

## **Reducing Costs, Protecting Consumers: The Affordable Care Act on the One Year Anniversary of the Patient's Bill of Rights**

For too long, too many hard working Americans paid the price for policies that handed free rein to insurance companies. In the eighteen months since the Affordable Care Act became law, President Obama's health reform has begun to give hard-working families the security they deserve and to help better control health care costs.

- The law put an end to the worst abuses of the insurance industry by implementing a Patient's Bill of Rights that protects consumers through policies like prohibiting insurers from denying coverage to children with pre-existing conditions and making lifetime dollar limits on coverage illegal.
- It holds insurers accountable through new tools to crack down on unreasonable health insurance premium increases and ensure that at least 80% of premium dollars are spent on quality health care, not administrative costs like profits, CEO salaries and marketing.
- It makes it easier to afford health insurance for businesses, young adults, uninsured people with pre-existing conditions, and early retirees.
- And the health reform law strengthens Medicare and Medicaid for the millions of Americans who rely on these programs, while implementing reforms that will ensure that we spend taxpayers' money wisely, improve health care quality, and control health care cost growth.

This report outlines how the Affordable Care Act is strengthening the health care system for all Americans and helping to control health care costs. The report finds that the Affordable Care Act's reforms have helped reduce premiums and hold insurance companies more accountable, and the Administration's anti-fraud efforts alone will save \$1.8 billion through 2015. In fact, a series of reforms to drive down costs for businesses are already helping to make it easier for employers to provide coverage to their employees.

### **Giving Families the Security They Deserve and Ending Insurance Industry Abuses**

A major goal of the Affordable Care Act is to put American consumers back in charge of their health care and put an end to the worst abuses of the insurance industry. On September 23, 2010 – just 6 months after the Affordable Care Act was signed into law – a series of reforms went into effect, taking aim at insurance company practices that left consumers vulnerable just when they needed their coverage the most. One year later, this Patient's Bill of Rights is strengthening health care coverage for millions of Americans.

Thanks to the law:

**Insurance companies can no longer deny coverage to children based on pre-existing conditions.** Before the Affordable Care Act, insurance companies could refuse to cover a child

because he or she had diabetes or other pre-existing conditions. And, if an insurer did cover a child, it could exclude coverage for the very conditions for which she needed treatment, such as her asthma or a heart defect. One year later, this practice is a thing of the past. The Administration estimates that up to 72,000 children who would otherwise be uninsured will gain coverage, and an additional 90,000 children are seeing their coverage limitations disappear because of this provision of the law. In 2014, no American will be denied coverage based on a pre-existing condition.

### *Reform in Action*

Eight-year old Wesley Josephson, who has an eye condition requiring frequent surgery, has coverage without exclusions for the first time in years. His mother Dawn was so used to seeing denials and exclusions when she tried to find coverage for her son that she could barely believe it when the insurance company explained this new access to coverage, all thanks to the health care law.

#### *Reform in Action Spotlight*

Because of his hemophilia, Paul Brayshaw of Virginia exhausted a \$1 million lifetime limit in just three years; he was fortunate to find new insurance last time, but the new coverage still came with a \$6 million cap. Now Paul knows he won't ever have to worry about hitting a lifetime limit again. The law is also phasing out annual dollar limits on coverage.

**Insurers can't place lifetime limits on benefits.** Until last year, insurers could place an arbitrary cap on the total amount of coverage they provide in a lifetime as well as low annual limits on coverage. These dollar caps meant that many Americans facing a serious illness like cancer found themselves suddenly without the coverage they had been counting on. Today, the 102 million Americans whose health plan included lifetime dollar limits have seen their coverage expanded, and as many as 20,400 patients who would have otherwise hit a lifetime limit each year are instead getting treatment they

need.

**Insurers can't drop your health coverage when you get sick.** The Affordable Care Act has finally put an end to one of the most abusive practices of the insurance industry: retroactively canceling coverage for a sick patient based on an unintentional mistake in her paperwork. Before the health care law was signed, an estimated 10,700 people suffered through a coverage rescission each year, often leaving them suddenly responsible for thousands of dollars in past expenses and no coverage to pay for needed care. One year after this prohibition went into effect, all Americans can be confident that they will not see their coverage rescinded over a trivial error.

The Patient's Bill of Rights is also bringing important benefits to tens of millions of Americans in new insurance plans. These individuals can now:

- **Receive preventive services without paying an additional penny out-of-pocket.** New health insurance plans have to cover recommended preventive services without cost-sharing, helping more patients receive needed services that can keep them healthy. This year, as many as 41 million Americans are benefitting from this provision, and millions more will benefit in the years to come. Americans now have access to services such as

blood pressure testing, diabetes and cholesterol screening; many cancer screenings; routine vaccinations; pre-natal care; and regular wellness visits for infants and children at no additional cost. The elimination of copayments, co-insurance, and deductibles, will improve access to affordable, quality health care and will help prevent serious health conditions before they start. The recent release of Women's Preventive Services Guidelines adds additional services targeted directly to women such as family planning services to improve maternal health and birth outcomes, and breastfeeding support that can help improve child health and development.

This provision of the law will save money for consumers. For example, guidelines suggest that a 58-year old woman who is at risk for heart disease should receive a mammogram, a colon cancer screening, a Pap test, a diabetes test, a cholesterol test, and an annual flu shot. Before the Affordable Care Act, these tests could cost more than \$300 out of her own pocket; now, she can schedule the services she needs without having to pay any cost-sharing.

- **Choose a primary care doctor, OB/GYN, and pediatrician.** Consumers in new health insurance plans are guaranteed the ability to choose a primary care doctor in their insurer's network, including a pediatrician in the case of a child, and women have the right to access an OB/GYN without getting an authorization or referral.
- **Use the nearest emergency room without higher cost-sharing.** In an emergency, families can go to any emergency room, regardless of whether or not it's in their network, without facing higher cost sharing than would be owed in-network.
- **Appeal an insurance company decision.** Consumers in new plans have more opportunities to appeal their insurance companies' decision and request an independent review if their insurance company denies them care. As many as 40 million Americans already have coverage where these benefits are guaranteed by the Affordable Care Act, and millions more will have these protections in years to come.

## **Fighting High Premium Increases**

Thanks to the Affordable Care Act, insurance companies can no longer raise premiums without any transparency or accountability. The health reform law brings an unprecedented level of scrutiny and transparency to health insurance rate increases. It ensures that, in every state, proposed increases of 10% or more will be evaluated by experts to assess whether they are based on reasonable cost assumptions and solid evidence. This review and scrutiny will highlight unjustified premium hikes and help provide those who buy insurance with greater value for their premium dollar. Additionally, consumers will benefit from greater transparency as they will be able to access online easy-to-understand information about why insurers are seeking the increases.

To help states strengthen and improve their rate review processes, the Affordable Care Act provides states with \$250 million in Health Insurance Rate Review Grants. Available through Federal Fiscal Year 2014, these grants are helping to create a more level playing field by improving how states review proposed health insurance rate increases. For example, nine states are implementing legislation passed in the last year, and seven states are introducing legislation to improve their review of insurance rates. Other states are using these grants to bolster the information required from issuers when a rate increase is proposed, to improve the transparency of rate increase data, and to increase the ease with which consumers can find and understand this information.

### *Reform in Action*

Already, states have used their review authority to benefit consumers by rejecting and/or reducing rate increases.

- Connecticut's Insurance Department rejected a proposed 20% rate hike by one of the state's major insurers.
- In August 2010, a major insurer in Massachusetts agreed to a significant reduction of proposed increases – less than 13% instead of the nearly 23% they initially requested.
- In 2010, Oregon disapproved health insurance premium requests of 10%, 18%, and 20% in the individual market.
- Rhode Island's Insurance Commissioner used his rate review authority to reduce a proposed rate increase by a major insurer in that state from 7.9% to 1.9%.
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7% cut to 14% following a public outcry.
- In 2010, Californians were saved from rate increases totaling as high as 87% after a California insurer withdrew its proposed increase after scrutiny by the State Insurance Commissioner.

## **Spending Your Premiums on Health Care, Not Overhead, Advertising and Bonuses**

To ensure that consumers receive value for their premium dollars, the Affordable Care Act establishes minimum standards for spending by health insurance issuers on clinical services and activities that improve quality – these are known as the Medical Loss Ratio (MLR) provisions.

These MLR standards (generally 80% for the individual and small group markets and 85% for the large group market) apply in 2011. Insurance companies that don't meet these standards will provide rebates to their consumers. Rebates must be paid by August 1st of each year following the year that the MLR requirement is not satisfied. The MLR provision also directs insurance companies to publicly report how they spend premium dollars, providing consumers with meaningful information on how much of their premium dollar goes toward actual medical care and activities to improve health care quality versus how much money is spent on administrative expenses. Estimates indicate that up to 9 million Americans could be eligible for rebates starting in 2012 worth up to \$1.4 billion.

### *Reform in Action*

The MLR provision is already forcing insurance companies to carefully evaluate their rates, slow the rate of premium growth and, in some cases, decrease premiums. Indeed, more than 15,000 customers of one insurer in Connecticut may see their health insurance premiums drop by between 5% and 19.5% due, in part, to the new MLR policy. Similarly, another carrier recently cited the MLR requirements as a factor in reducing its 2012 rate increase request, benefitting more than 45,000 individual market customers in Connecticut. And industry analysts have begun to suggest that this is nationwide trend. For example, analysts at one firm noted that health care cost growth in the private market was near its all time low, and emphasized that this slowed growth “reflects the impact of the industry’s adaptation to the health reform minimum MLR regulations.”

*Reform in Action Spotlight*  
A recent GAO report indicated that several issuers are already reducing administrative expenses, making adjustments to premiums, and making changes to their other business practices in response to the Affordable Care Act MLR requirements.

## **Reducing Costs for Businesses**

The Affordable Care Act includes a series of reforms that are also making it easier for businesses, especially small businesses, to provide affordable health insurance to their employees.

Small businesses with fewer than 25 full-time equivalent workers qualify for a federal tax credit of up to 35% of the cost of insurance. In 2014, that will increase to 50%. The size of the credit depends on your average wages and the number of employees you have. The full credit is available to firms with average wages below \$25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between \$25,000 and \$50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

Reforms to slow health care costs nationwide are well underway. This includes policies to:

- **Reduce paperwork:** The Affordable Care Act calls for improved use of electronic standards that will help eliminate paperwork. This will save health care providers, insurance companies, and employers as much as \$12 billion.
- **Increase transparency:** For many years employers, consumers, providers, and quality measurement organizations have been frustrated with the limited and piecemeal availability of health care data. The health reform law provides patient-protected Medicare data to produce public reports on physicians, hospitals and other health care providers, empowering employers to design the best plans for their workers.

- **Improve quality while lowering costs:** The Partnership for Patients, also described below, was announced earlier this year and is investing up to \$1 billion of Affordable Care Act funding into public-private partnerships. This initiative will help doctors and hospitals share best practices to improve patient safety.

Early evidence suggests that health care costs are slowing. Recent data from the Bureau of Labor Statistics found that the first quarter health insurance employer cost index, a measure of health insurance prices, was 3.4% – the lowest it has been in the quarterly series in more than 10 years. Similarly, the Thomson Reuters Healthcare Spending Index for Private Insurance found that employers’ health insurance cost rose by 3.8% in early 2011, nearly half of the 6.3% from early 2010. And, according to a recent survey by Mercer, health costs for employers will grow in 2012 at the slowest rate since 1997.

## **New Options for Young Adults**

### **Ensuring health insurance coverage for young adults.**

Young adults have historically had the highest uninsured rate of any age group. One of the first coverage provisions in the Affordable Care Act to take effect was the extension of dependent coverage, which enables young adults up to age 26 to be covered through a parent’s private health insurance plan. This coverage is available to young adults who do not have employment-based coverage even if they are not students, live away from their parents, and are not financially dependent on their parents. This policy is already increasing the number of young adults with health insurance. During the first three months of 2011, about 1 million young adults age 19 to 25 gained health insurance according to new data released by the CDC. This data confirms the trend seen in recent Census numbers, where young adults were the only age group to experience a significant increase in the share with health coverage, and in results from surveys conducted by the Gallup organization.

*Reform in Action Spotlight*  
 This new rule is helping people like Kylie R. Logsdon of Gerlaw, Illinois. The New York Times reported that Kylie had health insurance through her father’s health insurance plan, which enabled her to receive the heart transplant she needed. As Kylie told the Times “I honestly don’t know what we would have done. There was no way we could have afforded it. I might not be here right now.”

## **Coverage for Uninsured Americans with Pre-Existing Conditions**

The Affordable Care Act created the Pre-Existing Condition Insurance Plan (PCIP) to make health insurance available to those that have been denied coverage by private insurance companies because of a pre-existing condition. It is a bridge to 2014 when everyone will have access to affordable health insurance choices through a new competitive marketplace called an Exchange, which prohibits discrimination based on a pre-existing condition. To date, over 30,000 people have gained coverage through this program.

*Reform in Action*

In March of this year, Gail O'Brien was diagnosed with high grade non-Hodgkin's lymphoma. She had no health insurance. Thankfully, the Pre-Existing Condition Insurance Plan was established through the Affordable Care Act. As a result, Gail now has insurance that will pay for her treatments.

## **Support for Early Retiree Health Insurance Coverage**

Rising costs have made it difficult for employers to provide quality, affordable health insurance for workers and retirees while also remaining competitive in the global marketplace. Many Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of exorbitant rates in the individual health insurance market. The Early Retiree Reinsurance Program offsets some costs of early retirees' health insurance, providing much-needed financial relief for employers so retirees can get quality, affordable insurance. Over 6,600 health plan sponsors are participating in this program which provides coverage to well over 4.5 million early retirees, workers, and their families. In 2010, 97% of the funds from this program went to reduce premiums and/or cost sharing for health plan enrollees.

### *Reform in Action*

CalPERS, the California Public Employees' Retirement System, requested reimbursement for claims incurred by 5,302 early retirees, spouses, surviving spouses, and dependents in 2010. In anticipation of ERRP reimbursement CalPERS worked with its benefits carriers to mitigate 2011 premium increases by 3% – a savings of up to \$200 million.

According to CalPERS officials, the ERRP funding will directly benefit 1.1 million public employees, retirees, and their dependents including 115,000 ERRP eligible early retirees, many of whom have been subject to declining wages due to state furloughs imposed to address budget shortfalls. Over 6,600 health plan sponsors are participating in this program which provide coverage to well over 4.5 million early retirees, workers, and their families. In 2010, 97% of the funds from this program went to reduce premiums and/or cost sharing for health plan enrollees.

## **Strengthening Medicare and Medicaid – Improving Care and Saving Money for Seniors and Taxpayers**

The Affordable Care Act is strengthening Medicare and Medicaid – spending taxpayer dollars more wisely and improving the way Medicare and Medicaid pay doctors and hospitals while providing the kind of high-quality care beneficiaries expect and deserve. These changes provide Americans with better health care by rewarding what works – like focusing on preventive care – instead of just how many patients a doctor can see in a day or how many hospital beds a hospital can keep full. The Affordable Care Act also strengthens benefits for seniors and people with disabilities on Medicare. The law makes preventive services like many cancer screenings available for free and offers new coverage through the “donut hole” coverage gap in prescription drug coverage until the donut hole is completely closed in 2020. Thanks to these benefits and

the reforms in the law, a senior in Original Medicare could save more than \$3,500 over the next 10 years. Already, millions of seniors are being helped:

- This year, over half of those enrolled in Original Medicare – 18.9 million people – have used preventive services that are now provided at no cost to them. Many of these free services will help prevent chronic diseases that can cost Medicare billions to treat. During the same time period, almost 1.3 million Americans with traditional Medicare have taken advantage of the new free Annual Wellness Visit.
- Also this year, thanks to the Affordable Care Act, nearly 1.3 million people have received assistance on their prescription drug costs. Thanks to a 50% discount on their covered brand name prescription drugs in the donut hole, these Americans have saved a total of \$660 million so far this year through July – an average of \$517 per person.
- In 2010, nearly 4 million seniors who reached the prescription drug donut hole received a \$250 rebate check to help them afford the cost of their prescription drugs.
- At the same time, the premiums that seniors pay for standard prescription drug coverage has held steady over the last two years. From 2010 to 2011, premiums increased by only \$1. And from 2011 to 2012, the average premium actually decreased by 76 cents.
- And Medicare Advantage remains strong. On average, Medicare Advantage premiums will be 4% lower in 2012 than in 2011, and plans project enrollment to increase by 10%. Of people with Medicare, 99.7% continue to enjoy access to a Medicare Advantage plan, and benefits remain consistent with those offered in 2011.

Taxpayers are seeing lower costs as well. As a result of the reforms in the Affordable Care Act and other efforts by the Obama Administration, taxpayers will save up to \$120 billion over the next five years because Medicare dollars are being spent more wisely. Some of the most significant efforts include:

- **Reforming provider payments – saving \$55 billion**  
The Administration has begun implementing payment methods that reward efficiency and quality of care. The Affordable Care Act ties provider payments to broader economic productivity, creating incentives for greater efficiency. In addition, the Administration recently finalized rules that reward hospitals that deliver high-quality care – a reform that will be applied to physicians in the coming years. These provisions, which emphasize safer care that reduces preventable injuries and unnecessary readmissions, will save \$55 billion.



- Investing in patient safety through the Partnership for Patients – saving up to \$50 billion over ten years**

Hospitals, physicians, and other health care professionals have shown that it is possible to reduce medical errors and improve patient safety dramatically. The Partnership for Patients, announced earlier this year, is investing up to \$1 billion of Affordable Care Act funding into public-private partnerships – helping doctors and hospitals share best practices to improve patient safety.
- Reducing excessive payments to insurance companies – up to \$43 billion**

Medicare paid Medicare Advantage insurance companies over \$1,000 more per person on average than Original Medicare. These additional payments were paid for in part by increased premiums by all Medicare beneficiaries—including the 77% of seniors not enrolled in a Medicare Advantage plan. The new law levels the playing field by gradually eliminating Medicare Advantage overpayments to insurance companies. These changes will achieve an estimated \$43 billion in savings over the next five years. In addition, authority provided by the Affordable Care Act protected beneficiaries from significant increases in costs or cuts in benefits in 2012, leading to average premium declines for the second year in a row: 2012 premiums are projected to be 11.5% below 2010 premiums. Enrollment is expected to increase by 15.6 % from 2010 to 2012.

*Reform in Action Spotlight*  
 So far, over 4,500 organizations – including over 2,000 hospitals – have pledged to be part of the Partnership for Patients. If we achieve the Partnership’s goals – reducing preventable hospital-acquired conditions by 40%, we will prevent 1.8 million injuries and avert 60,000 deaths over the next three years, and reducing unnecessary hospital readmissions by 20% – we will save up to \$35 billion across our health care system over three years, including up to \$10 billion for Medicare alone.

## Fighting Fraud

Fighting fraud and abuse in the health care system and the Medicare program is a top priority for the Obama Administration. The centerpiece of the Administration’s anti-fraud campaign is prevention: keeping fraudulent actors out of Medicare and Medicaid and not making fraudulent payments in the first place. We have focused our efforts in a number of high priority areas.

- Enhanced screening and coordination.** Tougher provider screening and enrollment requirements, along with better coordination of fraud prevention efforts across programs, is helping keep bad actors out of the program. New tools to target high-risk entities are improving our ability to screen them effectively. Combined, these efforts are estimated to save taxpayers \$210 million over five years.
- Using credit card technology to stop fraud.** By using techniques similar to the tools credit card companies use to identify and catch fraudsters CMS and other health care payers can identify real-time aberrant trends that could be indicators of waste or fraud and keep fraudulent payments from going out the door.

- **Increased penalties for bad actors.** These tough front-end defenses are complemented on the back end by tough new rules and sentences for criminals pursued by the Inspector General and Department of Justice.
- **Cutting waste in Medicare and Medicaid.** The Medicare Recovery Audit Contractor program has already recovered nearly \$670 million in improper Medicare payments. Based off of this successful program, HHS released a final rule earlier in September for the Medicaid Recovery Audit Contractor Program, a waste-cutting program created by the Affordable Care Act and projected to save \$2.1 billion over the next five years. Over \$900 million of that money will be returned to states.
- **More stringent payment and enrollment requirements.** The Affordable Care Act establishes rules that require face-to-face meeting for Medicare and Medicaid home health and Medicare hospice and durable medical equipment (DME) items and services. New rules also require providers and suppliers who order and refer certain items or services for Medicare beneficiaries to enroll in Medicare and maintain documentation on those orders and referrals.

To date, the Administration's priority on rooting out fraud and abuse is paying off. The Health Care Fraud and Abuse Control program (HCFAC) activities resulted in a record \$4 billion in recoveries in FY 2010. One HCFAC initiative, the HHS/DOJ Strike Force, has charged more than 1,000 individuals who collectively have falsely billed the Medicare program for more than \$2.3 billion. According to one study, the Administration is on track to increase the number of indictments by 85% in 2011 over 2010. The Affordable Care Act also provides additional tools to help prevent fraud and abuse that will achieve \$1.8 billion in savings through 2015.

## **Investing in Innovation, Improving Care and Saving Money**

In addition, the Affordable Care Act is giving Medicare and Medicaid the tools to control costs over the long run – changing the way we pay doctors and other providers to reward better, more coordinated care. Much of this work is being piloted by the CMS Innovation Center, which was created by the Affordable Care Act and is helping to test innovative new ways to deliver better health care. Medicare and Medicaid are poised to bring successful pilots to Medicare beneficiaries across the country. Key initiatives include:

- **Better Coordinated Care for Individuals Enrolled in Medicare and Medicaid**  
Patients enrolled in both Medicare and Medicaid (i.e., Medicare-Medicaid enrollees) have some of the greatest health care needs in the country, and also incur the highest health care costs. Approximately 9 million Americans are enrolled in both Medicare and Medicaid. These individuals are a small percentage of the people who receive care through these programs (16 and 15%, respectively) but account for a disproportionate amount of spending – 27% of Medicare spending and 39% of Medicaid spending. With the creation of the Medicare-Medicaid Coordination Office, CMS has announced several

initiatives that will improve coordination of care for these individuals. Fifteen states across the country have been selected to design new ways to coordinate care for these individuals. To further support these efforts, CMS is providing states with improved and faster access to Medicare claims data.

- **Accountable Care Organizations**

Accountable Care Organizations (ACOs) are a way for health care providers to organize and work together to coordinate care for an individual patient. Under the Affordable Care Act, ACOs will be rewarded for reducing the rate of growth in health care costs while meeting performance standards on quality of care and putting patients first. CMS has released a proposed rule outlining policies for ACOs that participate in the Medicare Shared Savings Program and is working with stakeholders and the public to strengthen this proposal. Additionally, the Innovation Center has developed a plan to begin testing the Innovation Center's Pioneer ACOs model designed for organizations that already have experience providing coordinated care.

- **Independent Payment Advisory Board (IPAB)**

Under the Affordable Care Act, IPAB recommends policies to reduce the rate of growth in Medicare spending, while not harming beneficiaries' access to or the quality of needed services. The IPAB begins its work next year, and starting in 2014, may submit recommendations to Congress every year on how to best improve quality of care for Medicare beneficiaries while slowing cost increases. IPAB is prohibited from recommending changes that would ration care, increase costs for beneficiaries, reduce benefits, or change eligibility. IPAB recommendations only take effect if Medicare cost growth exceeds cost growth targets and Congress fails to act to reduce Medicare spending.

- **Improving Access to Long Term Care in Home and Community Based Settings**

More than 3 million Americans rely on Medicaid for long-term services and supports. Home and community based services, rather than services in an institution, are not only the services individuals often prefer, they are also cost effective. The Affordable Care Act contains a number of tools designed to help make it easier for the most vulnerable Americans to get Medicaid long-term care at home and in the community. The Affordable Care Act's Community First Choice option and the Balancing Incentive Payments Program will provide enhanced federal support to incentivize states to make Medicaid home and community based services more readily available.

- **Testing Bundled Payments.** The CMS Innovation Center launched a program to "bundle" or combine payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement. Bundling payments is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged. Such initiatives that have put into practice around the country have shown that they can help improve health, improve the quality of care, and lower costs.

- **Preventing Costly Conditions.** In conjunction with several public and private partners, HHS launched Million Hearts, an initiative aimed at preventing 1 million heart attacks and strokes over the next five years. By empowering Americans to make healthy choices and improving care for those with high blood pressure and high cholesterol, Million Hearts will help improve Americans' health and productivity.

## **Medicare Spending and the Affordable Care Act**

Following implementation of the Affordable Care Act, growth in Medicare per capita spending has declined significantly. From 2006 through and 2009 (the period after the introduction of the Part D drug benefit), per capita Medicare spending grew by an average of 5.0% annually. In contrast, per capita spending is estimated to have increased by 2.8% in 2010 and by 2.6% in 2011. Further, spending growth per beneficiary in 2010 and 2011 is approximately at the rate of growth of the economy, and much slower, relative to GDP per capita, than during the previous decade.

## **Conclusion**

In just a year and a half, the Affordable Care Act has made the health care system better for millions of Americans. By cracking down on insurance industry abuses, strengthening Medicare and Medicaid, and making sure we are spending taxpayer dollars wisely in our health care programs, we are ushering in a new day for American consumers. We will continue to build on these reforms in the years to come, and look forward to 2014 when all Americans will have access to quality, affordable health insurance.

## **Appendix: Quick Facts about the Affordable Care Act**

Thanks to the Affordable Care Act:

- One million young adults have health insurance thanks to the new rule that enables young adults up to age 26 to be covered through a parent's private health insurance plan.
- Seniors who hit the donut hole receive a 50% discount on brand-name drugs. Nearly 1.3 million seniors have already received the discount.
- Nearly 19 million seniors have already received one or more free preventive services and 1.3 million seniors have already received a free Annual Wellness Visit.

- Insurance companies must spend at least 80% of your premium dollar on health care, not overhead, advertising and bonuses. More than 165 million are now getting a better value for their insurance dollar.

*Posted on: September 23, 2011*