



**United Spinal  
Association**



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## **Impact of Health Care Reform on People with Disabilities**

The disability community has worked together tirelessly for more than a year to achieve health care reform. After health care reform nearly died several times, Congress revived it and it became law in March 2010.<sup>1</sup>

From any perspective, the final legislation is not perfect, but it will bring important improvements in health care coverage for people with spinal cord injuries and disorders and people with disabilities in general. The insurance market reforms alone are clearly beneficial. Once the permanent provisions go into effect, no longer will health insurers be able to deny coverage, charge outrageous premiums, offer less coverage to people with pre-existing conditions or impose annual or lifetime caps on benefits. In addition, the bill enacts several provisions that encourage home and community based services so that people with disabilities do not have to choose between living at home and getting the services they need.

As of 2014, when many permanent provisions go into effect, states must have health insurance exchanges (or alternatives) through which people and some employers may purchase health insurance. In addition, most people will be required to have health insurance unless they are eligible for health care through government programs such as Medicare, Medicaid, Department of Veterans Affairs and military service. Multistate plans are allowed but individual states can require additional benefits to be covered by health insurance in their states. There will be refundable tax credits for some people based on income and tax credits for some small businesses that provide health insurance to their employees.

Summarized below are major final health care reform provisions that particularly impact people with disabilities. This list is by no means exhaustive. The final legislation not only reforms health insurance but also addresses many health care issues including prevention and wellness and improving the health care workforce.

With enactment of the law, reform is only beginning. The disability community must stay involved and present as implementing regulations are drafted, proposed, promulgated, and implemented. For the foreseeable future, we will need to be vigilant in making our voices heard

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<sup>1</sup> The Patient Protection and Affordable Care Act (HR 3590, Public Law 111-148, signed into law 3/23/10) as modified by the Health Care and Education Reconciliation Act (HR 4872, Public Law 111-152, signed into law 3/30/10).

with regard to the countless rules and regulations to be issued, advisory boards and commissions to be established, and many other steps to be taken to implement health care reform.

Find more information on our public policy website [www.spinalcordadvocates.org](http://www.spinalcordadvocates.org) or contact our Washington, DC public policy staff Peggy Hathaway and Andrew Morris at 202-556-2076, [phathaway@unitedspinal.org](mailto:phathaway@unitedspinal.org) or [amorris@unitedspinal.org](mailto:amorris@unitedspinal.org).

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## **Insurance Market Reforms**

Generally, health care reform legislation includes many provisions that make private market health insurance far more available and affordable to people with disabilities and other chronic conditions.

### **No Discrimination Based on Pre-Existing Conditions**

As of 2014 health insurers will no longer be able to discriminate against people due to disabilities or other pre-existing conditions. Health insurers will no longer be allowed to deny coverage, charge higher premiums, exclude benefits relating to pre-existing conditions, rescind coverage after someone is injured or acquires a new condition, or impose annual caps on benefits. Most of these provisions go into effect for children in September 2010.

### **Lifetime and Annual Benefits Caps**

Lifetime caps on benefits are prohibited immediately. This will end the common insurance practice of imposing lifetime caps such as \$1 million. Between now and 2014, the Secretary of Health and Human Services (HHS) may restrict annual caps on benefits. As of 2014, both lifetime and annual caps on benefits are prohibited.

### **Temporary High-Risk Pools**

Between now and 2014, many people with pre-existing conditions are eligible to purchase coverage through high risk pools.

Unfortunately, to be eligible to purchase this insurance, people must have been without any health coverage whatsoever for at least six months. Also, the insurance could be unaffordable for many people. Premiums are subject to restrictions, but even so, the law allows insurers to charge older people four times as much as younger people. Limits on

out-of-pocket expenses must be consistent with high-deductible health savings account plans—currently \$5,950 for an individual and \$11,900 for a family.

It is currently uncertain when the temporary high risk pools will become available or where people will apply for insurance in these pools. If a state does not offer the required insurance, HHS will either help establish a pool in that state or residents of that state will be eligible for a national high risk pool. This decision-making process is now underway.

## **Mandatory Health Plan Coverage Provisions**

### **Essential Benefits**

For most health insurance plans (including plans offered in the exchanges and individual and small group plans but excluding grand-fathered individual and employer-sponsored plans) the law mandates coverage of at least the following essential benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

HHS has the authority to further define essential benefits consistent with these required elements and is expected to do so. If HHS adds essential benefits, the law requires HHS to take into account the health care needs of people with disabilities and other diverse groups. We will continue to make our voices heard as HHS goes through the process of defining essential benefits.

For people with disabilities, it is a substantial improvement that rehabilitation and habilitation services are essential services. Many people with disabilities depend on them (e.g. to maintain muscle bulk and minimize spasticity) but pre-health care reform insurance policies did not cover them or severely limited the number of treatments.

As we understand it, the term “devices” is meant to include all durable medical equipment (including wheelchairs), prosthetics, orthotics and supplies (DMEPOS). This provision would be stronger if it made this point more explicitly. Because DMEPOS are critically important to many people with disabilities, we are advocating that anticipated HHS regulations defining essential benefits will explicitly provide that all DMEPOS are included in the meaning of “devices” as essential medical benefits.

It is important that mental health and substance abuse services are included as essential benefits.

### **Limits on Cost Sharing**

The amount that people will have to pay out-of-pocket cannot be greater than the limits for health savings accounts. Small group market plans are prohibited from deductibles greater than \$2,000 for individuals and \$4,000 for families. These maximums may

increase only in accordance with increases in average per person health insurance premiums.

## **Home & Community-Based Services**

Health care reform has enacted or enhanced several provisions to expand home and community based services to help make it easier for people with disabilities and chronic conditions to live at home and participate in their communities, rather than having to live in a nursing home or other institution in order to receive needed services. No one should have to choose between living at home and receiving the services they need.

### **Community Living Assistance Services and Supports -CLASS**

The CLASS provisions establish a national voluntary, insurance program whereby people with functional limitations receive benefits of not less than an average of \$50 per day to pay for services and supports of their choice that help them with activities of daily living. To qualify, people will have had to pay premiums, by means of a voluntary payroll deduction plan, for at least five years. These services can enable them to remain independent, employed and participate in their communities. Unlike Medicaid, CLASS does not require people to be impoverished to qualify for this program. HHS is required to develop an actuarially sound benefit plan so that the program is self-sustaining.

### **Community First Choice Option**

Creates the Community First Choice Option. This allows state Medicaid plans to choose home and community-based services and supports as the rule, rather than the exception, for Medicaid-eligible individuals with disabilities with incomes up to 150% of the Federal Poverty Level, who would otherwise require institutional care. To encourage states to choose this option, states that opt in will receive an additional six percent to the federal government's share of Medicaid costs (referred to as the Federal Matching Assistance Percentage or FMAP) for five years. Effective October 1, 2011.

### **Money Follows the Person**

Extends the popular Money Follows the Person demonstration grants until September 2016. These grants help state Medicaid programs defray the cost of moving eligible Medicaid recipients who have resided in an in-patient facility for a minimum number of consecutive days into community-based settings for eligible Medicaid recipients.

### **Home and Community Based Services in Medicaid**

Makes it easier for state Medicaid programs to offer home and community based services by allowing states to do so by amending their state plan, rather than having to apply for a Medicaid waiver, which can be a lengthy process.

## **ADDITIONAL IMPORTANT CHANGES**

### **Substantial Expansion of People Eligible for Medicaid**

Health care reform substantially increases the number of people who are eligible for Medicaid. Since many people with disabilities have low or very modest incomes, this Medicaid expansion will give many more people with disabilities the right to health care coverage

As of 2014, health care reform expands Medicaid to cover non-elderly, childless adults for the first time and adults with incomes up to 133% of the Federal Poverty Level. It also expands Medicaid to cover children in families with incomes up to 133% of the Federal Poverty level, and it extends Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) mandates to all children on Medicaid including those in managed care. EPSDT services address developmental disabilities and delays. States will receive an increased Federal matching share for the first few years. In 2009, 133% of the Federal Poverty Level for individuals was \$14,404 and for families of four was \$29,327.

Between now and 2014, states have the option of extending Medicaid coverage to these groups.

In addition, states are required to maintain their current services under Medicaid and have incentives to cover preventive services and immunizations without cost-sharing to adults under Medicaid.

Note regarding Medicare 2-year waiting period. Under existing law, people found eligible to receive disability benefits under Social Security's SSDI and other Title II programs must wait two years before they can receive Medicare benefits. In the meantime, many people with disabilities go without needed health care, which often causes dire consequences, including exacerbation of existing conditions and death.

While health care reform does not directly address this problem, it mitigates it for some people in the two-year waiting period. They may be able to obtain health coverage through the temporary high risk pool or through the health insurance exchanges once they go into effect (which cannot discriminate on the basis of pre-existing conditions) or they may qualify for Medicaid under its extended eligibility standards.

### **Medicare Part D Donut Hole Gap in Prescription Drug Coverage**

Phases out the famous "donut hole" in prescription drug coverage under Medicare by 2020. Currently, when Medicare enrollees are in the donut hole (after they reach a certain limit on prescription drug coverage and before additional coverage kicks in), they must pay for prescription drugs at full price.

Provides a one-time \$250 rebate for prescription drugs after enrollees enter the donut hole in 2010. Beginning January 1, 2011, it provides a 50 percent discount on brand name drugs and other discounts for generic drugs for enrollees in the donut hole.

### **Substantial Increased Funding for Community Health Centers**

Provides an additional \$11 billion of funding from the Public Health Trust fund for Community Health Centers located across all 50 states and territories (over 1200 facilities). Community Health Centers are major providers of health care to people who are uninsured or are underinsured

### **Medicare Outpatient Therapy Caps**

Health care reform extends until December 31, 2010 some exceptions to caps on Medicare Outpatient Part B Therapy Services, thus allowing Medicare enrollees to get medically necessary therapy services beyond the \$1,860 cap for occupational therapy, and \$1,860 cap for physical therapy and speech-language pathology services.

### **Accessible Medical Diagnostic Equipment**

Requires the U.S. Access Board, in consultation with the Food and Drug Administration, to establish regulatory standards setting the minimum technical criteria for medical diagnostic equipment for people with disabilities. While existing law requires medical equipment to be accessible, these standards are intended to clarify how to comply with this requirement.

These standards, to be completed in two years, will clarify minimum technical criteria for medical equipment in doctors' offices and other medical facilities to be considered accessible for people with disabilities including people who use wheelchairs. The standards shall ensure the equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible. At a minimum medical diagnostic equipment covered by the new standards will include: examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

### **Elimination of Medicare First-Month Purchase Option for Power Wheelchairs**

Under existing law, Medicare beneficiaries have the option to purchase their power wheelchairs, rather than rent them. This enables the person with long-term need of a wheelchair to have it adjusted to his or her size and unique needs. Under health care reform, Medicare will only pay for rental, rather than purchase, of certain power wheelchairs for the first thirteen months of use (with exceptions for certain classes of complex rehab power wheelchairs). During the 13-month rental period Medicare will pay 80 percent and the beneficiary will pay 20 percent of the rental cost.

We are concerned because wheelchairs, like people, are not fungible. They require many adjustments to meet the individual user's size and needs. With purchased wheelchairs, suppliers are likely to bear the cost of individualization, but they are not likely to do so for a rental that can be so easily returned. Without individualization, users frequently suffer exacerbated or secondary conditions that require treatment and often hospitalization, thus offsetting any cost savings to Medicare.

### **Durable Medical Equipment Excise Tax**

A new excise tax (\$20 billion over 10 years) on medical devices will be imposed on manufacturers of medical equipment. It is intended to help offset the costs of health reform. Although the tax is imposed on manufacturers, the consumer will ultimately bear the cost because manufacturers are likely to pass these costs on to consumers through increased prices.

### **Medicare Durable Medical Equipment Competitive Bidding Program**

Existing law requires HHS to implement a competitive bidding program for suppliers of wheelchairs and other durable medical equipment, under Medicare, as a cost-savings measure. Wherever competitive bidding goes into effect, Medicare will only pay suppliers selected by HHS. It is likely that there will be far fewer suppliers to choose from for both purchase and repairs of wheelchairs and other durable medical equipment and that the quality of products and repairs may go down. People who use wheelchairs may well have to give up their existing suppliers and find it difficult to get to the new suppliers for repairs.

Health care reform speeds up the pace of expanding competitive bidding to additional Standard Metropolitan Statistical Areas and requires coverage of all areas by 2016.

### **Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan**

Provides Medicare Part B coverage, with no co-payment or deductible, for personalized prevention plan services. Personalized prevention plan services means the creation of a plan for an individual that includes a health risk assessment and may include other elements, such as updating family history, listing providers that regularly provide medical care to the individuals, body-mass index measurement, and other screenings and risk factors.

### **Comparative Effectiveness Research**

Creates a federal coordinating council for comparative effectiveness that will be responsible for the annual funding of research to compare the effectiveness of various treatments on specific conditions. Comparative effectiveness research compares available treatments to see which works best based on research findings.

The law also creates a patient-centered outcomes research institute responsible for the development of national comparative effectiveness research priorities and the conduct of clinical outcomes research. Research must take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, and quality of life preferences.

### **Training of Future Health Practitioners**

Requires that medical professionals receive disability awareness training to help reduce the health disparities that exist for people with disabilities. Grants and other incentives are available to develop programs and model curricula to train health professionals and

increase the number of health professionals (including dentists) trained to meet the health care needs of individuals with disabilities.

### **Nondiscrimination**

Except as provided elsewhere in the law, prohibits discrimination based on disability under any health program or activity which receives federal 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) and provides Section 504 of the Rehabilitation Act as the enforcement mechanism for violations. The Secretary of HHS may promulgate regulations to implement this.

### **Comprehensive Workplace Wellness Programs**

Authorizes an appropriation for grants to eligible small businesses for the purpose of giving their employees access to comprehensive workplace wellness programs that meet criteria to be developed by HHS. Employee wellness programs can be a good way to encourage better health. However, this provision could inadvertently have a negative impact on people with disabilities. For example, a person with a disability may be unable to participate in an exercise program or another benchmark of the wellness program. If employees who do participate receive a reduced deductible under the employer-sponsored health plan (or another financial incentive), the person with a disability who is unable to participate would end up paying a higher deductible (or would not be eligible for other financial incentive). To avoid inadvertent negative impacts on people with disabilities and chronic conditions, it will be important to work with HHS in designing the programs.

### **Coverage of Anti-seizure, Anti-spasm, and Smoking Cessation Medications**

Mandates coverage of barbiturates, benzodiazepines, and tobacco cessation agents under Medicare Part D. Barbiturates include phenobarbital and other medications that treat seizures. Benzodiazepines include sedatives, anti-anxiety medications, and anti-spasm medications. Both of these categories of medications were previously specifically excluded from coverage under Medicare Part D.

### **Data Collection and Analysis to Understand and Address Health Disparities**

Requires the federal government to collect health survey data from people with disabilities to enable better understanding of the health of people with disabilities compared to other minority groups.

Also requires the government to collect survey data from health care providers in order to learn where people with disabilities receive their care, the number of providers with accessible facilities and equipment, and the number of health care professionals trained in meeting the health care needs of patients with disabilities.

Requires the development of recommendations for quality measures to improve the quality of health care for individuals with disabilities.