



Monitoring and Enforcing the Affordable Care Act:

**A Roadmap for People with
Disabilities**



National Council on Disability

February 2, 2016



National Council on Disability

An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

Letter of Transmittal

February 2, 2016

President Barack Obama
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

The National Council on Disability (NCD) is pleased to submit *Monitoring and Enforcing the Affordable Care Act (ACA) for People with Disabilities*. This document is the final report in a series resulting from NCD's cooperative agreement with the Urban Institute in NCD's study called "The Affordable Care Act and What It Means for People with Disabilities."

NCD is an independent federal agency, composed of nine members appointed by the President and the U.S. Congress. The purpose of NCD is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, and to empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society.

The current report recognizes some of the steps the U.S. Department of Health and Human Services Centers for Medicare and Medicaid has taken to assist members of the public in navigating the relatively new law and its proposed rules. The report includes illustrative questions in each chapter to raise awareness about potential options and topics to consider after the rule becomes final. Specifically, this report:

- Describes some of the key legal safeguards in ACA and its implementing regulations that can assist people with disabilities obtain necessary health care and support services;
- Identifies the entities bound by each statutory and regulatory duty and gives clear examples of the kinds of actions that may be required or forbidden;
- Discusses disparities and discrimination in terms of selected legal requirements applicable in these contexts:
 - General health plan issues involving disparities and discrimination, which affect multiple systems of coverage; and
 - Essential health benefits, which ACA requires of many different systems of public and private health coverage;
- Addresses the operation of Health Insurance Marketplaces with regard to enrollment and coverage through qualified health plans by people with disabilities; and
- Highlights Medicaid expansion and application/renewal procedures.

1331 F Street, NW ■ Suite 850 ■ Washington, DC 20004

202-272-2004 Voice ■ 202-272-2074 TTY ■ 202-272-2022 Fax ■ www.ncd.gov

We urge the White House and Congress to engage critical stakeholders, including people living with disabilities, in ongoing and future dialogue opportunities and in taking strategic actions to improve health care across our nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Clyde Terry". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Clyde Terry
Chair

(The same letter of transmittal was sent to the President Pro Tempore of the U.S. Senate, the Speaker of the U.S. House of Representatives, and the Director of the Office of Management and Budget.)

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Acronym Glossary

ABP	Medicaid Alternative Benefit Plans (often for newly eligible, low-income adults in expansion states)
ACA	Patient Protection and Affordable Care Act
ADA	The Americans with Disabilities Act
APTC	Advance premium tax credit
CFC	Community First Choice, an option for Medicaid coverage of HCBS
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
EHBs	Essential health benefits
EPSDT	Early and periodic screening, diagnosis, and treatment, the Medicaid benefit for children
ESI	Employer-sponsored insurance
FDA	The Food and Drug Administration
FEHB	Federal employees health benefit program
FMAP	Federal medical assistance percentage, the percentage of Medicaid or CHIP costs paid by the federal government
FPL	Federal poverty level
HCBS	Home- and community-based services
HHS	U.S. Department of Health and Human Services
HMO	Health maintenance organization (a form of managed care)
IAP	Insurance affordability program (typically either Medicaid, CHIP, or federal subsidies for Marketplace coverage)
IHS	Indian Health Service
LTSS	Long-term services and supports
MAGI	Modified adjusted gross income
M/SUD	Mental health and substance use disorders
OCR	HHS Office of Civil Rights
PHS Act	Public Health Service Act
P&T committee	Pharmacy and therapeutics committee
QHP	Qualified health plan (offered in a health insurance Marketplace)
SAMHSA	The Substance Abuse and Mental Health Services Administration
SBM	State-based marketplace
SSI	Supplemental Security Income
USP	United States Pharmacopeia

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Introduction

This report describes some of the key legal safeguards in the Patient Protection and Affordable Care Act (ACA) and its implementing regulations that can help people with disabilities obtain essential care and supports. Our goal is to flag issues for monitoring by the disability community, nationally and in states, to ensure that people with disabilities fully share in ACA's promised gains while avoiding potential risks posed by ACA. We describe applicable legal duties, identify the entities responsible for fulfilling those responsibilities, and, in some cases, explore potential avenues for redress.

We address issues in the following categories:

- Disparities and discrimination, which can affect multiple systems of coverage;
- Essential health benefits (EHBs), which ACA requires of many different systems of public and private health coverage;
- The operation of Health Insurance Marketplaces (sometimes called "Marketplaces" or "Exchanges"), including the enrollment of consumers and the provision of coverage through qualified health plans (QHPs);
- Medicaid¹—
 - Coverage of low-income adults with incomes up to 138 percent of the federal poverty level (FPL); and

- Procedural requirements involving Medicaid applications and renewals.

Several introductory caveats are important. This roadmap is not intended as legal advice or comprehensive legal analysis. Rather, it seeks to provide a starting point for people with disabilities and their advocates, facilitating the process of spotting issues that may warrant further work.

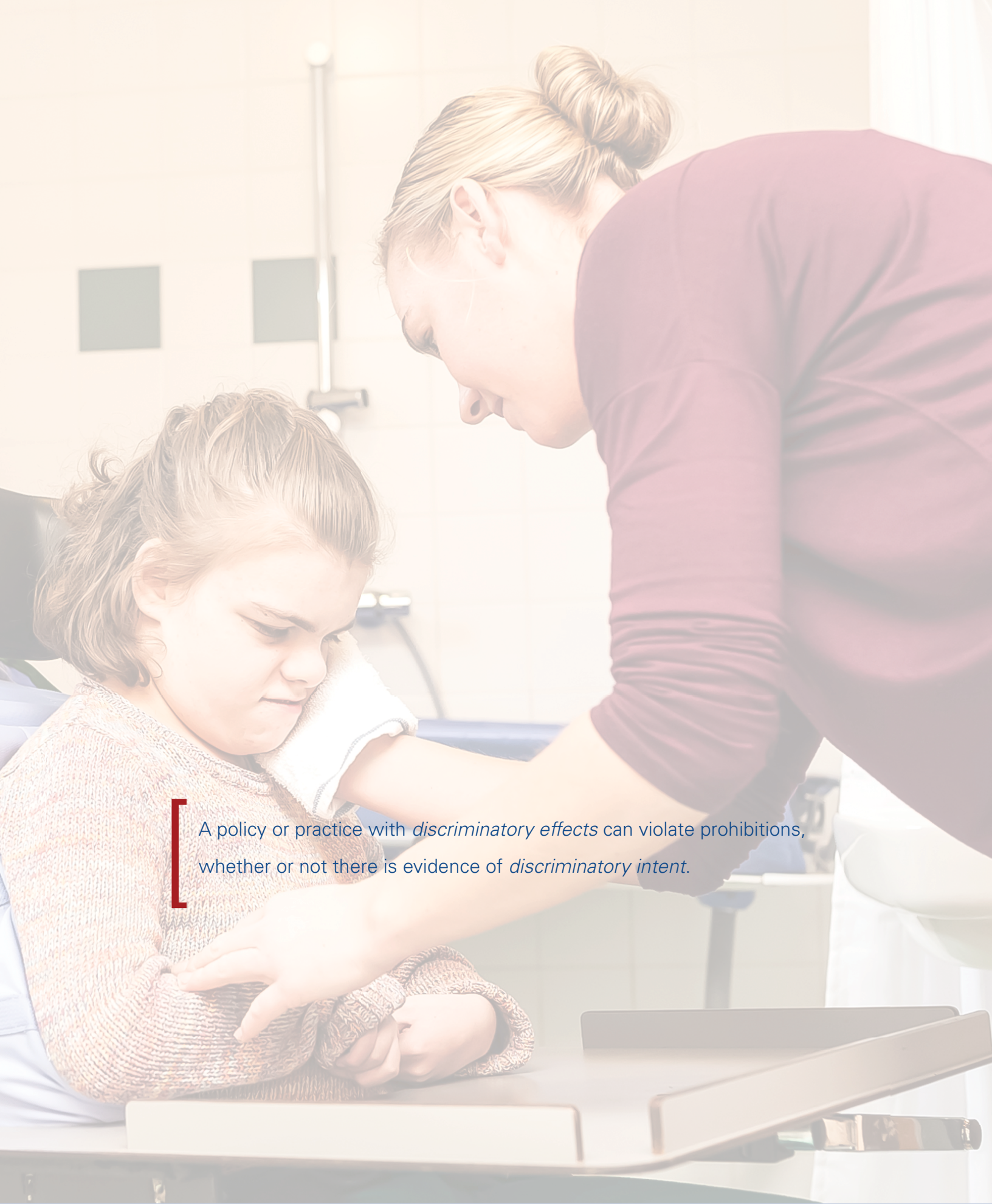
Also, much of our analysis is necessarily provisional. Many key ACA provisions, statutory and regulatory, have not received judicial interpretation. Moreover, many important regulations remain subject to revision.

This is the second "roadmap" that analyzes ACA's impact on people with disabilities. Our earlier roadmap, "Implementing the Affordable Care Act: A Roadmap for People with Disabilities," identified key policy choices facing federal and state officials and explored how particular approaches to those choices could help or hurt people with disabilities. Here, the focus is different. This roadmap charts legal standards, already in place, that apply to private- and public-sector entities. The other roadmap sought to inform decisions by disability-rights organizations and people with disabilities about whether and how to educate decision-makers about the impact of key policy choices on people with disabilities. This roadmap raises issues that

the disability community can track to make sure that people with disabilities are receiving the services and supports they are guaranteed under federal law.

To help in that process, this report follows each discussion of the legal rights of people with disabilities under ACA with a checklist of possible monitoring questions. These checklists

are illustrative, not all-inclusive. They seek to prompt further ideas about how to track ACA implementation to ensure that the legislation's promises are realized for people with disabilities. Most are asked from the standpoint of state-based disability-rights organizations, but some are relevant at the federal level.



A policy or practice with *discriminatory effects* can violate prohibitions, whether or not there is evidence of *discriminatory intent*.

Chapter 1. Disparities and Discrimination

In this chapter, we discuss two ACA provisions involving disability-based disparities and discrimination: Sections 1557 and 4302. Later, we explore antidiscrimination protections that apply more narrowly, such as to insurers required to furnish essential health benefits.

ACA Section 1557

Section 1557 prohibits discrimination based on disability (and other grounds, not discussed here) by entities receiving federal health care funding:

“[A]n individual shall not, on the ground prohibited by . . . section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such . . . section 504 . . . shall apply for purposes of violations of this subsection.”

Federal agencies viewed this statute as effective upon enactment. The Office for Civil Rights

(OCR) of the U.S. Department of Health and Human Services (HHS) thus began accepting and processing administrative complaints about alleged violations. On September 8, 2015, OCR published proposed regulations fleshing out the meaning of Section 1557.² Explored below are some of the proposed rule’s key features, which define: (1) the organizations and people forbidden from discrimination; (2) the general scope of prohibited discrimination; (3) specific types of discrimination that are barred; and (4) enforcement. The final rule may change from the proposed regulations.

One final preliminary comment is important. Section 1557 is one of many anti-discrimination prohibitions in ACA. Later we discuss others, some of which forbid conduct that is also within the sweep of Section 1557’s prohibitions.

Entities Forbidden from Disability-Based Discrimination

Entities in three categories are subject to the proposed rule’s antidiscrimination prohibitions.

First, every health program or activity, any part of which receives federal financial assistance, is barred from discriminating. Such entities include hospitals, health clinics, community health centers, group health plans, health insurance issuers, health plans, physician practices, nursing facilities, residential or community-based treatment facilities, and state agencies administering Medicaid or

the Children’s Health Insurance Program (CHIP).³ In its proposed regulation, OCR indicates that it expects almost all physicians to be subject to antidiscrimination prohibitions.

If one part of an entity that is principally engaged in providing or administering health services or health insurance coverage receives federal funding, the entire entity is forbidden to discriminate. For example, if an insurance company offers a QHP that serves people who use federal subsidies to buy Marketplace coverage, the prohibition of discrimination applies to all of the insurance company’s health plans and products, including employer coverage for which the insurer serves as third-party administrator.

Federal financial assistance under the proposed rule includes grants, contracts, loans, reimbursement, and any other funding from the

Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services (CMS), and the Indian Health Service (IHS), among other federal agencies. It also includes HHS funding that individuals use to purchase coverage

or care—for example, tax credits and other subsidies that low- and moderate-income consumers use to buy QHPs offered in the Marketplace.

Covered entities must provide the public with notices that contain specified information, including that the entity does not discriminate; that it provides appropriate interpreters and auxiliary aids and services, free of charge . . . ; the entity’s grievance procedures; and how consumers can obtain auxiliary aids and services, file a grievance, or file a complaint with OCR.

Illustrative Monitoring Questions

- Which *health care providers* in my area (doctors, medical groups, hospitals, clinics, providers of long-term services and supports, and so forth) receive federal funds and so are bound by Section 1557? This includes organizations and individuals paid by Medicare, Medicaid, grants for health centers, or other federal grants or programs (e.g., Ryan White funding for people with HIV-AIDS; SAMHSA funding of programs that treat mental health and substance use disorders, IHS, etc.) Note: although the Federal Employees Health Benefits (FEHB) program is not mentioned in the proposed rule—presumably because it is not administered by HHS—by the terms of the statute, entities participating in FEHB, including providers and insurers, appear subject to Section 1557.

Illustrative Monitoring Questions (*continued*)

- Which *health insurers* that receive federal funds and operate in my area offer health plans that receive or benefit from federal funds? All of an insurance company's health plans (including employers' self-funded plans administered by the company) are bound by Section 1557 if the insurer receives federal funds, such as through Medicare, Medicaid, CHIP, Marketplace coverage, or other programs.
- Which *state and federal agencies* serving people in my area operate a health program or activity that receives federal funding and so is bound by Section 1557? This includes state-based and federally facilitated Marketplaces, state and federal Medicaid and CHIP agencies, and other state or federal programs.
- *Who contracts with those state and federal agencies* to operate health programs and activities? Contractors barred from discrimination may include Navigators, companies operating websites for the Marketplace or Medicaid, and other contractors helping with operations (e.g., eligibility determination, information technology, call-center-operation, public education campaigns, and so forth).

Note: Monitoring questions for Section 1557 reflect a proposed, not a final, rule. Disability organizations will need to track changes made in final regulations. However, the questions touch on factual issues that are likely to remain important.

Second, entities that were created by ACA Title I to administer health programs and activities are forbidden to discriminate. Such entities include health insurance Marketplaces and their subcontractors, including Navigator programs that help consumers enroll and select coverage.

The third and final set of covered entities consists of health programs and activities administered by HHS. This includes Medicare, federally facilitated Marketplaces, and federally conducted health research. Note that the statute itself addresses all federal agencies, not just those within HHS; future regulations may specify federal duties that go beyond HHS.

General Duties of Nondiscrimination

Covered entities must ensure that people are not denied the full benefit of health programs and activities because of disability. *Disability* is defined as under Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA)—namely, “a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.” The proposed rule also bars discrimination based on association with a person with a disability. For example, the regulatory preamble explains that “a physician could not deny a medical appointment to a

Illustrative Monitoring Questions

In my state or locality, ask for each provider, insurer, public agency, or contractor subject to antidiscrimination prohibitions:

- Is it engaging in any practices that have the effect of denying people with disabilities the full benefit of a health care program or activity?
- Does it discriminate against a patient or client without a disability who is associated with a person with a disability? For example, does it fail to give family members with disabilities the full benefit of the health care program or activity (such as by not providing sign-language interpreters for deaf family members)?
- Could the entity make reasonable modifications in policies, practices, or procedures that would prevent disability-based discrimination?
- Has the entity provided public notice of nondiscrimination? Does that notice meet all regulatory requirements for content and distribution? Is the entity using OCR's multilingual model notices (or an adaptation of such notices)?
- Does the entity have 15 or more employees? If so, has it appointed a coordinator to address antidiscrimination rules; and has it established grievance procedures with appropriate due process protections?

patient who is an individual without a disability on the basis that the patient will be accompanied by a family member who is deaf and who will require a sign language interpreter.”

The proposed regulations require covered entities to “make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability.” However, such modifications are not required if the covered entity can “demonstrate that the modification would fundamentally alter the nature of the health program or activity.”

If the covered entity has 15 or more employees, it must appoint a coordinator who is responsible for ensuring compliance with antidiscrimination rules. It must also establish grievance procedures, with appropriate due

process protections, through which complaints of discrimination are addressed.

Regardless of size, a covered entity must provide the federal government with assurances of compliance with Section 1557 and implementing regulations in order to obtain federal financial assistance. Examples of entities required to make such assurances include state-based Marketplaces and insurers offering QHPs. Covered entities must also provide the public with notices that contain specified information, including that the entity does not discriminate; that it provides appropriate interpreters and auxiliary aids and services, free of charge, to ensure effective communication; the entity's grievance procedures; and how consumers can obtain auxiliary aids and services, file a grievance,

or file a complaint with OCR. Such notices must be included in significant public communications (like patient handbooks) and posted in conspicuous locations both in the covered entity's physical space and its website home page. OCR will publish multilingual versions of model notices.

More Specific Duties of Nondiscrimination

As a general rule, accessibility requirements for entities subject to the proposed rule replicate those in Title II of the ADA, which applies to state and local government entities, rather than Title III, which addresses places of public accommodation and commercial facilities. Accessibility involves, among other things, making offices and facilities physically accessible to people with disabilities. The proposed rule thus requires that when covered entities engage in new construction or alter existing facilities, they must comply with 2010 ADA standards for accessible design. OCR also announced that, once the U.S. Access Board's standards for medical diagnostic equipment are finalized,⁴ OCR intends to issue regulations or policies that will require covered entities to meet those standards.

Covered entities are similarly required to use effective and accessible communications channels. This includes providing auxiliary aids and services, as under ADA regulations. The proposed Section 1557 rule defines such aids and services to include the following:

(1) Qualified interpreters on-site or through video remote interpreting (VRI) services, as defined in 28 CFR 35.104, 36.303(b); note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listen-

ing systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

(2) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

(3) Acquisition or modification of equipment and devices; and

(4) Other similar services and actions.⁵

Accessibility duties also include "electronic and information technology." One example requires full accessibility of Marketplace websites:

A Health Insurance Marketplace creating a Web site for application for health insurance coverage must ensure that individuals with disabilities have an equal opportunity to benefit from the Web site's tool that allows comparison of health insurance coverage options, quick determination of eligibility, and facilitation of timely access to health insurance coverage by making its new Web site accessible to individuals who are blind or who have low vision.⁶

Illustrative Monitoring Questions

- Is new construction or alteration to existing facilities occurring in my state or locality with covered entities? Such entities may include insurers; hospitals, clinics, residential treatment programs, or other health care providers; social services agencies or other government agencies that administer health programs; etc. If there is such new construction or alteration, does it meet the 2010 ADA standards for accessible design?
- Are accessible and effective communications methods being used by covered entities, such as state Medicaid and CHIP programs, Marketplaces, insurers, and health care providers? Do these entities offer auxiliary aids and services, as described in ADA regulations and reiterated in regulations under ACA Section 1557?
- Do covered entities make health programs and activities offered through electronic and information technology accessible? For example, do the Marketplace and Medicaid program meet accessibility requirements for their websites, call centers, social services offices, and application kiosks?
- Are health insurers limiting their issuance or renewal of coverage based on disability? Do any health plans use benefit designs or marketing practices that discourage enrollment by people with disabilities or otherwise discriminate against people with disabilities?

The obligation to make electronic and information technology fully accessible to people with disabilities goes beyond websites, however. According to the regulatory preamble:

[OCR] decided to include an explicit accessibility requirement that applies to all of a covered entity's electronic and information technology. The term electronic and information technology includes, but is not limited to, telecommunications products (such as telephones), information kiosks and transaction machines, [I]nternet sites, multimedia, and office equipment such as copiers and fax machines.⁷

A covered entity is not required to make its health programs and activities provided through

electronic and information technology accessible if that would "impose undue financial and administrative burdens or would result in a fundamental alteration in the nature of the health program or activity." If such an undue burden exists, the covered entity must use other methods to convey the information that avoid discrimination.

A final set of specific duties involves health insurers. The proposed rule prohibits denying, cancelling, limiting, or refusing to issue or renew a health-related insurance plan or policy or other health-related coverage on the basis of disability. It also forbids the use of marketing practices or benefit designs that discriminate on that basis. For example, "a plan that covers bariatric surgery in adults, but excludes such coverage for adults with particular developmental disabilities would not be in compliance."

Enforcement

Aggrieved individuals can file complaints with OCR, which will use the same procedures that apply to claimed violations of Section 504. The proposed rule notes that, if informal resolution fails, OCR’s enforcement tools include “suspension of, termination of, or refusal to grant or continue Federal financial assistance” and “referral to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States.” OCR can also order remedial actions to help particular individuals, including former participants in a covered entity’s health program or activity and those who would have been participants if the discrimination had not occurred.

The proposed rule specifically includes a private right of action to enforce Section 1557 in federal court.⁸ The regulatory preamble explains that “a private right of action and damages for violations of Section 1557 are provided for and available under . . . Section 504 . . . with respect to recipients of Federal financial assistance” subject to Section 1557. OCR added that “a private right of action and damages are also available for violations of Section 1557 by Title I entities”—that is, entities created by Title I of ACA (primarily Marketplaces).

One final enforcement tool involves the federal False Claims Act. Entities, like private insurers, that obtain federal funds based on the above-described assurances of compliance with Section 1557 may be liable for three times the

amount of federal funds such entities received. The False Claims Act permits “whistleblowers” to share in recoveries if they bring fraud to the attention of the Justice Department or the federal courts. This remedy is discussed with some additional detail in the section of this roadmap that addresses Marketplace coverage.

ACA Section 4302⁹

Gathering and reporting data about the care people with disabilities receive is important to assessing whether policies and practices have a disparate adverse impact on people with disabilities and whether such people fully share in the gains of reform. Section 4302 of ACA thus requires much collection of data about possible

disparities based on “race, ethnicity, sex, primary language, and disability status.”¹⁰

One provision that has not yet been implemented requires provider surveys that specifically focus on the access to care enjoyed

by people with disabilities. ACA Section 4302(a) created Public Health Service (PHS) Act Section 3101 [42 USC 300k], subsection (a)(1)(D) of which requires HHS to:

survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

- (i) locations where individuals with disabilities access primary, acute (including intensive), and long term care;

The absence of appropriations may have prevented HHS from carrying out [an ACA Section 4302(a)] provider survey. . . . Nevertheless, such a survey could move forward for providers who participate in Medicaid and CHIP.

(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 510 of the Rehabilitation Act of 1973; and

(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities.¹¹

However, PHS Act Section 3101 limits this duty based on funding: “data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.”¹² The absence of appropriations may have prevented HHS from carrying out this provider survey.

Nevertheless, such a survey could move forward for providers who participate in Medicaid and CHIP. Without language that limits obligations based on available appropriations, ACA Section 4302(b)(1) requires that “any data collected” by

Medicaid must “meet . . . the requirements of section 3101 of the [PHS] Act” and that CHIP programs must have “data collected and reported in accordance with section 3101” of the PHS Act.¹³ In a recent report to Congress, HHS noted that, under ACA Section 4302(b), “Collection and reporting of [disparities] data in Medicaid and CHIP must adhere to the standards developed under section 3101 of the PHS Act.”¹⁴ Since PHS Act Section 3101 applies to Medicaid and CHIP, notwithstanding the absence of appropriations, HHS can (and arguably must) move forward with provider surveys to assess access to care in Medicaid and CHIP for people with disabilities.

To be clear, HHS is gathering considerable data to assess disparities in care experienced by people with disabilities, as well as data about the impact of policy initiatives that include people with disabilities as a core beneficiary group.¹⁵ However, Section 4302’s survey requirement has not yet been met, and it could provide useful information about care options for Medicaid and CHIP beneficiaries with disabilities.

Chapter 2. Health Plans Furnishing Essential Health Benefits

This chapter begins by explaining the types of health plans that must cover essential health benefits (EHBs). It then describes the basic structure of EHBs, the requirements that apply to plans governed by EHB rules, and the entities that can be held accountable for failing to meet such requirements.

Health Plans Required to Cover EHBs

ACA applies EHB requirements to many different types of coverage:

- QHPs sold in Marketplaces, whether or not enrollees qualify for federal subsidies;
- Medicaid alternative benefit plans (ABPs), which states may choose to provide to newly eligible adults with incomes at or below 138 percent FPL (and that must also provide benefits that supplement EHB, as explained later in this roadmap’s Medicaid section); and
- Any private coverage sold outside Marketplaces, whether to individuals or employers. This “catch-all” category has several exceptions:
 - Employer-sponsored insurance (ESI) is not required to provide EHBs if the ESI comes from companies that either (1) are too large for the state’s small-group market or (2) self-insure rather

than buy insurance. Self-insuring firms typically arrange for insurance companies to administer the ESI plan, but the employers retain ultimate responsibility for paying health care claims.¹⁶

- Insurance that is “grandfathered” is not required to cover EHBs. To qualify as “grandfathered,” insurance cannot have undergone any significant changes in benefits or out-of-pocket cost-sharing since March 23, 2010. An employer plan can remain grandfathered even though it continues to enroll new members. By contrast, an individual market plan cannot be grandfathered if it enrolls new members.

The Structure of EHBs

The ACA statute identifies 10 general categories of essential health benefits:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorders (M/SUD) services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;

The Structure of EHBs

The ACA statute identifies 10 general categories of essential health benefits:

1. Ambulatory patient services;
2. Emergency services;
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4. Maternity and newborn care;
5. Mental health and substance use disorders (M/SUD) services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services (including oral and vision care).

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9. Preventive and wellness services and chronic disease management; and
10. Pediatric services (including oral and vision care).

To fill in the details within these broad categories, the statute directs HHS to “ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan.”¹⁷ Rather than create federally specified rules about the amount, duration, and scope of coverage within the above ten EHB categories, HHS has given each state the responsibility to select a so-called benchmark plan that will provide the basis for EHB coverage within the state. States can choose from among ten options for such a benchmark:

- The three small group plans with the highest enrollment in the state;
- The three state-employee-benefit plans with the highest enrollment;
- The three national health plans for federal employees with the highest enrollment; and
- The health maintenance organization (HMO) within the state that has the highest commercial enrollment.

For pediatric coverage, benefits covered by CHIP are available as an additional benchmark option. If the state’s chosen benchmark does not cover a particular EHB category, another benchmark plan is used for that category.

If a state does not select a benchmark plan to define EHBs, the small group plan with the largest enrollment within the state, as determined by HHS, becomes the benchmark. If the benchmark plan, whether chosen by the state or HHS, does not cover a particular EHB category, and the state does not fill that gap by selecting another benchmark plan, federal rules specify which benchmark options are used to fill in the gaps.

After benchmark coverage has been chosen for each EHB category, other plans governed by EHB rules must provide benefits that “are substantially equal to the EHB-benchmark plan including covered benefits, [and] limitations on coverage including coverage of benefit amount, duration, and scope.”¹⁸

As a general rule, insurers can substitute, within a particular EHB category, benefits that are “actuarially equivalent” to the benefits covered by the benchmark plan; this means that for consumers as a whole, average claims costs within the benefit category would be the same as for the benchmark plan. Under 45 CFR 156.115(b) (1), a substitution is actuarially equivalent only if it is so certified by a member of the American

Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies, using a standardized plan population, and determined regardless of cost-sharing.¹⁹

Actuarial equivalent substitution is not allowed if it is forbidden by the state or if it involves prescription drugs. Ten states and the District of Columbia have prohibited actuarial substitution, but its use has been explicitly affirmed in 20 other states.²⁰ In the remaining 20 states, actuarial substitution is permitted, since state law does not forbid it.

Legal Duties Involving Plans That Provide EHB Coverage

Both statutory and regulatory safeguards apply to plans that are required to furnish EHB coverage.²¹

Departing from the Amount, Duration, and Scope of Benchmark Coverage

As noted earlier, within all EHB categories except prescription drugs, plans must provide coverage

that is “substantially equal” to the benchmark plan. Applicable regulations do not define this term. Clearly, they permit less change than the actuarial equivalence standard, since in states that forbid substitution

of actuarially equivalent benefits, insurers can provide “substantially equal” benefits that depart somewhat from the EHB benchmark. However, it is unclear precisely how much variation from benchmark benefits is allowed.

CMS interprets the requirement of “substantial equality” as imposing a duty *on health plans* to modify details of benchmark coverage when necessary to meet ACA requirements.²² Examples include changes (1) to ensure that at least one

[W]ithin all EHB categories except prescription drugs, plans must provide coverage that is “substantially equal” to the benchmark plan. The final regulations do not define this term.

Illustrative Monitoring Questions

For a health plan in my state or locality that is required to meet EHB requirements:

- Does the state’s EHB benchmark fail to meet applicable federal standards for a particular benefit category? If so, does this health plan supplement benchmark coverage to meet federal requirements?
- Has the state forbidden actuarial equivalent substitution? If not, and this health plan engages in such substitution, has the plan met ACA’s technical requirements (e.g., certification by a member of the American Academy of Actuaries, using a standardized population)? Does any actuarial substitution involve prescription drugs or substitution between EHB categories?
- If the state forbids actuarial equivalent substitution, how much do the plan’s covered benefits depart from the benchmark plan? Is the plan’s coverage still “substantially equal” to the amount, duration, and scope of EHBs within the benchmark package?

drug is covered within each category and class listed in the United States Pharmacopeia (USP) (see later discussion), (2) to meet mental health parity requirements, and (3) to cover certain preventive services free of cost-sharing.

Actuarial substitution may occur only within a particular EHB category, not between categories. For example, within the category of rehabilitative and habilitative services and devices, a plan could increase coverage of physical therapy visits and reduce coverage of occupational therapy, compared to the EHB-benchmark plan. However, an insurer could not lower the number of physical therapy visits in order to cover additional mental health visits, since that would involve substitution between EHB categories.

Habilitative Services and Devices

Pre-ACA ESI, which furnishes the starting point for defining EHBs, was structured to address the needs of relatively healthy workers. It thus typically covered rehabilitative services, which seek to restore functioning after an injury or acute medical problem. By contrast, habilitative services, which can help people attain basic functioning for the first time, were outside the scope of many employer plans.²³ When such plans serve as EHB benchmarks, habilitative services may not be covered. As a result, special rules apply.

If the benchmark plan does not cover habilitative services, the state may define such benefits, so long as the state definition does not violate more general EHB requirements, such as the prohibition of discriminatory benefit design. If neither the benchmark plan nor the state define covered habilitative services and devices, 45 CFR 156.115(a)(5) specifies a three-part standard requiring that EHB-compliant plans:

- (i) Cover health care services and devices that help a person keep, learn, or

improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings;

- (ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and

- (iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices. [For example, an EHB-compliant plan cannot cover 40 visits for habilitation and rehabilitation services combined; any limits must apply separately for each of these two categories.²⁴]

In explaining the meaning of this federal definition, CMS described the difference between habilitative and rehabilitative services:

Habilitative services, including devices, are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.²⁵

If the benchmark plan covers some habilitative services but does not fully meet these federal

Illustrative Monitoring Questions

Monitoring questions will vary, depending on state policy, as shown by Table 1.

Table 1. Illustrative monitoring questions about habilitative services in states with various EHB policies

State EHB policy			Illustrative monitoring questions	
EHB-benchmark coverage of habilitative services and devices		If the benchmark plan does not cover habilitative services, has the state defined the benefit?	Questions about the state	Questions about health plans
Are any habilitative services included?	Do benchmark habilitative services meet the three-part federal standard?			
Yes	Yes	N/A		Are plans covering benchmark services or the equivalent?
Yes	No	N/A	Has the state supplemented benchmark services to meet federal standards?	Are plans supplementing benchmark services to meet federal standards?
No	N/A	Yes	Does the state definition meet general EHB requirements (e.g., nondiscrimination)?	
No	N/A	No		Are plans meeting federal standards?

Note: N/A = not applicable. The three-part federal standard requires (1) covering services and devices that help a person “keep, learn, or improve skills and functioning;” (2) covering habilitation no less generously than rehabilitation; and (3) starting in 2017, not imposing a shared visit limit on habilitation and rehabilitation.

standards, the state must “supplement the benchmark plan,” according to CMS, since the federal definition comprises the “minimum for States to use when determining whether plans

cover habilitative services.” Accordingly, states as well as insurers must go beyond benchmark plans when necessary to ensure adequate coverage of these services.

Prescription Drugs²⁶

EHB coverage of prescription drugs has several requirements, which, unless stated otherwise, apply in 2016 and later years.²⁷

Breadth

A plan must cover at least one drug within each USP category and class of prescription drugs. Within a particular category or class, if the benchmark plan covers more than one drug, then other plans must cover at least the same number of drugs.

Illustrative Monitoring Questions

For a particular health plan in my state or locality that must cover EHBs:

- Does the formulary include at least one drug in each USP category and class?
- If there is a USP category or class where the benchmark plan covers more than one drug, does this particular plan cover at least as many drugs?

Pharmacy and Therapeutics Committees

Starting in 2017, each EHB-compliant plan must use a pharmacy and therapeutics (P&T) committee that (1) consists primarily of pharmacists and physicians or other clinicians licensed to prescribe drugs, (2) “represent[s] a sufficient number of clinical specialties to adequately meet the needs of enrollees,” (3) prohibits members from voting on matters for which they have a conflict of interest, and (4) has at least 20 percent of its members without any conflicts of interest involving the issuer or any drug manufacturer. Committees must meet at least quarterly; record the rationale

for all decisions involving the plan’s drug formulary; “review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange”; “review and approve all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug”; “evaluate and analyze treatment protocols and procedures related to the plan’s formulary at least annually”; and more broadly “develop and document procedures to ensure appropriate drug review and inclusion.”²⁸ In addition, the committee is required to review new Food and Drug Administration (FDA) approvals of drugs and new authorized uses approved by the FDA. The P&T committee must:²⁹

- “Base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmaco-economic studies, outcomes research data,” and other information;
- “Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs”; and
- Ensure that the plan’s drug formulary:
 - “Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states”;
 - “Does not discourage enrollment by any group of enrollees”; and
 - “Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.”

Note that, while these requirements are couched in terms of required procedures for

Illustrative Monitoring Questions

In 2017 and beyond, with a plan in my state or locality that must cover EHBs:

- Does the plan have a P&T committee that fulfills ACA's requirements for committee membership (pharmacists and prescribing clinicians, enough specialties to meet enrollee needs, limits on conflicts of interest)?
- Do meetings of the P&T committee meet ACA's procedural requirements (timing at least quarterly, rationale recorded for formulary decisions)?
- Does the P&T committee review aspects of the plan's prescription drug coverage as required by ACA (exceptions procedures, utilization management, prior authorization criteria, step therapy rules, quantity limits)? Does it evaluate formulary protocols and procedures at least annually?
- Do the committee's documented procedures ensure appropriate drug review and inclusion?
- Does the committee regularly review FDA approvals of (1) new drugs and (2) new uses for already approved drugs?
- Does the committee use ACA's criteria for making decisions (based on the strength of scientific evidence and standards of practice, considering drug safety and efficacy)?
- Has the committee ensured that the formulary meets regulatory standards (treating all disease states, not discouraging enrollment, providing access consistent with treatment guidelines and current best practices)?

plan committees, they also appear to establish substantive criteria for gauging the adequacy of prescription drug coverage.

Exception Requests

Plans must establish procedures that let a consumer, the consumer's designee, or the consumer's prescribing clinician "request and gain access to clinically appropriate drugs not otherwise covered by the health plan." If the request is granted, the plan treats the drug as an essential health benefit, counting out-of-pocket costs toward annual cost-sharing limits.

Plans must provide for requests in three categories:

1. *Standard exception requests*, which apply to plan years starting in 2016. Each standard exception request must be decided within 72 hours.
2. *Expedited exception requests*. These involve "exigent circumstances," which "exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug." Each request in this more urgent category must be decided within 24 hours.

Illustrative Monitoring Questions

With a health plan in my state or locality that must cover EHBs:

- Are procedures in place through which consumers can request and gain access to drugs not otherwise covered by the plan? Can the request be made by the consumer's designee or prescribing clinician?
- If the request is granted, what cost-sharing arrangements apply? Do out-of-pocket payments count toward the plan's annual limit on consumer costs?
- In exigent circumstances (health condition that may seriously jeopardize health or ability to regain maximum function, or enrollee undergoing course of treatment using nonformulary drug), are exception requests decided within 24 hours? In other circumstances, are they decided within 72 hours?
- When the plan denies an exception request, can enrollees seek a review by an independent review organization? Does the plan decide on whether to grant review within the same time frame that applied to the original exception request (24 hours and 72 hours for exigent and standard requests, respectively)?

3. *External review.* Starting in 2016, plans must offer procedures through which a consumer or the consumer's prescribing clinician or other designee can request a review by an independent review organization of plan decisions to deny standard or expedited exception requests. The plan must resolve requests for external review within the same time periods that applied to the original exception request (72 hours for standard requests, 24 hours for expedited requests).

Treatment of Mental Health and Substance Use Disorders

Under ACA, mental health parity requirements that formerly governed ESI sponsored by firms with 50 or more employees³⁰ now apply to all coverage subject to EHB requirements,³¹ including Medicaid ABPs for low-income adults.³² Plans may not cover

mental health and substance use disorders (M/SUD) services differently than treatment of physical ailments along any of the following dimensions:³³

- Annual or aggregate limits on coverage;
- Treatment or visit limits;
- Out-of-pocket cost-sharing (deductibles, copayments, co-insurance);
- Access to non-network care;
- Classification of outpatient benefits (e.g., office visits vs. other outpatient visits); and
- Other nonquantifiable treatment limitations, which include provider network tier design; restrictions based on geographic location, facility type, and provider specialty; prior-authorization requirements; "medical management standards, prescription drug formulary design, standards for provider admission to networks, determination of

provider reimbursement rates, requirements for step therapy (for example, using lower-cost treatments first before trying others), and requirements to complete a course of treatment as a condition of benefits.”³⁴

To determine equivalence, physical and M/SUD benefits are divided into six categories: emergency care; prescription drugs; and in-network and non-network inpatient and outpatient care. Plans may not apply separate deductibles and out-of-pocket cost-sharing limits for M/SUDs and for physical health care, since that would increase out-of-pocket costs for consumers who need treatment of M/SUDs in addition to physical health care.

State standards apply to the extent that they are more rigorous than federal rules. As a matter of process, plans and issuers must disclose, upon request, the medical necessity criteria used in denying an M/SUD service, along with the reasons for denial.

Discriminatory Benefit Design

Both ACA's statute and implementing regulations prohibit discrimination in connection with plans required to cover EHBs. The statute provides that, in defining EHBs, HHS shall:

- “not make coverage decisions . . . or design benefits in ways that discriminate against individuals because of their . . . disability”;

Illustrative Monitoring Questions

With a health plan in my state or locality that must cover EHBs:

- Does it use different *quantitative* standards for M/SUD services and physical health care? Possible examples include annual or aggregate limits on visits, treatment, or coverage; and out-of-pocket cost-sharing rules.
- Does the plan use different *qualitative* standards for M/SUD services and physical health care? Examples include access to non-network care, formulary design, provider networks and payments, medical management, step therapy requirements, requiring completing treatment to obtain other benefits, and so forth.
- Do such quantitative or qualitative differences emerge when one compares the plan's M/SUD coverage to its physical health coverage within any of the six categories specified in the regulation (emergency services, prescription drug coverage, in-network inpatient care, non-network inpatient care, in-network outpatient care, non-network outpatient care)?
- Does the plan apply deductibles or out-of-pocket cost-sharing limits specifically to M/SUD services?
- When the plan denies a requested M/SUD service, does it disclose the reasons for the denial and the medical necessity criteria that were used?

- “take into account the health care needs of diverse segments of the population, including . . . people with disabilities”; and
- “ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.”³⁵

A 2015 law review article characterized the first two provisions

as requiring nondiscrimination in *defining EHBs*, whereas the final provision establishes that “a benefit defined as essential using nondiscriminatory criteria might still *in practice be denied* . . .

in a way that violates” this section of ACA.³⁶

One important unresolved issue is whether these statutory requirements apply just to HHS, in its development of EHB policy, or whether they also govern states and health plans.

Regulations are relevant as well:

- Under 45 CFR 156.125:
 - Subsection (a) provides that a plan fails to cover EHB “if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.”

- Subsection (b) requires EHB plans to comply with 156.200(e), which forbids QHPs from “discriminat[ing] on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.” It is not clear whether Section 156.125(b) applies this requirement to plans other than QHPs.
- Subsection (c) provides that these anti-discrimination rules do not bar insurers from “appropriately utilizing reasonable medical management techniques.”

One important unresolved issue is whether [ACA’s prohibition on discrimination in benefit design] requirements apply just to HHS, in its development of EHB policy, or whether they also govern states and health plans.

As with the above-noted statutory provisions, 45 CFR 156.125(a) forbids not just discriminatory benefit design but also discrimination in the “implementation of its benefit design.”

This bars plans from creating or permitting practical obstacles that prevent people with disabilities from sharing in the gains of a theoretically non-discriminatory benefit design. Several examples listed below fall into this category, such as the example involving mail-order delivery.

- More broadly, 45 CFR Section 147.104(e) prohibits all nongrandfathered insurance from engaging in discriminatory marketing or benefit design:

A health insurance issuer and its officials, employees, agents and representatives must comply with any applicable state laws and regulations

regarding marketing by health insurance issuers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

This regulatory language illustrates a critically important feature of the regulations: **A policy or practice with discriminatory effects can violate ACA's prohibitions, whether or not there is evidence of discriminatory intent.** It is much easier to show discriminatory effects than to find proof of discriminatory intentions. The precise parameters of this "effects" test remain to be fleshed out, however.

In February 2015, CMS finalized revisions to these regulatory prohibitions of discrimination.³⁷ In its regulatory preamble, the agency provided examples of practices that could potentially violate antidiscrimination rules in ways that are relevant to people with disabilities:

[M]aking drugs available only by mail order could discourage enrollment by, and thus discriminate against . . . individuals who have conditions that they wish to keep confidential;

Attempts to circumvent coverage of medically necessary benefits by labeling the benefit as a "pediatric service," thereby excluding adults;

[R]efusal to cover a single-tablet drug regimen or extended release product that is customarily prescribed and is just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal;

[P]lacing most or all drugs that treat a specific condition on the highest cost tiers.

[QHP quality improvement strategies] will be reviewed to ensure that they are not designed and do not have the effect of discouraging the enrollment of individuals with significant health needs.³⁸

As noted earlier, the regulatory preamble to the proposed rule implementing ACA Section 1557 provides another example of discriminatory benefit design: a plan that "covers bariatric surgery in adults, but excludes such coverage for adults with particular developmental disabilities would not be in compliance."³⁹

CMS's explanation of how it will analyze discriminatory plan designs in the federally facilitated Marketplace sheds further light on the contours of forbidden discrimination. In its Notice of Benefit and Payment Parameters for 2016, CMS explained:

[W]e will notify an issuer when we see an indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices. We conduct this examination whenever a plan subject to the EHB requirement reduces benefits for a particular group. Issuers are expected to impose limitations and exclusions based on clinical guidelines and medical evidence, and are expected to use reasonable medical management. Issuers

may be asked to submit justification with supporting documentation to HHS or the State explaining how the plan design is not discriminatory.⁴⁰

In setting out ground rules for 2016, CMS's letter to health insurance issuers provided further

insights about CMS's analysis of possible QHP discrimination:⁴¹

CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance). CMS's outlier analysis will compare benefit packages with comparable

Illustrative Monitoring Questions

With a health plan in my state or locality that must cover EHBs:

- Does the plan's *benefit design* discriminate against people with present or predicted disabilities? For example:
 - Are most or all drugs that treat a particular chronic condition placed on higher cost-sharing tiers?
 - Does the formulary require multi-tablet regimens when single-tablet regimens are customarily prescribed?
 - Does the plan limit to children any medically necessary services that could fit within EHB categories for adults?
 - Are any benefits subject to limits or exclusions for people with particular disabilities?
 - Have benefits been reduced or limited for particular subpopulations where such reductions or limitations do not appear consistent with accepted clinical guidelines and medical evidence?
 - Is the plan unusual among its peers in the amount of cost sharing it imposes on benefits needed by people with disabilities? Compared to other plans, is this particular plan unusual in the amount of cost sharing that would be charged for standard treatment protocols that affect people with disabilities more than other consumers?
- Do any practical obstacles cause *discriminatory implementation of benefit designs* that, on paper, appear non-discriminatory? For example, does the plan require mail-order delivery of all prescription drugs, even though people with disabilities may wish to keep some medications confidential?
- Do any features of the plan's *marketing practices or benefit designs* have the effect of *discouraging enrollment* by people with present or predicted disabilities?

cost-sharing structures to identify cost-sharing outliers with respect to specific benefits.

Additionally, CMS is considering conducting a review of each QHP to identify outliers based upon estimated out-of-pocket costs associated with standard treatment protocols for specific medical conditions using nationally-recognized clinical guidelines. The conditions under consideration include: bipolar disorder, diabetes, HIV, rheumatoid arthritis, and schizophrenia.

Also in reviewing a plan's cost-sharing structure, CMS will analyze information contained in the Plans and Benefits Template, including, but not limited to the "explanations" and "exclusions" sections, with the objective of identifying discriminatory features or wording. Discriminatory cost sharing language would typically involve reduction in the generosity of a benefit in some manner for subsets of individuals for reasons not clearly based on common medical management practices.⁴²

CMS's procedures to monitor for illegal discrimination are relevant in two ways. First, disability-rights organizations can apply these analytic methods to assess whether plans governed by EHB requirements are engaging in forbidden discrimination. Second, people with disabilities can urge state-based Marketplaces and state insurance regulators to use similar methods in evaluating whether insurers may be violating anti-discrimination standards.

Accountable Entities

Several different entities can be held accountable for violating the above standards.

Health Plans and Their Sponsoring Insurers

Most of the above EHB obligations apply to nongrandfathered individual and group insurance, including Marketplace coverage, and to Medicaid ABPs. People with disabilities who are aggrieved by plan failures to meet the above standards may be able to file administrative complaints with the insurance regulator and, depending on the type of coverage involved, either the Marketplace or Medicaid program. State agency enforcement tools include "cease and desist" orders for plans to stop implementing particular policies, required corrective action plans from insurers, "enrollment freezes" that prevent a plan from signing up new members, fines and penalties, orders to compensate consumers for costs incurred because of illegal plan conduct, license suspension, and disqualification from operating as a QHP or Medicaid plan. In many cases, the initiation of a formal enforcement action results in a settlement through which the carrier agrees to change its practices going forward.

One context for administrative complaints involves the periodic renewal of insurers' authorization to provide coverage. With insurance regulators and Marketplaces, this occurs annually. Medicaid health plans typically operate with multi-year contracts. If a plan slated for renewal has violated people with disabilities' legal rights or otherwise operated in a problematic fashion, disability organizations can bring those problems to the attention of state agencies. Complaints can recommend terminating permission to continue offering coverage and/or urge that, if renewal occurs, certain terms and conditions should attach to prevent the recurrence of past problems.

Marketplaces and Medicaid programs present special issues for administrative complaints. First, an insurer must be licensed to sponsor a QHP.⁴³ Marketplaces can thus refer allegations of illegal conduct to the state regulator; such action may be particularly likely with the federally facilitated Marketplace, except in the few states where HHS has assumed enforcement responsibilities, based on the state's notice that it cannot or will not enforce ACA's insurance market reforms.⁴⁴ By contrast, federal law does not require Medicaid plans to have insurance licenses. Accordingly, the Medicaid agency may be the only state-level administrative venue for raising issues about Medicaid managed care.

Second, a carrier can be denied permission to sponsor a QHP, without any evidence of legal violation.

Before certifying a plan as qualified, a Marketplace must find that offering the plan "is in the interests of qualified individuals."⁴⁵ The disability community can thus bring problems that fall short of legal violations to Marketplaces' attention. As with charges of illegal plan behavior, requested remedies can involve decertifying a problematic plan and/or legal restrictions that prevent the recurrence of past problems.

Aggrieved people with disabilities may also be able to bring suit to vindicate their above-described rights. It is outside the scope of this roadmap to analyze the potential offered by court action, but several general observations may be helpful. Whether state court is an option and, if

so, what relief is available will depend on state law. Access to federal court is likely to vary, based on factors that include the legal violation that is claimed. Questions to resolve in assessing the availability of relief through the courts include standing to bring suit, jurisdiction, and available remedies after a legal violation has been established.⁴⁶

Government Agencies

It may be possible to hold state insurance regulators and Marketplaces accountable in court for failing to regulate carriers as required by ACA. In practice, such efforts may be more

promising if they involve agency policy that violates explicit federal rules, rather than an agency's largely subjective determination of whether a particular enforcement measure

Before resorting to litigation, disability-rights groups in particular states could consider petitioning government agencies to implement unmet federal requirements.

is appropriate to remedy a certain legal violation. To illustrate the former, courts may be willing to strike down a state's definition of habilitative services and supports that, in 2017 or later, allows combined limits on the number of covered annual visits for habilitation and rehabilitation. Such a state policy would involve a federal regulatory violation that is established objectively, without any consideration of whether the state made an error in judgment.

Before resorting to litigation, disability-rights groups in particular states could consider petitioning government agencies to implement unmet federal requirements. If such a petition succeeds, it may yield results with a substantially

reduced level of effort, compared to litigation. And if it does not succeed, failed attempts to obtain redress administratively can show the need to turn to the courts.

Again, we caution the reader that these are only general observations intended to

flag issues for further analysis. This roadmap does not offer a rigorous or comprehensive examination of potential judicial relief, on this or any other issue.

Chapter 3. Marketplaces

Marketplace Operations

As noted earlier, ACA Section 1557's discrimination rules apply to Marketplace operations. Marketplaces are thus required to make services accessible to people with disabilities as Marketplaces carry out their basic duties, including providing public information about health coverage; using Navigators and other application assisters, insurance brokers, and call centers to give consumers hands-on help; operating a web site; facilitating and processing applications for IAPs; structuring notices and forms; determining whether carriers' proposed health plans qualify for being offered in the Marketplace; and helping consumers choose between Marketplace plans.

In addition to the general antidiscrimination requirements discussed earlier, specific ACA regulations governing the operation of the Marketplace establish duties to meet the needs of people with disabilities. One regulation broadly prohibits Marketplace discrimination based on disability (45 CFR 155.120(c)(iii)). Other regulations require the accessible performance of specific Marketplace functions:

- The overall provision of timely, accessible information to consumers with disabilities (45 CFR 155.205(c));
- Marketplace websites (45 CFR 155.205(c)(1));

- "The provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act" (45 CFR 155.205(c)(1));
- Consumer assistance, including Navigators (45 CFR 155.205(d)(1)), non-Navigator assistance in federally facilitated marketplaces (FFMs) (45 CFR 155.215(d)), and Certified Application Counselors (45 CFR 155.225(d)(5));
- Outreach and education (45 CFR 155.205(e)); and
- Marketplace forms and notices (45 CFR 155.230(b)).

In any state, the disability community could monitor Marketplace performance to evaluate the accessibility of each of these functions. Other, more specific requirements apply to consumer assistance furnished by federal Marketplaces. These mandate that such assistance (45 CFR 155.215(d)):

- "Ensure that any consumer education materials, Web sites, or other tools utilized for consumer assistance purposes, are accessible to people with disabilities, including those with sensory impairments, such as visual or hearing impairments, and those with mental illness, addiction, and physical, intellectual, and developmental disabilities";

- “Provide auxiliary aids and services for individuals with disabilities, at no cost, when necessary or when requested by the consumer to ensure effective communication,” with use of friends and family “only when requested by the consumer as the preferred alternative to an offer of other auxiliary aids and services”;
- “Provide assistance to consumers in a location and in a manner that is physically and otherwise accessible”;
- “Ensure that authorized representatives are permitted to assist an individual with a disability to make informed decisions”;
- “Acquire sufficient knowledge to refer people with disabilities to local, state, and federal long-term services and supports programs when appropriate”; and
- “Be able to work with all individuals regardless of age, disability, or culture, and seek advice or experts when needed.”

These more detailed requirements are useful to consider in monitoring Marketplace performance. They are directly binding on federally facilitated Marketplace operations, and they may also serve as touchstones for assessing state-based marketplace policies and practices.

QHPs in the Marketplace

The above discussion explores requirements that apply to insurers that receive federal funds and to plans subject to EHB duties. Additional requirements that apply specifically to QHPs include:

- A general prohibition against discrimination “on the basis of race, color, national origin,

disability, age, sex, gender identity or sexual orientation” (45 CFR 156.200(e));

- Statutory and regulatory prohibitions against employing “marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs” (45 CFR 156.225(b); see also ACA Section 1311(c)(1)(A));
- A requirement to provide “all applications and notices to enrollees” in “a manner that is accessible and timely to . . . [i] individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act” (45 CFR 156.250, cross referencing 155.230(b), which cross-references 155.205(c)); and
- Requirements to maintain a provider network “that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay” (45 CFR 156.230(a)(2)).

This is the only requirement not discussed above in connection with Section 1557 or EHB compliance. However, network adequacy requirements typically apply to nongroup plans outside the Marketplace as well as to QHPs. In most states, such requirements are enacted by the insurance regulator. Relevant information for monitoring varies among states. Typically, insurers must file access plans with the insurance regulator showing detailed information about provider networks and the plan’s relevant

rules and procedures. Depending on the state, enrollees may be able to obtain non-network care for in-network cost-sharing amounts if the provider network does not meet enrollees' needs. Consumers can use insurers' internal grievance and appeals procedures to seek non-network care, and many insurance regulators are responsive to consumer complaints about the adequacy of plan networks.

Two final comments are important. First, if insurers offer coverage in the Marketplace despite their violation of the requirements described in this report, available remedies may include actions under the Federal False Claims Act. ACA Section 1313(a)(6)(A) specifies:

Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits

and cost-sharing reductions, through the Exchange.

The False Claims Act provides treble damages—in this case, a requirement for insurance companies to refund three times the amount of all federal subsidies they received while they were violating any of the above ACA requirements. “Whistleblowers” who bring such violations to the attention of the Department of Justice or the courts can share in the resulting recoveries, so long as the information they provide is not part of the general public record.

As with this report's earlier discussions of judicial remedies, these comments about the False Claims Act are not intended as anything like a comprehensive guide or legal advice. Rather, the goal is to flag important issues for further consideration by people with disabilities and their representatives.

Finally, the National Association of Insurance Commissioners' model state law for health plan networks and draft CMS regulations setting out revised standards for network adequacy are not addressed in this roadmap. They were published in October and December 2015, respectively.⁴⁷

Chapter 4. Medicaid

Here, we analyze monitoring issues involving expanded coverage for low-income adults under ACA as well as ACA's new requirements for Medicaid applications and renewals. Medicaid issues involving long-term services and supports (LTSS), including home- and community-based services (HCBS), are discussed in other NCD publications, including this project's ACA implementation roadmap.

However, we begin the Medicaid chapter with two discrete comments about issues to monitor in analyzing implementation of selected ACA reforms to Medicaid coverage of LTSS. First, with integrated systems of care for adults who are dually eligible for Medicaid and Medicare, disability-rights groups in a state implementing an integration demonstration could review ACA Section 2702(c), which lists goals for the CMS office overseeing such demonstrations, and all of the demonstration's key contractual documents. The latter documents include memoranda of understanding between CMS and the state and three-way contracts among CMS, the state, and private managed care plans. People with disabilities and their representatives could analyze whether the state's implementation of the demonstration and any involvement of private health plans in the demonstration (1) advances the listed statutory goals and (2) meets each applicable requirement of the governing contractual documents.

Second, in analyzing state implementation of ACA's new Community First Choice (CFC) option, disability organizations could identify issues to monitor by examining (1) the detailed requirements of the CFC's governing statute (Social Security Act Section 1915(k)) and (2) the "community-based setting" regulations in 42 CFR Section 441.710, which govern CFC as well as other forms of Medicaid-covered HCBS.

Expanded Coverage for Low-Income Adults

A key ACA provision established a new Medicaid eligibility category for adults with incomes at or below 138 percent of FPL who are not otherwise eligible based on such categorical grounds as a disability that has been found to meet the severity standards for Supplemental Security Income (SSI); age 65 or older; or pregnancy.

Services provided to such newly eligible, income-based adults qualify for a much higher federal matching rate than applies to most Medicaid services. While the Federal Government pays an average of 57 percent of state Medicaid costs under the standard federal medical assistance percentage (FMAP), states receive 100 percent FMAP for newly eligible adults through the end of calendar year 2016, after which that FMAP gradually declines to 90 percent in 2020 and thereafter.

ACA originally mandated nationwide coverage of such low-income adults, but the U.S. Supreme Court ruled that each state had the constitutional right to decide whether to implement this new eligibility category. As of December 8, 2015, 31 states and the District of Columbia had expanded Medicaid eligibility as provided by ACA.⁴⁸

Two issues involving expanded eligibility are particularly important to people with disabilities: the alternative benefits plan (ABP), which defines covered services for newly eligible adults; and procedures through which people with disabilities can obtain benefits more generous than what the state includes in its ABP.

Alternative Benefit Plans

ACA provides that low-income adults receive covered benefits in the form of an ABP. At a state's option, an ABP can be based on any of the following four benchmark plans:

- The Blue Cross/Blue Shield Preferred Provider Option, offered through the Federal Employees Health Benefit program;
- State employee coverage that is offered and generally available;
- The HMO with the largest commercial, non-Medicaid enrollment in the state; or
- Secretary-approved coverage that HHS determines meets the needs of the covered population. A state can use this option to align benefits for newly eligible, low-income adults with the benefits that other Medicaid adults receive. Such alignment may require

improvements to the pre-ACA Medicaid package for adults, since that package must comply with EHB requirements in a state

with aligned benefits.

EHB requirements that may require changes to pre-ACA adult services include the potential addition of benefits

(such as treatment of M/

SUDs, habilitation, and preventive services) as well as compliance with applicable EHB safeguards (including mental health parity and non-discrimination).

ABPs must meet several requirements:

- They must cover all EHBs. This duty can be fulfilled by:
 - Using as the ABP benchmark one of the plans that the state can use to define EHBs for all nongrandfathered plans; or
 - Ensuring that the ABP is consistent with a plan that the state is allowed to use to define EHBs for all nongrandfathered plans.
- Several principles apply, under either of these approaches:
 - The Medicaid program can select a different EHB-benchmark plan than what the state uses to define EHBs for private plans;
 - The Medicaid program can use more than one EHB-benchmark plan to define different EHBs for purposes of the ABP;
 - The ABP must meet EHB requirements that go beyond selection of a benchmark plan. As explained earlier, such requirements include mental health parity, nondiscrimination, and

As of September 1, 2015, 30 states and the District of Columbia had expanded Medicaid eligibility as provided by ACA.

special rules for prescription drugs and habilitative services.

- In comparing a Medicaid ABP to the applicable EHB-benchmark plan, actuarial substitution is allowed so that the estimated net claims costs for combined ABP benefits for the eligible population are no less than for the benchmark plan. Unlike general EHB rules:
 - The actuarial value test for ABPs applies to all covered benefits, rather than to each individual EHB category; so
 - A state can substitute benefits between EHB categories. For example, an ABP could increase coverage of laboratory services to compensate for reduced coverage of habilitative and rehabilitative care. However, with four specific services—prescription drugs, mental health care, vision care, and hearing services—ABP coverage within the service category must have an actuarial value at least 75 percent of the benchmark plan’s coverage within that category.⁴⁹
- ABPs must include certain categories of coverage that go beyond EHBs, including an assurance of non-emergency transportation (whether furnished through covered benefits or Medicaid administration), services provided by federally qualified health centers and rural health centers, family planning supplies and services, and, for beneficiaries age 0–20, early and periodic screening, diagnosis, and treatment (EPSDT). The latter category includes, whenever needed by a particular young person, any medically

necessary care potentially coverable under the Medicaid statute.

Obtaining Services That Go beyond the ABP

A state may define the ABP to include fewer services than the Medicaid program offers to other adults, including HCBS or other LTSS. In that case, many (but not all) people with disabilities could be better off with standard Medicaid benefits than the ABP, and the state must provide two options for beneficiaries to move from the ABP to standard services:

1. *Medical frailty.* A low-income adult beneficiary who meets the state’s definition of “medically frail or otherwise an individual with special medical needs” is exempt from the requirement to receive the ABP rather than broader benefits the state covers for other adults. That state definition must include at least the following:

[I]ndividuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.⁵⁰ [In addition, the state defini-

Illustrative Monitoring Questions

If my state has expanded Medicaid and its ABP differs from benefits that Medicaid covers for other adults:

- Which of the four specified ABP benchmark options is the state using as the basis for ABPs?
- Which EHB-benchmark plan(s) has (have) the state chosen as the standard that defines EHBs for the ABP? If the ABP differs from such EHB-benchmark plan(s), is the total actuarial value of all benefits at least as high as the EHB-benchmark plan(s)? In assessing actuarial value, was the relevant population of low-income adults used to estimate claims costs?
- Does the ABP differ from the EHB-benchmark plan(s) in covering prescription drugs, mental health care, vision services, or hearing services? If so, is the ABP's actuarial value, within that benefit category, at least 75 percent of the actuarial value for the EHB-benchmark plan(s)?
- Does the ABP's coverage of EHBs meet all requirements for EHB-compliant plans (including special rules for habilitative services and prescription drugs, mental health parity, and nondiscrimination)?
- Does the ABP cover non-EHB services required by ACA (health center services, family planning, and, for those age 0–20, EPSDT)? Does the state assure that ABP recipients can obtain necessary nonemergency transportation, either by including such transportation as an ABP service or by providing it as part of Medicaid program administration?

If my state has expanded Medicaid and aligned the ABP with benefits for other adults:

- Do Medicaid benefits for adults cover all EHBs?
- Does Medicaid's coverage for adults meet the requirements that apply to EHB-compliant plans (e.g., mental health parity, special rules for habilitation and prescription drugs, non-discrimination, preventive services without cost-sharing)?

tion must include certain young people who have disabilities or are connected with the foster-care system.]⁵¹

Someone who qualifies as medically frail can opt for either standard adult benefits or the ABP; depending on the state and beneficiary, one or the other package may be better in meeting consumer needs.

New Medicaid enrollees must be given “information based on eligibility regarding benefits and services that are available to them,” including ABPs vs. other Medicaid benefits for adults. Such “information must be sufficient for the individual to make an informed choice” between available benefits.⁵²

Illustrative Monitoring Questions

If my state has expanded Medicaid and its ABP differs from benefits that Medicaid covers for other adults:

- How does the state define eligibility for the medical frailty exemption? Is the state definition at least as broad as the federal definition?
- How does the state inform beneficiaries about (1) the differences between the ABP and other Medicaid benefits for adults and (2) the steps required to qualify for a medical frailty exemption?
- What actions (if any) does the state Medicaid program take (1) to identify low-income adults who may qualify for a medical frailty exemption and, (2) once those adults are identified, to ensure that they can benefit from the exemption?
- What steps must a consumer take to qualify for the medical frailty exemption?
- If state procedures do not effectively inform potentially eligible beneficiaries about the medical frailty exemption and create an accessible process for qualifying as medically frail, are such shortcomings inconsistent with Medicaid program objectives, people with disabilities' rights under Section 504, or the best interests of applicants and beneficiaries? Do these shortcomings have a disparate adverse impact on people with disabilities, thus triggering a potential violation of ACA Section 1557?
- How does the state inform low-income adults about their right to have eligibility determined based on disability? What steps must such adults take to obtain such an eligibility determination? Are the state's policies and practices in this area inconsistent with Medicaid program objectives, people with disabilities' rights under Section 504, the best interests of applicants and beneficiaries, or nondiscrimination requirements of ACA Section 1557?

CMS has not required states to follow any particular procedures in identifying newly eligible adults who may qualify for the medical frailty exemption. However, more general laws could be read to impose duties of effective state action. For example, general Medicaid regulations require states to determine eligibility using standards

and methods that are "consistent with the objectives of the program and with the rights of individuals under the United States Constitution, the Social Security Act . . . section 504 of the Rehabilitation Act of 1973, and all other relevant provisions of Federal and State laws"⁵³ and in a manner "consistent with simplicity of administration

and the best interests of the applicant or beneficiary.”⁵⁴ And, as explained earlier, the nondiscrimination requirements of ACA Section 1557 apply to state Medicaid agencies.

2. *Beneficiary choice of eligibility category.*

CMS has made clear that given more than one basis for Medicaid eligibility, each beneficiary can select his or her eligibility category.⁵⁵ A consumer whose eligibility is based on a disability determination, using standards no less strict than those applied for SSI, is exempt from ABPs.⁵⁶ However, if a beneficiary requests such a determination and is found to meet those disability standards, from that point forward the state is limited to standard FMAP, rather than the highly enhanced FMAP that applies to low-income adults.⁵⁷ It is thus in states’ financial interests to ensure that people with disabilities can have their needs met within

the low-income adult category, without requesting a change in eligibility categories.

Not all people with disabilities will improve their circumstances by seeking a transfer to pre-ACA, disability-based Medicaid, which almost always limits eligibility to people with assets below a specified level. Such assets tests both limit coverage and complicate the enrollment process by requiring evidence of asset value. By contrast, ACA’s new eligibility category for low-income adults predicates financial eligibility on income alone, without regard to assets.

ACA’s new [Medicaid] eligibility category for low-income adults predicates financial eligibility on income alone, without regard to assets.

Application and Renewal Procedures

Among ACA’s requirements for Medicaid applications and renewals, two issues stand out in their potential impact on people with disabilities: (1) helping applicants for insurance affordability programs (IAPs) learn about and qualify for forms of Medicaid that are available above 100 or 138 percent FPL, which is the income range typically reserved for Marketplace subsidies; and (2) streamlined renewal, including administrative renewal based on reliable data showing continued eligibility.

One preliminary comment is important. People with disabilities in many states will have various options for the kinds of coverage they can receive, such as standard Medicaid benefits versus ABPs, or disability-based Medicaid versus Marketplace subsidies.⁵⁸ They may be asked questions with significant consequences

for their coverage options that are not self-evident. For example, people with disabilities may lose access to comparatively generous benefits available through traditional Medicaid if

they fail to answer disability-related questions on the IAP application form or if, after qualifying for Marketplace subsidies, they respond in the affirmative to questions about whether they want to drop their Medicaid applications. All of these complexities make it critically important for Medicaid agencies and Marketplaces to provide information and counselling during the application and enrollment process to help people with disabilities make informed choices.

Otherwise, they may not receive the full measure of gains from ACA that other people enjoy, raising questions under ACA Section 1557's non-discrimination rules.

Medicaid Eligibility above the Federal Poverty Level

ACA requires “no-wrong door” application procedures through which, regardless of where and how a consumer seeks coverage, the consumer is routed to the IAP for which he or she qualifies. Often this results in consumers with incomes above 100 or 138 percent FPL qualifying for Marketplace subsidies. Such subsidies are available to U.S. citizens and lawfully present adults who: (1) are not offered employer-sponsored insurance that meets ACA's standards for affordability and minimum value; (2) have incomes at or below 400 percent of FPL; and (3) have incomes above a specified minimum threshold. For adults, that threshold is 100 percent of FPL in states that do not expand Medicaid eligibility and 138 percent of FPL in expanding states.⁵⁹ For children, QHP subsidy eligibility is limited to those with family incomes above the upper income bound for Medicaid or CHIP eligibility.

In many states, Medicaid is available for some people with disabilities whose incomes are in the range where most consumers qualify for Marketplace subsidies.

Depending on the state, examples of such Medicaid eligibility categories may include:

- Medically needy coverage, available to those whose unreimbursed medical expenses reduce their disposable income to specified levels;
- Medicaid “buy-in coverage,” through which working people with disabilities can increase their earnings above standard Medicaid income limits without losing Medicaid services needed for employment; and
- Medicaid coverage of HCBS and other LTSS. Depending on the state and the characteristics of the individual consumer, such coverage may extend well above 100 or 138 percent of FPL.

These categories are sometimes termed “non-MAGI-based Medicaid.” In structuring eligibility

[P]eople with disabilities may lose access to comparatively generous benefits available through traditional Medicaid if they fail to answer disability-related questions on the IAP application form or if, after qualifying for Marketplace subsidies, they respond in the affirmative to questions about whether they want to drop their Medicaid applications.

for low-income adults and children, pregnant women, and certain other categories, ACA bases income determinations on modified adjusted gross income (MAGI). MAGI rules rely on federal income tax principles to define households, determine the value of income, and identify the deductions that reduce gross income to the net income level used to assess Medicaid eligibility. MAGI also defines eligibility for Marketplace subsidies. Medicaid eligibility

categories based on a finding of disability, in contrast, define income using pre-ACA financial

eligibility rules, including traditional income disregards and household definitions.

Used by the federal marketplace and in states that have not gained CMS approval for state-specific forms, the national IAP application contains several questions about

applicants' capacity to engage in basic activities of daily living. The online version asks whether applicants have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs; and whether they need help with activities of

Illustrative Monitoring Questions

If my state provides Medicaid eligibility for people with disabilities with incomes above the minimum level that qualifies for Marketplace subsidies:

- How does the IAP application used in my state ask about potential disability experienced by the applicant or members of the applicant's family?
- When an application indicates potential disability, what procedures are used to route the application to the Medicaid program? How often does the application fail to reach the Medicaid program? How (if at all) does the Marketplace inform consumers about Medicaid coverage above normally applicable income levels?
- How can applicants for Marketplace subsidies (or people found eligible for such subsidies) request a determination of eligibility for disability-based Medicaid? How are consumers informed about such procedures? How many requests have been received?
- For people with disabilities, what actions, if any, limit access to determinations of disability-based Medicaid, such as a consumer's (1) failure to answer disability-based questions on the IAP application or (2) agreement to withdraw a Medicaid application? How do the Medicaid agency and the Marketplace inform people with disabilities about the consequences of those actions?
- What procedures ensure Medicaid follow-up when the state Medicaid program receives an IAP application signaling the possibility of disability-based Medicaid? How frequently are these procedures used?
- While the Medicaid program is considering potential disability-based eligibility, do the affected household members receive subsidized Marketplace coverage?
- Are effective procedures in place for electronically transferring applicant's files between Medicaid and the Marketplace?

daily living or live in a medical facility or nursing home.⁶⁰ These questions seek to flag:

- The potential presence of disabilities and consequent eligibility for Medicaid above normal income thresholds; and
- Potential eligibility for the medical frailty exception among those who qualify for Medicaid as low-income adults.

When an IAP application signals potential disabilities within a household that is eligible for Marketplace subsidies, the application is sent to the state Medicaid program for analysis of disability-based eligibility. The Medicaid agency is supposed to follow up

with the family and obtain additional information to see whether family members qualify for Medicaid. In the meantime, the household can receive subsidized

Marketplace coverage, including advance premium tax credits (APTCs). If such an APTC recipient winds up qualifying for disability-based Medicaid, he or she shifts to Medicaid and is not required to repay the APTCs.

Whichever agency receives the IAP application must transfer the applicant's file electronically to the other agency without delay when such a transfer is needed to determine eligibility for assistance administered by the latter agency. These procedures apply either if the IAP application suggests potential disability-based Medicaid eligibility or if a consumer requests a determination of eligibility under non-MAGI Medicaid categories. However, consumers qualifying for Marketplace subsidies may be asked whether they want to drop their Medicaid applications; an affirmative answer

could foreclose a determination of eligibility for more comprehensive services through disability-based Medicaid.

Medicaid Administrative Renewal

Historically, so-called procedural terminations have been a significant problem facing Medicaid. Traditionally, consumers whose Medicaid eligibility periods were coming to an end would receive a notice from the state asking them to complete a form describing their current circumstances. Failure to complete and return the form would trigger a procedural termination, even if the beneficiary continued to be eligible.

[Under ACA], [i]f reliable data show continued eligibility for Medicaid, coverage is renewed administratively, without seeking information from the beneficiary.

ACA has created new renewal procedures.⁶¹ Medicaid programs must, on their own, examine available sources of data that can potentially demonstrate continuing eligibility. This

obligation to obtain information on the agency's own volition is termed *ex parte* renewal. Such data gathering can include the case records of other government programs, data provided by a federal data hub that furnishes IAPs with information from multiple federal agencies, quarterly wage and new-hires data from state workforce agencies, and private vendors that have payroll data from many large employers.

If reliable data show continued eligibility for Medicaid, coverage is renewed administratively, without seeking information from the beneficiary. In such cases, the state sends the beneficiary a notice of renewal, explaining the basis of the state's determination of continued financial eligibility. The beneficiary is informed of the legal duty to notify the state of any changed

Illustrative Monitoring Questions

- What rules and procedures has my state Medicaid program established for *ex parte* data gathering and administrative renewal?
- Does my state renew Medicaid eligibility administratively when case records from other need-based programs, like SSI and the Supplemental Nutrition Assistance Program (formerly known as food stamps), show continued financial eligibility?
- Has my state conducted data mining to identify beneficiary groups whose circumstances are so stable that continued eligibility is highly likely, such as people with disabilities whose eligibility is based on SSI receipt?
- Does my state provide administrative renewal under circumstances where such renewal occurs in other states (e.g., participants in Medicare Savings Programs, households where income consists entirely of Social Security payments, recipients of LTSS or HCBS, people with incomes below certain levels)?

circumstances that could affect Medicaid eligibility. Medicaid continues in place unless and until the beneficiary provides notice of changed circumstances. Administrative renewal also applies to households with characteristics that the state has found are reliably associated

with continuing eligibility. These procedures are required for all Medicaid eligibility categories.⁶² Our earlier roadmap discussed these issues at length, providing both federal authorities and state examples of the kinds of data that can trigger administrative renewal.

Conclusion

ACA and its implementing regulations contain numerous important safeguards that are intended to help people with disabilities receive the complete benefit of this landmark legislation. The full meaning of these safeguards will become apparent with time, as

both HHS and the courts resolve questions that arise. One fact is already clear: the disability community's active involvement will be essential for people with disabilities to benefit fully from ACA's legal protections.

Endnotes

- 1 We very briefly touch on Integrated systems of Medicare and Medicaid coverage for dually eligible beneficiaries under demonstration projects authorized by the Centers for Medicare and Medicaid Services, which typically include home- and community-based services and other long-term services and supports.
- 2 U.S. Department of Health and Human Services, “Nondiscrimination in Health Programs and Activities; Proposed Rule,” 80 Federal Register 54172–54221 (September 8, 2015), <http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf>.
- 3 In some cases, Section 1557 applies to employer-sponsored insurance—namely when (1) the coverage is for employees engaged in a health program or activity on behalf of the employer or (2) the employer receives federal financial assistance that helps fund its health coverage for employees.
- 4 See our earlier Roadmap to ACA Implementation for a discussion of the Access Board’s draft standards.
- 5 Proposed 45 CFR §92.4.
- 6 Proposed 45 CFR §92.204(a).
- 7 Proposed 45 CFR §92.204(b).
- 8 Proposed 45 CFR §92.302(c).
- 9 Much of the discussion in this section is taken from National Council on Disability, “Implementing the Affordable Care Act: A Roadmap for People with Disabilities,” 2015.
- 10 42 USC 300k(a)(1)(A), enacted in ACA §4302(a).
- 11 Public Health Service Act §3101(h) [42 USC 300k(h)].
- 12 Public Health Service Act §3101(h) [42 USC 300k(h)].
- 13 These provisions are codified in Social Security Act §§ 1902(a)(76) and 2108(e)(7) [42 USC §§ 1396a(a)(76), 1397hh(e)(7)].
- 14 HHS, November 2014, “Report to Congress Improving the Identification of Health Care Disparities in Medicaid and CHIP,” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/4302b-rtc-2014.pdf>.
- 15 An example of the latter is the work being done by the National Quality Forum to develop quality measures for HCBS. See, for example, National Quality Forum, Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Initial Components of the Conceptual Framework: Interim Report, July 15, 2015, <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=79920>.
- 16 Employers typically limit their exposure by purchasing so-called “stop loss” coverage, through which an insurer agrees to pay claims that exceed a specified, threshold amount.
- 17 ACA §1302(b)(2)(A).
- 18 45 CFR 156.115(a)(1).
- 19 <http://www.ecfr.gov/cgi-bin/text-idx?SID=e57482648c344b31ae3b450b2791ea40&mc=true&node=sp45.1.156.b&rgn=div6>.
- 20 Harrison Institute for Public Law, Georgetown Law, “Issue Brief: State Implementation of Essential Health Benefit Requirements,” January 8, 2014, http://webcache.googleusercontent.com/search?q=cache:-zhyuhczvM1QJ:www.law.georgetown.edu/academics/academic-programs/clinical-programs/our-clinics/hip/upload/harrison_chir-issue-brief-v-1-8-14-1.docx+&cd=2&hl=en&ct=clnk&gl=us.
- 21 The roadmap focuses on the safeguards that appear to be of greatest importance to people with disabilities. Notable examples of provisions we do not explore are (1) requirements under ACA §1302 (b)(4)(A) and 45 CFR § 156.110(e) that the total EHB package should “reflect an appropriate balance” among service categories, “so that benefits are not unduly weighted toward any category”; and (2) the requirement to cover, without any

- out-of-pocket cost-sharing, all preventive services that have a rating of A or B from the United States Preventive Services Task Force. For the latter, see Public Health Service Act §2713 (42 U.S.C. 300gg–13), added by ACA §1001(1), 45 CFR §§156.115(a)(4), 147.130.
- 22 Center for Consumer Information and Insurance Oversight (CCIIO), “Information on Essential Health Benefits (EHB) Benchmark Plans” (undated), https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#review_benchmarks.
- 23 Laura Skopec, et al., “Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans,” *ASPE Research Brief*, HHS Assistant Secretary for Planning and Evaluation, December 2011, <http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml>.
- 24 As explained in our Roadmap to ACA implementation, this prohibition would increase the total number of covered services if insurers feel constrained against reducing rehabilitation visits significantly below the amounts that were covered in the past.
- 25 HHS, Notice of Benefit and Payment Parameters for 2016, Final Rule at 10811.
- 26 This section of the roadmap does not discuss several provisions within the EHB regulation for prescription drugs that go beyond issues of the medicines that the plan covers. Such issues include (1) transparency requirements for formularies and (2) rules for access to retail pharmacies within plan networks. See 45 CFR §156.122 (d) and (e).
- 27 45 CFR §156.122.
- 28 45 CFR §156.122(a)(3)(iii)(A), (D), (E), and (F).
- 29 45 CFR §156.122(a)(3)(iii).
- 30 45 CFR §146.136.
- 31 45 CFR § 156.115(a)(3).
- 32 ACA §2001(c), adding Social Security Act §1937(b)(6) (42 U.S.C. 1396u–7(b)).
- 33 For a good summary of parity requirements, see Sarah Goodell, “Health Policy Brief: Mental Health Parity,” *Health Affairs*, April 3, 2014, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=112. Further information about parity is available on websites for CCIIO at CMS, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html; the Substance Abuse and Mental Health Services Administration, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>; and the U.S. Department of Labor, <http://www.dol.gov/ebsa/mentalhealthparity/>.
- 34 Goodell, Health Policy Brief: Mental Health Parity.
- 35 ACA §1302(b)(4)(B), (C), and (D).
- 36 Govind Persad, “Priority Setting, Cost-Effectiveness, and the Affordable Care Act,” *American Journal of Law & Medicine*, (41) 119–165, 2015.
- 37 HHS, Notice of Benefit and Payment Parameters for 2016; Final Rule at 10821-22.
- 38 *Ibid.*
- 39 HHS, Nondiscrimination in Health Programs and Activities; Proposed Rule.
- 40 HHS, Notice of Benefit and Payment Parameters for 2016, at 10823.
- 41 CCIIO, “FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces,” February 20, 2015, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>.
- 42 *Ibid.*, p.38.
- 43 ACA §1301(a)(1)(C)(i).
- 44 As of January 2014, such states were Alabama, Missouri, Oklahoma, Texas, and Wyoming. See <https://www.cms.gov/ciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html>.
- 45 ACA §1311(e)(1)(B).
- 46 One unique issue involves the duty of P&T committees to ensure satisfactory drug formularies, discussed earlier. If a plan’s formulary fails to meet the regulatory standards that such committees are required to uphold, it is not clear whether the plan or its P&T committee would be the entity held responsible.

- 47 NAIC, "Health Benefit Plan Network Access and Adequacy Model Act," October 2015, <http://www.naic.org/store/free/MDL74.pdf>; HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Proposed Rule," 80 Federal Register 75488 (December 2, 2015), <http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf>.
- 48 Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," *State healthfacts*, Dec. 2015, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.
- 49 42 CFR 440.335 (c)(2).
- 50 42 CFR 440.335 (f).
- 51 42 CFR 438.50(d)(3), cited in 42 CFR 440.335(f).
- 52 CMS indicated that "benefits option counselling," as required by the proposed (and then withdrawn) 42 CFR 435.917(b) and (c), must be made available to new enrollees into the income-based eligibility category. CMS, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment," 78 *Federal Register* 42160- 42322 (July 15, 2013).
- 53 42 CFR 435.901.
- 54 42 CFR 435.902.
- 55 CMS. "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. Final Regulations." *Federal Register*. Vol. 77, No. 57. Friday, March 23, 2012. 17144; CMS. May 22, 2012. "Medicaid/CHIP Affordable Care Act Implementation. Answers to Frequently Asked Questions: Eligibility Policy." <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>.
- 56 42 CFR 440.315(b).
- 57 CMS, Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. Final Regulations.
- 58 In theory, someone who qualifies for disability-based Medicaid is ineligible for QHP subsidies. However, ACA regulations provide that unless and until someone eligible for QHP subsidies is found to qualify for Medicaid, such a person remains eligible for QHP subsidies.
- 59 One group can qualify for QHP subsidies with incomes below the specified FPL thresholds: namely, lawfully present noncitizens whose citizenship and immigration status make them ineligible for federally funded Medicaid coverage of non-emergency services.
- 60 Musumeci M. "The Affordable Care Act's Impact on Medicaid Eligibility, Enrollment, and Benefits for People with Disabilities," Kaiser Family Foundation, April 2014.
- 61 The text focuses on administrative renewal, which applies to all Medicaid categories. Another key renewal provision that affects all eligibility groups bars state Medicaid agencies from asking questions that are not needed to redetermine eligibility. See 42 CFR 435.916(e). Other ACA renewal provisions govern MAGI categories, but a state may extend them to non-MAGI groups as well, including those with people with disabilities. For example, if a state has partial information required for renewal but needs certain items from the beneficiary, the state sends the beneficiary a form pre-populated with the relevant information known to the state; the beneficiary is required to answer only the questions requesting additional information. Also, if a consumer is terminated for failing to provide the Medicaid agency with requested information, the consumer has 90 days in which to reinstate Medicaid eligibility by providing the missing information; and states may not require in-person interviews. See 42 CFR 435.916(a)(3). Renewal regulations specifically addressing non-MAGI categories give states the ability to automatically renew findings of disability and blindness, pending new determinations by the relevant review panel. See 42 CFR 435.916(b)(1) and (2). In addition to the above accessibility requirements, the renewal regulations specifically require renewal forms and notices to be accessible to people with disabilities. See 42 CFR 435.916(g).
- 62 42 CFR 435.916 (a)(2) and (b).



**National Council on Disability
1331 F Street, NW, Suite 850
Washington, DC 20004**