

## The Affordable Care Act at Age Four

### 2014 Leadership Day on Capitol Hill

#### Background

#### **Where Things Stand**

The Affordable Care Act (ACA) was enacted in March 2010 – just over four years ago – implementing sweeping reforms across the health care system. It remains controversial to this day, just as it was when it was enacted. This stems not only from the continued partisan differences between Republicans and Democrats on the merits of the law but also because it ushered in comprehensive changes to how health care is delivered in this country, which concerned many Americans in terms of how it would affect them personally. A recent [study](#) concluded that Americans are still conflicted about the law, but are less negative about its impact.

#### **Enrollment**

The majority of the ACA's many provisions take effect in [2013 and 2014](#) and, with few exceptions; the rollout of its many policies since 2010 has gone well, as so many Americans are now enjoying the many [protections](#) afforded by the law. Since enrollment began in the new health insurance marketplaces on Oct. 1, 2013, preliminary estimates indicate that as of April 15, over 8 million Americans have obtained coverage through a qualified health plan offered through an exchange (either through a federally operated exchange, or a state-run exchange); this exceeds the original enrollment estimates set by the Congressional Budget Office (CBO) prior to the troubled roll-out of the [healthcare.gov](#) portal last Fall. Several hundred thousand people have obtained coverage from an ACA-qualified plan that they purchased from an insurance company or broker outside of the exchanges. Although the exchange open enrollment period for this year ended on April 15, people whose circumstances change (such as by having a baby) can continue to enroll in a qualified health plan throughout the year. In addition, another 5 million have been estimated to have obtained coverage through Medicaid or the Children's Health Insurance Plan (CHIP) program, and several million people under the age of 26 have obtained coverage through the ACA under their parents' plans. As a result, the total number of people who have obtained coverage through the ACA is estimated to be between 14.4 and 23.5 million.

Even though there is still much to be learned about ACA enrollment in 2014, the numbers to date show that the law is meeting ACP's goal of substantially expanding coverage to the uninsured and offering improved benefits and consumer-protections to many more.

#### **The Politics**

The political parties continue to be divided on the ACA. Most Democrats are unified in their support for it, and continue to tout its benefits and protect its funding, although some Democrats running for re-election in more conservative parts of the country are reluctant to champion their support for the ACA and/or are seeking changes in it (but not repeal). Republicans continue to try to dismantle the law, by every means available to them, including scheduled House votes to repeal it or by restricting funding for its many provisions through the appropriations process. Not to over simplify the arguments, but to most Republicans, the law represents a massive federal reach into the lives of most Americans, where government controls how care is delivered. Many Republicans also are concerned that the country cannot afford the ACA, even though the CBO says it will lower the deficit. The negative stigma of the ACA is so strong with most Republicans that the mere mention of most policies derived from it is met with scrutiny. Yet the ACA relies principally on competition between private insurers to expand coverage with government premium subsidies and consumer protections; it does not give the government the authority to regulate the decisions of physicians and other providers or ration benefits.

To Democrats, the law means expanding access to health care for millions of uninsured Americans, ensuring that all health plans provide coverage for services like mental health and prevention, prohibiting insurance company practices that exclude or overcharge people with pre-existing conditions, and banning annual and lifetime caps on benefits. Some Democrats prefer a single payer system, but believe that the ACA is a step toward the goal of universal coverage. Most

Democrats agree that the ACA is an historic achievement, on par with the creation of Medicare in 1965, in extending access affordable health care.

The gap between each party's views on the ACA is so great that they have been unable to achieve bipartisan consensus on its future or possible changes in it.

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. The ACA is not a perfect product, but it takes substantive steps to improve upon our broken 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, as described in more detail below. ACP's intent all along has been to advocate in a constructive way to help ensure that implementation of the ACA will be the best that it can be.

The background information below outlines key ACA provisions of importance to the College and their status four years after enactment of the ACA. While we have no specific "asks" of Congress on these provisions, Leadership Day attendees should be familiar with these issues as they are routinely discussed in congressional offices.

## **Background**

### **Health Insurance Exchanges**

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 had an option to establish its own exchange and make it operational by October 2013, allow the federal government to operate an exchange for them, or create a quasi-federal-state exchange to operate in the state.

In 2011, states began receiving funding to help establish and operate the exchanges but by 2015 they must be self-sufficient. Open enrollment for all state, federal, and partnership exchanges began on October 1, 2013, with a very rocky rollout of the federal enrollment portal and in some states as well. Those technical difficulties appear to have been largely remedied but the federal government and some states elected to extend the deadline for open enrollment beyond April 1, 2014 for extenuating circumstances. More information about the enrollment period can be found [here](#).

As of April 2014, 17 marketplaces are operated by states, 27 are run by the federal government, and 7 are partnership marketplaces managed by the state and federal government. 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 stands on establishing an exchange, please see [here](#).

As noted earlier in this document, over 8 million people have obtained coverage through a qualified plan offered in an exchange. Although it is not yet known how many of the more than 8 million have paid their premiums for their qualified exchange plans, preliminary estimates are that more than 85 percent will end up doing so, which is typical for other health insurance options offered through an open-enrollment process. Some of the people who will end up not paying their premium will have gotten coverage through an employer, causing them not to continue coverage through an ACA exchange plan.

It also is not known yet precisely how many of the people who obtained coverage to date through the ACA were previously uninsured. The Rand Corporation estimates that approximately 9 million of the people who obtained coverage were previously uninsured. Gallup and other polling firms have also reported a substantial decrease in the number of surveyed Americans who say they are without health insurance coverage. The CBO projects that 12 million previously uninsured persons will obtain coverage in 2014.

It also is not known precisely how many of the newly enrolled through the exchanges are younger people, although the Administration reported on April 15 that 35 percent were under the age of 35. Most independent experts expect that enough young people will have enrolled to prevent a “death spiral” in premiums.

It is estimated that approximately 3 percent of the population, or about 12 million people, had the health plans they had bought on the individual insurance market (non-grandfathered plans) canceled because they did not meet the ACA’s benefit, cost-sharing, consumer protection, and other standards. They were offered the opportunity to buy a plan that meets the ACA’s requirements. Many were able to find a plan with comparable premiums, cost-sharing and benefits, although some of them ended up paying more than they were before, and/or felt that they were being forced to buy a plan with benefits they did not want. Many others were able to buy a better ACA-qualified plan at a premium they could afford, especially since more than 70 percent of them qualified for the ACA’s premium subsidies. The Administration also made it easier for people to continue to keep their “cancelled” policies if their state agrees. The Rand Corporation recently reported that fewer than a million of those whose insurance was cancelled remain without health insurance.

You may be asked in Republican offices about the “canceled” insurance policies and whether more people lost coverage as result than gained it. Although it is not advisable for you to debate the ACA with them, factually speaking (and as noted above), the millions who have gained coverage far outnumber the relatively small percentage of the population that had their individual plans canceled and had to pay more and/or were unable to find an affordable replacement policy. Yet it is true that some people who had their policies canceled, and in some cases are now paying more for a replacement policy, have expressed strong unhappiness to their members of Congress about being forced to switch. ACP cautions you not to express personal agreement with comments you may hear in Republican offices that contradict ACP’s support for the ACA—remember, you are representing ACP—but to listen politely, and offer to have the ACP staff send more information on the enrollment numbers, and any other information on why the College supports the ACA, if asked.

Finally, the vast majority of Americans who get coverage from their large employers are mostly unaffected by the changes that the ACA made this year, since their plans already meet the ACA’s benefit and consumer protection requirements. In addition, the deadline by which large employers had to offer a plan that meets the ACA’s requirements or pay a penalty was delayed by the Administration for one year, until January 1, 2015.

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. At the same time, ACP has offered recommendations to the Administration and those involved in implementing the exchanges on the potential challenges that can create barriers to care. The trend to narrow provider networks and to restrictive formularies, which can make it difficult for patients to see the physicians they trust and get the medications they need. While such trends pre-date and are not limited to health plans offered through the ACA, ACP observed that the federal government has a particular responsibility to address such barriers to access in federally qualified plans. State regulatory agencies and the insurance industry itself also have important roles. In a [February 2014 letter](#) to then-Administrator of Health and Human Services, Kathleen Sebelius, ACP called for a balanced, constructive and transparent approach to allow patients/consumers to make informed choices, to reduce unnecessary interruptions in continuity of care, and to ensure fairness and due process for clinicians and patients, including improvements in federal and state regulatory oversight of qualified health plans.

## **Subsidies**

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 are available on a sliding-scale basis to people with incomes between 133 percent and 400 percent of the Federal Poverty Level. 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 is a maximum of 50 percent of the employer’s contribution (35 percent for non-profit firms) towards their employees’ health insurance premium.

## 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 percent<sup>1</sup> 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. Republicans called for "block-granting" Medicaid in their budget resolution that passed the House on April 10, 2014 but has no chance of succeeding in the Democrat-controlled Senate.

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 of April 2014, 27 states including the District of Columbia have come out in favor of accepting the ACA's dollars to expand Medicaid, including several states with Republican governors and/or legislatures, arguing that it is in the best interests of their states, both fiscally and in terms of access to care for their poorer residents.

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 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.

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<sup>1</sup> The ACA expands Medicaid to 133 percent of the federal poverty level plus a 5 percent technical adjustment, which increases the eligibility level to 138 percent.

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 and again in March 2014, 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 are 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.

### **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 the Medicaid Pay Comparability Program 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. The continued preservation and enhancement of this provision is a top priority for ACP for Leadership Day this year and for the rest of 2014, and those details are discussed in the backgrounder, *Expiring Payment Policies Could Mean Cuts to Primary Care and Other Internists' Services*.

### **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. This program is a priority for ACP but because it is an election year and the program does not expire until the end of 2015, ACP will not be actively pushing for an extension of the program during this Leadership Day. However, Leadership Day attendees need to be familiar with it and be prepared to discuss it with lawmakers as another critical component in helping to ensure access to primary care services. More details about this program can be found in the backgrounder, *Expiring Payment Policies Could Mean Cuts to Primary Care and Other Internists' Services*.

### **Support for Primary Care**

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of over 45,000 primary care physicians by 2020, growing to a shortage of over 65,000 primary care physicians by 2025.

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. Funding for these programs is an important priority for ACP at Leadership Day and those specific details can be found in the backgrounder, *Understanding the Current Fiscal Environment and Its Impact on ACP's Funding Priorities*.

For more information on ACP's positions on the Affordable Care Act, please visit the Advocacy section of ACP Online, [http://www.acponline.org/advocacy/where\\_we\\_stand/affordable\\_care\\_act/](http://www.acponline.org/advocacy/where_we_stand/affordable_care_act/)

Attendees wishing to gain a broader understanding of the Affordable Care Act can view ACP's [Internist's Guide to Understanding Health System Reform](#).