

The Affordable Care Act at Age Three
Leadership Day on Capitol Hill
May 21-22, 2013

Background

Where Things Stand

Comprehensive health reform legislation, known as the Affordable Care Act (ACA), was enacted just over three years ago in March 2010 amidst much controversy. Since then, debate in Congress and in the court of public opinion continues to ebb and flow but the ACA remains the law of the land and we do not expect that to change. To date, [Republicans and Democrats](#) in Congress still remain sharply divided on the law, with Democrats seeking to ensure its full implementation while Republicans continue to push for dismantling it, if not calling for its full repeal. The [public](#), while also divided, seems to be more confused than anything about the ACA and how it will affect their lives.

Implementation of the many provisions of the ACA began in 2010 and will continue to be rolled out over a ten year period, with the majority of the provisions taking effect in [2013-2014](#). ACP offered a qualified endorsement of the ACA when it was enacted in 2010 because, on balance, it advances many of ACP's key priorities related to: expansion of health coverage to nearly all legal U.S. residents; payment and delivery system reforms to support primary care; and workforce improvements that will help ensure that all patients have access to an internist. While the ACA is by no means a perfect product, and improvements to the law should be considered, it takes substantive steps to improve upon the current health care system, which is not sustainable without such reforms.

Over the past few years, the College has urged Congress to fully fund the ACA but to also improve upon it and advance other reforms, such as enacting more meaningful medical liability reforms, not only through caps on damages in malpractice cases but also in the piloting of health courts as an alternative to traditional attempts at reform (explained in more detail in the *Finding Common Ground in Congress on Medical Professional Liability Reform* backgrounder); doing more to ensure an adequate supply of internists and other specialties facing shortages; providing more options, earlier, for states to design and implement their own approaches to expanding coverage; and [eliminating a burdensome requirement](#) that physicians provide written authorization for OTC drugs paid for out of a flexible spending account. Equally important to the College is the need for Congress to repeal once and for all Medicare's flawed Sustainable Growth Rate (SGR) formula and transition to new physician payment models that are aligned with value, as outlined in the backgrounder *Medicare Physician Payment Reforms and Their Impact on Practices*.

The background information below outlines key ACA provisions of importance to the College, some of which have a state advocacy component. Each provision includes a description at enactment in 2010, its status today and, if applicable, what ACP advocates for the future. Leadership Day attendees should be familiar with these key provisions as they are routinely discussed in congressional offices. ACP also developed, and has updated each year since 2010, an [Internist's Practical Guide to Understanding Health System Reform](#), which was designed to serve as a resource for ACP members.

Background

HEALTH INSURANCE EXCHANGES AND SUBSIDIES

The ACA establishes [health insurance exchanges](#), which are marketplaces that offer one-stop-shopping to eligible individuals and small businesses to purchase more affordable health insurance coverage that fits their own needs. Each state has to establish its own exchange and make it operational by October 2013. If a state fails to do so, the federal government will create and operate the state's exchange or states can enter into a partnership with the federal government to jointly run their exchanges. The federal government has distributed over \$3.8 billion to states to help fund their exchange planning and implementation activities. To view where each state currently stands on establishing an exchange, please see [here](#).

Equally important are the subsidies provided through the ACA, not only to individuals and families but to small business as well. The ACA provides tax credits, starting in 2014, to assist U.S. citizens and legal residents who do not have access to health coverage through the exchanges to purchase it on their own. The tax credits will be made available on a sliding-scale basis to people with incomes between 133 percent and 400 percent of the Federal Poverty Level. The specifics on

who is eligible for these credits and how they work can be found [here](#). As for small businesses, the ACA provides tax credits to small businesses to help them purchase employee health insurance. Beginning in 2014, the amount of the tax credit will be a maximum of 50 percent of the employer's contribution (35 percent for non-profit firms) towards their employees' health insurance premium. A smaller tax credit began in 2010 and continues on a sliding scale through 2013. More information on who qualifies can be found [here](#).

Conservatives in Congress remain skeptical that the federal government has the ability, man-power, and resources to operate exchanges in those states that choose not to do it on their own. However, the Secretary of the Department of Health & Human Services, Kathleen Sebelius, has provided assurances that her agency is on track to assume that role.

ACP believes that the successful implementation of these health insurance exchanges, along with coverage expansions for the uninsured, is critical to ensuring near universal health coverage for this nation's citizens and legal residents, a long-held [policy goal](#) of the College. This provision of law is designed to help those people who do not have access to health insurance through their employer and who, in today's market, are too often priced-out of any type of affordable health coverage to fit their needs. Small businesses often have similar problems, since they do not have the negotiating power of large employers and may face a significant increase in premiums if an employee gets sick. ACP also continues to encourage the involvement of its chapters in [state-based advocacy](#) on the exchanges as they are in the formative stages.

MEDICAID EXPANSION

Beginning in 2014, the ACA includes a provision giving states the [option to expand Medicaid](#) eligibility to individuals with incomes at or below 133 percent¹ of the federal poverty level, which translates to \$14,856 for an individual and \$30,657 for a family of four, although actual income amounts will be updated in 2014. The federal government pays the full cost of this expansion from 2014 through 2016 and finances no less than 90 percent of the cost in subsequent years. When the ACA was enacted in 2010, this provision required states to expand their Medicaid programs or risk losing their federal Medicaid funds for their existing Medicaid programs. However, after numerous states filed lawsuits against the federal government citing that this provision of law was unduly coercive, the U.S. Supreme Court ruled that the financial penalty on the states for not expanding their Medicaid programs was unconstitutional. Therefore, on June, 28, 2012, the Supreme Court gave states the option to expand their Medicaid program without the threat of a reduction in federal funding.

Most Republicans in Congress are strongly opposed to the ACA's Medicaid expansion, for ideological (overall opposition to the ACA), fiscal (concern that it will cost federal taxpayers too much), and other reasons. Instead, congressional Republicans generally support movement toward a finite "block grant" to states for use in caring for their uninsured and underinsured. Under a block grant, the federal government would provide a set amount of money to the states to use as they see fit to provide coverage to the poor, providing flexibility to the states to determine eligibility, benefits, and other decisions now set by federal law but ending Medicaid as a guaranteed benefit (entitlement) program for eligible persons. The block grants also would likely provide much lower levels of funding to the states compared to the current federal "match" and the additional funds being provided through the ACA.

Most Republican governors have so far declined to accept the offer of federal dollars to expand Medicaid to persons up to 133 percent of the FPL, again for ideological reasons (opposition to the ACA) and also, because of concerns that Medicaid expansion will cost the states too much, that the federal government cannot be counted on to provide the funds authorized by the ACA, and because they want more flexibility in how the program would be implemented in their states. However, as many as eight Republican governors have come out in favor of accepting the ACA's dollars to expand Medicaid, arguing that it is in the best interests of their states, both fiscally and in terms of access to care for their poorer residents. Other Republican governors may decide in the future that it is in the best interest of their state to expand Medicaid. (Under the ACA, there is no deadline for a state to expand Medicaid, although the amount of federal funding will gradually decline from 100 percent to 90 percent over the next seven years—so states that wait will be leaving federal

¹ The ACP expands Medicaid to 133 percent of the federal poverty level plus a 5 percent technical adjustment, which increases the eligibility level to 138 percent.

dollars behind for each year that they wait.) In exchange for agreeing to expand Medicaid, some governors from more conservative states (Republicans but also some more conservative Democratic governors) are seeking waivers from the Obama Administration to “privatize” Medicaid by turning it over to managed-care plans. The Obama Administration has indicated a willingness to allow such privatization as long as the benefits, eligibility and cost-sharing standards for enrolled persons are generally the same as conventional Medicaid. The Obama Administration, congressional Democrats, and virtually all Democratic governors strongly support the ACA’s Medicaid expansion provision, arguing that it is essential to ensure access to care for the poor and near-poor. To view where each state stands on expanding their Medicaid program, please see [here](#).

As noted earlier in this document, ACP believes it is critical that states choose to participate in Medicaid expansion in order to achieve near universal health coverage for all citizens and legal residents in this country. This provision is consistent with long-standing ACP policy for expanding Medicaid to all of the poor- and near-poor. If all states participate, this provision would expand coverage to up to 33 million previously uninsured people in 2022—resulting in coverage for about 94 percent of all legal residents. ACP is particularly concerned that people with incomes at or below the federal poverty level *will have no access to subsidized coverage* if their states turn down ACA’s Medicaid expansion. This is because under the ACA, Medicaid coverage is the *only* coverage option available for persons with incomes at or below the FPL—they are ineligible for subsidized coverage through the health exchanges, because Congress, when it enacted the ACA, could not have anticipated that the Supreme Court would have made the Medicaid coverage optional for the states. This means that many of the most vulnerable and poorest persons will have no access to coverage in states that turn down the Medicaid expansion.

In September 2012, ACP initiated the involvement of its chapter governors to influence state governments to accept federal funding to extend Medicaid coverage to their poorest residents. Dubbed the *ACP Medicaid Patient Advocacy Campaign*, this effort provided chapters with uniquely-customized state-specific reports on the benefits of states accepting federal dollars to expand their Medicaid programs. Based on available information to date, almost all ACP chapters are participating in this campaign.

PATIENT PROTECTIONS AND INSURANCE MARKET REFORMS

The ACA also created new patient protections and other reforms designed to curb abuses by health insurers. Starting in 2010, new requirements for health insurers were put in place, many of which will be expanded in 2014. Some key examples include: increasing the age to 26 for which dependents can remain covered under their parents’ health insurance, banning pre-existing conditions exclusions for children in 2010 and for all starting in 2014, restricting insurers from imposing annual or lifetime dollar limits on coverage, requiring insurers to cover core preventive services such as immunizations and other services recommended by the U.S. Preventive Services Task Force. And, starting in 2011, if an insurer in the small group market directs less than 80 percent of an individual’s premium to anything other than to clinical and quality care improvement costs (85 percent in the large group market), the insurer will be required to refund the difference to the enrollee. More detail regarding these reforms can be found [here](#).

MEDICARE BONUS PAYMENT FOR PRIMARY CARE SERVICES

In calendar years 2011-2015, the ACA provides a 10 percent bonus payment on select primary care services furnished by primary care physicians. To qualify for the bonus, a physician must be self-designated in a primary care specialty, defined as general internal medicine, family practice, geriatrics, and pediatrics, and he or she must predominantly provide select primary care services to be eligible. To view the specifics on eligibility, please see [here](#). To better understand how this bonus could impact your practice, please visit [here](#).

Mandatory funds have been provided in the ACA to fully implement this bonus, which means the funds are not subject to the annual appropriations process in Congress. The bonus begins to address disparities in payments that are major barriers to physicians entering and remaining in primary care specialties. A report by the Council on Graduate Medical Education (COGME) recommends that compensation to primary care physicians be increased to 70 percent of the average payment for other physician specialties in order to train and retain a sufficient supply of primary care physicians. While the

Primary Care Incentive Program falls considerably short of COGME's recommendation, it will result in the largest sustained increase in payments to primary care physicians in decades.

ENHANCED MEDICAID REIMBURSEMENT RATES FOR PRIMARY CARE SERVICES

The ACA includes a provision to increase Medicaid payment rates for certain primary care services to at least the level of Medicare in 2013 and 2014. This is often referred to as the [Medicaid Parity](#) provision of the ACA. This initiative provides for higher Medicaid payments to physicians practicing a specialty designation of family medicine, general internal medicine or pediatric medicine. It also provides for higher payment for subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association and the American Board of Physician Specialties. Physicians who are in those designated specialties but not board certified (are Board eligible) can also qualify if at least 60 percent of the codes billed by the physician for all of CY 2012 (or the prior month if the physician is new to Medicaid) be for the E&M codes and vaccine administration codes specified in this regulation.

Mandatory funds have been provided in the ACA to fully implement this program at no cost to the states. However, to qualify for the payment increase, physicians must first self-attest to a covered specialty or subspecialty, then they must attest that they are either board certified in an eligible specialty or subspecialty or that 60 percent of their Medicaid claims for the prior year were for E&M or vaccine administration codes specified in the regulation. Each qualifying physician must complete and file a self-attestation form created by his/her state Medicaid program. The attestation form and other state specific resources should be available on each state's Medicaid website. A list of the contact information for the offices of each state's Medicaid Director is available at <http://medicaiddirectors.org/about/state-directors>.

Studies show that the disparity in payments between primary care and other specialties is a principal barrier to physicians entering and remaining in primary care specialties and that low Medicaid payment rates, particularly for primary care, are a major reason why substantial numbers of physicians in many states do not participate in Medicaid or limit how many Medicaid patients they will see.

ACP strongly supports this provision as a step in the right direction, as it will help ensure that the growing numbers of individuals who are expected to enroll in Medicaid will be able to find primary care physicians to care for them, especially as Medicaid eligibility for the program is expanded in 2014. Congress should sustain and ensure continued dedicated (mandatory) funding for this program and begin to explore ways to re-authorize funding for the program beyond the January 1, 2015 termination date.

CENTER FOR MEDICARE AND MEDICAID INNOVATION

The ACA established a new Center for Medicare & Medicaid Innovation that allows the Centers for Medicare and Medicaid Services (CMS) to test models that promote broad payment and practice reform within Medicare, Medicaid and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care. Most relevant to the College, the law specifically suggests the consideration of models that promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

The Innovation Center is now testing numerous payment and delivery system models including: Accountable Care Organization models, Bundled Payments for Care Improvement, Comprehensive Primary Care Initiative, and the Independence at Home Demonstration. For more information on these models, please visit [here](#).

Congress should ensure continued dedicated (mandatory) funding at the current levels authorized by the ACA. This dedicated funding is needed to ensure that the Center has the resources needed to accelerate broad pilot-testing and adoption of new payment and delivery models to improve access to primary care services, improve outcomes, and achieve better value for beneficiaries and taxpayers.

SUPPORT FOR PRIMARY CARE

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 90,000 physicians by 2020; about half of the shortage will be in general surgery and medical specialties, while the other half will be in primary care. In 2010, COGME told Congress that in order to have an adequate supply of primary care physicians we need to increase their ratio to 40 percent of all physicians, an 8 percent increase over what was at the time 32 percent.

The ACA contained numerous key provisions to enhance the primary care workforce, including [improvements](#) to loan and scholarship programs under Title VII of the Public Health Service Act that help recruit and retain medical students in the practice of primary care. The ACA also permanently reauthorized the National Health Service Corps (NHSC), a federal program that provides scholarship and loan forgiveness to enable primary care physicians to be trained to serve in underserved communities. It includes an increase in full-time awards for the NHSC from \$35,000 to \$50,000 per individual and a new part-time award program. The ACA also redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots for primary care and general surgery. Sixty-five percent of the slots must be redistributed to primary care and general surgery. More information on these programs can be found in the backgrounder, *Federal Programs and Legislation Addressing Physician Workforce Shortages*.

NATIONAL HEALTH CARE WORKFORCE COMMISSION

The ACA establishes a [National Health Care Workforce Commission](#), a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy beginning in 2010. The Commission is to analyze and make recommendations for eliminating barriers to entering and staying in careers in primary care, including physician compensation among other things. However, to date, Congress had not provided the necessary funding for the Commission to be convened.

ACP is disappointed that Congress has chosen not to fund this important commission, which is subject to the annual appropriations process in Congress. We have urged Congress to appropriate funds so the commission can begin its work. However, in this difficult environment of fiscal constraints, Congress has focused its appropriations on other priorities. ACP is pleased that the President's FY2014 budget request does call for \$3 million for the commission but his budget request only serves as a blueprint for spending and does not have the force of law.

On March 28, Bob Doherty, ACP's SVP for Governmental Affairs and Public Policy, blogged about his assessment (reflecting ACP policies) of the Affordable Care Act at Age Three. You can read his post [here](#).

For more information on ACP's positions on the ACA and health reform, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/where_we_stand/affordable_care_act.html.