

The Affordable Care Act Insurance Reforms: Where Are We Now, and What's Next?

M. Claire Borelli,¹ Miryam Bujanda,² and Krista Maier¹

The Affordable Care Act (ACA), signed into law by President Obama in March 2010, provides for comprehensive health reform in the United States. A major part of the ACA includes insurance reforms designed to make adequate and affordable health insurance accessible to nearly everyone. Five years after the ACA became law, and 1 year after major insurance reforms took effect, we discuss in this article the gains that have been made and the road ahead, with a focus on individuals with diabetes. This article is focused solely on changes in insurance plans and does not address the many other provisions in the massive ACA that affect people with diabetes, including the establishment of the National Diabetes Prevention Program, the Prevention and Public Health Fund, or menu labeling requirements.

Why Was the ACA Needed for People With Diabetes?

Under the old health care system, it was legal in most states to deny health insurance to people with diabetes or require them to pay more for insurance coverage simply because they had diabetes. Even for people who had insurance coverage, their plans did not necessarily cover the most basic diabetes needs, leaving them with large out-of-pocket expenses in addition to the cost of insurance. Without access to affordable care, some people with diabetes went without the care they needed by cutting back on—or even forgoing—the doctor visits, medicines,

education, and testing supplies necessary to adequately manage diabetes. As a result, many people developed complications of diabetes that could have been prevented had affordable care been available to them. People with diabetes who had affordable coverage through their employer feared (and rightfully so) there would be few insurance options available to them if they left their job and did not start immediately at another job that offered good health coverage benefits.

The American Diabetes Association (ADA) fought hard to ensure that health care reform would benefit people with and at risk for developing diabetes. Diabetes Advocates from around the country visited with their elected officials to share their stories about how important it was for Congress to end the discrimination that prevented people with diabetes from protecting their health.

What Improvements Did the ACA Make?

The ACA changed the health insurance landscape through numerous new insurance protections that improved access to coverage for people with diabetes, as well as the quality of that coverage. Since the ACA passed in 2010, ADA has made great progress in ensuring that the law is implemented in a way that will benefit people with or at risk for developing diabetes and that these individuals are aware of the numerous improvements made by the law. Some of the health

¹American Diabetes Association, Alexandria, VA

²American Diabetes Association Latino Diabetes Action Council, San Antonio, TX

Corresponding author: Krista Maier, kmaier@diabetes.org

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insurance improvements and advocacy victories include:

- Health plans cannot deny people coverage or charge them more because they have diabetes or any other preexisting condition.
- Plans cannot have annual or lifetime dollar limits on essential health benefits.
- The amount of cost-sharing that individuals and families pay for their care each year is limited.
 - In 2015, after out-of-pocket spending of \$6,600 for individual coverage or \$13,200 for family coverage, the plan pays 100% of the cost of covered essential health benefits.
- A Health Insurance Marketplace (Marketplace) is available in every state, through which individuals and families can shop for and buy health insurance. Marketplace plans are separated into four categories: Bronze, Silver, Gold, and Platinum. Moving from Bronze to Platinum, in general, out-of-pocket costs decrease and premiums tend to increase. People who meet income requirements qualify for assistance in paying their Marketplace plan premiums (through a tax credit) and may qualify for other assistance to lower their out-of-pocket costs when they access care.
 - For example, in 2015, help in paying Marketplace premiums was available to individuals earning \$11,770–\$47,080 and families of four earning \$24,250–\$97,000. In addition, individuals earning up to \$29,425 and families of four earning up to \$60,625 were eligible for help paying cost-sharing expenses for certain Marketplace plans.
- Plans and issuers that offer dependent coverage are required to make the coverage available until adult children reach the age of 26.
- A minimum set of essential health benefits (EHBs) such as hospitalization, prescription drugs, chronic disease management, and preventive services must be covered in most individual and small-group plans, including all plans sold in the state Marketplaces.
 - The design of a plan's package of EHBs also cannot discriminate against individuals with a disability or chronic health care needs.
- All plans must provide a plain-language summary (called a Summary of Benefits and Coverage [SBC]) of its benefits to help people better understand its coverage and compare plans.
 - The SBC includes a coverage snapshot of how much the plan might pay for medical care for a sample patient with type 2 diabetes. ADA advocated for this example to be included in the SBC.
- Most plans must provide coverage of numerous preventive services without a copayment if the services are obtained through an in-network provider.
 - Currently, plans must cover without cost-sharing type 2 diabetes screening for adults with high blood pressure, type 2 diabetes screening for pregnant women at high risk, and gestational diabetes screening for all pregnant women. ADA is working toward expanding the requirement for type 2 diabetes screening for all adults at high risk in accordance with ADA standards, and there is currently a draft recommendation from the U.S. Preventive Services Task Force to that end.
- The Medicare “donut hole” (a coverage gap in many Medicare Part D prescription drug plans that used to make beneficiaries responsible for 100% of the cost of their drugs above an initial coverage limit but less than the amount needed to trigger “catastrophic” coverage) is gradually closing and will no longer exist in 2020.

- Medicaid eligibility was extended to all Americans earning up to 138% of the federal poverty level (FPL; \$16,243 for individuals and \$33,465 for families of four in 2015), although, as a result of a 2012 Supreme Court ruling, this extension is optional for states. Currently, 30 states and the District of Columbia have expanded Medicaid.

Who Is Benefiting From Implementation of the ACA?

Implementation of the ACA has decreased the number of uninsured Americans. A Gallup survey reports the percentage of American adults lacking health insurance fell from 18% at the end of 2013 to 11.9% in the first quarter of 2015 (1). The largest gains in insurance rates occurred for Americans earning <\$36,000 in annual household income as well as among Hispanics—groups that were previously most likely to be uninsured (1). As of March 2015, ~11.7 million people had enrolled in a Marketplace plan (including both federally facilitated and state-run Marketplaces) (2). A little less than two-thirds of Marketplace enrollees in states using the www.healthcare.gov platform self-reported their race. Of those who did, just over one-third indicated that they were members of a race or ethnicity at high risk for developing diabetes, including 11% Latino, 14% African American, and 8% Asian (2).

Most Marketplace enrollees are receiving financial help to pay for their coverage. In the open enrollment process for 2015, 87% of Marketplace consumers who enrolled in coverage in the 37 states using the [healthcare.gov](http://www.healthcare.gov) platform qualified for premium tax credits, and 60% were eligible for cost-sharing reductions (2). Among individuals who qualified, average monthly premiums would have been \$364; however, after the premium tax credits, monthly premiums averaged \$101 (2).

In addition to requiring Marketplace plans to provide a plain-

language SBC to help consumers shop for and compare plans, all Marketplaces must have some form of Assister program to help consumers understand their options and enroll. One type of Assister, called Navigators, not only are available to help consumers enroll in plans, but are also required to provide outreach and education to raise awareness about the Marketplaces. According to a 2014 survey of Marketplace Assister programs, during the first Marketplace open enrollment period in 2013/2014, >4,400 Assister programs helped an estimated 10.6 million people (3). To support the work of Assistors, the U.S. Department of Health and Human Services (HHS) has created and distributed consumer education tools in multiple languages, including a toolkit to help people with new health coverage understand their benefits and connect to primary care and the preventive services that are right for them (4).

The ACA has also ensured that the millions of people who have enrolled in a plan through the Marketplaces have access to benefits and services that meet their health care needs. ADA has been working to ensure that each state's package of EHBs offers comprehensive coverage to meet the health care needs of individuals with or at risk for diabetes and that plans' benefit provisions do not discriminate against people with diabetes. ADA research has shown that, in addition to the required categories of benefits such as physician office visits and prescription drugs, EHBs in at least 44 states include coverage for diabetes self-management education, and at least 28 states include coverage for medical nutrition therapy.

The ACA also enabled low-income individuals to gain health care coverage through Medicaid. The impact of Medicaid expansion varies in each state, depending on the state's previous Medicaid eligibility rules. Research conducted by the RAND Corporation estimates that, between 2013 and 2015, 9.6 million Americans gained

coverage through the Medicaid program (5). According to a report from the White House, in states that have already expanded their Medicaid programs, 1 million people have gained a regular source of primary care; beneficiaries are able to make an additional 11.6 million physician office visits each year; and 5,000 deaths per year can be avoided (6).

In addition to opening up new avenues for people to purchase and enroll in health insurance, the ACA also made changes improving the affordability and coverage options for all types of health insurance. For example, the ACA requires health insurance companies to spend at least 80% of the premiums they receive on health care coverage and quality improvement activities. If a company does not meet this requirement, it must pay money back to the plan enrollees. As a result of this rule, health insurers were required to pay back >\$330 million in 2013, which averaged a rebate of ~\$80 per covered family (7). In addition, as a result of the ACA, ~137 million Americans have health insurance coverage without cost-sharing for certain preventive services (8). Finally, the ACA has decreased the burden of the Medicare "donut hole"; Medicare beneficiaries with high prescription drug costs that put them in the coverage gap got a 55% discount on covered brand-name drugs and a 35% discount on generic drugs while in the gap in 2015. Additional savings will occur each year for beneficiaries in the gap until 2020, when the coverage gap will no longer exist. According to HHS, since ACA passage in 2010, 9.4 million Medicare beneficiaries have saved >\$15 billion on prescription drug costs (9). In 2014, 5.1 million beneficiaries saved \$4.8 billion, or an average savings of \$941 per beneficiary that year.

What Challenges Remain?

Medicaid Gap

Despite the strides made with the ACA, health insurance still is not yet

accessible to all Americans. As a result of the 2012 Supreme Court ruling that made the ACA's Medicaid expansion provision optional for states, 20 states have not expanded their Medicaid programs, leaving many low-income, uninsured adults without an affordable option for health insurance. Overall, states implementing Medicaid expansion saw enrollment increase by >26%, whereas states that did not expand had enrollment increases of just under 8% (10). States expanding their Medicaid program have seen a 23% increase in the number of Medicaid enrollees with newly identified diabetes, compared to an increase of only 0.4% in states that did not expand Medicaid (11).

The ACA was written with the assumption that every state would extend Medicaid eligibility to individuals earning <138% of the FPL. Therefore, the premium and cost-sharing subsidies to help individuals purchase health care coverage through the Marketplaces are only available to those earning 100–400% of the FPL. In many states that have not expanded Medicaid, nondisabled adults who have dependent children at home and earn as little as \$2,400 per year would not be eligible for Medicaid (12). Adults who do not have children living at home are not eligible for Medicaid in most nonexpansion states. Consequently, in states that do not expand their Medicaid programs, individuals earning <100% of the FPL are left without an affordable health care coverage option; their incomes are too low to qualify for Marketplace subsidies, but too high to qualify for Medicaid. According to the Kaiser Family Foundation, 3.7 million uninsured adults are in the Medicaid gap in states that have not expanded their Medicaid programs (13).

Unfortunately, this gap in affordable coverage options affects those at highest risk for developing diabetes. In general, people with diabetes are disproportionately covered by Medicaid (14). In addition, nation-

ally, African Americans comprise just over 20% of Medicaid enrollees, and Latinos comprise 30% (15). According to the Urban Institute, African Americans disproportionately live in states that have not expanded their Medicaid programs (16). If all states were to expand their Medicaid programs, 41% of uninsured adults of color would likely be eligible, including almost 1 million uninsured black adults and almost 900,000 uninsured Hispanic adults (13).

Next Steps

Medicaid expansion made available through the ACA offers the promise of significantly reducing disparities in access to care and health status. Despite a large amount of data and information confirming the positive impact Medicaid expansion can have on the health of low-income individuals, as well as on the fiscal health of a state (17–20), 20 states still have not expanded their Medicaid programs to ensure that all residents have access to affordable health care coverage. Encouraging the remaining states to do so remains a top ADA priority.

Family Glitch

Tax credits to purchase health insurance in the Marketplace are available to individuals who lack affordable employer health insurance. When determining whether an employer's coverage is "affordable," what an employee pays for the lowest-cost, self-only coverage is considered—not what that employee pays for family coverage. If the employee's share of the monthly premium for self-only coverage is <9.56% of the family's income in 2015, the plan is technically "affordable" under the rules, and family members are not eligible for subsidies in the Marketplace, *even if the cost of including a spouse or other family members results in insurance costing >9.56% of the family's income.*

Because family coverage often costs much more than self-only coverage, some low- to moderate-income families may not be eligible for financial help to buy health insurance in

the Marketplaces even if coverage is not otherwise affordable to them. This situation is referred to as the "family glitch." Although many children in these families are eligible for coverage through Medicaid or the Children's Health Insurance Program (CHIP), spouses and some children in such families do not have access to affordable health insurance (21). Estimates of the number of spouses and children affected by this vary from 2 to 4 million (21).

Next Steps

Eliminating the family glitch will help ensure that all members of low- to moderate-income families have access to affordable health insurance. Determining whether employer coverage is affordable for all members of a family using the cost of covering the whole family—as opposed to the cost of covering just one person—is more representative of the reality faced by many families. Making this change could help millions more people access help to pay for health insurance coverage through the Marketplaces.

Outreach and Education

Despite strides toward decreasing the number of individuals without affordable and adequate health insurance since the ACA passed, gaps in knowledge about the ACA and its opportunities and requirements persist. According to a March 2015 Kaiser tracking poll, about one-third of respondents were unaware that the ACA created Health Insurance Marketplaces or that financial assistance was available to low- and moderate-income Americans who do not get insurance through their jobs (22).

In states running their own Marketplaces or partnering with the federal government to run them, there were about twice as many Assisters available per uninsured person than in states with Marketplaces fully implemented and run by the federal government alone (3). In a recent survey on the experiences of ACA-funded Assister programs

in 13 states, >80% of Assister programs surveyed reported that most or nearly all consumers who sought help did not understand the ACA or the coverage choices available or lacked confidence to apply for coverage on their own (23). At the end of the open enrollment period, demand for Assisters sometimes exceeded supply, with some Assisters reporting that they had to turn people away.

In addition to building awareness about the Marketplaces and the ACA, more education is needed on health insurance generally, particularly for individuals who are new to health insurance coverage. According to the survey of Assister programs, there is a lack of health insurance literacy among consumers who seek help from the programs, particularly for Marketplace consumers who have no experience with private health insurance (23). Lack of understanding of common health insurance terms can confound the process of selecting a plan that adequately meets a person's needs and can mean that coverage is not used effectively once a person is enrolled. However, improving health insurance literacy can only be effective if individuals shopping for health insurance have access to all the information they need to make an informed decision.

Next Steps

Further lowering of the uninsurance rate will require additional public education about the ACA and the new ways individuals can access coverage, especially in areas and within populations that may not have fully benefited from previous outreach efforts. According to Nadine Gracia of the HHS Office of Minority Health, a lesson from the first open enrollment period in the Marketplaces was that outreach and education must be tailored to reach minority communities (24). Groups experienced in working with the Asian-American, Native Hawaiian, and Pacific Islander populations made recommendations to address barriers and challenges faced

by these groups during the first open enrollment (25). These recommendations included improving training for Marketplace call center operators, interpreters, Navigators, and other enrollment Assistants to better serve consumers with low English proficiency (LEP) and immigrants; creating more useful translated resources and in-language tools; and making call centers more accessible to LEP consumers and Assistants. Heeding this advice, HHS provided dedicated funding to 13 organizations to support enrollment of racial and ethnic minorities in coverage during the second Marketplace open enrollment period (24).

Marketplace outreach and enrollment efforts should continue to include health insurance literacy as a focus. These efforts, combined with additional tools to improve health plan transparency, will help consumers gain a better understanding of health insurance and how to select and use a health coverage plan. In addition, continued and stable funding for in-person assistance will remain important to support consumers of all races and ethnicities, help increase health insurance literacy, and increase enrollment through the Marketplaces.

Health Plan Transparency

Although the outreach efforts described above have been positive steps in the right direction, more needs to be done to ensure that all consumers, including racial and ethnic minorities, fully understand their options and are able to make informed choices regarding their coverage. Despite the ACA's requirement that plans provide a plain-language SBC, consumers still want more information to help them select a plan. According to a National Health Council survey of consumers with chronic health conditions, consumers had difficulty finding information on plan deductibles, copayments, covered medications, and participating providers (26). Specifically, nearly one-third of

respondents said they had to change doctors because their doctor was not in the plan they chose, and more than one-fourth reported having to change a medication because it was not covered by the plan they chose (26).

Next Steps

It is still difficult for some consumers to get the full picture of coverage available in the Marketplaces and to estimate their potential out-of-pocket costs. Consumer decision support tools such as out-of-pocket cost estimators and searchable drug lists will help to ensure that individuals can put to use their newly gained health insurance literacy skills to shop for a plan that best meets their needs.

Affordability of Coverage

As previously mentioned, insurers are now prohibited from denying health insurance or charging a person higher premiums because of a preexisting condition, which has improved access to care. In addition, the ACA rules have helped low- and moderate-income individuals and families afford their monthly health insurance premiums through premium tax credits and reduce their annual cost-sharing requirements. Plus, there are annual caps on out-of-pocket expenses, insurance cannot be cut off when an annual or lifetime expense limit has been reached, and some preventive services are free to consumers.

However, premiums are not the only factor contributing to health insurance expenses, and health plans have some leeway in applying the cost-sharing reductions. Specifically, to apply cost-sharing reductions, insurers must first lower the plan's out-of-pocket maximum amounts and then, if needed, can make other reductions to the deductible, copayments, or coinsurance amounts for various benefits. Thus, some consumers who are eligible for cost-sharing reductions could still face high deductibles or high cost-sharing for particular benefits. For example, the previously mentioned survey of ACA-funded Assistant programs showed

some consumers continue to face challenges with access to affordable prescription drugs and high deductibles for Marketplace plans (23). An analysis of 2015 Marketplace plans in nearly all states found the nationwide average deductible in 2015 ranged from \$5,203 for Bronze plans to \$552 for Platinum plans, although average deductibles among states vary (27). High deductibles can impede access to health care for those who have regular ongoing care needs, such as people with diabetes and other chronic conditions (28).

Next Steps

Although improved consumer health literacy combined with increased health plan transparency will go a long way to ensure that consumers are enrolled in a health plan that best suits their needs (e.g., people with a chronic condition such as diabetes are usually better off with a low-deductible plan), some adjustments still can be made to help improve the affordability of Marketplace plans. For example, states can develop a standard benefit design with lower up-front cost-sharing requirements that all plans sold on the Marketplace in their state must follow. Several states have adopted this approach to help keep cost-sharing more affordable for Marketplace enrollees (29).

State Innovation Waivers

Section 1332 of the ACA, known as the State Innovation Waivers provision (not to be confused with Medicaid waivers), invites states to tailor implementation of certain ACA policies and to find alternative delivery models while staying within the fiscal constraints established by the ACA. These waivers begin in 2017 (30).

The State Innovation Waivers permit states to submit plans modifying their health insurance Marketplace, premium tax credits or cost-sharing reduction subsidies, and the requirements for large employers to offer health coverage and for most individuals to have health coverage.

However, this is not a blank check for states. To exercise this option, states must continue enforcing nondiscrimination statutes, such as prohibiting carriers from denying coverage or increasing premiums based on pre-existing conditions. Any alternative plans must meet four criteria:

- Coverage must be equal to or better than that of the existing Marketplace.
- Affordability regarding premiums and cost-sharing charges must be comparable to those in the existing Marketplace.
- Comparable enrollment must be ensured; any changes must maintain or increase the number of insured individuals in the state.
- The plan must remain budget-neutral to the federal government for 10 years.

Under this provision, CHIP and Medicaid are nonnegotiable; therefore, any proposed changes to these programs would require a Section 1115 Medicaid waiver.

Next Steps

Although this ability to tailor health insurance reform to each state's health care environment may be an attractive alternative for some states, advocates must closely monitor these efforts to ensure that they do not undermine the progress made since the ACA was enacted.

Conclusion

Although the ACA dramatically improved the health care landscape, there is work to be done to ensure that the momentum continues and the law's potential is fully realized. Health care professionals, as patient advocates, are encouraged to join the American Diabetes Association in its advocacy efforts to ensure that individuals with or at risk for diabetes have access to adequate and affordable health insurance so they can obtain all of the services, supplies, and support needed to prevent or manage the disease. Take the first step by signing up to be a Diabetes Advocate at www.diabetes.org/advocate. You will

receive advocacy updates and alerts providing information about pending issues and assistance in creating and delivering timely messages to your elected officials.

Duality of Interest

No potential conflicts of interest relevant to this article were reported.

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