



**Answers to 20 Often Asked Questions
Raised By Those with Disabilities
About the One-Year Old Health Reform Law**

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The report is dedicated to the millions of Americans that are living with
Spinal Cord injuries and disorders, whom United Spinal Association and its subsidiaries –
the National Spinal Cord Injury Association, New Mobility Magazine, VetsFirst and Users First –
proudly serve and represent each day.

Introduction

On March 23, 2011, “The Patient Protection and Affordable Care Act” (P.L. 111-148/152) celebrated its first anniversary and there remains significant confusion among those with disabilities about the law, including concerns as to whether it even still exists. In honor of this milestone in the life of this landmark legislation so important to those with disabilities and chronic illnesses and more than 32 million uninsured Americans, the United Spinal Association is taking this opportunity to compile answers to the most often heard queries we have received from our members and others about the law, which also is widely referred to as the “Affordable Care Act” (ACA) or the health reform law or, by its detractors, as “Obamacare.”

Like the game so many of us have played on those long car trips, we identified “20 Questions” that have often been raised about the law’s status, provisions, benefits and impacts. These questions and answers are presented in no particular order of importance, as the definition of “importance” is in the eyes of the beholder.

While the law is steadily being implemented, several of its key provisions will not become effective until 2014. But we hope our responses will assist readers to better appreciate the structure and benefits of the new law and what lies ahead. At the conclusion of the questions and answers presentation, we provide the reader with an easy-to-read table that highlights the major provisions of the Affordable Care Act and the timeline for their implementation.

The United Spinal Association remains vigilant in its efforts to ensure that the Affordable Care Act fulfills its promise for more accessible, affordable high quality care for those with spinal cord injuries and disorders. And we remain focused in our efforts to avert disastrous consequences to Medicare, Medicaid and Social Security coverage for our constituents and to help identify better and more responsible ways to reduce the nation’s deficit without adding unfairly to the burden of those most vulnerable in our society.

United Spinal conveys its sincere gratitude to Barbara Kornblau, JD, OTR, FAOTA, for her invaluable assistance in the development of this report. Ms. Kornblau’s efforts were instrumental in securing the inclusion of several provisions in the Affordable Care Act that respect those with disabilities as a health disparity population.

We welcome your feedback on this United Spinal Association report and any additional questions you may have about the Affordable Care Act at (202) 556-2076, EXT. 7101 or 7103, or by e-mail at jisaacs@unitedspinal.org or amorris@unitedspinal.org.

Questions and Answers

1. Repeal and De-funding of the Law

Question: There has been a lot written about Republican-led efforts in Congress to repeal or block funding the new law. Didn't the House of Representatives kill the health reform law?

The U.S. House of Representatives, which has a Republican majority, did vote along highly partisan lines to approve H.R. 2, a bill they labeled rhetorically the “Repealing the Job-Killing Health Care Law Act,” though there is no conclusive evidence that supports the job-killing claim. The bill then went to the Democratic-led U.S. Senate where it was rejected. So the Affordable Care Act (ACA) remains the law of the land.

The House Republicans also voted to pass H.R. 1, a spending reduction bill. The proposal included significant cuts to many government programs including prevention programs, research programs at the National Institutes of Health (NIH), the Centers for Disease Control (CDC), the Food and Drug Administration (FDA) and programs to train the workforce to treat people with disabilities. The bill also would have de-funded major provisions of the health care reform law. The Senate, however, rejected H.R. 1 as well.

So, Congress has neither seriously de-funded nor repealed the Affordable Care Act to date and the law continues to be implemented pretty much on schedule. In fact, had a repeal bill passed in both houses of Congress, President Obama intended to veto the legislation and send it back to the Senate, where Republicans would not likely have the number of votes needed to override the President's veto.

2. Health Care Coverage Options Under the Law

Question: If I do not get coverage through my employer and am not eligible for Medicare or Medicaid, what are my options for affordable coverage under the law?

You have several options. Under the Affordable Care Act, Medicaid eligibility will expand in 2014 to include all legal residents with incomes up to 133% of the federal poverty level (or \$14,484 for an individual and \$29,725 for a family of four in 2011). Thus, after that date, you might become eligible for Medicaid coverage. If not, you will be able to purchase insurance through “insurance exchanges” that states will create under the law to match people with affordable health insurance plans.

If you have a pre-existing condition, the states or the federal government are providing coverage through pre-existing condition insurance plans (PCIPs) until after 2014, when pre-existing condition clauses in health insurance policies will become illegal. Currently, the federal government operates programs in 23 states and the District of Columbia and 27 states operate their own PCIPs. In the interim, many of the state high risk insurance programs include premium subsidies to make insurance coverage more affordable in the form of premium tax credit or cost-sharing reductions or other premium assistance based on income.

3. The Law's Constitutionality

Question: I've seen reported that the courts have found the health reform law unconstitutional. So is it dead?

No it is alive and well for now. The two key issues that have been the bases of suits claiming the law to be unconstitutional are whether federal law would be exceeding its authority by requiring that: (1) everyone in some form or fashion owns health care coverage and (2) states must expand the eligibility of their Medicaid programs. To date, three federal district courts have upheld the law's constitutionality and two others have ruled against the law.

A Florida Court decision, however, is the only one that has ruled the entire law unconstitutional based on the law's provision requiring all individuals to own health insurance. If the Florida court decision is upheld it could mean the demise of the entire law as there is no severability clause in the law so that finding the single provision unconstitutional would mean the overall law would be deemed unconstitutional.

The Obama administration has initiated an appeal of the Florida decision. The arguments boil down to whether the individual mandate can be considered an unfair tax or a penalty. The Administration had argued in federal court that the mandate does not overstep the boundary of the commerce clause in the constitution. It ultimately will be up to the United States Supreme Court to make a final decision on the matter.

A Virginia court found that the federal government cannot require the states to expand eligibility in their Medicaid programs, arguing that it would usurp the states' sovereign authority. This case is also being appealed by the federal government on the grounds that the Medicaid program is a federal-state partnership and that the federal government is prepared to commit its fair share to underwrite these expansions.

Currently, most governors are proceeding with the planning necessary to implement the ACA provisions in their states, but a number of Republican governors and/or state legislatures, including Alaska, Florida and Louisiana, have refused federal planning support and taken a wait and see approach as the appeal process inches forward. Ultimately, these lawsuits will have to be decided by the United States Supreme Court and that is not likely to happen until 2012, during its next session.

4. Obtaining Insurance as A High Risk Patient

Question: I'm considered a high-risk patient and until 2014 my pre-existing condition could preclude my ability to obtain insurance. What can people like me do for coverage until then and will it be affordable?

If you have a pre-existing condition, the law requires the states (or the federal government on behalf of a state) create Preexisting Condition Insurance Plans (PCIPs) that you can purchase. The federal government currently operates PCIP programs in 23 states and the District of Columbia,

while the remaining states run their own programs. On November 5, 2010, HHS announced new plan options for 2011 that include lower premiums for the federally administered programs. These plans are for individuals with pre-existing conditions who have been uninsured for at least six (6) months. Premiums are based on the standard population's health status. Annual out-of-pocket costs are capped at \$5,950 for individuals and \$11,900 for families.

5. Pre-Existing Condition Clause Elimination

Question: The law already disallows insurers from discriminating against children up to age 26 by denying them coverage based on pre-existing conditions. This protection will be extended to all policies in 2014. Though my insurer will not be able to deny me coverage based on my condition, can it charge me higher premiums or require a separate rider to cover that condition?

No, insurers cannot do that. Plans must operate on the basis of "standard population risk," which looks at everyone -- i.e., both those with and without existing conditions -- to determine reasonable costs. So your condition cannot be singled out as a reason to charge you higher premiums. A beneficiary's premium costs may be influenced by their age and smoking habits because these factors are known contributors to heightened health care consumption.

6. Elimination of Benefit Annual and Lifetime Payment Caps

Question: In 2014, both lifetime and annual caps (limits) on benefit payments will be strictly prohibited. Does this pertain to all health care needs or just those defined as "essential benefits" under the law?

New plans written or renewed on or after September 23, 2010 that did have annual or lifetime caps in place would be "grandfathered" under the law, as could plans in existence when ACA was signed into law if they already offer a generous benefits package and do not significantly raise premiums or reduce these benefits. Other plans will gradually have to phase out their benefit payment limits to be in compliance with the law after 2014. Or as plans are changed after enactment of the law such as during open enrollment, annual and lifetime caps would be prohibited.

A "grandfathered" health plan is an existing group health plan or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled on the date of enactment. Therefore, as long as a person was enrolled in a health insurance plan on March 23, 2010, that plan has been grandfathered. Current enrollees in grandfathered health plans are allowed to re-enroll in that plan, even if renewal occurs after date of enactment. Family members are allowed to enroll in the grandfathered plan, if such enrollment was permitted under the plan at the time the law was enacted. For grandfathered group plans, new employees (and their families) may enroll in such plans.

7. Definition of Essential Benefits

Question: I was excited to learn that the law requires that rehabilitation and habilitation services have to be included by 2014 in the “essential benefits” of certain policies to be finalized by 2014 under the law. Where does the development of the detailed definition of these benefits stand to date? What if those definitions are more limited than my current coverage, can my insurer scale back my benefits? What if they are more generous, can I demand more from my insurer?

The Institute of Medicine (IOM) was charged with examining the essential benefits package and making recommendations on how the essential benefits should be defined in more detail. The essential benefits apply to the insurance coverage that will be sold through the insurance exchanges described earlier. The Consortium for Citizens with Disabilities (CCD), a coalition in which United Spinal is an active member and leader, presented testimony before the IOM regarding the benefits people with disabilities particularly see as essential, including habilitation, rehabilitation, maintenance of function, and durable medical equipment, and how they could be defined. We anxiously await the IOM’s recommendation to the Department of Health and Human Services.

The “essential benefits” will apply to policies offered to individuals and small businesses through the insurance exchanges previously discussed, as well as to policies offered to individuals through a nationwide qualified health plan or multi-State qualified health plan (SEC. 1333). They do not apply to existing policies that have been “grandfathered in” under the law (see definition of grandfathered plans under question 6).

8. Cost -Sharing Limits

Question: I seem to pay a lot of money out-of-pocket for deductibles and co-pays above and beyond my premium payments. Does the law establish any limits on such cost sharing and out-of-pocket expenses and, if so, when do they go into effect?

Effective January 1, 2014, the law limits deductibles for health plans to \$2,000 for a single person for employer-sponsored plans offered in the small group market and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.

Additionally, the following four benefit tiers would be created, as well as a separate catastrophic plan to be offered through a state’s insurance exchange, and in the individual and small group markets:

1. Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010);

2. Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;
3. Gold plan provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; and
4. Platinum plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits;

A catastrophic coverage-only plan set at the HSA coverage level would be available to those 30 years of age and under and to those who are exempt from the law's requirement that all individuals purchase coverage. It would provide catastrophic coverage only with the coverage level set at the HAS current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.

The law also reduces the out-of-pocket limits for those with incomes up to 400% of the federal poverty level (FPL) to the following levels:

- 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family);
- 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family);
- 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family).

The FPL as of 2011 is \$10,890 for an individual and \$22,350 for a family of four.

9. Home- and Community-Based Services

Question: I do not want to end up in a nursing home if I can help it. What does the law provide in the way of home- and community-based services support and are these benefits already in effect?

On August 6, 2010, CMS sent a letter to all state Medicaid directors informing them in great detail of the changes to Home and Community Based Services (HCBS) under Medicaid that ACA put in place. It stressed that the changes “under the ACA enhance an important tool for States in their efforts to serve individuals in the most integrated setting and to meet their obligations under the Americans with Disabilities Act (the ADA) and the Olmstead decision. In order to promote State utilization of 1915(i), the ACA includes changes that enable States to target HCBS to particular groups of people, to make HCBS accessible to more individuals, and to ensure the quality of the HCBS.”

United Spinal urges everyone to monitor what their own states are doing, as states deal with budgetary challenges, and to speak out in support of funding for such valuable programs as:

- Extension of the popular “Money Follow the Person” demonstration grants through September 2016. These grants help states defray the cost of moving eligible Medicaid beneficiaries who have resided in an inpatient facility for a minimum number of consecutive days into community-based settings where their medical and daily function can be served.

- The “Community First Choice Option” created under by ACA that allows state Medicaid plans to choose home- and community-based services and supports as the rule, rather than the exception, for those eligible for Medicaid with disabilities who would otherwise be institutionalized and have incomes up to 150 percent of the federal poverty level (i.e., \$16,245 for an individual and \$33,075 for a family of four in 2010). To encourage states to opt in to this program, they will receive an additional six percent payment on top of the Federal Matching Percentage for their Medicaid programs.

Additionally, beginning in 2011, the “Community Living Assistance and Supports” (CLASS) program is scheduled to start. It will be a voluntary insurance program that, after a five-year vesting period, will provide cash benefits for purchasing community living assistance services and supports.

10. Community Health Center Access

Question: If I'm recalling correctly, the law invests a good deal more funding in the 1200 Community Health Centers across the country. Who will those dollars support and can anyone make use of their services?

This money supports the Federally Qualified Health Centers (FQHCs). These centers are designed as a safety net to meet the health care needs of underserved populations based on income and other factors in the absence of coverage or for those who cannot afford traditional physician care. Anyone can use these services. They operate on a sliding scale and accept Medicaid for payment. Since they are funded by the federal government, FQHCs are required to be accessible under Section 504 of the Rehabilitation Act. Access to health care services is a determination based on income and the number of primary care providers in the geographic area.

11. Medicare Outpatient Therapy Caps

Question: As someone with a disability on Medicare, I've come up against the payment cap for my outpatient physical, occupational and speech therapy and had to obtain an exception ruling with the help of my doctor to exceed these caps. Does the Affordable Care Act eliminate these arbitrary caps?

ACA does not eliminate the therapy caps. However, the President signed a different bill, the Medicare and Medicaid Extenders Act of 2010 that extends the Medicare Part B Outpatient Therapy Cap Exceptions Process for all of 2011. The cap amount for 2011 is \$1,870 for physical therapy and speech language pathology combined and \$1,870 for occupational therapy. If your need for therapy is documented and your costs are above the therapy limits, your therapist's billing office will add an explanation to the claim to justify your continuing need for services and Medicare will make a determination on your extended benefits. Such benefits are extended in well over 90% of such appeals.

12. Accessible Diagnostic Medical Equipment

Question: I use a wheelchair and cannot easily get on an examination table or weight scale at my doctor's office. Is the law doing anything to make medical diagnostic equipment more accessible to people with disabilities?

Yes. The Access Board is developing minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The Access Board held a public meeting to collect information from interested members of the public. United Spinal provided testimony. The Access Board will release the voluntary standards for improved accessibility prior to the second anniversary of the ACA. Though voluntary in nature, it does establish the standard of practice. We will advocate for these changes to become mandatory in the future. We encourage that these standards be shared by readers with their providers when the criteria are released.

13. Medicare Power Wheelchair Coverage

Question: I am a Medicare beneficiary and need a new power wheelchair. Medicare only allows me to rent one and will pay for 80% of the cost. But as a renter, I cannot make the individual adjustments that I need based on my size and needs. Is there any likelihood that Medicare will go back to its previous policy of covering the purchase of a power wheelchair if done in the first month of usage?

Not at this time. Medicare is not likely to go back to its previously policy and unless you require complex rehabilitation technology (more advanced power wheel chairs), you will be required to rent the power wheelchair for 13 months and pay 80% of the cost before qualifying for purchase of the equipment. If you do require a complex rehabilitative wheelchair you will still be able to purchase it using Medicare *without* the required 13 month rental period.

14. Medicare Durable Medical Equipment Competitive Bidding

Question: I receive Medicare coverage and use a wheelchair and other durable medical equipment. The Affordable Care Act intended to accelerate the implementation of Medicare's Competitive Bidding Program for suppliers of these products to reduce costs. What is the current status of the program and has it resulted in many significant problems for beneficiaries in fulfilling their needs?

The Centers for Medicare & Medicaid Services (CMS) launched the first phase of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program in January, 2011, in nine different areas of the country. This includes equipment such as wheelchairs, walkers, oxygen and diabetes blood monitoring devices. Off-the shelf orthotics are exempted from competitive bidding when provided by physicians or hospitals to their own patients.

Multiple concerns have been raised about the bidding program. These include fears that it will:

- (1) reduce choice of products and suppliers of such equipment;
- (2) lead to the unavailability of the most highly preferred and effective products,
- (3) alter long-term relationships between Medicare beneficiaries and their equipment suppliers which could delay repairs or timely receipt of replacement parts and undermine the provision of complex adaptations needed to the equipment, and
- (4) reduce convenience of access, customer service and the quality of the beneficiary's care.

Last year, a bill was introduced in the house to repeal the competitive bidding program. That bill, H.R. 3790, garnered 259 co-sponsors but never made it out of committee or found a Senate companion bill. On March 14, 2011, Reps. Jason Altmire, D-Pa., and Glenn Thompson, R-Pa. introduced H.R. 1041, Fairness in Medicare Bidding Act, in the House, as another attempt to revamp the bidding process. No immediate action is anticipated that would alter the bidding requirements in the near-term.

15. Comparative Effectiveness Research

Question: There is a lot of talk about “comparative effectiveness” in the law. What does it mean and what are its pros and cons?

Comparative effectiveness research compares the outcomes or effectiveness of different treatments or therapies for the same condition. It is supposed to improve quality of care and lower costs by finding the most effective treatment. However, some argue that while it may save expense, it does not adequately take into account individual differences among patients that may affect effectiveness. For example, some medications for seizures work very well to control one person's seizures, but may not do anything for another person's seizures. Some health care providers view it as another step toward “cookbook, one size fits all” medicine,” and a disincentive to investing in medical advances.

16. Training Health Care Providers on the Care of Those with Disabilities

Question: The law requires health care professionals receive training to add to the supply of providers addressing people with disabilities and reduce health disparities people with disabilities experience. What is the status of these efforts to accommodate these needs?

These are several groups of health professionals working on developing curriculum on the special needs of those with disabilities that could be incorporated more broadly into academic training for these professionals. However, training health care providers in the field will require grants and funding which may be at risk as part of efforts to de-fund the health reform law or generally reduce

spending to lower the nation's deficit. Though the likely agencies to handle this will be HHS's Health Resources and Services Administration, it remains unclear where the grant support for development of these disability-trained providers remains unclear at this time.

17. Medicare Coverage of Anti-Seizure, Anti-Spasm and Smoking Cessation Medications

Question: Under the new law, Medicare Part D extends coverage to include barbiturates, benzodiazepines and tobacco control agents? Has this additional coverage been activated already?

This additional coverage will become effective January 1, 2014.

18. Medicare Part D Prescription Drug Coverage "Donut Hole" Relief

Question: I keep hearing that the law is supposed to help Medicare beneficiaries with their prescription drug costs during the so-called Part D Donut Hole Gap. The whole thing is very confusing. Can you explain to me how it does this?

The process is gradual. This past year, Medicare recipients who reached the donut hole received a check for \$250. In 2011, Medicare recipients who reach the donut hole will get a 50% discount on all brand-name drugs. The gap will gradually be further closed each year so that by 2020, the donut hole will be entirely closed.

19. Prevention Benefits

Question: It is often said that an ounce of prevention is worth a pound of cure. Obesity, smoking and other lifestyle behaviors are major risk factors across many diseases and disorders. Does the Affordable Care Act do anything to promote such prevention?

The ACA includes a prevention fund that will fund prevention programs for people with and without disabilities, including grants for healthy communities. On February 11, 2011, HHS announced \$750 million in funds from the Prevention and Public Health Fund to help prevent tobacco use, obesity, heart disease, stroke and cancer; and to increase immunizations.

Unfortunately, this fund is under attack in the House and has been the subject of hearings that do not show support for appropriating the money needed to carry out the full program. Until enactment of the law, seniors and people with disabilities received a one-time free visit with a physician when they joined the Medicare Part B program but had to pay for annual visits after that. Under ACA, annual wellness visits are now fully covered under Medicare and since this coverage went into effect on January 1, 2011, these visits have proven very popular, with more than 150,000 Americans already taking advantage of the new benefit.

During the appointment, the physician and patient are supposed to develop or update personal prevention plans taking into account medical and family history, detection of any impairment, potential risk factors from depression and review of the patient's functioning ability and level of safety. Doctors can also give their patients advice on daily health habits and refer patients to other agencies or services for counseling or programs.

20. Better Understanding of Health Disparities

Question; President Obama has pledged to promote equality in the delivery of health services In the United States. Does the Affordable Care Act do anything to foster improved understanding of the treatment of people with disabilities and how effective it is or isn't?

ACA provides several provisions to collect data on where people with disabilities get their health care, which providers are trained to treat people with disabilities and how many providers there are with accessible facilities and equipment.

Collection of this data will provide a better understanding of the health disparities or differences in care provided to people with disabilities differences in health status, and a basis to try to fix disability health disparities. The provisions that address training health care providers in cultural competence are also expected to improve the quality of care people with disabilities receive and decrease the health disparities.

Dates For Implementing Affordable Care Act Provisions Important to People with Disabilities*

Comparative Effectiveness Research	January 2010	The Patient-Centered Outcomes Research Institute has been established and is currently being funded compare and contrast the clinical effectiveness of various medical treatments addressing a disease, disorder or injury. (See question #15)
Community Living Assistance and Supports (CLASS)	January 2011	A CLASS office was opened within the Administration on Aging in early 2011. It is expected to require a couple of years for the CLASS program to get up and running before people can start paying into the program. DHHS recently acknowledged that the financial basis for the program will need to be revamped to ensure program sustainability. (See question #9)
Medicare First Month Power Wheelchair Purchase Option	January 2011	The first month purchase option for power wheel chairs went into effect in January 2011. Medicare beneficiaries will be required to rent power wheelchairs for 13 months before being able to purchase the equipment. Complex rehabilitative wheelchairs will be exempt from the required rental period. (See question #13)
Medicare Part D Doughnut Hole Gap	January 2011	Starting in 2011 Medicare will started phasing out the “doughnut” hole in Medicare Part D prescription drug coverage. Drug companies are required to give a 50% discount on brand name drugs and other generic savings will be phased in. (See question #18)
Community First Choice Option	October 2011	The Community First Choice Option for Medicaid programs to pursue community-based care options first (rather than institutional choices) will go into effect in October 2011. (See question #9)
Medicaid Rebalancing Initiative	October 2011	Provides states that spend less than 50% of their Long Term Services and Supports money on Home and Community Based Services increased federal Medicaid funding to transition people to community based living.
Medicare Independence At Home	January 2012	Creates a new demonstration program for high-need Medicare beneficiaries to receive primary care at home.
State Exchanges	January 2013	In January of 2013 states will have to let the federal government know if they are going to participate in health insurance exchanges.
Tax on Medical Devices	January 2013	A 2.3% excise tax on medical equipment will take effect in January 2013. This will impact wheelchairs and power wheelchairs.
Expanded Medicaid Coverage	January 2014	Medicaid coverage will be expanded up to 133% of the federal poverty level, including childless adults. There will be increased federal funds available to help offset costs to the states.
Individual Insurance Requirement	January 2014	In 2014, absent existing coverage, individuals will be required to purchase qualifying health insurance plans. A tax penalty will be phased in. There will be subsidies and tax credits available for low-income individuals and families to help defray costs.
Health Insurance Exchanges	January 2014	Health exchanges at which insurance can be purchased will be set up in 2014 for individuals who do not have employer sponsored health coverage. People will have the option of purchasing different levels of health insurance and coverage.
No Annual Limits	January 2014	In January 2014 limits on annual and lifetime benefits under health insurance plans will be eliminated. (See question #6)
Pre-existing Conditions	January 2014	Insurance companies will no longer be able to deny individuals coverage based on their pre-existing conditions, such as disabilities. However, insurance rates can vary based on the age and smoking habits of the beneficiary. (See question #5)
Essential Benefits Covered	January 2014	The requirement that all plans provide a basic set of “essential” health benefits will go into effect in January of 2014. The health reform law did state that certain broad areas of service must be covered but did not define these further. The Institute on Medicine and Department of Health & Human Services are working to determine these more specifically. (See question #7)

***These are examples of issues that will impact people with disabilities. This list is not meant to be exhaustive.**