Insurance Coverage for Persons with Disabilities: The Affordable Care Act and More

The Affordable Care Act (ACA) is here to stay

- The Supreme Court ruled that the ACA is constitutional
- The individual mandate that requires most individuals to have health insurance
- If a person cannot get coverage from their employer they can purchase it from an exchange or marketplace
- Some states under the ACA have elected to expand their Medicaid coverage to 133% of the FPL using additional monies from the federal government.
- In Florida, the state legislature is not in favor of Medicaid expansion. However, other expansion proposals are being considered.
- For more information on Medicaid visit http://www.healthcare.gov/using-insurance/low-cost-care/medicaid/
- Keep track of where each state stands on Medicaid expansion at http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/

Expanded coverage and benefits for persons with disabilities

Current Coverage Options

- *Pre-Existing Condition Insurance Plans (PCIP)* are high risk pools operated by the states and federal government to provide coverage for individuals who have been denied coverage for a pre-existing condition or have a pre-existing condition
- PCIP's apply to all 50 states until 2014
- Individuals must have been uninsured for 6 months AND be a U.S. citizen or legal resident
- Covers primary and specialty care (including occupational therapy, physical therapy, and speech and language pathology), hospital care, and prescription drugs
- Locate your PCIP or apply online at https://www.pcip.gov/

Pre-existing Conditions

- Insurance companies cannot deny coverage to individuals based on a pre-existing condition beginning on or after 1/1/2014
- Insurers can't charge higher premiums because of your disability or medical condition
- Plans must operate on the basis of "standard population risk", that looks at everyone with or without existing conditions, to determine reasonable costs
- Premium costs *may* be influenced by your age or smoking habits

Wellness Benefits

- ACA requires health plans cover recommended prevention services with NO cost sharing
- Wellness benefits include
  - Pap smears and women's health, Immunization vaccines, Screening for blood pressure, cholesterol (depending on age and risk), depression, type 2 diabetes (for those with high blood pressure), Diet counseling (for those at risk of chronic conditions, Screening and counseling for: alcohol misuse; drug abuse; obesity; tobacco use, Colonoscopies for adults over 50, HIV screenings for high risk adults
- ACA also includes patient protections such as guaranteed access to OB-GYNs and pediatricians
- Medicare will now include a *Free Annual Wellness Visit*
  - Physician and patients develop a personal prevention plan taking into account medical and family history, detection of any impairment, potential risk factors from depression and review of the patient's functioning ability and level of safety
  - Must check with your Medicare Advantage Plan if you are covered for wellness services

Essential Health Benefits (EHB)

- Under ACA, plans must cover 10 benefit categories:
  - Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.
- States will have the ability to define the services they will include under "habilitative services."
- ACT NOW: Disability advocates have a unique opportunity to encourage their states to include preventive therapy services and other services in their definition of habilitative services through their state representatives.
- EHB apply in 2014 to the individual and small employer group insurance coverage that will be sold through the health insurance exchanges and Medicaid plans.

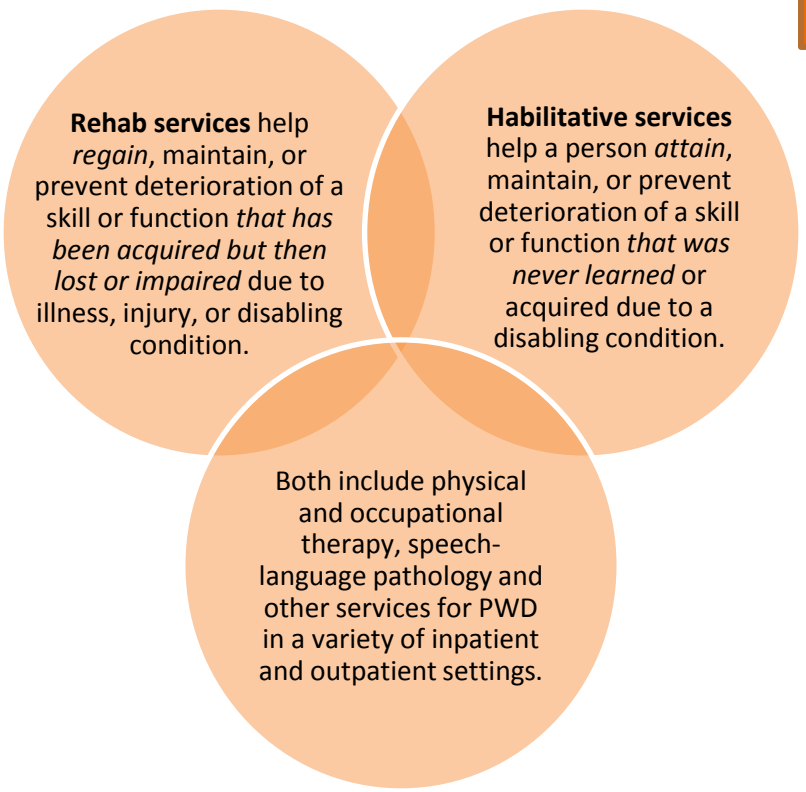
Limits on coverage and exceptions

- Lifetime limits or caps on essential health benefits (EHB) are eliminated from all plans by 9/23/2010.
- Annual limits or caps on EHB will be phased out and eliminated for all new plans issued between 3/23/10-1/1/14.
- After that, all plans issued or renewed will be prohibited from including annual limits or caps on EHB.
- Grandfathered individual plans are an exception and not required to phase out annual limits or caps on EHB.
- All plans can put annual and lifetime dollar limits on spending for non-essential health benefits, or those not included in the 10 benefit categories above.

State Insurance Exchanges

- ACA requires that Americans must have access to a Health Insurance Exchange, an on-line marketplace through which individuals and small businesses will be able to compare, choose, and purchase high-quality private health insurance.
- Florida failed to meet the deadline to tell Health and Human Services (HHS) how they plan to set up their state-based exchange for 2012.
- Florida has been given until 2/15/13 to decide how they plan to implement the exchange or a Federally facilitated Exchange will be established to serve Floridians in 2014.

Rehabilitation vs. Habilitation



Training health care professionals to treat people with disabilities

- Healthcare providers are at work to develop curriculum on how to treat people with disabilities.
- Health Resources and Services Administration (HRSA) is funding some of these programs.
- You should consider assisting with training health professionals at your local community colleges and universities.
  - Many health professionals lack any experience with people with disabilities.
  - Who better to assist with training them to treat people with disabilities than people with disabilities.

Home and Community Based Services

- States, including Florida, are having budget crises.
- Monitor what your state is doing to address budgets and speak out in support of funding for valuable programs in your state, such as *Money Follows the Person* and *Community First Choice Option.*

Money Follows the Person (MFP)

- The program provides states with grants to develop programs designed to move elderly Medicaid participants out of nursing homes and into the community.
- Grants help states offset the cost giving eligible Medicaid beneficiaries living in nursing homes or other institutions, new opportunities to live in the community with the services and support they need.
- ACA provides states with enhanced federal matching funds for 12 months for each Medicaid beneficiary transitioned from an institutional setting to a community based setting.
- Florida's MFP program goes by the name of *Florida Nursing Home Transition.*

Nursing Home Transition

- You may be eligible for transition services if:
  - You are 18 or older
  - You are Medicaid eligible
  - You are a current resident in a nursing home and have been there for at least 90 days
  - You are able to live safely in the community
- Contact the toll-free number or website below to get started:
  - **1-866-273-2273**
  - http://www.fdhc.state.fl.us/Medicaid/nh-transition/faqs.shtml

Community First Choice Option

- This is a new program created by ACA that allow State Medicaid plans to choose home and community based services.
- Applies to individuals with disabilities who are:
  - Eligible for Medicaid
  - Would otherwise be nursing-home eligible, and Have incomes up to 150% of the federal poverty level

Medical Equipment

Accessible Medical Equipment

- ACA has given the Access Board the responsibility of developing minimum technical criteria for medical diagnostic equipment used in physician's offices, clinics, emergency rooms, hospitals, and other medical settings.
- The Access Board appointed a committee of experts to develop voluntary standards for improved accessibility to medical equipment for persons with disabilities.
- These voluntary standards will establish the standard of practice for accessible medical diagnostic equipment.
- Although health care providers are not required to comply with the standards, the Department of Justice or other federal agencies can adopt the standards as requirements for health care providers under the Americans with Disabilities Act or other laws.
- The proposed accessibility standards can be found at http://www.access-board.gov/mde/nprm.htm#3
- Final recommendations have not been released yet but will be found on the Access Board's website at http://www.access-board.gov/medical-equipment.htm
- When the standards are complete and published online, you can share them with your health care provider and encourage them to comply.

Durable Medical Equipment and Supplies

- The competitive bidding program started in January 2011 in 9 regions in Florida.
- Phase 2 starts in July 2013 in 91 additional locations including large metropolitan areas.
- The program changes the amount Medicare pays suppliers for certain durable medical equipment, prosthetics, orthotics, and supplies by allowing companies to bid for *sole coverage* of a region or city.
- Includes wheelchairs, walkers, oxygen, diabetes blood monitoring devices, enteral nutrients (tube feeding), continuous positive air pressure (CPAP), respiratory assistive devices, and hospital beds.
- Complex rehab wheelchairs and off the shelf orthotics provided by physicians and hospitals are exempt from competitive bidding.
- Potential problems for consumers with disabilities:
    - You can no longer chose your DME provider.
    - You can only purchase covered DME from Medicare authorized providers who may not carry the most effective products and services.
    - Limited access or no access to critical equipment, supplies, and equipment repairs.
    - Providers must re-bid every 3 years leaving consumers without needed DME items carried by previous authorized providers.
- For more information on the competitive bidding program, visit: http://www.medicare.gov/Supplier/static/SupportTab.asp?activeTab=3&viewtype
- To find a supplier of durable medical equipment, prostheses and prosthetic devices, orthotics, or suppliers visit: http://www.medicare.gov/Supplier/Include/DataSection/Questions/SearchCriteria.asp?version=default&browser=Firefox|18|WinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True
- For more information about Medicare-covered Equipment and Supplies, call **1-800-MEDICARE (1-800-633-4227)**
    - TTY users should call **1-877-486-2048**

Information source: AAHD and United Spinal Association's webinar on Health Care Reform's Impact on People with Disabilities: The Road Ahead by Barbara L. Kornblau - http://www.aahd.us/wp-content/uploads/2013/01/ACAwebinarUnitedSpinalAAHD.01302013.pdf

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