



Now You Know

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Volume: 5 Issue: # 1

January 10, 2011

Welcome to *Now You Know*, an e-publication from ACHIEVA, Pittsburgh's leader in providing **lifelong supports** for individuals with intellectual and developmental disabilities and their families.

Correction on the Time: ACHIEVA's Link for Upcoming Parent-to-Parent Webinars Scheduled from 12 - 1 p.m.

ACHIEVA Parent-to-Parent webinars are scheduled from **12 - 1 p.m.** on the following dates:

- Jan. 14 - Extended School Year
- Feb. 10 - Advocacy 101
- Mar. 10 - Grassroots Advocacy

Please [click here](#) to register for the webinars.

Office of Developmental Programs Statewide Training Report for Fiscal Year 2009-2010

From the Office of Developmental Programs

The Office of Developmental Programs (ODP) has released its Statewide Training Report for FY 2009-2010. The Statewide Training Report gives an account of the trainings delivered throughout Pennsylvania in support of ODP's mission of helping people have everyday lives.

Please [click here](#) to review the statewide report.

Please [click here](#) to visit ODP's website.

How will the Affordable Care Act Expand Health Care Coverage?

From The Arc of the United States

The Affordable Care Act (ACA) will provide health insurance coverage to millions of Americans who are presently uninsured or underinsured. By 2014 year, 32 million more

Promenade Auction

Saturday, March 26, 2011
Westin Convention Hotel

**ACHIEVA's 13th Annual
Million Dollar Golf Outing**
Monday, August 22, 2011

Valley Brook Country Club

Contact Connie Reilsono at
412-995-5000 x404 or

email to

creilsono@achieva.info

**Choose ACHIEVA as
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Americans will have access to health insurance through a combination of new private insurance market reforms, Medicaid expansions, employer requirements and individual responsibilities.. Each of these changes promises to be particularly beneficial for people with disabilities.

This issue of National Policy Matters addresses the cornerstones of the ACA's coverage expansions:

Pre-existing Condition Insurance Plans
Medicaid Expansion
Health Insurance Exchanges
Individual Responsibility

PRE-EXISTING CONDITION INSURANCE PLANS

What are Pre-existing Condition Insurance Plans? Also known as "high risk pools," it is basic health coverage for people who have been turned down for health insurance because of a pre-existing condition. The new Pre-Existing Condition Insurance Plan (PCIP) is a bridge program to make health coverage available to those who have a pre-existing condition and who have gone without coverage for at least six months. The PCIP offers transitional coverage until 2014 when health insurance exchanges become available and pre-existing condition exclusions are prohibited.

What is a pre-existing condition exclusion? It is a limitation or exclusion of a benefit based on the fact that a condition was present before the date of enrollment in coverage (or a denial of enrollment), whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. For example, people who are denied coverage because they already had a heart defect or seizure disorder when they applied.

Is there a plan in every state? Yes. Each state has a plan and some states have requested the federal government run their PCIP. Other states have requested to run their own programs. In 24 states, the federal government is operating the plan.

Who is eligible? People with pre-existing conditions who are uninsured 6 months prior to applying for coverage in the plan are eligible. They need to be a United States citizen and a resident of the state in which the PCIP operates. They must also document that they have been turned down, have good reason to believe they would have been turned down for insurance based on their pre-existing condition or show they were offered coverage, but the policy excluded coverage of treatment for pre-existing conditions such as diabetes, seizures or heart defects.

Are the plans really expensive? The premiums vary depending on the age of the person and geographic locations. States determine the premiums and cost sharing. However, the ACA does set some limits to ensure that they are roughly comparable to each states individual market rates. PCIP premiums won't cost more because of medical conditions and they are not based on income eligibility like Medicaid.

What is the out-of-pocket limit? In 2010, the limit for the federal plans was \$5,950. This includes the deductibles, co-pays and other costs (excluding premiums) that an individual would pay. To view more information about the state plans, please visit the following website: <http://www.healthcare.gov/law/provisions/preexisting/index.html>.

What benefits does the PCIP provide? PCIP covers major medical and prescription drug expenses. It will cover at least the following categories:

- (1) Hospital inpatient services
- (2) Hospital outpatient services
- (3) Mental health and substance abuse services
- (4) Professional services for the diagnosis or treatment of injury, illness or condition

- (5) Non-custodial skilled nursing services
- (6) Home health services
- (7) Durable medical equipment and supplies
- (8) Diagnostic x-rays and laboratory tests
- (9) Physical therapy services (occupational therapy, physical therapy or speech therapy)
- (10) Hospice
- (11) Emergency services and ambulance services
- (12) Prescription drugs
- (13) Preventive care
- (14) Maternity care

Can you see any doctor that you want? No. The plans may establish a list of providers. However, they must demonstrate that they have a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible to people.

MEDICAID EXPANSION

The ACA greatly expands the number of people who are eligible for Medicaid. The law establishes a new eligibility group that all states participating in Medicaid must cover as of January 2014.

Who is eligible? Low income individuals who are not otherwise eligible under mandatory eligibility categories and have incomes below 133 percent of the Federal Poverty Level. This means that eligible people must NOT be age 65 or older, pregnant, entitled to or enrolled in benefits under Medicare Part A or Part B, SSI beneficiaries or other mandatory groups.

What is 133 percent of the Federal Poverty Level? For an individual in 2010, it is about \$14,000 per year. It varies by size of the family as shown below:

\$14,403 (Individual), \$19,378 (2), \$24,352 (3), \$29,326 (4), \$34,300 (5), \$39,274 (6), \$44,249 (7) or \$49,223 (8).

How is eligibility changed? Currently, to qualify for Medicaid, applicants must meet both asset and income thresholds in most states. In 2014, there will not be an asset test when determining eligibility for this new group. This means that items like cars, small savings accounts or life insurance policies will not be considered when determining eligibility. Income will also be counted differently. Social Security benefits will not be counted as income. This will mean that individuals newly eligible for SSDI in the two year waiting period for Medicare may be eligible for Medicaid during that period.

Does the Medicaid expansion help people seeking long term services and supports? No. The expansion does not change current eligibility rules for home and community based services. People must meet current rules for determining financial eligibility, including any asset test used in their state and the standards for having a disability and qualifying for services.

When does the coverage expansion take effect? In 2014 all states must expand coverage. However, the Centers for Medicare and Medicaid Services (CMS) will provide guidance allowing states to start earlier and to phase in coverage beginning in April, 2010.

Who is paying for the expansion? The federal government is paying 100 percent of the extra costs to cover the newly eligible individuals for the first three years. Federal funding: 2014 (100 percent), 2015 (100 percent), 2016 (100 percent), 2017 (95 percent), 2018 (94 percent), 2019 (93 percent) and 2020 (90 percent).

HEALTH INSURANCE EXCHANGES

The ACA requires the establishment of health insurance exchanges which are a market

place where individuals and small businesses can purchase insurance. Each state has flexibility on how to establish the exchanges. States can decide to run regional exchanges or can let the federal government run the exchange in its state. The ACA will provide general guidance on what the exchanges must do, what the federal and state role will be and what the health insurance plans must look like.

What essential benefits must the exchanges provide?

- Hospitalization, emergency services, ambulatory (i.e. outpatient) services
- Prescription drugs and laboratory services
- Rehabilitative and habilitative services and devices
- Mental health and substance abuse disorder services including behavioral health treatment
- Preventative and wellness services and chronic disease management
- Pediatric services including dental and vision care
- Maternity and newborn care

What are the levels of coverage? Plans that offer essential benefits can offer varying levels of coverage:

- Bronze plan will pay for 60 percent of the cost of covered benefits
- Silver plan will pay for 70 percent of the cost of covered benefits
- Gold plan will pay for 80 percent of the cost of covered benefits
- Platinum plan will pay for 90 percent of the cost of covered benefits

What is the federal role? The HHS Secretary will:

- Ensure that benefits are balanced among categories
- Establish that benefits are not denied based on individuals' "present or predicted disability, degree of medical dependency, quality of life, age or expected length of life."
- Develop uniform explanation of coverage documents and standardized definitions including the following key terms: rehabilitation and habilitative services and devices; devices intended to include durable medical equipment and behavioral health treatment (intended to encompass autism treatments).

What must the exchanges do?

- Certify qualified health plans, provide required information and assistance to consumers and determine eligibility for federal premium credits and cost-sharing reductions
- Operate a risk adjustment system and implement the requirement that issuers calculate risk across all of their health plans inside and outside an exchange
- Implement insurance market reforms
- Build capacity at the state level to enforce the new requirements
- Ensure non-discrimination
- Establish consumer education campaigns
- Expand technical capabilities and create accessible electronic information systems
- Create a seamless eligibility and enrollment systems

Will the coverage be affordable? There are subsidies for low income individuals and limits on out of pocket expenses for covered benefits.

Specifically all group plans must limit out of pocket expenses for covered benefits using the same out of pocket limits that apply to high deductible plans that are used with Health Savings Accounts (\$5,950 for an individual and \$11,900 for a family in 2010).

In the small group market, they must limit deductibles to \$2,000 for individuals and \$4,000 for families in 2014. After that, the limits will be updated each year as average premiums increase.

INDIVIDUAL RESPONSIBILITY

The ACA requires that individuals who can afford to do so maintain a minimum level of health insurance coverage or else pay a tax penalty.

Why is it in the law? The goal of the ACA is to increase the number of people who are insured. The main purpose of the requirement is to encourage people to accept coverage they are eligible for or to purchase coverage.

Covering everyone helps bring the costs of health care down. It is also important because insurers will be required to offer coverage to everyone who applies regardless of their health status or pre-existing conditions.

If people are not encouraged to purchase coverage then the concern is they might wait until they get sick, have a need for coverage and that would drive up costs.

Are children required to be covered? Yes, the parents or caretakers must secure coverage for their children.

Is everyone subject to a penalty for not securing coverage? No, a number of people are exempt including:

- No access to affordable coverage
- A short coverage gap (less than three months)
- American Indian tribes and other hardship exemptions designated by the HHS Secretary

What is acceptable coverage? Government sponsored health plan (Medicare, Medicaid, Children's Health Insurance Program (CHIP) or TRICARE), employer based coverage and individual coverage (including the health insurance exchanges).

What is the penalty? The penalties are administered by the Internal Revenue Service and change each year.

Tax penalties for no coverage are the larger of:

2014: \$95 per adult plus \$47.50 per child under age 18 up to a maximum of \$285 or 1 percent of income

2015: \$325 per adult plus \$162.50 per child up to a maximum of \$975 or 2 percent of income

2016: \$695 per adult plus \$347.50 per child up to a maximum of \$2,085 or 2.5 percent of income

When does it take effect? The individual responsibility provisions take effect in 2014.

What help is available for moderate income people? There are premium subsidies for low and moderate income individuals. Premiums are the amount of money that you must pay for a health insurance plan. It is usually paid monthly, quarterly or yearly by you or your employer. It does not include co-pays, deductibles or other out of pocket costs.

Subsidy amounts are presented for a family of four in the table below:

Income as Percent of Poverty; Annual Income for a Family of Four; Premium Contribution

as a Percent of Income; Monthly Dollar Amount for Family of Four:

133 percent; \$29,326; 3 percent; \$ 73

150 percent; \$33,075; 4 percent; \$110

200 percent; \$44,100; 6.3 percent; \$232

250 percent; \$55,125; 8.05 percent; \$372

300 percent; \$66,150; 9.5 percent; \$524

350 percent; \$77,175; 9.5 percent \$610

400 percent; \$88,200; 9.5 percent; \$608

Who are eligible for the subsidies? Premium subsidies will be available for individuals and families with incomes between 133 percent and 400 percent of poverty (\$14,404 to \$43,320 for individuals and \$29,326 to \$88,200 for a family of four).

How will the subsidies work? These payments will be made directly to insurance carriers on behalf of eligible individuals and families. It is only available to people purchasing coverage in the health insurance exchanges. The subsidies will be on a sliding scale. For example a family with income at 133 percent of poverty (\$29, 326) would have the amount of premiums they are responsible for capped at 3 percent of their income or \$879 a year (\$73 each month).

Is there any assistance with out of pocket costs? Generally people with incomes below 400 percent of poverty will have limits on how much out of pocket expense they will have. The premium subsidy is a sliding scale offering more assistance to lower income individuals.

HELPFUL LINKS

Health Care for People with Disabilities:

<http://www.healthcare.gov/foryou/disabilities/index.html>

Find Insurance Options: <http://finder.healthcare.gov/>

Pre-Existing Condition Insurance Plan (PCIP):

<http://www.healthcare.gov/law/provisions/preexisting/index.html>.

Magee-Womens Hospital of UPMC Offers the "Social You / Sexual You" Series

The "Social You, Sexual You" is a series of programs for parents and their children with intellectual, developmental and physical disabilities. The program is being offered at Magee-Womens Hospital of UPMC in Pittsburgh.

Growing Up Together for Daughters and Sons with Special Needs

This three-part series will explore social and sexual development. **The first session on February 1, 2011 is only for parents or caregivers.**

Parents and their children (ages 10 - 18) will learn about physical, emotional and social changes of puberty. Information on hygiene, self-care, communications and social skills will be offered.

Cost is \$50 per family. Offered on Tuesdays, February 1, 2011 to February 15, 2011 from 6:30 p.m. - 8:30 p.m.

Social Interactions for Youth with Special Needs

This three-part Circles ® curriculum will be used to involve children (ages 10 - 18) and their parents in discussion activities related to touch, talk and trust to assist in the development of appropriate social behaviors.

The first session on May 17, 2011 is only for parents or caregivers.

Cost is \$50 per family. Offered on Tuesdays, May 17, 2011 to May 31, 2011 from 6:30 p.m. - 8:30 p.m.

Sexual Responsibility for Teens and Young Adults with Special Needs

This three-part program will help young adults (ages 14 and older) understand the many aspects of sexuality. Topics to be discussed will include sexual myths, abstinence, pregnancy prevention, sexually transmitted diseases, decision-making and healthy dating relationships.

The first session on September 20, 2011 is only for parents or caregivers.

Cost is \$50 per family. Offered on Tuesdays, September 20, 2011 to October 4, 2011 from 6:30 p.m. - 8:30 p.m.

For more information or to register, please call 412-802-8299 or visit www.magee.upmc.com and click on "classes".

Please [click here](#) to view the flyer.

Sincerely,

Nancy Murray
President, The Arc of Greater Pittsburgh
serving Allegheny and Beaver Counties

ACHIEVA (412) 995-5000 x424
nmurray@achieva.info