Access to Rehabilitation for the Uninsured and Underinsured Individuals with Disabilities

The American Academy of Physical Medicine and Rehabilitation advocates that all individuals with disabilities receive adequate medical care and rehabilitation to meet their physical, psychological, social and vocational needs regardless of age, income or medical status.

Inability to pay for health insurance is one barrier to achieving this goal in the United States. According to the 2010 National Health Interview Survey, a significant portion of the US population, 16% or 49.5 million Americans, were uninsured. Obtaining health insurance can be even more of a challenge for individuals with disabilities' whose employment rates are lower than those for people without disabilities.[1] Without employment or other sources of income, they are ineligible for employer-based insurance and may be unable to pay for individual private health insurance. Possible options for some become either Medicaid, Medicare, or both. However, many uninsured or underinsured people with disability have low income levels that exceed the threshold for Medicaid eligibility, often at or below the Federal Poverty level.[2]

Under the Patient Protection and Affordable Care Act (PPACA), Medicaid becomes a primary program for insuring many individuals who were previously uninsured. However, this increase in patients covered through Medicaid is projected to increase state Medicaid costs. As a result unfortunately, state lawmakers may seek to limit eligibility criteria and covered services in order to balance state budgets.

The potential for underfunding health care exists in part because of the variability in health care programs. Disability-related health care expenditures as a proportion of total spending differs among states and payers. In 2006, disability-related health care spending for adults was estimated at $400 billion dollars. The lowest spending state was Wyoming at $600 million ($1,810 per capita) and the highest was New York at $40 billion ($3,332 per capita). Among payers, disability-related expenditures were 12.5% for private health care expenditures, 38.7% for Medicare, and 68.7% for Medicaid. [3] Paring back state budgets and Medicaid funding will therefore disproportionately affect people with disabilities.

Another concern with access is underinsurance. While individuals may have health insurance, that coverage may not include medically necessary services and/or requires large out-of-pocket payments. Insurance policies with low coverage limits, high deductibles, large copayments or coinsurance requirements leave patients at risk of underinsurance and limited access to care. Underinsurance has a disproportionate impact on people with disability since they often have more health related expenses compared to people without disabilities.

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[1] The proportion of the population employed in 2009--the employment-population ratio--was 19.2 percent among those with a disability and 64.5 percent for persons without a disability. The unemployment rate of persons with a disability was 14.5 percent, higher than the rate for those with no disability, which was 9.0 percent. From www.bls.gov/news.release/disabl.nr0.htm, accessed 4.29.11.

[2] 2011 – annual income of $10,890 for a single individual, $22,350 for family of 4 (http://aspe.hhs.gov/poverty/11fedreg.shtmlm. Accessed 4.29.2011)

[3] Anderson WL, Armour BS, Finkelstein EA, Wiener JM. Estimates of State-level Health-Care expenditures associated with disabilities. Public Health Reports 2010;125:44-51.

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PPACA makes several changes to health care funding through new health insurance requirements. The Secretary of Health and Human Services is directed to create an essential benefits package. Certain insurance practices are either limited or eliminated altogether: benefits cannot be denied based on pre-existing conditions; insurance rescission is eliminated; annual and lifetime benefit caps are eliminated. These changes have the potential to improve access to care through improved insurance availability. However, possible increases in insurance premiums risk making health insurance less affordable for people with and without disabilities.[4] In addition, government subsidies for insurance may be required to preserve access.

Underinsured individuals with disabilities face many of the same obstacles for obtaining rehabilitation care as able-bodies individuals with insurance. For example, without proper health education, people with disabilities may not seek preventive care and timely treatment of problems leading to additional medical complications. Physician and allied health professional shortages in rural and inner city areas and inadequate transportation systems present other barriers to treatment. Ensuring all Americans have access to high quality health care will further ensure that all Americans with disabilities do as well.

The American Academy of Physical Medicine and Rehabilitation believes that the following objectives are important for meeting the rehabilitation needs of all adults and children with physical disabilities who are uninsured or underinsured:

1. All Americans with physical and/or cognitive disabilities require access to appropriate health insurance coverage, regardless of age or medical status. A sustained, cooperative effort is needed among physiatrists and other health care providers, insurers, and legislators to assure that adequate medical care, including rehabilitation services, are available to all individuals with physical and/or cognitive disabilities through the elimination of underinsurance and lack of insurance.

2. All insurance coverage for rehabilitation needs to include inpatient and outpatient services provided by physicians, physical therapy, occupational therapy, speech therapy, psychological care, rehabilitation nursing services, social services, prosthetics and orthotics, vocational training, patient education services, preventive care and durable medical equipment.

3. Federal health care policies require ongoing evaluation to minimize disability-related disparities. These disparities include qualifications for insurance, benefit caps, and out-of-pocket expenses. Effects of budgetary changes of programs that fund health care require ongoing monitoring for effects on individuals with disabilities.

4. When determining the appropriateness of rehabilitation services, criteria are medical necessity and potential for improvement. Providers using criteria for appropriateness need to refer to current evidence-

[4] National Average for Employer-provided insurance – single $5,049/yr, family $13,770/yr with employee contribution component $899 and $3,997 respectively (median annual family income 2008-2009 in United States $49,495). Kaiser Family Foundation/HRET Survey of Employee Benefits, 2010 at http://ehbs.kff.org/pdf/2010/8086.pdf and www.statehealthfacts.org/comparemaptable.jsp?cat=1&ind=15, accessed 4.29.11.

based standards and guidelines written by knowledgeable experts. These criteria should be applied consistently to all patients.

5. Federal programs to reduce other barriers to obtaining health care need ongoing support. Examples include increasing the number of allied health professionals; encouraging physicians and allied health professionals to practice in underserved areas; expanding the number of rural and inner city health facilities; and strengthening programs to train medical personnel in disability-related issues. [5]

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[5] Kirschner KL, Curry RH. Educating Health Care Professionals to Care for People with Disabilities. JAMA 2009;302:1334-1335.

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