Health Care Reform: What Every Health Care Practitioner Needs to Know

1 CE Hour

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Learning objectives

Upon completion of this course the learner should be able to:

- Describe recent changes to the United States’ healthcare system, analyze how changes impact health care practitioners and patients, and learn the positive role they can play.
- Apply changes to practice in the delivery of patient education related to better understanding of Health Care Reform and the Marketplace.

Introduction

This course was designed and developed for licensed professionals who provide patient care in multiple settings along the healthcare continuum. These professionals need to understand the Affordable Care Act and associated Health Care Reform to be confident in their role as educators for patients and the community at large.

The purpose of this course is to provide the health care practitioner with knowledge and understanding of the Affordable Care Act and Health Care Reform. Universally, across every care setting and in every role, the health care professionals have a duty and responsibility as a relentless patient advocate. Advocating for the patients’ best outcomes requires the health care professional to understand and deliver accurate patient education that enables informed decision-making. Continual learning is foundational to skilled and knowledgeable practice, and exists as the platform that ultimately and collectively elevates professional practice.

Healthcare practitioners have many reasons to become informed about the recent changes to healthcare. Not only does their job involve helping patients navigate the healthcare system, but they are also healthcare consumers, with children, parents, and other family members who turn to them for guidance. But with all of the information that is “out there”, what is most important for healthcare consumers to know and understand? This workshop will take a closer look at the facts and myths that revolve around the changes the Affordable Care Act has brought forth.

Overview

On March 23, 2010, the Affordable Care Act (ACA) was signed into law, with most of its provisions scheduled to take full effect by Jan. 1, 2014. After numerous legal challenges, the U.S. Supreme Court found, in a 5-4 decision, that the majority of the Affordable Care Act is constitutional.

The primary objective of the ACA is to:

- Increase the quality and affordability of health insurance.
- Lower the uninsured rate by expanding public and private insurance coverage.
- Reduce the costs of healthcare for individuals and the government.
- It provides a number of mechanisms including mandates, subsidies, and insurance exchanges to increase coverage and affordability. The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex.

Additional reforms are designed to reduce costs and improve healthcare outcomes by shifting the system toward quality over quantity through increased competition, regulation, and incentives to streamline the delivery of healthcare. The Congressional Budget Office (CBO) projected that the ACA will lower both future deficits and Medicare spending.

With any topic, individuals will have varying opinions. Health Care Reform has been the center of much heated discussion, at times with significant outcomes to our government and politics.

In an interesting article presented in Healthcare Finance News, Ellis & Razavi (2012) discussed three pros and three cons of healthcare reform and its impact on hospitals:

Pros:
1. **Becoming more efficient:** Health Care Reform and all its provisions are already making hospitals find new ways to increase facility efficiency, better manage care and streamline costs. One item is renovating hospitals to cut down on operating expenses and implementing new programs, such as a nurse call center, which has shown the reduce emergency room trips by an average of 12.1 percent.
2. **New model of care:** Hospitals are moving away from the contemporary fee-for-service model, a contributing factor for our excessive healthcare spending, and are switching to value-based models of care. Before, the more services hospitals performed, the more money they would make. Now, hospitals are being held more accountable for their patients. Patient treatment outcomes are compared to costs, and hospitals who meet the requirements receive a bump in federal payments.
3. **Helps the bottom line:** The vast majority of uninsured costs would be covered, giving some money back for what was previously written off. This suggests more money will be available to healthcare providers and, if the theory holds, a healthier population that needs less care over time.

Cons:
1. **Administrative costs:** Hospitals and health systems will have to do on their own as they take care of the influx of new patients. That means much more paperwork, disease and care management, oversight and time dealing with Medicare for the millions of newly insured patients.
2. **Coverage:** The sheer act of providing coverage to more people would produce a new order of challenges. If access cannot be improved then there is still a problem of providing care. Medicare and Medicaid patients already indicate difficulty in finding...
a physician. Coupled with the high attrition rate of doctors, finding healthcare providers to treat these new patients will be in increasingly short supply. Much depends on the government’s website which is designed to accept applications and connect people to providers.

3. **Cut in payments**: In anticipation of decreases to Medicare reimbursements, there will also be a loss in tax breaks—which are viable government-issued methods used to help health systems meet their costs.

### Health care coverage

The ACA has two primary mechanisms for increasing insurance coverage. First, it expands Medicaid eligibility to include individuals within 138 percent of the federal poverty level. Second, it creates state-based insurance exchanges where individuals and small businesses can buy health insurance plans.

The CBO had initially estimated that the legislation will reduce the number of uninsured residents by 32 million, leaving 23 million uninsured residents in 2019 after all of the bill’s provisions have taken effect. With the elderly covered by Medicare, the CBO estimate projects that the law would raise the proportion of insured non-elderly citizens from 83 percent to 94 percent. A July 2012 CBO estimate raised the expected number of uninsured by 3 million, reflecting the successful legal challenge to the ACA’s expansion of Medicaid.

Despite the increase in the number of people insured, there are some who will remain uninsured, such as:

- Undocumented Citizens, estimated at around eight million (which is approximately one third of the 23 million projection), will be ineligible for insurance subsidies and Medicaid. Undocumented citizens will also be exempt from the health insurance mandate, but will remain eligible for emergency services under provisions in the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA).
- Citizens not enrolled in Medicaid despite being eligible.
- Citizens not otherwise covered, who opt to pay the annual penalty instead of purchasing insurance. These are mostly younger and single Americans.

### Costs and fees

With any discussion about healthcare coverage, there is discussion about cost. As might be expected, health plans will differ in the average percentage of healthcare costs covered by the plan and the corresponding out-of-pocket costs for the insured.

In an effort to make it easier to differentiate between Marketplace health plans, they will be categorized as bronze, silver, gold, or platinum. Bronze plans, which have the lowest premiums, also have the least amount of coverage. Platinum plans, which have the most coverage, also have higher premiums.

When a person has insurance, they pay some costs and the insurance plan also pays some:

- **Premium**: A premium is a fixed amount the insured person pays to the insurance company, usually every month. The insured pays this even if they do not use medical care that month.
- **Deductible**: If medical care is necessary, a deductible is the amount the insured pays for care before the insurance company starts to pay its share. Once the deductible is met, the insurance company begins to cover some care costs. Some plans have lower deductibles, like $250. Some have higher deductibles, like $2,000. Many plans provide preventive services, and sometimes other care, before the deductible is met.
- **Copayment**: A copayment is a fixed amount paid for a medical service after the deductible is met. For example, after meeting the deductible the insured may pay $25 for a visit to the doctor’s office that might cost $150 if they didn’t have coverage. The health plan pays the rest.
- **Coinsurance**: Coinsurance is similar to copayment, except it is a percentage of costs paid by the insured. For instance, a person may pay twenty percent of the cost of a $100 medical bill. That means they would pay $20 and the health plan would pay the rest.

**Did you know?**
The average cost of a three day hospital stay is approximately $30,000. Fixing a broken bone can cost up to $8,000. Having health coverage can help protect an insured person from unexpected high costs like these.

**Insurance coverage protects you from high medical costs in two ways:**

- **Out-of-pocket maximum**: This is the total amount the insured will pay if they get sick. For example, if their plan has a $3,000 out-of-pocket maximum, once they pay $3000 in deductibles, coinsurance, and copayments, the plan will pay for any covered care above that amount for the rest of the year.

Overall, healthcare professionals have a vested interest not only in having knowledge of recent and ongoing developments of the ACA in order to answer patients’ questions, but also how it directly impacts them and the healthcare field. It is inevitable that patients will seek the advice of nurses, doctors, therapists, etc., just as they always have done. They need to be ready with the answers, or at least know where to find them. In the upcoming sections, we will take a closer look at general information, as well as detailed specifics regarding the newly created Marketplace that will be useful to all stakeholders in a variety of ways.
• No yearly or lifetime limits: Health plans in the Marketplace cannot put dollar limits on how much they will spend each year, or over a person's lifetime, to cover essential health benefits. After a person has reached their out-of-pocket maximum, their insurance company must pay for all covered medical care with no limit.

People without health coverage are exposed to these costs. This can sometimes lead people without coverage into deep debt or even into bankruptcy.

Fees and exemptions

Starting in 2014, most people must have health coverage. If a person can afford health insurance but chooses not to buy it, they must pay a fee known as the individual shared responsibility payment. The fee in 2014 is one percent of their yearly income or $95 per person for the year—whichever is higher. The fee increases every year. In 2016 it is 2.5 percent of their yearly income, or $695 per person—whichever is higher. In 2014, the payment for uninsured children is $47.50 per child. The most a family would have to pay in 2014 is $285.

Payments must be made when filing 2014 taxes, which are due in April 2015.

Exemptions from the payment

Under certain circumstances, a person does not have to make the individual shared responsibility payment. This is called an “exemption”.

A person may qualify for an exemption if:

- They are uninsured for less than three months of the year.
- The lowest-priced coverage available would cost more than eight percent of their household income.
- They don’t have to file a tax return because their income is too low (visit www.irs.gov to learn about filing requirements).
- They are a member of a federally recognized tribe, or eligible for services through an Indian Health Services provider.
- They are a member of a recognized healthcare sharing ministry.
- They are a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare.
- They are incarcerated, and not awaiting the disposition of charges.
- They are not lawfully present in the U.S.

Hardship exemptions

If someone has any of the circumstances below that affect their ability to purchase health insurance coverage, they may qualify for a “hardship” exemption:

- They were homeless.
- They were evicted in the past six months or were facing eviction or foreclosure.
- They received a shut-off notice from a utility company.
- They recently experienced domestic violence.
- They recently experienced the death of a close family member.
- They experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to their property.
- They filed for bankruptcy in the last six months.
- They had medical expenses that could not be paid in the last 24 months.
- They experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
- They expect to claim a child as a tax dependent who has been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, they do not have the pay the penalty for the child.
- As a result of an eligibility appeals decision, they are eligible for enrollment in a Qualified Health Plan (QHP) through the Marketplace, lower costs on monthly premiums, or cost-sharing reductions for a time period when they weren’t enrolled in a QHP through the Marketplace.
- They were determined ineligible for Medicaid because their state didn’t expand eligibility for Medicaid under the Affordable Care Act.

How to apply for an exemption

If patients are applying for an exemption based on: coverage being unaffordable; membership in a healthcare sharing ministry; membership in a federally-recognized tribe; or being incarcerated; patients have two options:

- They can claim these exemptions when they file their 2014 federal tax return, which is due in April 2015.
- They can apply for the exemptions in the Health Insurance Marketplace.

Note: If you get an exemption because coverage is unaffordable based on your expected income, you may also qualify to buy catastrophic coverage through the Marketplace. This may be more affordable than your other options.

If patients are applying for an exemption based on: membership in a recognized religious sect whose members object to insurance; eligibility for services through an Indian Healthcare Services Provider; or one of the hardships described above:

- Patients are required to fill out an exemption application in the Marketplace.
- If a patient’s income will be low enough that they will not be required to file taxes:
  - They do not need to apply for an exemption. This is true even if they file a return in order to get a refund of money withheld from their paycheck. They will not have to make the individual shared responsibility payment.
- If a patient has a gap in coverage of less than 3 months, or they are not lawfully present in the U.S.
  - They do not need to apply for an exemption. This will be handled when they file taxes.

Medicare

It is suggested that recent healthcare reform means that the insured will get more from Medicare. New protections and benefits in the healthcare law strengthen Medicare, protecting earned benefits and providing more care through more coverage.

- Guaranteed benefits are protected.

People have earned Medicare over a lifetime of work. The healthcare law protects the benefits originally promised to ensure a patient can always get the care they need when they need it. The law also adds resources to fight fraud, scams and waste, and helps the Medicare program save money.

- More preventive care is covered.

Medicare now covers a yearly wellness visit and preventive care at no cost. This includes cancer, cholesterol and diabetes screenings, immunizations, diet counseling and more.

- Lower prescription drug costs.

If you have Medicare Part D, and you reach the coverage gap or what’s often referred to as the “doughnut hole” in 2013, you will get a 52.5
percent discount on brand name prescription drugs and a 21 percent discount on generic drugs while in the coverage gap. The discounts are projected to continue until 2020, when the gap is anticipated to be a thing of the past.

Healthcare Reform myths

One of the best ways to learn about an issue is to understand what information is factual, as opposed to what is a random myth or common misperception in the community. Let’s take a look at some of the more common myths about ACA:

- **MYTH 1: The new law cuts Medicare drastically, so I won’t be able to get quality healthcare.**
  The Affordable Care Act (ACA) in fact prohibits cuts to guaranteed Medicare benefits. There are provisions in the law to help curb the soaring costs of Medicare, but savings will come from reining in unreasonable payments to providers, taxing high-premium plans (beginning in the year 2018), cracking down on fraud and waste, and encouraging patient-centered, coordinated care.

- **MYTH 2: Medicare Advantage plans will be cut or taken away.**
  Additionally, the ACA covers preventive care designed to avert chronic conditions like heart disease and diabetes, which currently costs billions of dollars. Medicare beneficiaries get an annual wellness exam, as well as numerous screenings and vaccines free of charge. The new system also improves coordination of care between doctors, nurses and other providers to prevent harmful and costly hospital readmissions.

- **MYTH 3: Patients will have to wait longer to see their doctor or won’t be able to see a doctor at all.**
  Finally, the law closes the infamous Medicare Part D prescription drug “doughnut hole” in which Medicare beneficiaries paid full price for prescription drugs, after exceeding a certain dollar limit each year.

- **MYTH 4: If a person has Medicare, they will need to get additional or different insurance.**
  The ACA does not eliminate Medicare Advantage plans, which are privately administered plans that provide benefits to about a quarter of Americans with Medicare. These plans were created to bring market efficiencies to Medicare. However, they actually cost taxpayers fourteen percent more per enrollee than the traditional Medicare program. The ACA aims to bring costs back into line.

- **MYTH 5: The new law “raids Medicare of $716 billion.”**
  Any other reason. And, the law’s “medical loss ratio requirement” dictates that 80 to 85 percent of premiums be spent on medical costs. As of August 1, 2013, approximately 12.8 million Americans received an estimated $1.1 billion in rebates from insurance companies in cases where overhead expenses exceeded 15 to 20 percent of premiums charged in 2011.

- **MYTH 6: The law is going to bankrupt America.**
  Medicare Part B premiums, which cover doctors’ services and outpatient care, are determined by a formula designed decades ago by Congress. These are based on the previous year’s Medicare healthcare costs. In essence, the government pays 75 percent of Part B costs, and Medicare beneficiaries pay the remaining 25 percent. The law did not change this formula. There is no truth to a rumor that Part B premiums will rise from $99.90 a month in 2012 to $247 a month by 2014, according to AARP (2013).

- **MYTH 7: The new law will drive up premiums astronomically.**
  Small businesses that already provide health insurance will not be impacted by $247 a month by 2014, according to AARP (2013).

- **MYTH 8: If a person cannot afford to buy health insurance, they will be taxed or worse.**
  If a person cannot afford health insurance because of financial hardship, and the cheapest plan exceeds 8 percent of their income, they will be exempt from the tax penalty. Special taxes (from $95 the first year to $695 a year by 2017) will be phased in over the next seven years for those who choose to forgo coverage, and are not exempt. Even then, the government will not criminally prosecute or place property liens on people who ignore the tax. At worst, the IRS will withhold the tax amount from individuals’ tax refunds.

- **MYTH 9: Small-business owners will pay big fines if they don’t provide health insurance to their employees.**
  Small businesses that already provide health insurance will not be affected. Penalties for not providing healthcare coverage apply only to companies with 50 or more workers.

- **MYTH 10: The ACA turns our healthcare system into universal healthcare; leaving the government in charge of how patients and their needs are treated.**
  In fact, many small companies will be eligible for tax credits to offset the burden of providing insurance. From now through 2013, eligible employers will receive a business credit for up to 35 percent of their contribution toward employees’ premiums.

For 2014 and beyond, the tax credit rises to as much as 50 percent of the contribution. These credits apply to companies with fewer than 25 full-time employees, whose average annual salaries are less than $50,000. Companies with more than 50 workers that do not provide coverage will be subject to a fine of $2,000 to $3,000 per employee per year.

Healthcare under the ACA will not be government run.

Conversely, the law builds on and strengthens the existing private insurance system. Approximately 60 percent of the U.S. population
will continue to get insurance through their employer, and people who are buying their own insurance will still buy private health plans. The choice of plan is not dictated, and individuals will be able to choose the provider they want.

- **MYTH 11:** If a state doesn’t set up an insurance exchange, residents of that state cannot get health coverage.

### ASSESSING THE NEW MARKETPLACE: CHANGES IN HOW PEOPLE “SHOP” FOR INSURANCE:

The Affordable Care Act (ACA) was created to reduce the number of uninsured Americans (currently about 41 million people) by helping these people find quality, affordable healthcare. The cornerstone of this goal is known as the Health Insurance Marketplace; a single, online source where consumers can get information about their health coverage options.

Commonly referred to as the “health insurance exchange,” the Marketplace allows for side-by-side “bottom line” comparisons of private insurance plans in terms of coverage and costs. With respect to healthcare insurance, this type of comparison simply does not exist anywhere else today.

A large benefit of the Marketplace is that consumers will find out immediately whether they are eligible for any discounts on premiums, deductibles, or copayments for a Marketplace health plan, or whether they or anyone in their family is eligible for Medicaid or the Children’s Health Insurance Program, by simply filling out one online application.

The Affordable Care Act establishes state-based health insurance exchanges. The exchanges are regulated, online marketplaces, administered by either federal or state governments, where individuals and small businesses can purchase private insurance plans. Individuals with incomes between 100 percent and 400 percent of the federal poverty level who purchase insurance plans via an exchange will be eligible to receive federal subsidies to help pay premium costs.

The exchanges exist in the form of websites, where the private plans sold through them will be regulated and comparable. During limited open enrollment periods, consumers will be able to visit these websites or place a call to a call center, compare the plans offered, fill out a government form used to determine eligibility for subsidies, and then purchase the insurance of their choice from the available options.

After the first open enrollment period, which ended March 31, 2014 uninsured individuals generally may not purchase insurance through an exchange until the following open enrollment period. In subsequent years, the open enrollment period will start on October 15th and end on December 7th, annually.

Outside of open enrollment, an individual cannot enroll in Marketplace coverage unless they have a qualifying life event. HealthCare.gov (2013) defines a **qualifying life event** as:

A change in a person’s life that can make them eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in income, and changes in family size (for example, marriage, divorce, or the addition of a child).

Insurance exchanges are intended to create a market for private insurance in a way that addresses market failures in the current system, such as the high number of uninsured individuals, medical bankruptcies, coverage limits, unaffordability, and inflation through regulations. Only approved plans that meet certain standards are allowed to be sold on the exchanges, and insurers will be prohibited from denying insurance to consumers on the basis of pre-existing conditions.

The regulations intended to reduce prices through competition should result in plans and prices being more transparent and price comparisons more accessible for consumers with online information; federally approved, multi-state plans will be phased in to state exchanges to help guarantee enough options.

Additionally, price regulations will be implemented. This includes a minimum medical loss ratio and partial community rating that prevents price discrimination from pricing individuals out of the market through unaffordable plans or premium increases less wealthy and sick individuals who are insured, but more expensive to cover.

Patients will naturally want to know what kind of coverage they can get from a Marketplace health plan. These plans will offer comprehensive coverage, which means that they will cover a set of “essential health benefits.”

At a minimum, this includes:

- Ambulatory patient services.
- Prescription drugs.
- Emergency services.
- Preventive and wellness services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance abuse disorder care—including behavioral health treatment, counseling, and psychotherapy.
- Rehabilitation and habilitative services and devices.
- Laboratory services.
- Chronic disease management.
- Pediatric services (including oral and vision care).

One of the first questions on everyone’s mind is: “Who is eligible to shop at the Marketplace?” Individuals can buy insurance through the Marketplace if they live in the United States, are U.S. citizens or nationals (or are lawfully present), and are not currently incarcerated.

Insurance companies cannot turn people away. No one can be denied coverage or charged more for coverage because of their sex or a pre-existing health condition.

Depending on household income and family size, people may qualify for tax credits that will lower their share of monthly premiums, or for assistance to reduce deductibles or copayments. For example, a family of four with an annual income of less than $94,200, and ineligible for other health coverage, would qualify for a discount on their premiums.

An estimated 90 percent of currently uninsured people will receive discounted (or even free) health insurance, which is an important fact for healthcare professionals to know and to share with skeptics and procrastinators.

### Guiding the 18- to 35-year-old uninsured

For some patients, healthcare professionals have an even more important role than guiding them to an insurance marketplace.

These are the patients who often do not see the need to carry health insurance. Let’s face it, there is almost always bound to be a group of
people who are relatively young and healthy, and who cannot imagine ever being sick enough to be hospitalized or need surgery. They know that they will be cared for in hospital emergency departments if something catastrophic happens, and they are not losing sleep over preventive care. Why spend their hard-earned dollars on something they don’t need?

Healthcare practitioners can help uninsured people understand why this is a dangerous path to follow. Drawing from their vast clinical experience with the unpredictability and often harsh reality of health and illness, practitioners can convince the deliberately uninsured of the wisdom of buying healthcare coverage. Real-world examples can be used to explain how bypassing preventive care or delaying care because a person lacks health insurance can have devastating consequences. If patients need more incentive to get insured, they should be reminded that in 2014, a tax penalty will be assessed on the tax returns of people who do not carry health insurance (with some exemptions).

Effectively targeting the 18- to 35-year-old uninsured population is extremely important if the goal of insuring the U.S. population is to be achieved. Healthcare practitioners should take advantage of the fact that they are “trusted messengers” for this group and initiate dialogue about health insurance at every encounter. “One-stop” Internet shopping should appeal to this media-savvy group1.

Medicaid expansion

In conversations about health insurance, some patients will raise the issue of Medicaid, having heard that the government planned to loosen its requirements for Medicaid health coverage. It is important for healthcare professionals to understand the facts so that they can guide patients appropriately.

Along with the creation of the Health Insurance Marketplace, the ACA was developed to fill gaps in insurance coverage for low-income Americans through an expansion of Medicaid eligibility. Under the ACA, 15 million uninsured Americans who were previously ineligible for Medicaid could qualify for this coverage beginning in 2014. For the first time, childless and non-disabled adults aged 19- to 64-years-old could receive Medicaid benefits if their annual income is less than 138 percent of the federal poverty level.

Finding answers for your patients

In the upcoming months, patients will turn to their most trusted caregivers to guide them through a changing, and hopefully improving, healthcare landscape. It is likely that healthcare professionals will not be able to answer each and every patient’s question about the changes to healthcare and the various elements of the Health Insurance Marketplace, and may even have many more of their own. So, in addition to just getting the word out about the Marketplace, healthcare professionals can help patients by encouraging them to visit www.healthcare.gov for additional information.

Patients who do not have Internet access, or prefer other means of shopping for insurance, can do so by telephone, through insurance agents or brokers, or with the personal assistance of trained helpers called navigators, application assistants, or certified application counselors.

Understanding these changes will not only help patients, but will help all stakeholders prepare for the expected increase in the number of insured patients accessing healthcare in 2014.

Some key speaking points:

- The Marketplace is a new way to find quality health coverage. It can help someone who does not have coverage now, or if they have it but want to look at other options.
- With one Marketplace application, an individual can learn whether they qualify for lower costs based on income, compare coverage options side-by-side, and enroll.
- When using the Health Insurance Marketplace, an individual will fill out an application and see all the health plans available in their area. They should be prepared to provide some information about household size and income, in order to find out if they can get lower costs on monthly premiums for private insurance plans. They will also learn if they qualify for lower out-of-pocket costs.
- The Marketplace can also tell someone if they qualify for free or low-cost coverage available through Medicaid or through the Children’s Health Insurance Program (CHIP).
- The Health Insurance Marketplace is sometimes known as the health insurance “exchange”.
- Individuals are able to apply by mail, online, by phone, or in person.

In 2012, the Supreme Court’s landmark decision in National Federation of Independent Business v. Sebelius upheld the provisions of the ACA that were challenged, one of which was the proposed expansion of Medicaid2. At the same time, however, the Court ruled that the federal government could not withhold federal Medicaid funds from states in an effort to encourage them to expand Medicaid eligibility. This ruling effectively allowed states to opt out of Medicaid expansion, and many have decided not to participate in spite of generous federal funding for this initiative.

From 2014 to 2017, the federal government will pay for 100 percent of the difference between a state’s current Medicaid eligibility level and the ACA minimum. Federal contributions to the expansion will drop to 95 percent in 2017 and remain at 90 percent after 20203.

Finding local help

In all states, there will be people trained and certified to help applicants understand health coverage options and enroll in a plan. Although known by different names depending on who provides the service and where they are located, all will provide similar kinds of help. These people may be known as:

- Navigators.
- Application assisters.
- Certified application counselors.
- Government agencies, such as State Medicaid and Children’s Health Insurance Program (CHIP) Offices.

Insurance agents and brokers can also help with applications and choices. Applicants should visit https://localhelp.healthcare.gov to find help in their area. They can search the site by city and state, or zip code, to see a list of local organizations with contact information, office hours, and types of help offered—such as non-English language support, Medicaid or CHIP, and Small Business Health Options Programs (SHOP).
These organizations can assist in finding the kind of help that works for each individual.

**Getting help filling out an application online**
The Marketplace website will walk applicants step-by-step through the online health coverage application. It keeps track of where they are and guides them through to the end. If the applicant has to stop completing their application and come back later, the Marketplace lets them re-start where they left off.

Useful information on each page explains the questions being asked, how much time each step might take, and if any forms or other documents are necessary. If the applicant wants live help while applying, they can call the toll-free support center or chat with someone online.

**Useful information based on categories of patients**

This section groups together information that may be helpful to healthcare workers by the “type” of patient they may be interacting with. The top three most encountered categories of patients are:

1. Those who have private or employer-based insurance plans.
2. Those who are uninsured or have a pre-existing condition.
3. Those who have Medicare.

**If a patient has a private or employer-based insurance plan:**
- As long as they pay their premiums, an insurance company can no longer drop coverage if they become sick or disabled.
- An insurance company can no longer place lifetime dollar limits on their health coverage.
- Many private health insurance plans must now cover more preventive care services, such as mammograms and other screenings, at no additional cost to the insured.

**If a patient is uninsured or has a pre-existing condition:**
- The Affordable Care Act provides a way for many adults with pre-existing medical conditions who have been denied coverage to purchase health insurance. Also, insurance companies can no longer deny coverage to children up to age nineteen who have preexisting conditions.
- The law enables young adults up to age twenty-six to be covered under a parent’s health insurance plan, reducing the number of uninsured young adults and helping ease parental worries. In the past, young people were typically forced off their family’s health plan upon turning eighteen or twenty-one, or graduating from college.
- Insurers may no longer deny coverage to anyone with a preexisting health condition. New health insurance “exchanges” will provide better insurance access and more options to self-employed people, small businesses and others who have been denied coverage or were unable to find affordable coverage.

**If a patient has Medicare:**
- Annual wellness visits are provided at no additional cost, as are certain preventive care services such as immunizations and screenings for cancer or diabetes. In 2011, more than one million people took advantage of Medicare’s new annual wellness visit, and more than 32.5 million Americans in traditional Medicare used one or more of the program’s free preventive services.
- People with Medicare Part D now receive discounts on prescription drugs while in the doughnut hole. (In 2011, this provision resulted in a savings of $2.1 billion or an average of $604 per person, on prescription drugs for 3.6 million people on Medicare.) The Part D discounts will gradually increase until 2020, when the doughnut hole will disappear.
- The law provides new resources to fight waste, fraud and abuse in the Medicare program, and adds about ten years to the solvency of Medicare.

**Resource information**

Since [www.healthcare.gov](http://www.healthcare.gov) is the portal to the Marketplace as well as a provider of information, it is most likely to continue to be the most up-to-date resource in existence for all things related to healthcare reform, coverage, providers, changes in legislation, etc.

*Healthcare.gov* serves as both an informational and functional website with a variety of attached services. Its primary function is that it can help an applicant complete the entire application process from beginning to end with information that can be provided online or over the phone, including reviewing options and helping an applicant enroll in a plan. Customer service representatives providing phone assistance can also answer questions as an applicant fills out an online or paper application. Assistance is available 24 hours a day, 7 days a week. The phone number is:

1-800-318-2596 (TTY: 1-855-889-4325)

Healthcare.gov can also help individuals obtain help finding and managing their health coverage on a local level, with a search engine that asks an applicant to provide their city and state, or zip code, in order to return a list of providers in the local area.

**Conclusion**

Healthcare practitioners utilize many skills and tools on a regular basis. Often, the most useful tool is the ability to become informed of changes to existing healthcare systems that impact their daily responsibilities and the people they serve. Changes in the recent Health Care Reform follow various timeframes. For example, the Affordable Care Act was signed into law in March 2010, though not all changes were designed to become active simultaneously. Some elements have already been implemented, or at least initiated, while others became active in January 2014. Overall, these are changes that impact millions of Americans, any healthcare patient, and the healthcare professionals who work within the system undergoing such change. Reform on such a large scale can be very confusing for many patients. Additionally, changes and the way in which things change in the healthcare system are still being debated by politicians, healthcare professionals, and provider agencies, making it even more important for healthcare professionals to keep current with existing and upcoming potential change.
HEALTH CARE REFORM: WHAT EVERY HEALTH CARE PRACTITIONER NEEDS TO KNOW

Final Examination Questions

Select the best answer for each question and proceed to www.EliteCME.com to complete your final examination.

1. The ACA has two primary mechanisms for increasing insurance coverage. First, it expands Medicaid eligibility to include individuals within 138 percent of the federal poverty level. Second, it creates ___________ where individuals and small business can buy health insurance plans.
   a. Federal-based insurance exchanges
   b. Nationally standardized insurance agencies
   c. State-based insurance exchanges
   d. Federally funded incentives

2. Young adults can now remain on their parents’ health plans until they turn ____ years of age. It doesn’t matter if they’re in school, live with you or even if they’re married.
   a. 19
   b. 21
   c. 23
   d. 26

3. A __________ is a fixed amount the insured person pays to the insurance company, usually every month. The insured pays this even if they do not use medical care that month.
   a. Deductible
   b. Premium
   c. Co-payment
   d. Co-insurance

4. Medicare now covers a yearly wellness visit and at no cost. This includes cancer, cholesterol and diabetes screenings, immunizations, diet counseling and more.
   a. Phone consultation.
   b. Preventive care.
   c. Follow up care.
   d. Elder care.

5. The ACA does not eliminate ____________, which are privately administered plans that provide benefits to about a quarter of Americans with Medicare.
   a. Medicare Advantage plans
   b. Social Security plans
   c. Retirement plans
   d. Social networking plans

6. Medicare beneficiaries will continue to have Medicare, and there is no requirement that they get ____________.
   a. Life insurance
   b. Individualized prescription plans

7. The ACA builds on and strengthens the existing private insurance system. Approximately ____ of the U.S. population will continue to get insurance through their employer and people who are buying their own insurance will still buy private health plans.
   a. Half
   b. One third
   c. 60 percent
   d. 80 percent

8. The cornerstone of this goal is known as the ____________; a single, online source where consumers can get information about their health coverage options.
   a. Independent Marketplace
   b. Health Insurance Marketplace
   c. Black Market of Insurance
   d. Cornerstone Health Market

9. A ____________ is defined as a change in a person’s life that can make them eligible for a Special Enrollment Period to enroll in health coverage.
   a. Qualifying life event
   b. Qualitative change
   c. Significant event
   d. Unexpected turn

10. While the _________ helps one find health insurance that is available outside the Marketplace, before 2014 protections and features where available, it is important to note that it is not the Health Insurance Marketplace.
    a. Provider Locator
    b. Federal Insurance Finder
    c. Plan Finder
    d. Hotline Helper

References