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The Affordable Care Act: What it Means For Occupational Therapy Practice & the People We Serve

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Objectives

• Outline the basic consumer protections provided by ACA.
• Discuss the significance and benefits to the occupational therapy profession, of 5 policies from ACA.

Objectives

• Explain 5 ways ACA benefits the health, well-being, and participation of people with disabilities.
• Analyze the status and impact of states’ participation in the Community Choice Option, Medicaid expansion, & access to coverage and their impact on practice and those we serve.
How did we get here?

Health Reform - 1994

• Lacked transparency
• Limited input from stakeholders
• Hillary Care
• Opposition party had its own plan
  - developed by conservative Heritage Foundation
  - relied on the individual mandate, private carriers, and market competition

Health Reform - 1994

• Fear campaign
  - Government will dictate your health care
• Result:
  - Reform failed
  - Insurance companies - not government ran health care/made health care decisions
What changed since then

- Almost 50 million were uninsured
- Severe unemployment
- Everyone felt the pain of the healthcare crisis
- All of the players are unhappy
  - “Strange bedfellows”
- Support of a then popular president

Other Differences

- Transparency
- Significant involvement of multiple stakeholders by Congress and the White House
- Public support
- Negotiations with key groups that stopped health reform in the past
- Starting point – the former republican plan

March 23, 2010

- Congress passes the Patient Protection and Affordable Care Act ACA
- Was phased in
- Most provisions took effect Jan 1, 2014
- Not socialized medicine
- Not single payer
Socialized Medicine Vs. Single-Payer

• Government owns the means of providing medicine.
• Government employs docs, and other hcps, owns hospitals, and negotiates and buys technology
• Ex. VA System
• Refers to federal control

• One institution purchases most of the care
• The payer does not employ the hcps or MRIs
• Multiple private insurers to chose from with gov. as the major purchaser
• Ex. Medicare
• Refers to market share

ACA Brings 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.

States Sue to Stop ACA

• ACA relied heavily on Medicaid expansion to provide health care to childless, single adults, and the working poor
• Government was to pay for the expansion at first and decrease to 90%
• States didn’t want the federal government telling them to expand Medicaid
Supreme Court Ruling

- ACA is constitutional
- Individual mandate is a permissible ‘tax’
- The Feds cannot force the states to expand Medicaid.
- If they don’t expand
  - No coverage for single, non-disabled adults from FPL to 133% of the Federal Poverty Level (FPL)
  - $15,521 for an individual and $31,721 for a family of four in 2014

ACA Consumer Protection

- Provides coverage to Americans with pre-existing conditions
- Choose the primary care doctor you want from your plan’s network and no longer require a referral to see an OB-GYN.
- Keeps most young adults covered on their parent’s health plans until they are 26.
- Ends lifetime limits on coverage on most benefits for all new health insurance plans.

ACA Consumer Protection

- Health plans can no longer limit or deny benefits to children under 19 due to pre-existing conditions.
- Insurers can no longer cancel coverage just because you made an honest mistake on your application for insurance.
- Insurance companies can no longer charge you higher premiums because you are a woman.
ACA Consumer Protection

- Your premium dollars (80% +) must be spent primarily on health care – not administrative costs.
- Insurance companies must now publicly justify any unreasonable rate hikes.
- Annual limits on your health benefits were phased out as of 2014.

ACA Consumer Protections

- You may be eligible for recommended preventive health services – some without copayment.
- You can seek emergency care at a hospital outside of your health plan’s network.
- You now have the right to ask that your plan reconsider its denial of payment. (Appeal)

Pre-Existing Conditions

- Prohibition on coverage exclusions for pre-existing health conditions became effective for most enrollees on January 1, 2014.
- Insurers cannot charge you higher premiums because of your disability or medical condition.
  - Plans must operate on the basis of “standard population risk,” which looks at everyone – i.e., both those with and without existing conditions -- to determine reasonable costs.
- Your premium costs may be influenced by your age & smoking habits.
- Grandfathered individual (non-employer based) insurance plans are not required to eliminate pre-existing condition exclusions for children under 19 years old in individual children only or non-group family plans.
Grandfathered Plans

- Definition:
  - an existing group or individual (not through an employer) health insurance plan in which a person was enrolled on the date of enactment of ACA – March 23, 2010.
- As long as a person was enrolled in the plan on March 23, 2010, that plan has been grandfathered.
  - “If you like your health plan you can keep it”
- If a plan significantly reduces benefits or increases out-of-pocket costs for the insured person, then the plan will lose its “grandfathered” status and you get additional benefits***

No Discrimination Based on Pre-Existing Conditions

- As of 2014, health insurers can no longer discriminate against people due to disabilities or other pre-existing conditions.
- Health insurers can no longer
  - 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 went into effect for children in September 2010. Sec 1201

Temporary High Risk Pools

- There were temporary high risk pools that allowed people with pre-existing conditions to purchase coverage.
- Had to be without health coverage for at least six months.
- They ran out of money in February 2013.
- Was supposed to last until the new plans bought on the exchanges kicked in
Lifetime & Annual Benefits Caps

- Lifetime caps on benefits were prohibited immediately. This will end the common insurance practice of imposing lifetime caps such as $1 million.
- As of 2014, both lifetime and annual caps on benefits are prohibited.
  - Sec. 2711

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.
  - Section 1301

HOWEVER…..

- States enforce the consumer protection provisions but Alabama, Arizona, Missouri, Oklahoma, Texas and Wyoming will not enforce consumer protection provisions of ACA…
- CMS intervened with plans
Medicare Part D Donut Hole Gap in Prescription Drug Coverage

- Closes the “donut hole” in prescription drug coverage under Medicare by 2020.
- Before ACA, Medicare enrollees in the donut hole (after they reach $2850 on prescription drug coverage and before additional coverage kicks in at $4550), had to pay for prescription drugs at full price.

Sec 3301 et seq. (3315 replaced by Section 1101 Reconciliation bill)

Medicare Part D Donut Hole Gap in Prescription Drug Coverage

- In 2010, beneficiaries received a one-time $250 rebate for prescription drugs after they entered the doughnut hole.
- Beginning January 1, 2011, ACA provided a 50% discount on brand name drugs and other discounts for generic drugs for enrollees in the donut hole.

Anti-seizure, Anti-spasm, & 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, anxiety medications, and anti-spasm medications.
  - Before ACA, these categories of medications were specifically excluded from coverage under Medicare Part D.
ACA - Medicare Benefits

- In 2014:
  - Beneficiary pays 47.5% of the plan's cost for covered **brand-names** & entire cost counts toward out of pocket to get out of donut hole
  - Medicare pays 28% for **generic drugs** in the donut hole. Beneficiary pays the remaining 72% of the price. Only what beneficiary pays will count towards getting out of the donut hole

ACA - Medicare Benefits

- Cost of prescriptions decreases until
  - 2020 when beneficiary pays 25% for brand-names and 25% for generics

ACA Medicare Benefits Coverage of Annual Wellness Visit

- 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.
  - Sec 4103
ACA - Medicare Benefits*

- Medicare covers a Yearly Wellness Visit with preventive services (Part B coverage):
  - Bone mass measurement
  - Cervical cancer screening, Pap smears & pelvic exams
  - Cholesterol and other cardiovascular screenings
  - Colorectal cancer screening (except for barium enemas)
  - Diabetes screening
  - Flu shot, pneumonia shot, and the hepatitis B shot
  - ***(Check with individual Medicare Advantage Plan to see if these are free services)***

ACA - Medicare Benefits*

- HIV screening for people at risk or who ask for the test
- Mammograms
- Medical nutrition therapy to help people manage diabetes or kidney disease
- Prostate cancer screening (except digital rectal examinations)
- ***(Check with Medicare Advantage Plan to see if these are free services)***

Medicare 2-yr Waiting Period

- Under existing law, people who are 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.
Medicare 2-yr Waiting Period

- Health care reform didn’t end this practice but mitigated this problem because people in the two-year waiting period may
  - obtain health coverage through the health insurance exchanges (which cannot discriminate on the basis of pre-existing conditions) or
  - qualify for Medicaid under its extended eligibility standards in expansion states.

Medicare Outpatient Therapy Caps

- ACA ext 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 $1860 cap for occupational therapy, and $1860 cap for physical therapy and speech-language pathology services. Sec 3103

Preventive Services for All Adults under ACA

- Of these services, the following apply to women:
  - Adult immunization vaccines
  - Screenings 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)
  - For high risk adults: HIV screening, syphilis screening, and sexually transmitted infection (STI) prevention counseling
Preventive Services for All Adults

- Screening and counseling for:
  - Alcohol misuse
  - Obesity screening
  - Tobacco use screening for all adults and counseling for users
  - Colorectal cancer for adults over 50
- Aspirin use for men & women of certain ages

Preventive Services for Women

- There are 22 preventive services specifically covered for women. These include:
  - Screenings for pregnant women for anemia, urinary tract and other infections, Hepatitis B, Rh Incompatibility, and tobacco use and tobacco counseling; and folic acid supplements for pregnant women
  - Mammograms every 1-2 yrs for women over 40, BRCA counseling about genetic testing and breast cancer chemoprevention counseling for high risk women, and osteoporosis screening for women over 60 depending on risk factors

Preventive Services for Women for Women

- Screenings for:
  - Cervical cancer for all sexually active women
  - Chlamydia Infection for younger women and other women at higher risk
  - Gonorrhea for all women at higher risk
  - Syphilis for all pregnant women or other women at increased risk
- 8 of the 22 preventive services for women were added August 1, 2012
New Preventive Services for Women

- These are based on recommendations from the Institute of Medicine and are covered with No cost-sharing:

  1. **Well-woman visits:** An annual well-woman preventive care visit for adult women to obtain the recommended preventive services.

  2. **Gestational diabetes screening:** This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.

Preventive Services for Women

3. **HPV DNA testing:** Women who are 30 or older will have access to high-risk human papilloma virus (HPV) DNA testing every three years. Early screening, detection, and treatment have been shown to help reduce the prevalence of cervical cancer.

4. **STI counseling for Sexually Active Women:** Access to annual counseling on sexually transmitted infections (STIs).

5. **HIV screening and counseling:** Sexually-active women will have access to annual counseling on HIV.

Preventive Services for Women

6. **Contraception and contraceptive counseling:** Women will have access to all FDA-approved contraceptive methods, sterilization procedures, and patient education & counseling. These recommendations do not include abortifacient drugs.

7. **Breastfeeding support, supplies, and counseling:** Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.

8. **Interpersonal and domestic violence screening and counseling:** Screening and counseling for interpersonal and domestic violence should be provided for all adolescent and adult women.
Preventive Services for Children

- There are 27 Covered Preventive Services for Children, which include:
  - Immunizations for influenza, meningitis, tetanus, HPV, hepatitis A & B, measles, mumps, rubella, & varicella
  - Behavioral and developmental assessments,
  - Iron and fluoride supplements,
  - Oral health risk assessment for young children and hearing and other screenings for newborns.
  - Screenings for autism, vision impairment, lipid disorders, tuberculosis, lead exposure, obesity (includes counseling), and certain genetic diseases
  - Screening of adolescents for depression, HIV and sexually transmitted infections, cervical dysplasia (if sexually active), and alcohol and drug use.

Can Congress Repeal ACA?

- Several bills were introduced in the House of Representatives to repeal ACA (113th & 114th Congress)
- Repeal can pass the House
- Repeal can’t pass the Senate
- When people realize what they have, will they want to give it up?

Essential Health Benefits

- ACA required new plans (including plans offered in the exchanges and individual and small group plans but excluding grand-fathered individual and employer-sponsored plans) to cover 10 essential health benefits.
Essential Health Benefits

- ACA gave Secretary Sebelius authority to define the EHB
- She asked the IOM to study it and they wrote a report. AOTA & disability advocates participated in the IOM's process. Secretary chose another path.
- 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. **

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Qualified Health Plans cover Essential Health Benefits which include at least these 10 categories

<table>
<thead>
<tr>
<th>Ambulatory patient services</th>
<th>Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Rehabilitative and habilitative services and devices</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Laboratory services</td>
</tr>
<tr>
<td>Maternity and newborn care</td>
<td>Preventive and wellness services and chronic disease management</td>
</tr>
<tr>
<td>Mental health and substance use disorder services, including behavioral health treatment</td>
<td>Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)</td>
</tr>
</tbody>
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Essential Health Benefits

- ACA included coverage for rehabilitation and habilitation in its "essential health benefits" (EHB)
- HHS: states will choose four benchmark plans based on private plans currently in existence in their state.
- These newly established plans would theoretically include rehabilitation, habilitation, and the other specified essential health benefits.
- However, most private plans exclude habilitation and this creates a dilemma in the states establishing their plans based on existing plans.
Essential Health Benefits

- Nov 2012, HHS released an EHB proposed rule to address the dilemma.
- HHS proposed that if a state's base-benchmark plan does not cover habilitation, the state can define the services it will include under habilitative services.
- HHS proposed to give the states the ‘flexibility’ to lead the development of habilitation services policy.
- The essential benefits apply in 2014 to the individual and in 2015 to small employer group insurance coverage that will be sold through the insurance exchanges, and Medicaid plans.

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.

Community Living Assistance Services & Supports -CLASS ACT -

- Establishes 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 -- and choose -- services and supports that help them with activities of daily living.
- To qualify, people will have paid premiums, by means of a voluntary payroll deduction plan, for at least five years.

(continued)
Community First Choice Option

• Creates the Community First Option by which state Medicaid plans can choose to make home and community based services and supports the rule – rather than the exception –
  - for Medicaid-eligible individuals with disabilities
  - who would otherwise require institutional care &
  - whose income is up to 150% of the Federal Level

Section 1915(k) Community First Choice State Plan Option

• Promotes community-based supports and services over institutional care
  - Provides states with 6% increase in federal Medicaid matching funds to encourage them to participate.
• CMS released final rule April 26, 2012

Community First Choice State Plan Option - Participants

• As of August, 2013, 8 states plan to implement CFC in FY 2013 or FY 2014
• Arizona, Arkansas, California, Maryland, Minnesota, Montana, New York, Oregon

Money Follows the Person

- Extends the popular Money Follows the Person demonstration grants until September 2016.
- These grants help state Medicaid programs defray the costs of moving people into community-based settings for eligible Medicaid recipients – those who have resided in an in-patient facility for a minimum number of consecutive days. Sec 2403

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. Sec. 2402

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. Sec. 2001
Medicaid Incentives

- As of 2014, ACA expanded Medicaid to cover non-elderly, childless adults and adults with incomes up to 133% of the Federal Poverty Level in some states.
- It also expanded Medicaid to cover children in families with incomes up to 133% of the Federal Poverty level in some states.

Medicaid Match Incentives

- States that expand receive an increased Federal matching share for the first few years.
- In 2014, 133% of the Federal Poverty Level for individuals is $15,521 and for families of four was $31,721.

- Up until 2014, states had the option of extending Medicaid coverage to these groups.
- 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.
EPSDT

- 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.

Substantial Increased Funding for Community Health Centers

- Provides for $11 billion of increased funding from the Public Health Trust fund for Community Health Centers that are spread across all 50 states and territories and totaling over 1200 facilities. Sec 10503

Elimination of Medicare First Month Purchase Option for Power Wheelchairs

- Before ACA, Medicare beneficiaries could purchase their power wheelchairs, rather than rent them. This enabled the person with long-term need of a wheelchair to have it adjusted to his or her unique needs.
- Under ACA, 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% & the beneficiary pays 20% of the rental cost. Sec. 3136
With purchased wheelchairs, suppliers are likely to bear the cost of individualization, but they are not likely to do so for a rental.

Without customization, users frequently suffer exacerbated or secondary conditions that require treatment and often hospitalization – thus offsetting any cost savings to Medicare. Sec. 3136

DME Excise Tax

- A new excise tax ($20 billion over 10 years) on medical devices will be imposed on manufacturers of medical equipment - offset the costs of health reform.
- Consumer may ultimately bear the cost - manufacturers are likely to pass these costs on to consumers through increased prices. Sec 9009

Medicare DME 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. - Expect fewer suppliers to choose from for both purchase and repairs of wheelchairs and other durable medical equipment - quality of products and repairs may go down.
- Sec 6410
Medicare DME Competitive Bidding Program

- 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.
- Implementation has been delayed from time to time.

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 & interventions to see which works best based on outcomes.

Comprehensive Workplace Wellness Programs

- Authorizes an appropriation for grants to eligible small businesses to give their employees access to comprehensive workplace wellness programs that meet criteria to be developed by HHS.
- Employees can get discount for participation.
- Fear was this provision could have a negative impact on people with disabilities.
Exchanges/Marketplaces

- New rules were released in early July
- Open enrollment began October 1, 2013 for people currently uninsured and some others and was supposed to end March 1, 2014
- Large employers don't have to participate until 2015 & marketplaces for small businesses were extended

Plan Levels of Coverage

<table>
<thead>
<tr>
<th>Levels of Coverage</th>
<th>Plan Pays On Average</th>
<th>Enrollees Pay On Average* (In addition to the monthly plan premium)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>10%</td>
</tr>
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</table>

*Based on the aggregate cost under the plan when benefits are provided to a standard population. This may not be the same for every (or any specific) enrolled person.

Bottom Line

- The lower the premium, the higher the out-of-pocket costs when you need care;
- The higher the premium, the lower the out-of-pocket costs when you need care.
- Note: The Marketplace also offered "catastrophic" plans to people under 30 years old and to some people with very low incomes.
Alternative Benefit Plans (ABPs)

- Available to the Medicaid expansion group
  - Benchmark or benchmark equivalent
  - The minimal required benefits (MRB) – states can + more
- ABPs must cover the 10 Essential Health Benefits (EHB) whether the state uses an ABP for Medicaid expansion or coverage of any other groups of individuals
- Individuals in the new adult eligibility group will receive benefits through an ABP
- If habilitation is not in the benchmark plan, the state will define habilitative services and devices
  - either in parity with rehabilitative services and devices or
  - as determined by the state and reported to CMS in the ABP template

States must select a coverage option from 4 benchmark options
- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program
- State employee coverage that is offered and generally available to state employees
- Commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state
- Secretary-approved coverage, a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population

Summary of ABPs

- ABP must cover
  - 10 EHB
  - Preventative care (without cost sharing)
  - Mental health parity
- So ABP = Benchmark (MRB) + Supplement or Substitute Benefits to cover required benefits
  - (those listed above)
Prescription Drugs

• EHB prescription coverage standard:
  - Provide at least the greater of:
    • 1 drug in every USP category and class; or,
    • Same # drugs in each category and class as EHB benchmark plan.
  - This may be less than what they have now & may be less than Medicare Part D
• Must include a provision to allow an enrollee to request and gain access to clinically appropriate drugs not covered by the plan

Cost Sharing and Premiums

• Updates the maximum allowable nominal cost-sharing levels to be a flat $4 for outpatient services and preferred drugs, and $75 for an inpatient stay
• Allows states to charge up to $8 for non-preferred drugs and non-emergency use of the ED for individuals with income at or below 150% of the FPL
• Applies the 5% aggregate limit to all cost sharing incurred by all individuals in the household

Medicaid Expansion

• Supreme Court left some folks in limbo – said Medicaid expansion was optional for states
• ACA expands Medicaid coverage for most low-income adults to 138% of the federal poverty level (FPL) ($15,521 for an individual or $26,321 for a family of three in 2014)
Medicaid Expansion

- Some states (Arkansas) are talking about putting people in Medicaid in the exchanges/marketplaces via premium assistance
  - Establishes rules regarding premium assistance to support enrollment of individuals eligible for Medicaid in health plans in the individual market, including enrollment in QHPs doing business on the Exchanges/Marketplaces
  - These can put PWD living in the community in jeopardy if the providers don’t know how to treat them or are not accessible

Current Status of Medicaid Expansion Decisions as of January 28, 2014

Kaiser Family Foundation

Gov=22 D’s & 4 R’s
Not Moving Forward at this Time
Implementing Expansion in 2014
Open Debate

Over 1.1 Million Dual Eligibles Affected By Demonstrations

http://kff.org/medicaid
As of November 25, 2013
CMS has approved financial or administrative alignment demonstrations that will affect over 1.1 million dual eligible beneficiaries in nine states.
Source: GAO analysis of CMS data

Health Insurance Exchanges Status for 2014 As of May 10, 2013

*On May 10, 2013, CMS announced it intended Utah would operate a state-based Small Business Health Options Program (SHOP) exchange, but the individual exchange would be an FFE, for which Utah would assist with plan management

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Marketplace/Exchanges

Issues

- 17 State-based Marketplace;
- 7 Partnership Marketplace;
- 27 Federally-facilitated Marketplace
- State Exchanges worked & enrolled


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Marketplaces/Exchanges

- Health Navigators
  - Major impact on participation by PWD
  - CMS gave grants for navigator programs
- 45 CFR 155.210(e)(5) and 155.205(d) and (e) required Navigators and non-Navigator assistance programs to provide meaningful access to people with disabilities
  - Certified application counselors provided information with reasonable accommodations for those with disabilities through referrals to Navigators, non-Navigator assistance personnel, and/or the Exchange call center.

- 42826 Federal Register / Vol. 78, No. 137 / Wednesday, July 17, 2013 / Rules and Regulations

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Required Training & Certification

<table>
<thead>
<tr>
<th>State-based Marketplace</th>
<th>State training and certification (state may choose to use federal training)</th>
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<tbody>
<tr>
<td>State Partnership Marketplace</td>
<td>Federal training and certification, which may be supplemented by the state</td>
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</tr>
<tr>
<td>Federally-facilitated Marketplace</td>
<td>Federal training and certification</td>
<td>Not applicable</td>
<td>Federal training and certification</td>
<td>Federal training and certification</td>
</tr>
</tbody>
</table>

Misc Provisions

- Training for navigators is public through marketplace.cms.gov
  - supposed to cover services to PWD
- Will require annual continuing education
- New rules amends meaningful access standards to require that translation services and accessibility aids be provided when necessary or when requested by the consumer.

Advanced Premium Tax Credits

- Eligibility is based on
  - Household income, and family size (at end of year)
  - Income between 100% to 400% of the Federal Poverty Level (FPL) ($23,850 – $95,400 for a family of four in 2014)
  - Obtaining qualified health insurance through the Marketplace
  - Ineligibility for government-sponsored coverage, affordable employer-sponsored insurance, or certain other minimum essential coverage
Advanced Premium Tax Credits

- This tax credit is **paid up front directly to the insurer.**
  - Advanced each month when premiums are due.
- The advance payment of the tax credit is based on the consumer’s anticipated annual income.
- This is reconciled at the end of the year with the annual filing of the income tax return when actual income is known.
- If the family’s income (or other circumstances, such as family size) changes from the original estimate for the credit amount, the family gets a refund or repays the excess amount up to $1,500, the maximum amount for their income level.
Reducing Health Disparities of People With Disabilities

- Improving public health data collection for PWD
- Where do PWD get their health care
- Which providers are trained to treat PWD
- How many providers have accessible facilities & equipment
- Coverage of preventive services without cost sharing requirements.
- Standards for accessible medical equipment (guidelines)
- Training health care workers to treat PWDs in a culturally competent manner.
- Improving care coordination for people with chronic conditions
- Anti-discrimination provisions

Data Collection & Analysis to Understand & Address Health Disparities

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

Data Collection

- Require all HHS data collection to include information about PWD
- All public health surveys now include 6 standard questions
  1. Is this person deaf or does he/she have serious difficulty hearing?
  2. Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?
Data Collection

3. Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?
4. Does this person have serious difficulty walking or climbing stairs?
5. Does this person have difficulty dressing or bathing?
6. Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor’s office or shopping?

Quality Measures

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

Accessible Medical Diagnostic Equipment

• Required 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.

Sec 4203
- Weight scales, exam tables, etc
Access to Medical Care

- Access board – voluntary guidelines for accessibility
- Secret shopper study
  - 256 subspecialty medical practices in 5 large U.S. cities in 4 states
  - 56 practices (22%) couldn’t accommodate pt
  - 9 practices: buildings inaccessible,
  - 47 could not transfer pt to exam table.

Access Board Guidelines

- Access Board's Medical Diagnostic Equipment (MDE) Accessibility Standards Advisory Committee
  - Released its report on January 7, 2014
  - http://www.access-board.gov/
  - Committee included an OT from University of the Sciences in Philadelphia, Department of Occupational Therapy

Accessible Medical Diagnostic Equipment

- Advancing Equal Access to Diagnostic Services: Recommendations on Standards for the Design of Medical Diagnostic Equipment for Adults with Disabilities
- Includes an overview of the types of equipment to be covered by the standards and specific recommendations for the substance of provisions that address transfer access, armrests, lift compatibility, and other features for accessibility.
Training of Future Health Practitioners

- Encourages medical professionals education to include disability awareness and 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. Sec 5307 (Authorized but not appropriated – translated? No $)

Comparative Effectiveness Research

- Compares the outcomes or effectiveness of different treatments or therapies for the same condition.
- Patient-Centered Outcomes Research is another name for CER.
- CER is supposed to improve quality of care and lower costs by finding the most effective treatment.
- ACA established the Patient-Centered Outcomes Research Institute (PCORI).
- PCORI has funded $316 million for 192 studies covering a wide range of clinical conditions, geographic locations, and socioeconomic characteristics for patient-centered comparative clinical effectiveness research projects.
- Selby, & Lipstein PCORI at 3 Years — Progress, Lessons, and Plans n engl j med 370:7 p592

PCORI

- Has an advisory panel on health disparities or another topic
- Suggest a topic that you want studied
- Be a reviewer
- Apply for grants
- pcori.org for more info
ACA Antidiscrimination Provisions § 1557

- An individual shall not, on the ground prohibited under... or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title

HHS OCR Questions § 1557

1. Please describe experiences you’ve had, or examples, with respect to the following types of discrimination in health programs & activities
2. What are examples of the types of programs and activities that should be considered health programs or activities under Section 1557 and why?

HHS OCR Questions § 1557

3. Impact? What studies/other evidence documents costs of discrimination and/or the benefits of equal access to health programs & activities PWD?
4. In the interest of ensuring access to health programs & activities for individuals with limited English proficiency (LEP)
5. Title IX
HHS OCR Questions § 1557

6. Health IT - what are the benefits & barriers encountered by people with disabilities in accessing electronic and information technology in health programs and activities?

7. 504 enforcement - How effective are processes in addressing discrimination? How we could strengthen enforcement processes?

8. Other issues important to implementation

Marketplace/Exchanges Issues

- Majority of people who signed up for coverage in states reporting were Medicaid expansion: As of November:
  - Kentucky: 25,654 Medicaid enrollees, about 4X 5,891 private insurance enrollees
  - Washington: 42,605 enrollments in Medicaid program & 6,390 sign-ups for private insurance

- Arkansas: reported 70,595 Medicaid applications
- Oregon cut its uninsured rate by 10%—without signing up a single person for private insurance.
- 56,000 Oregonians flocked to the health law’s expansion of Medicaid
- Arkansas & Oregon sent notices to food stamp recipients who states knew to fall below Medicaid’s income cutoff. Call or mail form back

Sarah Kliff ‘in first month, the vast majority of Obamacare sign-ups are in Medicaid’ Washington Post. November 1
Marketplace/Exchanges
Issues

- Navigators, & Certified Applications Counselors
  - Require training
  - AAHD got an RWJF grant (YEAH!)
    - To help train navigators about PWD
    - http://www.nationaldisabilitynavigator.org/
    - Visit this site and find out additional info

Questions?

Thank you!
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