The Impact of the ACA on Elder Law and Special Needs Planning

by

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I. Introduction[1]

A. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act,[2] as amended by the Health Care and Education Reconciliation Act of 2010.[3] These two statutes are commonly referred to as the Affordable Care Act (ACA). The two most important legislative purposes of the ACA are**:**

1. To increase the number of Americans with health insurance; and

2. To ensure that health insurance satisfies certain minimum standards of coverage.

B. While some provisions of the ACA are already in effect, the main impact will be felt beginning January 1, 2014. Enrollment for plans beginning on January 1, 2014 will begin October 1, 2013.

C. In May 2013, the Congressional Budget Office estimated that by 2023, the ACA will reduce the number of uninsured nonelderly people from 55 million to 31 million, thereby increasing the percentage of nonelderly people with health insurance to 89%.[4]

D. Only one state, Wisconsin, will spend less per capita than Virginia in providing information to the public about the ACA.[5] For this reason, it is essential for elder law and special needs attorneys to educate their clients about the ACA, its implementation, and the benefits available under the ACA.

II. Means of Expansion of Coverage

A. The expansion of health insurance coverage will come about due to a mandate requiring individuals to purchase insurance, certain financial incentives for those who enroll, and penalties for those who refuse to do so.

B. The mandate requires all individuals to have health insurance coverage. An exemption applies to (i) those having a religious exemption; (ii) non-U.S. citizens or illegals; and (iii) incarcerated individuals. Subject to such exceptions, individuals who

[1] This outline is based in part on an article entitled "The Impact of the ACA on Special Needs Trusts" written by Thomas D. Begley, Jr. and Andrew H. Hook, to be published in the fall of 2013 in Estate Planning magazine.

[2] HR 3590, PUB. L. NO. 111-148.

[3] HR 4872, PUB. L. NO. 111-152.

[4] *See* http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareAct HealthInsuranceCoverage_2.pdf.

[5] *See* http://www.wric.com/story/22918299/virginia-near-bottom-in-health-care-reform-awareness-spending.

fail to obtain a medical insurance policy providing minimum essential coverage will be penalized.[6]

C. Small employers will be encouraged to provide coverage for their employees. There will be a tax credit for 2014 and 2015 for certain small employers who comply, but there will be no penalties for failure to participate.

D. Large employers (50 or more full-time equivalent employees) will be required to offer coverage to employees. There will be financial penalties for noncompliance.[7]

E. Expansion of health care coverage is to be achieved largely by expansion of the Medicaid program to families having income up to 138% (133% plus a 5% income disregard) of the Federal Poverty Guidelines (FPL),[8] by providing premium subsidies to make insurance more affordable for people with income up to 400% of the FPL, and by building on employer-based coverage.

1. The Supreme Court of the United States has determined that states cannot be required to expand Medicaid coverage.[9]

2. 26 states have expanded Medicaid coverage as of June 2013.

3. Many other states will likely elect not to do so.

4. Virginia is still undecided on Medicaid expansion. In its 2013 session, the General Assembly created the Medicaid Innovation and Reform Commission[10] to

[6] In 2014, the annual individual penalty will be $95 per adult and $47.50 per child, up to a family maximum of $285 or 1% of family income, whichever is greater. In 2015, the penalty will be $325 per adult and $162.50 per child, up to a family maximum of $975 or 2% of family income, whichever is greater. In 2016, the penalty will be $695 per adult and $347.50 per child, up to a family maximum of $2,085 or 2.5% of family income, whichever is greater

[7] Regardless of whether a large employer offers health care insurance to its employees, it will only be potentially liable for a penalty if a full-time employee obtains coverage through a Marketplace and receives a premium tax credit. If this is the case and the employer offers no coverage, the penalty is $2000 per full-time (30 hours per week or more) employee over a threshold of 30 covered employees. If the employer offers coverage but it is not adequate (i.e., does not pay at least 60% of the health care expenses of the typical person) and affordable (i.e., the premium is less than 9.5% of the employee's household income), the penalty is $3000 times the number of employees receiving subsidized coverage on a Marketplace, up to a maximum of $2000 times the number of full time employees less 30. However, in June 2013, the Internal Revenue Service and the White House announced that large employers will not be required to report on health care coverage for their employees and will not be penalized for failure to provide coverage until 2015.

[8] The 2013 FPL for a single individual is $11,490; $15,510 for a family of two; $19,530 for a family of three; and $23,550 for a family of four. *See* Exhibit A for 2013 FPL.

[9] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. ____, 132 S.C. 2566 (June 28, 2012).

[10] Virginia Code § 30-347.

study the issue. The Commission could approve expansion as early as the middle of 2014, if it finds the goals of a three-phased plan of Medicaid reform set out in the budget have been met. The issue will probably be influenced by the 2013 gubernatorial elections.[11] The Republican candidate is opposed to expansion, and the Democratic candidate supports expansion.[12]

III. Health Insurance Marketplaces

A. Health Insurance Marketplaces (Marketplaces), previously known as Health Insurance Exchanges, are designed to assist low and moderate income individuals and families and small businesses in purchasing a health insurance plan that is eligible to receive federal subsidies. If an individual is eligible for Medicare,[13] he or she will not qualify for health coverage under a Marketplace.

B. Marketplaces can be established by states or state/federal partnerships, or operated through the federal government**.**

C. Marketplaces must offer qualified health plans (QHPs),[14] which provide Essential Health Benefits. Essential Health Benefits (EHBs) are defined in the Act.[15]

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[11] The central issue in this debate is who will pay for the health care of about 400,000 low income Virginians who would become eligible for Medicaid if expansion is approved. If expansion is not approved, the cost will be shifted to the hospitals due to ACA reductions in federal Disproportionate Share Hospital Grants beginning in October 2013. If the cost is shifted to the hospital, the hospital must in turn shift the cost to its other patients and their health insurance companies. If Medicaid is expanded, the federal government will pay 100% of the cost in 2014 and 2015. The federal share phases down to 90% by 2020 and beyond. From 2013 to 2022, if Medicaid is expanded, the Urban Institute projects that the expansion will cost the state about $2.7 billion. The Virginia Hospital and Healthcare Association projects expansion will generate about $3.9 billion in annual economic benefits and 30,000 jobs.

[12] Medicaid expansion in Virginia will result in 425,000 additional people being covered by Medicaid who do not have it at the present time and $10 billion of federal spending in the state over the next 5 years. If Virginia fails to expand Medicaid, the ACA does not provide any assistance for people with income below 100% of the FPL in obtaining health insurance.

[13] In light of the one-year delay in reporting by large employers, in 2014, how will the Marketplaces determine if the individual is eligible for subsidies for the purchase of insurance on the Marketplace? This is an open question at the present time.

[14] QHPs must be certified as meeting the criteria for Marketplaces, provide an essential health benefits package, and be offered by a licensed health insurance issuer. The QHP must satisfy limits of cost-sharing and deductibles.

[15] EHBs must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative (gaining function when patient did not previously have this function) services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. Essential Health Benefits do not include abortion services, dental and vision services, long-term care insurance, coverage for specific diseases, hospital indemnity policies, and Medicare supplemental health insurance.

1. The states will designate the services offered to provide these EHBs by using one of the top three plans sold in the state. If the state fails to choose, then the largest small group plan will determine the services used to provide the EHBs. EHBs will vary from state to state**.** Therefore, the policies sold by different state Marketplaces will vary slightly**.**

2. Virginia chose the 1) Anthem PPO KeyCare 30 plan, the small group health care plan with the largest enrollment and 2) the Medicaid CHIP plan for pediatric dental services to serve as the EHBs benchmark plans for policies sold on the Virginia Health Insurance Marketplace.**[16]**

D. The ACA provides that Marketplaces offer four levels of coverage.[17]

E. An applicable taxpayer[18] is eligible for a refundable tax credit, known as a premium tax credit or premium assistance credit (PTC), to pay for insurance from a QHP.

1. The taxpayer does not have to file and receive the credit on his or her tax return, but may elect to have the credit paid directly to the insurance company to help pay premiums**.**

2. The amount of the PTC is determined by comparing the taxpayer's household income and the FPL. Household income is defined as the taxpayer's and his household members' Modified Adjusted Gross Income (MAGI) increased by (i) tax exempt interest and (ii) the excluded portion of the taxpayer's Social Security benefits.[19]

3. The amount of the PTC is based on a sliding scale determined by reference to the premium for a Silver level plan and the applicable percentage (the

[16] *See* http://www.scc.virginia.gov/boi/co/acafilinginfo/files/ehbcheck.pdf.

[17] Bronze - 60% of full actuarial value of the benefits provided under the plan; Silver - 70%; Gold - 80%; and Platinum - 90%. There is a fifth level called the Catastrophic Plan Coverage Level, but is only available to persons under the age of 30 or who are otherwise exempt from the individual mandate tax due to the fact that they cannot afford coverage or have suffered a hardship.

[18] An applicable taxpayer is one whose household income is at least 100% but not more than 400% of the Federal Poverty Line.

[19] The Marketplace is supposed to verify whether people who buy insurance at exchanges are eligible for federal subsidies to help with monthly premiums. That depends on an applicants' current income, something the Marketplace won't know from querying IRS tax records, which can be a year out-of-date or more. To verify eligibility, applicants will be asked to attest to their current income. For people who report income 10% more or less than the most recent tax return, or if there is no recent tax return and the hub cannot access data verifying income, a random sample of applicants will be asked to provide additional documentation.

maximum percentage of household income the taxpayer will have to pay for health insurance).[20]

F. Individuals enrolling for coverage under a Marketplace may be eligible for a percentage reduction of the maximum out-of-pocket cost based on their household income.[21]

G. After President Obama's re-election, Governor Bob McDonnell notified the United States Department of Health and Human Services (HHS) that Virginia would not proceed with a state-based Marketplace. While the norm for the federally-operated Marketplace leaves no role for the state, McDonnell did lobby for oversight of the health plans that will operate on the Marketplace within the state. HHS approved McDonnell's request in March 2013. The General Assembly authorized the State Corporation Commission to manage health insurance plans offered on the Marketplace and to enforce insurance reforms under the ACA. Therefore, Virginia will have a hybrid health insurance Marketplace.

H. In Virginia, as of August 1, 2013, the State Corporation Commission has recommended fifteen plans to compete in the Virginia health insurance Marketplace. Nine insurance carriers will offer health coverage for the individual market, and six will sell coverage for small businesses, although the number of available offerings will vary across the state. Among the insurers that have been recommended to participate in the exchange are Aetna Life Insurance Co., Coventry Health Care of Virginia Inc., Anthem BlueCross BlueShield, the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and Optima Health Plan. Most regions of Virginia will have three or four plans available; however, several regions in southwest Virginia will have only one plan. Because Virginia did not elect a state-based Marketplace, the final rates will remain unknown until the federal government decides which plans will compete on the Marketplace and what they can charge.[22] However, the Department of Health and Human Services projects that on average, a Silver plan for an individual will cost about $320 per month.

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[20] A sliding scale beginning at 2% for household income at 100% of the FPL and rising to 9.5% for those taxpayers at 400% of the FPL.

[21] People who qualify for premium assistance will also get a cost sharing subsidy if they purchase a Silver level plan. Depending on their income, the subsidy will reduce the limit on out-of-pocket expenditures. In addition to the reduction on the limit on out-of-pocket expenditures, for people with income below 250% of the FPL, the federal government will make a payment to the insurer to increase the actuarial value of the plan. The federal government will make payments directly to the insurer for the costs associated with these subsidies.

[22] Michael Martz, *Virginia Set to OK 15 plans in Insurance Exchange*, Richmond Times-Dispatch, August 1, 2013.

I. The health insurance Marketplace will begin enrolling individuals on October 1, 2013 and will begin operating on January 1, 2014. The first open enrollment period closes on March 31, 2014. The ACA requires health insurance Marketplaces to have annual open enrollment periods and special enrollment periods.[23] Individuals can only purchase a QHP on a Marketplace during one of the permitted enrollment periods.

IV. ACA Provisions Applicable to all Health Insurance Plans

A. No lifetime or annual limits;[24]

B. Prohibition of rescission of coverage;[25]

C. Extension of dependent coverage;[26]

D. Prohibition on preexisting conditions exclusions;[27]

E. No excessive waiting periods for eligibility to become covered by a plan;[28]

F. Providing a summary of benefits and coverage (SBC) to participants;[29]

G. Deductible limitation;[30]

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[23] Special enrollment periods will be the same as under current law for group health plans.An individual will be able to enroll him- or herself and eligible dependents if other coverage is lost mid-year due to divorce, death of a spouse or dependent, or loss of other employment-based coverage; or if a new dependent is gained due to marriage, birth or adoption.

[24] The ban on caps for lifetime or annual limits is somewhat deceptive. The statute bans dollar caps. Beginning January 1, 2014, annual limits on the dollar value of essential health benefits for any participant cannot be established. However, while limits based on dollar value are specifically excluded, there appears to be nothing to prevent limits being placed on a benefit (e.g., number of visits or treatments per plan year).

[25] An insurer cannot rescind a policy except for fraud or intentional misrepresentation of a material fact.

[26] If a plan covers children, they can be added or kept on the health insurance policy until they turn 26 years old.

[27] Under the ACA, an individual with preexisting conditions must be covered without regard to medical history. A *preexisting condition* is a condition that existed prior to the effective date of health coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received prior to that date.

[28] Waiting periods cannot exceed 90 days.

[29] An SBC is a short, plain-language Summary of Benefits and Coverage including a Uniform Glossary of terms used in health coverage and medical care. This information permits comparisons of different plans. All individual and group health plans must use the same standard form. The SBC is available for every plan in the Marketplace. You may also ask an insurance company or group plan for an SBC at any time.

H. No cost sharing for preventive care;[31]

I. Plan enrollees are allowed to select any available participating primary care provider;[32]

J. Premiums can be based only on limited factors;[33]

K. Limitation on Medical Loss Ratio (MLR);[34] and

L. Effective process to appeal coverage determinations and claims.[35]

V. The Impact of the ACA on Elder Law

A. *Income Tax Planning Will be Increasingly Important*

1. Medicare Tax on Earned Income. Beginning in 2013, individuals must pay an additional .09% Medicare tax on earned income in excess of $200,000 for an

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[30] The combined annual deductible of annual out-of-pocket expenses (not including premiums) in 2013 is $6,250 for individuals and $12,500 for family coverage. This is indexed for inflation. However, the federal government has granted a one-year grace period to some group health plans, allowing them to maintain separate out-of-pocket limits for benefits in 2014. For example during 2014, a consumer may be required to pay $6,350 for doctor's services and hospital care and an additional $6,350 for drugs. After 2014, all plans will be required to have a single overall limit on out-of-pocket costs for each individual or family.

[31] Most health plans must cover a set of preventive services like shots and screening tests at no cost to the insured. This includes Marketplace private insurance plans. For a list of preventive services, see: https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

[32] The insured can choose any available primary care provider in their insurance plan's network. The insured can choose any available network pediatrician as his or her child's primary care doctor. The insured does not need to get a referral from a primary care provider before she can get obstetrical or gynecological (OB-GYN) care from a specialist. Insurance plans cannot require higher copayments or coinsurance. if the insured gets emergency care from an out of network hospital. The insurance company also cannot require the insured to get prior approval before getting emergency room services from a provider or hospital outside his or her plan's network

[33] These factors are: 1) coverage for an individual or a family; 2) geographic location; 3) age; and 4) tobacco use.

[34] Medical expenses/premiums. A large group plan must maintain an MLR of 85%, while an individual or small group policy must maintain an MLR of 80%. If these ratios are not maintained, the insurer must issue a refund. Medicare has an MLR of 97%. As of July of 2013, the Department of Health & Human Services found the limitation on MLR has saved Americans an estimated $1 billion.

[35] An insured will have the right to appeal private health plan decisions. Private insurance plans must disclose why a claim has been denied and must let you know how you can dispute their decision. The insured can ask the insurance company to reconsider its decision to deny payment for a service or treatment, and the insurer must review its decision. If the insurance company still denies payment, the law allows the insured to have an external review. The review will be done by an independent organization that will decide if the insurance company should pay or not.

individual, $250,000 for married couples filing jointly, or $125,000 for married couples filing separately.

2. Medicare Tax on Net Investment Income. Beginning in 2013, a 3.8% unearned income Medicare tax applies to all or a portion of the net investment income of certain individuals estates and Trusts.

a) Individuals. The tax applies to individuals with modified pay Adjusted Gross Income over $200,000, $250,000 for married filing jointly and $125,000 for married filing separately.

b) Estates and Trusts. The tax applies to estates or trusts with Adjusted Gross Income (AGI) over $11,950 in 2013. This tax should further encourage distributions of income to beneficiaries rather than accumulation of income.

3. Itemized Deduction for Medical Expenses. Beginning in 2013, the threshold for tax deductibility of unreimbursed medical expenditures is increased from 7 1/2% to 10% of AGI.[36]

4. PTC and Cost Sharing Subsidies. Beginning in 2014, a taxpayer's PTC and cost-sharing subsidies will be calculated using his or her household MAGI increased by tax exempt interest and the excluded portion of Social Security benefits.

B. *Medicaid*

1. Medicaid Parity. The ACA requires parity of reimbursement for Medicaid and Medicare services to primary care physicians in 2013 and 2014. This should encourage primary care physicians to participate in the Medicaid program.[37]

2. Traditionally Eligible. Traditionally eligible individuals (i.e., those who are already eligible for Medicaid in their state) will continue to receive the services to which they are already entitled, whether they enroll before or after 2014.

3. Newly Eligible. If Virginia approves Medicaid expansion, beginning in January 2014, individuals under 65 years of age with income below 133% of the Federal Poverty Level (FPL) will be eligible for Medicaid without regard to their resources.

[36] The 7.5% threshold is retained for persons age 65 or older until 12/31/2016.
[37] Section 1202 of the ACA.

a) The newly eligible will not necessarily be entitled to the same standard Medicaid benefits as the traditionally eligible.

b) The states may provide them with a package of benefits similar to those provided by plans sold on the insurance Marketplaces.

C. Medicare.

1. The doughnut hole in Medicare Part D will be gradually reduced to 25% in 2020 for both brand name and generic drugs.

2. Medicare Part A will provide minimum essential coverage under the ACA, i.e., satisfy the individual mandate.[38]

3. Payments to Medicare Advantage plans will be reduced to levels comparable to payments for traditional Medicare. This may reduce the level of benefits provided by Medicare Advantage plans.

D. Retirement Planning.

1. Retirement Planning has increasingly become an important component of elder law. Our clients are concerned about running out of money and being unable to pay for essential health and long-term care.[39] The new taxes imposed by the ACA must be factored into their retirement plans.

2. Beginning in 2014, individuals retiring before age 65 will be able to obtain health insurance without pre-existing condition exclusions. It is likely that many such retirees will elect to obtain coverage under a Marketplace, rather than electing COBRA continuation coverage because of the greater range of insurance options. Because COBRA coverage is limited to 18 months while there is no similar limitation under the ACA, some individuals may elect to retire at an earlier age.

E. Long-Term Care Services

[38] Medicaid, Tricare for Life, and the Veterans Health Care Program also provide minimum essential coverage.

[39] According to a Merrill Lynch study, paying for healthcare expenses is the top financial concern of retirees. Only one in nine pre-retirees feels completely confident in his or her ability to pay retirement healthcare expenses. Pre-retirees feel they are in uncharted territory and feel the need for guidance. See Americans's Perspectives on New Retirement Realties and the Longevity Bonus, a 2013 Merrill Lynch Study, conducted in partnership with Age Wave.

1. The American Taxpayer Relief Act of 2012 (ATRA) repealed the ACA long term care benefit called the Community Living Assistance Services and Support Act (CLASS Act).

2. In its place, ATRA created a 15-member commission to make recommendations to Congress concerning how to develop and finance a plan that assures the availability of long-term care services and support to individuals. In April 2013, all members of the commission were appointed. The Commission has 6 months to make its report. Expectations for this commission are not high.

3. Private long-term care insurance policies are not covered by the ACA.

4. Long-term care benefits are not included in the EHBs that will be provided by health insurance policies sold on state Marketplaces.

VI. The Impact of the ACA on Special Needs Planning

A. Guardians, conservators, and agents under advance medical directives should determine if they should purchase health insurance for their ward/principal from a Marketplace.

B. In the future, guardianship and conservatorship appointments should expressly authorize the purchase of health insurance.[40]

C. The advantage to avoiding special needs trusts (SNTs) is that there are no attorney's fees for drafting the document or trustee's fees for administering the trust. In the case of a self-settled SNT, the Medicaid payback could be avoided.

D. Factors that must be considered in determining whether or not a SNT will be necessary:

1. *No Asset Test.* Under the ACA, there is no asset test for medical insurance.

2. *Coverage.* The good news for clients with disabilities, particularly those that fall into the 24-month waiting period for Medicare and are not afforded a

[40] For example: The guardian/conservator is authorized to purchase health insurance for the benefit of the ward, including health insurance purchased through a Marketplace created pursuant to the Affordable Care. The guardian/conservator is further authorized to retain the services of and rely upon an attorney or health insurance consultant to assist in the selection of the appropriate health insurance coverage.

COBRA policy,[41] is that they will be able to obtain medical insurance under the ACA despite their preexisting conditions. The question then arises as to what the impact of this provision will have on SNTs. It is likely that there will be some impact on these trusts and that it will be different for third party and first party trusts. The key issue for both types of trusts is coverage. Policies under the ACA, like current private medical insurance policies, tend to cover acute care, rather than chronic care. Hospitalization, surgeries, and doctor's visits are likely to be included under the new policies. However, home and community-based services are likely to be excluded. Clients will still need Medicaid to pay for these services. Typically, home and community-based services include therapies (speech, physical, occupational, and cognitive) beyond what private or ACA insurance will provide, behavioral programs, environmental/vehicular modifications, structured day programs, supported day programs, respite care (in-home or at a Community Residential Services [CRS] facility) and adult companion care. For clients residing in a Community Residential Services (CRS) facility, certain services such as personal care, night supervision, transportation and therapeutic recreation may be covered by Medicaid but not by insurance under the ACA. Eventually, many individuals with disabilities require placement in some form of residential setting. This could be a group home, an assisted living facility, or a nursing home. Private insurance covers little, if any, of that care. Typically, this residential care is funded through Medicaid dollars. Significantly, while the ACA prohibits dollar caps on benefits provided under an ACA policy, the statute appears to be interpreted to mean that there is no reason why limits cannot be placed on services such as number of hospital visits, number of therapies, etc. Once a client has reached those limits, Medicaid would provide the necessary services. For a third party SNT, it is likely that the ACA will have little impact, because most clients with disabilities require coverage that will not be included in the ACA policies.

3. *SSI.* For many clients, SSI is an important benefit. Currently, the 2013 federal SSI benefit for a single individual is $710 per month, or $8,520 per year. Many states provide small supplements to the federal benefit. This is a significant amount of income for a person of modest means who will never be able to work in the future. SNTs ensure continuation of this benefit for beneficiaries with

[41] The ACA makes it clear that Health Insurance Marketplaces must allow "special enrollment" for employees and their dependents losing employment based essential health coverage. Therefore, employees and their dependents may be less likely to elect COBRA coverage because of the range of insurance options and premiums under the Marketplace. Under Health Insurance Portability and Accountability Act (HIPAA), health insurance plans and insurers must allow "special enrollment" for employees and/or their dependents who are losing other coverage.

disabilities. Over twenty years, that could amount to $170,400 plus the state supplement and inflation adjustments.

4. *Self-Settled SNTs.* For a self-settled SNT, all of the previously mentioned considerations apply. In cases involving inheritances, alimony, equitable distribution, and child support payments, the ACA should have little impact. However, in personal injury cases there is an additional consideration.

5. *Collateral Source Rule.* A large component of most personal injury settlements is the amount paid by the defendant to the plaintiff for future medical care. Going forward, after the implementation of the ACA, the effect of the Collateral Source Rule must be considered. The common law version of the Collateral Source Rule prohibits the introduction of evidence regarding collateral payments received by the plaintiff in his suit for damages. The rule prevents the reduction of an award by any amount owed by third parties already paid to or on behalf of the plaintiff. In states such as Virginia, which strictly observes the Collateral Source Rule,[42] the ACA is likely to have little effect on the payment of monies from a defendant to a plaintiff for future medical care.

a) However, many states have modified versions of the Collateral Source Rule and other states permit subrogation rights for the collateral source to collect either against the defendant or by placement of a lien on the personal injury settlement. The effect of the ACA on personal injury settlements in these jurisdictions will depend on the form of the Collateral Source Rule in effect in any given state.

b) Other states have completely abrogated the Collateral Source Rule. In those states, defendants may argue that they no longer need to pay large sums of money to the injured plaintiff for future medical care; instead, they should only be responsible for the defendant's out-of-pocket expenses. Therefore, an argument can be made in those states without a Collateral Source Rule that damage awards for health expenditures should be capped at a maximum of annual premiums plus $6,250 (the maximum deductible) for an individual in 2013. There would have to be some provision made for future increases in the ACA premiums and in the deductible caps, because they are indexed for inflation. However, this cap would apply only to future health care expenditures covered by the ACA. The ACA provides coverage for acute care, rather than chronic care. Therefore, home and community-based services, such as attendant care, home care, assisted living facilities, and nursing homes, would not be

[42] *See, e.g., Acuar v. Letourneau*, 260 Va. 180, 531 S.E.2d 316 (2000).

covered. At the time of this writing, it is too early to determine what else will not be covered.

c) There is also an argument being made that once the ACA is fully implemented, there is little reason to continue the Collateral Source Rule.[43] If the Rule is discontinued, this would be significant tort reform. The argument against the Collateral Source Rule is that it results in double recovery for some claimants and inflated insurance costs. To address rising healthcare costs, it is likely that the call to eliminate or modify the Collateral Source Rule will continue.[44]

d) Whether or not personal injury awards are reduced because defendants are not required to pay for future medical expenses covered by the ACA remains to be seen. Unless and until the Collateral Source Rule is repealed, it is likely that personal injury settlements will include a component for future medical care.

6. *Current Trusts.* There will be some instances in which an SNT is no longer required. Attorneys may want to analyze the existing trusts and consult with the beneficiary as to the advisability of terminating the trust. If the trust is a self-settled trust, it will be necessary to pay off Medicaid for services rendered to date, and then distribute the remaining principal and accrued income, if any, to the trust beneficiary. In the case of an incapacitated beneficiary, the distribution would have to be made to a guardian. In some instances, the guardian may want to continue the trust for the beneficiary. In addition to public benefits eligibility, other reasons for continuing a trust include money management and protection of the beneficiary from himself and from family, friends and predators. In the case of a minor beneficiary, it might be wise to continue the trust to ensure the minor does not obtain the funds until some age beyond legal majority, i.e., 30 or 35.

VII. Conclusion

A. *General Observations*

1. The ACA is an extremely complex law, and rules and implementation continue to evolve.

[43] Ann S. Levin, *The Fate of the Collateral Source Rule after Healthcare Reform*, UCLA Law Review, 60 UCLA L. Rev. 736 (2013).

[44] As of 2006, 39 states have modified or eliminated the Collateral Source Rule. *See* Schap and Feeley, *(Much) More on the Collateral Source Rule*, College of the Holy Cross, Department of Economics Faculty Research Series, Paper No. 06-05, June 2006.

2. It is improbable that the ACA will be repealed, but further amendment of and/or change in the implementation of the ACA is certain.[45]

3. The ACA reduces the "tie" between marriage or employment and health care coverage**.** The ACA may result in more divorces, increased job mobility, and more retirements before age 65, the Medicare eligibility date.

4. Because the ACA penalizes large employers for failing to provide healthcare coverage for employees who work 30 hours or more per week, some large employers may reduce the hours of employees below this threshold**.**

5. The expansion of the number of people with health insurance will increase the need for primary care physicians. This will require the training of additional primary care providers**.**[46] To avoid crowded waiting rooms for primary care physicians, there may be a growing demand for concierge medicine and licensing of independent Nurse Practitioner practices.

6. To reduce costs and hold premiums down. many policies sold on the Health Insurance Marketplaces will be structured as HMO's or PPO's with limited choice of network providers. Insurers will likely bet that persons shopping on Marketplaces will be willing to exchange flexibility and choice for lower premiums.[47]

7. Income tax return preparation will be more complex for persons with household income between 100% and 400% of the FPL.

8. Because 60% of bankruptcies are a result of unpaid medical bills,[48] the ACA may reduce the number of bankruptcies**.** Avoidance of bankruptcy will permit our clients to better prepare for their retirement**.**

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[45] The ACA has already begun to evolve. First the Class Act was repealed, followed by the Supreme Court declaring penalties for failure to expand Medicaid coverage unconstitutional, and concluding with the recent delay in the implementation of employer mandates.

[46] Section 5301 of the ACA authorizes funds to increase the primary care workforce by training more doctors, nurses, nurse-practitioners, and physician assistants. It includes more graduate medical education training positions, with priorities for primary care and general surgery, and more money for scholarships and loans for all health professionals.

[47] Many Health Insurers to Limit Choice of Doctors, Hospitals, Anna Wilde Mathews, Wall Street Journal, August 14, 2013.

[48] Medical Bankruptcy in the United States, 2007; Results of a National Study, Himmelstein and others, The American Journal of Medicine (2009). The study concludes that illness and medical bills contribute to a large and increasing share of U.S. bankruptcies. *See also* "Bitter Pill: Why Medical Bills Are Killing Us." Time.com (2013). Available at http://www.time.com/time/magazine/article/0,9171,213 6864,00.html. Accessed March 13, 2013.

9. Our clients, including fiduciaries for incapacitated persons, will require expert assistance to comply with its rules and to obtain its benefits.

10. Elder law and special needs attorneys should undertake a thorough review of the ACA to provide this counsel to our clients**.**

B. *Elder Law*

1. To assist clients in navigating a complex set of rules including the ACA, Medicare, Social Security, and the Internal Revenue Code, comprehensive retirement planning will become an essential part of elder law services.

a) Income tax planning and return preparation for retirees, near retirees, and fiduciaries will become increasingly complex.

b) With the introduction of the Marketplaces, retirees and near retirees will have additional options to consider when evaluating how to pay for medical expenses.

c) For peace of mind and to avoid running out of money, our clients will require a comprehensive retirement plan incorporating planning for: 1) cash flow and budgeting, 2) income tax, 3) insurance, 4) investment, 5) retirement plan withdrawal, and 6) estate planning.

d) Elder law attorneys must educate staff and develop infrastructure to provide these services**.**

2. The increased estate tax exemption[49] and the increased use of the income tax to raise revenue will result in strategies to include assets in the client's estate to obtain a step-up in basis**.**

3. The increased threshold for deduction of unreimbursed medical expenses will increase the after-tax cost of private payment of long-term care expenses**.**

4. Our clients will require advice concerning healthcare and long-term care options.[50] We should be prepared to provide it by undergoing substantial education concerning health insurance and the ACA.

[49] $525,000 in 2013.

[50] Merrill Lynch reports that healthcare is the top issue about which retirees and pre-retirees are seeking information. *See* Americans' Perspectives on New Retirement Realities and the Longevity Bonus, a 2013 Merrill Lynch Study, conducted in partnership with Age Wave.

5. For clients who require long term care services to address a chronic illness, the ACA will not diminish the need for traditional Medicaid and VA asset protection planning.

C. *Special Needs Planning*

1. The ACA will have a significant positive impact on individuals with disabilities.

2. There may be less need for third party SNTs. When there is no likely need for Medicaid long-term care, or waiver services in the immediate future, a parent or grandparent may consider creating a discretionary trust that permits decanting[51] into a third party SNT.

3. It is likely that the ACA will have little impact on third party SNTs, and may eventually have some impact on first party SNTs. However, that impact seems to be minimal in most states (those having a Collateral Source Rule), but may be more significant in those states that do not have a Collateral Source Rule.

4. In any event, in drafting a third party or self-settled SNT, it makes sense to include a provision authorizing the trustee to purchase private medical insurance under the ACA.[52]

5. Appeals of coverage determinations and claims may develop into a new practice area**.**

Exhibit A

2013 Federal Poverty Level Guidelines

Family Size	**100%**	**400%**
1	$11,490	$45,960

[51] Virginia Code § 64.2-778.1 expressly authorizes decanting a discretionary trust into an SNT.

[52] For example, the Trustee is authorized to purchase health insurance for the benefit of the beneficiary, including health insurance purchased through a Marketplace created pursuant to the Affordable Care Act. The Trustee is further authorized to retain the services of and rely upon an attorney or health insurance consultant to assist in the selection of the appropriate health insurance coverage.

Family Size	100%	400%
2	$15,510	$62,040
3	$19,530	$78,120
4	$23,550	$94,200
5	$27,570	$110,280
6	$31,590	$126,360