



The Affordable Care Act Three Years Post-Enactment

Three years ago, on March 23, 2010, the Affordable Care Act (ACA) was signed into law. Although the date for full implementation of most provisions of the law is January 1, 2014, the ACA has already had an impact on the goals of expanded coverage of the uninsured, improved access and better care delivery models, broader access to community-based long-term care, and more integrated care and financing for beneficiaries who are dually eligible for Medicare and Medicaid. Although the ACA remains controversial, with many debates about its future as well as provisions already implemented, implementation is proceeding.

Much remains to be put in place leading up to 2014. This brief summarizes ACA-related activities to date in terms of tangible benefits and policy changes on the ground with respect to private insurance and Exchanges, Medicaid coverage, access to primary care, preventive care, Medicare, and Medicare and Medicaid dual eligible beneficiaries.

Private Insurance and Exchanges

- **Young adults up to age 26 can stay on their parents' insurance policies.** Young adults can qualify for this coverage even if they are no longer living with a parent, are not a dependent on a parent's tax return, or are no longer a student. Census data show that over two million young adults have gained coverage, contributing to the decline of 1.3 million in the number of uninsured Americans in 2011.
 - KFF resources:
 - [Explaining Health Care Reform: Questions about the Extension of Dependent Coverage to Age 26](#)
 - [The Uninsured: A Primer](#)

- **Many states are moving forward with building new health insurance marketplaces.** To date, 17 states and the District of Columbia are establishing state-based health insurance exchanges while another seven states will partner with the federal government to run their exchanges. These states are making critical decisions about how insurers will participate in the exchanges, what types and how many plans will be offered, and what types of consumer assistance will be available to help people enroll in coverage. States are also building the IT infrastructure for the exchanges to be ready when open enrollment begins on October 1. In the remaining 26 states, the federal government will operate a federally-facilitated exchange, and residents will get the same benefits and tax subsidies as in states operating their own Exchanges.
 - KFF resources:
 - [Establishing Health Insurance Exchanges: An Overview of State Efforts](#)
 - [State Health Exchange Profiles](#)

- **Coverage exclusions for children with pre-existing conditions were prohibited as of September 23, 2010.** Insurers are no longer permitted to deny coverage to children due to their health status, or exclude coverage for pre-existing conditions. Protections for adults will take effect in 2014. In addition, lifetime limits on coverage in private insurance have been eliminated and annual limits are being phased out.
 - KFF resources:
 - [What protections are there in the new health reform law for people with pre-existing conditions?](#)
 - [Health Insurance Market Reforms: Pre-Existing Condition Exclusions](#)
 - [Implementing New Private Health Insurance Market Rules](#)

- **Medical loss ratio and rate review requirements are improving value and lowering premium growth for consumers.** Medical loss ratio standards require insurers to spend 80-85% of premium dollars on direct medical care instead of on administrative costs, marketing, or profits, or pay rebates back to consumers. Failure to meet these standards has resulted in insurer payments of over \$1 billion in rebates to consumers. In addition, expanded review of insurance premium increases by states and the federal government has led to some rate increases requested by insurers being denied, withdrawn, or lowered, which has slowed overall premium growth.
 - KFF resources:
 - [Explaining Health Reform: Medical Loss Ratio \(MLR\)](#)
 - [Total Medical Loss Ratio \(MLR\) Rebates in All Markets for Consumers and Families, 2012](#)
 - [Quantifying the Effects of Health Insurance Rate Review](#)

- **All health plans must provide a standardized, easy-to-read Summary of Benefits and Coverage (SBC).** The SBC gives consumers consistent information about what health plans cover and what limits, exclusions, and cost-sharing apply. It includes illustrations of how coverage works by estimating what a plan would pay and what consumers would be left to pay for common health care needs such as an uncomplicated pregnancy or management of diabetes. Kaiser Family Foundation tracking polls indicate the SBC is one of the most popular provisions in the ACA.
 - KFF resources:
 - [The Most Popular Provision in the ACA?](#)
 - [Health Insurance Transparency under the Affordable Care Act](#)

Medicaid Coverage

- **More than half the Governors have announced support for the Medicaid expansion.** Twenty-seven Governors intend to implement the Medicaid expansion. Another seven are still weighing their options. Seventeen Governors have stated their opposition to the expansion.
 - KFF resource:
 - [State Activity Around Expanding Medicaid Under the Affordable Care Act](#)

- **Seven states have expanded Medicaid to adults since the enactment of the ACA, helping to build on the very limited base of coverage available to low-income adults today.** While the enhanced federal funding for the ACA Medicaid expansion to low-income adults does not take effect until January 1, 2014, seven states – CA, CO, CT, DC, MN, NJ, and WA – have used the ACA option to expand Medicaid earlier at their regular match rate, or used Section 1115 waiver authority to do so. Nearly all these states previously covered low-income adults using state-only dollars, but transitioning that coverage to Medicaid enabled them to preserve and, in some cases, expand adult coverage by securing federal matching funds.
 - KFF resource:
 - [Getting into Gear for 2014: Findings From a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013](#)

- **Medicaid and CHIP have remained primary sources of coverage for low-income children and pregnant women.** To help preserve the existing base of coverage in the period leading up to the coverage expansions in 2014, the ACA required states to maintain the Medicaid and CHIP eligibility, enrollment, and renewal policies they had in place when the ACA was enacted. Notwithstanding the recent recession and state budget pressures, eligibility for these programs has remained largely stable, and the programs have remained

primary sources of coverage for low-income children and pregnant women. The preservation of Medicaid and CHIP coverage has been important to progress in reducing the number of uninsured Americans – which declined by 1.3 million in 2011.

- KFF resource:
 - [Getting into Gear for 2014: Findings From a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013](#)

- **Nearly all states are modernizing and streamlining their Medicaid enrollment systems.** Taking advantage of a time-limited 90% federal match rate available for systems development, almost all states are already moving forward with major improvements to their information technology (IT) infrastructure to prepare for the ACA's new streamlined, coordinated enrollment system. In addition, an increasing number of states – now totaling 37 – have implemented an electronic online application in Medicaid or CHIP, and the number of states with an online renewal process rose from 20 in 2011 to 28 in 2012. Over two-thirds of states now provide online accounts.
 - KFF resource:
 - [Getting into Gear for 2014: Findings From a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013](#)

- **Ten states have adopted the ACA's new Medicaid option to provide health homes for those with chronic conditions or serious mental illness.** Another five states plan to implement health homes. Health homes are among the ACA's broader set of initiatives to improve care and better manage spending for people with complex and high-cost needs. Building on patient-centered medical homes, health homes incorporate comprehensive care management, health promotion, transitional care, and other services and supports to provide more integrated, “whole person” care for Medicaid beneficiaries with multiple chronic conditions or a serious and persistent mental illness.
 - KFF resources:
 - [Health Homes for Medicaid Beneficiaries with Chronic Conditions](#)
 - [State Adoption of Health Homes for Beneficiaries with Chronic Conditions Provided by the Affordable Care Act, 2013](#)

- **States are taking advantage of new and expanded opportunities to provide home and community-based long-term services.** Many people with long-term care needs prefer to receive services at home or in the community rather than in institutional settings, and home and community-based services (HCBS) are often less expensive. The ACA expands states' opportunities to rebalance their long-term care programs toward community-based care and provides new federal funding for this purpose. A total of 46 states, including DC, have received federal grant money to transition Medicaid beneficiaries from institutions back to their homes or community-based settings through the “Money Follows the Person” demonstration program, which the ACA extended. Sixteen of these states first undertook a demonstration this past year. A growing number of states – 25 currently – are responding to other new flexibility and federal financial incentives the ACA provided to increase access to HCBS.
 - KFF resources:
 - [How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports \(LTSS\) Today? State Adoption of Six LTSS Options](#)
 - [Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law](#)
 - [Money Follows the Person: A 2012 Survey of Transitions, Services and Costs](#)

Access to Primary Care

- **Primary care providers get increased Medicare and Medicaid payment rates under the ACA.** The ACA provides for a 10% bonus payment on top of the regular Medicare fee schedule amount for many primary care services provided by primary care physicians (and other practitioners) from 2011 through 2015. The law also requires states to raise their Medicaid payment rates in 2013 and 2014 to Medicare payment levels for many primary care physician services. As a result, Medicaid primary care fees will increase by 73%, on average, in 2013 although the size of the increase will vary by state. The Medicaid increase is fully federally funded up to the difference between states' July 1, 2009 fees and Medicare fees in 2013 and 2014.
 - KFF resources:
 - [How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees](#)
 - [Ensuring Access to Care in Medicaid Under Health Reform](#)

- **Because of new ACA investments in the health center program, health centers' patient capacity has expanded.** The ACA created a five-year \$11 billion Health Center Trust Fund to support health center growth in preparation for the coverage expansion beginning in 2014. Drawing on this fund, health centers are serving an additional 1.5 million patients, and they have been able to maintain their capacity to serve another 2.2 million patients whom they were earlier able to reach only because of a (now-expired) temporary increase in federal funding when the recession was at its deepest. In addition, over 700 health centers received grants for capital improvements from funds provided by the ACA for this purpose.
 - KFF resource:
 - [Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth](#)

- **Thousands of new primary care providers have been added to the ranks of the National Health Service Corps (NHSC), bolstering the health care workforce in medically underserved communities.** The ACA provided increased funding of \$1.5 billion for the NHSC, which provides loan repayment to medical students and others in exchange for service in low-income underserved communities. Health centers, which serve millions of people in these communities, rely heavily on the NHSC to recruit their physicians, dentists, and other health care professionals. As a result of the ACA investment and earlier investments by the American Reinvestment and Recovery Act of 2009, the number of NHSC clinicians is at an all-time high – triple the number in 2008. Today nearly 10,000 NHSC providers are providing primary care to approximately 10.4 million people at nearly 14,000 health care sites in urban, rural, and frontier areas.
 - KFF resources:
 - [Primary Care Health Professional Shortage Areas \(HPSAs\), 2012](#)
 - [Dental Health Professional Shortage Areas \(HPSAs\), 2012](#)

- **Additional efforts to expand the primary care workforce are also underway.** New training and retention programs have also been created to develop and strengthen the primary care workforce. The ACA has increased the number of graduate medical education residency programs, including establishing 11 Teaching Health Centers to support primary care training in ambulatory care settings. Other efforts include investments in training for nurses and physician assistants, and financial support for nurse-managed clinics.
 - KFF resource:
 - [Summary of New Health Reform Law](#)

Access to Preventive Services

- **Preventive benefits with no patient cost-sharing are now required in Medicare and private insurance (except for grandfathered plans).** The benefits that must be covered include services found to be effective by the USPSTF, immunizations for adults and children endorsed by the CDC Advisory Committee on Immunization Practices, and pediatric services recommend by HRSA's Bright Futures for Children. Private plans must cover additional preventive services for women without cost-sharing, including all FDA-approved contraceptive methods (non-profit, religious employers that object to that requirement are exempt) and at least one annual well-woman visit. HHS estimates that, as a result of the ACA, 71 million children and adults with private insurance, and 34 million Medicare beneficiaries have received no-cost preventive care. Enhanced federal matching funds in Medicaid are available to states providing all USPSTF-recommended preventive benefits without cost-sharing, but, to date, few states have made the changes required to gain the higher match rate.
 - KFF resources:
 - [Preventive Services Covered by Private Health Plans under the Affordable Care Act](#)
 - [Impact of Health Reform on Women's Access to Coverage and Care](#)
 - [Coverage of Preventive Services for Adults in Medicaid](#)
- **The ACA supports population-based prevention activities through a new Prevention and Public Health Fund.** This Fund has been used to make over \$1 billion in critical investments in programs aimed at reducing the burden of chronic disease and improving the overall health of communities. Funding has supported Community Transformation Grants in 36 states to reduce the incidence of heart attacks, strokes, cancer, and other diseases; rebuilding the immunization infrastructure; tobacco cessation programs; and substance abuse and suicide prevention activities.
 - KFF resource:
 - [Summary of New Health Reform Law](#)

Medicare

- **Medicare beneficiaries enrolled in Part D drug plans are receiving additional help with their “doughnut hole” prescription drug costs.** The ACA required drug manufacturers to offer a 50% discount on brand-name drugs in the coverage gap phase of the Medicare drug benefit, known as the “doughnut hole,” beginning in 2011. It also required Part D plans to offer additional coverage for brand-name and generic drugs for enrollees who reach the coverage gap, and phases out the gap by 2020. In 2013, plans pay for 21% of the cost of generic drugs and 2.5% of the cost of brands, on top of the 50% manufacturer discount. According to HHS, as of March 2013, 6.3 million Medicare beneficiaries have saved over \$6.1 billion on prescription drugs in the Medicare Part D doughnut hole since the ACA was enacted.
 - KFF resources:
 - [Medicare Part D: A First Look at Part D Plan Offerings in 2013](#)
 - [Explaining Health Care Reform: Key Changes to the Medicare Part D Drug Benefit Coverage Gap](#)
- **New initiatives testing delivery system and payment reforms are being developed and implemented rapidly around the country, including Accountable Care Organizations (ACOs) and bundled payments.** The ACA established a new Center on Medicare and Medicaid Innovation charged with reducing costs in Medicare, Medicaid, and CHIP while preserving or enhancing quality of care. The Innovation Center develops, tests, and supports new delivery models to increase coordination of care and improve quality, along with new payment systems to encourage more value-based care and move away from fee-for-service payment. For example, the Innovation Center has approved more than 250 ACOs to participate in the Medicare Shared Savings Program in 47 states and territories; these ACOs cover more than four million beneficiaries in traditional Medicare.

- KFF resource:
 - [Summary of Key Changes to Medicare in 2010 Health Reform Law](#)
- **Medicare savings in the ACA have helped extend the solvency of the Medicare Part A trust fund.** The ACA included Medicare savings measures that were projected to reduce growth in Medicare spending over time. The measures included reduced payments to Medicare Advantage plans, smaller updates in payment levels to hospitals and other providers, and increased premiums for higher-income beneficiaries. These changes, along with a payroll tax increase for higher-income taxpayers, contributed to the extended solvency of the Medicare Part A trust fund. Medicare spending per beneficiary is projected to grow more slowly than private health insurance spending per capita over the next decade, and premiums and cost-sharing for many Medicare-covered services are lower than what they would be without the ACA.
- KFF resources:
 - [Explaining Health Reform: Key Changes in the Medicare Advantage Program](#)
 - [Medicare Spending and Financing Fact Sheet](#)

Medicare and Medicaid Dual Eligible Beneficiaries

- **Many states have responded to the ACA initiative to develop and test models that align Medicare and Medicaid financing for dually eligible beneficiaries.** About 9 million seniors and younger people with significant disabilities are dually eligible for Medicare and Medicaid. Many have complex medical and long-term care needs and they account for a disproportionate share of spending in both programs. A total of 26 states responded to a CMS solicitation for proposals to test models that align Medicare and Medicaid financing for this population; four of these states now have memoranda of understanding approved to implement demonstrations in 2013, and another 21 proposals are pending CMS's approval.
- KFF resources:
 - [State Demonstration Proposals to Integrate Care and Align Financing for Dual Eligible Beneficiaries](#)
 - [Illinois, Massachusetts, Ohio, and Washington: Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared](#)

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