

Monday, July 22, 2013

## HELPING PEOPLE GET INSURANCE COVERAGE: OPTIONS FOR HOSPITALS

### AT A GLANCE

#### **The Issue:**

America's hospitals play a vital role in their communities, providing not only access to needed health care services but also connections to health care coverage. This role will take on even greater importance as the *Patient Protection and Affordable Care Act's* (ACA) coverage expansions take effect at the beginning of 2014. Making information on coverage options and financial assistance available to low-income individuals and families will require an "all-hands-on-deck" approach – combining as broad a cross-section of stakeholders as can be mustered. Open enrollment will begin Oct. 1.

This advisory offers an overview of:

- the ACA's coverage opportunities, including private options available through the new Health Insurance Marketplaces, as well as public options through Medicaid and the Children's Health Insurance Program (CHIP); and
- the kinds of roles hospitals and health care organizations can play in assisting patients in obtaining appropriate coverage.

Additional resources can be found at [www.aha.org/getenrolled](http://www.aha.org/getenrolled).

#### **What You Can Do:**

- ✓ Tune in to a special AHA Town Hall Interactive webcast on Thursday, July 25 at 1 p.m. Eastern Time to learn more about the role hospitals can play. Click here (<http://www.aha.org/events/townhall.shtml>) for more information.
- ✓ Share the attached advisory with members of your team responsible for health coverage outreach and enrollment.
- ✓ Visit [www.aha.org/getenrolled](http://www.aha.org/getenrolled) for additional resources; the site will be updated as resources become available.

#### **Further Questions:**

Please contact Ellen Pryga, policy director, at (202) 626-2267 or [epryga@aha.org](mailto:epryga@aha.org), or Molly Collins Offner, policy director, at (202) 626-2326 or [mcollins@aha.org](mailto:mcollins@aha.org).

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This advisory offers an overview of the ACA's coverage opportunities, including private options available through the new Health Insurance Marketplaces as well as public options available through Medicaid and the Children's Health Insurance Program (CHIP). The advisory also provides an overview of the kind of roles hospitals and health care organizations can play in assisting patients in obtaining appropriate coverage. For more, visit: [www.aha.org/getenrolled](http://www.aha.org/getenrolled).

### **BACKGROUND**

#### ***The Health Insurance Marketplace ("Exchanges")***

Central to coverage access is the Health Insurance Marketplace, also known as exchanges. They are not insurance companies and do not offer insurance products that they develop and underwrite themselves. They are marketplaces through which, beginning in 2014, individuals (who do not have an offer of qualifying and affordable coverage from their employers) and small businesses may purchase coverage from private insurance companies. Individuals who purchase coverage through an insurance exchange may be eligible to receive federal subsidies that make the insurance more affordable. There also are special temporary tax credits available to certain very small employers to provide coverage to their employees.

The ACA calls for the establishment of two types of insurance marketplaces in each state: one for individuals and one for small businesses. The insurance marketplace for individual coverage operates separately from the small employer marketplace, unless a state decides to merge them into a single marketplace. The small business insurance marketplace is known as the Small Business

Health Options Program (SHOP). For purposes of this advisory, we use the term “marketplace” to include both individual and small group marketplace.

States have the flexibility to decide the nature of the marketplaces in their state. There are three choices; they can:

- establish a State-Based Marketplace (SBM);
- participate in a State-Federal Partnership Marketplace (SPM); or
- allow the federal government to run a Federally-Facilitated Marketplace (FFM) in the state.

The chart below outlines these options for states. In each option, either the state or the federal government has the overall responsibility for operation of the marketplace, but each option allows certain tasks to be performed by either the state or the federal government.

<b>Health Insurance Marketplace Options for States</b>		
<b>Type of Marketplace</b>	<b>Level of Government Responsible Overall for Operations</b>	<b>Flexible Functions</b>
<b>State-Based (SBM)</b>	State	State may use Federal government services for: <ul style="list-style-type: none"> <li>• Premium tax credit and cost sharing reduction</li> <li>• Exemptions from tax penalties</li> <li>• Risk Adjustment Program</li> <li>• Reinsurance Program</li> </ul>
<b>State Partnership (SPM)</b>	Federal	State can accept responsibility for: <ul style="list-style-type: none"> <li>• Plan Management</li> <li>• Consumer Assistance</li> </ul>
<b>Federally-Facilitated (FFM)</b>	Federal	State may elect to operate: <ul style="list-style-type: none"> <li>• Reinsurance Program</li> <li>• Medicaid and CHIP eligibility determinations</li> </ul>

If a states chooses not to establish a marketplace (SBM) or partner with the federal government (SPM) for certain market place functions, the federal government will operate the marketplace (FFM). States that are not planning to operate a marketplace by Oct. 1, 2013, may apply later to operate their own exchanges for plan years 2015 and beyond. Eighteen states (including the District of Columbia) have established an SBM, six states have formed an SPM, and the remaining 27 states will have FFMs (see chart below). Marketplaces have to be ready to accept enrollees Oct. 1, 2013, through March 31, 2014 (the initial open enrollment season), and be fully operational on Jan. 1, 2014.

Marketplace Type	State
<b>State-Based</b>	CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT*, VT, WA
<b>State Partnership</b>	AR, DE, IL, IA, MI, WV
<b>Federally-Facilitated</b>	AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, NE, NH, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY

Source: Centers for Medicare & Medicaid, [www.cms.gov/CCIIO](http://www.cms.gov/CCIIO)

(\* UT has a hybrid marketplace arrangement with the state operating the SHOP and the federal government operating the individual marketplace)

### **Qualified Health Plans (QHPs)**

The 18 SBMs have adopted a range of approaches in terms of organizational structure and the control of the number and type of QHPs, which will be offered to consumers through the marketplace. The organizational structures fall into three basic types: quasi-governmental (government and private sector share in operation); operated by state agency (state agency has control over operation); and non-profit. With regard to the control of type and number of QHPs, the most open approach is a “clearinghouse” where all QHPs are allowed to participate; the most restrictive approach is an “active purchaser” where the marketplace limits the number and/or types of QHPs that can participate.

State	Marketplace Operated By	QHP Selection
CA	Quasi-Governmental	Active Purchaser
CO	Quasi-Governmental	Clearinghouse
CT	Quasi-Governmental	Active Purchaser
DC	Quasi-Governmental	Active Purchaser
HI	Non-Profit	Clearinghouse
ID	Quasi-Governmental	Clearinghouse
KY	Operated by State	Clearinghouse
MD	Quasi-Governmental	Clearinghouse
MA	Quasi-Governmental	Active Purchaser
MN	Operated by State	Clearinghouse
NM	Quasi-Governmental	Clearinghouse
NV	Quasi-Governmental	Clearinghouse
NY	Operated by State	Active Purchaser
OR	Quasi-Governmental	Active Purchaser
RI	Operated by State	Active Purchaser
UT	Operated by State	Clearinghouse
VT	Operated by State	Active Purchaser
WA	Quasi-Governmental	Clearinghouse

Source: [www.kff.org](http://www.kff.org)

### **Essential Health Benefits (EHB)**

The ACA requires that all QHPs offered in the marketplaces must include Essential Health Benefits (EHB), which is a robust set of benefits that cover 10 general categories. The categories include such items as hospitalization, prescription drugs, and maternity and newborn care, and are equal in scope to a typical small employer health plan. The levels of coverage in the marketplace QHPs are defined based on their actuarial equivalence to the benchmark metal levels: Bronze Level (60 percent), Silver Level (70 percent), Gold Level (80 percent) and Platinum Level (90 percent). The metal levels represent the health plan and plan enrollee costs. For example, in the Silver Level, the health plan will pay 70 percent of the health care expenses with the enrollee paying 30 percent through some combination of deductibles, copays and coinsurance. Department of Health and Human Services (HHS) regulations gave states the ability to set their own EHB benchmarks within certain federal parameters.

The ACA also requires that the Medicaid benefit package, available to the new eligibility group of low-income adults, also known as the “expansion population,” must be modified to include the EHB requirements. The state Medicaid agency has the responsibility to ensure that the EHB requirements are met. (See the AHA’s Feb. 21 Special Bulletin on EHB at: <http://www.aha.org/hospital-members/advocacy-issues/bulletin/2013/130221-bulletin.shtml> and the July 10 Special Bulletin on Medicaid eligibility at: <http://www.aha.org/hospital-members/advocacy-issues/bulletin/2013/130710-bulletin.shtml> for more.)

### **Insurance Market Reforms and Patient Protections**

The ACA required that certain insurance market reforms be adopted soon after enactment. The effective date for these immediate insurance market reforms was plan years (PYs) beginning on or after Sep. 23, 2010; they included:

- No lifetime limits
- Restricted annual limits
- Restrictions on rescission of coverage
- First dollar coverage of preventive services
- Extended dependent coverage to age 26
- No pre-existing condition exclusions for children
- Disclosure of justifications for premium increases

Other ACA insurance market reforms become effective on Jan. 1, 2014, including:

- No pre-existing condition exclusions for adults
- Limitations on rate variations state-wide
- Required separate state-wide risk pools for individual market and for small group market

### **Premium Tax Credits**

Beginning in 2014, qualified individuals and families can take a new premium tax credit on their federal income taxes to help them pay for health insurance

coverage purchased through a marketplace. The premium tax credit is refundable so taxpayers who have little or no income tax liability can still benefit. The credit also can be paid in advance by the marketplace to a taxpayer's insurance company to help cover the cost of premiums. Individuals with access to employer-sponsored health insurance can apply for a premium tax credit through the marketplace if the employer-sponsored coverage is unaffordable.

When an individual applies for a premium tax credit through a marketplace, the individual is responsible for providing the marketplace with information as to whether he or she has access to employer-sponsored coverage. HHS recently clarified questions raised by the administration's recent decision to delay the ACA's employer shared responsibility provisions requiring employers to offer their employees health insurance coverage and report such information to the marketplace until 2015. Marketplaces will rely on the individual's self-reported information to determine an individual's eligibility for premium tax credits during the first year.

### **Medicaid Eligibility, Enrollment and Expansion**

The ACA changed many Medicaid and CHIP eligibility and enrollment provisions to:

- Expand Medicaid eligibility, at the state's discretion, for non-elderly adults with incomes up to 133 percent of the Federal Poverty Level (FPL) (138 percent FPL when taking into account a 5 percent income disregard; in 2013, 133 percent FPL, for a family of four, is \$25,974.90);
- Simplify Medicaid eligibility categories;
- Modernize eligibility verification rules, relying primarily on electronic data sources;
- Base income eligibility on a new income methodology known as Modified Adjusted Gross Income (MAGI) to make it consistent with federal subsidy eligibility determinations in the marketplaces;
- Streamline Medicaid and CHIP applications and renewals; and
- Coordinate eligibility across Medicaid, CHIP and the marketplaces.

States have flexibility to design their eligibility determination process, but they must ensure that the eligibility determination process for all Insurance Affordability Programs (IAPs), including Medicaid programs, is simple, coordinated, seamless and timely. The goal is to ensure that the eligibility determination process is consistent between state Medicaid agencies and insurance marketplaces, whether the Medicaid agency is accepting an eligibility determination from a marketplace or whether the marketplace is conducting an initial assessment and transferring the information and findings to the Medicaid agency.

The June 2012 Supreme Court decision allows states to decide to expand or not expand their Medicaid programs without penalty. There are more limited coverage options for low-income individuals living in states that choose not to expand their Medicaid program. In these states, individuals with incomes between 100 and 138 percent FPL can seek coverage in the marketplace and apply for premium tax credits to help pay for that coverage. However, individuals

with incomes below 100 percent FPL who are not eligible for Medicaid cannot access premium support through the marketplace. Low-income individuals in states that do not expand Medicaid will not be subject to the individual mandate penalties if they fail to secure health insurance coverage beginning Jan. 1, 2014.

To date, 24 states have declared that they will expand their Medicaid programs, 21 states have chosen not to move forward with expansion and six states remain undecided.

## **THE ROLE OF HOSPITALS AND HEALTH SYSTEMS IN HELPING CONSUMERS ACCESS COVERAGE THROUGH THE MARKETPLACES**

Consumer assistance programs are intended to provide unbiased information to consumers about their coverage options, including insurance plans offered through the marketplaces as well as public programs including Medicaid, CHIP, federal premium assistance and other available programs.

The insurance marketplaces will provide individuals with assistance through the following roles:

- Navigators;
- Non-navigator assistance personnel; or
- Certified application counselors (CACs).

**As discussed further below, most hospitals and health systems are likely to provide assistance as CACs.**

<b>What kind of assistance will be available through the Marketplace?</b>			
	<b>Navigators</b>	<b>Non-Navigator Assistance Personnel</b>	<b>Certified Application Counselors</b>
<b>State-based Marketplace</b>	Yes	Optional for states	Yes
<b>State Partnership Marketplace</b>	Yes	Yes	Yes
<b>Federally-facilitated Marketplace</b>	Yes	Not applicable; Navigators provide this assistance	Yes

Agents and brokers also can provide consumers with help in applying for coverage through the marketplace. Below are descriptions of the funding and training requirements of the different types of consumer assistance that will be available.

<b>How are these roles funded?</b>			
	<b>Navigators</b>	<b>Non-Navigator Assistance Personnel</b>	<b>Certified Application Counselors</b>
<b>State-based Marketplace</b>	State-based grant program	State-based grants or contracts, which can be funded by Exchange Establishment grants	Certified application counselors will not receive new federal grant money through the Marketplace. Federal funding through other grant programs or Medicaid may be available. Some examples of possible application counselors include staff at community health centers, hospitals, other health care providers, or social service agencies.
<b>State Partnership Marketplace</b>	Federal grant applications are being reviewed and awards will be announced in late summer 2013	State-based grants or contracts, which can be funded in states with consumer partnerships by Exchange Establishment grants	
<b>Federally-facilitated Marketplace</b>	Federal grant applications are being reviewed and awards will be announced in late summer 2013	Not applicable	

<b>What training and certification is required?</b>			
	<b>Navigators</b>	<b>Non-Navigator Assistance Personnel</b>	<b>Certified Application Counselors</b>
<b>State-based Marketplace</b>	State training and certification (state may choose to use federal training)	State training and certification (state may choose to use federal training)	State training and certification (state may choose to use federal training)
<b>State Partnership Marketplace</b>	Federal training and certification, which may be supplemented by the state	Federal training and certification, which may be supplemented by the state	Federal training and federal designation of organizations, which may be supplemented by the state
<b>Federally-facilitated Marketplace</b>	Federal training and certification	Not applicable	Federal training and federal designation of organizations

Source CMS Product No. 11647-P July 2013



On July 12, the Centers for Medicare & Medicaid Services (CMS) released its final rule (available at: [http://www.ofr.gov/OFRUpload/OFRData/2013-17125\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-17125_PI.pdf)) implementing the ACA provisions regarding consumer assistance programs for the FFMs and SPMs. The rule finalizes standards for navigators, non-navigator assistance programs and CACs. The standards relate to training, conflicts of interest, privacy and security of personal information, nondiscrimination and serving people with limited English proficiency and people with disabilities. SBMs may use these standards or develop their own.

Official consumer assistance is provided through three programs: navigators, non-navigator assistance personnel and CACs. Navigators and non-navigator assistance personnel receive federal and/or state funds to perform the comprehensive range of consumer assistance functions. The only real differences between these two types of funded assisters are their source of funding and which type of exchange operates in their state.

In contrast, CACs provide assistance on a voluntary basis, cannot charge fees for their assistance, and are not required to perform all of the functions of navigators and non-navigator assisters. **CMS clarified in the July 12 rule that, while certification is encouraged, non-certified organizations and individuals are not prohibited from assisting individuals or engaging in community outreach and education.**

For more, see the CMS factsheet at: <http://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf>.

The requirements for navigators and non-navigator assisters differ in some respects from those that apply to CACs and the organizations that support them. **To avoid confusion, the remainder of this discussion focuses on CACs because most hospitals and health systems are likely to provide assistance on this basis.**

### ***Certification Application Counselors (CACs)***

All marketplaces must have CAC programs. CACs provide information to consumers and help facilitate consumer enrollment in QHPs and insurance affordability programs (i.e., premium tax credits, Medicaid and CHIP). The marketplace may designate organizations to certify employees or volunteers to perform the duties of CACs according to regulatory standards that include training to protect personally identifiable information.

CMS issued the following guidance for the FFMs and SPMs. SBMs can use CMS's guidance or establish their own for CAC programs.

Organizations that Can Designate CACs. Organizations apply to the FFMs and SPMs to participate in the CAC program. Examples of eligible organizations are hospitals, community health centers, federally-qualified health centers, behavioral and mental health agencies, social service agencies and energy and tax assistance entities. The FFMs and SPMs can designate only certain types of organizations that:

- have processes in place to screen their staff members and volunteers who are certified application counselors to ensure personally identifiable information is protected; and/or
- engage in health care related services; and/or
- have experience providing social services.

The FFM and SPMs can designate organizations already designated as a Medicaid-certified application organization by a state Medicaid or CHIP agency. These organizations still have to apply directly to the FFM or SPM.

Process for CAC Organizations Designation. **Organizations must apply directly to the FFM or SPM to be a designated organization.** CMS will post the on-line application on its website, [www.cms.gov/CCIIO](http://www.cms.gov/CCIIO), sometime during the month of July. A sample application may be found at: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html>. The application asks the following:

- Organization's name, contact information and nature of business
- Organization's type (i.e., government entity or IRS 501( c ))
- Organization's screening process for employees and volunteers
- Organization's process for handling personally identifiable information
- Organization's experience in assisting individuals in health care insurance enrollment

The organization applying for designation does not need to include supporting documentation, but the FFM and SPM can request additional information.

Organizations that the FFM and SPM designate to participate in the CAC program must enter into a written agreement. The written agreement will contain the organization's assurances that its employees and volunteers will comply with the privacy and security standards established by the FFM and SPM. Designated organizations participating in the CAC program will be listed on the FFM and SPM website.

CAC Training Requirements. CAC training will be offered through CMS's website with content-specific training modules. **The modules are expected to be available by the end of August.** The training hours will be less than the 30 hours required for navigators because the CAC training content will be tailored to the functions they will perform and the training they already have (such as compliance with privacy rules).

CAC Conflict of Interest Standards and Serving People with Limited English Proficiency and People with Disabilities. Hospitals or health systems with health plans within their corporate structure are **not** prohibited from participating in the CAC program as long as employees of the health plan are not involved and they disclose the conflict of interest to the marketplace and potential enrollees. If CACs participate in the networks of some, but not all, of the health plans available in the area, they also must disclose this information to those to whom

they provide assistance. CACs can serve people with disabilities or people with limited English proficiency directly or through appropriate referrals to other marketplace consumer assistance sources, such as the marketplaces and the CMS toll-free consumer assistance call line. CMS has identified the *Culturally and Linguistically Appropriate Standards* (CLAS) as a best practice resource.

## **THE ROLE OF HOSPITALS AND HEALTH SYSTEMS IN MEDICAID ENROLLMENT**

CMS recently issued final regulations implementing several provisions of the ACA with regard to eligibility and enrollment for Medicaid and CHIP, and the coordination with the marketplaces. Of particular interest to hospitals are two provisions that address how hospitals can assist in Medicaid enrollment:

- presumptive eligibility; and
- CACs for Medicaid and CHIP.

### ***Presumptive Eligibility***

States have long used presumptive eligibility to temporarily enroll pregnant women and children in Medicaid or CHIP through the state option authority. Thirty-two states have adopted presumptive eligibility for pregnant women, and 17 states have adopted presumptive eligibility for children. The ACA created not an option, but rather a new requirement for states to specifically allow hospitals to make presumptive eligibility determinations, even if a state had not previously established a presumptive eligibility program. CMS's recent rule (available at: [http://www.ofr.gov/OFRUpload/OFRData/2013-16271\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-16271_PI.pdf)) implements this requirement by allowing hospitals to self-elect to make presumptive eligibility determinations.

A presumptive eligibility program allows providers, on behalf of their patients, to begin the enrollment process based on some key pieces of information at the point of service. There are five basic criteria that a hospital must meet to be authorized to make presumptive eligibility determinations. Specifically, a hospital must:

- participate as a Medicaid provider;
- notify the state Medicaid agency of its decision to make presumptive eligibility determinations;
- agree to make determinations consistent with state policies and procedures;
- assist individuals in completing and submitting the full application, at the state's discretion; and
- not be disqualified by the agency.

Hospitals will need to proactively work with their state Medicaid agencies to develop the process for how the new presumptive eligibility requirement will work. Enroll America's Best Practices Institute has developed a toolkit for hospitals in getting started on presumptive eligibility determinations. To access the toolkit, go to: [www.enrollamerica.org/best-practices-institute](http://www.enrollamerica.org/best-practices-institute) and will be available by August.

### ***Certified Application Counselors (CACs) for Medicaid and CHIP***

CMS in its July rule (available at: [http://www.ofr.gov/OFRUpload/OFRData/2013-16271\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-16271_PI.pdf)) recognizes that many state Medicaid and CHIP programs have established relationships with providers, such as hospitals, to assist individuals seeking health coverage. In this capacity, many hospitals have served as “application assisters,” promoting health coverage enrollment for low-income populations and often providing much-needed language translation assistance. The regulation outlines the certification standards for states to follow including procedures to ensure that trained Medicaid CACs have authority to access and protect confidential information about individuals they serve, and that the state Medicaid agency enables the counselors to track and monitor applications.

For Medicaid and CHIP, the states can allow the CACs to limit the activities they will perform for applicants. States must ensure that Medicaid CACs are properly trained prior to certification. States are free to adapt training materials developed by HHS for use by Medicaid and CHIP agencies for CACs registered with the FFM or SPM. Hospitals should work closely with their state Medicaid agencies to make certain they receive the appropriate training and certification that will allow them to continue their work in enrolling eligible individuals in Medicaid or CHIP.

### ***NEXT STEPS AND AVAILABLE RESOURCES***

The AHA will continue to monitor forthcoming regulations and guidance, engage in discussions with the administration, and provide updated information to AHA members and the state, regional and metropolitan hospital associations as new resources and training become available.

Visit [www.aha.org/getenrolled](http://www.aha.org/getenrolled) for updates and links to both national and state-specific resources.

CMS is holding regular stakeholder engagement conference calls on the new Health Insurance Marketplaces. The next round of quarterly calls will begin the week of July 29 in each state with an FFM or SPM. Individuals and organizations that will interact with and utilize the Marketplace are encouraged to join these calls. To register go to: [http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF\\_HealthInsuranceMarketplace.html](http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HealthInsuranceMarketplace.html).

### ***FURTHER QUESTIONS***

If you have questions, please contact Ellen Pryga, director for policy, at (202) 626-2267 or [epryga@aha.org](mailto:epryga@aha.org), or Molly Collins Offner, director for policy development, at (202) 626-2326 or [mcollins@aha.org](mailto:mcollins@aha.org).