



Analysis of Affordable Care Act in Relation to the Employment of Persons with Disabilities

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Executive Summary

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA—H.R. 3590). One week later, on March 30, he signed the reconciliation bill, the Health Care and Education Reconciliation Act of 2010 (HCERA—H.R. 4872) and Public Law 111–148. Together these measures represent the largest reform to national health care in U.S. history. In addition to dramatically expanding private health insurance coverage, the new law fundamentally alters the rules of insurance, expands Medicaid, and makes a number of payment and policy changes to Medicare affecting hospitals, physicians, postacute care providers, the Part D drug benefit, and the government’s ability to combat health care fraud and abuse.

Particularly important to persons with disabilities are provisions of the Affordable Care Act (this term will be used herein to refer to all the legislation referenced above) that put in place antidiscrimination requirements for private and employer-based insurance, and support community-based alternatives for long-term and acute care. The Affordable Care Act (Act) also contains measures that attempt to transition the U.S. health care system from treating disease to treating the person, including provision of financial incentives for prevention by paying for results as opposed to items and services (Powers, Pyles, Sutter, & Verville PC Attorneys at Law, 2010). Considering the high medical needs and costs of care for most persons with disabilities (PWD), the impact of reform on this segment of the population may be one of the best indicators for how well the reformed health care system will address the needs of all Americans.

The present analysis summarizes the key provisions of the Affordable Care Act that pertain to persons with disabilities, and specifically to those PWD who are seeking employment or are employed. Due to the staggered implementation of many provisions of the law, its full impact will not be seen for several years. For this reason, suggestions for further research to study longer-term effects of the legislation are also offered.

Introduction

With passage of the Patient Protection and Affordable Care Act (PPACA—H.R. 3590) on March 23, 2010, and one week later the Health Care and Education Reconciliation Act of 2010 (HCERA—H.R. 4872) and Public Law 111–148, the landscape of health care in the U.S. has been fundamentally altered. In the current analysis, a summary of the major provision of these legislative changes (which will herein be referred to as the Affordable Care Act or the Act) is provided as it is relevant to employers and to persons with disabilities (PWD) who are seeking employment or are currently employed.

The majority of this analysis is organized along three major aspects of health care—coverage, benefits, and financing. Additional sections of the report focus on areas of the

legislation specifically referencing or pertaining to PWD, supports provided to the health care workforce, and provisions affecting transition age youth. The final segment of the report contains suggestions for further research and technical assistance related to the new health care reform legislation.

Throughout the paper, text boxes are used to highlight the relevance of specific provisions to persons with disabilities who are seeking employment or are currently employed. Within the report, direct links have been embedded to allow easy reference to the source legislative language that serves as the basis for the summary of provisions relevant to persons with disabilities. Finally, to provide a better perspective on the staggered nature of implementation of the many provisions of the Affordable Care Act, a timeline chart is included in Appendix A.

1.0 Summary of Major Changes in Health Care Relevant to Persons with Disabilities

Prior to the enactment of the Affordable Care Act, the type of health care coverage available to working-age persons with disabilities was tied almost exclusively to their employment status. This system resulted in a significant dependence among persons with disabilities on public health coverage (such as Medicaid) due to their (a) relatively high rates of unemployment and underemployment, (b) high incidence of pre-existing conditions that many insurance companies refused to cover, and (c) lifetime caps on benefits that insurance companies agreed to pay. Adding to this dependence on public coverage was the rising cost of health care premiums that encouraged employers to limit health coverage or, more drastically, discouraged them from employing or retaining employees with high health care needs (Stapleton & Liu, 2009). This link between employment status and health care coverage prevented many persons with disabilities from entering the labor force for fear of losing health care coverage they had under public programs (Goodman, Stapleton, Livermore, & O'Day, 2007). Eligibility for Medicaid has restricted employment, due to the requirement to prove an inability to work to receive public benefits.¹

In the following sections, major provisions of the Act relating to PWD who are seeking employment or are employed and their employers are summarized in relation to three key dimensions of health care—coverage, benefits, and financing.

¹ To be eligible for disability benefits, a person must be unable to engage in substantial gainful activity (SGA). A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA. The amount of monthly earnings considered as SGA depends on the nature of a person's disability. The Social Security Act specifies a higher SGA amount for statutorily blind individuals; federal regulations specify a lower SGA amount for sighted individuals. Both SGA amounts generally increase with increases in the national average wage index. The monthly SGA amount for statutorily blind individuals for 2010 is \$1,640. For non-blind individuals, the monthly SGA amount for 2010 is \$1,000. SGA for the blind does not apply to Supplemental Security Income (SSI) benefits, while SGA for the nonblind disabled applies to Social Security and SSI benefits (Social Security Online, 2010).

1.1 Health Care Coverage

The most significant provision in the Affordable Care Act is the mandate for **universal coverage** (§ [1501](#)). Under this provision, all Americans must have a minimum level of health care coverage or be subject to a penalty. The penalty will be phased in starting at \$95 or 1% of taxable income in 2014, increasing to \$325 or 2% of taxable income in 2015 and to \$695 (up to \$2,085 per family) or 2.5% of household income in 2016. Coverage exemptions exist for a number of groups, notably for those individuals and families for whom the lowest level coverage exceeds 8% of their total income, those without coverage for less than three months, and those with incomes below the tax filing threshold for that year. The two categories of health care coverage that can be used to meet the requirements of this mandate are **private** (e.g., employer-sponsored or individually purchased) and **public** (e.g., Medicaid, Medicare, TRICARE).

Significance for All Persons with Disabilities

The Affordable Care Act, in essence, strengthens the ADA for employer-sponsored health insurance and other private plans, and vastly expands health coverage options for persons with pre-existing and chronic conditions (Powers, Pyles, Sutter, & Verville PC Attorneys at Law, 2010).

1.1.1 Private Coverage

Overall, health care reform includes many provisions that make private health insurance a more affordable and accessible option for all persons with disabilities. In addition to the application and scope of the consumer protections and nondiscrimination provisions applying to all individuals and group health plans, there are several provisions that are especially significant to PWD.² The **lifetime and annual limits** provision prohibits all plans from establishing lifetime limits on the dollar value of essential benefits within a new American Health Benefit Exchange (§ [1001](#), [10101](#); HCERA § [2301](#)). The Affordable Care Act eliminates the ability of insurers to discriminate against persons with **pre-existing conditions** (§ [1201](#)). The types of **health status discrimination** specifically mentioned that will no longer be allowed include: health status, medical condition or history, claims experience, genetic information, disability, or evidence of insurability. The U.S. Department of Health and Human Services (HHS) is also empowered to define other factors which this protection will cover (§ [1201](#)).

² Exceptions to this provision are group health plans that fall under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. ERISA requires plans to provide participants with plan information including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty. In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability law (Department of Labor, 2010a). Because ERISA plans continue to be exempt from the jurisdiction of state insurance commissioners, and instead report to the U.S. Department of Labor, not all ERISA group health plans will be affected by private market reforms.

The Act also requires health insurers to provide **guaranteed issue** and **guaranteed renewability**, which means they must accept every employer and individual that applies for coverage in the state and renew coverage when necessary (§ [1201](#)). Effective immediately, private insurers are not allowed to **rescind coverage** after an insured person is injured or acquires a new condition (§ [1001](#)). As a result of these changes, a broader range of health insurance plans will be available to all individuals, including those with disabilities. Except as noted, these provisions are effective in 2014. One additional exception is that for children under the age of 19 with pre-existing conditions, discrimination in coverage is eliminated beginning in 2010 (see section 4 of this report).

Significance for Employed PWD

Uninsured employees who have pre-existing conditions (those that prevented them from being able to qualify for health insurance for at least 6 months) or develop disabilities as they age, will no longer have to leave the labor force to become eligible for public programs such as Medicaid. Eligibility for Medicaid has restricted employment, due to the requirement to prove an inability to work to receive public benefits. With the new provisions of the Affordable Care Act, these employees can continue to work and will be eligible to receive insurance through their employer or through a health insurance exchange (§ [1311](#), [10104](#)). In addition, companies are barred from instituting caps on coverage in all plans (§ [10101](#)), and must remove restrictive annual limits on benefits in all new plans and existing group health plans (§ [10101](#)).

Significance for PWD Seeking Employment

By removing discrimination based on pre-existing health status and coverage caps in private insurance, the Affordable Care Act should help eliminate or lessen a number of the work disincentives that have previously existed for individuals with disabilities attempting to enter the labor force.

In addition to the basic provisions listed above, insurance companies will have to follow a **premium rating** system, which means they can only adjust premiums based on five factors: (1) type of coverage (individual or family), (2) geography, (3) the actuarial value of the benefit, (4) tobacco use (limited to a 1.5:1 ratio), and (5) age (limited to a 3:1 ratio).

Significance for Employed PWD and Their Employers

Changes relating to premium rating adjustments based on age are especially relevant to employees who develop chronic conditions and become employees with disabilities. Due to the more frequent onset of disabilities among older workers (primarily between the ages of 55 and 64), they have generally paid higher individual premiums for health insurance than younger persons. Similarly, insurance carriers have charged higher premiums for small companies with predominantly older workforces. Premiums have varied according to age by as much as 25 to 1 in the individual and small-group markets (The Commonwealth Fund, 2010). With the limits on insurers' ability to raise premiums based on age, health care coverage should become more affordable for older employees and their employers, and their continued employment more likely.

States will also be required to establish a new **American Health Benefit Exchange** to provide a source of more affordable coverage within the individual and small group markets. Exchanges must (a) offer private plans that include at least the essential benefits package—the cost of additional benefits must be covered by states, (b) certify and rate plans that meet established criteria, (c) ensure plans have the same cost sharing requirements for essential services inside and outside plan networks, and (d) establish a Small Business Health Option Program (SHOP) to assist small employers obtain employee coverage (further details on SHOP are provided in section 1.3.2 of this report). If a state fails to establish an exchange by 2014, HHS will do it for them, following the requirements stated above and ensuring that the percentage of the state's population specified in the law is covered under these requirements. Initially funded by an HHS grant, each exchange must be self-sustaining by 2015 (§ [1311](#), [10104](#)).

1.1.2 Employer-Based Coverage

Under the provisions of the Act, employers are required to play a more central role in supporting the health of all of their employees—including those with disabilities. As codified in the Affordable Care Act, employers must review their employee status (i.e., number of full-time employees, whether they are currently offering health insurance, if they have a worksite wellness program, etc.) to see what they are required to do by law. Large businesses will be “required” to do more or risk being fined whereas small and medium businesses will be given the “opportunity” to do more by applying for tax credits and grants.

The requirements enumerated in the Affordable Care Act that are relevant to businesses, are primarily based on the number of full-time employees they have. Employers with more than 50 employees will have to provide affordable coverage to their employees. If they do not, or one or more of their employees applies for premium tax credit through an exchange,³ they will have to pay a shared responsibility fee or fine of at least \$2,000 per employee (§ [1513](#), [10106](#); HCERA § [1003](#)). The first 30 employees are not counted when calculating the total fee. Additionally, employers cannot base eligibility for health care benefits on wages or salaries of full-time employees (§ [10101](#)). This is particularly important for PWD who

³ This provision is intended to discourage employees of larger companies from applying for premium tax credits reserved for middle to low income families who do not have access to employer-based health insurance.

disproportionately work in lower waged service occupations, such as food preparation and grounds cleaning and maintenance (U.S. Department of Labor, 2010c).

Significance to Employed PWD

Removal of consideration of employee wage levels in offering health care benefits should be particularly beneficial to employees with disabilities who often hold lower salaried and non-managerial positions than employees without disabilities (U.S. Department of Labor, 2010c).
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In addition to providing affordable coverage, employers must also offer “free choice vouchers” to their employees (§ [10108](#)). The voucher related provisions become effective in 2014 and require that employers offering coverage to their employees provide a free choice voucher to employees with incomes less than 400% of the federal poverty level and whose share of the premium exceeds 8% but is less than 9.8% of their income, or who choose to enroll in a plan in one of the new American Health Benefit Exchanges (§ [1311](#)). The voucher amount must be equal to what the employer would have paid to provide coverage to the employee under the employer’s plan, and it is intended to be used to offset the premium costs for the plan in which the employee is enrolled.

Employers with more than 200 employees will be required to automatically enroll employees into their provided health insurance plans (although employees may opt out of coverage). The provision is designed to require large employers to automatically provide coverage for all employees unless they can prove they have health insurance through other sources (§ [1513](#), [10106](#)). The law exempts all firms that have fewer than 50 employees—which represent 96% of all firms in the United States, or 5.8 million out of 6 million total firms—from any employer responsibility requirements (The White House, 2010b).

Significance to Employed PWD

Employed PWD who work for large companies may have an advantage over those who work for small companies because the burden of applying for health insurance is on their employers, not the employees in large companies, whereas in small companies, it is the reverse. That is, due to the requirements put in place by the Affordable Care Act, large businesses (i.e., those that have more than 200 employees) are required to enroll all employees in health insurance plans. Thus, the company is required to process the applications, not the employees; however, in small businesses (i.e., those with less than 50 employees) the burden is more likely to be on the employees to seek out their health care options and file their own applications through portals such as the American Health Benefit Exchange.
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Relevant to all businesses, regardless of size, is the Act’s change to the definition of full-time employee. Previously, a full-time employee was typically defined as an employee who worked at least 30 hours a week on average when calculated on a weekly basis.⁴ Under the Affordable Care Act, full time employees will include those who work on average at least 30

⁴ According to the Department of Labor (see <http://www.dol.gov/dol/topic/workhours/full-time.htm>), the definition of full time varies among employers.

hours per week when calculated on a monthly basis (§ [1513](#); HCERA § [1003](#)). This change takes into account fluctuation in employee work hours from week to week in a given month, thus allowing employees to work flexible schedules as needed.

Significance for Employed PWD

The new basis for determining full-time employment under the Act should expand coverage to more employees with disabilities, who may require flexible schedules.
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One final employer-based coverage provision is the new reinsurance program that is available to group health plan sponsors who provide medical coverage to early retirees and their spouses, surviving spouses, and dependents. To encourage employers to provide health coverage to early retirees until state health exchanges and federal subsidies for health coverage are implemented, the Affordable Care Act creates a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare (§ [1102](#)). This new retiree reinsurance program went into effect June 1, 2010.

Finally, reinforcing the antidiscrimination features of the law, the Affordable Care Act has a section on **immediate nondiscrimination**. This language highlights existing laws that were put in place to stop discrimination through exclusion from participation in or benefits denial under any health program or activity (§ [1557](#)). Antidiscrimination legislation referred to in the section include title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794),

Significance to Employers

The U.S. health care system has tended to inhibit entrepreneurship and small business formation by locking workers into jobs at large firms that offer family coverage and have a big enough risk pool to absorb the cost of covering pre-existing conditions. The result of this situation, termed “job lock,” has been many workers staying at large firms even if they would be more productive working at a small business or by becoming an entrepreneur. By providing health security for every American and eliminating exclusions for pre-existing conditions (§ 1201 , 1557) and price discrimination against those who are sick, health reform should make it easier for small businesses to attract the best workers and easier for entrepreneurs to strike out on their own. Although small business are not required to provide health care coverage for their employees, the guaranteed individual coverage and greater affordability of health care related provisions of the law should make coverage by employers less of a disincentive to employment with a small business or self-employment.
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1.1.3 Public Coverage

The Affordable Care Act simplifies enrollment in Medicaid, CHIP, and state exchanges through **enrollment simplification**, which allows individuals to enroll via state-run websites using coordinated procedures for all programs (§ [2201](#)). The standardized information sharing capabilities of the state-run sites will allow consumers to seek out information that is

relevant to them and make the most appropriate choice of coverage for them. This provision becomes effective January 1, 2014.

Significance for All PWD

The enrollment simplification provision is particularly important for PWD who often have more complex coverage and benefit needs for which multiple sources of support are needed.

Medicaid

The most notable coverage provision impacting Medicaid under the Affordable Care Act is the substantial **Medicaid expansion** of persons eligible for Medicaid coverage (§ [2001](#)). In 2014, the Act will expand Medicaid eligibility to all non-elderly, childless adults, and adults with incomes up to 133% of the federal poverty level (FPL). Newly eligible adults will be guaranteed a benchmark benefits package that matches the essential health benefits available through the state exchanges and private plans. States will receive 100% federal funding between 2014 and 2016 for newly eligible recipients, decreasing gradually to 90% in 2020. Medicaid is also required to offer **premium assistance and wrap-around benefits** to Medicaid beneficiaries who are offered insurance through an employer (§ [2003](#)).

As part of widening coverage, beginning in 2014, states will be required to use **modified adjusted gross income** as the standard for determining Medicaid eligibility (§ [3308](#)). This change will require that a new mandatory eligibility category be created for persons who are under age 65, not eligible for Medicare, low-income, and not pregnant.

Significance for All PWD

Expanded eligibility means that more PWD, both employed and unemployed, whose income is below 133% of the FPL, will become eligible for Medicaid coverage. In addition, states will not be allowed to apply any assets or resources test for purposes of determining eligibility for medical assistance under state Medicaid plans or under any state defined waiver of the plan. Rather, they will be required to use a net income standard. Exceptions to this provision are provided for people who are eligible for Medicaid through another program, such as children in foster care, or SSI/SSDI, the elderly (over the age of 65); medically needy individuals; and those individuals eligible for Medicare cost sharing (§ [2002](#)). Asset limits will be subject to state authority.

Medicare

Individuals who qualify for Social Security Disability Insurance (SSDI) benefits are also eligible for Medicare benefits (Social Security Online, 2010). However, Medicare coverage does not begin until 24 months after a person first becomes eligible to receive an SSDI payment. While the Affordable Care Act does not remedy the waiting period issue, individuals who fall into this coverage gap may be eligible to obtain coverage in the temporary high-risk pools (§ [1101](#)) or to purchase coverage through the newly developed health exchanges (§ [1311](#), [10104](#)). These individuals may also be eligible for Medicaid coverage under the expanded eligibility standards (§ [2001](#)).

1.2 Health Care Benefits

Prior to the enactment of the Affordable Care Act, the types and levels of benefits offered varied considerably among private plans and between private and public sources. Too often, services such as rehabilitative and habilitative services and mental health and substance abuse services were not covered or were subject to coverage limits. Further, prevention and wellness services were often not fully reimbursed. When relevant provisions are enacted, the Act will bring greater uniformity to the types and levels of benefits covered—in most cases expanding the benefits package offered (National Spinal Cord Injury Association, 2010).

1.2.1 Private Plans

The Affordable Care Act (§ [1302](#)) mandates coverage of an **essential benefits package** that includes the following services: hospitalization, ambulatory patient services, emergency services, physician services, prescription drugs, pediatric services including oral and vision care, laboratory services, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, chronic disease management services, preventive and wellness services (including some immunizations), and rehabilitative and habilitative services and devices (the term ‘device’ is meant to include all durable medical equipment [including wheelchairs], prosthetics, orthotics, and supplies—referred to as DMEPOS). These provisions will go into effect in 2013 (§ [1302](#)).

Significance for Those Seeking Employment and Those Employed

Particularly important for all PWD, specifically those seeking employment, is the inclusion of both rehabilitative and habilitative services, mental health services, and chronic disease management in the essential benefits package. Under the former health care system, these essential benefits were not required, despite a critical need for these services by PWD. These services may alleviate a number of the obstacles typically associated with obtaining and maintaining employment such as difficulty with activities of daily living, mobility, and management of chronic disease, in addition to supporting employers’ efforts to provide needed accommodations.

1.2.2 Employer Benefits

The changes in covered services mentioned above will apply as well to employer plans. However, in addition there will be important changes for employers in relation to their health and wellness programs, and options for coverage of long-term health care needs.

Health and Wellness Programs

Wellness programs are attractive to businesses for many reasons, including their effectiveness in controlling health care costs and reducing absenteeism. However, there are a variety of financial and legal issues that must be considered when implementing a wellness program. First, worksite wellness programs only make sense for businesses if there is a positive return on investment. Small businesses often cannot afford the startup costs required for these programs. Second, depending on the nature of the program and the type of incentives it may offer, the Health Insurance Portability and Accountability Act (HIPAA), the Age Discrimination in Employment Act, ERISA, ADA, Title VII of the Civil

Rights Act, the Internal Revenue Code, the Public Health Service Act, as well as individual state laws need to be adhered to, which may affect program design and implementation.

Before the Affordable Care Act, the financial burden, uncertainty about regulations, and fear of liability deterred some businesses from offering wellness programs. However, starting in 2014, businesses will be able to offer employees rewards in the form of premium discounts, waivers of cost-sharing requirement, or other benefits not otherwise provided, of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related criteria such as losing a certain amount of weight (Henry J. Kaiser Family Foundation, 2010). Small businesses (without existing wellness programs) are being incentivized via grants to create worksite wellness programs for their employees, including those with disabilities (§ [10408](#)).

CLASS Act

According to the Congressional Budget Office, over 5 million persons under age 65 living in communities have long-term care needs, and over 70,000 employed individuals with severe disabilities need assistance with activities of daily living to maintain their jobs and their independence (Democratic Policy Committee, n.d.). To address this issue, the Affordable Care Act establishes a national, voluntary, self-funded, long-term care, insurance program known as the Community Living Assistance Services and Supports program or the CLASS Act. It expands options for individuals who become functionally disabled and require long-term support and services.

The CLASS Act will be open to individuals who pay monthly premiums into the program for at least 5 years. If these individual have been employed 3 of those 5 years and meet the criteria for eligibility, they will receive a daily cash benefit to purchase services and supports necessary to help them remain independent and maintain community residence. The CLASS Act is designed to work with other long-term services and has no effect on eligibility for Medicaid, Medicare, Social Security retirement, disability benefits, or Supplemental Security Income (SSI) benefits.

The benefits provided by the CLASS Act are flexible and can be used for nonmedical services and supports such as adult day care, assistive technology, home modifications, accessible transportation, and homemaker services. Individuals are eligible to receive benefits when they develop a limitation that functionally restricts them from performing two or more activities of daily living (e.g., eating, bathing, dressing, toileting, transferring) lasting for a continuous period of more than 90 days, or those with cognitive impairments that require supervision or hands on assistance.

The benefit amount will be set by the HHS Secretary based on the level of impairment. According to the Congressional Budget Office, this benefit is expected to average roughly \$75 per day, or more than \$27,000 per year.⁴ The CLASS Act implementation is to begin in January 1, 2011. The HHS Secretary is expected to define CLASS Act benefits by October 2012 with enrollment to begin subsequently. The first payouts of benefits would occur in 2017 after the minimum required 5 years of program enrollment (§ [8002](#)).

Significance for Those Employed or Seeking Employment with Disabilities

The CLASS Act provisions extend the opportunity to secure critical long-term care services to all individuals with disabilities or a chronic condition, not just those with Medicaid coverage. This provision provides individuals with functional limitations the tools to allow them to maintain their personal and financial independence through employment while continuing to live in their community.

1.2.3 Public Benefits

One of the major goals of the Affordable Care Act is to keep individuals living in the community rather than in institutions where possible. Thus, there are several provisions of the Act that focus on home and community based services (HCBS) through public coverage with the same intent as the CLASS Act in the private market.

Medicaid Benefits

Effective in October 2011, the **Community First Choice Options** provision creates a new benefit that provides attendant services and supports for Medicaid beneficiaries who would otherwise be in an institution. This option will be available for Medicaid eligible individuals with incomes up to 150% of the FPL (§ [2401](#); HCERA § [1205](#)). **Removal of barriers to HCBS** should allow states to continue to encourage more persons with disabilities to remain in their communities. The provision will allow provision of a greater range of home and community based services to individuals with higher levels of need. States will be able to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment, rather than requiring a special state waiver. This provision will go into effect on the first day of the first fiscal year quarter that begins after the date of enactment of the law (§ [2402](#)). **State incentives for HCBS**, which go into effect October 1, 2011, will also create financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into HCBS. The provision accomplishes this by providing federal matching assistance percentage increases for states to rebalance their spending between nursing homes and HCBS (§ [10202](#)).

There are also provisions of the Affordable Care Act to **improve access to Medicaid preventive services** (effective January 1, 2013) as well as to encourage beneficiaries to participate in **Healthy Lifestyles** programs (effective January 1, 2011). The goals of these provisions are to expand current Medicaid options to provide beneficiaries with diagnostic, screening, preventive, and rehabilitation services and immunizations, as well as to encourage healthy living. States that cover these services would receive increased federal funding (§ [4106](#), [4108](#)).

For Medicaid beneficiaries who can no longer live in the community, the Affordable Care Act gives states the option of enrolling beneficiaries in **Medicaid health homes**. The beneficiaries that would qualify for this benefit include those with at least two chronic conditions, with one chronic condition and at risk of developing another, or with at least one serious and persistent mental health condition. Teams of health professional serving individuals who meet these criteria may be designated as a health home. The health home team would provide a comprehensive set of medical services, including care coordination, care management, and health promotion. This provision is effective January 1, 2011 (§ [2703](#)).

The **Money Follows the Person Demonstration** project was originally authorized in the Deficit Reduction Act of 2005, and extended under the Affordable Care Act until 2016 to encourage states to transition Medicaid enrolled individuals from nursing homes to the communities. Under these demonstrations, Medicaid coverage continues as the person moves back to the community and pays for the home and community-based services required. The grants also helps states defray the cost of moving eligible Medicaid recipients who have resided in an inpatient facility for a minimum number of consecutive days into a community-based setting for eligible Medicaid recipients (§ [2403](#)).

Significance for All PWD

These provisions will allow a greater range of preventive, and home and community based services to be available for PWD with higher levels of need. With these added supports available within communities, PWD should find it easier to seek and retain employment since inpatient facility stays which tend to be disruptive to employment, should be less necessary.

Medicare Benefits

Although currently only relevant to small subset of persons with disabilities who are employed or seeking employment, there are several provisions of the Affordable Care Act relating to Medicare that are likely to have growing significance. To be eligible for Medicare, a person must be 65 years or older or meet one of three exceptions: PWD who has been receiving SSDI for more than 24 months, individual who has end-stage renal cancer, or one who has been diagnosed with amyotrophic lateral sclerosis (ALS). Because more individuals over age 65 are remaining in the workforce, there are a growing number of persons who are employed and receiving Medicare benefits.

Under the Affordable Care Act, there are a number of changes to Medicare that affect persons with disabilities who are employed or seeking employment. Effective in 2011, Medicare beneficiaries who have Part B benefits will be eligible to receive **annual wellness visits and a personalized assessment and prevention plan** without a copayment or a deductible (§ [4103](#)). The personalized assessment and prevention plan will include referrals to education and preventive counseling and community-based interventions to address health risk factors. The Act also eliminates the Medicare outpatient Part B **therapy services cap** for physical, occupational, and speech-language pathology services beginning in 2011 (§ [3103](#)). Occupational and physical therapy are pivotal services for PWD seeking employment and access to the workplace.

Medicare will begin providing coverage for certain **medications**, including antiseizure, antispasm, and smoking cessation medications for Medicare Part D beneficiaries effective January 1, 2014 (§ [2502](#)). In addition, costly drugs should become more attainable with gradual elimination of the Medicare Part D coverage gap termed the “donut hole.” (See section 1.3.3 of this report.)

Effective January 1, 2011, the Act will impact Medicare with a change to its policy of allowing immediate purchase of wheelchairs. Medicare will only pay for the rental for the first 13 months of use. Further, during this 13-month period, Medicare will cover only 80% of

chair rental, leaving the beneficiary with 20% of the rental cost. However, complex rehabilitative power wheelchairs are exempt from this mandatory rental policy (§ [3136](#)).

Significance for All PWD

While affecting only a small number of employed PWD, these changes to Medicare are likely to have mixed effects for this population. An expansion of needed preventive and therapy services along with the closing of the “donut hole” represent significant new supports for PWD. However, the increased cost and likely decrease in chair customization associated with the change from wheelchair purchase to partially reimbursed rental may impact mobility choice and options for PWD seeking employment and employees who become disabled. The option for immediate purchase has facilitated permanent adjustment of chairs for specific size and need requirements of the owner.

1.3 Financing of Health Care Coverage

The financing of health care has been an issue subject to extensive debate. The growing costs of health care and the fragmented system for paying for care spread among several public and private sources has presented particular difficulties for PWD. While the Affordable Care Act attempts to increase the affordability of care and to ensure that no one falls through the cracks in receiving health care benefits, it does so while retaining the current structure of separate financing sources, and in fact, adds additional discrete funding programs.

1.3.1 Private Coverage Financing

Beginning in 2014, the Affordable Care Act provides refundable and advanceable **premium credits** to eligible individuals and families with incomes between 133 and 400% of the FPL to assist them in purchasing insurance coverage through the state exchanges (§ [1401](#)). The premium credits are tied to silver-level plans, which provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full value of the benefits. Premium credits provided are set on a sliding scale ranging from a limit to 2% of income for those at up to 133% of the FPL, to a high of 9.5% of income for those between 300 and 400% of FPL. Within the same provision of the Affordable Care Act are **individual tax credits** to employees who are offered coverage through their employer, and wherein their employer’s share of the total cost is less than 60% of the premium cost or where the premium is greater than 9.5% of the employee’s income.

Significance for PWD Seeking Employment and Employed

Premium assistance and individual tax credits are important for PWD who have disproportionate rates of underemployment and unemployment and may have difficulties purchasing insurance on their own, or are covered under their employer’s plans yet have higher premiums due to the conditions related to their disability.

To help finance health insurance for persons with pre-existing conditions, the Affordable Care Act established, upon enactment, a **temporary high-risk pool** guaranteeing eligibility

for coverage to anyone who has not been insured for at least 6 months (§ [1101](#)). The maximum cost for coverage under the high-risk pool will be capped at the current health savings account limits. The pool itself will be eliminated in 2014 when insurers will no longer be allowed to discriminate against individuals with pre-existing conditions.

Significance for PWD Seeking Employment

The temporary high-risk pool is important for PWD without coverage (13% in 2009) as it will allow them to obtain subsidized coverage as part of this pool in the interim prior to the point when other benefits provisions become available as the various provisions of the Affordable Care Act are phased in. Particularly, PWD moving into employment have had difficulty in affording employers plans due to high premiums which increase by age and other pre-existing conditions, and the high initial deductibles that are typically a part of these plans (\$5,950 individual, \$11,900 family).

The Affordable Care Act also places limits on **cost sharing and out-of-pocket** expenses (§ [1402](#)). The amount that persons will have to pay out of pocket cannot be greater than the limits for health savings accounts and can only increase in accordance with increases in average per person health insurance premiums. Effective in 2014, this provision provides cost-sharing and premium subsidies, on a sliding scale, to eligible individuals and families with incomes between 133 and 400% of the FPL to help them purchase insurance directly through private insurers or through the state exchanges. Small group market plans are prohibited from setting deductibles greater than \$2,000 for individuals and \$4,000 for families. These maximums may only be increased in line with increases in average per person health insurance premiums.

According to the Congressional Budget Office, the effect of these changes will be reductions in current standard out-of-pocket maximum limits (\$5,950 for individuals and \$11,900 for families) to one-third of these amounts for those between 100 and 200% of the FPL, one-half for those between 200 and 300% of the FPL, and two-thirds for those between 300 and 400% of the FPL. These provisions of the Affordable Care Act also will modify private health care plans' share of total allowed costs of benefits. Insurer costs will increase to 94% increase for those between 100 and 150% of the FPL, 87% for those between 150 and 200% of the FPL, 73% for those between 200 and 250% of the FPL, and 70% for those between 250 and 400% of the FPL (Congressional Budget Office, 2009).

The cost-sharing assistance does not take into account benefit levels mandated by states (Congressional Budget Office, 2009). If a state does not offer the insurance benefits required by the ACT, the HHS Secretary will make a decision to either establish a pool in that state or offer residents of that state eligibility to a national high-risk pool. The review of state-mandated benefit levels is now underway. The temporary high-risk pools became effective on June 21, 2010, and will be terminated upon creation of the exchange in 2014 (§ [1402](#)).

Significance for All PWD

Cost sharing and out-of-pocket provisions are particularly relevant for PWD who often fall at or below the FPL because of their higher rates of unemployment and underemployment. In May 2010, the unemployment rate for PWD was 6% higher than that for persons without a disability (15% and 9% respectively; U.S. Department of Labor, 2010b).

1.3.2 Employer Health-Related Benefit Financing

Provisions of the Affordable Care Act will impact the financing of employer health care plans and health and wellness programs. Supports will be offered with the intent of increasing the availability of both types of benefits.

Employer Health Insurance Plans

Many small businesses currently want to provide health coverage for their workers, but often lack the necessary resources. On average, small businesses are charged premiums 18% higher than large businesses for the same coverage (The White House, 2010a). To help employers and employees of small businesses, the Affordable Care Act contains several important changes including provisions (a) allowing small businesses to qualify for a small business health care tax credit to help them afford the cost of covering their workers (§ [1421](#)), (b) creating Small Business Health Options Program exchanges for businesses with up to 100 employees to increase bargaining power and reduce administrative costs (§ [1311](#)), (c) ending price discrimination against small businesses with sick workers, and (d) reducing the hidden tax on small business employees with health insurance. These provisions are more fully described on the following paragraphs.

Small Business Health Care Tax Credit—Small employers with fewer than 25 full-time equivalent employees and average annual wages of less than \$50,000 that purchase health insurance for employees are eligible for the tax credit. Under the Affordable Care Act the maximum credit will be offered to businesses with 10 or fewer full-time equivalent employees and average annual wages of less than \$25,000. However, eligibility for a tax credit will be based on the employer's willingness to contribute at least 50% of the total premium cost. Employers who receive state health care tax credits may also be eligible for federal tax credits. Dental and vision care qualify for the credit as well (§ [1421](#)). From 2010 through 2013, eligible employers will receive a small business credit for up to 35% of their contribution toward the employee's health insurance premium. In 2014, the reimbursement rate for employee health insurance policies will increase to 50%. Tax-exempt small businesses meeting the aforementioned requirements are eligible for tax credits of up to 25% of their contribution.

Small Business Health Option Programs (SHOP)—To assist small employers in obtaining coverage for their employees (small employers are considered employers with 100 or less employees), the Affordable Care Act's new American Health Benefit Exchange (§ [1311](#), [10104](#)) will establish the Small Business Health Options Program. Currently, small businesses face not only premiums that are on the average 18% higher than large businesses pay, but also face higher administrative costs to set up and maintain a health plan. The premiums they pay have up to three times as much built in administrative cost as

plans in the large group market. Small businesses are also at a disadvantage in negotiating with insurance companies because they lack bargaining and purchasing power (The White House, 2010b). Small employers who purchase coverage through the new exchanges can receive a tax credit for 2 years of up to 50% of their contribution. Tax-exempt small businesses meeting the requirements are eligible for tax credits of up to 35% of their contribution. Starting in 2017, the Act also provides states with flexibility to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange (§ [1311](#)).

Price Discrimination against Employers with Sick Workers—Currently, small businesses with just one sick worker can face significantly higher premiums from insurers, and having a worker fall ill can lead to a precipitous price increase for the employee. Beginning in 2014, “community rating” rules will prevent insurers from charging more to cover small businesses with sicker workers or raising rates when an employee becomes ill (§ [1201](#)).

Hidden Tax on Small Business Employees—It has been estimated that prior to passage of the Affordable Care Act, the cost of treating the uninsured has added a “hidden tax” of over \$1,000 to every health care premium. Private health insurance premiums have been higher than they needed to be partially due to the costs of treating the uninsured. This burden has resulted in higher insurance premiums for both individuals and businesses (Families USA, 2009). By dramatically expanding coverage, it is estimated that health reform will significantly reduce this tax by covering an additional 32 million Americans by 2019 (§ [1501](#), [10106](#)).

Significance for Employed PWD
Taken together, these provisions affecting small businesses should make the option of employment with a small business and creation of a small business through self-employment more attractive to PWD.

Employer Health and Wellness Programs

Worksite wellness programs can benefit all employees, including those with disabilities, by helping them to stop smoking, lose weight, become or stay active, and by preventing depression. While large businesses often have wellness programs in place already, small- and medium-sized businesses are further behind in establishing these programs. To address the differences in progress, the Affordable Care Act has added provisions addressing issues facing both small and large businesses. For the first time, small employers will have a financial incentive to create worksite wellness programs through the following provisions.

Grants to small businesses for worksite wellness programs—The Act authorizes an appropriation for grants to eligible small businesses for the purpose of giving their employees access to comprehensive workplace wellness programs that meet criteria to be developed by HHS. Between 2011 and 2015, \$200 million in grants will be made available to fund comprehensive health promotion programs for employers with 100 employees or less who work 25 or more hours a week. A comprehensive program must meet at least three of four components: awareness, motivation, skills, and opportunities—referred to as the AMSO Framework (O’Donnell, 2010). However, the grant program is only for companies who do not have an existing program in place (§ [10408](#)).

Significance for Employed PWD

As long as the worksite wellness programs are designed to accommodate all employees—including those with disabilities—they should help promote improved health and may delay or prevent further disabling conditions.

Premium Differentials for Healthy Behavior in Large Businesses—Current HIPAA regulations allow employers to offer premium differentials of up to 20% for employees who meet specific health goals. These goals have included smoking cessation, achieving a recommended weight or fitness level, or having normal biometric levels. Until now, these goals were only stated in regulation; they weren't codified in statute, and some employers were reluctant to implement these policies because they have been concerned that the rules could change at any time. To address these problems, provisions in the Act codify in statute the ability to offer premium differentials, increase the amount of the premium differential from 20 to 30%, and give the U.S. Department of Health and Human Services the authority to increase the amount of premium differentials to 50% if they believe it is warranted.

No later than 2 years after the Affordable Care Act enactment, the Centers for Disease Control and Prevention (CDC) have been tasked with studying employer-based wellness practices and come up with an educational campaign and technical assistance to assist employers with worksite health promotion activities (§ [4303](#)). Once these measures have been implemented, but no later than July 1, 2014, HHS will evaluate the impact of these incentives on improving health and reducing medical costs through the Wellness Program Demonstration Project. Individual goals an employee meets could be worth a 10%, or \$1,000 premium differential (§ [1201](#)). Increasing the premium differential will provide greater incentives for employees to participate in worksite wellness programs. Greater participation in turn, should improve their health status and lower the cost of employer health premiums.

1.3.3 Public Coverage Financing

Medicaid Financing

The Affordable Care Act makes several payment adjustments to Medicaid that should benefit all beneficiaries including those with disabilities. The **Medicaid primary care adjustment** requires that payment to primary care physicians be no less than 100% of the Medicare payment rate in 2013 and 2014 (HCERA § [1202](#)). In most cases, this change will result in an increase in reimbursement rates for these physicians and should create an incentive for physicians to accept Medicaid patients. The **Medicaid prescription drug rebates** increases the flat rebate percentage for outpatient brand name prescription drugs from 15.1 to 23.1% (except for certain clotting factors and outpatient drugs, for which the basic rebate would increase to 17.1%). An individual's total rebate liability would be capped at 100% of the average manufacturer price. This provision became effective in 2010 (§ [2501](#); HCERA § [1206](#)).

Significance for Employed PWD and PWD Seeking Employment

One area of impact of the Affordable Care Act affecting PWD that is not clear is the future of **Medicaid buy-in programs**. While these programs are affected by a number of other legislative measures, the Affordable Care Act is likely to significantly impact them. Medicaid buy-in programs allow employed recipients whose incomes exceed the eligibility threshold for Medicaid but who do not receive coverage through their employer, to purchase back their benefits at a reduced cost. Whether or not this program will continue is uncertain for several reasons. First, the Act substantially increases the allowed income for eligibility for Medicaid, which may diminish the number of PWD making too much to qualify for Medicaid. Additionally, employers of PWD will likely be mandated to provide coverage for these employees under the Affordable Care Act. Finally, because of the antidiscrimination provisions in the Act, it will become exceedingly difficult for insurance companies to deny coverage for any reason. These reforms, in essence, nearly eliminate the lapses in coverage that Medicaid buy-in programs sought to fill, and help ensure that PWD seeking employment will not face the disincentive of loss of health care coverage when they move into employment (National Consortium for Health Systems Development, 2010).

Medicare Financing

One of the most important changes the Affordable Care Act is making to Medicare is the phase out of the Medicare Part D coverage gap – informally known as the Medicare “donut hole” for prescription coverage (§ [3301](#)). The donut hole is the difference between the initial coverage limit in Medicare Part D and the catastrophic coverage threshold. After a Medicare beneficiary expends more than the prescription drug coverage limit, the Medicare beneficiary has been financially responsible for the entire cost of their prescription drugs until these expenses reach the catastrophic coverage threshold. Under the Affordable Care Act, Medicare beneficiaries who enter the “donut hole” during 2010 will receive a one-time \$250 rebate for prescription drugs (Democratic Policy Committee, n.d.). Effective January 1, 2011, beneficiaries will receive a 50% discount on brand name drugs and other discounts for generic drugs while in the gap. Thereafter, drug discounts will increase to 75% and also apply to generics until the hole is eliminated in 2020. In related provisions, the Affordable Care Act mandates payment coverage for antiseizure, antispasm, and smoking cessation medications for Medicare Part D beneficiaries (§ [2502](#), [2602](#)).

Significance for All PWD

Because of the often high costs of prescriptions drugs to treat and manage chronic illness, these Medicare Part D provisions may alleviate health care costs for PWD and increase their expendable income.

Another important provision affecting Medicare beneficiaries is that beginning in 2014, the Secretary of HHS will rebase home health prospective payment amounts based on a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant (§ [3131](#)). This **home health adjustment**

provision establishes a 10% cap on the amount of reimbursement a home health provider can receive from “outlier” payments (§ [3131](#), [10315](#)).

The Affordable Care Act also creates the Independence at Home Demonstration Program for beneficiaries with multiple chronic conditions to promote and test payment and delivery systems that improve health outcomes while meeting spending targets. The demonstration program requires minimum savings of 5% annually and provides for sharing of savings with providers beyond 5%. This provision is effective January 1, 2012 (§ [3024](#)).

Significance for PWD Seeking Employment and Employed PWD

The Affordable Care Act gives states the option to provide coordinated care through a home health adjustment for individuals with chronic conditions. The home health adjustment requires the HHS Secretary to rebase home health payments by an appropriate percentage to reflect the number, mix, and level of intensity of home health services in an episode and the average cost of providing care. These changes are especially important to PWD transitioning into employment or to employees who become disabled because the overall care they need to manage or treat their chronic conditions will be financed based on their individual needs rather than a one-size-fits-all plan. Thus, receiving care through a home health care provider may provide PWD with the overall care they need to participate in the labor force. To the extent that home health options can be shown to be cost effective, the continued movement to this form of care should be supported, facilitating greater independence and the flexibility needed for employment.

Finally, to help offset the cost of expanding health care coverage, one of the provisions in the Affordable Care Act introduces a new 2.3% excise tax (which is estimated to result in added revenue of \$20 billion over 10 years) on Class I, II, and III medical devices (with exemptions for eyeglasses, contact lenses, hearing aids, and other retail items) that will be imposed on manufacturers of durable medical equipment (§ [9009](#), [10904](#); HCERA § [1405](#)). The Act also expands the competitive bidding program for suppliers of wheelchairs and other DME; specifically, increasing the number of areas to be included in round two of the DME competitive program from 79 to 100 of the largest metropolitan statistical areas, and to use competitive bidding prices in all areas by 2016 (§ [6410](#)).

Significance for All PWD

The provisions of the Act impacting medical devices needed by PWD may affect the quality, variety, and supply of durable and nondurable medical devices. With the new tax on manufacturers, it may be less profitable to produce medical devices (unless this tax is passed on to the buyer or absorbed through the use of less expensive parts). Expansion of the number of areas required to participate in the current competitive bidding program, will likely decrease the number of manufacturers as only a limited number of them will be selected for the program.

2.0 Disability-Specific Provisions

In addition to the Affordable Care Act provision reviewed above that directly pertain to health care coverage, benefits, and financing, the Act contains some specific provisions directly related to PWD. These provisions are summarized below.

2.1 Accessible Medical Diagnostic Equipment

The Affordable Care Act contains provisions that require the Architectural and Transportation Barriers Compliance Board, in consultation with the commissioner of the Food and Drug Administration to establish accessibility and regulatory standards for all medical diagnostic equipment (exam tables, weight scales, etc.) for individuals with disabilities within 24 months of passage (§ [4203](#)). The provision ensures, to the extent possible, that all equipment allows independent entry, use, and egress by individuals with mobility limitations.

Significance for All PWD

The provision relating to accessibility of medical diagnostic equipment is important for PWD who have access and mobility limitations that prohibit them from accessing diagnostic and preventative services needed in providing for their adequate health care.
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2.2 Increased Funding for Community Health Centers

Provisions of the Act call for an increase in funding for community health centers (CHC) with an additional \$11 billion of funding from the Public Health Trust Fund for CHCs in all 50 states and territories (§ [10503](#)).

Significance for PWD Seeking Employment

Increased funding for CHCs should benefit PWD who often seek medical care at these facilities as an affordable option. Data from the Health Resource and Service Administration (HRSA) shows that in 2009 approximately 60% of those using CHC services were working age adults and that 38% of those served were uninsured (Health Resources and Services Administration, n.d.).

2.3 Research on Health Care Disparities Relating to PWD

The Affordable Care Act replaces the Federal Coordinating Council for Comparative Effectiveness Research with a private, nonprofit entity to identify priorities and conduct comparative effectiveness and patient-centered outcomes research effective in FY 2010 (§ [6301](#), [10602](#)). As part of this provision, the Act mandates data collection and analysis to understand and address health disparities (§ [4302](#)). The federal government is required to collect health survey data from PWD to develop a better understanding of their health relative to other minority groups. The federal government is also required to collect survey data from health care providers in order to determine where PWD are receiving care, the

number of providers with accessible facilities and equipment, and the number of health care professionals trained in meeting the specific health care needs of PWD.

3.0 Health Care Workforce Supports

The Affordable Care Act introduces a number of provisions to attempt to bolster the health care workforce. According to HHS Secretary Kathleen Sebelius, through the Affordable Care Act \$250 million in investments will be provided for the health care workforce.⁵ These investments are being made in four broad areas: data gathering and analysis on the health care workforce supply, demand, distribution, diversity, and skill needs; increasing the supply of qualified health care workers; enhancing health care workforce education and training; and, supporting the existing workforce.

This support will come in multiple forms. The Affordable Care Act expands some federal student loan forgiveness or repayment programs, makes public and allied health workers eligible for loan programs, provides grants for workforce recruitment demonstration programs, and provides grants for training programs for various professionals.

Provisions to Extend Funding for Research, Demonstrations, and Training

While any expansion of the health care workforce will have an impact on persons with disabilities, there are three programs in particular that should help produce expansions in the workforce that are likely to benefit persons with disabilities. The Act amends the Public Health Service Act to add \$10 million in funds for the training of direct care workers between 2011 and 2013 (§ 5302). The direct care workers eligible for these funds can be those employed in home or community settings, as well as those in institutional long-term care settings at the Secretary's discretion.

Further provisions in the Act allow for the creation of a grant program in the Public Health Service Act for the "development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health profession schools and continuing education programs" (§ 5307). With passage of the Act there was no specific monetary amount designated the grant program. Funding for these activities will be appropriated in years 2010 through 2015.

Finally, the Affordable Care Act amends the Social Security Act with a new "Demonstration Project to Develop Training and Certification Programs for Personal or Home Care Aides" (§ 5507). This grant program supports state efforts to develop core competency and training programs for personal or home care aides. Such a program may include personal care skills, health care and nutritional support, infection control, and other areas. There is \$5 million allocated for personal or home care aide demonstration projects between 2010 and 2012.

⁵ <http://www.hhs.gov/news/press/2010pres/06/20100616a.html>

4.0 Transition Age Youth and Health Care Reform

The Affordable Care Act contains promising provisions for all youth and particularly for young adults with disabilities. Features of the Act hold potential to increase their access to health care and wellness programs aimed at reducing the likelihood of secondary health conditions for these young persons. Most notably, beginning in the fall of this year, employer-based and individual plans will not be allowed to deny coverage to children younger than 19 year olds based on pre-existing conditions, and this law will be applied across the board for all age groups by 2014 (§ [1201](#)). For young adults who are currently uninsured for more than 6 months, the bill provides an option for the federal government to establish or contribute to the existing state high-risk pool plans that will be able to offer subsidized health insurance plans for young adults with pre-existing conditions (§ [1101](#)). More importantly, the bill provides the option for young adults to obtain health care coverage by allowing them to be enrolled in their parent's employer-based or individual health insurance plans as dependents up to their 26th birthday, irrespective of the labor market engagement of the young person (§ [1001](#)). This latter provision will go into effect starting this September, helping many young adults with disabilities access affordable health care services.

Modifications in the public insurance programs also help in expanding the opportunities for accessing health care for young adults. Specifically, beginning in 2014, the Medicaid coverage will be extended to all young persons (including children between ages 6 and 19 years) who are at or below 133% of the federal poverty level (i.e., earning approximately \$15,000 or less annually for an individual) a move up from the current 100% FPL requirement (§ [2001](#)). In a similar vein, the law extends coverage to former foster care children who aged out of the system as of the date of enactment (§ [2004](#)). Additionally, states are required to offer premium assistance and wrap-around benefits to Medicaid beneficiaries, without any age limit, who are offered employer-sponsored insurance (§ [2003](#)). For young adults with special health care needs, the Community First Choice Option of the Affordable Care Act requires that states extend community-based attendant services and supports to Medicaid beneficiaries and allows states to incorporate newer options within home and community-based services programs, rather than using the traditional waiver system to provide necessary services and supports in community-based settings (§ [2401](#), [2402](#)).

Another provision likely to help youth and young adults, especially those with emotional disturbances or psychiatric disabilities is in the extension of Medicaid coverage for prescription medications that will include smoking cessation drugs, barbiturates, and benzodiazepines. Further, to better coordinate health care services for young adults who need additional services due to the nature of their chronic conditions, the bill supports establishment of patient-centered health homes—a system in which a team of health professionals coordinates health care services for the patient (§ [2703](#), [3502](#)). The bill also provides funding for evidence-based maternal and childhood home visitation programs intended to improve maternal and newborn health, parenting skills, school readiness, juvenile delinquency, and family economic sustainability—all of which are critical for teenage pregnant youth with disabilities (§[2951](#), [2952](#), [2953](#), [2954](#)).

The Title IV of the bill focuses specifically on provision for preventive and wellness services with a focus on reducing secondary health conditions, especially among persons with disabilities, through establishment of nationwide systems and better coordination among

various preventive health task forces. Demonstration programs to study the impact of employer-based wellness programs also provide a scaffolding to support the prevention efforts with potential impacts on health-related outcomes for young adults with disabilities (§ 4303). The bill provides grants and funding for demonstration projects for school-based health centers and oral health prevention. Furthermore, specific provisions in Medicaid and Medicare are aimed to expand the access to preventive services and annual wellness assessments (§ 4103, 4104). The law also provides establishment of access boards to develop specific recommendations for increasing accessibility of diagnostic equipments to improve access for persons with disabilities.

5.0 Recommended Areas for Further Research and Technical Assistance

With the multitude of changes that the Affordable Care Act will put in place over time, few aspects of the U.S. health care system will remain untouched. However, the phased nature of many provisions of the Act combined with the use of previously untested approaches leaves a high degree of uncertainty as to the eventual impacts of the Act. With these facts in mind, recommendations are offered below for research that could shed more light on how the Affordable Care Act will affect PWD who are attempting to enter the workforce (including youth transitioning into the workforce) or PWD who are already employed and their employers. Other recommendations are provided for technical assistance materials that could be developed to ease the transition of PWD and employers to health care reform.

Recommendation One: Survey of PWD Seeking Employment

Background

The Affordable Care Act brings with it significant changes in where and how Americans obtain health benefits. For unemployed PWD and those transitioning into employment, this means increased access to private and employer-sponsored coverage. Regardless of where PWD have received coverage, they will soon have access to new benefits and a broader variety of care options. In order to more fully understand the impact of Affordable Care Act provisions on PWD, it will be necessary to establish baseline data using quantifiable measures of coverage, cost, access, and utilization of benefits by PWD.

Research Idea

Develop and collect comprehensive baseline and follow-up data on health care coverage for a sample of PWD seeking employment as different provisions of the Affordable Care Act are implemented. Specific topics for this research could include: What sources (private, employer, public, or a combination) are PWD using to obtain needed health care? What are PWD's perceptions of incentives and disincentives for working in relation to their health care? How do PWD who are seeking employment perceive the costs and quality of health care? Do attitudes and behaviors differ among various subgroups of this population (e.g., by age, type of disability, location)?

Recommendation Two: Toolkit “What Does Health Care Reform Mean for Me?”

Background

The Affordable Care Act is one of the most complex and extensive pieces of legislation in U.S. history. Many experts in the health care field are struggling to determine what the ramifications of the Act will be and how the various provisions of the Act will affect different populations. With this level of confusion, it is important that PWD and their families have accurate and easy to understand information available that will allow them to sort through the maze of provisions of the new law and determine what changes are relevant to them in relation to their employment options.

Technical Assistance Idea

Develop a toolkit for PWD providing them with information on what health care reform means for them as they transition into employment. Topics to be covered would include health care availability, access, funding, eligibility, and benefits. A special section would be devoted to youth transitioning into the workforce for the first time.

Recommendation Three: Researching “Falling through the Cracks”

Background

A point of uncertainty currently exists under the Affordable Care Act in how coverage gaps will be dealt with for PWD as they transition from public to private or employer-sponsored coverage. While individuals will not be subject to the mandatory coverage penalty if they are without insurance for less than 3 months or their income falls below the minimum threshold, it is not clear whether the insurance policies will overlap, or if there will be a gap in coverage when a person changes from public to private or employer insurance. Any lapse in coverage could be catastrophic for this population because of their relatively high medical care needs and costs. Further, the fear of potential lapses in coverage may influence them to remain unemployed.

Research Idea

Conduct a study of PWD transitioning from unemployment to employment to determine if coverage gaps exist and if so, their frequency and the circumstances in which they occur. A special focus would be disadvantaged populations including minorities, women, and those with less than a high school education.

Recommendation Four: Researching “Unlocking Job Lock?”

Background

The current health care system has in the past been seen as inhibiting movement of PWD between employers, and into smaller companies and self-employment because of fear of losing health care benefits. This phenomenon has been called “job-lock.”

The Affordable Care Act contains provisions eliminating exclusions for pre-existing conditions and rate variances discriminating against those who are ill. The Act also increases the affordability of health care for those working in small companies or self-

employed. With these changes, the Affordable Care Act should promote the ease with which employees with disabilities move between jobs, and into small business or self-employment.

Research Idea

Research would be conducted to explore current levels of job mobility among PWD to establish a baseline and to establish the basis for follow-up studies as additional provisions of the Act fall in place. Initial research topics could include the following:

- Examination of the rate of employment of persons with disabilities at large firms and number of years the individuals have held the same job.
- Exploration of the frequency with which persons with disabilities seek employment at small businesses and seek entrepreneurship and career advancement opportunities.

Recommendation Five: Helping Small Businesses Navigate through Provisions of the Affordable Care Act

Background

While employment in small businesses is often an attractive option for PWD because of the tendency of these employers to offer greater workplace flexibility, employment with small businesses has been hampered by the infrequency with which these companies offer health care benefits. For these reasons, the unprecedented opportunities offered through the Affordable Care Act supporting the provision of health care coverage by small employers is especially important.

While employers with fewer than 50 employees are exempt from being fined if they do not provide coverage, the Affordable Care Act has several provisions aimed at encouraging small businesses to invest in improving their employees' overall health status. As described earlier, these incentives include tax credits for the purchase of health insurance, SHOP exchanges, and worksite wellness program grants. Taken together, these provisions allow small businesses not only to improve the health of their current employees, but also to become an attractive option for employees who may have felt "locked" into working for large businesses due to access to health care coverage.

However, one potential issue facing small business employers is the amount of startup time it takes for them to learn the new provisions of the Act and how to apply for the grants and tax credits to offer health insurance and worksite wellness programs.

Technical Assistance Idea

Provide small businesses with lessons, tools, and information to help them better understand, as well as apply for, the grants, tax credit, and SHOP exchanges offered through the Affordable Care Act.

Recommendation Six: An Unintended Effect of Health Care Reform—the Downsizing of Small Businesses?

Background

The Affordable Care Act was enacted with the expectation that large businesses will provide health insurance for the majority of their employees. The Act has different requirements depending on the number of employees in the company. Employers with 50 or more employees are required to provide affordable coverage to their employees and offer “free choice vouchers” for their employees who have low income and choose to purchase coverage elsewhere. Employers with more than 200 employees are required to automatically enroll employees into their employer-sponsored health plans with a provision allowing employees to opt out if they already have health insurance. Employers with less than 50 employees are not required to offer health care coverage, but are encouraged to do so via several new provisions.

A related change in the Act alters the definition of FTE from its previous definition as an employee who worked at least 30 hours a week on average when calculated on a weekly basis, to those who work on average at least 30 hours per week when calculated on a monthly basis. This change allows more flexibility and will likely allow more employees with disabilities to be considered full time.

The difference between being “required” to offer health insurance and being “encouraged” to offer health insurance is significant. Employers who are required to offer health insurance could face fines if they do not follow the provisions of the Act. Employers who are encouraged to offer health care face a large amount of paperwork and might be incentivized not to grow their company past 50 employees—or even to downsize to get below the 50 FTE limit.

These changes raise a number of questions. Did the Affordable Care Act create the unintended consequence of having employers limit the number of employees in their company so as not to have to offer health insurance? Will positions disappear to stay below 50 employees? Will employees with disabilities, who formerly did not count as full time nor have eligibility for benefits, who now would qualify as FTEs because of the new definition, be terminated so that the companies do not go beyond the 50 FTE mark?

Research Idea

Survey companies to see if the new requirements of the Affordable Care Act will influence whether they create new positions that may bring their company over the 50 FTE limit or downsize to get below 50 FTEs. The question of whether these provisions supporting provision of health insurance will result in an improved economic position for small employers would also be examined.

Recommendation Seven: Retaining Older Workers with Disabilities

Background

Although large businesses are often more concerned with bottom line issues such as return on investment in comparison to other organizations that offer wellness programs (i.e., community-based services or government agencies), there is one factor that may unite

these groups: the increase in the prevalence of chronic conditions among older working age adults. Over time, the definition of an “employee with disabilities” has expanded to include employees who develop chronic conditions such as arthritis as they age.

As the Baby Boomers begin to leave the workforce in large numbers, businesses are going to feel a greater need to do more to retain their employees. One way the Affordable Care Act addresses this issue is by including provisions to help large businesses encourage the participation of all employees (including those with disabilities) in worksite wellness programs. The Act does this by codifying HIPAA’s amended wellness program regulations and allowing employers to offer larger discounts on health insurance premiums. This change should help large businesses improve the overall health status of their employees, thereby delaying their exit from the labor force or encouraging those who may have left the workforce due to health conditions to return.

Research Idea

Conduct a baseline study on the impact that worksite wellness provisions in the Affordable Care Act will have on retaining employees with disabilities or encouraging those who left employment after becoming disabled to return to work.

Recommendation Eight: Effects of Availability of Private and Employee Health Care on Youth Seeking Employment

Background

Several provisions of the health care reform bill enhance access to health insurance, health care, preventive health, and coordinated systems of care for young adults with disabilities. Assuming a full and complete implementation of these provisions, it is likely that a greater number of young adults with disabilities will have access to health care while they enter the labor market and the impact of disincentives for those working (especially for those on public benefits) could be mitigated by these strategies. However, several implementation-related factors need to be studied as these provisions are implemented sequentially nationwide. From the labor market engagement perspective, the hypotheses implicit in the health care bill is that increase in access to health care services and prevention services will increase labor market engagement among young adults with disabilities. Yet this assumption has yet to be tested.

Research Idea

The assumption that the provisions of the Affordable Care Act will increase employment rates among youth with disabilities would be studied. Although disabilities are less prevalent at younger ages, they do impact labor force participation and earnings. This research would represent a major extension of the simple models used previously by Altarum Institute to estimate labor force years and earnings lost due to aging into disabilities

Conclusion

Considering the range and extent of changes the Affordable Care Act will make on almost every aspect of the U.S. health care system, it is likely that almost every American will be affected in some way by this legislation. Yet, it can be argued that PWD as a group will be one of the most heavily impacted since health care tends to be such a major factor in their lives—particularly as it relates to their employment. For this reason, it will be important for ODEP to study and review how this legislation is affecting PWD who are seeking employment or who are employed as the legislation's various provisions take effect over the next several years. With the benefit of careful study, ODEP will be in a better position to assist in preparing PWD who are seeking employment or employed to take advantage of the benefits the Act offers and to navigate the challenges it may present.

Appendix A: Timeline for Affordable Care Act Implementation

Effective Date	Legislation	Impacted Health Care Reform Area
<i>Provisions beginning in 2010</i>		
January 2010	New excise tax on medical devices on manufacturers of durable medical equipment (PPACA § 9009 ; 10904)	Financing of Health Care Coverage
January 1, 2010	Medicaid prescription drug rebates increase the flat rebate percentage for certain prescription drugs (PPACA § 2501 ; HCERA § 1206)	Financing of Health Care Coverage
March 2010 (Secretary to issue regulations)	Prohibition of discrimination through exclusion from participation in or benefits denial under any health program or activity (PPACA § 1557)	Health Care Coverage
March 2010	Exceptions process for Medicare therapy caps extended through December 2010 (PPACA § 3103)	Health Care Benefits
April 1, 2010	Removal of barriers to providing home and community-based services under Medicaid (PPACA § 2402)	Health Care Benefits
April 23, 2010	Money follows the person rebalancing demonstration (PPACA § 2403)	Health Care Benefits, Financing of Health Care Coverage
June 22, 2010 ,to January 2014	Access to insurance for uninsured individuals with a pre-existing condition; establishment of temporary high-risk pools (PPACA § 1101)	Health Care Coverage, Financing of Health Care Coverage
June 2010	Establishment of reinsurance programs for early retirees and dependents (PPACA § 1102)	Health Care Coverage
July 1, 2010	Conditions for coverage of certain drugs under Medicare Part D (PPACA § 2602 ; 3301)	Financing of Health Care Coverage
September 23, 2010	Prohibition of pre-existing condition exclusions and health status discrimination for children (PPACA § 1201)	Health Care Coverage

Effective Date	Legislation	Impacted Health Care Reform Area
September 23, 2010	End to lifetime or annual limits and recessions; prohibition on discrimination in favor of highly compensated individuals (PPACA § 1001 , 10101)	Health Care Coverage
September 23, 2010	Lifetime and annual limits provision prohibits all plans for establishing lifetime limits on the dollar value of essential benefits within the exchange (HCERA § 2301)	Health Care Coverage
September 23, 2010	Extension of dependent coverage under private insurance to age 26 (PPACA § 2001)	Transition Age Youth
September 23, 2010	Establishment of Maternal, Infant, and Early Childhood Home Visiting Programs (PPACA § 2951)	Transition Age Youth
October 1, 2010	Establishment of a program to study postpartum depression, a program to study personal responsibility education, and restoration of abstinence education funding (PPACA § 2952 , 2953 , 2954)	Transition Age Youth
October 1, 2010, through FY 2015	Demonstration projects and model curricula for cultural competency and working with individuals with disabilities (PPACA § 5307)	Health Care Workforce Support
October 1, 2010	Replacement the Federal Coordinating Council for Comparative Effectiveness Research with a private, nonprofit entity to identify priorities and conduct comparative effectiveness and patient-centered outcomes research (PPACA § 6301 , 10602).	Disability Specific Provisions
<i>Provisions beginning in 2011</i>		
January 1, 2011	Credit for eligible small businesses for insurance expenses (PPACA § 1421)	Financing of Health Care Coverage

Effective Date	Legislation	Impacted Health Care Reform Area
January 1, 2011	Establishment of Medicaid health homes for enrollees with chronic conditions (PPACA § 2703 , 3502)	Financing of Health Care Coverage, Transition Age Youth
January 1, 2011	Elimination of the Medicare provision for the first-month purchase option for power wheelchairs (PPACA § 3136)	Financing of Health Care Coverage
January 1, 2011	Grants awarded for incentives for Medicaid beneficiaries to participate in Healthy Lifestyles programs (PPACA § 4108)	Health Care Benefits
January 1, 2011	Medicaid coverage of annual wellness visits and removal of barriers to preventive services (PPACA § 4103 , 4104)	Health Care Benefits, Transition Age Youth
January 2011	National voluntary insurance program for purchasing community living assistance services and support (the CLASS Act) is implemented (PPACA § 8002)	Health Care Benefits, Financing of Health Care Coverage
March 2011	Assistance to states to establish Small Business Health Options Program (SHOP) exchanges (PPACA § 1311)	Health Care Coverage, Financing of Health Care Coverage
October 1, 2011	Incentives for states to offer home and community-based services as an alternative to nursing homes (PPACA § 10202)	Health Care Benefits
October 1, 2011, through FY 2015	Grants for small businesses to give employees access to comprehensive workplace wellness programs (PPACA § 10408)	Health Care Benefits, Financing of Health Care Coverage
October 1, 2011, through FY 2015	Increase in funding for community health centers (PPACA § 10503)	Disability Specific Provisions
October 1, 2011	Establishment of Community First Choice Options providing attendant services for eligible Medicaid beneficiaries (PPACA § 2401 ; HCERA § 1205)	Health Care Benefits

Effective Date	Legislation	Impacted Health Care Reform Area
October 1, 2011, through FY 2013	Training opportunities for direct care workers (PPACA § 5302)	Health Care Workforce Support
November 2011	Demonstration project to develop training and certification programs for personal or home care aides (PPACA § 5507)	Health Care Workforce Support
<i>Provisions beginning in 2012</i>		
January 1, 2012	Independence at home demonstration program for Medicaid beneficiaries with multiple chronic conditions (PPACA § 3024)	Health Care Benefits
March 2012	Establishment of standards for accessible medical diagnostic equipment (PPACA § 4203)	Disability Specific Provisions
March 2012	Data collection to understand health disparities for certain demographics, including persons with disabilities (PPACA § 4302)	Disability Specific Provisions
<i>Provisions beginning in 2013</i>		
January 1, 2013	New 2.3% excise tax on manufacturers of durable medical equipment (HCERA § 1405)	Financing of Health Care Coverage
January 1, 2013	Medicaid primary care adjustment requires that payment to primary care physicians be no less than 100% of the Medicare payment rate in 2013 and 2014 (HCERA § 1202)	Financing of Health Care Coverage
January 1, 2013	Addition of certain diagnostic, screening, preventative, and rehabilitative services to available services for eligible Medicaid enrollees (PPACA § 4106)	Health Care Benefits
March 2013	CDC study of employer-based wellness practices and development of technical assistance (PPACA § 4303)	Financing of Health Care Coverage

Effective Date	Legislation	Impacted Health Care Reform Area
<i>Provisions beginning in 2014</i>		
January 1, 2014	Establishment of responsibilities of large employers to offer health care coverage (PPACA § 1513 , 10106 ; HCERA § 1003)	Health Care Coverage, Financing of Health Care Coverage
January 1, 2014	Establishment of the American Health Benefit Exchange, Small Business Health Options Program, and free choice vouchers (PPACA § 1311 , 10104 , 10108)	Health Care Coverage, Financing of Health Care Coverage
January 1, 2014	Prohibition of pre-existing condition exclusions and health status discrimination for adults (PPACA § 1201)	Health Care Coverage
January 1, 2014	Guaranteed availability and renewability of coverage, prohibitions on large differences in premiums (PPACA § 1201)	Health Care Coverage, Financing of Health Care Coverage
January 1, 2014	Limits on cost-sharing and deductibles (PPACA § 1302)	Health Care Benefits
January 1, 2014	Premium tax credits to eligible individuals to purchase insurance coverage through the SHOP exchanges (PPACA § 1401)	Financing of Health Care Coverage
January 1, 2014	Requirement that all individuals and dependents have some minimum health insurance (PPACA § 1501)	Health Care Coverage, Financing of Health Care Coverage
January 1, 2014	Medicaid eligibility expanded to all non-elderly, childless adults, and adults with incomes up to 133% of the federal poverty level for a benchmark benefits package; modified adjusted gross income becomes the standard for determining Medicaid eligibility (PPACA § 2001 , 2002 , 3308)	Health Care Coverage

Effective Date	Legislation	Impacted Health Care Reform Area
January 1, 2014	Medicaid required to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered insurance through an employer (PPACA § 2003)	Health Care Coverage
January 1, 2014	Establishment of simplified enrollment in Medicaid, CHIP, and state exchanges allowing individuals to enroll via state-run websites using coordinated procedures for all programs (PPACA § 2201)	Health Care Coverage
January 1, 2014	Elimination of the Medicare exclusion coverage for antiseizure, antispasm, and smoking cessation medications (PPACA § 2502)	Health Care Benefits, Financing of Health Care Coverage
January 2014, phased in through 2017	Rebasement of the home health prospective payment amount (PPACA § 3131 , 10315)	Financing of Health Care Coverage
July 2014 through 2017	Wellness program demonstration project (PPACA § 1201)	Financing of Health Care Coverage
<i>Provisions beginning in 2016 and beyond</i>		
January 1, 2016	Competitive bidding program for suppliers of wheelchairs and other durable medical equipment (PPACA § 6410)	Financing of Health Care Coverage
January 1, 2019	Medicaid coverage extended to former foster children who aged out of the system (PPACA § 2004)	Transition Age Youth

(Note: These dates are preliminary and may change as the bill is implemented and the Secretary of HHS issues or revises rules and regulations.)

Appendix B: Resources

Additional Analysis of Affordable Care Act

Citation	Summary
<p>National Academy of Elder Law Attorneys, Inc. (2010, March 26). <i>Health care reform provisions affecting older adults and persons with special needs</i>. Retrieved June 6, 2010, from http://www.naela.org/MemberPages/documents/HCRprovisions-OlderAdults3-26-10.doc</p>	<p>This document provided a summary of health care reform provisions affecting older adults and persons with disabilities. The NAELA membership is made up of attorneys in the private and public sectors who deal with legal issues affecting seniors and persons with disabilities.</p>
<p>Powers, Pyles, Sutter, & Verville PC Attorneys at Law. (2010, May 14). <i>Overview of the new healthcare reform law</i> [webinar]. Retrieved May 26, 2010, from http://www.ppsv.com/about-news-66.html</p> <p>Powers, Pyles, Sutter, & Verville PC Attorneys at Law. (2010, April, 16). <i>Highlights of the new health reform law—H.R. 3590 as modified by H.R. 4872</i>. Retrieved June, 21, 2010, from http://www.ppsv.com/assets/attachments/98.pdf</p>	<p>This firm devotes its entire legal practice to complex legal issues facing participants in the health, education, and certain complementary sectors of the economy. This document and webinar provide summaries of health care reform provisions.</p>
<p>Davis, P. A., Hahn, J., Morgan, P. C., Stockdale, H., Stone, J., & Tilson, S. (2010, April 21). <i>Medicare provisions in PPACA (P.L. 111-148)</i>. Congressional Research Service. Retrieved May 23, 2010, from http://assets.opencrs.com/rpts/11-148_20100421.pdf</p> <p>Williams, E. D. & Redhead, C. S. (2010, June 7). <i>Public health, workforce, quality, and related provisions in the Patient Protection and Affordable Care Act (PPACA)</i>. Congressional Research Service. Retrieved May 23, 2010, from http://www.aamc.org/reform/summary/ph.pdf</p>	<p>The Congressional Research Service (CRS) provides Congress with analytical support to address the most complex public policy issues facing the nation. This report examines the Medicare related provisions in the Patient Protection and Affordable Care Act (PPACA) and the Reconciliation Acts.</p> <p>This report examines the Medicare related provisions in PPACA and the Reconciliation Acts.</p>
<p>Nebraska Advocacy Services. (2010). <i>Health care reform for persons with disabilities: Key principles and recommendations</i>. Omaha, NE. Retrieved, May 19, 2010, from http://www.nebraskaadvocacyservices.org</p>	<p>Nebraska Advocacy Services, Inc., (NAS) is a private, nonprofit organization designated by the governor to protect and</p>

Citation	Summary
	<p>advocate for the rights of Nebraskans with significant physical or mental disabilities. This report discusses key principles and recommendations of the health care reform as it relates to persons with disabilities.</p>
<p>PACER Center Technical Assistance on Transition and the Rehabilitation Act. (2010). <i>The health care reform act: Key details for families of children and youth with disabilities</i>. Retrieved May 19, 2010, from http://www.pacer.org/tatra/pdf/healthcareact2010.pdf</p>	<p>The Pacer Center's Technical Assistance on Transition and the Rehabilitation Act (TATRA) Project lists critical provisions of the health care reform act affecting families of children and youth with disabilities. This report discusses changes that will occur in insurance and health care coverage, including Medicare and Medicaid requirements.</p>
<p>National Spinal Cord Injury Association. (2010). <i>Impact of health care reform on people with disabilities</i>. Retrieved June, 18, 2010, from http://www.spinalcordadvocates.org/pdf/impact_of_health_care_reform.pdf</p>	<p>A review of the ACA from the perspective of persons with spinal cord injuries that is also relevant to most PWD.</p>

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