CONSORTIUM FOR CITIZENS WITH DISABILITIES

Protect the ACA's Gains for People with Disabilities

Members of the Consortium for Citizens with Disabilities strongly oppose repealing key provisions of the Affordable Care Act (ACA) without simultaneously passing a replacement plan that maintains or improves existing coverage, access, and affordability. Losing or undermining key enrollee protections or disrupting care would endanger millions of people with disabilities who have gained coverage under the ACA.

The ACA includes vital consumer protections that made it possible for many people with disabilities to get and stay covered. Prior to the ACA, millions of people with disabilities in this country had no access to health insurance, either because they had pre-existing conditions or because their conditions made premiums far too expensive. People with disabilities who need extensive care often faced annual or lifetime caps and were left with no way to pay for them. The ACA eliminated those coverage caps and set annual limits on cost sharing. It also barred insurance companies from refusing coverage (guaranteed issue) or charging more to people with pre-existing conditions (community rating). CCD members urge you to keep these key ACA consumer protections without changes.

The ACA created an adult Medicaid expansion group that now covers millions of people with disabilities and their caregivers who previously fell through coverage gaps. Over one in five enrollees in Ohio's Medicaid expansion reported treatment needs that indicated a disability, including many with mental or behavioral health conditions.[1] Nearly 40% had a chronic condition before enrolling, and 25% received a new chronic condition diagnosis *after* they enrolled.[2] This is consistent with reported data from other states.[3] Medicaid expansion covers people who previously fell into one of many gaps in our coverage safety net. For example, each year roughly 1.5 million individuals with disabilities are stuck in the required two year waiting period before they can become eligible for Medicare due to their disability.[4] Prior to the ACA, many had no affordable coverage options during this time despite their recognized disability. The adult Medicaid expansion can help many bridge the gap until Medicare coverage begins.

The ACA makes coverage more affordable for low and middle-income people. Health care is expensive, especially for people with disabilities and older adults. The ACA helps low- and middle-income individuals and families pay for premiums and out-of-pocket costs. Medicaid expansion includes strong protections that greatly reduce out-of-pocket costs for enrollees. By reducing the consumer costs for accessing services, the ACA makes it easier for people with disabilities to get needed care to stay healthy, find a better job, or go to school. Every repeal and replace proposal

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to date would shift more healthcare costs back onto consumers, even as many people find current costs too high. For example, coverage using high-deductible health plans tied to health savings accounts typically raises costs for enrollees, especially people who require more services. High risk-pools were similarly unaffordable for people with pre-existing conditions.

The ACA improved access to services for people with disabilities and chronic conditions to help them live healthy, independent, and fulfilling lives. Before the ACA, health plans and Medicaid programs often limited necessary services for people with disabilities or simply did not cover them, such as habilitation services like speech therapy that help people with disabilities to acquire new skills. The ACA created 10 essential benefit categories that all qualified plans must cover. This established a floor to ensure that coverage is reasonably comprehensive. Now, Medicaid programs and health plans in all 50 states cover habilitation services and devices that help people overcome challenges, as well as the other essential benefits.

The ACA helps millions with mental or behavioral health conditions get services they need. The ACA expanded access to mental health and substance use disorder services by listing them as essential health benefits. The law also reinforced mental health parity requirements to ensure that mental and behavioral health services are covered comparably to physical health services. Many people who gained coverage under the ACA face serious mental health or other functional challenges. One university study showed that individuals with serious mental illness were 30% more likely to receive treatment when they were covered by Medicaid.[5] Another randomized experiment found that adult Medicaid coverage resulted in a 30% reduction in the rate of depression.[6]

The ACA expands access to home- and community-based services. The ACA gave states new options for home- and community-based services (HCBS) programs and offered financial incentives to expand community-based care. Medicaid HCBS provide over 5 million individuals with supports like assistance with bathing, eating, cooking and managing medications that help them live at home rather than in more costly institutions such as nursing homes.[7] Supporting people in the community protects social networks, improves well-being, and lowers Medicaid costs.[8] Medicaid continues to be a driving force innovating quality HCBS programs.[9] Eight states have adopted the ACA's Community First Choice option, a program that provides states extra federal matching funds to help individuals remain at home instead of in expensive institutions.[10] That program has been cut or eliminated in recent proposals.

The ACA protects people with disabilities from health care discrimination. The ACA includes a number of non-discrimination provisions that hold health plans accountable for maintaining accessibility and preventing policies that unfairly disadvantage people with disabilities and other protected classes. Repeal of the ACA could threaten many of these critical protections.

Endnotes

[1] Ohio Medicaid Assessment Survey, *The Changing Landscape of Healthcare Coverage Across Ohio*, 17 (August 19, 2015).
[2] OHIO DEPT. OF MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT: A REPORT TO THE OHIO GENERAL ASSEMBLY, 3, 28 (2016).
[3] *See e.g.* PENNSYLVANIA DEPT. OF HUMAN SERVICES, *Medicaid Expansion Report* (2017) (finding that 17% of the expansion population had a cardiovascular condition and an additional 31% had a behavioral health conditions) available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_257436.pdf; DELOITTE, *Commonwealth of Kentucky, Medicaid Expansion Report* 45 (2014) (finding that the Medicaid expansion includes a greater percentage of individuals with multiple chronic conditions and is more likely to have a higher prevalence of chronic diseases than even traditional Medicaid) available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.
[4] *Selected Data from Social Security's Disability Program*, SOC. SEC. ADMIN., https://www.ssa.gov/oact/STATS/dibStat.html (last visited Jan. 4, 2017). The total number of SSDI awards in 2014-15 was 1.59 million, though this data may include some duplicates, which translates into roughly 1.5 million people each year in the two year waiting period for Medicare.
[5] B. Han et al., *Medicaid Expansion Under the Affordable Care Act: Potential Changes in Receipt of Mental Health Treatment among Low-Income Nonelderly Adults with Serious Mental Illness*, 105 AM. J. PUB. HEALTH 1982 (2015).
[6] Katherine Baiker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1717 (2013).
[7] Steve Eiken, TRUVEN HEALTH ANALYTICS, *Medicaid Long-Term Services and Supports Beneficiaries in 2012*, 2 (Sept. 16, 2016.)
[8] Carol V. Irvin et al., MATHEMATICA POLICY RESEARCH, *Money Follows the Person 2014 Annual Evaluation Report*, 42, 68 (Dec. 18, 2015).
[9] HCBS funding increasing by 21% from 2010 through 2014 while institutional expenditures remained flat Steve Eiken et al., TRUVEN HEALTH ANALYTICS, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending*, 30 (Apr. 15, 2016). HCBS funding has likely increased since 2014, but that data is not yet available.
[10] Those states are CA, CT, MD, MT, NY, OR, TX, and WA. Additional states (AR, CO, MN, and WI) have applied or are considering Community First Choice. Joe Caldwell, *State Talk for Seniors: The Affordable Care Act and Long-Term Care*, NAT'L. COUNCIL ON AGING (Dec. 19, 2016), https://www.ncoa.org/blog/straight-talk-affordable-care-act-long-term-care/.