

Understanding the Impact of the Affordable Care Act: An Overview for People Managing Epilepsy

by Abby Nash

Edited by Robin Owen, Managing Editor



Abstract

Health care reform is a work in progress and the federal Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA) are the foundation upon which all new programs and health insurance products will be developed. The new requirements are a floor, not a ceiling; thus, if a state already has stricter requirements, then state law still applies. While many required health insurance changes will not occur until 2014 or later, several provisions that require compliance as of September 23, 2010 will make it easier for individuals with epilepsy or other preexisting conditions to obtain more affordable health insurance.

Introduction

The need for health care reform has been recognized for nearly one hundred years.

During previous administrations, programs and protections targeting varying population groups based on age, health status, disability and income were created. After extensive research and debate, the federal Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), which together comprise the new federal health care reform law, were signed into law by President Obama on March 23, 2010, and March 30, 2010, respectively. Throughout this article, the term “the Affordable Care Act” will be used to refer to provisions in either PPACA or HCERA.

This article provides a cursory overview of some the changes that impact eligibility and benefits under private sector insurance, self-insured plans, Medicare and Medicaid. The Affordable Care Act will enable those with preexisting conditions who do not have

insurance to purchase it for a more reasonable cost. It encourages employers to provide health insurance for their employees and individuals without health insurance to purchase it for themselves. Tax incentives will be offered for small businesses that provide health insurance for their employees and over time, with limited exceptions, large group employers who do not provide insurance and individuals who opt not to purchase health insurance will be penalized.

In many instances, patients are encouraged to receive preventive treatment and participate in wellness programs while providers are encouraged to use quality-of-care measures to determine what services are most advantageous in the treatment of specific conditions and to be more efficient through the use of electronic health records.

The Affordable Care Act Controversy

Unlike other health care reform legislation, the Senate Democrats and House Representatives enacted the Affordable Care Act with no support from their Republican colleagues. In response to the passage of the Affordable Care Act, attorney generals from several states, the National Federation of Independent Businesses and others filed a joint lawsuit alleging that the Affordable Care Act infringes on the sovereignty of the states and exceeds the powers granted under the US Constitution.¹ They argue that the Constitution, in particular the interstate commerce clause, does not permit taxation based upon a failure to act such as refusing to purchase health insurance. While this case is likely

to reach the US Supreme Court, it may take years before it gets there. The Justice Department ensured it will “vigorously defend” these cases and a Justice Department spokeswoman said “We are confident that this statute is constitutional and that we will prevail.”²

Who Will Be Covered Under the Affordable Care Act?

■ Grandfathered Plans

A “grandfathered health plan” is defined as any group health plan (including self-insured plans) or health insurance coverage (including group and individual health insurance policies) that was in effect on March 23, 2010. Under the Affordable Care Act, grandfathered plans will not be obligated to comply with many new requirements; however, other requirements that are valuable to those with chronic conditions such as epilepsy will apply to these plans.

The idea behind grandfathered plans is that if you like your plan, you may keep it. Thus, individuals, employers, and other groups who are satisfied with their benefits may continue their coverage. If changes to a grandfathered plan benefit those covered, then the plan may retain grandfathered status.³

Premium increases will not automatically alter a plan’s grandfathered status; however, the following changes will cause plans to lose their grandfathered status:

- **Significant Reduction of Benefits:** e.g., a plan’s decision to stop covering essen-

The Affordable Care Act will enable those with preexisting conditions who do not have insurance to purchase it at a more reasonable cost.

tial services for a particular illness such as prescription drug coverage for those with epilepsy

- **Increased Coinsurance Percentage:** any increase in fixed cost sharing amounts (e.g., a plan amendment requires the insurance to pay 25 percent of an inpatient hospital stay rather than the 20 percent they were previously paying)
- **Increased Copayments:** Copayments may not be increased by the greater of:
 - \$5.00 (or its equivalent based upon inflation) or
 - a percentage equal to medical inflation plus 15 percentage points (Currently medical inflation equals approximately 4 to 5 percent; thus, the maximum increase allowed would be 19 to 20 percent of the copayment amount or \$5.00, whichever is greater.)
- **Increased Deductibles and Out-of-Pocket Limits:** Deductible and out-of-pocket limits may not be raised higher than a percentage equal to medical inflation plus 15 percentage points (see above).
- **Annual and Lifetime Dollar Limits:** Plans that have an annual dollar limit may not decrease the limit in existence as of March 23, 2010. Plans that do not have

a dollar limit may not include one unless they had a lifetime limit (see pages 51 and 52).

- **New Insurer:** any change in insurance company (This does not apply to collective bargaining agreements.)*

**Collective bargaining agreements are subject to the same rules as other grandfathered plans. However, there are two special rules for insured collectively bargained plans. First, if changes are made to an insured collectively bargained plan that would cause other plans to lose their grandfathered status, then the insured collectively bargained plan will lose its grandfathered status but not until the end of the last related collective bargaining agreement in effect as of March 23, 2010. At that time, the new and old plans will be compared to determine whether the plan may retain its grandfathered status. Second, a change in insurer during the course of the agreement will not cause a collectively bargained plan to lose its grandfathered status. However, if the plan changes insurers after the agreement terminates, it may no longer be treated as a grandfathered plan.*

■ Self-insured Plans

The Employee Retirement Income Security

Act of 1974 (ERISA) applies to insured and self-insured plans. State health insurance laws apply only to approximately 45 percent of all health plans. The other 55 percent are self-insured plans under which unions, associations, and large employers assume the risk and set aside funds to pay anticipated health care claims.⁴ This enables them to avoid the cost of premiums that can be substantial. Only the United States Department of Labor (DOL) regulates self-insured plans. Thus, prior to the Affordable Care Act, state regulated plans were often required to meet standards and provide mandated benefits that were not required by self-insured plans. However, many new requirements contained in the Affordable Care Act also apply to self-insured plans.

What this means for you: If you're unsure whether your plan is collectively bargained, self-insured or grandfathered, you should speak with your employer or plan administrator. If you still have questions regarding your plan, you may contact your state's insurance commission with information contained in your policy/certificate of coverage. By March 23, 2012, your employer and/or insurer is required to provide you with new documents that clearly explain your current plan benefits and other provisions such as appeals rights and plan administration. It's important to keep these documents together in a safe place. However, if you lose this information, your plan administrator/human resources department must provide you with a new copy though it may charge a fee for doing so.

Is It Too Early to Know How the Affordable Care Act Will Benefit You?

In some cases, laws are detailed as to how they should be put into practice; however, in other situations, laws create a framework in which the relevant agencies are either required or permitted to draft regulations or policies that interpret and expand upon the provisions in the law. Under the Affordable Care Act, there are at least forty provisions that require the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Department of the Treasury to create programs and draft rules/regulations that must be adhered to by insurers, employee benefit plans, individuals and businesses when purchasing, selling, creating and administering health plans. In many other instances, more informal policies and guidelines are required or recommended.

What this means for you: With so many issues still to be resolved, this article provides a brief overview of some of the most helpful provisions for those with chronic conditions such as epilepsy. To determine how the Affordable Care Act provisions are being implemented in your state, you should visit your state insurance commission's website on a regular basis. If you have specific questions, you should contact them directly by telephone or email. The National Association of Insurance Commissioners' (NAIC) and HHS websites contain helpful outlines and fact sheets regarding the Affordable Care Act. Contact information for all fifty states may be found at http://www.naic.org/state_web_map.htm. Also, see the Appendix for additional websites.

The following consumer benefits will make insurance more accessible for many individuals with epilepsy or other chronic conditions:

- **High Risk Pools** (preexisting condition insurance plans)
 - **Eligibility:** People with preexisting conditions, who have been uninsured for at least six months, will be eligible to receive health insurance coverage under a high-risk pool. (Illegal immigrants will not be eligible.)
 - **Maximum Limits:** Under the new high-risk pools, out-of-pocket maximums may not exceed \$5,950 for individuals or \$11,900 for families in 2010. (This amount may increase or decrease in accordance with the Health Care Savings Account Limits.)
 - **Premiums:** Premiums under the high risk pools may not exceed those charged for comparable plans for individuals without preexisting conditions. However, premiums may be increased based upon age. The maximum premium for the oldest age group may not exceed four times the premium for the youngest age group.
 - **State versus Federal Plans:** States were given the option to run their own Pre-Existing Condition Insurance Plan or use an HHS run plan. Twenty-one states have elected to have HHS administer their plans, while twenty-nine states and the District of Columbia have chosen to run their own programs. As of July 1, 2010, the national Pre-Existing Condition Insur-

ance Plan became available to applicants in the twenty-one states where HHS is operating the program. For the other twenty-nine states and the District of Columbia, coverage should be available for applicable residents by the end of the summer 2010.

The high-risk pool program will end on July 1, 2014 when insurance coverage is required to be available through the health care exchange (see page 55).

What this means for you: If you have been without health insurance for six or more months, you should review the information on your state's website to determine if you are eligible for coverage under the high-risk pool and learn how to apply. Those with epilepsy or other preexisting conditions who have been without insurance for six or more months should be eligible for coverage. However, coverage under the state's Children's Health Insurance Plan (CHIP), Medicare or Medicaid may be a better option.

If you have not been without health insurance for six months, you may be eligible for other state run programs. Also, if you have questions regarding eligibility and/or benefits for state run programs, you should contact the insurance commission for your state. Finally, if your insurer provides you with strong incentives to leave their plan and seek coverage under the high-risk pool, you should inform them they are not permitted to do so and file a complaint if you receive no response.

The following provisions, which in many cases apply to grandfathered plans, will assist individuals with chronic conditions in obtaining the insurance coverage they have needed for years:

- **Preexisting Condition Exclusions**

- **Preexisting Condition Exclusion**

Definition: A limitation or exclusion of benefits relating to a condition that existed before the individual signed up for coverage. This is true even if no medical advice, diagnosis, care, or treatment was received prior to the enrollment date.

- **Age Eighteen and Under:** Group health plans that begin on or after September 23, 2010 will be prohibited from using preexisting condition exclusions (PCE) to deny coverage for those under age nineteen. Individual plans in existence on March 23, 2010 are not required to comply.

- **All Ages:** By January 1, 2014, all group health plans will be prohibited from containing any PCE. Individual plans in existence on March 23, 2010 are not required to comply.



- **Dependent Coverage**

- **Plans beginning on or after**

- September 23, 2010 but prior to January 1, 2014:**

- For all plans that cover dependent children, coverage for adult dependent children through age twenty-five (married or single and under age twenty-six) must be provided at no additional cost if the child is not eligible to enroll in a health plan offered by his/her employer. Secretary of HHS, Kathleen Sebelius, formally requested that insurers begin to implement this provision prior to September 23, 2010 or the date the new plan year begins. Health insurance providers that cover the majority of privately insured individuals have agreed to implement this provision as soon as possible (perhaps as early as June 1, 2010). For a list of those providers, please see the following website: http://www.hhs.gov/ociio/regulations/adult_child_fact_sheet.html.

- **Plans beginning on or after January 1, 2014:**

- coverage for the participants' adult dependent children through age twenty-five (married or single and under age twenty-six) must be provided at no additional cost to the participant even if the child is eligible to enroll in other employer-provided coverage.

- **Denial of Dependent Coverage:**

- A mother's health plan may not deny dependent coverage because it is available through the father's plan and vice versa.

- **Coverage for grandchildren and/or**

sons- or daughters-in-law: the Affordable Care Act does not require coverage of either a dependent child's spouse or children (sons-in-law/daughters-in-law or grandchildren).

- **Coverage Beyond Age Twenty-five:** Some state laws require coverage for dependents over age twenty-five. If a state's law requires dependent coverage of single not married individuals, then this provision will apply to those dependents age twenty-six and older who meet the state laws' eligibility requirements.

- **Emergency Services**

- **Preauthorization Requirements Not Permitted:** Group plans must provide emergency services without requiring preauthorization even if the emergency services are provided in an out-of-network facility and/or by a non-participating physician or other health care provider.

- **Emergency Copayments/Coinsurance:** Copayments/coinsurance for an out-of-network provider may not exceed the copayments/coinsurance charged for an in-network provider. However, individuals may be required to pay the difference in cost between the out-of-network provider charges and the amount approved for in-network providers.

- **Lifetime and Annual Limits on Essential Health Benefits** (Essential Benefits*)

- **Essential Benefits:** "Essential Benefits" are certain core benefits, such as ambulatory services; emergency

services; hospitalization; maternity and newborn care; mental health and substance use disorder benefits including behavioral treatment; prescription drugs; rehabilitation and habilitation services and devices; laboratory services; pediatric services including oral and vision care; and preventive and wellness services and chronic disease management.

- **Lifetime Limits for Essential Benefits:**

- All plans that begin on or after September 23, 2010 may not establish lifetime limits on the dollar value of essential benefits.
- Those who reached their lifetime limit prior to March 23, 2010 must be notified they are now automatically eligible to enroll in plans currently available to those who participated in their prior plan.
- Employees may be provided notice regarding their child's eligibility.

- **Restricted Annual Limits for Essential Benefits Prior to 2014:**

- Annual limits on essential benefits will be limited until they are ultimately phased out in 2014. For example:
- The annual limit may not exceed \$750,000 for plans issued on or after September 23, 2010 but before September 23, 2011.
 - The annual limit may not exceed \$1,250,000 for plans issued on or after September 23, 2011 but before September 23, 2012.
 - The annual limit may not exceed

\$2,000,000 for plans issued on or after September 23, 2012 but before January 1, 2014.

– **Limits Regarding Individual Medical**

Procedures: While lifetime limits may not be imposed and annual limits will be regulated for essential benefits, it is permissible for all plans to place limits on the amount of money that may be reimbursed for individual medical procedures if these limits are reasonable.

– **Limits Regarding Nonessential**

Health Benefits: Limits may still be imposed upon those benefits not determined to be essential benefits by HHS.

**Essential benefits must be covered under all plans issued after September 23, 2010. However, until HHS issues regulations, it is uncertain as to exactly which treatments and services will be deemed essential. If regulations are not issued by September 23, 2010, insurers will be asked to act in accordance with what they view to be essential and states must be somewhat lenient in their interpretation until regulations are issued.*

• **Prohibition of Rescissions** (Cancellation of Coverage)

– **Permissible Rescission:**

- Plans may only rescind coverage in cases of fraud, intentional misrepresentation of a material fact or failure to pay premiums.
- Cancellation of a policy that will take place in the future (not the

past) is not considered a rescission and may be allowed if permission was granted by the state in which it was offered.

– **Expensive Medical Claims:** Health insurance coverage may not be canceled in response to someone submitting expensive medical claims.

– **Notice Requirement:** As of September 23, 2010, coverage may not be canceled without advance notice. It may only be canceled if an individual commits fraud or makes an intentional misrepresentation of material fact to the health plan (e.g., an adult denying the existence of a preexisting condition when applying for an individual plan).

– **Early Rescission Bans:** After receiving pressure from Democrats and Kathleen Sebelius (Secretary of HHS), many insurers have agreed to ban rescissions as of May 2010.

• **Limitation of Waiting Periods**

– Pursuant to the Affordable Care Act, as of January 1, 2014, waiting periods during which employees must work prior to becoming eligible for health insurance coverage may not exceed ninety days. In some instances, (e.g., HMO affiliation periods) some states may already have stricter waiting period restrictions in place; if so, the state law would supersede the Affordable Care Act's ninety-day limit.

• **Appeals Process**

– For plan years beginning on or after September 23, 2010, the Affordable

Care Act requires insurance plans to have rules in place regarding both an internal claims appeal process and an external review process. In some instances, insurers who already have external appeals provisions in place may retain the external review process currently in place.

What this means for you: Epilepsy advocates should closely monitor new regulations and guidelines that could impact important issues such as what is considered an “essential benefit.” These benefits must be included in all new individual, small and large group health plans. For example the type of prescription drug coverage and chronic disease management required as “essential” will be important to those with epilepsy and other chronic conditions.

Many of the provisions referred to above will be required to be put into place for plan years that begin on or after September 23, 2010. Most plans are issued on a calendar year basis in which case these benefits will be required for those plans that begin on January 1, 2011. Others such as dependent coverage for children under age twenty-six and bans on canceling coverage due to illness or expensive medical bills are already being implemented by many insurers.

If (on or after September 23, 2010) you receive a new plan certificate or policy that does not specifically contain language referring to the new rights and benefits required under the Affordable Care Act, you should contact your employer and/or insurer and ask why those provisions are not specifically mentioned. If it appears you are not receiv-

ing benefits to which you and your family are entitled, you should immediately contact your employer or plan administrator. If you are not satisfied with their response, you may wish to speak with a consumer services representative from your state insurance commission or file a complaint or appeal.

Wellness Programs and Preventive Care Should Lead to Decreased Spending Later

In many instances, epilepsy is “idiopathic;” meaning doctors are unable to determine



Many chronic conditions that are costly to treat may be prevented if people live healthy lifestyles and receive preventive care on a regular basis.

what caused epilepsy to manifest itself. However, many chronic conditions such as diabetes and heart disease that are costly to treat may be prevented if people live healthy lifestyles and receive preventive care on a regular basis. Unfortunately, those who live with epilepsy are not immune from other illnesses.

Most health plans will now be required to cover preventive care services at no cost to the insured and report to HHS what programs, services, and incentives are being made available to encourage those who are insured lead healthier lives. For plan years that begin on or after September 23, 2010, group health plans must submit reports on wellness programs that address the following issues: diabetes prevention, healthy lifestyle support, heart disease prevention, nutrition, physical fitness, smoking cessation, stress management and weight management. Grandfathered plans are not required to provide these services but many are already doing so.

What this means for you: Those with epilepsy should take advantage of new benefits that encourage participation in all types of wellness programs since they are as prone to heart disease as others and perhaps

more prone to osteoporosis, depression, anxiety and social isolation. Annual wellness visits result in early detection and treatment of many illnesses. Aerobic activities make your heart stronger and release tense muscles. In addition to improving one's physical health, for many individuals with epilepsy, aerobics classes often decrease seizure frequency, provide a place to socialize, and help reduce anxiety and depression.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Many of the rules contained in HIPAA that prohibit discrimination based on one's health are contained in the Affordable Care Act. Thus, an individual with epilepsy should not be discriminated against for not participating in a sporting event his doctor has determined to be potentially dangerous (e.g., swimming or skiing).

While discrimination based on health is not permitted, currently individuals may receive a "reward" or incur a "penalty" equal to or less than 20 percent of the cost of the health insurance coverage. For plan years beginning on or after January 1, 2014, health insurance premiums for those who participate in wellness programs may be decreased by 30 percent and perhaps as much

as 50 percent if HHS, the DOL and the Treasury determine this to be appropriate.

What this means for you: Technically, there is no limit imposed upon incentives or penalties if they are based upon actions rather than results (e.g., attending a health education program). If incentives are granted for satisfying certain health requirements, then alternatives must be offered or waivers provided for those individuals who would find the requirements extremely difficult or dangerous. However, determinations as to what is a comparable alternative may be subjective.

The Health Insurance Exchange (“the Exchange”)

All states must enable individuals and small group health plans to purchase insurance through the Exchange by January 1, 2014. For those states that opt not to create and service an Exchange, HHS will run the Exchange. Small group businesses may include one hundred or fewer employees; however, prior to January 1, 2016, states may limit the exchange to individuals and small businesses with fifty or fewer employees. Finally, as of January 1, 2017 states may permit employers with more than one hundred employees to participate. States may offer more than one exchange based upon geographic area and/or join together with other states to form a multi-state exchange. Deductibles are limited to \$2,000 per individual and \$4,000 per family but may be increased subject to inflation.

Prior to selling a plan through an Exchange, insurers must submit their health plans for approval as a qualified plan. Qualified plans must at a minimum cover all essential health benefits. There are four types of qualified plans that differ based upon the percentage of cost the plan pays: bronze (60 percent), silver (70 percent), gold (80 percent) and platinum (90 percent). The plans will be reviewed by the exchange to ensure adequate provider networks (medical professionals whose services will be covered) and coverage of all essential benefits as discussed on pages 51 and 52.

Plans may vary based upon different provider networks and coverage of different nonessential benefits. In addition to plan approval, each Exchange must provide the following: (a) outreach to the communities to encourage enrollment, (b) customer service representatives who respond to health insurance questions and counsel small businesses and individuals regarding available tax credits and (c) the creation and maintenance of a website that provides a comparison of all available standardized health plans.

The Affordable Care Act does not prohibit insurers from offering insurance outside the Exchange. However, when up and running effectively, the Exchange will enable those who have had difficulty obtaining affordable health insurance to purchase insurance through the Exchange. Based on income, many individuals will be entitled to premium

assistance and decreased copayments and deductibles.

Premium Subsidies and Financial Assistance for Out-of-Pocket Health Care Costs

When insurance becomes available through the Exchanges, individuals and families who earn less than 400 percent of the poverty level will be able to receive tax credits toward the cost of health insurance if they purchase it through an Exchange. Additionally, individuals and families whose income is equal to or less than 250 percent of the poverty level may receive financial assistance regarding copayments and deductibles.

What this means for you: It is uncertain how plans sold through the Exchange will compare to employer-provided health plans not contained under the Exchange. While we know these plans must include coverage for prescription drugs and chronic disease management, we don't know what restrictions may apply. The majority of people will still receive health insurance through large employer-based plans and benefits will vary from plan to plan. Because plans available under an exchange may be less comprehensive than employer-based plans, if your health insurance coverage is terminated, you should still be provided the opportunity to continue your employer-based coverage in accordance with the COBRA provisions. If you lose your job on or after January 1, 2014, you should compare your COBRA benefits and premiums with those available through the Exchange. It is likely that as time goes on, small group employers will

purchase through an exchange and large groups will retain their plans.

Affordable Coverage, Expanding Eligibility for Medicaid and the State Children's Health Insurance Program (CHIP)

■ Medicaid and CHIP

The Affordable Care Act expands coverage to many who are currently uninsured by revising Medicaid eligibility requirements. By January 1, 2014, the date health care exchanges must be up and running, without regard to parental status or disability, states will be required to provide Medicaid coverage for children and adults from families whose incomes do not exceed 133 percent of the poverty level (approximately \$14,404 for an individual and \$29,326 for a family of three in 2009) or the current state eligibility level as of March 23, 2010, whichever is greater.⁵ Thus, when implemented, adults who meet the income criteria and are not covered under Medicare Part A and/or B, including those who do not have children, will now be eligible for Medicaid. Another significant effect of this provision is that many individuals who will be eligible for Medicare twenty-four months after being found to be disabled might qualify to receive Medicaid in the interim based on income. Additionally, while January 1, 2014 is the date new eligibility requirements must take effect, states may begin implementing this standard prior to that time.

While states may wait until 2014 to expand the eligibility requirements, they may not



impart eligibility standards for Medicaid or CHIP that are more restrictive than those in existence on March 23, 2010. Eligibility standards for adults with Medicaid must remain in place until the new health care exchanges become operational (January 1, 2014). If a parent with children under age nineteen is newly eligible for Medicaid as a result of the higher income limits, then in order to obtain Medicaid coverage he/she must also enroll all his/her children unless they are already covered under another health plan.

The Affordable Care Act also requires cover-

age of barbiturates (e.g., Phenobarbital) and benzodiazepines (e.g., Klonopin or valium/diazepam) as of January 1, 2014.

■ CHIP

For children covered under Medicaid or CHIP, eligibility standards must remain in effect through 2019. Currently, approximately seven million low-income children receive health insurance coverage under CHIP. Each state will receive a set amount allotted for its CHIP program. Once the Exchanges are running (January 1, 2014), if a state uses all its federal money allocated for CHIP, then children who are eligible but not accepted, due to lack of funds, will receive tax credits so they may enroll in comparable coverage through an Exchange.

What this means for you: Because many, though not all, individuals with disabilities are low-wage earners, it is expected that a high percentage of individuals newly eligible for Medicaid will be those with epilepsy or other chronic conditions. Additionally, many children who currently receive health insurance under CHIP will become eligible for Medicaid. In those situations, children should be transferred from CHIP into Medicaid because the Medicaid benefits are more comprehensive and out-of-pocket costs less expensive.

Since states may choose to begin expanding Medicaid eligibility at any time now, you should review information provided on the Centers for Medicare & Medicaid Services (CMS) website, your state health department's website, or your state insurance commissioner's website. You may contact

The Affordable Care Act promotes early detection and treatment of illnesses and chronic conditions such as epilepsy before they spiral out of control.

the commission directly if you have questions regarding what state programs may help you receive coverage at an affordable price.

Medicare

In 2010, Medicare provides health insurance for thirty-nine million people age sixty-five and older and eight million people under age sixty-five who are permanently disabled. Many of the Affordable Care Act changes to Medicare impact providers more than participants.

Medicare will begin covering annual wellness visits and services (including mammographies and colonoscopies) at 100 percent of the Medicare approved amount and wellness programs will be developed. Financial assistance will be provided to enable those living in institutions to return home and states will be encouraged to develop "health homes" to coordinate care for Medicare and Medicaid participants. Additionally, prescription drug coverage will be made more affordable.

Medicare law creates a standard Medicare Part D prescription drug plan. In 2010, this plan contains a \$310 deductible and a 25 percent coinsurance until participants re-

ceive \$2,830 in prescription drug coverage. Once Medicare participants reach this limit, they enter a gap in coverage commonly referred to as the "donut hole" when they are required to pay 100 percent of all drug costs. Once out-of-pocket prescription drug costs have reached the threshold (\$4,550 in 2010), catastrophic coverage begins at which point payments are reduced to \$2.50 per generic drug and \$6.30 per brand name drug or 5 percent co-insurance, whichever is greater.

Changes in the Medicare Part D reimbursement will not begin until January 1, 2011 but those who reach the "donut hole" in 2010 will automatically receive a check for \$250 tax-free. Through the end of 2010, if beneficiaries enter the "donut hole", they must pay 100 percent of the cost of covered drugs until they reach the catastrophic threshold. In 2011, those who enter the "donut hole" will receive a 50 percent discount on brand name drugs they purchase during the "donut hole." The discount will increase gradually and in 2020, the "donut hole" will disappear and Medicare will pay 75 percent of the cost of brand name drugs, and generic drug prices will be discounted as well.

Additionally, according to the Center for Medicare Advocacy, it is anticipated that coverage will begin in 2013 for benzodiazepines and barbiturates used for the treatment of epilepsy, cancer or chronic mental disorders.

What this means for you: At age sixty-five, those who worked or whose spouses worked for at least ten years will automatically be enrolled in Medicare Part A that provides coverage for inpatient hospital stays. Medicare Part B provides insurance for outpatient health services but for most individuals, monthly payments are required. If your income is at or below a certain level, state Medicare Savings Programs may help pay for your Medicare Part A or B premiums. Based on income and assets, Medicare Savings Programs may also provide assistance with payment of deductibles, coinsurance and copayments.

Prescription drug costs can wreak havoc for many individuals on Medicare who are being treated for epilepsy or other chronic conditions. If you purchase a Medicare Advantage Plan, you may receive prescription drug coverage. If you have limited income and resources and think you may be eligible for financial assistance regarding the cost of the Medicare Part D prescription drug program, you should apply for "Extra Help" through the Social Security Administration. Those who qualify for "Extra Help" will not be subject to any gap in prescription drug coverage. If you have questions or wish to apply, you may go to your local social security office, call 1-800-777-1213 or complete an

application on-line at [Application for Extra Help with Medicare Prescription Drug Plan Costs \(SSA-1020\)](#).

Medicare Part D participants should be aware that while there is a minimum benefit for all Part D prescription drug plans, companies offering this coverage have substantial leeway in how they structure their benefit. Epilepsy drugs covered under one plan may be denied under another Part D plan. When selecting any type of Medicare Plan, you should ensure that your doctors (especially neurologist or epileptologist) and the medicines you take (or may need in the future) are covered under this plan. As several Medicare scams have been reported, Medicare participants should not provide any information to individuals who call to request personal information alleging that this information is necessary in order for them to receive the \$250 rebate check. Participants who receive suspicious telephone calls regarding their rebate check should report this to Medicare by calling (800) 633-4227.

According to Kathleen Sebelius, whether you have a Medicare Advantage Plan through a private insurance company or an original Medicare Plan you will not lose coverage for any guaranteed Medicare benefits as a result of the Affordable Care Act. Others question whether cuts in Medicare funding will ultimately result in fewer doctors and other providers who are willing to accept Medicare. Only time will tell.

The following Kaiser Family Foundation web

page also provides contact information that may be helpful to you as you decide what Medicare options would be best for you. http://www.kff.org/medicare/7067/med_prescription.cfm. If you have general questions regarding Medicare you should see www.medicare.gov or call 1-800-633-4227.

Community Living Assistance Services and Supports (CLASS) Long-Term Care Insurance

The creation of CLASS will enable many individuals with preexisting conditions such as epilepsy to purchase long-term care insur-



ance. Individuals may not be denied coverage due to preexisting conditions. Premiums may not vary based on medical conditions but they may vary based on age.

The CLASS benefits may be used for a variety of services and equipment ranging from wheel chairs and home health aids to nursing home coverage. All working individuals, age eighteen or older, may voluntarily enroll in the CLASS program. Employers may enroll all their employees and those who do not want this coverage may opt out. However, those who opt out and join at a later time will be subject to a penalty. Premiums have not yet been determined except that premiums for full-time students and those whose incomes fall below the poverty level may not exceed \$5 per month. To be eligible for benefits under CLASS, individuals must have been enrolled in the program for at least five years (sixty months). It's unclear exactly what the premiums will be; however, the benefits must be at least \$50 per day. That equals less than one-third of the cost of one day at a nursing home but a much higher percentage of the cost of an adult day care.⁶

What this means for you: While many factors regarding the CLASS implementation have yet to be determined, long-term care insurance will be provided to all those with preexisting conditions such as epilepsy. Increased benefits will be provided to those with more serious cognitive or functional delays, and for all participants there will be no lifetime or monetary limit.

Conclusion

The Affordable Care Act promotes early detection and treatment of illnesses and chronic conditions such as epilepsy before they spiral out of control. Many of its programs illustrate the lawmakers' intent to curb the costs of health care in the United States and to make people live healthier lifestyles. For providers, it increases the need for standardization of electronic billing and development of health information technology programs to enable easy reporting of medical information for analyses of various medical services and procedures. It emphasizes the need for increased preventive care and exercise. Ideally, this will decrease the cost of treatment for serious conditions that are often detected late or not properly treated due to lack of health insurance and other high costs. While the end results will be uncertain for years, the enactment of the Affordable Care Act was the first but very significant step toward the goal of providing high-quality health care for all Americans.

Abby Nash is an attorney whose job entails reviewing insurance products and pending legislation and responding to questions and concerns regarding health insurance. She participated on the New York State Inter-agency Autism Task Force and is currently an agency representative on the Early Intervention Coordination Council.

Appendix

Suggested websites for updated information on health care reform:

http://www.naic.org/state_web_map.htm
<http://healthreform.kff.org/>
<http://www.familiesusa.org/heath-reform-central/>
<http://www.medicare.gov>
<http://www.healthcare.gov/>

Notes and Citations

1. "Courts Will Examine PPACA's Constitutionality," Managed Health Care Executive, June 1, 2010.
2. May 11, 2010, New York Times, Page A10.
3. Permitting an individual to reenroll in the plan or adding a new employee to a health insurance policy will not impact grandfathered status. Additionally, for plans that covered dependents prior to March 23, 2010, adding coverage for the dependent of a participant or new employee will not impact their grandfathered status.
4. Medicaid and Children's Health Insurance Program Provisions in the New Health Care Reform Law, modified April 7, 2010, Kaiser Family Foundation
<http://aspe.hhs.gov/poverty/09fedreg.shtml>
5. Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA) (2010) CRS Report for Congress 7-5700, May 3, 2010
6. Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA) CRS Report for Congress 7-5700, May 3, 2010