MARKETPLACE GUIDE 2024

Getting Ready for the 2024 Open Enrollment Season

Contents

Introduction

The Health Insurance Marketplace, also known as the Marketplace or exchange, is a federal government operation that makes health insurance available to all. Through the Health Insurance Marketplace, individuals can go shopping, find, and enroll in a health insurance plan that works for them.

For insurance agents, the Health Insurance Marketplace presents a unique opportunity to connect with individuals shopping for health insurance, as well as small businesses providing health insurance to their employees. It's an important sales outlet if you plan on selling health insurance coverage.

In this guide, we'll explore how the Marketplace works and how you can get started selling plans through it.

The Health Insurance Marketplace was born from the Affordable Care Act (ACA) in 2010. By the fall of 2013, exchanges were available for individuals, with family health coverage following in 2014. Most states rely on the federal government's HealthCare.gov site and other states run their own marketplaces.

Individuals seeking health insurance provide information about their household and income. Through the Marketplace, they will then get information on health insurance qualifications. They may qualify for premium tax credits, as well as other savings. It is also possible they will get coverage through the Medicaid and Children's Health Insurance Program (CHIP), depending on their state's requirements.

The Marketplace is designed to make health plan shopping simpler with a centralized hub of call centers, website information, and in-person assistance as needed. The goal for the Marketplace is to be a resource for anyone seeking health insurance outside their employer.

How the Marketplace Works

The Marketplace eliminates barriers like set costs and pre-determined coverage. All plans hosted on the Marketplace are required to offer the same essential health benefits. These include doctor visits, preventive care, hospitalization, and rehabilitation services.

Benefits that come with using the marketplace include:

- Exposure to a new set of clients - you can build up your profile
- The enrollment process is simplified on the marketplace portal – completing applications, enrollments, renewals, and plan changes
- Helping your clients find the best deal on insurance – businesses can also qualify for a tax credit for offering marketplace insurance

Understanding these key advantages of marketplace insurance will allow you to best communicate the benefits to your clients.

The Marketplace offers a combination of government and private health insurance offerings, but there are standards plans must meet for insurers to be eligible to participate. For an insurer to offer a policy, it must offer ten essential health benefits:

1. Laboratory services
2. Emergency services
3. Prescription drugs
4. Maternity and newborn care
5. Services for mental health and substance abuse
6. Hospitalization
7. Pediatric services, inclusive of oral and vision
8. Ambulance services
9. Preventative and wellness services, inclusive of chronic care
10. Rehabilitative services

Plans must also offer a minimum value of 60%, meaning the insurance company pays 60% of allowable charges, while the insured is responsible for the other 40%. This is known as the Bronze plan category. The metallic category levels of insurance plans under the Health Insurance Marketplace include the following:

Bronze Plan: Split of 60% payment by insurance company, 40% by insured

Silver Plan: Split of 70% payment by insurance company, 30% by insured

Gold Plan: Split of 80% payment by insurance Company, 20% by insured

Platinum Plan: Split of 90% payment by insurance company, 10% by insured

The federal government enforces these standards so everyone can have adequate coverage. Another noteworthy standard is that plans cannot exclude individuals with pre-existing conditions.

Insurance agents or brokers must understand these requirements before starting to sell on the Marketplace. Insurers offering Platinum levels will carry higher premiums and cover more claims and of course Bronze plans will have lower premiums and cover less.

Getting Started to Sell Insurance on the Marketplace

To sell health insurance on the Marketplace, you need to get set up on the Centers for Medicare and Medicaid Services CMS portal at www.cmc.gov. Once you are up and running on the portal, you can get started as an active agent.

Step 1: Create a CMS Enterprise Portal Account

The Centers for Medicare and Medicaid Services run the federal Marketplace. You will need to create an account through the CMS Enterprise Portal at https://portal.cms.gov/

Note: If you already have a CMS Enterprise Portal account, you just need to renew it.

Step 2: Request access as an agent or broker

In the CMS Enterprise Portal, you will need to complete the following set of selections: Request Access Now, FFM/Training – Agents/Brokers/Assisters as the title, and then FFM Agent Broker from the dropdown menu.

Step 3: Complete the ID Verification

CMS will need you to confirm your identity through some basic information. Once you've completed this step you'll return to the CMS Enterprise Portal home page. From there, you will need to log out and wait a few minutes for your profile to be assigned as an agent/broker.

Step 4: Complete the Marketplace training.

In your CMS Enterprise Portal, navigate to Complete Agent Broker Training. Select the 'Access Training' link next to the Marketplace Learning Management System (MLMS).

Select the Individual Market curriculum and then 'Complete Enrollment'. You will then need to complete all required training.

Note: You also can complete this training through a CMS-approved vendor. Many of these training will be paid courses, and they may also offer continuing education units (CEUs). The MLMS training from CMS is free, but it doesn't offer CEUs.

Step 5: Privacy and security agreements

After you've completed the training, the final step in your CMS Enterprise Portal is to launch and electronically sign the CMS Privacy and Security agreements.

To do this, go to ‘Current Learning’ and select ‘Curriculum State’. From there, you’ll click the ‘Actions’ link to the right of a completed curriculum.

It is recommended that you save a digital or physical copy of your Registration Completion Certificate.

Congratulations — once you have completed this step, you are officially a FFM-licensed agent!

Step 6: Get appointed with Marketplace carriers

Now that you’re a licensed FFM agent, you will need to get appointed with insurance carriers. Without carrier appointments, you cannot receive a commission for your enrollments.

If you’re not sure which carrier appointments to prioritize, you can run a few quotes for zip codes in the area you intend to sell insurance in. After you compile your list, do an online search (e.g., Google) for ‘[Carrier] Marketplace Appointments’ to find the directions you’ll need to follow to get the appointment process started. Many carriers will ask you to create an Agent account and fill out a form.

Consultative Selling for Open Enrollment

When working with clients to find the right ACA coverage, it’s important to have a comprehensive understanding of their current needs. Consider their current health status, average number of visits to a provider in a year, medications, budget, and preferred hospital network. Having a complete understanding of your clients’ health insurance priorities will allow you and your clients to make an informed decision about which plan will be the best fit for them.

The insurance industry is constantly changing; that’s why it’s important to stay on top of new plans, new carriers in your area, as well as new compliance and regulation changes. As things change in the industry, make sure that your clients can trust you and easily approach you with questions about their insurance plans. We recommend becoming a “subject expert” on the types of insurance you plan to sell.

There are several educational resources available to agents looking to gain a better understanding of marketplace insurance. We recommend HealthCare.gov’s blog for help with tricky situations or other questions you may have. Ritter also has resources available for agents looking to grow their ACA knowledge or brush up on facts, like our eBook, The Complete Guide to Selling Affordable Care Act Insurance Plans. This guide covers the basics, marketing tips to reach more clients, and provides resources such as a cold call script, customizable letter, and helpful metal tiers comparison chart for clients.

If your clients can sense you're a knowledgeable agent, they'll likely feel comfortable coming to you with questions and referring you to their family, friends, coworkers, and more! Your clients should be able to trust you with something as important as their health insurance. They should always feel as if you're in their corner.

There isn't a shortage of options when it comes to health insurance. However, finding just the right plan for your client can be overwhelming for them. One reason that we recommend knowing your clients' needs well is so that you can eliminate plans that won't be beneficial to them.

While having options and being able to choose your own plan can be empowering, too many choices can create decision fatigue. You'll also save time by being able to present your clients with a shorter list of plans to choose from. While navigators cannot recommend one plan over another, you can, as you provide them with a few options to choose from.

If your client qualifies for Advanced Premium Tax Credit subsidies, but not cost-sharing reductions (CSRs), consider quoting a few of the lowest-cost bronze, silver, and gold plan options.

If your client does qualify for a CSR, concentrate your efforts on silver plans. These plans are the only options available to use with a CSR.

As an agent selling ACA plans, your target clients are under 65 years old. This means they're also most likely online. One survey reports that 99 percent of young adults aged 18 to 29 use the internet frequently. We recommend you stay up to date in your lead-generation methods and determine your social media strategy. Social media platforms such as Facebook, Twitter, and LinkedIn make it easy to connect with others at any time, making relationship-building happen outside of business hours.

Since the beginning of the pandemic, more people are more familiar with remote meeting software due to a large amount of the workforce working remotely. Platforms such as Zoom and Microsoft Teams can make meeting with clients virtually even easier. Try using them to get in touch with your clients periodically throughout the year, and especially before the Open Enrollment Period (OEP).

Practicing client retention is one of the most important things you can do for your business. At minimum, we recommend responding to emails within two days, responding to calls within 24 hours, and being on time for business meetings.

Marketplace Agents Sales and Service Responsibilities

Insurance Agents have a duty to operate with honesty and loyalty in all of their transaction with the insurance companies they represent and on the insurance company's behalf.

Responsibilities to the Policyowners

An Agent has the responsibility to:

1. Sell policies that best fit the insured's needs and wants.
2. Sell policies that are affordable for the insured.

An Agent can meet these responsibilities by:

1. Maintaining the required knowledge and skill commensurate with the profession.
2. Educating their clients about products with honest recommendations.

Service and the Sale

Service is a post sales-function AND is implied in the sale; service includes:

1. Educating the clients throughout the sales process and making sure that the client understands the policy purchased.
2. Treating all individual's information with confidentiality.
3. Disclosing relevant information so that individuals can make informed decisions.
4. Keeping clients informed of rejections, cancellations, and exclusion of coverages.
5. Demonstrating loyalty to all clients.

Service Begins with the Application

First and foremost, an Agent's responsibility regarding the completion of the Application is to the insurance company. The Application is the number one source of information used in underwriting a policy.

Agents have a duty to the insured when completing an application as follows:

1. Advise the insured why information is required.
2. Advise the insured how the information will be evaluated.
3. Encourage accurate and honest information from the insured.
4. Explain the meaning of insurance terms like waiver of premium, premium loans, non- forfeiture options, and conditional receipts.

Responsibilities to the Public

Insurance is complicated and there are many options available for the insured to consider. Agents have a duty to provide the public with a fair and honest representation of polices and services offered. The NAIC has developed model regulations how individuals and professionals can advertise insurance information. Agents should ethically use carrier material and should not use them to deceive or misrepresent.

Deceptive sales are unethical and illegal; deceptive sales include any presentation that would:

- give an insured the wrong idea about an insurance policy
- not provide full disclosure
- includes misleading coverage comparisons

Skill and Competence

Agents have an ethical responsibility to develop skill and competence:

- Agents should develop knowledge and skills dedicated to their line of work.
- Agents have a responsibility to acknowledge situations that are beyond their skill level...
- Agents have other “professional obligations”.

Professionalism requires Agents to do the following:

- put the insured‘s interest beyond their own interest
- be dedicated to the insurance industry and support the companies they represent
- offer insurance plans of good quality and represent quality carriers

Moral Issues

Moral issues can occur when an Agent is tempted to make false or misleading representations for his or her own financial gain or other personal benefit; these actions are of course unethical and against industry practice.

Ethical Agents should do the following:

- discern early between right and wrong in business practices and treat them accordingly
- consistently adhere to personal values and maintain integrity in their sales career
- assume the obligation to perform duties in a way that reflects the highest degree of dignity on the industry and best serves the interest of the client or prospect

Ethics – Needs Based Selling

Communication

It is an Agent's ethical responsibility to communicate product knowledge and information so that clients can make an informed decision and determine which products work best for them.

Complete and Honest Representation

An Agent has a responsibility to present each product with absolute honesty and disclosure; this means discussing benefits and liabilities of products with their insureds. The goal is to uncover the specific needs of your insureds and show which insurance policies can satisfy these needs. Your ethical duty is to specifically sell products that are "best fit" for the insured and not for your own personal gain.

The Organized Sales Presentation

The organized presentation has six basic steps:

1. the approach
2. establishing a general problem
3. establishing the specific problem
4. assessing the needs
5. presenting the insurance solution
6. implementation – acquiring the best option for the insured

Informed Decisions

Informed decisions: your proper approach for the insured should be needs-based selling. Needs- based selling is presenting products that meet specific needs of the insured. The goal is to educate the insured so they can make their own decisions about what products are best for them.

Overview of the Presentation

The presentation should flow through the following four steps:

1. Review and establish a relationship with your insured including a fact-finding interview.
2. Review insured's needs and prioritize their insured's needs and wants.
3. Introduce specific product solutions demonstrating to the insured how the various options meet their needs.
4. Review the best options with the insured with an agreement to implement the chosen policy or plan on behalf of the insured.

Full Disclosure

Full disclosure requires an Agent to explain facts so that insureds understand benefits, options, limitations, and exclusions fully; enabling them to make informed decisions based on their situation and goals. An agent is responsible for providing information in an understandable manner; the goal is to educate the insured. Ultimately the insured needs to make the decision of what's best for their situation.

Moving On

In the remaining sections of this guide we will be discussing the historical overview and construction of the Affordable Care Act which mandated the creation of the Marketplace(s).

How the Marketplace Got Started

Background

The Affordable Care Act (ACA) as amended by the Health Care and Education Reconciliation Act is the comprehensive healthcare reform signed into law by President Obama in 2010. Formally known as the Patient Protection and Affordable Care Act, and often referred to as Obamacare, the law includes a list of healthcare policies intended to extend health insurance coverage to millions of uninsured Americans. Provisions included in the Affordable Care Act were intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs.

Purpose

The Affordable Care Act (ACA) is aimed primarily at decreasing the number of uninsured Americans and reducing the overall costs of health care. It provides a number of mechanisms including mandates, subsidies, and tax credits to employers and individuals in order to increase the rate of covered individuals in the United States. Additional reforms are aimed at improving healthcare outcomes and streamlining the delivery of healthcare. The Affordable Care Act (ACA) requires insurance companies to cover all applicants and offer the same rates regardless of pre-existing conditions or gender. The Congressional Budget Office projected that PPACA will lower both future deficits and Medicare spending.

By driving down the number of people who are uninsured, the Affordable Care Act helps to control costs for everyone. However, the law doesn't stop there. With its first-ever consumer protection for everyone who has insurance, the Affordable Care Act gives you and your family the peace of mind that comes from knowing that:

- You have financial protections if you face severe illness.
- If you have a pre-existing health condition, insurers can no longer refuse to cover you.
- A dependent can now stay on their parent's plan until you turn 26.
- Insurers can't charge higher premiums if you are a woman.

Insurers can't sell substandard plans that don't pay for essential health care benefits.

Key Provisions of ACA

PPACA is divided into nine titles and contains provisions that became effective immediately, ninety days after enactment, and six months after enactment, as well as provisions phased in through to 2020.

Title I—Quality, Affordable Health Care for All Americans

Title II—Role of Public Programs

Title III—Improving the Quality and Efficiency of Health Care

Title IV—Prevention of Chronic Disease and Improving Public Health

Title V—Health Care Workforce

Title VII—Improving Access to Innovative Medical Therapies

Title VIII—Class Act

Title IX—Revenue Provisions

Title X—Strengthening Quality, Affordable Health Care for All Americans

The Affordable Care Act (ACA) has several major goals. The first and central goal is to achieve affordable coverage for all and doing so through shared responsibility among government, individuals, and employers. The second goal is to improve the fairness, quality, and affordability of health insurance coverage. The third goal is to improve healthcare value, quality, and efficiency while reducing wasteful spending and making the healthcare system more accountable to a diverse patient population. The fourth goal is to strengthen primary healthcare access while bringing about long-term changes in the availability of primary and preventive health care. The fifth and final goal is to make strategic investments in the public's health, through both an expansion of clinical preventive care and community investments.

Income-Based Subsidies

The Affordable Care Act (ACA) established a system of subsidies for the purchase of health insurance that were based primarily on household income and family size. The subsidy was implemented to help create availability of coverage to the large group of Americans who are obligated to buy health insurance but who can't afford it.

These subsidies were designed to assist in meeting the obligation, and they are in three categories:

1) An income test

2) An asset test

3) Covered category status (children, pregnant women, or a person who is disabled.)

The second of these subsidies, and the most discussed, was an extensive cost-sharing arrangement for health insurance purchased through new state and federal exchanges. The exchanges were designed to be state-run administrative organizations that would organize and approve health insurance plans being sold by the insurance industry and present those plans accurately as a form of one-stop shopping.

The Affordable Care Act defines four tiers of insurance based on the percentage of a person's healthcare costs that are expected to be covered by the insurance carrier itself.

These levels are called in the legislation:

- Bronze (60% of the expected health care costs covered by the insurance)
- Silver (70% of the expected health care costs covered by the insurance)
- Gold (80% of the expected health care costs covered by the insurance)
- Platinum (90% of the expected health care costs covered by the insurance)

The Silver plan is used as the baseline plan in calculating how much subsidy is available to an individual or family.

Providing Affordable, Quality Health Care for All Americans

The Affordable Care Act (ACA) aims to extend health insurance coverage to about thirty-two million uninsured Americans by expanding both private and public insurance. Key provisions in the Affordable Care Act include the following and became effective on January 1, 2014:

- The Affordable Care Act (ACA) required employers to cover their workers, or pay penalties, with exceptions for small employers.
- To provide tax credits to certain small businesses that covered specified costs of health insurance for their employees, beginning in tax year 2010.
- It required individuals to have insurance, with some exceptions, such as financial hardship or religious belief.

- Required the creation of state-based (or multi-state) insurance exchanges to help individuals and small businesses purchase insurance. Federal subsidies would limit premium costs to between two percent of income for those with incomes at 133 percent of federal poverty guidelines, rising to 9.5 percent of income for those who earn between 300 percent and 400 percent of the poverty guidelines.
- Expand Medicaid to cover people with incomes below 133 percent of federal poverty guidelines.
- Required creation of temporary high-risk pools for those who cannot purchase insurance on the private market due to preexisting health conditions, that was to begin on the July 1, 2010.
- Required insurance plans to cover young adults on parents' policies to the age of twenty-six.
- Establish a national, voluntary long-term care insurance program for "community living assistance services and supports" (CLASS), with regulations to be issued by October 1, 2012.
- Enacted consumer protections to enable people to retain their insurance coverage

Through a series of provisions that create premium and cost-sharing subsidies, it established new rules for the health insurance industry, and created a new market for health insurance purchasing. The Affordable Care Act made health insurance coverage a legal expectation on the part of U.S. citizens and those who were legally present in the country.

The Affordable Care Act (ACA) strengthens both the existing forms of health insurance coverage while building a new, affordable health insurance market for individuals and families that do not have affordable employer coverage or another form of minimum essential coverage such as Medicare or Medicaid.

By expanding existing coverage, the Affordable Care Act fundamentally restructured Medicaid to cover all citizens and legal U.S. residents with family incomes with less than 133 percent of the federal poverty level to streamline enrollment. Medicaid's five-year waiting period for legal residents continues to apply to individuals that have recently arrived in the U.S., and those who during the time qualified for tax subsidies and enrollment through a health insurance exchange.

The quid pro quo for legally guaranteed coverage was the duty to secure it, as it is not possible to extend such a guarantee of insurance coverage without an attendant coverage obligation. This duty extended to all U.S. taxpayers, but individuals not legally present in the U.S. were excluded from both the coverage guarantee and the obligation to secure coverage.

The law also provides exemptions for individuals whose enrollment is contrary to their religious beliefs, those to whom it remains unaffordable, or a hardship. Otherwise, the mandate extends to all people, it is this type of legal mandate that makes the Affordable Care Act (ACA) feasible, because without it, large numbers of healthy individuals, whose presence is essential to the formation of a risk pool, would fail to enroll.

Without the mandate, the private health insurance companies would not and indeed could not eliminate tiered pricing and coverage exclusions. Such tactics are the means by which insurers protect themselves against adverse selection. Thus, without the mandate, guaranteed coverage is virtually impossible, as is stabilization of the insurance foundation on which the entire healthcare system lies.

In short, the Affordable Care Act represents an effort to reframe the financial relationship between Americans and the healthcare system to stem the health insurance crisis that has enveloped individuals, families, communities, the healthcare system, and the national economy as a whole. It is also this basic reinvention of Americans' relationship to health insurance that lies at the epicenter of the legal battle over the law's constitutionality.

In addition to establishing guaranteed coverage and shared responsibility, the Affordable Care Act sets federal standards for health insurers offering products in both the individual and small-group markets, as well as employer-sponsored health benefit plans. These requirements considerably expand on federal standards first introduced as part of the Health Insurance Portability and Accountability Act of 1996.

The broadest reforms prohibitions against pricing and coverage discrimination against adults became effective in 2014, when the mandate and subsidies went into effect. The Affordable Care Act (ACA) expanded insurance standards are designed to set a federal minimum; it is the expectation under the Affordable Care Act that state insurance departments will implement and enforce these laws as part of their legal insurance oversight.

Years later the National Association of Insurance Commissioners would report that half the states indicate that their insurance departments hold implementation powers, either through explicit legislation or as a result of their general powers, while nearly all states have the capacity to enforce federal standards.

At the same time, however, the federal government cannot force states to oversee and enforce federal laws without running afoul of the U.S. Constitution's 10th Amendment protection against the commandeering of state law enforcement resources. Thus, under federal law, state implementation of federal insurance regulations remains voluntary, and the Public Health Service Act provides for direct federal regulation of state insurance markets if necessary.

The Affordable Care Act sets an array of federal standards for insurers that sell products in both the individual and group health insurance markets, as well as with certain limited exceptions for self-insured group health benefit plans sponsored by employers subject to the Employee Retirement Income Act. The purpose of these standards, as noted, is to restrict higher rates against women, older people, and children and adults in less than perfect health.

Thus, the Act restricts lifetime and most annual dollar coverage maximums, the use of preexisting condition exclusions, excessive waiting periods for example longer than 90 days, requires the use of modified community rating so that prices can vary only to a limited degree based on age, and as well as by family size and tobacco use. The law also guarantees the right to internal and external impartial appeal procedures when coverage is denied, and requires insurers to cover routine medical care as part of clinical trials involving cancer and life-threatening illnesses.

Of particular note in a public health context is the extent to which the Act regulates the content and design of coverage itself. With the exception of "grandfathered" plans, which are given a transition period that lasts until they make a significant change in coverage, premiums, or cost-sharing, insurers and employee health benefit plans will be required to cover (without cost-sharing) clinical preventive services with an "A" or "B" rating from the U.S. Preventive Services Task Force. Immunizations recommended by the Advisory Committee on Immunization Practices; and other preventive services for children, adolescents, and women identified by the Health Resources and Services Administration.

This requirement began with the first plan year that occurred after September 23rd, 2010, six months after the date of enactment. Parallel reforms are made under Medicare as well as in the case of Medicaid coverage for newly eligible adults, although for "traditionally eligible" adult Medicaid beneficiaries, preventive services remain an optional benefit.

The Act also encourages employers to undertake workplace wellness activities that promote and incentivize actual health outcomes. Wellness activities need not be limited to the act of participating in wellness programs but can include incentives aimed at actually achieving improved health results.

Beyond subsidizing coverage and regulating the insurance and group health plan markets, the Affordable Care Act creates state health insurance Exchanges for both individuals and businesses.

Exchanges are meant to simplify and ease health insurance purchasing by creating a one-stop shopping experience for insurance products that qualify for federal tax subsidies and that meet federal and state standards thus, certified as “qualified health benefit plans.”

Under the Act, Exchanges offer the following:

- calculate subsidy eligibility and purchase a qualified health plan
- provide information and enrollment assistance
- coordinate enrollment with state Medicaid programs
- Regulate plans
- provide information to the federal government regarding subsidy eligibility
- plan performance information

Qualified health benefit plans, whether sold on or off the Exchange, will have to meet a series of federal requirements including coverage of “essential benefits,” defined under the Affordable Care Act to include both preventive services as well as a range of benefit classes that reflect a standard employer-sponsored plan. Qualified health plans also will be required to meet federal standards related to provider network sufficiency including contracts with essential community providers and healthcare quality. In addition, qualified health benefit plans will be required to make performance information conforming to national quality measurement benchmarks available to patients and consumers.

PPACA has also enabled states to establish basic healthcare plans for lower income individuals that do not qualify for Medicaid. Additionally, states will be able to contract with other states to permit cross-state insurance sales. Employers that already provide insurance will be able to continue to provide the benefits under the “grandfather” provision.

Individuals who choose not to purchase basic health coverage will be required to pay a penalty that is going to be $95 in 2014 and $350 in 2015 and will gradually increase to $750 in 2016. There are going to be exceptions to this rule, including Indian tribe members, taxpayers below 100% of the federal poverty line, those with hardship waivers, incarcerated individuals, and those without coverage for fewer than three months.

PPACA is also going to ensure that the quality-of-care patients receive is adequate through the implementation of new patient care models. Accountable Care Organizations will be responsible for ensuring that patients receive appropriate and efficient healthcare through the use of quality metrics that will be tied to provider reimbursement. Multiple hospital readmissions for chronic medical conditions are considered a disadvantage to patients and their healthcare.

Therefore, we have seen the implementation of various systems designed to improve this situation, such as home-based primary care teams for Medicare beneficiaries. These teams consist of a physician or nurse practitioner with other medical personnel that provide home visits and medical management of patients with chronic illnesses. The expectation is that these medical teams will help patients avoid frequent hospital admissions. Many hospitals have started to utilize these teams with great success.

The Impact of ACA on Healthcare

Improving Quality and Efficiency of Healthcare

The Affordable Care Act contains several provisions related to improving quality and system performance, including, but not limited to, the following:

- Comparative research to study the effectiveness of various medical treatments
- Demonstration projects to develop medical malpractice alternatives and reduce medical errors
- Demonstration projects to develop payment mechanisms to improve efficiency and results
- Investments in health information technology
- Improvements in care coordination between Medicare and Medicaid for patients who qualify for both
- Options for states to create “health homes” for Medicaid enrollees with multiple chronic conditions to improve care
- Data collection and reporting mechanisms to address health disparities among populations based on ethnicity, geographic location, gender, disability status and language.

Beyond insurance, the Affordable Care Act begins the job of realigning the healthcare system for long-term changes in healthcare quality, the organization and design of healthcare practice, and health information transparency. It does so by introducing broad changes into Medicare and Medicaid that empower both the Secretary of the U.S. Department of Health and Human Services (HHS) and state Medicaid programs to test new modes of payment and service delivery, such as medical homes, clinically integrated accountable care organizations, payments for episodes of care, and bundled payments.

All of these changes are intended to allow public payers to slowly but forcefully:

(1) nudge the healthcare system into behaving in different ways in terms of how health professionals work in a more clinically integrated fashion

(2) measure the quality of their care and report on their performance

(3) target for quality improvement serious and chronic health conditions that result in frequent hospital admissions and readmissions

HHS and the states are expected to test payment and delivery system reforms that also attract private payer involvement to maximize the potential for cross-payer reforms that can, in turn, exert additional pressure on healthcare providers and institutions.

The Act also invests in the development of a multi-payer National Quality Strategy, whose purpose is to generate multi-payer quality and efficiency measures to promote value purchasing, greater safety, and far more extensive health information across public and private insurers. In this regard, the Act ultimately will build on the Health Information Technology for Economic and Clinical Health Act, enacted into law in 2009 as part of the American Recovery and Reinvestment Act, and further lays the groundwork for performance reporting on a system-wide basis so that patients can more readily get information about their own health care and how their healthcare providers perform.

In addition, the Act establishes the Institute for Comparative Clinical Effectiveness Research to promote the type of research essential to identifying the most appropriate and efficient means of delivering health care for diverse patient populations. Throughout these initiatives to improve quality and information, the Act emphasizes efforts to collect information about health and healthcare disparities to allow the nation to better assess progress not only for the population as a whole, but also for patient subpopulations who are at elevated risk for poor health outcomes.

Even as the legislation invests nearly $1 trillion over the 2010–2019 time period aimed at making coverage affordable, the Act more than offsets these expenditures through curbs on Medicare and Medicaid spending, new taxes on high-cost plans, and tax shelters used most heavily by affluent families. In addition, and of particular note to public health policy and practice, the Act significantly alters the obligations and reporting rules for nonprofit hospitals by imposing new conduct and reporting obligations on hospitals as a condition of maintaining their federal nonprofit status.

The changes include requiring hospitals to undertake ongoing community health needs assessments; furnish emergency care in a nondiscriminatory fashion (a requirement already applicable under the Emergency Treatment and Active Labor Act; which is unaltered by the Affordable Care Act); alter their billing and collection practices; and maintain widely publicized written financial assistance policies that provide information about eligibility, how the assistance is calculated, and how to apply for assistance.

Improving Overall Health and Chronic Disease Prevention

While the United States certainly has some of the world's best physicians and health facilities, U.S. medicine fails to deliver reliably high-quality care: We have far too many unplanned readmissions, medication errors, and hospital-acquired infections. We also fall short in delivering effective primary and secondary prevention for patients with chronic conditions who account for a majority of health care costs. Numerous barriers inhibit achieving higher-quality care.

One barrier relates to patients' utilization of primary prevention. Because a patient is not feeling sick, engaging in prevention seems optional. Other barriers include patient financial responsibility as a substantial barrier to utilization of prevention, poor reimbursement, and underdeveloped clinical reminders at the point of care that assure patients are getting appropriate preventive services.

The Affordable Care Act addresses two major barriers to consistently delivering high-quality care: information and incentives. Too often have physicians lacked information on whether their patients are taking their medications and following through on prevention recommendations and referrals. In some cases, they also lack information about what treatments work best for which patients. Physicians rarely get patient-specific reminders about treatment goals, gaps in care, or risk-reduction approaches at the point of care, when physicians and patients are most likely to be responsive to information.

The combination of the American Recovery and Reinvestment Act and the Affordable Care Act should help address these information gaps. The American Recovery and Reinvestment Act provides about $25 billion in incentives for physicians and hospitals to use electronic health records. Achieving the full extent of benefits necessitates streamlining office practices to enhance patient tracking, teamwork, and patient outcome orientation. The Affordable Care Act provides long-term funding for patient-centered outcomes research, which should give physicians and patients the clinical and research information they need to make better informed and personalized decisions.

The Affordable Care Act provides physicians with financial support for making these changes. Today, the fee-for-service system encourages ordering tests and performing interventions. It does not support—and may discourage—coordinated care that averts complications and secondary prevention. The Affordable Care Act changes this by encouraging and establishing patient-centered medical homes and accountable care organizations that should allow physicians to focus on coordinating care and preventing avoidable hospitalizations. The pilot projects on bundled payments reward physicians for providing care that keeps chronically ill patients healthier and out of the hospital.

Aims to Increase Healthcare Affordability

The Affordable Care Act's signature health insurance marketplaces portals for people purchasing coverage on their own launched in the fall of 2013 and made financial assistance for private coverage newly available. In 2019, nearly nine out of ten, or eighty-seven percent, of marketplace enrollees qualified for financial help with premiums, and roughly half or fifty-four percent received reduced cost sharing. Although the average plan premium was $612 per month, the average enrollee owed just $87 per month after applying the Affordable Care Act's financial assistance.

In addition to enabling states to expand Medicaid to millions of newly eligible low- and middle-income Americans, the Affordable Care Act "included provisions to streamline eligibility, enrollment, and renewal processes" for Medicaid and CHIP. These changes make it easier for children to be enrolled in and stay covered by coverage with little or no cost sharing. The Affordable Care Act also accelerated the development and promotion of data-driven systems: As of January 2019, all states allow potential Medicaid beneficiaries to apply online and most allow for application by phone.

Across nearly all health plans, both public and private, the Affordable Care Act eliminated copayments and other forms of cost sharing for preventive services. This provision allows beneficiaries to seek contraception, screenings for cancers, blood pressure, cholesterol, and other illnesses; and immunizations without out-of-pocket payments. In addition, the Affordable Care Act holds private insurance companies accountable for charging fair premiums, whether for individual market policies or for employer-sponsored coverage. The medical loss ratio (MLR) rules require insurance companies to return money to policyholders and employers if their health plans spend less than 80 percent to 85 percent of premium funds on medical care. In 2019, insurers returned $1.37 billion in MLR rebates to consumers for overpricing premiums relative to actual medical care.

The evidence shows that better affordability translates into better access. Between 2010 and 2018, the share of nonelderly adults who skipped a medical test or treatment fell 24 percent. ACA implementation reduced the probability of not receiving medical care due to cost by about one-quarter, and it dramatically increased the share of people who reported having a usual place of care.

Provisions for Women and Women's Services

Prior to the Affordable Care Act, women faced unique barriers to adequate care. Insurers in the individual market could charge women up to one and a half times more than men for health insurance, a discriminatory practice known as gender rating, and insurers treated pregnancy as a preexisting condition. Plans could also exclude critical women's health benefits from coverage: In 2011, sixty-two percent of individual market enrollees were in plans without maternity coverage. The Affordable Care Act outlawed gender rating and prohibited insurers from discriminating against people with preexisting conditions. The latter is a crucial protection for women: About one in two girls and non-elderly women has a preexisting condition.

The Affordable Care Act mandates that a plan include maternity coverage and makes key preventive services available without cost sharing, including breastfeeding support services and supplies; annual well-woman visits; and screenings for cervical cancer, HIV, and interpersonal and domestic violence. With the aid of the Affordable Care Act, about sixty-one million women nationwide can access contraception without any out-of-pocket cost. It is estimated that the Affordable Care Act's contraception benefit has saved women at least $1.4 billion annually on birth control pills alone.

The Affordable Care Act also recognized that supporting maternal and infant health required policy changes beyond health coverage. The law mandates that employers provide breastfeeding mothers break time and a private space to express milk during the workday.

Access to Prescription Medication

Prior to the Affordable Care Act, nine percent of individual market plans did not cover prescription drugs. The ACA expanded drug coverage by requiring marketplace plans to "cover at least one drug in each drug class" and to count out-of-pocket drug expenses toward a beneficiary's deductible. By expanding Medicaid eligibility as well as broadening the Medicaid Drug Rebate Program, the ACA gave more low-income Americans access to brand-name and generic drugs and lowered the costs for taxpayers. The Affordable Care Act also expanded the 340B drug discount to include more providers, including critical access hospitals and rural referral centers.

The Affordable Care Act also laid out a process for faster Food and Drug Administration approval of biosimilars, biologic drugs that are essentially analogous to generic versions of branded drugs. By encouraging competitors for high-cost biologic drugs, the ACA rules on biosimilars can potentially help bring down the price of these types of prescription drug costs and help make new therapies available to patients who need them.

Expansion to Preexisting Conditions

Prior to the Affordable Care Act, insurers in the individual market routinely set pricing and benefit exclusions and denied coverage to people based on their health status, a practice known as medical underwriting. Nearly one in two non-elderly adults have a preexisting condition, and prior to the ACA, they could have faced discrimination based on their medical history if they sought to buy insurance on their own.

The Affordable Care Act added a number of significant new protections for people with preexisting conditions. One group of reforms involved changes to the rating rules, prohibiting insurers from making premiums dependent on gender or health status and limiting their ability to vary premiums by age. The Affordable Care Act also established guaranteed issue, meaning that insurers must issue policies to anyone and can no longer turn away people based on health status.

Another crucial protection for people with preexisting conditions is the Affordable Care Act's requirement that plans include categories of essential health benefits, including prescription drugs, maternity care, and behavioral health. This prevents insurance companies from effectively screening out higher-cost patients by excluding basic benefits from coverage. The law also banned insurers from setting annual and lifetime limits on benefits, which had previously prevented some sick people from accessing necessary care and left Americans without adequate financial protection from catastrophic medical episodes.

Expansion to Children and Young Adults

One of the first ACA provisions to go into effect was the rule guaranteeing young adults the right to remain under their parent's insurance until they reached the age of 26. About 2.3 million young adults a group that is less likely to have an offer of employer-sponsored insurance than their older counterparts gained coverage under the Affordable Care Act's dependent coverage provision. Later on, additional young adults gained coverage though marketplace financial assistance and Medicaid expansion. As a result, the uninsured rate among people ages 18 to 24 fell by half, dropping to 15 percent in 2017.

The Affordable Care Act raised standards to ensure that children in low- and middle-income families can access health coverage. It extended the minimum Medicaid eligibility level for children to 138 percent of the federal poverty level and mandated that states "use a uniform definition of income" to set standards for children's coverage. About one-quarter to one-third of new enrollees under Medicaid expansion are children.

The Affordable Care Act also defined pediatric dental and vision care as part of essential health benefits, ensuring that kids covered through both the marketplace and Medicaid have coverage for those services. Further, expanding coverage to adults through the Affordable Care Act marketplaces and Medicaid expansion helps parents stay healthy and provides financial security to the entire family.

The Healthcare Workforce

The Affordable Care Act addresses workforce issues through a number of provisions, including reforms in graduate medical education training; increases in health profession scholarship and loan programs; support for training programs for nurses; support for new primary care models, such as medical homes and team management of chronic diseases; increased funding for community health centers and the National Health Service Corps; and support for school-based health centers and nurse-managed health clinics.

In addition, attempting to provide coverage to most Americans, making an effort to rationalize health care, investing in primary health care in medically underserved communities, and broadening coverage for effective clinical preventive health services, the Affordable Care Act makes direct public health investments.

Part of these investments come in the form of new regulatory requirements related to coverage of clinical preventive services without cost sharing, a fundamental shift in the relationship between health insurance and clinical preventive care. In addition, the Act provides for the development of a national prevention plan and the establishment of a Prevention and Public Health Trust Fund to finance community investments that will improve public health.

The Fund, with a value set at $15 billion, provides additional funding for prevention activities which began in the year 2010 and continued annually. The Act also targets specific subpopulations for new public health and health investments, particularly the area of Indian health care, which receives focused attention aimed at improving the performance of health and healthcare programs.

New investments are made in school-based health centers, oral healthcare prevention activities, tobacco cessation programs for Medicaid-enrolled pregnant women, and the addition of personalized prevention planning to Medicare. The Act also authorizes new investments in training primary care health professionals. With the exception of new investments in establishing “teaching health centers,” these changes are authorized but not funded as part of the Act and will need separate appropriated funding.

Physician Advantages

Another key provision of PPACA is to ensure that there is increased access to clinical preventative services through new programs and benefits, which should create a trend of decreased morbidity and reduced healthcare costs. An example of these new benefits is the elimination of copayments or deductibles for annual wellness visits or personalized prevention plan visits. In the future, there will be lower or waived deductibles for the most frequently used preventative services. Since September of 2010, deductibles, copays, and coinsurance have been eliminated for screening mammograms and colonoscopies. Medicare will adjust its coverage of services per U.S. Preventative Services Task Force (USPSTF) recommendations. According to USPSTF recommendations, Medicare should have coverage benefits similar to those that Medicaid has now. Furthermore, the Advisory Committee on Immunization Practices states that there will be no cost sharing under PPACA.

However, preventative services go hand in hand with a healthy lifestyle, which many patients do not follow. Therefore, there will be grants given to Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. Even though PPACA was designed to make healthcare affordable for all Americans, it does have some advantages for physicians as well. One of the essential benefits for physicians is having more control over treatment decisions due to the elimination of coverage exclusions for preexisting conditions and patient access to preventative services. We also expect to see less insurance company administrative paperwork and bureaucracy with the use of electronic medical records.

There is an indication that there will be standardized billing and implementation of rules for the secure and confidential exchange of health information that will help make this possible. There is also a perception that medical practices will have increased financial security, especially in primary care, due to some of the changes made through PPACA. Over the past few years, we have seen a decrease in young doctors going into primary care. One of the reasons for this is that insurance reimbursement for primary care services has been half of what specialists receive.

Since January of 2011, there has been a 10% increase in Medicare payments for the reimbursement of primary care services. This increase in Medicare payments has been applied to physicians practicing in rural areas as well as general surgeons who work in underserved areas. In addition to the Medicare increase, Medicaid will also match Medicare reimbursements for primary care services, which is going to be fully funded by the federal government.

Another PPACA provision that will help with increased financial security is the limitation of out-of-pocket expenses, resulting in fewer unpaid patient bills. With the increasing numbers of insured people, there will need to be a larger supply of healthcare workers, especially in primary care and rural/underserved areas. Many areas of the country have already been recruiting medical students to work in rural areas by offering scholarships. PPACA awards a high dollar amount of scholarships for disadvantaged students who commit to working in underserved areas.

Under PPACA, the National Health Service Corps scholarship and repayment program has been granted more money for the loan repayment of physicians who commit to serving in rural and underserved areas, which has been a great recruitment tool for the primary care services. Plans are also being made for redistribution of unfilled residency positions for training of primary care physicians.

Medicare, Medicaid, and the Affordable Care Act

The Medicaid Expansion

An analysis of the success of the Affordable Care Act in reducing the number of uninsured Americans, the Medicaid provisions of the law are likely to prove to be as important as its private insurance-market programs. The expansion of eligibility for Medicaid to people with incomes up to 138% of the poverty level is the largest expansion since the inception of the program in 1965. Before this expansion, only people with low incomes who fell into certain categories like children, parents, pregnant women, people with disabilities.

The expansion in Medicaid eligibility was also well financed from the perspective of the states. The federal government has covered 100% of the costs for most states through the year of 2016, before gradually reducing its contribution to 90% for all states by the year 2020. This new financing translates into an infusion of federal dollars into states to the tune of $800 billion through the year 2022.

Despite the economic and health care rationale for expanding Medicaid, state officials who are opposed to the Affordable Care Act have refused to allow this expansion in many states. In such states, people with incomes at or above 100% of the federal poverty level can apply for subsidies for private plans on the marketplace. But those with income below the poverty level cannot apply for such subsidies, since drafters of the Affordable Care Act assumed that the poor would be eligible for Medicaid.

In the states that have not yet expanded their programs, nearly 5 million uninsured people with low incomes are expected to be left out of the new coverage options this year. Despite these facts, 6 months after the launch of the coverage provisions of the Affordable Care Act, 6 million people had enrolled in Medicaid or the Children's Health Insurance Program (CHIP). This tally includes people who were found to be eligible as they sought insurance through federal and state marketplaces or through other means.

Many individuals who went to online marketplaces were informed of their Medicaid eligibility. Consequently, this figure also includes people living in non-expansion states who were found to be eligible under their state's preexisting Medicaid and CHIP programs. The CBO is now projecting that new enrollment in Medicaid and CHIP will reach 7 million this year and 13 million eventually. Even with uncertainty about state participation, this means that 46 million people or 17% of the non-elderly U.S. population could be enrolled in Medicaid or CHIP by at the time, 2018.

If history is a guide, most states will ultimately expand their programs. The fiscal benefits to states are enormous, and hospitals and other providers generally favor participation.

Access to Healthcare

To date, a good number of states including Washington, D.C., have expanded Medicaid under the Affordable Care Act, with 12.7 million people covered through the expansion. While the Medicaid program has historically covered low-income parents, children, elderly people, and disabled people, the Affordable Care Act called for states to expand Medicaid to adults up to 138 percent of the federal poverty level and provided federal funding for at least 90 percent of the cost.

Medicaid expansion has led to better access to care and health outcomes for low-income individuals and their families across the country. Researched has proved that Medicaid expansion increases utilization of health services and diagnosis and treatment of health ailments, including cancer, mental illness, and substance use disorder. Medicaid expansion is associated with improvements in health outcomes such as cardiac surgery outcomes, hospital admission rates for patients with acute appendicitis, and improved mortality rates for cardiovascular and end-stage renal disease. Beyond health outcomes, evidence points to improved financial well-being in Medicaid expansion states, including reductions in medical debt and improved satisfaction with one's current financial situation.

Evidence shows that Medicaid expansion saves lives. According to a 2019 study, Medicaid expansion was associated with 19,200 fewer deaths among older low-income adults from 2013 to 2017; 15,600 preventable deaths occurred in states that did not expand Medicaid. As the Center on Budget and Policy Priorities points out, the number of adults ages fifty-five to sixty-four whose lives would have been saved in 2017 had all states expanded Medicaid (equal to the number of lives saved by seatbelts in 2017).

Rural Communities and Medicaid

Medicaid expansion is particularly important for coverage and the sustainability of the health care system in rural areas. Rural residents are more likely to be covered by Medicaid: 22.5 percent of rural Americans have Medicaid coverage, including nearly half of all rural children. Medicaid expansion reduced the amount of uncompensated care that hospitals provide, boosting the financial viability of rural hospitals relative to their counterparts in non-expansion states. While more than 100 rural hospitals have closed in the past decade, the closures have occurred disproportionately in non-expansion states.

The Affordable Care Act provides patients and the health care system with resources to combat the opioid crisis, which has hit rural areas particularly hard. The Affordable Care Act requires plans to cover substance use disorder (SUD) treatment as an essential health benefit. Without this requirement, only one in three people covered through the individual market would have had access to SUD treatment.

Many people in rural and other medically underserved communities rely on community health centers and other Federally Qualified Health Centers (FQHCs) for comprehensive primary care. Federal grants provide one in five revenue dollars that community health centers receive, and seventy percent of that funding comes from the Health Center Trust Fund set up by the Affordable Care Act.

Affordable Coverage for Seniors

Altogether, ACA programs have saved seniors more than $20 billion on prescription drugs since the law's passage, and seniors have benefited from no-cost preventive services such as cancer screenings and wellness visits. By closing the Medicare Part D coverage gap also known as the "donut hole" the Affordable Care Act has helped lower beneficiaries' out-of-pocket costs for prescription drugs. Prior to the Affordable Care Act, seniors who reached a certain level of prescription drug spending faced a coverage gap, in which they had to pay the full cost of all prescription drugs, before the plan's catastrophic coverage kicked in. Before the Affordable Care Act closed the coverage gap, about 5 million Medicare enrollees fell into it.

The Affordable Care Act also invested in other improvements for the Medicare program by establishing the Center for Medicare and Medicaid Innovation, which is responsible for developing ways to improve patient care and lower health care costs.

Protection For the Disabled

Millions of Americans are disabled and rely on the Affordable Care Act's consumer protections and coverage. Prior to the Affordable Care Act, people would be functionally uninsured after hitting arbitrary annual or lifetime coverage limits. The Affordable Care Act prohibits insurers from setting coverage limits, as well as from denying coverage or raising prices for preexisting conditions.

Medicaid expansion has helped many disabled people and caregivers access care based on their income status. Not all disabled people qualify for the traditional Medicaid disability pathway. Medicaid expansion allows disabled people to join the workforce without jeopardizing their Medicaid benefits and gives low-income workers a fallback option for coverage if they lose access to employer-sponsored insurance.

Essential health benefits help disabled people access necessary services. Prior to the Affordable Care Act, 45 percent of individual market plans did not cover SUD services and 38 percent did not cover mental health care. Following ACA implementation, people with mental health conditions became significantly less likely to report unmet need due to cost of mental health care.

Medicare and Healthcare

Before the Affordable Care Act, the health care system was dominated by "fee-for-service" payment systems, which often penalized health care organizations and health care professionals who find ways to deliver care more efficiently, while failing to reward those who improve the quality of care. The Affordable Care Act has changed the health care payment system in several important ways. The law modified rates paid to many that provide Medicare services and Medicare Advantage plans to better align them with the actual costs of providing care. Research on how past changes in Medicare payment rates have affected private payment rates implies that these changes in Medicare payment policy are helping decrease prices in the private sector as well. The Affordable Care Act also included numerous policies to detect and prevent health care fraud, including increased scrutiny prior to enrollment in Medicare and Medicaid for health care entities that pose a high risk of fraud, stronger penalties for crimes involving losses in excess of $1 million, and additional funding for antifraud efforts. The Affordable Care Act has also widely deployed "value-based payment" systems in Medicare that tie fee-for-service payments to the quality and efficiency of the care delivered by health care organizations and health care professionals. In parallel with these efforts, my administration has worked to foster a more competitive market by increasing transparency around the prices charged and the quality of care delivered.

Most importantly over the long run, the Affordable Care Act is moving the health care system toward “alternative payment models” that hold health care entities accountable for outcomes. These models include bundled payment models that make a single payment for all of the services provided during a clinical episode and population-based models like accountable care organizations (ACOs) that base payment on the results health care organizations and health care professionals achieve for all of their patients’ care. The law created the Center for Medicare and Medicaid Innovation (CMMI) to test alternative payment models and bring them to scale if they are successful, as well as a permanent ACO program in Medicare. Today, an estimated 30% of traditional Medicare payments flow through alternative payment models that broaden the focus of payment beyond individual services or a particular entity, up from essentially none in 2010. These models are also spreading rapidly in the private sector, and their spread will likely be accelerated by the physician payment reforms in MACRA.

Despite the challenges that ACA has faced over the years, it also done so much good to US citizens by allowing them further access to these health insurance programs.