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Understanding the Effects of Healthcare Reform on the Disability Community

The Internet now abounds with interpretations of the recently passed healthcare reform legislation, also known by its formal name -- the Patient Protection and Affordable Care Act (PPACA). These recaps of reform are often so complicated that many remain confused. Here is what we hope is a clear description of a few of the major changes which will affect persons with disabilities and their families, as well as the time frames for implementation. It's important to note that the changes brought about by PPACA affect the privately insured, the uninsured and those who are covered under government programs, including Medicare and Medicaid.

If the past year has taught us anything, it is that healthcare is complicated and difficult to navigate. One beneficial aspect of the new healthcare law is that the Secretary of Health and Human Services has established a new Web site to make it easy for individuals in any state to seek out affordable health insurance options. The site can be found at www.healthreform.gov. For the privately insured, PPACA brings about several significant changes.

(A) Children with pre-existing conditions may not be denied access to their parents' healthcare insurance plans [takes effect within six months of enactment of the bill]. There will be a gap for current dependents that could be uncovered for those six months. While the term "dependent" is yet to be defined, a good place to go for a glossary of terms in the new Act is www.kff.org/healthcarereform. The glossary was completed by the Kaiser Family Foundation which has a tremendous amount of good information about health care reform on its website.

(B) Adults with pre-existing conditions may not be denied access to insurance [takes effect by 2014]. Between now and 2014, the Department of Health and Human Services will set up a temporary "high risk" pool to provide coverage to persons with pre-existing conditions who have not had creditable insurance coverage for the preceding six months. The pool will be funded with \$5,000,000,000 and goes into effect June 23, 2010. Currently, there is no guidance regarding the price of coverage. The pool must cover at least 65% of health care costs. Premiums are allowed to vary by age (4:1), geographic location, family composition and tobacco use.

(C) Dependent coverage for children up to age 26 must be offered in all individual and group policies in which a parent is participating and which was in effect prior to the enactment of the legislation. Dependents can include both married and unmarried children. However, there is no guidance regarding the inclusion of children who have pre-existing conditions. The effective

date for this legislation is September 23, 2010 although certain insurers are planning to offer the coverage before that date.

(D) There can be no lifetime limits on the dollar value of coverage [takes effect in 2014]; this means that insurance companies will no longer be able to cap the amount of medical coverage they will provide based on cost. Until the provision takes effect in 2014, there can be no annual limits on coverage.

(E) Once coverage has been obtained, it cannot be rescinded except in cases of fraud; this means insurance companies cannot cancel a policy once an individual becomes sick, unless the individual initially misrepresented their health information. For those who depend upon government benefits including Medicare and Medicaid, there are many additional changes:

(1) The “Community First Choice Option” will be established to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to individuals with disabilities in accomplishing activities of daily living and health related tasks. States that choose to implement the program will receive an increase federal matching rate of six percentage points. This option begins on October 1, 2011 and sunsets in five years. It modifies the “Money Follows the Person” (MFP) programs to reduce the amount of time to qualify for MFP to 90 days.

(2) The Community Living Assistance Services and Supports (CLASS) Act has been established to enable individuals to purchase community living assistance services and supports when they might be needed. Working individuals can invest in the program through payroll deduction or direct deposit. Adults with multiple functional limitations or cognitive deficits can begin collecting once they have paid into the program for at least five years; the first payments will not begin until 2016. The amount of the cash benefit will depend on the degree of impairment, but will not exceed an average of \$50.00 per day. The funds can be used to purchase non-medical services and supports which allow the individual with impairments to remain in his or her home. If the eligible individual is also receiving Medicaid benefits, the CLASS Act payments will be primary, Medicaid secondary. While the initial program will include enrollment for all working people, anyone may opt out.

(3) A \$250 rebate will be given in 2010 to Medicare Part D enrollees who reach the doughnut hole—a gap in coverage that exists for individuals whose expenses exceed the Medicare prescription drug coverage limit, but have not yet qualified for catastrophic coverage.

(4) The Medicare Part D doughnut hole will be gradually reduced by 2020 so that enrollees in the coverage gap pay no more than 25% of the cost of either brand or generic drugs. Starting in January 2011, pharmaceutical manufacturers must provide a 50% discount on brand name prescriptions filled in the gap. Beginning in 2013, the federal government will add on to the subsidy for brand name drugs, starting at 2.5% and rising to 25% by 2020. For less expensive generic drugs, federal subsidies will begin at 7% in

2011 and rise to 75% of generic drug cost by 2020 for prescriptions filled in the coverage gap.

(5) An Independence at Home demonstration project will be created, providing high need Medicare beneficiaries with primary care services in their homes and allow participating teams of healthcare professionals to share in any savings which prevent hospitalizations and other improvements in health outcomes.

(6) Medicare beneficiaries can access a comprehensive risk assessment and create a personalized prevention plan. [Assessment model to be developed within 18 months].

(7) A new office will be created within the Centers for Medicare and Medicaid Services (CMS) to coordinate between the state and federal governments to improve access and quality of care and services to dual eligibles—people who qualify for both Medicare and Medicaid.

(8) Medicaid coverage will be expanded to include persons 64 and under without dependent children and with income up to 133% of the federal poverty level (FPL), which in 2010, is income up to \$896 monthly. There are no assets restrictions under the new law. Seniors 65 and over and individuals with disabilities will continue to receive the broader Medicaid package that includes long-term care benefits. The new law includes a higher federal matching rate to encourage states to offer preventive care services with no cost sharing, and to “provide ‘health home’ services” to better help coordinate care for individuals with chronic conditions. Ultimately, these changes are intended to increase spending on home and community based services and decrease the need for nursing home spending.

(9) States must expand spousal impoverishment protections to their Home and Community Based Services Waiver programs, including those individuals who qualify for a Medically Needy waiver.

(10) Medicaid payments for fee-for-service and managed care primary care doctors will be increased beginning in 2013. The law provides a 10% bonus payment to primary care physicians beginning in 2011, in order to keep primary care doctors in the practice area and to encourage new doctors to become primary care physicians.

(11) New incentives will be created for states to offer home and community based services to Medicaid recipients with incomes up to 300% of FPL with a higher level of need.

This information provides only an overview of the impact of the PPACA. Consumer protections, revamped oversight programs, insurance reform and data collection are included in many provisions. We would like to thank The Kaiser Family Foundation, NAELA public policy consultant Brian Lindberg, and Stetson University Law School Professor Rebecca Morgan for the information they provided that contributed to this overview.