Abstract

Two health reform-related changes to Medicaid could dramatically expand access to family planning services for low-income individuals: the expansion of Medicaid coverage to all individuals with incomes at or below 133% of the federal poverty level (FPL) in 2014, and the option for states to implement permanent Medicaid family planning expansion programs. Further, states can enhance the benefits of these changes by taking advantage of a new option to offer presumptive eligibility enrollment for family planning services, which would allow immediate Medicaid coverage for needed family planning services and supplies, including highly effective contraception, and create an accessible gateway to ongoing coverage.

Introduction

Low-income women and those living in poverty experience far higher rates of unintended pregnancy than higher income women. While a number of factors contribute to this disparity, a recent analysis found that an estimated 12.4 million adult women in the United States are in need of publicly funded contraceptives; the same analysis found that publicly funded family planning clinics meet 41% of the need for such services, averting some 1.5 million unintended pregnancies. Ready access to publicly funded family planning services, including the most effective methods of contraception, could improve the ability of low-income women to choose whether and when to bear children.

The passage of the Patient Protection and Affordable Care Act (ACA) created new opportunities to improve access to family planning services for women and men. Two broad changes to Medicaid have the potential to significantly expand access to publicly-funded family planning services for low-income individuals: the expansion of Medicaid coverage to all individuals with incomes at or below 133% of the federal poverty level (FPL) in 2014, and the option for states to implement permanent Medicaid family planning expansion programs. These changes extend eligibility for Medicaid family planning services and include other provisions for improved service delivery.

One important provision of the new Medicaid family planning expansion option allows states to offer presumptive eligibility enrollment specifically for family planning services. Presumptive eligibility enrollment allows individuals to temporarily enroll and receive covered services at the initial family planning visit. By offering presumptive eligibility for family planning services, a state can simplify the enrollment process, allowing a low-income woman to obtain affordable, effective contraception at her first family planning visit and maintain seamless coverage while she seeks approval for ongoing coverage.

This policy brief explores how ACA’s extension of Medicaid coverage and improvements to state Medicaid family planning programs have the potential to improve contraceptive access and affordability, which could also lower rates of unintended pregnancy and offer cost savings to states. In particular, this brief will focus on the ways in which presumptive eligibility enrollment could serve as a gateway to continuous Medicaid coverage and offer eligible low-income women more immediate access to an affordable, effective contraceptive method of their choice.

Access to All Contraceptive Methods

Easy access to effective contraceptive methods can help reduce the risk of unintended pregnancy. However, cost can present a barrier for a woman wishing to use a specific method. Contraceptive effectiveness is associated with a woman’s level of satisfaction with her contraceptive method. Nearly four in
10 contraceptive users are not satisfied with their current method; users who are not entirely satisfied are more likely than satisfied users to be at risk for unintended pregnancy as dissatisfaction with a contraceptive method is associated with incorrect or inconsistent use. While slightly more than half of unintended pregnancies occur among women who were not using any method of contraception in the month they conceived, more than four in 10 occur among women who used their method inconsistently or incorrectly. Providing women with access to their desired method may improve rates of satisfaction as well as consistent and correct use.

In addition to considerations of satisfaction, the mechanisms of certain contraceptive methods make them more effective. Long-acting reversible contraceptive (LARC) methods, which include intrauterine devices (IUDs) and contraceptive implants, are the most effective contraceptive methods. These methods are safe and acceptable for a wide range of women and have lower failure rates than other methods because they provide long-lasting protection against pregnancy and require minimal user compliance after the initial implantation or insertion.

Current use of LARC methods is low in the United States; for example, only 5.5% of contraceptive users rely on the IUD. However, IUD use is becoming more popular as a result of improved attitudes, training, access, and awareness. Support for adolescent IUD use has also been growing in the medical community and a pilot study among 14-18-year-old females found that most participants rated their overall experience with an IUD as “happy” or “very happy.” Other studies have demonstrated user satisfaction with LARC methods; researchers with the Contraceptive CHOICE Project found that, among 4,167 women who chose a new contraceptive method, those who chose LARC methods had the highest levels of satisfaction and highest continuation rates compared to those using non-long-acting methods.

While lower rates of LARC use may stem from lack of awareness, concerns about side effects, or other issues, cost can also be a barrier — for both patients and providers. LARC methods often present greater up-front costs than other methods of contraception, making them less affordable to low-income women and, in some cases, more difficult for clinics to stock without guaranteed payment. The only brand offering a hormone-releasing IUD doubled its price in 2010 and the device alone can cost up to $850, not including the appointment for insertion and any follow-up. However, while initial costs are high, the contraceptive implant remains effective for three years and the available IUDs remain effective for five and ten years, depending on the device. Looking at costs over time, IUDs and implants have been found to be more cost-effective than oral contraceptives, the most widely used method.

Several studies have shown that when women receive counseling and the cost barrier is removed, rates of LARC use increase. One study found evidence that a change in California’s Kaiser Foundation Health Plan benefit structure to include 100% coverage of LARC methods (i.e. no copayments), accompanied by training of health care providers, contributed to a 137% increase in their use. As part of the Contraceptive CHOICE Project study, women who were not using a contraceptive method or who were willing to start a new method were offered free coverage of any contraceptive method they chose; within this group, more than two-thirds (67%) chose a LARC method. Citing examples like these, leading family planning scholars recently made the argument for greater public funding of effective methods, including LARC methods. Removing cost and other barriers enhances the ability of low-income women to choose the contraceptive method that is most effective for them.

**General Medicaid Family Planning Coverage**

Current Medicaid recipients have access to a broad array of contraceptive services. With the changes made by the ACA, comprehensive Medicaid coverage will become available to individuals with an income at or below 133% of the federal poverty level (FPL), starting in 2014. Given this expansion, approximately 10 million uninsured women could be eligible for comprehensive Medicaid coverage, which will include access to family planning services and supplies.

Under federal law, Medicaid enrollees of childbearing age must be provided with desired family planning services and supplies as part of their comprehensive Medicaid coverage. The phrase “family planning services and supplies” is not defined by law, but generally includes the full range of FDA-approved contraceptive methods and accompanying counseling. Currently, comprehensive Medicaid coverage is only available to specific populations that meet certain eligibility criteria, which can include age, pregnancy, disability, and blindness, as well as income and immigration status.

Coverage for family planning services makes financial sense for the federal government as well as states administering the program, given the longer-term cost savings for a range of government safety net programs. For example, Guttmacher Institute research shows that every dollar invested in helping women avoid pregnancies they do not want saves $4.02 in Medicaid expenditures that otherwise would have been needed for pregnancy-related care. The federal government provides
an enhanced 90% reimbursement rate for family planning services, which leaves states responsible for only the remaining 10% of these costs in their Medicaid programs.\textsuperscript{19} Such high federal reimbursement rates suggest that family planning is considered an important feature of Medicaid coverage. With the coming Medicaid expansion in 2014, eligible low-income women in all 50 states will benefit from access to a range of family planning services and supplies once they are approved for enrollment.

**Family Planning Expansion Programs**

Since 1993, states have demonstrated creativity in developing programs to expand Medicaid family planning services to individuals who are not otherwise eligible for Medicaid. These state-developed family planning expansion programs offer Medicaid coverage to low-income women, and sometimes men, who wish to obtain family planning services and supplies. Historically, states have needed to seek approval from the Centers for Medicare and Medicaid Services (CMS) in order to develop a family planning expansion program. Approval is regularly granted by CMS because the provision of family planning services “has been found to be cost effective for the Medicaid program.”\textsuperscript{20} The same 90% federal reimbursement rate applies to family planning services and supplies provided through a state family planning expansion program. The approval process requires states to obtain a research and demonstration “waiver” in order to develop and implement their program for offering coverage.\textsuperscript{21} The waivers are time-limited and require routine evaluations; states must seek renewed approval through a burdensome paperwork process every three years after an initial five-year period.

As of June 2011, 28 states have implemented some form of expanded Medicaid family planning eligibility.\textsuperscript{22} The most common method of expansion uses an applicant’s income to

### Terms Used in this Report

- **Medicaid**: Federal medical assistance program administered by the states which provides health coverage to low-income individuals who meet specific eligibility criteria (e.g., age, pregnancy, disability, and blindness). As a result of ACA, Medicaid coverage will become available to all individuals with an income at or below 133% of the federal poverty level (FPL), starting in 2014.

- **Medicaid Family Planning Expansion Program**: State-based programs created to provide Medicaid family planning services to individuals who are not otherwise eligible for Medicaid.

- **Patient Protection and Affordable Care Act (ACA)**: Passed in March of 2010 and often referred to as “health care reform,” this federal legislation contains numerous provisions affecting public and private health care.

- **Presumptive Eligibility**: Enrollment mechanism that allows qualified entities to enroll individuals temporarily in a medical assistance program based on initial assessment of income and eligibility criteria.

- **Qualified Provider/Entity**: An individual provider or organization that is eligible to receive payments under the state Medicaid plan and has also been approved by the state to make presumptive eligibility determinations.

- **State Plan Amendment (SPA)**: States seeking to change a state’s Medicaid program may make amendments. Under health care reform, states may use a SPA to add a permanent eligibility category eligible to receive family planning services and supplies.

- **Children’s Health Insurance Program (CHIP)**: Federal insurance program administered by the states; offers affordable insurance to uninsured children and pregnant women in families with incomes too high to qualify for most state Medicaid programs, but often too low to afford private coverage.

- **Family Planning Services & Supplies**: As used in Medicaid programs, this phrase generally includes the full range of FDA-approved contraceptive methods and accompanying counseling.

- **Family Planning-related Services**: Defined by federal guidelines as services provided in a family planning setting as part of or as a follow-up to a family planning visit; such services are usually provided because they were identified, or stem from a diagnosis made, during the family planning visit.

- **Federal Poverty Level (FPL)**: Income guidelines set by the US Department of Health and Human Services and used as a measure of eligibility for assistance in various federal programs. The “poverty line”, or 100% of the FPL, is $10,890 for a single person and $22,350 for a family of 4. Many individuals and families are considered “low-income” even if they have incomes above the poverty line.

- **Long-acting Reversible Contraception (LARC)**: Considered the most effective contraceptive methods, LARCs can include intrauterine devices (IUDs) and contraceptive implants.
have approved family planning SPAs. The Medicaid family planning expansion programs were initially authorized as “demonstration” projects in order to allow for creativity and close evaluation; the programs have since demonstrated their success. Studies and evaluations of state family planning expansion programs have revealed a number of benefits, including: increased coverage for those who need it; improved birth spacing; lower rates of unintended pregnancy; and significant federal and state cost savings. According to individual state evaluations, the savings associated with helping women avoid unintended pregnancies greatly exceed the costs of providing family planning services to enrollees.

The demonstrated benefits of the family planning expansion programs suggest that similar benefits may be realized with the expansion of comprehensive Medicaid coverage.

State Plan Amendment: New Option for Family Planning Expansions

Given the proven benefits of the experimental family planning expansion programs, health reform legislation now gives states the option of creating a permanent and more accessible family planning expansion program via a State Plan Amendment (SPA). Rather than develop and facilitate a “waiver” program, states may amend their state Medicaid plan with a SPA that outlines the features to be included in the family planning program. With the SPA, the Medicaid family planning expansion program will become a permanent offering in a state’s Medicaid program. The family planning expansion program will exist as an entitlement without capped funds and states will no longer need to seek renewal. Guidelines also allow for easier program administration and enrollment. As of June 2011, Wisconsin, California, New Mexico, and South Carolina have approved family planning SPAs.

The ACA guidelines for structuring a SPA build on the successful income-based waiver programs. The state can create a permanent Medicaid eligibility category for family planning services based on income level. States may set the income limit up to the highest limit set for pregnant women under either the state’s Medicaid plan or its Children’s Health Insurance Program (CHIP). This provision allows state Medicaid programs to offer parity by covering family planning services and supplies for an individual who could be eligible to receive pregnancy-related care. Some states have set the limit as high as 300% of FPL for pregnant women in these programs.

Guidelines for SPAs include some mandatory provision along with some flexibility for states. States must extend eligibility to both women and men in a SPA. Adolescents also must be eligible and upper age limits are removed. States do have some flexibility in choosing how to determine income eligibility for family planning coverage and enrollment. In making rules for determining income eligibility, states may choose only to consider the income of the recipient and use pregnancy income counting rules – meaning the state may count the individual as a two-person household when determining the percentage of FPL. States may also waive the use of an asset test, which includes assets beyond income earnings in the determination.

If a state amends its Medicaid plan to embrace the new family planning eligibility category, enrollees can receive an expanded range of services. In addition to the core family planning services and supplies, states must cover some of a recipient’s “medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting.” Federal guidelines have described this secondary set of services as “family planning-related services.” According to Health and Human Services (HHS), family planning-related services are those services provided in a family planning setting as part of or as a follow-up to a family planning visit; such services are usually provided because they were identified, or stemmed from a diagnosis made, during the family planning visit.

Examples of these types of services include: treatment of sexually transmitted disease/infections and other genital infections and disorders; a men’s annual family planning visit; other preventive family planning services such as HPV vaccination; and treatment of major complications resulting from family planning-related care. While core family planning services and supplies are eligible for the 90% federal payment rate under the SPA, “family planning-related services” are only reimbursable at the state’s regular federal medical assistance percentage (FMAP) rate, which varies by state.

An additional benefit of the SPAs is that coverage is not limited to individuals who are uninsured, which was a past requirement for family planning expansion programs operating under waivers. While states are still obligated to receive reimbursement from third-party payers, this change represents a benefit for those low-income individuals who may have private insurance that does not fully cover family planning services and supplies.
Presumptive Eligibility: Gateway to Improved Family Planning Access and Medicaid Enrollment

States can build on the benefits of Medicaid coverage expansions with the use of presumptive eligibility enrollment, which offers immediate access to family planning services while also streamlining long-term Medicaid enrollment. Health reform legislation allows those states who adopt family planning SPAs to offer presumptive eligibility enrollment in order to “avoid any delay in the provision of services to women at risk of unwanted pregnancy.” In addition, in 2014, hospitals will be able to make presumptive eligibility determinations for all Medicaid-eligible populations under a state’s plan or waiver.

Through Medicaid and CHIP, many states already offer presumptive eligibility enrollment to pregnant women, children, and certain breast or cervical cancer patients with the same goal of avoiding delay in care and facilitating long-term enrollment. Currently, 30 states plus the District of Columbia have adopted presumptive eligibility for pregnant women while 4 states have a different expedited process. Sixteen states offer presumptive eligibility for children’s enrollment in Medicaid or CHIP. Twenty-two states offer presumptive eligibility for certain groups of women in need of treatment for breast and cervical cancer.

The following sections will explore how presumptive eligibility enrollment for family planning services would benefit many low-income individuals by providing them with immediate, temporary Medicaid coverage for family planning services and providing a simplified entry point – the clinic – to obtain Medicaid coverage. Offering presumptive eligibility for family planning services could lead to a number of benefits for individuals, providers, and government programs.

Presumptive Eligibility in Family Planning SPAs

Usually, if an individual is not enrolled in a state’s Medicaid program or family planning expansion program, he or she must submit an application to the relevant state agency and wait for a determination and proof of enrollment. This process can sometimes take several weeks or longer. In the meantime, if a woman cannot afford to pay for her preferred contraceptive method out of pocket, some clinics may be able to offer financial assistance using Title X or other funds. However, this depends on the clinic and assistance may only partially cover costs.

As part of the new SPA option, states may choose to offer presumptive, or temporary, eligibility to individuals seeking to enroll in the state’s Medicaid family planning expansion program. This means low-income individuals could receive covered family planning services, supplies and family planning-related services at an initial health center visit without prior application for Medicaid coverage. The individual would then maintain coverage until a formal Medicaid determination.

If a state adopts presumptive eligibility enrollment as part of the family planning SPA, qualified health care providers would make the determination that an individual is presumptively eligible to receive services based on an initial assessment of an individual’s income information. A qualified entity or provider is one that is eligible to receive payments under the state Medicaid plan and has also been approved by the state to make presumptive eligibility determinations. Once a qualified provider makes a presumptive eligibility determination, they must inform the state within five working days and also inform the individual that he or she must still apply to enroll in continuous coverage.

If an individual is deemed presumptively eligible, health care providers will receive reimbursement for services and supplies provided during the presumptive eligibility period and states will receive the federal Medicaid matching funds. According to guidelines, the temporary eligibility period begins on the day that the qualified provider makes the determination and ends either when a final eligibility determination is made or, if no application is filed, on the last day of the month following the month when eligibility was first determined (e.g., if an individual is found presumptively eligible on April 5th, temporary eligibility would end on May 31st).

Enrollment mechanisms similar to presumptive eligibility have been developed in several state Medicaid family planning expansions. California, Oregon and Iowa all offer some form of same-day, “point of service” enrollment option for patients at an initial visit. In these programs, clinic staff members do not make the eligibility determination themselves. Instead, a trained clinic staff member walks the client through the application process, verifies any documentation, and enters the patient’s information into a state’s computer system. During the patient’s visit, the system determines eligibility. This allows the patient to avoid the additional delays from having to visit another office or separately submit an application to enroll.
State Model: Wisconsin’s Temporary Enrollment

Wisconsin was the first state with an approved SPA and, while changes to Wisconsin’s law and funding for the SPA appear imminent, the system offers an example of how presumptive eligibility enrollment can be implemented. Wisconsin developed guidelines for implementing the process within its Medicaid family planning program (using the term “temporary enrollment” rather than “presumptive eligibility”).

To obtain temporary enrollment for family planning services onsite in Wisconsin, individuals must visit a health center certified as a qualified entity (e.g., Planned Parenthood) and fill out the provided forms. The form asks for information about such things as age, citizenship, state residency, income, and any prior temporary enrollment in the past 12 months. In Wisconsin, men and women are eligible for temporary enrollment if they are: aged 15 or over, a resident of Wisconsin, a U.S. citizen, have an income at or below 300% of federal poverty level for their household size, have not been temporarily enrolled in the last 12 months, and are not already receiving Medicaid benefits.32 If the individual is temporarily enrolled, he or she can receive coverage for family planning services and supplies that day and the provider is guaranteed reimbursement from Medicaid family planning funds. The individual will also receive a paper card to use for future visits during the temporary enrollment period.

Even though an individual is temporarily enrolled, he or she must apply separately for more permanent, “continuous enrollment” status. To do this, the individual must complete a longer, more complex form and, among other things, provide proof of identity, residency, immigration status (legal residents may be eligible at this stage), and income. Temporary enrollment coverage will last until a continuous enrollment decision is made or through the end of the month following the first month of temporary enrollment, whichever is first. Once an individual obtains continuous enrollment, he or she will receive a plastic card and be asked to renew enrollment annually.

Benefits of Presumptive Eligibility Enrollment

Presumptive eligibility enrollment can benefit low-income individuals by providing immediate access to contraception that is affordable, effective and satisfactory and by offering a pathway to longer-term access. Removing financial and other system barriers can ensure that women have a choice among contraceptive methods and increase their ability to find an effective method that works for them.

Presumptive eligibility enrollment could allow a low-income woman to arrive at a family planning visit, receive counseling on contraceptive methods, and obtain her desired method without delay. Eligible women will not need to wait for approval of a Medicaid application and proof of enrollment before receiving covered services if trained clinic staff can conduct presumptive eligibility screening. Under current rules, Medicaid coverage can, in some cases, be backdated to the time of application; however, reimbursement payments are not made to a patient or a provider unless the individual completes their application and eligibility is officially determined. Presumptive eligibility would ensure ease of access that removes upfront cost and system barriers to an individual motivated to begin using her preferred contraceptive method as soon as possible.

Since presumptive eligibility enrollment guarantees that family planning providers will be reimbursed for services provided during the presumptive eligibility period, it can help clinics maintain a ready stock of all contraceptive methods. In particular, since some LARC methods are more expensive and can expire after a certain date, clinics may feel more confident ordering supplies if they can anticipate Medicaid reimbursement. In 2003, a Guttmacher Institute survey of publicly-funded family planning agencies found that more than half of respondents (57%) did not stock certain methods because of cost; most often, the methods that agencies were not able to offer because of cost were the IUD, vaginal ring and the patch.34 The ability to maintain a more robust on-site supply increases the range of contraceptive methods available to patients at an initial visit.

Hospitals & Presumptive Eligibility

Starting in 2014, hospitals that participate in a state’s Medicaid program may choose to be a qualified entity for purposes of determining presumptive eligibility for all Medicaid-eligible populations under a state’s plan or waiver.33 This opportunity accompanies the 2014 Medicaid expansion and will take effect whether or not a state has already implemented any presumptive eligibility mechanisms. The qualified hospitals will be able to assist in enrolling newly eligible individuals with incomes at or below 133% FPL as well as those eligible for a state’s family planning expansion program (whether it is a SPA or a waiver program). It will also offer another practical entry point for low-income individuals to access ongoing coverage.
Presumptive eligibility enrollment can offer additional benefits, including seamless family planning coverage and a streamlined enrollment process for ongoing Medicaid coverage. Since a woman would maintain her temporary enrollment while applying for longer-term coverage, she would be able to receive covered care during the application and approval process. Furthermore, the state can design a system that offers an easy way for a woman with presumptive eligibility enrollment to simultaneously apply for comprehensive Medicaid coverage or family planning-only Medicaid coverage. Six in 10 women who obtain care at a family planning center describe it as their usual source of medical care, so it is a natural entry point for Medicaid enrollment. In fact, as part of ACA implementation, states will be required to establish processes for assessing eligibility for all medical assistance programs when an individual seeks enrollment. States can encourage ongoing enrollment by drawing on the innovations developed by other Medicaid and CHIP presumptive eligibility programs. For example, states may offer a fee to qualified providers for assisting an individual in completing and submitting the regular application or use technology to create more efficient electronic databases through which presumptive eligibility enrollment data is transferred to a regular application and assigned to a state eligibility worker. Such efforts to simplify and streamline both types of Medicaid enrollment would help states meet the Healthy People 2020 goal of increasing the overall proportion of women receiving needed, publicly-supported contraception services from 53.8% to 64.5%.

Finally, immediate enrollment in Medicaid family planning programs would improve allocation of Title X and other funding. For example, if a low-income individual seeks family planning services but is not enrolled in a Medicaid program, a clinic receiving Title X funds may be able to draw on these resources to provide an individual with services or supplies if he or she cannot afford them. If that same individual could enroll in Medicaid through a presumptive eligibility mechanism, the clinic could more effectively allocate Title X funds rather than having to divert them for someone who is otherwise eligible to receive Medicaid coverage. This approach may mean more effective use of Title X resources, including care for other underserved individuals, including those who struggle to pay for contraception but do not fall below the Medicaid income caps, those who are not eligible due to immigration status, or those who cannot use insurance because they wish to keep their visit confidential.

Conclusions

Health care reform legislation offers numerous opportunities to improve reproductive health and contraceptive access. The

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**SPA’s Presumptive Eligibility Enrollment Pathway to Medicaid Coverage for Family Planning Services**

- **Individual seeks publicly-funded family planning services**

  - **May be presumptively enrolled in Medicaid:**
    1) if found eligible for a Medicaid family planning program in a state with the SPA presumptive eligibility option, or
    2) after Jan. 1, 2014, if found presumptively eligible for Medicaid by a qualified hospital, or
    3) if found presumptively eligible for Medicaid in another category (e.g., youth).

- **Applies for ongoing Medicaid coverage**

  - **Eligible for Medicaid** if meets current eligibility criteria. In 2014, found eligible for Medicaid if income is at or below 133% FPL.

  - **Eligible for family planning-only Medicaid coverage** if meets income & other state criteria. May still be eligible even with private insurance.*

  - **Ineligible for any Medicaid coverage**; once notified, PE enrollment period ends.

- **Does not apply for any ongoing Medicaid coverage**

  - **PE enrollment expires** at the end of the subsequent month.

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*In 2014, uninsured individuals will be able to purchase private insurance through state exchanges, receiving subsidies to help pay for coverage if they fall within 136% - 400% of FPL. Under a SPA, a state can still offer family planning coverage to those with private insurance.*
potential benefits of expanded Medicaid coverage and the adoption of family planning SPAs are key advances. Together, they can increase coverage for family planning services among low-income women, removing cost barriers and allowing more women to exercise reproductive self-determination. As demonstrated by Medicaid family planning programs, greater family planning access can also lead to lower rates of unintended pregnancy, better health outcomes, and long-term cost savings. Presumptive eligibility enrollment can provide an accessible gateway to the Medicaid coverage options described above. It could also lead to more efficient use of funding and resources. Lastly, presumptive eligibility enrollment could ensure that women motivated to obtain effective methods of contraception can do so without delay.

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References
27. Patient Protection and Affordable Health Care Act, §2303 (2010).
33. Patient Protection and Affordable Care Act, §2202 (2010).