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## How Did Healthcare Affordability Change for U.S. Adults with Intellectual Disability After the Implementation of the Affordable Care Act?

Nastassia Vaitsiakhovich

Individuals with intellectual disability<sup>a</sup> are a marginalized group in the United States, with a higher prevalence of chronic diseases,<sup>1</sup> earlier age at death,<sup>2</sup> and greater mortality risk<sup>3</sup> than the general population. These health disparities are related to this group's relatively low socioeconomic status, which results in a heavy reliance on social welfare benefits and public health insurance programs, such as Medicaid and Medicare. Addressing disability-related health needs often requires additional healthcare services not covered by federal and state programs.<sup>4</sup> This situation creates barriers to healthcare access for intellectually disabled Americans.<sup>5</sup>

In 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. This comprehensive healthcare reform aimed to make healthcare services accessible for many vulnerable groups, including persons with intellectual disability. The ACA prohibits charging higher premiums or denying coverage based on preexisting health conditions, allows people under the age of 26 to be covered by their parents' insurance plans, and extends Medicaid eligibility to all working-age adults with incomes at or below 138% of the federal poverty level.<sup>6</sup> Additionally, the ACA requires all insurance plans to cover ten essential benefits, including emergency services, prescription drugs, mental health services, preventive and wellness services, chronic disease management, rehabilitative and habilitative services and assistive technologies,

### KEY FINDINGS



U.S. adults with intellectual disability were less likely to forego medical care, specialty, dental, and mental health services after the Affordable Care Act (ACA) was implemented than they were prior to implementation.



There were no statistically significant differences in patterns of foregone follow-up care, eyeglasses, and prescription drugs in the pre-versus post-ACA periods.



Addressing healthcare disparities among persons with intellectual disability requires a set of policies, including the transition of the healthcare delivery system towards the value-based model and new national standards for measuring disability.

laboratory services, and outpatient care.<sup>7</sup> These benefits are particularly important for intellectually disabled persons who are more likely to face both chronic diseases and mental health problems.

This brief summarizes findings from [our recently published study](#) that examined patterns in healthcare affordability under the ACA for noninstitutionalized adults ages 18-64 with intellectual disability. The study compares instances of foregone medical care, dental care, eyeglasses, prescription medicines, mental

health care, follow-up care, and specialty care due to costs before (2011 - 2013) versus after the ACA's full implementation (2014 - 2016).

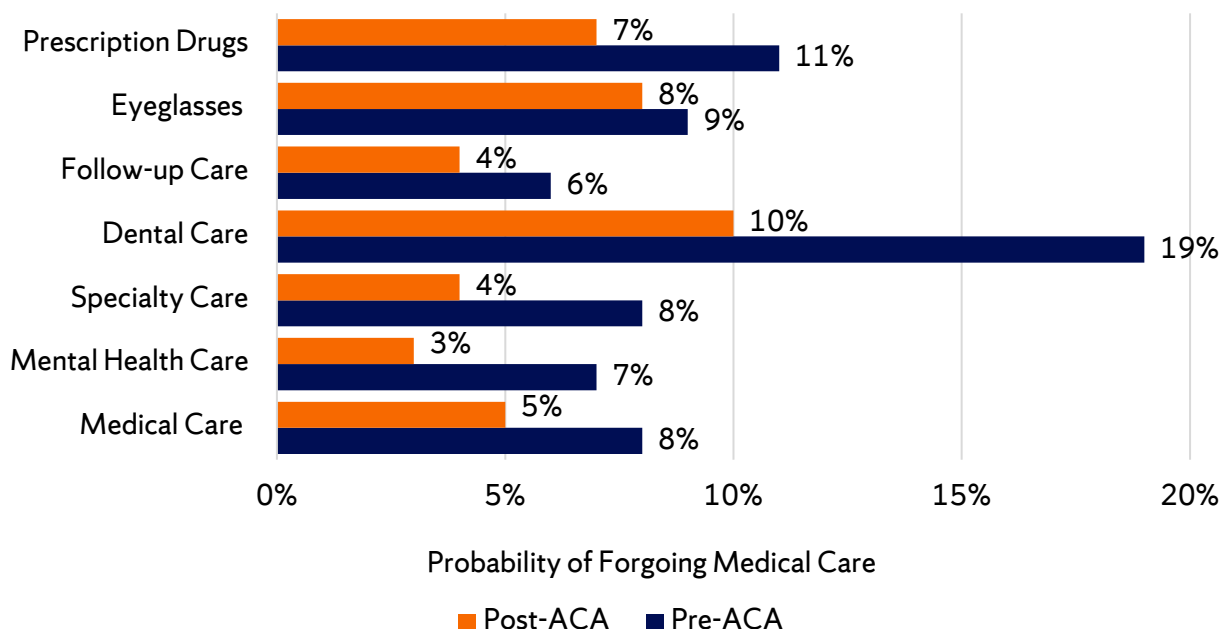
### Adults with Intellectual Disability Reported Fewer Foregone Health Care Services After the ACA Was Implemented

Figure 1 demonstrates the prevalence of foregone healthcare services accounting for age, education, poverty, self-reported health, and insurance coverage plan. Compared to the pre-ACA period (2011 - 2013), the probability of foregone care declined in the post-ACA period (2014 - 2016) by three percentage points (37.5%) for medical care, four percentage points (50%) for specialty care, nine percentage points (47.3%) for dental care, and four percentage points (57.1%) for mental health. These differences are statistically significant.

These findings suggest that the financial burden of healthcare services included in essential benefits was lower for adults with intellectual disability after the ACA was implemented. The difference in dental care affordability was especially large. Although dental care is not compulsory for coverage under the ACA, most states include it in their Medicaid plans. In addition, the eligibility for parents' health insurance might have improved dental care affordability for intellectually disabled adults under 26.

### Even with the ACA, Many Adults with Intellectual Disability Still Cannot Afford Some Care Services

As Figure 1 shows, the probability of foregone prescription drugs, eyeglasses, and follow-up care in the post-ACA period were four, one, and two percentage points lower, respectively,



**Figure 1: Predicted Probabilities of Foregone Use of Healthcare Services due to Cost Among Adults ages 18-64 with Intellectual Disability**

Data Source: National Health Interview Survey, 2011-2016; N=623.

Note: The models control for: age, education, poverty, self-reported health, Medicaid, and private insurance plans.

than in the pre-ACA period. However, these differences are not statistically significant.

This may indicate that U.S. adults with intellectual disability still experience persistent financial challenges in long-term treatment involving medications and frequent practitioner visits. Considering this population's higher prevalence of vision problems,<sup>8</sup> a lack of a significant reduction in foregone eyeglasses raises concerns about the potential for the ACA (in its current form) to reduce vision disparities in this vulnerable population.

### **The Making Health Care More Affordable Requires a Holistic Approach**

Our findings suggest that the ACA effectively reduced the probability that adults with intellectual disability would forgo certain types of health care due to cost. However, the ACA has not appeared to reduce forgoing follow-up care, prescription drugs, and eyeglasses.

Several policy changes are needed to address these ongoing healthcare access barriers among adults with intellectual disability.

1. Eyeglasses and routine eye examinations must be included in the list of essential benefits under Medicaid, Medicare, and private insurance plans.
2. The Build Back Better Act of 2021 includes provisions intended to decrease the cost-sharing for prescription drugs covered by Medicare and private insurance plans. However, persons with intellectual disability are at high risk of poverty and may not be able to afford cost-sharing. The federal government should enact policies to eliminate out-of-pocket expenses for Medicare and Medicaid prescription drugs that prevent or treat

life-threatening health conditions, such as diabetes and cardiovascular diseases.

3. States that have not expanded Medicaid should do so immediately.
4. The federal government must develop long-term strategies to transition the U.S. healthcare system from fee-for-service to value-based care. The healthcare reimbursement system should be related to patient health outcomes rather than the number of services and procedures.<sup>5</sup> For instance, the prevalence of prescription psychotropic medicine use is relatively high among persons with intellectual disability even though non-pharmacological treatment may be more effective and poses fewer health risks.<sup>9</sup>
5. The ACA's efficient allocation of financial resources into healthcare programs necessitates extensive and timely information about the healthcare needs of persons with intellectual disability. Section 4302 of the ACA requires the tracking of federal information on race, ethnicity, sex, primary language, and disability.<sup>10</sup> In 2011, the Department of Health and Human Services issued data collection standards that apply the six American Community Survey (ACS) questions for measuring disability.<sup>10</sup> However, the ACS uses only one question on difficulty concentrating - remembering or making decisions - which does not allow users to differentiate intellectual disability from other disability statuses (e.g., attention-deficit/hyperactivity disorder and Alzheimer's disease). It is critical to revise federal standards for

disability measurement and include a set of questions that enable accurate identification of persons with intellectual disability. The U.S. Census Bureau and other federal statistical agencies conducting national surveys should include questions on 1) self-reported intellectual disability, 2) age of onset, 3) anticipated duration of

disability, 4) self-direction, and 5) independent living skills.<sup>11</sup> Changing how disability is measured will allow researchers and policymakers to account for the heterogeneity of the population with intellectual disability and advance healthcare equity.

## Data and Methods

This study used the 2011 - 2016 National Health Interview Survey (NHIS), a cross-sectional household interview survey of the U.S. civilian noninstitutionalized population. The NHIS measures intellectual disability through self or proxy reports. First, an interviewer identified individuals with any activity limitations. Then, respondents were asked if their limitations are caused by health conditions listed in the questionnaire, including intellectual disability. The sample included 623 adults ages 18-64 with intellectual disability. The results in Figure 1 are based on logistic regression models. Models controlled for age, education, poverty, self-reported health, Medicaid, and private insurance plans. Results can be considered representative of the U.S. population of non-institutionalized adults ages 18-64 with intellectual disability. Additional methodological details can be found in the [published paper](#).

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