

Early Coverage Options for Direct-Care Workers and Their Families

President Obama signed into law **Pub.L.111-148**, the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), on March 23, 2010, and **Pub.L.111-152**, the Health Care and Education Reconciliation Act of 2010 (HCERA), on March 30, 2010. These two laws will change both the availability of health insurance and how health care is delivered in America. In addition, several of the legislation's provisions directly impact eldercare and disability employers and direct-care staff. This is the fourth in a series of **fact sheets** describing those provisions.

Summary

The Affordable Care Act, which significantly expands access to affordable health coverage, is being phased in over a four-year period. Though the legislation will not be fully implemented until 2014, many of the law's provisions, including efforts to expand coverage for the uninsured, take effect this year. Specifically, the new law gives states the option to expand public coverage immediately, establishes new rules for private insurers, helps seniors with the costs of prescription coverage, and provides new funding for community health centers.

Taken together, these provisions give direct-care workers and their families numerous opportunities to access more affordable health care before 2014. The chart below summarizes these coverage provisions.

Affordable Care Act: Pre-2014 Coverage Provisions	
Provision	Implementation
State Option to Expand Medicaid Eligibility Earlier than 2014 (Title II, Subtitle A, Sec 2001)	Effective April 1, 2010
Pre-Existing Condition Insurance Plan (Title I, Subtitle B, Sec 1101)	Effective July 1, 2010
Elimination of pre-existing condition exclusion for children on insurance plans (Title I, Subtitle C, Part I, Sec 1201)	Effective September 23, 2010 (or with new plan year beginning January 1, 2011)
Allowing young adults to stay on parent's health plan to age 26 (Title I, Subtitle A, Sec 1001)	Effective September 23, 2010 (or with new plan year beginning January 1, 2011)
Prohibitions against lifetime benefit caps and rescissions (Title I, Subtitle A, Sec 1001)	Effective September 23, 2010
Elimination of cost-sharing for preventive care in Medicare and private plans (Title I, Subtitle A, Sec 1001)	Effective September 23, 2010 (or with new plan year beginning January 1, 2011)
Reduced cost for Medicare drug benefit (Title III, Subtitle D, Sec 3301)	Effective calendar year 2010
Community Health Center Fund for services and capital needs (Title X, Subtitle E, Sec 10503)	Authorized and appropriated \$11 billion over five years (FY11 – FY15)

Expansion of Public Coverage

A major provision in the Affordable Care Act is the expansion of Medicaid, the federal-state health insurance program for low-income Americans. Beginning in 2014, states must provide coverage for all individuals under age 65 who make less than 133 percent of the federal poverty line (\$14,400 for an individual and about \$29,326 for a family of four in 2009). At that time, the federal government will pick up 100 percent of the cost of coverage for new enrollees. Recent reports by the Kaiser Family Foundation¹ estimate that by then, Medicaid will provide coverage for an additional 32 million people.

States, however, may expand Medicaid coverage prior to 2014, and despite tight fiscal times, some are doing so. Connecticut and Washington, DC, have applied and received permission from federal officials to expand their programs immediately. Other states have considered expansions but have not yet passed needed legislation. If states opt to expand their programs before 2014, they will receive the current federal funding formula.

New Insurance Rules

Beginning September 23, 2010, six months after the enactment of the health reform law, insurance plans will be required to adhere to the following new regulations that expand coverage and protect consumers from arbitrary practices of insurance companies:

Elimination of Pre-Existing Condition Exclusions. Insurance plans may no longer impose restrictions on children's coverage based on pre-existing conditions. Insurance companies will be required to accept all children who apply for coverage. In addition, insurers will be forbidden from charging higher premiums based on gender or pre-existing medical conditions. (The latter provision will be expanded to all individuals starting January 1, 2014.)

Expanded Coverage for Adult Children. Under the **new rules**, an employer-sponsored health plan or a company offering insurance policies must offer coverage to subscribers' children up to the age of 26. This applies regardless of whether a child is "dependent"—i.e., lives with his or her parents, attends college, or receives financial support from the parents. Parents may even cover married children under this provision. The only exception is for already existing employer-sponsored plans. Such plans may refuse coverage to adult children who have access to another employer-sponsored plan (e.g., through their own workplace).

Many insurance companies have voluntarily agreed to provide dependent coverage immediately, without waiting for the requirement to take effect in September (or in January 2011, when many companies renew their coverage). According to the U.S. Department of Health and Human Services (HHS), an estimated 1.2 million people will gain coverage as a result of this provision of the Affordable Care Act.

Elimination of Lifetime Benefit Caps and Arbitrary Termination of Policies. Group health plans or insurance companies providing group or individual market coverage are prohibited from setting a cap on the dollar value of lifetime benefits and from setting "unreasonable" annual limits on the dollar value of benefits (as defined by the Secretary of Health and Human Services). Beginning in January 2014, individual and group health plans will be prohibited from placing any annual limits on the dollar value of coverage.

In addition, insurers are prohibited from rescinding coverage except in cases of fraud. This limits the practice of insurance companies terminating the insurance coverage of individuals when they become seriously ill.

¹ Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL, Kaiser Commission on Medicaid and the Uninsured (prepared by Urban Institute), May 2010 <http://www.kff.org/healthreform/8076.cfm>

Elimination of Cost-Sharing for Preventive Care. All health plans, including Medicare, must eliminate cost-sharing for proven preventive care services. No co-payments will be charged for services such as breast cancer and cervical cancer screenings and bone density tests for women age 65 and older. In addition, Medicare beneficiaries will be fully covered (no copayment) for an annual wellness visit with their primary care physician.

Reduced Cost for Medicare Part D: For Medicare beneficiaries, the health reform law helps to address the high cost of Part D prescription coverage. Beneficiaries who are caught in the “donut hole”—a coverage gap that begins when they have spent somewhere around \$2,800 and continues (while they pay full price for prescriptions) until their out-of-pocket expenses reach \$4,450—will get a \$250 rebate check. Additionally, when a beneficiary reaches the donut hole, brand-name drugs will be discounted at 50 percent and generic drugs will be covered in full. (The law provides for the gradual elimination of the Medicare Part D coverage gap by 2020.)

Expanded Access to Services at Community Health Centers

The over 1,200 community health centers across the country make up the largest network of primary care providers serving low-income communities. The new law includes \$11 billion over five years in new, dedicated funding for these centers. Of these funds, \$9.5 billion may be used to fund new health centers for communities in need or expand capacity at existing health centers. The remaining \$1.5 billion in capital funding is to be used to modernize aging buildings and build new facilities to serve more patients. This funding adds to the \$2 billion in American Recovery and Reinvestment Act funds community health centers already received in 2010 for construction, renovation and patient services.

Community health centers have been a good source of care for many low-income workers and their families, and with additional funding, will be able to reach even more consumers with health care services priced on a sliding scale according to what the patient can afford. For a list of health centers near you, click [here](#).

Pre-existing Condition Insurance Plan

Pre-Existing Condition Insurance Plans are temporary high-risk insurance pools that provide coverage for individuals who cannot buy coverage due to a prior illness or chronic condition. Beginning in July 2010, 30 states began offering these plans; the federal government offers plans for eligible individuals in the other 20 states. In order to be eligible for coverage through the Pre-Existing Condition Insurance Plan, an individual must:

- 1) be a U.S. citizen or legal resident;
- 2) not have had coverage through a private group or individual health insurance plan, an existing state high-risk pool, COBRA, or a public program like Medicaid for six months prior to applying for coverage; and
- 3) have a pre-existing condition.

Many direct-care workers have chronic conditions that may make it difficult to purchase private insurance. For these individuals, a Pre-existing Condition Insurance Plan may provide an affordable coverage option. For more information on these high-risk pools, see [PHI Health Reform Facts 2](#) or go to www.healthcare.gov.

Conclusion

Approximately one out of four direct-care workers is uninsured. As described above, the Affordable Care Act offers many opportunities for improved access to coverage and services even before the law is fully implemented in 2014. With median annual incomes of \$17,000, many direct-care workers will be eligible for Medicaid under the new rules expanding coverage. Others, who have been without coverage because of chronic illnesses such as diabetes or hypertension, may be able to purchase insurance through state Pre-Existing Condition Insurance Plans. In addition, direct-care workers and their families may be able to take advantage of new rules that expand coverage for children and make preventive services available with no cost sharing. Finally, the government's investment in community health centers will make health care services more accessible to all low-income Americans, including direct-care workers.

What You Can Do

In July 2010, the U.S. Department of Health and Human Services launched a website (www.healthcare.gov), to help individuals identify affordable coverage options within their state. The website helps consumers understand the new law, compare the quality of various providers, and learn how to navigate the available insurance options. Stakeholders should use newsletters or other communication tools to get the word out to workers and families about this online resource as well as other information that explains available coverage options.

PHI will continue to keep stakeholders updated in our weekly newsletter and at our **Health Reform Resource Center** as programs are finalized and enrollment begins.

Resources

Federal government health care portal, <http://www.healthcare.gov>

National Association of Community Health Centers, www.nachc.com

Community Health Centers in an Era of Health System Reform,
<http://www.kff.org/uninsured/upload/7876.pdf>

Families USA, www.familiesusa.org/health-reform-central

For more information, contact Carol Regan, Director of PHI Government Affairs and *Health Care for Health Care Workers* Campaign at cregan@phinational.org or 202-223-8355 or Meghan Shineman, Policy Analyst at mshineman@phinational.org, 718-928-2061.



Health Care for Health Care Workers, an initiative of PHI, seeks to expand health coverage for workers who provide support and assistance to elders and people living with chronic conditions and/or disabilities. For more information, visit www.PHInational.org/healthreform.