Democratic Policy Committee Summary & Analysis of the two enactments](#)

http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm

[The Patient Protection and Affordable Care Act, Section by Section Analysis](#)

<http://dpc.senate.gov/healthreformbill/healthbill53.pdf>

[Summary of The Health Care and Education Reconciliation Act](#)

<http://dpc.senate.gov/healthreformbill/healthbill61.pdf>

[Health Insurance Reform: A Guide for Seniors](#)

<http://docs.house.gov/energycommerce/SENIORS.pdf>

[Help in Finding Health Insurance](#): If your client needs health care insurance, the Government has a website to help find coverage: www.healthcare.gov

1.2 Caregivers & Veterans Omnibus Health Services Act (May 5, 2010)

The Caregivers and Veterans Omnibus Health Services Act (S. 1963) will provide family caregivers of veterans with information and training, respite, counseling, and ongoing supportive services. In addition, family caregivers of veterans who were injured in the line of duty after September 11, 2001 are eligible for training and certification, health care coverage and a caregiver's stipend. The bill also improves health care for veterans in rural areas, helps the Veterans Administration adapt to the needs of women veterans, and expands supportive services for homeless veterans. A summary of the Act and full text are available at:

<http://www.govtrack.us/congress/bill.xpd?bill=s111-1963>

1.3 Dodd-Frank Wall Street Reform and Consumer Protection Act (Still Pending as of July 4, 2010)

Provisions of the Dodd-Frank Act (financial reform) give the government a larger role in guarding the wallets of consumers via the creation of a central Consumer Financial Protection Bureau. The bureau will be housed within the Federal Reserve, and headed by a director appointed by the president and confirmed by the Senate. It will write and enforce rules for most banks, mortgage lenders, and credit and debit card companies.

The Act gives the Securities and Exchange Commission (SEC) the authority to create a rule for brokers that would require them to put their clients' interests first. Currently, brokers are only required to recommend investments that are deemed "suitable," based on factors like their clients' financial goals and tolerance for risk. However, before regulating on this issue, the SEC

must first conduct a six-month study of the brokerage industry and consider any regulatory gaps or overlaps in regulation of brokers and investment advisers.

2. Other Federal Matters

2.1 Federal Estate Tax

The federal estate tax lapsed on Jan. 1, 2010. But under current law, it will return with vengeance on Jan. 1, 2011, and at that point--unless Congress intervenes--only \$1 million per estate (indexed for inflation) will be exempt from a stiff tax of up to 55% tax. That compares with a \$3.5 million exemption and a 45% rate in 2009.

The situation for clients dying in 2010 is truly bizarre. It appears that their estates will owe no taxes. For example, the estate of Dan L. Duncan, who died this Spring with an estimated wealth of \$9 billion will apparently owe no tax. On the other hand, with only a limited “artificial” step-up-in basis on inherited property (\$1.3 million available at the executor’s discretion and \$3 million on assets passed to a spouse), his heirs may end up paying enhanced income taxes when assets with capital appreciation are sold.

As the 2010 year goes on without an Estate Tax fix, elder lawyers may want to prepare for the growing possibility that there will be a greatly reduced estate tax exemption next year. A \$1 million (or \$1.3 million) exemption would mean that many more families will need to plan for the federal tax. Clients are often surprised to learn that, when they add up the value of their house, life insurance, retirement and other accounts, they have estates worth in excess of that level. Here are some examples of the kinds of planning measures that individuals of moderate wealth may wish to consider next year:

- Change life insurance policy ownership. Move insurance beyond the reach of the tax by making a child or irrevocable life insurance trust the owner of the policy.
- Maximize annual gifts. If your client is confident they have enough to meet their own needs they can start making annual gifts. \$13,000 a year can be given to as many recipients as they would like to benefit; spouses can combine their exclusions to give \$26,000 jointly to any person. If the client can afford to give away more than that, they can make “taxable gifts” that count against their \$1 million lifetime gift tax exemption. Since the value of the donated asset is valued at the time of the transfer any appreciation after that is not subject to estate or gift tax.
- Pay tuition and medical expenses. Clients can pay tuition, dental and medical expenses for anyone they want--provided they pay the providers of those services directly.
- Convert to a Roth IRA. In a conversion you declare a traditional individual retirement account or 401(k) taxable, pay any income taxes on pretax contributions and earnings (preferably from funds outside the retirement account) and hold the funds in a Roth where all future growth is tax free. The tax the client prepays at conversion reduces the size of his or her estate, at no gift tax cost, and the heirs will get an income-tax-free pot of money when they inherit.

2.2 Other Scheduled Federal Tax Increases

On Jan. 1, 2011, federal tax rates are scheduled to rise quite sharply. President George W. Bush's tax cuts expire on that date, meaning that the highest federal personal income tax rate will go 39.6% from 35%, the highest federal dividend tax rate rises to 39.6% from 15%, the capital gains tax rate increases to 20% from 15%, and the maximum estate tax rate goes to 55% from zero. Lots of other changes will also occur as a result of the sunset provision in the Bush tax cuts.

2.3 Tax Free Exchanges for Long Term Care Insurance

Effective January 1, 2010, The Pension Protection Act of 2006 allows life and annuity contracts to be exchanged directly into a qualified long term care insurance policy.²² An owner can exchange an existing policy without recognizing the gains on the underlying life or annuity contract. For more information and analysis of this new option see Thomas M. Lilly, JD CLU, "Long Term Care Insurance in Pennsylvania, What's What Today and What May Be Tomorrow" (PBI 2009).

2.4 Mental Health Parity Law Takes Effect

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)²³ essentially requires employer-sponsored health plans to provide coverage for addiction and mental illness on a level consistent with other health problems. The Act may apply to two different types of coverage:

- 1) Large group self-funded group health plans (CMS has jurisdiction over self-funded public sector (non-federal governmental) plans, while the Department of Labor has jurisdiction over private sector self-funded group health plans.);
- 2) Large group fully insured group health plans.

On February 2, 2010, regulations implementing MHPAEA were published.²⁴

Under the Act group health plans and health insurance issuers are required to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. The Act is effective for plan years beginning on or after October 3, 2009. For calendar year plans, the effective date is January 1, 2010. Regulations became effective on April 5, 2010, and applicable to plan years beginning on or after July 1, 2010.

In addition, the Affordable Care Act specifies that mental health and substance use disorder services are a part of the essential benefits package that all qualified health plans provide through state Health Benefits Exchanges. Such plans will have to provide mental health and substance use benefits at parity with medical/surgical benefits.

22 IRC Sec 1035(a)(1)-(3),

23 <https://www.cms.gov/HealthInsReformforConsume/Downloads/MHPAEA.pdf>.

24 <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>

Similar mental health parity protections are included in the Affordable Care Act for Medicare beneficiaries. Although initially effective in 2010 the Medicare protections will be phased in over several years and impose limits on inpatient treatment.

2.5 Asset Limits Increase for Medicare Savings Programs

Medicare Savings Programs help pay Part B premiums for low income Medicare beneficiaries who also have limited assets. The Qualified Medicare Beneficiary Program pays all Medicare Part B costs: premiums, co-payments and deductibles. The "Specified Low-Income Medicare Beneficiary Program," or SLMB, pays the Part B premium but not the other costs. The "Qualified Individual Program" (QI-1) also pays the Part B premium but enrollment is capped.

The income limits for these programs vary. Until this year, the asset limit was \$4,000 (\$6,000 for a couple). However, effective January 1, 2010, the asset limit for all of these programs has been increased to \$6,600 (\$9,910 for a couple).

Seniors can apply for these programs online, at www.compass.state.pa.us or at their local County Assistance Office.

2.6 National Commission on Fiscal Responsibility and Reform

Created in February 2010 by Presidential Executive order, the National Commission on Fiscal Responsibility and Reform is tasked with developing proposals to balance the budget by 2015 and to improve the country's long-term fiscal outlook. The Commission is to include an examination of changes that may be appropriate to address the growth of spending on Social Security, Medicare, and Medicaid and the gap between the projected revenues and expenditures for these programs over the long term.

3. Recent Pennsylvania Laws & Regulations

3.1. Act 54 of 2009

3.1.1 Other Medical Expenses

To qualify for Medical Assistance to help pay for long term care costs, seniors must qualify financially. One of the financial requirements is that the applicant's income must be low enough to meet the Medicaid program's guidelines. Another is that the individual who is receiving Medicaid financed nursing home care must contribute from their income towards the cost of care.

In determining income qualification for residents of long-term nursing facilities, Pennsylvania is one in a number of states that permits an individual to "spend down." This means that residents whose income would otherwise be too high for them to qualify for Medicaid are permitted to deduct their medical expenses from income to "spend down" to the income qualification

threshold.

Once qualified for Medical Assistance for nursing home care, the enrollee must use his or her income as a co-payment towards the cost of care. However, a Medical Assistance recipient can retain certain amounts that are allowed as “deductions” for purposes of determining the co-payment obligation. One of these allowable income deductions is for medically-necessary expenses incurred by the nursing home resident which are not paid by Medicaid. These are sometimes known as “Other Medical Expenses” or “OME.”

In the past, Pennsylvania had tried to place a dollar limit on the amount of OME an individual can deduct in calculating the co-payment obligation. But this type of dollar cost limitation was determined to violate federal Medicaid requirements.

Because there is no dollar limit on the deduction of OME, individuals have been able to use medical expenses incurred during transfer penalty periods and medical expenses incurred at the private pay facility rate for extended periods of time as medical expense deductions. This can effectively reduce or even eliminate an individual’s payment toward the cost of long-term care services for an extended period of time. Those costs end up being paid by Medicaid.

[Act 54 of 2009](#) was enacted to address this issue and reduce the potential cost burden on Medicaid. Although Federal law does not permit the kind of dollar limitations on deductibility that Pennsylvania once attempted to impose, it does allow Pennsylvania to place “reasonable limits” on the ability to deduct OME. Act 54 of 2009 (Senate Bill 47 enacted December 17, 2009) revised Pennsylvania law to establish limitations that are intended to be in accord with federal Medicaid requirements.

On March 24, 2010, DPW issued OPS100303²⁵ to guide County Assistance Office caseworkers on the new rules for limiting the deductibility of OTE. The guidance states that medical expenses are not deductible if the expense was incurred (1) for long term care expenses incurred six months or more prior to the application for MA, or (2) for long term care expenses incurred as a result of an imposed penalty.

In addition to impacting some seniors, these limitations may have a negative impact on nursing facilities which sometimes must rely on the OME rules to get paid for expenses a resident incurred prior to qualifying for Medical Assistance.

3.1.2 Seeking VA Benefits as a Condition of MA Eligibility

Act 54 of 2009 also requires any veteran who is applying for Medicaid benefits to contact an accredited veteran service officer or the county director of veterans’ affairs in the county in which the applicant resides in order to determine eligibility for veteran's benefits or to file a veteran claims packet.²⁶ The veteran must provide proof of compliance with this requirement.

25 Available at http://www.paelderlaw.com/pdf/ome_ops_memo.htm

26 Section 1 of Act 54 of 2009 amending the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code by adding a new Section 215. "Veteran claims packet" means an application requesting a determination or entitlement or evidencing a belief in entitlement to a benefit as provided for in 38 CFR (relating to pensions,

Curiously, perhaps due to an oversight, the provisions of Act 54 do not appear to apply where the spouse or widow of a veteran is the applicant.

DPW is required to provide benefits to eligible individuals while they are in the process of verifying their veteran status. Act 54 directs DPW to create a standard form by which veterans can prove compliance with this new requirement.

3.2. Act 14 of 2010 – Suitability of Annuities

[Act 14 of 2010](#) (Senate Bill 237) adds Article IV-B (40 P.S. §627-1 et. seq.) to the Pennsylvania Insurance Company Law to deal with the issue of the suitability of annuity transactions. The provisions of Act 14 apply to any recommendation to purchase or exchange an annuity made to a consumer by an insurer or insurance producer that results in the purchase or exchange recommended.

Under Act 14 the insurer or insurance producer has to have reasonable grounds for believing that the recommended annuity purchase or exchange is suitable for the consumer based on facts disclosed by the consumer. The insurer or insurance producer is required to make a reasonable effort to obtain information on the consumer's financial and tax status, investment objectives, and other reasonable information. If the consumer fails to provide complete or accurate information or enters into an insurance transaction that is not based on a recommendation of the insurer or insurance producer, the insurer or insurance producer has no obligation to the consumer if the recommendation was reasonable based on all circumstances known at the time.

An insurer is required to assure that a system to supervise recommendations that is reasonably designed to achieve compliance with the article is established and maintained. Insurers and insurance producers are also required to maintain records related to the provisions of the act. Compliance with the [Financial Industry Regulatory Authority Conduct Rules](#) pertaining to suitability satisfies the requirements under the section.

The Insurance Commissioner could impose various penalties or undertake other actions for violations of these requirements. These enforcement remedies are in addition to any remedies or penalties that could be imposed under other applicable statutes including the Unfair Insurance Practices Act. Section 407-B of Act 14 specifies that nothing in this new article IVB is to be construed to create or imply a private cause of action for a violation of its provisions. Certain recommended annuity contracts listed in the bill are excluded from these provisions.

3.3. Assisted Living Residence Regulations

The Department of Public Welfare published final [regulations on Assisted Living Residences](#) on May 4, 2010.²⁷ The regulations were approved by the Independent Regulatory Review Commission on June 3, 2010.²⁸

bonuses, and veterans' relief) or 51 Pa.C.S. (relating to military affairs).

27 <http://www.irrc.state.pa.us/Documents/SRCDocuments/Regulations/2712/AGENCY/Document-17996.pdf>

28 <http://www.irrc.state.pa.us/Documents/SRCDocuments/Regulations/2712/IRRC/Document-18295.pdf>

The new regulations were issued in accordance with Act 56 of 2007. Act 56 created a new classification of assisted living providers that will be able to accept individuals with higher care needs including some who are Nursing Facility Clinically Eligible and qualified for Medicaid. Unlike personal care homes, this new Assisted Living Residence (ALR) provider class will be able to deliver some health care services to their residents. ALRs are intended to have more of a private home-like feel than a nursing facility, including such amenities as separate bedrooms and baths and kitchen facilities and provide consumers will more direct control over their care.

Act 56 directed the Department of Public Welfare (DPW) to develop regulations for ALRs. This complex task required DPW to regulate in a manner that would entice facilities to apply for the designation while providing reasonable protections of consumer interests. Now that regulations are final the Department will seek a waiver from CMS so that Medicaid funding can be used to help pay the cost of care for some ALR residents.

Much more information on these controversial regulations is available through the website of the Pennsylvania Assisted Living Consumer Alliance (PALCA). <http://www.paassistedlivingconsumeralliance.org/index.php/assistedlivingregs>. (The Elder Law Section of the PBA is a member of PALCA). In addition, final comments on the regulation (including those filed by industry associations) are available on the IRRC website at <http://www.irrc.state.pa.us/Regulations/RegInfo.cfm?IRRCNo=2712>.

A session of the Elder Law Institute (Wednesday at 3:30) will be devoted to a discussion of the regulations.

4. Pending Issues in Pennsylvania

4.1. Expansion of Medicaid Estate Recovery

On May 3rd, a group of elder law attorneys met at the Capitol with Harriet Dichter, the Secretary of the Department of Public Welfare (DPW). Secretary Dichter noted that the Department does not intend to seek the expansion of Medicaid Estate Recovery this year (2010). In 2009, under prior Secretary Richman, the Department had sought legislation mandating a sweeping expansion of estate recovery. This proposal was defeated by a broad coalition of legal, business and consumer advocacy interests. However, under current law, the Department and Governor actually have the authority to expand estate recovery by regulation without the need for new legislation.

House Bill 2252, Session of 2010, would withdraw the authority of the Administration to unilaterally expand estate recovery without legislative oversight. More information on HB 2252 is available on the PAELA website at <http://paela.info/public-policy/paela-supports-hb2252>.

4.2. Family Caregiver Support

Pennsylvania's Family Caregiver Support Program offers support for caregivers who have accepted responsibility for providing at home care for functionally-dependent older adults and victims of chronic dementia like Alzheimer's disease. Reimbursement levels have not been

updated since the program was initiated in 1990. And current law excludes support of caregivers who do not reside with or are not related to the person receiving care. These limitations have prevented the Department of Aging from targeting funding in a manner that will allow the most care dependent seniors to remain in their home.

House Bill 245, Session of 2010, would modernize the Program by expanding the definition of “primary caregiver” to include non-relatives, remove the requirement that the caregiver resides with the care receiver, and adjust the amounts available to a qualified primary caregiver from the levels established in 1990. Maximum expense reimbursement would increase from \$200 per month to \$500 per month and from \$2,000 to \$6,000 for home modifications or assistive devices for the entire duration of the case.

Caregiver support is not available to caregivers who receive financial compensation for the care provided. Enactment of HB 245 will not involve any new funding nor create any new entitlements. Services are provided only to the extent that appropriations are made available by the General Assembly. In recent years the Department of Aging has been unable to fully utilize the Program’s appropriations due to the restrictions in the 1990 law.

HB 245 unanimously passed the House on March 30, 2009 and has been awaiting action in the Senate since that time.

4.3. Filial Support

Two bills have been introduced to amend the Pennsylvania’s filial support law (23 Pa. C.S § 4603). This controversial law has been enforced by nursing homes against children of residents with unpaid bills.²⁹ Given the lobbying power of the nursing home industry, it appears that neither bill will eliminate filial support altogether.

Changes to House Bill 2206 (introduced by Representative DeLuca) are currently being negotiated, while the Senate Bill 1195 (introduced by Senator Leach) proposes to restrict filial support so that it would not apply to a child who has taken no overt action to voluntarily accept responsibility or reasonably lead a provider to believe the child would accept responsibility for the costs of care of the parent.

4.4. Implementing Health Care Reform in PA

During the May 3rd meeting,³⁰ DPW Secretary Dichter gave an overview of the impact of the new national health reform law on the Department. The Secretary noted that the Department will be focused on the implementation on recently enacted national health care reform for the remainder of this Administration. By May 3rd, it had already identified 64 provisions in the health reform law that will involve DPW.

On May 19th, the Governor established a Health Care Reform Implementation Committee and a Health Care Reform Implementation Advisory Committee tasked with developing an efficient and effective set of strategies to implement these reforms with input from experts, providers and

²⁹ See, for example, the news article discussion at <http://abcnews.go.com/Business/story?id=8074570&page=1>.

³⁰ See Section 4.1 above.

citizens. Further information is available in 40 Pa.B. 3078, (June 12, 2010).³¹

4.5 Potential Federal Funding Cuts

The American Recovery and Reinvestment Act which was enacted in February 2009 included an \$87 billion temporary increase in federal share of Medicaid payments. This has provided a minimum 6.2% increase in the Federal Medical Assistance Percentage (FMAP) received by states including Pennsylvania. Without Congressional action this increased funding will expire on December 31, 2010.

Pennsylvania's budget relies on the assumption that there would be a continuation of the enhanced FMAP payments for the Medicaid program beyond December 31, 2010. A 6 month extension was widely expected. The loss of this 6 month extension will cost Pennsylvania approximately \$1 billion in federal funding.³² As of July 4, 2010, Congress has not enacted the extension.

Due to the Maintenance of Effort rules contained in the Affordable Care Act,³³ states are prohibited from making up the FMAP shortfall by placing new restrictions on eligibility criteria for Medicaid. That means states will have to find other options for cutting costs such as dipping into other funds, reducing provider reimbursements, increasing co-payments or dropping coverage for some services. Governor Rendell has expressed grave concern about the negative impact on Medicaid and other programs administered by DPW if Congress fails to extend the enhanced FMAP payments. The Governor has suggested that the loss of this funding would result in the lay off at least 20,000 government workers.

4.6 Omnibus Changes to PEF Code

[Senate Bill 53](#), Session of 2010, would make modifications of Pennsylvania law regarding wills, formula clauses for Federal tax purposes, dispositions independent of letters, family exemption, probate of wills and grant of letters, payments to family and funeral directors, grant and advertisement of letters advertisement, apportionment of death taxes, powers of attorney, the rule against perpetuities, the effect of divorce, notice of representation, creditor's claims, actions contesting validity of revocable trusts, removal of trustee, limitation of action against a trustee; principal and income, the power to convert to unitrust, retirement benefits, and individual retirement accounts, deferred compensation, annuities and similar payment. This bill appears to have a reasonable chance for enactment before the end of this Session of the Legislature.

31 <http://www.pabulletin.com/secure/data/vol40/40-24/1065.html>

32 Families USA Special Report, <http://www.familiesusa.org/resources/publications/pending-jobs-bill.pdf>

33 See discussion above at Section 1.1.3.2

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Marshall, Parker & Associates is the ONLY law firm in the United States with more than two Certified Elder Law Attorneys (CELAs) on its staff. Five of our attorneys are CELAs. Only a lawyer who meets all of the certification requirements set by the Pennsylvania Supreme Court is recognized as a CELA. The coveted status has only been attained by 37 attorneys in Pennsylvania. The Pennsylvania Supreme Court approved the CELA professional designation because it found that the CELA certification process provides valuable assurance to the public that the lawyer has an in-depth working knowledge of the legal issues impacting the elderly.

If you or someone you know needs assistance with estate or gas royalty planning or with qualification for Medicaid benefits for nursing home or home care, you can trust the lawyers at Marshall, Parker & Associates. Please call us toll free at 1-800-401-4552 or e-mail our Scheduling Coordinator, Lynn Wesley at webmail@paelderlaw.com