NEW HEALTHCARE LAW

HIGH POTENTIAL

The Affordable Care Act
for Individuals with Special Needs

The hope is that lessons learned in the coming months will provide the basis for ongoing enhancement of the quality of life and independence of individuals with special needs.

The Patient Protection and Affordable Care Act, sometimes referred to as Obamacare or the ACA, has the potential to transform medical treatment for many children and adults with disabilities. The goals of this landmark legislation, which became law in March 2010, and is being implemented in increments, are distilled in its very name—improving the quality of health care while dramatically expanding access to services.

Prior to January 1, 2014, many individuals, with special needs went without health coverage unless they could qualify for Medicaid, Medicare, or, in some cases, a combination of both. Pre-existing conditions meant that private insurance was either nonexistent or prohibitively expensive. Medicaid’s stringent asset and income limits rendered many of them ineligible for public assistance. For those under age 65, Medicare is available for SSDI (Social Security Disability Insurance) recipients, but only after a 24-month qualifying period or in the case of certain terminal illnesses. The ACA significantly expands the options available to individuals who previously were not able to qualify for Medicaid, Medicare or private insurance.

New Insurance Requirements

For the first time, private insurance has become a viable alternative for many individuals and families with special needs. Perhaps most important, policies cannot be denied or priced at a premium based upon pre-existing conditions. Annual and lifetime coverage limits have been abolished, and children can remain on a parent’s policy till the age of 26. All health insurance for individuals or small groups must include a bundle of 10 essential benefits, and preventive care is to be covered without requiring co-payments. While “essential benefits” are not required for insurance offered by large employers, it is generally believed that such policies will follow suit over time. Unfortunately, the benefit categories are broadly defined, so families will need to analyze each policy in order to understand precisely what is covered. The essential benefits are:

- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Inclusion of mental health services in the “essentials” bundle is especially noteworthy. When coupled with provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA), signed by President George W. Bush in 2008, it signals a sea change in care for mental illness. The MHPAEA requires that group health plans and insurers that offer mental health services provide coverage that is comparable to the coverage for medical and surgical care. Combined with the ACA requirement that all policies now offer mental health services, beginning in 2014, all insurers must address mental health in the same manner that they approach physical ailments. This translates into comparable co-payments and deductibles, as well as the removal of caps on treatment.

Another game changer is the listing of “habilitative” care. Whereas “rehabilitative” services address the regaining of capacities after illness or injury, habilitative services focus on capabilities yet to be developed. Speech therapy would be one example. For individuals with disabilities, this could open up dramatic care opportunities.

Allowing adult children to remain on parents’ policies until they reach the age of 26 is of particular benefit to families of children with special needs. Previously, upon reaching the age of 21, young adults with disabilities often turned to Medicaid for coverage of their health needs. In order to establish and maintain eligibility for Medicaid, the young adult could have almost no savings. As a result, this often required use of special needs trusts (SNTs) to protect funds needed to maintain their quality of life without rendering them ineligible for means-tested government benefits. Under the ACA, if they don’t qualify for Supplemental Security Income (SSI) and don’t require Medicaid waiver services such as housing or day support, they can postpone reliance on Medicaid.

Health Exchanges/Marketplaces

State-based health insurance exchanges, now referred to as marketplaces, are a key component of the Affordable Care Act. They are the places where individuals and small businesses are able to shop for comprehensive coverage. Geared towards insuring a population that previously was uninsured, the marketplace provides important insurance options for individuals who have not previously been able to afford it. The marketplace plans are not government insurance, but rather are insurance plans offered by private companies.

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Coverage through the health insurance exchanges begins on January 1, 2014, and enrollment started on October 1, 2013. Generous subsidies are available. Individuals and families with incomes between 100% and 400% of the federal poverty level ($45,960 for individuals and $94,200 for family of four in 2014) may apply for income-based subsidies. Likewise, small businesses will receive tax credits to assist with coverage for their employees.

States can build a fully state-based marketplace, enter into a state-federal partnership marketplace, or default to a federally-facilitated marketplace. Seventeen states and the District of Columbia have established their own exchanges, seven have partnered with the federal government, and residents of the remaining states can use the federal government’s exchange.

To ease comparison of available policies, which differ by state and within states by county, four “precious metal” categories (bronze, silver, gold, platinum) identify offerings that pay the same percentage of covered costs, in addition to having identical deductibles, co-pays and out-of-pocket expense limits. More information about marketplace options is available by calling 1-800-318-2596, or online at https://www.healthcare.gov/how-do-i-apply-for-marketplace-coverage/

**Medicaid Expansion**

The ACA provides for a nationwide expansion of Medicaid eligibility beginning in 2014. Before the ACA, to be eligible for coverage, an individual needed to belong to a “categorically” eligible group (children, pregnant women, parents, individuals who are blind or have a disability, persons 65 years of age, or older) and meet financial eligibility criteria. The ACA expands eligibility to include individuals between the ages of 19 and 65 who meet citizenship requirements and have income below 150% of the Federal Poverty Level, which in 2014 is $15,282 for an individual and $31,522 for a family of four. An additional 5% "income disregard" bumps these limits a little higher. Unlike the case with traditional Medicaid, eligibility is dependent only on income; assets are not considered.

In June of 2012, the Supreme Court upheld the Medicaid expansion, but limited the federal government’s ability to penalize states that don’t comply. As a result, the expansion is effectively optional. For states that participate in the expansion, the federal government will pay 100 percent of the costs through 2016 (Medicaid is typically a shared federal/state expense), gradually dropping to 90 percent by 2020. As of November, 25 states and the District of Columbia had agreed to the increase, with four additional states still deliberating. For ongoing updates concerning state participation, consult http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap.

**Ripple Effects**

Improved access to medical coverage also benefits families of individuals with special needs. Often, family members opt out of the work force to serve as caregivers. In doing so, they sacrifice not just a regular paycheck, but also other important employment benefits such as health insurance.

**Looking Up**

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under the ACA they will have better access to health care. The stresses of caregiving can be significant, and improved health can help them better handle the responsibilities of supporting a loved one with special needs.

The ACA could also open up work opportunities for individuals with special needs. Given exchange-based subsidies for insurance premiums, many working age individuals with disabilities will now be able to afford private insurance. They will no longer be concerned about meeting Medicaid’s income requirements and can pursue better paid positions.

**Improving Care, Reducing Costs**

Medicare is not part of the health insurance marketplace, but beneficiaries still receive benefits from the ACA. Medicare will now cover annual wellness visits, and co-pays and deductibles are eliminated for certain preventive services such as colonoscopies and mammograms. The notorious prescription drug “donut hole” that exists under Part D coverage will gradually shrink, disappearing entirely by 2020. Until then, there is a 50% discount when buying covered brand-name prescriptions while in the donut hole.

The ACA also created the Independence at Home Demonstration, a service delivery trial for Medicare beneficiaries that seeks to use home-based primary care teams to improve health outcomes and reduce costs. In this trial, health care providers will spend more time with their patients and perform assessments in their homes with a goal of improving health and keeping patients out of institutional settings.

In addition, under the ACA, Medicaid programs such as Money Follow the Person and Community First Choice have been enhanced or established to incentivize states to increase the availability of home and community-based alternatives to institutional care. A new Medicaid Health Home Option, as well as various Medicaid and Medicare demonstrations, seek to improve coordination and quality of care for individuals with chronic conditions.

Some other care improvement provisions of the ACA impacting individuals with disabilities are the establishment of standards for accessible examination equipment in order to improve preventive care and other diagnostic screenings for people with disabilities, better collection of data on health disparities affecting those with disabilities, and improved health provider training.

**Fine Print and Tradeoffs**

Families should review the options available to them and determine if their needs are better met through Medicaid-based programs or private insurance, including marketplace plans. This task can seem daunting, but the payoff of better health care will make the process worthwhile. Pay careful attention to the therapies and medical devices covered by each plan. Scan provider networks for specialists who have become important to you or your loved one’s care, and run the numbers to determine whether or not paying premiums is preferable to (SNT) planning to qualify for Medicaid based programs. Because the issues are complicated, consulting a special needs professional may be advisable prior to making a decision.

For individuals who need, or may need in the future, skilled nursing care, assistance with “activities of daily living” (such as toileting, dressing or bathing), housing, and/or supported employment or day programs, Medicaid will probably be required in order to qualify for state waivers that cover these types of services. On the other hand, since some medical professionals don’t accept Medicaid, you may find that you have more medical provider options with private insurance. Some families may, therefore, choose to purchase private insurance with a Medicaid “wrap-around” to cover the other services. In such a case, premiums may need to be paid through an SNT. It should also be noted that Medicaid-eligible individuals do not qualify for insurance exchange subsidies.

For all its benefits, Medicaid, with its stringent asset and income requirements, can be a time-consuming and intrusive option. The question for many families will be whether private insurance will answer needs previously met through Medicaid, allowing individuals to retain unencumbered access to personal funds and to avoid the Social Security Administration’s thicket of regulations.

**Tax and Financial Implications**

The ACA premium subsidies are based on income, so it is important to accurately report your income. If your income changes, you may be subject to a repayment when you file your income taxes. Many life events such as divorce, marriage, birth of a child, or a job change can impact your income during the year, which in turn may change the size of the subsidy to which you are entitled. To avoid having to repay a subsidy overpayment, it is important to promptly notify the IRS of any changes in your financial situation so your subsidy can be adjusted accordingly.

The ACA includes a couple tax provisions of note. As of tax year 2013, contributions to employer-sponsored Flexible Spending Accounts are capped at $2500, with that maximum to be indexed to inflation. In addition, the threshold for deducting medical expenses for income tax purposes has risen to 10 percent of adjusted gross income—unless you’re 65 or older, in which case it will remain 7.5 percent until 2016.

Also beginning in 2013, the ACA increases the Medicare Part A tax rate on wages by 0.9 percent on earnings over $200,000 for individual taxpayers. There is also a new 3.8 percent Medicare tax on certain investment income, based on the lesser of net investment income or modified adjusted gross income in excess of $200,000 for single taxpayers.

**Summary**

The ACA’s implications for individuals with disabilities are profound: better access to medical coverage, expanded community-based services, and improved quality of care through preventive services and coordinated delivery. Any program with such far-reaching objectives is bound to encounter unforeseen challenges, as the difficult launch of exchange websites has painfully illustrated. The biggest question for families with special needs is how smoothly the rest of the rollout will proceed. How difficult will it be to make changes to your insurance or Medicaid choices? How well will the system’s countless, interdependent pieces mesh? The hope is that lessons learned in the coming months will provide the basis for ongoing enhancement of the quality of life and independence of individuals with special needs.

**ABOUT THE AUTHOR:**

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