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.** Unfortunately, the American Health Care Act (AHCA) passed by the House would abandon or undermine key enrollee protections, and if enacted would endanger millions of people with disabilities who have gained affordable coverage and access to needed services under the ACA.

**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.** Roughly three in ten adults eligible for Medicaid expansion have a mental or behavioral health condition.[1] In Ohio, more than one in five expansion enrollees had claims that indicated a disability.[23] These are people who previously fell into one of many gaps in our health coverage system. For example, each year roughly 1.5 million people with disabilities fall into the required two year waiting period before they can become eligible for Medicare.[4] Prior to the ACA, many had no affordable coverage options during this period despite their recognized disability, but in thirty-two states, they can now turn to Medicaid expansion. Others do not meet Medicaid's strict definition of disability but still suffer from debilitating or chronic conditions. Nearly 40% of Ohio's expansion enrollees had a chronic condition before enrolling, and 27% received a new chronic condition diagnosis *after* they enrolled.[5] This is consistent with findings from other states. The AHCA would effectively end Medicaid expansion, and return states to the days when these adults had no viable alternative coverage.

**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 assistance to help them bathe, eat, cook, manage medications and other activities to facilitate living at home rather than in more costly institutions such as nursing homes.[6] Supporting people in the community protects social networks, improves well-being, and lowers Medicaid costs.[7] Medicaid continues to be a driving force innovating quality HCBS programs.[8] 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.[9] The AHCA would eliminate that enhanced match, effectively ending the incentive for the CFC option. Other provisions to cap Medicaid funding and roll back Medicaid adult expansion seriously threaten states' ability to fund these critical services. The cuts will lead to poorer outcomes and lower quality of life for millions of beneficiaries.

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**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 the U.S. had no access to health insurance, either because they had pre-existing conditions or because their conditions made premiums far too expensive. People with extensive care needs 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 (community rating) to people with pre-existing conditions. But the House-passed AHCA allows states to waive community rating for anyone with a gap in coverage, which could prevent them from reentering the market if they ever have a gap.

**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. The AHCA purports to reduce consumer costs yet actually shifts 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.[10]

**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 did not cover or limited access to needed services for people with disabilities. The ACA created 10 essential health benefit (EHB) categories all qualified plans must cover, including habilitation and rehabilitation services that help people with disabilities acquire or maintain new skills; mental health and substance use disorder services; and prescription drugs. EHB established a floor to ensure reasonably comprehensive coverage. Now, Medicaid programs and health plans in all 50 states cover these essential benefits. But the AHCA allows states to waive the federal EHB requirements and again allow plans to offer less comprehensive coverage. The result will be plans that charge much more to cover the key services people with disabilities really need, while healthy people will be incentivized to pick cheaper plans with skimpy coverage. This scenario would price many people with pre-existing conditions out of the market through benefit design, even if the law technically did not allow plans to charge more for pre-existing conditions.

**The ACA helps millions with mental or behavioral health conditions get services they need.** Many who gained coverage through the ACA face serious mental health or other functional challenges. The ACA categorized mental health and substance use disorder services as essential benefits, thus greatly expanding access. The law also reinforced mental health parity requirements to ensure that mental and behavioral health services are covered comparably to physical health services. One university study showed that individuals with serious mental illness were 30% more likely to receive treatment when they were covered by Medicaid.[11] Another experiment found that adult Medicaid coverage resulted in a 30% reduction in the rate of depression.[12] Allowing states to waive essential benefits, as the AHCA does, would price many people out of the market again.

**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. Allowing states to waive essential benefits would open pathways to new forms of health care discrimination through benefit design.

## Endnotes

[1] DEPT. OF HEALTH AND HUMAN SERV., JUDITH DEY ET AL, *Benefits of Medicaid Expansion for Behavioral Health* (Mar. 28, 2016) available at https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf.
[2] OHIO MEDICAID ASSESSMENT SURVEY, *The Changing Landscape of Healthcare Coverage Across Ohio*, 17 (August 19, 2015).
[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 (Feb. 2015) (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] OHIO DEPT. OF MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT: A REPORT TO THE OHIO GENERAL ASSEMBLY, 3, 28 (2016).
[6] Steve Eiken, TRUVEN HEALTH ANALYTICS, *Medicaid Long-Term Services and Supports Beneficiaries in 2012*, 2 (Sept. 16, 2016.)
[7] Carol V. Irvin et al., MATHEMATICA POLICY RESEARCH, *Money Follows the Person 2014 Annual Evaluation Report*, 42, 68 (Dec. 18, 2015).
[8] 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.
[9] 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/.
[10] Jean P. Hall, UNIVERSITY OF KANSAS, *Why a National High-Risk Insurance Pool is Not a Workable Alternative to the Marketplace* (Dec. 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/dec/1792_hall_highrisk_pools.pdf.
[11] 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).
[12] Katherine Baiker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1717 (2013).