



Accomplishments of the Affordable Care Act

A 5th Year Anniversary Report

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Executive Summary and Key Statistics

On March 23, 2010 President Obama signed the Patient Protection and Affordable Care Act into law (Affordable Care Act).ⁱ The enactment of this legislation came after nearly 100 years of effort to advance comprehensive health care reform in the United States. At its fifth anniversary, many of the law's key provisions have gone into effect and progress has been made toward its goals of improving the affordability, accessibility, and quality of health care nationwide.

This report summarizes key elements of the Affordable Care Act and provides detail on their implementation and results to date. It also provides key statistics on the impact of the law to date.

Key Statistics

Since the Affordable Care Act was enacted in 2010, the United States health care system has taken important steps toward providing all Americans with quality, affordable health care. Some key measures of that progress include millions more Americans with health insurance, tens of millions of Americans benefiting from improved consumer protections, slower health care cost growth, and improved health care quality.

More Insured Americans

- The past year has seen the largest decline in the uninsured rate since the early 1970s. Since several of the Affordable Care Act's coverage provisions took effect, about 16.4 million uninsured people have gained health insurance coverage.¹ Now the uninsured rate is now at the lowest level recorded across five decades of data.
- The uninsured rate declined across all race and ethnicity categories but there were greater declines among African Americans and Latinos than among Whites. Among African Americans, the uninsured rate declined by 9.2 percentage points, resulting in 2.3 million adults gaining coverage and among Latinos, the uninsured rate dropped by 12.3 percentage points resulting in 4.2 million adults gaining coverage.²
- During open enrollment for 2015, nearly 11.7 million Americans have selected plans or were automatically reenrolled in coverage through the Marketplaces.³
- As of January 2015, approximately 11.2 million additional Americans were covered under Medicaid and the Children's Health Insurance Program compared to the start of October 2013, when the Affordable Care Act's open enrollment began.⁴
- Since 2010, 5.7 million young adults have gained coverage, many through the Affordable Care Act's provision allowing young adults to remain on a parent's plan to age 26 and its broader expansion of coverage through the Health Insurance Marketplaces and Medicaid.⁵ By the second quarter of 2014, the uninsured rate among young adults had dropped by more than 40 percent.⁶

ⁱ On March 23, 2010 President Obama signed the Patient Protection and Affordable Care Act (Pub.L. 111-148) and on March 30, 2010 President Obama signed the Health Care and Education Reconciliation Act of 2010, which included amendments to the Patient Protection and Affordable Care Act (Pub.L. 111-152). This report refers to the final amended law as the Affordable Care Act.

Improved Consumer Protections

- Up to 129 million Americans with pre-existing conditions, including up to 17 million children, are no longer at risk of being denied coverage because of their health.⁷
- 105 million Americans no longer have a lifetime cap on their coverage.⁸
- 76 million Americans with private coverage are eligible for expanded preventive services coverage under the Affordable Care Act—including 30 million women and 18 million children.⁹
- Consumers have saved \$9 billion since 2011 because the law requires insurance companies to spend at least 80 cents of every premium dollar on consumers' health care and empowers States to review and negotiate premium increases.¹⁰

Lower Health Care Cost Growth and Better Value

- The average premium for employer-provided family health coverage went up only 3 percent in 2014, as measured by the leading survey of employer premiums. That's tied for the lowest rate increase on record since the survey began in 1999. Had premium growth from 2010 through 2014 matched the pace seen over the decade before the Affordable Care Act, the average premium for employer-based family coverage would be \$1,800 higher today.^{11 12}
- Prices of health care goods and services have risen at a 1.6 percent annual rate since the Affordable Care Act became law, the slowest rate of increase for any such period in nearly 50 years.¹³ Health care prices have risen at an even slower 1.2 percent rate over the last 12 months.
- Medicare spending growth per beneficiary was approximately flat in fiscal year 2014, and from 2010 to 2013, Medicare spending per beneficiary grew at a rate that was 2 percentage points less per year than rate of growth in GDP per capita.¹⁴
- At the time the Affordable Care Act was passed, the Medicare Trustees projected that the Hospital Insurance Trust Fund would be exhausted and unable to finance the program in 2017; most recently, largely as a result of the ACA, the Trustees projected that the Trust Fund will remain solvent until 2030, an improvement of 13 years.¹⁵
- Since 2010, 9.4 million seniors and people with disabilities have saved over \$15 billion on prescription drugs, an average of \$1,598 per beneficiary, by shrinking the Medicare prescription drug donut hole.¹⁶
- Reforms to improve the quality of hospital care have helped avoid an estimated 150,000 readmissions between 2012 and 2013, and prevent 50,000 patient deaths, and save approximately \$12 billion in health care costs between 2010 and 2013.¹⁷
- From 2010 to 2013, hospital patients experienced 1.3 million fewer hospital-acquired conditions, a 17 percent decline over the three year period.¹⁸
- Thanks to the Affordable Care Act, 424 Accountable Care Organizations (ACOs) are providing coordinated, quality care to more than 7.8 million beneficiaries and an estimated 20 percent of Medicare reimbursements have shifted to payment models directly linking provider reimbursement to the health and well-being of their patients.^{19 20}

- The law's anti-fraud provisions have contributed to several record-high years of health care fraud recoveries for the Health Care Fraud and Abuse Control Program. In FY 2014, these efforts recovered \$3.3 billion in taxpayer dollars. For every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered \$7.70.²¹

Early Consumer Protections and Health Insurance Reforms

Beginning soon after the law's enactment, reforms to the private health insurance market and consumer protections began. These early reforms included barring most health plans from imposing pre-existing condition exclusions on children under 19, prohibiting lifetime limits on coverage, ending insurance coverage rescissions, and improving consumer appeals rights. Many consumers gained improved rights to obtain information about why a claim or coverage had been denied, to appeal to the insurance company, and to obtain an independent third-party review of the insurer's decision. In addition to these new rights and protections, the Affordable Care Act took steps to increase transparency in the health insurance market, providing consumers a short, plain-language summary of benefits and coverage and a new website to review health insurance issuers and products available in their area.

Prohibiting Coverage Denials of Children Based on Pre-Existing Conditions (Section 2704), Effective Date: September 23, 2010

Prior to the Affordable Care Act, in the vast majority of States, insurance companies in the individual or small group health insurance market could deny coverage, charge higher premiums, and limit benefits to individuals based on pre-existing conditions. A 2009 survey found that 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market were turned down, were charged more, or had a specific health problem excluded from their coverage.²² For plan or policy years beginning on or after September 23, 2010, the Affordable Care Act prohibits group health plans and issuers of group health insurance from imposing pre-existing condition exclusions on children under 19. In the individual market, this prohibition applies to all policies issued after March 23, 2010. This provision protects as many as 17 million children under age 18 who have some type of pre-existing condition.²³

Eliminating Lifetime and Annual Limits (Section 2711), Effective Date: September 23, 2010

Before the Affordable Care Act, most health insurance plans imposed a dollar limit on the amount of care they would cover in a year or in a lifetime. In 2009, nearly 60 percent of people with employer based coverage and nearly 90 percent of people purchasing coverage on the individual market had a lifetime dollar limit on their coverage, leaving them exposed to high medical expenses.²⁴ An estimated 20,000 people hit a lifetime limit each year.²⁵ The Affordable Care Act prohibits lifetime and annual dollar limits in the large group, small group, and individual health insurance markets. The prohibition on lifetime limits took effect for plan years beginning on or after September 23, 2010 and applies to both grandfathered and non-grandfathered plans. The ban on annual limits does not apply to grandfathered individual health insurance plans and was phased in over three years for all other plans. The annual limits on essential health benefits could not be less than \$750,000 for plan years beginning after September 23, 2010, \$1.25 million for plan years starting on or after September 23, 2011, \$2 million for plan years starting between September 23, 2012 and January 1, 2014 and were prohibited entirely for plans issued or renewed beginning January 1, 2014. As a result of this policy, an estimated 105 million people, including 70 million people with coverage through a large employer, 25 million people with

coverage through a small employer, and 10 million people with individually purchased coverage, saw a lifetime limit on their coverage removed.²⁶

Prohibiting Rescissions and Improving Appeals Rights **(Section 2712 and 2719), Effective Date: September 23, 2010**

Prior to the Affordable Care Act, thousands of Americans lost health coverage each year due to “rescission,” a practice by which an individual's health coverage is retroactively cancelled and the insurance company is no longer responsible for medical care claims that they had previously accepted and paid. For plan years beginning on or after September 23, 2010, the Affordable Care Act prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from rescinding coverage except in the case of fraud or intentional misrepresentation of a material fact. This prohibition applies to both grandfathered and non-grandfathered plans in the individual, small group, and large group markets and protects those who may have otherwise had their coverage rescinded based on discrepancies that were unintentional or caused by others, applies to conditions that were unknown to plan participants or policyholders, and to discrepancies unrelated to the medical conditions for which patients sought medical care.

The Affordable Care Act also provides consumers new rights to appeal their insurer's coverage determinations. Before the enactment of the Affordable Care Act, health plan sponsors and issuers were not uniformly required to implement internal appeals and external review processes for claim or coverage denials. Effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, both non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage must provide consumers improved rights to: obtain information about why a claim or coverage has been denied, appeal to the insurance company and have an appeal expedited if necessary, and provide access to an independent review organization to conduct external reviews of the coverage determination. If the internal appeal or external review is resolved in a consumer's favor, that decision is binding on the issuer or plan.

Multi-Employer Welfare Arrangements **(Sections 6601 to 6607), Effective Date: April 2013**

The Affordable Care Act created new tools to protect the employees of small companies that band together to purchase benefits. A multi-employer welfare arrangement (MEWA) allows groups of employers to jointly provide health care and other benefits to their workers, but unscrupulous promoters, marketers and operators of certain MEWAs have taken advantage of gaps in the law and put enrollees at financial risk. The law closes these gaps by providing tools to target fraud and take action to remedy a financially hazardous condition. The rules also increase better transparency in MEWA operations by enhancing existing reporting requirements to include additional information to determine the financial condition of MEWAs.²⁷

Providing Consumer Information: Summary of Benefits and Coverage, HealthCare.gov **(Sections 2715, 2793, and 1103), Effective Dates: July, 2010 and September 23, 2012**

The Affordable Care Act provides consumers new tools to better understand and compare their health insurance coverage options. Under the law, health insurers and group health plans are required to provide consumers with clear, consistent and comparable information about their health plan's benefits and coverage. Beginning September 23, 2012, grandfathered and non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must provide

consumers with an easy-to-understand summary of benefits and coverage and a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "co-payment." The materials must provide information on plan deductibles, coinsurance, and copayments, information regarding any exceptions, reductions, or limitations of the coverage, displayed in a standard format to make it easier to compare plans. The materials also simulate coverage examples for two benefits scenarios, having a baby and managing type 2 diabetes, so consumers can see how each different plan applies cost-sharing to common benefit scenarios.²⁸

The law also directed the Secretary of HHS to create a web portal through which consumers can compare coverage options. In July 2010, a new website began providing consumers basic information on issuers and health insurance products available in their area. The site later added additional information on plan benefits and pricing, including – for the first time – data on how often consumers were denied coverage based on a pre-existing condition or charged more based on their health.

Early Improvements in Coverage and Affordability

As the early consumer protections and market reforms went into effect after the law's enactment, so did requirements to improve health insurance coverage and affordability and provide a bridge to 2014. The law's early improvements to coverage and affordability include requiring health plans to cover children up to age 26, providing coverage for certain recommended preventive services with no cost sharing or deductible in private insurance and Medicare, starting to close the Medicare donut hole, enhancing insurance rate review, and requiring that insurers spend at least 80 percent of premium dollars on clinical services and quality improvement. The law also took steps to provide a bridge to 2014, when the Affordable Care Act's ban on discrimination on the basis of pre-existing conditions and its principal coverage expansions went into effect. Beginning in 2010, the Affordable Care Act provided support for individuals locked out of coverage due to a pre-existing condition, early retirees at risk of losing coverage, States interested in expanding Medicaid, and small businesses offering coverage to their workers.

Dependent Coverage for Young Adults **(Section 2714), Effective Date: September 23, 2010**

Before the Affordable Care Act, insurance companies generally ended dependent child coverage under health insurance plans at age 19 or when children stopped being full-time students. This practice, plus the loss of Medicaid coverage for children and more limited access to employer sponsored coverage, contributed to young adults having the highest uninsured rate of all age groups. The Affordable Care Act requires health plans and health insurance issuers that cover dependent children to make coverage available to children up to age 26. Effective for plan years beginning on or after September 23, 2010, the provision applies to grandfathered and non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage. This provision increased the number of young adults ages 19 to 25 with health insurance coverage by 2.3 million. Since 2010 through the second quarter of 2014, the uninsured rate among young adults has declined by more than 40 percent, and, as of early 2015, the law as a whole has increased insurance coverage among this age group by a total of 5.7 million people.^{29,30}

Pre-existing Condition Insurance Program **(Section 1101), Effective Date: July 1, 2010**

As many as 129 million Americans have a pre-existing health condition.³¹ As a result, many of these individuals could have been denied coverage, charged significantly higher premiums, subjected to an extended waiting period, or had their benefits curtailed due to their condition. Before the Affordable Care Act's prohibition on these practices took effect in 2014, the law created a temporary high-risk pool program called the Pre-Existing Condition Insurance Program (PCIP) to serve as a bridge to comprehensive insurance reforms in 2014. PCIP was open to individuals who were citizens or nationals of the United States, or were lawfully present in the United States, who had been uninsured for at least six months and had a pre-existing condition. The law appropriated \$5 billion to support PCIP, and at its peak the program covered more than 100,000 individuals, many of them with serious medical conditions such as cancer, hemophilia, and heart disease. In 2012, the program served nearly 5,000 people with a diagnosis of heart disease, and 2,200 people suffering from cancer, including nearly 1,000 of whom had a diagnosis of breast cancer.³² Many PCIP enrollees were transitioned to other sources of coverage, including coverage offered through the Health Insurance Marketplaces, in 2014.

Early Retiree Reinsurance Program **(Section 1102), Effective Date: March 23, 2010**

In recent decades, the availability of group health coverage for retirees has declined significantly. The percentage of large employers providing workers with retirement health coverage dropped from 66 percent in 1988 to 26 percent in 2010.³³ The Early Retiree Reinsurance Program (ERRP) provided financial assistance to employment-based health plan sponsors to prevent further erosions of such coverage until 2014, when the Affordable Care Act's provisions ensuring the availability and affordability of coverage for individual health insurance coverage took effect. Specifically, the ERRP provided nearly \$5 billion in reinsurance payments to approximately 2,900 employers and other sponsors of retiree plans to offset up to 80 percent of eligible claims costs between \$15,000 and \$90,000 for claims incurred after June 1, 2010. These plan sponsors provide coverage to nearly 26 million people, including almost 2.6 million early retirees, many of whom may not have had any coverage alternatives prior to 2014.³⁴ The percentage of employers offering retiree health benefits was roughly the same from 2011 through 2014 in part due to this program.³⁵

Preventive Services Coverage with No Cost Sharing **(Section 2713), Effective Date: September 23, 2010**

Prior to the Affordable Care Act, many Americans were enrolled in health insurance plans that required them to pay out-of-pocket for key preventive services or did not cover all recommended preventive services. For plan years (in the individual market, policy years) beginning on or after September 23, 2010, the Affordable Care Act requires that non-grandfathered health insurance plans and policies provide coverage for recommended preventive services without cost-sharing. Recommended preventive services are those recommended by the U.S. Preventive Services Task Force with an A or B recommendation, the Advisory Committee on Immunization Practices, the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and comprehensive guidelines supported by HRSA on women's clinical preventive services, as specified in the statute.³⁶ Services required to be covered with no out-of-pocket cost include, but are not limited to, recommended immunizations like measles, mumps and rubella and influenza; cancer screenings; FDA-approved contraception methods and counseling for women with reproductive capacity; obesity screening and counseling; and behavioral assessments for children through adolescence. As a result of this provision, an estimated 76 million

Americas are newly eligible for expanded preventive services coverage under the Affordable Care Act—including 30 million women and over 18 million children.³⁷ According to data from the IMS Institute for Healthcare Informatics, the number of women who filled prescriptions for oral contraceptives with no co-pay more than quadrupled between 2012 and 2013.³⁸

Medicare Wellness Visit and Prevention Coverage **(Section 4103 and 4104), Effective Date: January 1, 2011**

The Affordable Care Act made many preventive services available to Medicare beneficiaries without cost sharing. The services now covered without cost sharing include, for example, an annual wellness visit, tobacco cessation counseling, and screenings such as bone mass measurements and mammograms. Since this provision went into effect in 2011, use of preventive services has also expanded among people with Medicare. An estimated 39 million people with Medicare (including those enrolled in Medicare Advantage) took advantage of at least one preventive service with no cost sharing in 2014 compared to 32.5 million in 2011.³⁹ Furthermore, nearly 4.8 million people with traditional Medicare took advantage of the Annual Wellness Exam in 2014.⁴⁰

Medicare Prescription Drug Discounts **(Section 3301), Effective Date: July 1, 2010**

Prior to the Affordable Care Act, seniors and individuals with disabilities enrolled in the Medicare Prescription Drug program faced a gap in coverage where beneficiaries had to pay the full cost of their prescriptions out of pocket before catastrophic coverage for prescriptions took effect. The gap is known as the donut hole. The Affordable Care Act makes Medicare prescription drug coverage more affordable by gradually closing the donut hole by 2020. In 2010, anyone with a Medicare prescription drug plan who was subject to the prescription drug donut hole received a \$250 rebate. In 2011, beneficiaries subject to the donut hole began receiving discounts on covered brand-name drugs and savings on generic drugs. People with Medicare Part D who are subject to the donut hole in 2015 will receive discounts and savings of 55 percent on the cost of brand name drugs and 35 percent on the cost of generic drugs. Since the enactment of the Affordable Care Act, 9.4 million seniors and people with disabilities have saved over \$15 billion on prescription drugs, an average of \$1,598 per beneficiary.⁴¹

Strengthened Rate Review **(Section 2794), Effective Date: September 2011**

Before the Affordable Care Act, in many States, insurers could raise rates without providing justification or explaining their actions to regulators or the public. The Affordable Care Act sets minimum standards for the review of rates and establishes a process for the annual review of unreasonable increases in premiums. Since September 2011, proposed rate increases for non-grandfathered coverage in the individual and small group markets at or above 10 percent have been scrutinized by independent experts to make sure they are justified. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for unreasonable rate increases, as well as publicly justify and post on their website any unreasonable rate increases that they implement. The law also provided \$250 million to help strengthen and improve States' rate review processes, and to increase transparency in medical loss. This improved rate review is estimated to have reduced total premiums in the individual and small group markets by approximately \$1 billion in 2013 and \$1.2 billion in 2012.⁴² The percentage of requests for rate increases of 10 percent or more in the individual market fell dramatically after this provision was implemented, from 43 percent in 2011 to 26 percent in 2012 and 25 percent in 2013.⁴³

Medical Loss Ratio

(Section 2718), Effective Date: 2011 Plan Year

Prior to the Affordable Care Act, many insurance companies were permitted to spend a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing. Beginning with the 2011 plan year, the Affordable Care Act requires health insurance issuers in the individual, small group, and large group markets – including both grandfathered and non-grandfathered plans – to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage of premium dollars on clinical services and quality improvement does not meet minimum standards: at least 80 percent in the individual and small group markets and at least 85 percent in the large group market. Since the provision went into effect, insurers have paid over \$1.9 billion in rebates. In 2013 alone, 6.8 million consumers received over \$330 million in rebates – an average of \$80 per family. Consumers have saved an estimated \$9 billion because companies are charging lower premiums and operating more efficiently than they would have been in the absence of the MLR requirements and other health care reforms.⁴⁴

Small Business Tax Credit

(Section 1421), Effective Date: Tax Year 2010

Before the Affordable Care Act, small businesses often paid significantly more in premiums than their larger competitors for the same benefits. To assist small businesses in affording coverage, the Affordable Care Act created a new tax credit for employers with fewer than 25 full-time equivalent employees, who pay at least half of their employees' health insurance premiums and provide average wages of less than \$50,000 (as adjusted for inflation beginning in 2014) per year. For tax years 2010 through 2013, the maximum credit was 35 percent of premiums paid for small business employers and 25 percent of premiums paid for small tax-exempt employers. Beginning in 2014, the maximum credit was 50 percent of premiums paid for small business employers and 35 percent of premiums paid for small tax-exempt employers. For tax years beginning in 2014 or later, the credit is primarily available to employers purchasing coverage through the Small Business Health Options (SHOP) Marketplace and is available for two consecutive years.

Indian Health Care Improvement Act

(Section 10221), Effective Date: March 23, 2010

The Affordable Care Act permanently authorizes the Indian Health Care Improvement Act (IHCIA) and establishes new programs to ensure that the Indian Health Service (IHS) is better equipped to meet its mission to improve the health status of American Indians and Alaska Natives. Among its many provisions, the IHCIA provides new authority to the IHS Director, updates reimbursement policies between Medicare, Medicaid, and the Children's Health Insurance Program and Indian health facilities, and gives tribes and tribal organizations new coverage options.⁴⁵ It also allows certain eligible tribes and tribal organizations to buy into the Federal Employees Health Benefits Program for their employees; over 10,000 tribal employees were covered by FEHBP in 2014.⁴⁶

Early Options to Expand Medicaid

(Section 2001), Effective Date: April 1, 2010

The Affordable Care Act's Medicaid expansion with significant new Federal funding began in 2014, but the law gave States the option to expand Medicaid to adults with incomes up to 133 percent of the FPL between April 1, 2010 and January 1, 2014 at the regular Federal matching rate. Seven States

implemented this early option for Medicaid expansion: California, Colorado, Connecticut, the District of Columbia, Minnesota, New Jersey, and Washington. Nearly 950,000 people were covered under these expansions.⁴⁷

2014 Improvements in Coverage and Affordability

Building on the policies implemented from 2010 through 2013, some of the Affordable Care Act's most significant reforms went into effect on January 1, 2014. Most plans are now prohibited from discrimination on the basis of pre-existing conditions and cannot charge women more than men for the same coverage. Most individual and small group market plans must cover essential health benefits like maternity care and prescription drugs. Additionally, starting in January 2014, eligible consumers began benefiting from the financial assistance the law made available to low and middle income Americans shopping for health coverage through the new Health Insurance Marketplaces, which offer new types of plans and choices. And, this new system is made stable and sustainable through shared responsibility provisions.

Prohibiting Discrimination Based on Pre-existing Conditions and Fair Health Insurance Premium Rating

(Section 2701-2705), Effective Date: January 1, 2014

Prior to the Affordable Care Act, many consumers in the individual or small group market could be refused coverage, charged a higher premium, or receive limited benefits because of a pre-existing health condition, their medical history, gender, or other factors related to their health status. In many States, consumers could also be charged higher premiums based on their gender or the industry in which they worked. Beginning January 1, 2014, non-grandfathered plans in the individual and small group health insurance market are prohibited under the law from discriminating on the basis of a pre-existing health condition, gender, industry, or any health status factor. The law also limits the degree to which issuers offering non-grandfathered coverage in the individual and small group market may vary premiums based on the age, family size, tobacco use, and geographic area of the applicant. The maximum ratio by which premiums can vary between older Americans and younger Americans is 3:1 and for tobacco users and non-tobacco users is 1.5:1. As a result of these provisions, as many as 129 million Americans with a pre-existing health condition and are now protected from discrimination when purchasing health insurance coverage, women can never be charged more than men for the same coverage, and all individuals and employers have certain basic protections with respect to the availability of the health insurance coverage.⁴⁸

Essential Health Benefits

(Sections 1302 and 2707), Effective Date: January 1, 2014

Prior to the Affordable Care Act, many health insurance policies could exclude key benefits like prescription drug coverage or maternity care. In the individual health insurance market, 62 percent of enrollees lacked coverage for maternity services, 18 percent lacked coverage for mental health services, and 9 percent lacked prescription drug coverage.⁴⁹ Beginning in 2014, the law requires non-grandfathered health plans offered in the individual and small group markets to offer a comprehensive package of items and services known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and

habilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The benefits must meet standards that ensure that the scope of benefits is equal to the scope of benefits provided under a typical employer plan. States selected a benchmark plan to serve as a reference point for insurers to design plans substantially equal to the EHB-benchmark. In 2011, HHS estimated that in the individual health insurance market, this policy would result in 8.7 million Americans gaining maternity coverage, 2.3 million Americans gaining mental health coverage at parity with medical and surgical benefits, and 1.3 million American gaining prescription drug coverage.⁵⁰

Out-of-Pocket Maximums

(Sections 1302 and 2707), Effective Date: January 1, 2014

The Affordable Care Act sets a limit on the amount consumers in non-grandfathered individual and group market health insurance plans (all markets, including self-funded plans) can be charged out-of-pocket each year. The out-of-pocket maximum applies to essential health benefits – such as hospitalizations, prescription drugs, and maternity care – provided by an in network provider. The limit was initially set at the Health Savings Account annual contribution limit in 2014 (\$6,350 for an individual and \$12,700 for a family) and is indexed to a premium adjustment percentage for future years. Prior to the Affordable Care Act, many consumers did not have this protection against catastrophic costs. A 2014 survey of employer based coverage reported a nearly two-thirds reduction from 2010 to 2014 in the percentage of covered workers in plans without an out-of-pocket maximum (18 to 6 percent).⁵¹

Individual Health Insurance Marketplaces

(Sections 1311 and 1321), Effective Date: January 1, 2014

The Affordable Care Act helps promote a more competitive private health insurance market through the creation of Health Insurance Marketplaces. The Marketplaces conduct eligibility determinations and allow consumers to directly compare available private health insurance options on the basis of price, quality, and other factors. Eligible individuals can purchase coverage through the Marketplaces during an annual open enrollment period or, following certain qualifying events, during a special enrollment period. Plans sold through the Marketplaces must be certified as qualified health plans and meet standards of quality and value such as accreditation, provider network adequacy standards, and the Affordable Care Act's market reforms. Plans offered to individuals through the Marketplaces fall into one of five categories based on their actuarial value – or the percentage of enrollees' care they are expected to cover. Platinum plans have an actuarial value of 90 percent, Gold 80 percent, Silver 70 percent, Bronze 60 percent, and Catastrophic plans, which are primarily available to individuals under 30 years of age and must comply with the maximum out-of-pocket limit. As of February 2015, nearly 11.7 million Americans had selected plans or been re-enrolled in coverage through the Health Insurance Marketplaces.⁵² This year there were 25 percent more issuers participating in the Marketplaces, based on analysis of 35 States, and consumers were able to choose from an average of 40 health plans in their county for 2015 coverage—up from 30 in 2014.⁵³

Premium Tax Credits and Cost Sharing Reductions

(Sections 1401, 1402, 1412 and 1415), Effective Date: January 1, 2014

Prior to the Affordable Care Act, health insurance coverage on the individual market was unaffordable for many low- and middle-income consumers. The Affordable Care Act makes financial assistance available to many individuals and families purchasing coverage through the Health Insurance Marketplaces. Individuals and families with household income between 100 percent and 400 percent of

the Federal poverty level who are not eligible for coverage from another source can qualify for premium tax credits. The amount of the premium tax credit is determined by calculating the difference between the cost of the second lowest cost silver plan premium – or benchmark premium – and a maximum percentage of a consumer’s household income – ranging from 2 percent to 9.5 percent depending on their income (with these percentages indexed over time). Marketplace consumers can benefit from these premium tax credits as advanced payments directly to their insurance company to lower their monthly premiums in bronze, silver, gold, or platinum level plans, or they can claim the credit when they file their taxes. Additionally, some individuals and families who qualify for premium tax credits may also qualify for cost-sharing reductions, which can further reduce their out-of-pocket spending for health services. Consumers with income below 250 percent of the Federal poverty level, and Indians with household income below 300 percent of the Federal poverty level who enroll in a silver plan qualify for cost-sharing reductions such as reduced deductibles, coinsurance and copayments. In 2014 and 2015, approximately 85 percent of consumers who selected plans through the Health Insurance Marketplaces qualified for an advanced premium tax credit.⁵⁴

SHOP Marketplaces

(Sections 1311 and 1321), Effective Date: January 1, 2014

Before the Affordable Care Act, many small businesses faced higher health insurance premiums and administrative costs than their larger competitors. The Affordable Care Act created the Small Business Health Options Program (SHOP) to assist qualified employers in providing health insurance options for their employees and to improve access to information about plan benefits, quality, and premiums. In 2015, employers with 1 to 50 employees, if otherwise eligible, can purchase coverage through the SHOP. Employers purchasing coverage through the SHOP must offer coverage to all of their full-time employees and, in 2015, can select either one plan to offer their employees or, in some States, select a coverage level and allow employees to choose any plan within that level. SHOP initial group enrollment is open all year round.

Multi-State Plan Program, CO-OPs, and the Basic Health Program

(Section 1334, 1322, 1331), Effective Date: January 1, 2014

As part of an overall effort to increase choice and competition in the health insurance market, the Affordable Care Act created the Multi-State Plan Program, the Basic Health Program, and the Consumer Operated and Oriented Plan (CO-OP) Program. The Multi-State Plan is administered by the Office of Personnel Management, which contracts with private health insurers to offer coverage on the Health Insurance Marketplaces. In 2014, 150 Multi-State Plan options were available in 30 States and the District of Columbia, covering approximately 371,000 individuals.⁵⁵ In 2015, the program expanded to a second group of insurance issuers and offers more than 200 plan options in 35 States and the District of Columbia.⁵⁶ The CO-OP program has fostered the creation of nonprofit health insurance issuers in more than 20 States through low interest start-up and solvency loans.⁵⁷ In States throughout the country, CO-OPs have competed effectively with established issuers and attracted significant enrollment. The Basic Health Program provides States the option to provide a public program option for certain low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. A State that operates a Basic Health Program will receive Federal funding equal to 95 percent of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to eligible individuals if these individuals enrolled in coverage through the Marketplace. The Basic Health Program offers this subsidized coverage to individuals with income between 139 and 200 percent of the Federal poverty level. Minnesota implemented the Basic Health Program for 2015.⁵⁸

Individual Shared Responsibility

(Section 1501), Effective Date: January 1, 2014

Starting January 1, 2014, the individual shared responsibility provision requires each individual to maintain minimum essential health coverage, qualify for an exemption, or pay a fee when filing a Federal income tax return. Requiring eligible individuals who can afford health insurance but who choose not to buy it to pay a fee helps reduce the amount of uncompensated care in the health care system, which drives up health care costs for everyone. It also, in combination with premium tax credits and insurance reforms, helps create an affordable, stable individual insurance market. Individuals can qualify for an exemption from the individual shared responsibility requirement for a number of reasons including: if the cost of coverage would have been too high as a portion of their household income, if they were uninsured for a short period of the year, or if they experienced a hardship.

Employer Shared Responsibility

(Section 1513), Effective Date: January 1, 2015

The Affordable Care Act requires applicable large employers to offer coverage to their full-time employees and their dependents that is affordable and provides minimum value. If employers do not provide this coverage and one or more full-time employees enrolls in coverage through the Health Insurance Marketplace and benefits from a premium tax credit, the employer will be subject to an employer shared responsibility payment. Approximately 96 percent of employers are small businesses that have fewer than 50 workers and are exempt from the employer shared responsibility provisions.⁵⁹ The overwhelming majority of the remaining 4 percent of businesses already offer quality coverage.⁶⁰

Medicaid and Children's Health Insurance Program Improvements

The Affordable Care Act included a wide range of improvements to Medicaid and the Children's Health Insurance Program. The most significant change is enhanced Federal funding and new options to cover low-income adults who previously were not eligible for the program, making Medicaid a true safety net for low-income Americans. Additionally, the law contains multiple provisions to streamline the application process, improve the quality and efficiency of Medicaid coverage, expand Medicaid long term services and supports, enhance coordination between the Medicaid and Medicare programs for people eligible for both (the dual eligible population), and lower drug costs paid by reforms to Medicaid's prescription drug purchasing.

Expanding Access to Coverage and Services

(Section 2001), Effective Date: January 1, 2014

The Affordable Care Act creates an opportunity for States to provide Medicaid eligibility, effective January 1, 2014, for individuals under 65 years of age with incomes up to 133 percent of the Federal poverty level. For this newly eligible population, the Federal government provides a matching rate of 100 percent in calendar years 2014-2016, 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent in calendar years 2020 and beyond. The law also guarantees the newly Medicaid eligible population benchmark health benefits including mental health services and prescription drug benefits. To date, 28 States and the District of Columbia have expanded their Medicaid programs and as of January 2015, approximately 11.2 million additional Americans were covered under Medicaid and the Children's Health Insurance Program compared to the

start of October 2013, when the Affordable Care Act's open enrollment began.⁶¹ If the remaining 22 States don't opt to expand Medicaid, 5.1 million people will be without health insurance coverage in 2016.⁶²

Enrollment Simplification and Improvements

(Sections 2201 and 2202), Effective Date: January 1, 2014

The Affordable Care Act took steps to promote streamlined, accurate and timely eligibility determinations in the Medicaid program. This included aligning income definitions with those used for premium tax credits, eliminating eligibility requirements based on assets or other complicated factors for many, and supporting information technology improvements. The law also expands the option for States to offer presumptive eligibility to adults and permits hospitals to make presumptive eligibility determinations for all Medicaid eligible populations. These changes contributed to an increase in Medicaid enrollment even in States that did not take the Medicaid expansion option.⁶³

Lowering Prescription Drug Spending

(Section 2501 and 2503), Effective Date: January 1, 2010

The Affordable Care Act took steps to make Medicaid an even more efficient purchaser of prescription drugs. These included revising the definition of average manufacturer price, establishing a new formula for calculating the Federal upper limit, increasing the rebate percentages for covered outpatient drugs, and extending rebates to drugs dispensed to enrollees in managed care organizations. Medicaid rebates for prescription drugs will save States and taxpayers an estimated \$17.7 billion from 2013 to 2018.⁶⁴

Expanding Long Term Services and Supports

(Section 2401-2405), Effective Dates: Various

The Affordable Care Act created and expanded opportunities to help ensure that older Americans and individuals with disabilities have options for receiving long-term services and supports in their homes and communities. For example, the Affordable Care Act created the Balancing Incentive Program, which increases Federal funding for States that expand access to home and community-based services. Twenty-one States are participating in this program.⁶⁵ The Community First Choice option provides enhanced Federal funding to States that provide person-centered home and community based attendant services and supports. Four States have approved Community First Choice plans.⁶⁶ The Affordable Care Act also expanded the Money Follows the Person program. Over 40,500 people with chronic conditions and disabilities have transitioned from institutions back into the community through Money Follows the Person programs.⁶⁷

Improved Coordination for Medicare-Medicaid Dual Eligibles

(Sections 2601 and 2602), Effective Date: March 23, 2010

Individuals who are eligible for both Medicare and Medicaid – often known as Medicare-Medicaid enrollees, or dual eligibles – are some of the most vulnerable and high-cost individuals in the health care system. The Affordable Care Act created a new Medicare-Medicaid Coordination Office to help coordinate care, improve the quality of and access to care, and reduce costs. The Office has worked on better aligning Medicare and Medicaid financing and benefits, offering technical assistance to States, and supporting demonstrations to enhance coordination of care for Medicare-Medicaid enrollees. As of 2015, twelve States have signed memoranda of understanding with CMS to engage in demonstrations to

better align the financing of these two programs and integrate primary, acute, behavioral health and long-term care.⁶⁸

Medicare Improvements

The Affordable Care Act included over 60 provisions intended to strengthen the Medicare program and to harness Medicare policy to support health system improvement. The law enhances access to preventive services and reduces costs for prescription drugs, promotes the adoption of new care models that improve care coordination, reduces excessive payments to insurance companies operating Medicare Advantage plans, makes Medicare more efficient by adjusting payment rates to promote the delivery of efficient, high-quality health care. It also adjusts Medicare payment policy to help reduce the rate of hospital readmissions and hospital acquired infections. Several key provisions are described below.

Reducing Hospital Readmissions and Hospital Acquired Conditions

(Section 3008), Effective Date: October 1, 2014 and (Section 3025), Effective Date: October 1, 2012

The Affordable Care Act takes a number of steps to reward hospitals for the quality of care they provide. Two of the key measures of quality are hospital acquired conditions and hospital readmissions. Hospital acquired conditions – defined as reasonably preventable conditions that patients did not have upon admission to a hospital – and other health care-associated infections are among the leading threats to patient safety. Over one million such infections occur across the U.S. health care system every year.⁶⁹ The Affordable Care Act established the Hospital Acquired Conditions Reduction Program to encourage hospitals to reduce the number of such conditions. Effective beginning fiscal year 2015, the Affordable Care Act reduces payments to the quartile of hospitals with the highest rates of Hospital Acquired Conditions. Beginning October 2012, the law also reduces Medicare payments to hospitals with excess hospital readmissions within 30 days of a hospital discharge.

These payment incentives complement the work under the Affordable Care Act's Innovation Center-funded Partnership for Patients initiative, a nation-wide public-private collaboration with 3,700 hospitals (serving 80 percent of the American population) to identify best practices and solutions to reducing hospital acquired conditions and readmissions. After holding constant at 19 percent from 2007 to 2011 and decreasing to 18.5 percent in 2012, the Medicare all-cause 30-day readmission rate has further decreased to approximately 17.5 percent in 2013. This translates into an 8 percent reduction in the rate and an estimated 150,000 fewer hospital readmissions among Medicare beneficiaries between January 2012 and December 2013.⁷⁰ And an estimated 1.3 million fewer patients experienced hospital-acquired conditions, 50,000 fewer patients died in hospitals and approximately \$12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013.⁷¹

Payment Accuracy

(Sections 3131-3143), Effective Date: Various

The Affordable Care Act includes numerous policies to make Medicare more efficient by adjusting payment rates to promote the delivery of efficient, high-quality health care. It also incorporates productivity improvements into certain market basket updates that lacked them previously. The law includes payment adjustments for home health care, hospice reforms, improvements to Medicare Disproportionate Share Hospital Payments, and a process for identifying and adjusting potentially mis-valued payment codes that have historically undervalued primary care in Medicare. Additional payment

accuracy improvements include a modification of the equipment utilization factor for advanced imaging services and revision of the payment conditions for durable medical equipment. These provisions have all been implemented in rulemaking over the years 2011 through 2015. These changes have contributed to an unprecedented slow-down in Medicare cost growth.⁷²

Ending Medicare Advantage Overpayments and Paying for Quality **(Section 3201), Effective Date: January 1, 2011**

Before the passage of the Affordable Care Act, Medicare paid \$800 per year more for every beneficiary in Medicare Advantage as compared to the traditional Medicare fee-for-service program. The Affordable Care Act phased out these excessive payments over seven years by tying Medicare Advantage payments to fee-for-service spending and instituted a requirement that Medicare Advantage organizations use 85 percent of their Medicare payments for patient care and quality improvement. Even as the program has grown more efficient, beneficiaries have retained choices for Medicare Advantage plans. Medicare Advantage has reached record-high enrollment each year since 2010, a trend continuing in 2015 with an enrollment increase of more than 40 percent since passage of the Affordable Care Act. Premiums have fallen by nearly 6 percent from 2010 to 2015 and more than 90 percent of Medicare beneficiaries have access to a \$0 premium Medicare Advantage plan.⁷³ Additionally, the new “star” quality rating system has led to improvements in plan performance and beneficiary choices: in 2015, CMS estimates that 60 percent of Medicare Advantage enrollees will be enrolled in a 4 or 5 star plan, compared to an estimated 17 percent in 2009.⁷⁴

Competitive Bidding for Durable Medical Equipment **(Section 6410), Effective Date: January 1, 2012**

The Affordable Care Act expanded the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program to help reduce excessive payments for these services for Medicare beneficiaries and taxpayers. Established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) but delayed until 2009 by Congress, competitive bidding awards contracts to suppliers who offer the best prices and meet applicable quality, access, and financial standards. The Affordable Care Act expanded the Competitive Bidding Program to additional metropolitan statistical areas and required rates observed in competitively bid areas to be applied nationwide no later than 2016. The program has saved more than \$580 million due to lower payments and decreased unnecessary utilization in nine markets at the end of the Round 1 contract period. Additional savings are being achieved as part of the Affordable Care Act’s expansion of the competitive bidding program—at the end of the first year of Round 2 and the national mail-order programs, Medicare has saved approximately \$2 billion.⁷⁵ The program is projected to save an additional \$30.2 billion for the Medicare program over the next 10 years.⁷⁶

Health Care Delivery System Improvements

The Affordable Care Act includes a number of provisions focused on improving the quality of the health care system and reimbursing providers based on the quality and efficiency – not the quantity – of the care they deliver. The law created a National Quality Strategy, promotes the development of new health care quality measures, and ties provider reimbursement to quality through value-based payment programs. A key element of this focus on quality is improving patient safety through a variety of national initiatives, public private collaborations, and programmatic requirements. Another pillar of the law’s delivery system reform effort is the Center for Medicare and Medicaid Innovation, which is

charged with testing innovative payment and service delivery models to reduce expenditures while preserving or enhancing quality of care. The Secretary of Health and Human Services has the authority to implement nationwide Innovation Center models that prove successful at improving quality and lowering costs relative to baseline. The Affordable Care Act also promotes payment reform among all health care purchasers, including States and private insurers. The Administration aims to have 30 percent of Medicare payments in these alternative payment models by the end of 2016, increasing to 50 percent by the end of 2018, and has called on State and commercial payers to meet or exceed those goals. Supporting all of these efforts are the new data sharing and transparency provisions in the Affordable Care Act, which make health care quality data and claims data more broadly available to consumers, providers, and researchers.

Quality Measures and Quality Strategy, and Value-based Payments **(Section 3001, 3002, 3004, 3005, 3007, 3011- 3015), Effective Dates: Various**

The Affordable Care Act directs the Secretary of Health and Human Services to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. First published in March 2011 and updated annually, the National Quality Strategy sets three aims – better care, healthy people/healthy communities, and affordable care –and describes levers stakeholders can use to align with the strategy. The law also calls for the development, improvement, and expansion of health care quality measures consistent with the National Strategy. Quality measures are used to help quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care. Quality measures are developed through a multi-stakeholder process and data is collected from a wide variety of provider types – from hospitals to nursing homes to dialysis centers. The Affordable Care Act established or enhanced payment incentives for quality reporting or achievement for: inpatient hospital services (Section 3001), physician services (Section 3002), long-term care hospitals, inpatient rehabilitation facilities, and hospice programs (Section 3004), and cancer hospitals (Section 3005).

Recently, the Centers for Medicare and Medicaid Services (CMS) strengthened the *Five Star Quality Rating System* for nursing homes on the *Nursing Home Compare* website to give families more precise and meaningful information on quality.⁷⁷ The law also ties performance on quality measures directly to provider payment through value-based payment programs. The Hospital Value-Based Purchasing Program links a portion of hospitals' Medicare payments for inpatient acute care to their performance on important quality measures, such as whether a patient received an antibiotic before surgery and how well doctors and nurses communicate with patients.⁷⁸ The Value Modifier program, phasing in to all physicians over the years 2015 through 2017, provides for differential payment under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period. Based on 2013 performance, 7,000 physicians across the country are receiving increases in their payments under this program in 2015.⁷⁹

Center for Medicare and Medicaid Innovation **(Section 3021), Deadline to Begin Carrying Out Duties: January 1, 2011**

The Affordable Care Act created the Center for Medicare and Medicaid Innovation, which is charged with testing innovative payment and service delivery models to reduce expenditures in Medicare, Medicaid, and the Children's Health Insurance Program, and at the same time, preserving or enhancing quality of care. The CMS Innovation Center partners with stakeholders across the country, other Federal agencies, and CMS components to build a health care delivery system that's better, smarter and

healthier – a system that delivers better care; a system that spends health care dollars more wisely; and a system that makes our communities healthier. The law appropriated \$10 billion for the FY2011 to FY2019 period—and \$10 billion for each subsequent 10-year period—to test and implement payment and service delivery models. The law also gives the Secretary of Health and Human Services authority to expand the duration and scope of the models being tested, including implementation on a nationwide basis, if spending and quality criteria are met. The Innovation Center has engaged with more than 60,000 health care providers in models to improve care, and an estimated 2.5 million Medicare, Medicaid and CHIP beneficiaries are receiving care through the Innovation Center’s payment and service delivery models.⁸⁰ Over 20 models are currently being supported by the Innovation Center funding. Initiatives have already demonstrated promising results. For example, in its first year, the Comprehensive Primary Care Initiative, a multi-payer partnership between Medicare, Medicaid, private health care payers and nearly 500 primary care practices serving 2.5 million patients, decreased hospital admissions by 2 percent and emergency department visits by 3 percent.⁸¹ And interest is high: over half of States, representing nearly two-thirds of the population, are participating in State Innovation Models.⁸² The Innovation Center is also supporting the overarching initiative to continue progress toward alternative payment models by supporting goals set for Medicare and working with States and the private sector to achieve the same.⁸³ The Innovation Center’s Health Care Payment Learning and Action Network aims to accelerate the transition to alternative payment models by fostering collaboration between HHS, private payers, large employers, providers, consumers, and State and Federal partners.⁸⁴

Accountable Care Organizations

(Sections 3021 and 3022), Effective Date: January 1, 2012

The Affordable Care Act creates a Medicare Shared Savings Program to facilitate coordination and cooperation among health care providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO), which is a network of doctors and other health care providers. ACOs are reimbursed based on the quality and efficiency of the overall care provided to their patients. In 2015, there are 405 ACOs participating in the Shared Savings Program, serving more than 7.2 million beneficiaries. Shared Savings Program ACOs who entered the program in 2012 improved on 30 of the 33 quality measures in the first 2 years, including patients’ ratings of clinicians’ communication, beneficiaries’ rating of their doctors, and screening for high blood pressure. They also outperformed group practices reporting quality on 17 out of 22 measures. Medicare ACOs participating in the Shared Savings Program and the Pioneer ACO Model combined generated over \$417 million in savings for Medicare.⁸⁵ Shared Savings ACOs often create similar contracts with State or commercial payers, supporting health system improvement overall.

Nineteen ACOs are currently participating in the Pioneer ACO Model, which is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Preliminary results from the independent evaluation of the Pioneer ACO Model show that Pioneer ACOs have generated gross savings of \$147 million in their first year. During the second performance year, Pioneer ACOs generated estimated total model savings of over \$96 million and savings to the Medicare Trust Funds of approximately \$41 million. Pioneer ACOs also outperformed published quality benchmarks in year one and improved in almost all quality and patient experience measures in year two.⁸⁶

Bundled Payments

(Sections 3021 and 3023), Effective Date: January 31, 2013

Medicare regularly makes separate payments to individual providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings. To help to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, the Affordable Care Act established a national pilot program on payment bundling. Under the Bundled Payments for Care Improvement initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care, which may lead to higher quality, more coordinated care at a lower cost to Medicare. The initiative currently has 105 Awardees in Phase 2 (risk-bearing), including 38 conveners of health care organizations, representing 243 Medicare organizational providers. Additionally within Phase 1 of the initiative are 870 participants, including 138 conveners of health care organizations, representing 6,424 Medicare organizational providers.⁸⁷ Operating under the authority of the Center for Medicare & Medicaid Innovation, if the Bundled Payments for Care Improvement project is found to reduce costs without reducing quality or improve quality without increasing costs, it can be expanded nationally.

Creating Pathway for Biosimilars

(Section 7002), Effective Date: March 23, 2010

The Affordable Care Act created a new approval pathway for biological products that are demonstrated to be biosimilar to or interchangeable with a Food and Drug Administration (FDA)-licensed biological product. This pathway is provided in the part of the law known as the *Biologics Price Competition and Innovation Act* (BPCI Act). In general terms, under this provision, a biological product can be demonstrated to be “biosimilar” if data show that, among other things, the product is “highly similar” to an already-approved biological product and there are no clinically meaningful differences in safety, purity, or potency between it and the branded product. This provision was estimated to save \$7 billion over 10 years at the time of the law’s passage.⁸⁸ FDA approved the first product under this provision on March 6, 2015, paving the way for additional products.⁸⁹

Open Data

(Sections Various), Effective Date: Various

Aligned with President Obama’s Open Government Initiative, the Affordable Care Act authorizes the Department of Health and Human Services to release new data resources that advance transparency in the health care system while protecting privacy. Data releases to date include: quality information on hospitals, nursing homes and health insurance plans; health care provider directories; health insurance rates; hospital and physician claims data; community health performance information; government spending data; and information on physician ownership and investment interests.⁹⁰ The Qualified Entity program created by the law allows for Medicare data to be used in conjunction with data from other sources to evaluate provider performance and produce public reports; 13 lead entities are participating in this program.⁹¹ In addition to making data publicly available, the Affordable Care Act has supported the direct provision of Medicare claims data to providers for purposes of care improvement and practice redesign through the Accountable Care Organization programs. And the law complements the progress made by the Health Information Technology for Economic and Clinical Health (HITECH) Act to catalyze the use of electronic health records: use of such records increased to more than 90 percent for hospitals and more than 75 percent for physicians.⁹² Increased electronic health information, in combination with more data available from HHS and other payers, is facilitating the ability of hospitals

and doctors to track and analyze their performance and improve over time and enabling patients and providers to make the right decisions at the right time to improve health.

Patient Centered Outcomes Research Institute **(Section 6301), Effective Date: September 2010**

To help close the gaps in evidence regarding the relative health outcomes, effectiveness, and appropriateness of a variety of clinical practices, the Affordable Care Act created the Patient-Centered Outcomes Research Institute (PCORI). This independent nonprofit organization funds research to improve the quality and relevance of evidence available to help decision makers — patients, caregivers, clinicians, employers, insurers, and policy makers — make better-informed health care decisions. To date, PCORI has provided \$734 million to 365 research projects in 39 States.⁹³ The research focuses on five broad priorities: Assessment of Prevention, Diagnosis, and Treatment Options; Improving Healthcare Systems; Addressing Disparities; Communication and Dissemination Research; and Accelerating Patient-Centered Outcomes Research and Methodological Research. PCORI funds large scale studies initiated by investigators as well as by patients and other stakeholders in order to answer questions of critical need and concern.

Public Health, Prevention, and Capacity Expansion

The Affordable Care Act's comprehensive approach to improving health care quality, expanding access, and reducing costs extends beyond the boundaries of the medical system. The law includes expanded and sustained investments in prevention, public health, community-based services, and the health care workforce. For example, the law creates the Prevention and Public Health Fund to invest in a broad range of activities including community and clinical prevention initiatives; public health research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and workforce and training. The law also created the Community Health Center Fund, which provides significant support for the operation, expansion and construction of health centers nationwide. The law also substantially expanded the National Health Service Corps, which provides scholarships and loan repayment to health care providers who provide care in underserved communities, along with other training programs. The Affordable Care Act supports prevention programs targeted to new mothers, workers, and seniors, and contributes toward the effort to promote healthy eating through standardizing menu labeling.

Prevention and Public Health Fund **(Section 4002), Effective Date: Fiscal Year 2010**

The Affordable Care Act established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. The law provided a permanent annual appropriation for the Fund beginning at \$500 million in Fiscal Year 2010. Today, the Fund receives \$1 billion annually. In 2018 and 2019, funding will increase to \$1.25 billion; for 2020 and 2021, it will increase to \$1.5 billion; and for 2022 and beyond, \$2 billion per Fiscal Year will be appropriated to the Fund. The Fund has supported key public health programs and initiatives including community-based strategies to combat obesity and reduce tobacco use; interventions to prevent diabetes; strategies to promote mental health; tools to prevent heart disease and stroke; an initiative to prevent viral hepatitis; and investments to expand the capacity of State and local public health, including investments in laboratory and epidemiology capacity. For example, with support from the Prevention and Public Health Fund, in 2012 CDC launched the *Tips*

From Former Smokers campaign, the first Federally funded national mass media anti-smoking campaign with a campaign cost of roughly \$48 million. A 2014 CDC analysis published in the *American Journal of Preventive Medicine* found that the campaign was responsible for an estimated 100,000 smokers quitting permanently.⁹⁴

Expanding Access through Community Health Centers **(Section 10503), Effective Date: Fiscal Year 2011**

The Affordable Care Act created the Community Health Center Fund, which provided \$11 billion over five years for the operation, expansion and construction of health centers nationwide. Of this funding, \$1.5 billion was appropriated to support major construction and renovation projects at health centers nationwide and \$9.5 billion to support ongoing health center operations, the establishment of new health center sites in areas that need them most, and the expansion of preventive and primary health care services at existing health center sites. Over the last four years, Affordable Care Act funding has supported more than 550 new health center service delivery sites, nearly 1,200 grants to allow centers to expand their services, over 400 grants to expand behavioral health services, nearly 700 capital development and immediate facility improvement grants, more than 1,700 quality improvement grants, more than 150 expanded HIV treatment and care grants, grants for outreach and enrollment activities in over 1,200 health center grantees nationwide, more than 40 network grants to promote health information technology and electronic health record adoption, and ongoing health center operations in nearly 1,300 health center grantees nationwide.⁹⁵ Because of this, health centers have increased the total number of patients served on an annual basis by nearly 5 million people, increasing the number of patients served from 17.1 million to 21.7 million annually.⁹⁶

National Health Service Corps Expansion and Support for the Primary Care Workforce **(Section 10503; Various), Effective Date: Fiscal Year 2011**

The Affordable Care Act built on the Recovery Act's investment in expanding the National Health Service Corps by appropriating \$1.5 billion in new dedicated funding over five years to better support the recruitment and retention of primary care providers in the communities that need them most. The National Health Service Corps provides scholarships and loan repayment to health care providers who commit to providing care in underserved communities. In 2008, 3,600 NHSC providers served approximately 3.7 million patients. By 2014, 9,200 clinicians were providing primary care to about 9.7 million patients. These primary care providers serve in high-need rural, urban, and frontier areas across the United States. The Affordable Care Act also provided nearly \$230 million to expand existing workforce programs to support the training of an additional 1,700 medical residents, nurse practitioners and physician assistants trained in primary care. By the end of Academic Year 2013-2014, more than 1,550 new primary care medical residents, nurse practitioner students, and physician assistant students entered training and were supported through this funding. Thus far, 737 have completed training and entered the primary care workforce. In addition, the Teaching Health Center Graduate Medical Education Program which expands primary care residency training in community-based settings will support the training of about 600 primary care physician and dental residents at 60 Teaching Health Centers located in 24 States during the 2015-2016 academic year.⁹⁷ The Affordable Care Act also supported primary care through payment incentives in Medicare and Medicaid. Section 5501 provided for a 10 percent increased payment for primary care services in Medicare beginning in 2010, and Section 1202 (HCERA) provided a two-year increase in Medicaid primary care payment rates to match Medicare levels for 2013 and 2014.

Promoting Healthy Mothers and Infants

(Section 2951, 4207, 1001), Effective Date: Fiscal Year 2010

The Affordable Care Act created the Maternal, Infant, and Early Childhood Home Visiting Program (Home Visiting Program) to support voluntary, evidence-based home visiting services for pregnant women and parents with young children up to kindergarten entry. Home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life has been shown to prevent child abuse and neglect, support parenting, improve maternal and child health and promote child development and school readiness. In fiscal year 2014, States reported serving approximately 115,500 parents and children in 787 counties in all 50 States, the District of Columbia, and five territories through the Home Visiting Program.⁹⁸ Additionally, the law amended the Fair Labor Standards Act to require employers with 50 or more employees to provide reasonable break time for employees who are nursing mothers, as well as a place other than a bathroom for such mothers to express breast milk. And, non-grandfathered individual and group health plans must cover, without cost sharing, the cost of breastfeeding education and supplies. Breastfeeding provides infants with, often, the best source of infant nutrition and immunologic protection, and provides mothers with health benefits as well.

Promoting Workplace Wellness

(Section 1201, 4203), Effective Date: Fiscal Year 2011

The Affordable Care Act includes provisions intended to encourage workplace health promotion and prevention as a means to reduce the burden of chronic illness, improve health, and slow the growth of health care costs. It provides guidelines for health plans that offer rewards to workers and their families in certain types of health promotion and disease prevention programs, while protecting participants from prohibited discriminatory practices based on health status. According to one survey, the majority of firms offering health benefits offer some type of wellness program, and about one in five firms offering wellness benefits have some type of financial incentive for participation.⁹⁹ Additionally, the Centers for Disease Control and Prevention, with Affordable Care Act funding, is implementing a comprehensive workplace health program initiative to support implementation and evaluation of targeted programs.¹⁰⁰

Preventing Elder Abuse

(Section 6703), Effective Date: Fiscal Year 2011

The Elder Justice Act was incorporated into and enacted as part of the Affordable Care Act. It focuses on identifying, responding to, and preventing elder abuse, neglect, and exploitation. The law created the Elder Justice Coordinating Council, chaired by the Secretary of Health and Human Services, to coordinate Federal activities on elder justice. With initial funding from the Affordable Care Act's Prevention and Public Health Fund, the Department of Health and Human Services is supporting efforts to test interventions designed to prevent elder abuse, neglect, and exploitation. These prevention projects draw on existing research and promising practices, while building a stronger evidence base and improving data collection systems that are needed to more effectively address this issue.

Menu Labeling and Vending Machine Labeling

(Section 4205), Effective Date: December 1, 2015 (Menu); December 1, 2016 (Vending)

The Affordable Care Act provides consumers with nutritional information about the foods they eat outside of their home by directing the Food and Drug Administration (FDA) to issue rules that require calorie information to be listed in a consistent, direct and accessible manner on menus and menu

boards in chain restaurants and similar retail food establishments with 20 or more locations, and on vending machines.¹⁰¹ Research has found that consumers tend to underestimate the number of calories and fat in food they do not prepare at home, and would like to see such information at places where they go to eat.¹⁰²

Transparency, Program Integrity, and Fiscal Responsibility

The Congressional Budget Office estimates that the Affordable Care Act reduces the deficit by more than \$100 billion during its first decade and by more than \$1 trillion during its second decade.¹⁰³ It takes aggressive action to reduce fraud, waste, and abuse. For example, the law increases Federal sentencing guidelines for criminal health care fraud and requires more rigorous scrutiny of providers and suppliers who may pose a higher risk of fraud or abuse when enrolling in Medicare or Medicaid. The law also increases transparency and accountability in key areas of the health care system such as public reporting of payments and gifts from drug and device manufacturers to physicians and teaching hospitals. It provides greater accountability and transparency regarding nursing home safety and charitable hospitals' billing practices. And, it includes targeted efforts to raise revenue from industries expected to gain insured customers and high income individuals.

Open Payment Disclosure

(Section 6002), Effective Date: February 2013

Open Payments (commonly known as the Physician Sunshine Act) requires drug and device manufacturers and group purchasing organizations (GPOs) to publicly report payments and other transfers of value made to physicians and teaching hospitals and the ownership or investment interest physicians and their immediate family members have in these entities. This information must be reported every year and is a part of the ongoing effort to increase transparency and accountability in health care. Data released to date contains approximately 4.4 million payments valued at nearly \$3.7 billion attributable to 546,000 individual physicians and almost 1,360 teaching hospitals. Future reports will be published annually and will include a full 12 months of payment data, beginning in June 2015.¹⁰⁴

Medicare and Medicaid Anti-Fraud Provisions

(Section: Title VI), Effective Date: Fiscal Year 2011

The Affordable Care Act includes a large number of policies to combat health care fraud, waste, and abuse. The law increases Federal sentencing guidelines for criminal health care fraud by 20 to 50 percent for crimes with over \$1 million in losses. It requires more rigorous scrutiny, including license checks and site visits, of providers and suppliers who may pose a higher risk of fraud or abuse when enrolling in Medicare or Medicaid. It also provides an additional \$350 million over 10 years to support anti-fraud efforts. The Administration has used authorities from the Affordable Care Act and subsequent legislation to move program integrity towards a preventive posture rather than just a "pay and chase" model. Since June 2011, the Centers for Medicare and Medicaid Services has used the Fraud Prevention System on all Medicare fee-for-service claims on a streaming, national basis. The identified savings associated with these prevention and detection actions were \$210.7 million in fiscal year 2012. The enhanced screening required by the Affordable Care Act has led to the removal of almost 500,000 Medicare provider enrollments since its implementation.¹⁰⁵ The law's anti-fraud provisions have contributed to several years of record-high health care fraud recoveries for the Health Care Fraud and Abuse Control Program. In FY 2014, \$3.3 billion in taxpayer dollars were recovered. For

every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered \$7.70.¹⁰⁶

Improved Accountability for Charitable Hospitals

(Section 9007 & 10903), Effective Date: In general, taxable years beginning after March 23, 2010.

The Affordable Care Act included additional consumer protection requirements for charitable hospitals so that patients are protected from abusive collections practices and have access to information about financial assistance at all tax-exempt hospitals. Specifically, as a condition of their tax-exempt status, charitable hospitals must take an active role in improving the health of the communities they serve, establish billing and collections protections for patients eligible for financial assistance, and provide patients with the information needed to apply for such assistance. The new rules restrict extraordinary debt collection activities and ensure that patients eligible for financial assistance are not charged more than amounts generally billed to Medicare or commercial insurers with which the hospital does business.¹⁰⁷

Fees on Industries Gaining Insured Consumers

(Section 9008, 9010, HCERA 1405), Effective Date: Various

The Affordable Care Act includes fees on health insurance issuers, medical device manufacturers, and branded prescription pharmaceutical manufacturers and importers. These industries are expected to benefit from increased demand as millions more Americans gain health insurance. The fees help offset the Federal cost of this expanded coverage.

Additional Medicare Taxes on High-Income Taxpayers

(Section 9015, HCERA 1402), Effective Date: Remuneration received, and taxable years beginning after December 31, 2012.

The law increases the Medicare hospital insurance tax only on high-income taxpayers by 0.9 percent, for a total of 3.8 percent, whose revenue is dedicated to the Medicare Hospital Insurance Trust Fund. The law also includes a new tax on net investment income of 3.8 percent for high-income taxpayers. Both apply only to those at or above: \$250,000 for married taxpayers who file jointly, \$125,000 for married taxpayers who file separately and \$200,000 for all other taxpayers.

Additional Premiums for High-Income Medicare Beneficiaries

(Section 3402, 3308), Effective Date: January 2011

Since 2007, Medicare beneficiaries with higher incomes have paid higher Part B monthly premiums. The Affordable Care Act placed a freeze on the income thresholds from 2011 through 2019, so they would not be increased by inflation. This means that an increasing share of beneficiaries would be subject to the higher premium. The income thresholds will start being indexed again starting in 2020. Additionally, the law extended the income-related premium policy to the Medicare Part D prescription drug coverage premium. Approximately 5 percent of people with Medicare are expected to pay an income-related premium in 2015.¹⁰⁸

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