

Montana 2016 Health Insurance and Medicaid Expansion Training for Assistors

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Montana Department of Health and Human Services

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2015 Enrollment Analysis: Successes

- In May 2015, CSI completed an insurer enrollment survey of the individual and small employer group markets, which produced the following results:
 - Between January 1 and May 1, 2015, enrollment in the individual market grew by 16,384 covered lives, compared to enrollment on December 31, 2014, an increase of 23.3%
 - During the same time period, the small employer group market increased by an estimated 2,739, an increase of 6.5%
 - The net gain in traditional Medicaid and Healthy Montana Kids (HMK) enrollment during that time period was 4,123

Enrollment Analysis: Successes (cont.)

- CSI estimates that approximately 23,000 previously uncovered individuals gained coverage between January and May 2015. The estimate of uninsured in Montana was 195,000 (approx. 20%) in 2013
- The overall uninsured rate has been reduced to an estimated 15 %
- The number of individuals estimated to be in the “Medicaid gap” is 50,000 to 70,000. Approximately 20,000 of those are American Indians.

Montana Medicaid and Expansion 101

Christie Twardoski , DPHHS, will present on changes in Medicaid coverage.

For more information about the HELP Act go to:

www.dphhs.mt.gov/medicaidexpansion

Coverage Groups

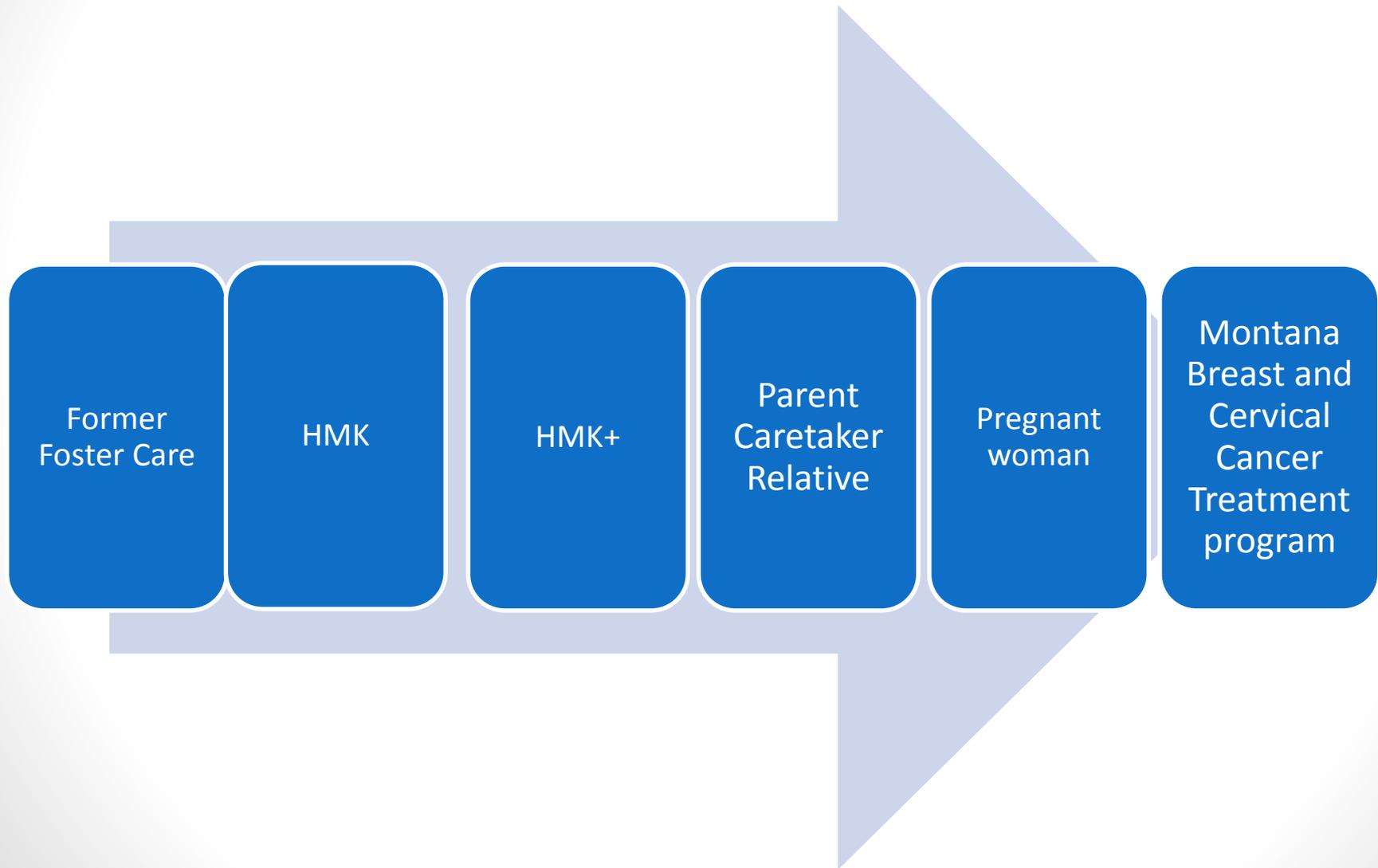
Other Medicaid programs

- Age 65 or older (aged) Blind or disabled according to Social Security criteria
- Women diagnosed with breast or cervical cancer or pre-cancer and receiving treatment
- Medicare Savings Plan coverage that pays Medicare premiums, and may pay co-pays/deductibles
- Medically needy* coverage for children and pregnant women
 - *Medically needy is coverage for individuals whose income exceeds regular program limits

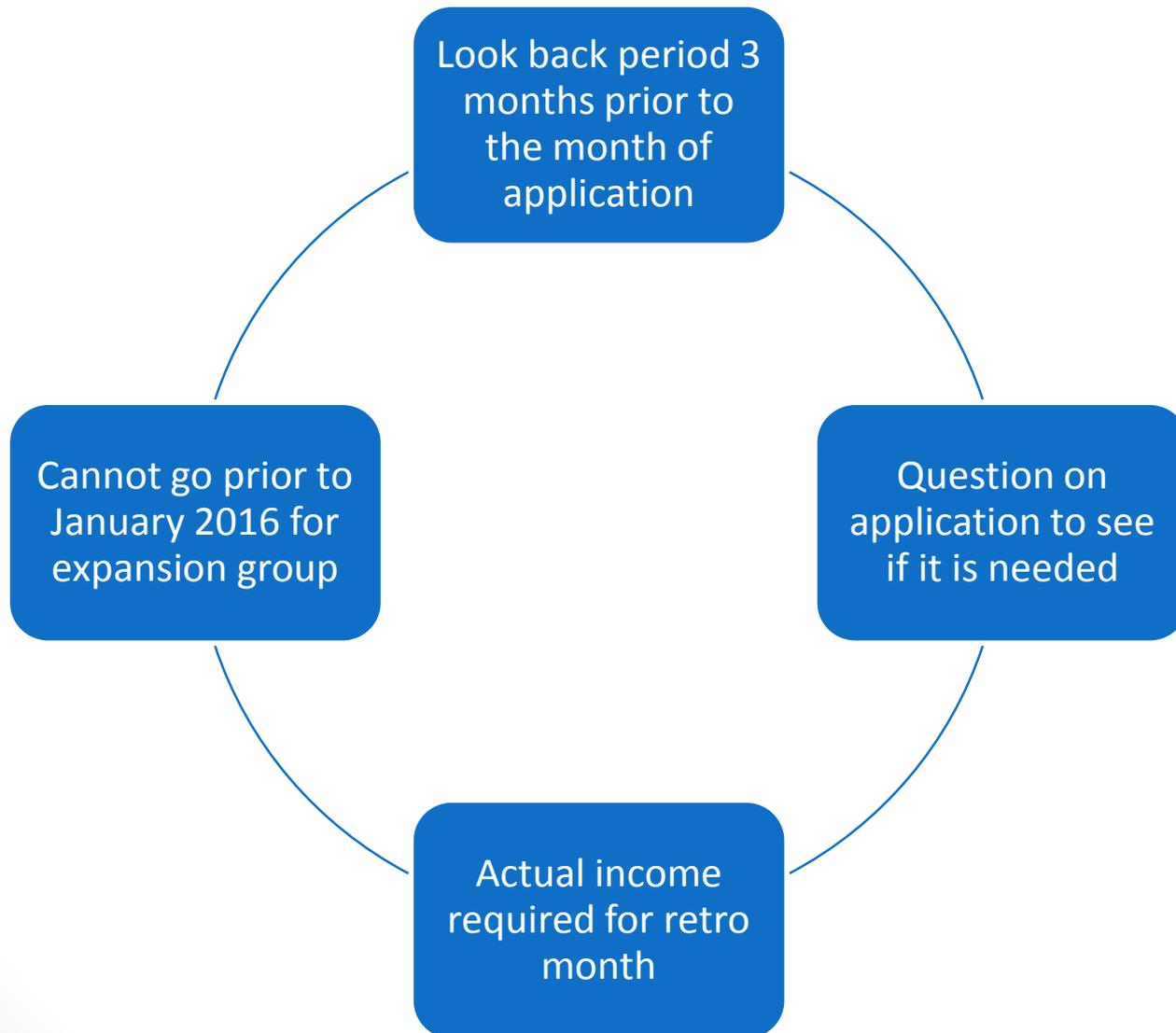
ACA Medicaid programs

- Parents and Caretaker Relatives
- Children age 18 and under
- Pregnant Women
- Former Foster Care children
- HMK (HMK and HMK+)
- ****Expansion****

Presumptive eligibility



Retroactive Medicaid Coverage

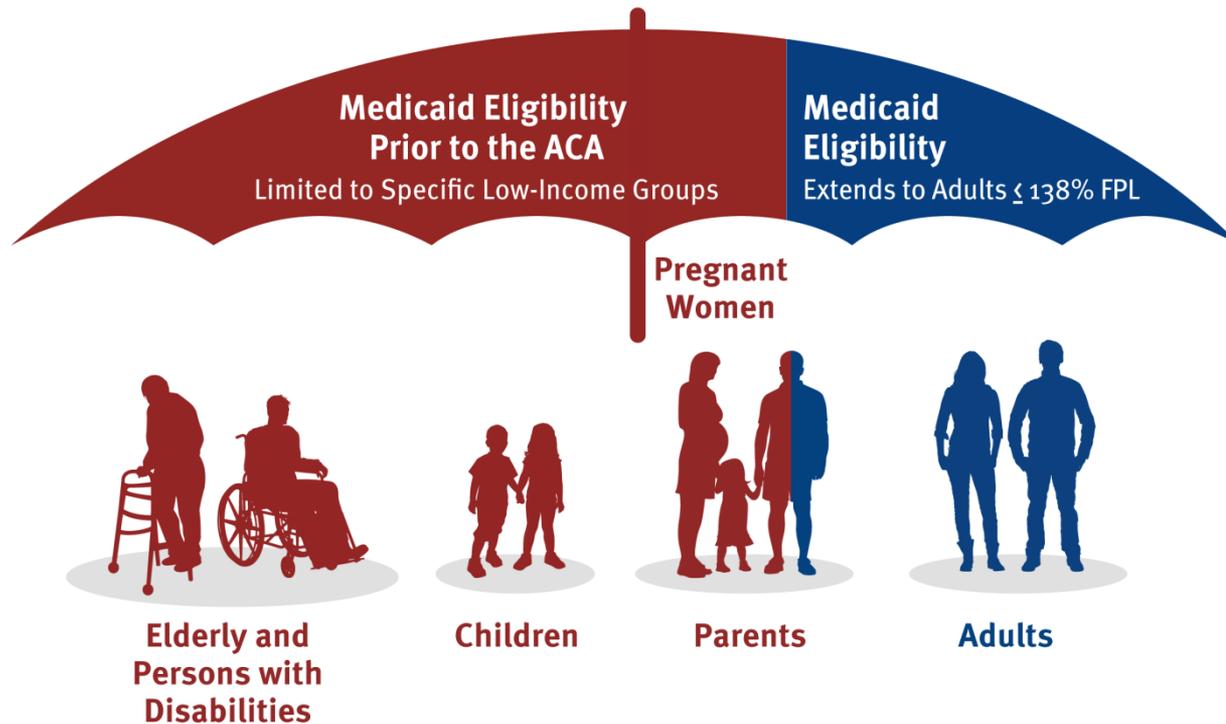


Is there a resource test for ACA programs?

No!

Expansion 101

Medicaid Eligibility



Parents and adults without kids living at home between the ages of 19-64 with an income at or below 138% of the Federal Poverty Level (FPL)

\$16,424 for an individual and \$27,724 for a family of three in 2015

Covered by the Help Act



Eligible and Services Delivered by Medicaid State Plan

(Subject to Copayment)

ACA Adult Medicaid

- **American Indians/Alaska Natives;**
- **Individuals with exceptional medical needs;**
- Individuals who live in a geographical area with insufficient health care providers;
- Individuals in need of continuity of care that would not be available or cost-effective; and
- Any other individuals exempt by federal law who are aged 19-64 and with incomes up to 138% FPL.

Eligible and Services Delivered by TPA

(Subject to Premiums and Copayment)

ACA Adult

- Other newly eligible adults and parents under 138% FPL, aged 19-64.

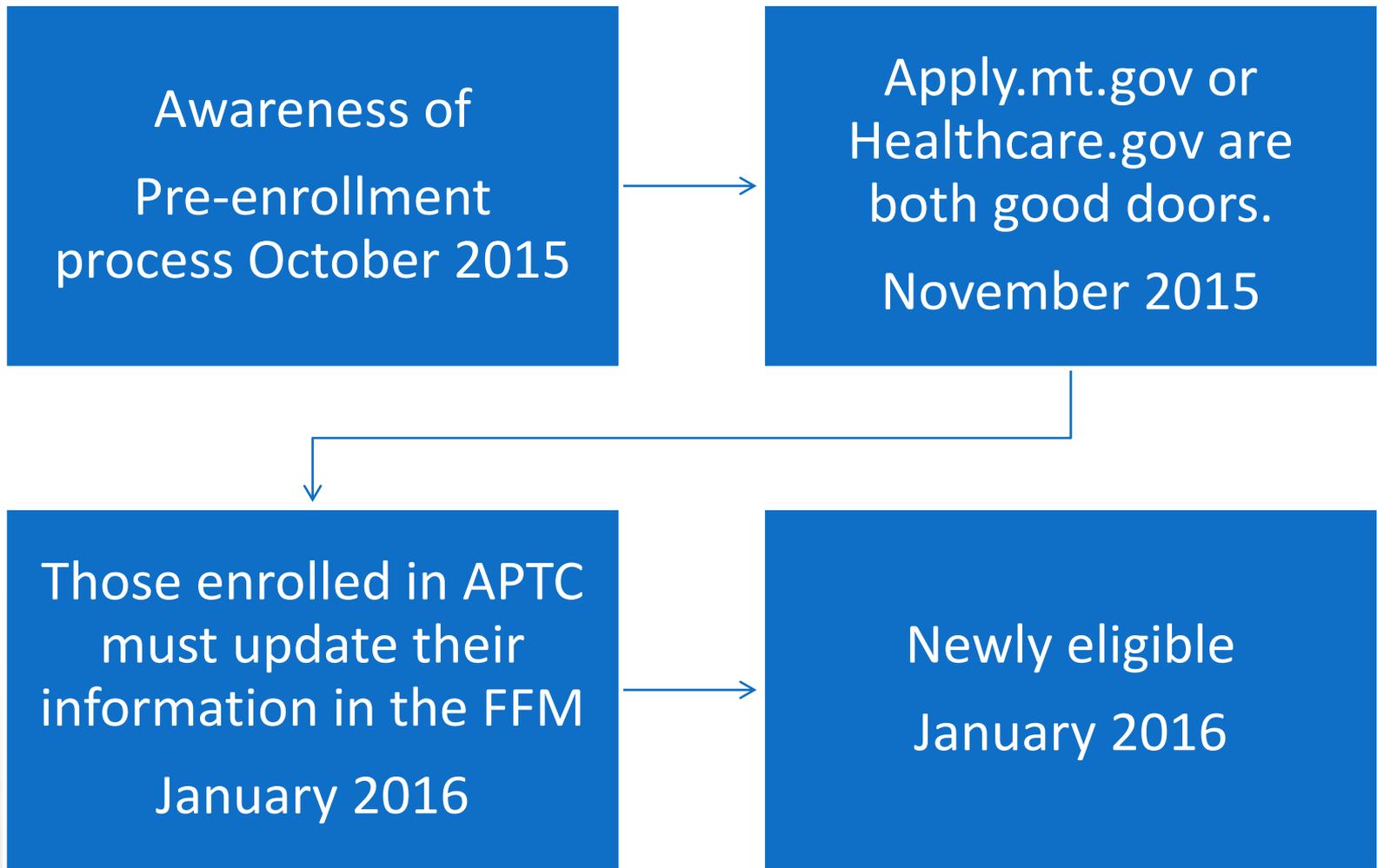
Workforce Assessment, Employment, and Training

Participation in job assessment and planning and wellness can earn exemption from disenrollment for those who earn 100-138% FPL.

All are eligible to participate in employment services assistance including those not subject to disenrollment.

Over 100% FPL
Under 100% FPL

What does this mean for CAC and navigators ?



Health Coverage Options: Pre-enrollment

What is Pre-enrollment?

Pre-enrollment is dependent on approval of the waiver by CMS.

Pre-enrollment will allow individuals to opt-in for coverage in 2016

- Pre-enrollment is allowed and supported by the federal Centers for Medicare and Medicaid (CMS)

A Pre-enrollment Health Coverage Option Notice is scheduled to be sent early October to eligible individuals on giving them the option to opt-in for benefits

Individuals can Pre-enroll by calling
1-844-792-2460 or through apply.mt.gov

After the individual opts-in, the system will automatically set up benefits and notify the individual via the About Your Case/Approval notice

Why Pre-enrollment?



It is allowed under federal law

Streamlined enrollment for eligible individuals, and already verified as eligible based on case and program data

Good news for the client and for staff

- Reduces work burden for staff related to new application processing for adding a program
 - Ease of use for client
-

Pre-enrollment Process

The Pre-enrollment process will contain three parts:

1

Identify individuals and send general notice for enrollment:

Individuals registered in CHIMES who are eligible for Medicaid Expansion benefits will be automatically identified by the system. The system will calculate a premium amount for each of these individuals, and a notice will be automatically sent with the premium amount details and an option to opt-in to receive coverage.

2

Collect Individual responses:

- Individuals can opt-in through apply.mt.gov or by calling # 1-844-792-2460.
- **The responses will be available monthly starting at the end of November.**

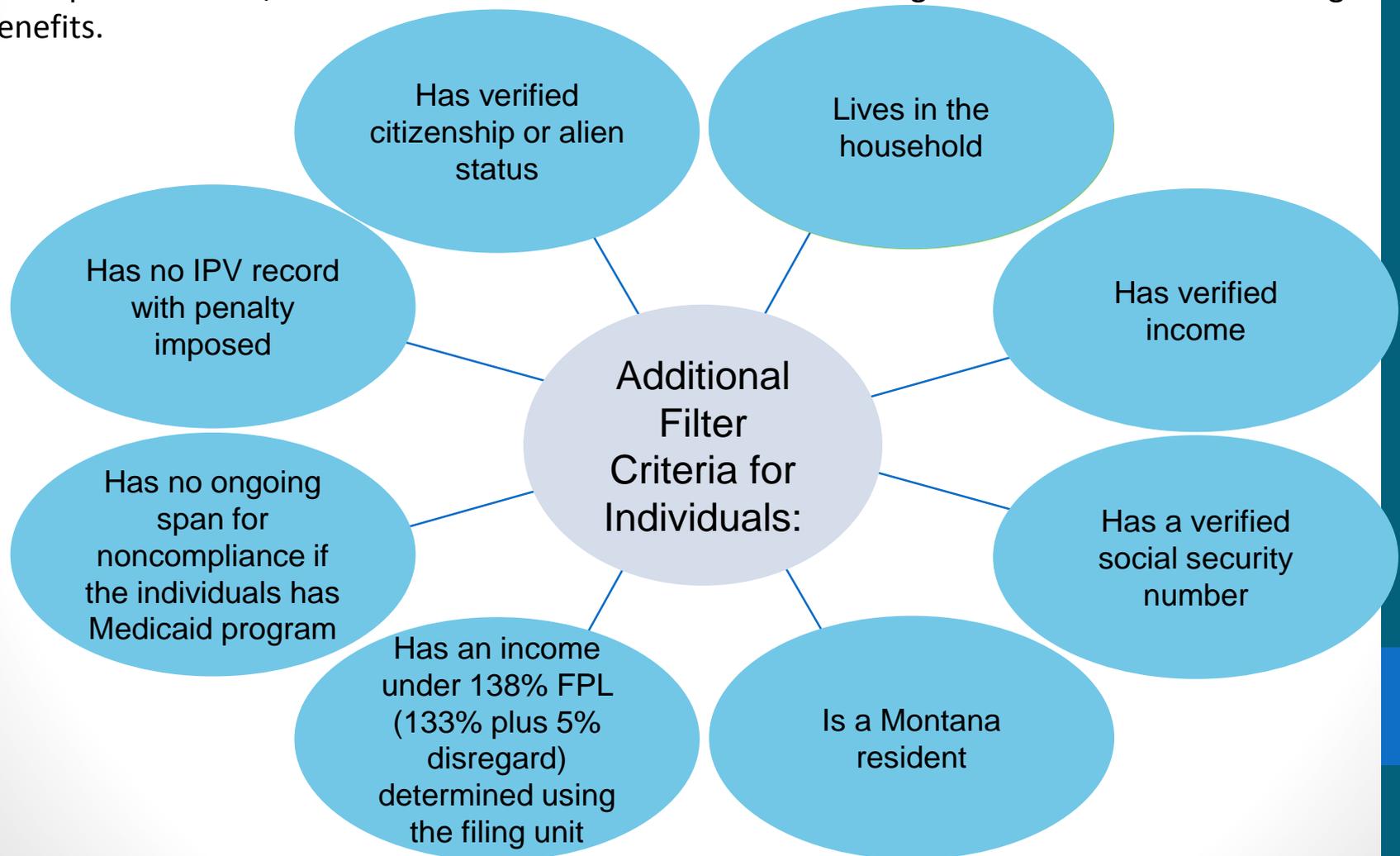
3

Set up benefits for individuals:

Benefits will be automatically processed for individuals who chose to opt-in.

Pre-enrollment Process - Filter Criteria

Individuals will be identified as eligible from existing and verified open SNAP/TANF cases or cases with open Medicaid/HMK that have at least one adult between ages 19-64 who is not receiving benefits.



Pre-enrollment Health Coverage Option Notice

The Pre- enrollment Health Coverage Option Notice will be sent automatically one time per household to the **Primary Individual** through *Correspondence* including the following:

Office of Public Assistance
PO BOX 202925
Helena, Montana 59620-2959



Steve Bullock
GOVERNOR

Richard H. Opper
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210

HELENA, MT 59604-4210

JOE SILVERSMITH
P.O. Box 123
Helena, MT 59601

Case #: 799596
Document #: 8537977
Print Date: 09/12/2015
Contact Phone: 1-888-706-1535

Pre-Enrollment Health Coverage Option

Dear JOE SILVERSMITH,

Good news, you or others in your household¹ have been identified as eligible for a new health coverage option that will soon be available in Montana.

Because your household currently participates in one of these programs - SNAP, Medicaid or Cash, it looks like the people listed below are income-eligible for a new health plan at a cost you can afford.²

The Montana Health and Economic Partnership Act makes health coverage more accessible in Montana. This new option, signed into law by Governor Bullock on April 29, 2015, includes essential healthcare benefits that include everything from doctor visits to hospitalization to prescriptions. You'll also have access to a variety of other services that will help you meet your medical needs.

You may sign up for health coverage by calling 1-844-792-2460 or going online to apply.mt.gov by January 31, 2016. To sign up, all you need is the Person ID listed below.

The Department of Public Health and Human Services expects expanded health coverage to be in place by January 1, 2016, but there are no guarantees. If you currently have health coverage, you should consider continuing your coverage until this new plan begins. If you receive health coverage through healthcare.gov, it is important to know that the open enrollment period with healthcare.gov is November 1, 2015 through January 31, 2016.

Under the new plan, eligible individuals and the monthly premiums are listed below. You may be responsible for small copays for some appointments, prescriptions, and other medical services.

Person Name	Person ID	Premium Amount
JOE SILVERSMITH	1234567	\$0.00
JANE SILVERSMITH	7654321	\$20.00

If you want more details about the process, please call 1-844-792-2460.

1

Request for eligible individuals to opt-in for benefits

2

Eligible start date

3

List of individuals eligible for Pre-enrollment

4

Premium amount

Timeline

Important next steps:

**The Pre-enrollment
Health Coverage
Option Notice is
scheduled to be
mailed out early
October**

**Benefits will be
automatically
set up in
CHIMES EA as
individuals
opt-in**

**The About
Your Case
Notice will be
automatically
sent out after
benefits are
set up in
CHIMES EA**

**The deadline to
opt-in will be
January 31, 2016**

What do 2016 plans look like?

Look for:

- Prescription drugs cost sharing
- Provider and mental health office visits-co-payments vs. coinsurance
- What can the consumer afford?
 - The premium is not the only factor
- Maximum out of pocket: (in 2016 - \$6,850 for an individual and \$13,700 for a family) – watch out for HSA compatible (maximum \$6550/\$13,100)
- New HMO plans in the market

Glossary of Terms

- **Cost-sharing** – Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include *deductibles, coinsurance* and *co-payments*. *Balance-billed* charges from *out-of-network physicians* are not considered cost-sharing.
- **Deductible** – A dollar amount that a patient must pay for health care services each year before the insurer will begin paying certain claims under a policy. Some health plans do not apply the deductible to certain kinds of claims, such as provider office visits.

Glossary of Terms

- **Out of pocket maximum** - An annual limitation on all *cost-sharing* for which patients are responsible under a health insurance plan. This limit does not apply to *premiums*, *balance-billed* charges from out of network health care providers or services that are not covered by the plan. The ACA limits the maximum out-of-pocket to \$6850 per individual and \$13,700 per family in 2016. These amounts are adjusted annually to account for the growth of health insurance *premiums*.
- **Coinsurance** - A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy, usually after the deductible is applied.
- **Co-payment** - A flat-dollar amount which a patient must pay when visiting a health care provider, sometimes before the deductible is applied.

Overview of Plan Comparison Chart

- Preventive services –not all are \$0
- Emergency Room services—additional cost sharing imposed
 - It is important for consumers to understand what an emergency medical condition is--don't go there unless you are certain.
 - The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A "prudent layperson" standard is applied.
- All this cost sharing is IN-NETWORK—OUT-OF-NETWORK is often four times higher
 - True emergencies are always treated as "in network."
- Out-of-network cost sharing is "tracked separately." It has a separate and much higher maximum out of pocket. Look to the SBC to see the out-of-network cost sharing.

Plan Comparison Chart, cont.

- Deductible and usually coinsurance always apply to in-patient services, but also to out-patient surgery, lab and diagnostic tests, emergency room services, some professional services services and sometimes drugs.
- In addition, there are sometimes “special” deductibles and copayments for certain services that insurers want to discourage, such as emergency room. These additional charges can be in addition to the regular deductible and coinsurance.
- However, none of these charges can add up to more than the maximum out-of-pocket.
- **The rate charts for all these plans are on our website at www.montanahealthanswers.com**

PacificSource

- Pacific Source has two networks: SmartHealth and PSN. SmartHealth is a more limited network, primarily in Billings and Missoula. The PSN plans offer a broader network.
- Pacific Source has two product lines for each network: balance and value.
 - All of the balance plans have pre-deductible, flat dollar copayments for office visits, including mental health, and for all prescription drug tiers.
 - All value plans have all services subject to a deductible before any payments are made by the insurer. However, the maximum out-of-pocket is lower.
 - For instance, you can choose a silver plan with a \$3,600 deductible and \$3,600 maximum out of pocket.
- Both the SmartHealth and PSN networks have a value and balance option.

Montana Health Coop (MHC)

- Montana Health Coop (MHC) has two networks: Access and Connected Care
- MHC has eliminated all platinum plans and has eliminated all pre-deductible copays for office visits, except in the gold plans.
- Connected Care is the more limited network, mainly in Billings and Missoula
- MHC has three product designs: Access, Connected Care and Connected Care “Plus”
 - Connected care “plus” is a deductible-only plan (including for drugs)—no coinsurance or copayments, but with a lower maximum out of pocket
 - For instance, in the gold connected care “plus” the consumer would pay \$2100 deductible before ANY services are covered (except mandated preventive); however, the maximum out-of-pocket is also \$2100

****What is a Co-op? - A non-profit health insurer** that is member-owned and operated. The ACA created co-ops and provided grants and loans to assist in the establishment to “start up” these new non-profits.

Blue Cross Blue Shield of MT (HCSC)

- BCBSMT (HCSC) PPO plans (gold, silver and bronze) and multi-state plans (which are basically the same as the PPO option). BCBSMT has fewer PPO plan offerings in 2016.
 - Pre-deductible copayments have been eliminated, but the plans (except bronze) still include three \$0 PCP visits, in addition to the \$0 preventive visits
- BCBSMT has added HMO plans in seven counties around Billings Clinic and Missoula Community Medical Center
 - Read these plans carefully to understand the consequences of going out of network
 - These plans include pre-deductible copayments for office visits

Things a Consumer Should Consider When Choosing a Plan

- Do I have health issues that may result in significant or frequent claims during the coming year?
- How much cost sharing can I afford?
 - Do I have \$6800 in a savings account to cover the cost of higher deductible health plan?
 - Is it better for me to choose a plan with a lower deductible and more up-front costs paid, at least in part?
 - Some plan options have copayments for office visits and drugs that are applied “pre-deductible.”
- Check the provider network for each insurer.
 - Are there enough primary care physicians or specialists available in my area? Do they take new patients?
 - Is my doctor in the network?
 - Is my town’s hospital in the network?

Considerations When Choosing a Plan cont.

- Do I need access to a high cost or specialty tier drugs?
 - Does this plan include that drug in their formulary? What is the cost-sharing for that drug?
- Do I travel out of state a lot or have family members that live out of state?
 - If so, evaluate that plan's "out-of-state" network.

****OUT-OF-NETWORK COST SHARING IS VERY HIGH**

- Consumers can link to the insurer's "summary of benefits and costs" (SBC) to obtain more detail about cost-sharing arrangements in each plan.
- In addition, www.montanahealthanswers.com now has a plan cost-sharing comparison chart for all marketplace plans.

NOT ALL SILVER HEALTH PLANS ARE CREATED EQUAL

- The ACA requires individual and small employer group health plans to be placed in “metal tiers” of the same actuarial value: platinum, gold, silver and bronze.
- However, there are numerous different health plans offered by the same issuer in each metal tier, each with significantly different cost sharing arrangements
 - For instance, deductibles in silver plans range from \$2000 to \$4100
- Higher deductibles may be combined with much lower other types of cost sharing, such as coinsurance and copayments
 - For some benefits, consumers pay only “pre-deductible” flat dollar copayments, i.e. out-patient

Silver Plans (cont.)

- Sometimes copayments are “pre-deductible”—But often they are not
- Consumers should evaluate all cost sharing options carefully, so they understand how the plan works before they purchase it
- Consumers must be reminded to stay “in-network”
- The “Summary of Benefits and Coverage” can help with that understanding
- The “same” actuarial value does not mean standardized cost sharing parameters

Always Look at the Drug Plan

- Does the consumer know they need a lot of drugs, or in particular high cost drugs?
 - Can they afford to pay the entire deductible before receiving any help paying for their drugs?
- Every insurer in the silver tier and above has at least one plan option that has “pre-deductible” copayments in the drug plan.
- All insurers are using pharmacy networks now—**check the network!**
- There is always an “exception” process, in addition to regular internal and external appeal.
 - May be expedited
- All drug plans are “managed” with tools such as “step therapy” and “tiering.”
 - Drug plans described on Montanahealthanswers.com

Glossary of Terms

- **Generic drugs** - the least expensive under a drug plan—a drug where the patent has expired and it is no longer only available as “brand name.” These are “tier one” drugs.
- **Preferred drug** - A drug formulary is a continually updated list of medications supported by current evidence-based medicine that encourages the use of safe, effective medications. Insurers often use the term “preferred drug” in their drug plans for these “brand name” drugs that are placed in “tier two” usually.
- Formulary development also includes elements of affordability—the most cost effective or lower priced drugs. Different brand name drugs may do the same thing, but the pricing on one is better than another. Formularies are updated quarterly—and changes are often driven by cost.
- **Non-preferred or non-formulary** - also brand name drugs - usually those that are more expensive than the preferred option, but treat the same illness or symptoms. Sometimes these drugs are also considered less effective or less safe.

Glossary of Terms, cont.

- Physicians may justify access to non-formulary drugs when medically necessary.
- Every drug plan has an “exception” process that allows the physician and the insured to approve the use of a different drug, but at the lower tier cost sharing.
- **Specialty Tier drugs** - Non-generic, brand name drugs that are used to treat complex or chronic conditions that usually require close monitoring, such as MS, hepatitis, rheumatoid arthritis, cancer and others. These drugs may require special handling and may need to be dispensed through a specialty pharmacy. These drugs are very expensive—often thousands of dollars for a 30 day supply. (\$600 to \$10,000+ for a 30 day supply)
- Insurers usually require prior authorization for these drugs.
- If authorization is denied, there is an exception process, followed by the normal internal and external appeal process.

Network Adequacy

- A new network adequacy law in Montana was effective October 1, 2013 for PPO plans. Most “network-type” health insurance plans, including dental and vision, sold in Montana are “PPO” plans.
- In May 2015, the CSI implemented new network adequacy administrative rules that further clarify how a network is determined “adequate.”
 - An adequate choice of necessary provider types, including mental health and pharmacies;
 - Provider to covered person ratios; available specialists; geographic accessibility; wait times for appointments;
 - If a specialist is not available to provide medically necessary care, the insurer must pay as if the service were provided “in-network.”

Network Adequacy cont.

- The rules require the provider directory to be searchable, accurate and updated monthly. Networks for different plans must be clearly designated.
- Consumers must be notified when a provider that they have accessed leaves the network.
- **Continuity of Care:** If a doctor leaves the network during the plan year, and if the consumer is in an “active course of treatment” for a serious disease or a pregnancy, the treating physician may seek to finish the course of treatment under the original contract terms of the provider contract, pursuant to the provisions of the administrative rule.

Network Adequacy Terms

- **Balance billing** - When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount. This is known as “balance billing.”
- **Out-of-network provider** - A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an HMO or PPO). The covered person will be required to pay a higher portion of the total costs (often 4 times higher) when he/she seeks care from an out-of-network provider (except for emergency services); plus they will pay the balance billing.

Mental Health Parity

- The Mental Health Parity and Addiction Equity Act of 2008 requires health insurance companies to cover mental health the same as physical health
- Health insurance companies cannot place more restrictions on mental health treatment or addiction disorder benefits than the restrictions they apply to physical illness, generally.
 - Also, cost-sharing cannot be higher; copayments and coinsurance must be the same as for physical illness
- Costs for mental health care can't have a separate deductible.
- This law originally only applied to large employer group health plans. However, the ACA expanded this law to all individual and small group employer health plans beginning on January 1, 2014.

Mental Health and Chemical Dependency

Individual and small group health insurance must include coverage for mental health and chemical dependency services:

- Behavioral health treatment, such as psychotherapy and counseling;
 - Mental and behavioral health inpatient services; and
 - Substance use disorder treatment.
- The dollar limits in the Montana insurance code for mental health and chemical dependency are preempted by operation of federal law.

Mental Health Parity and Addiction Equity Act

- Consumers need to understand their rights in this area
 - The law is still new and claims are not always processed correctly
 - A visit to a counselor, such as an LCSW or LCPC or psychologist is generally the equivalent of an “provider visit” such as a physician, PA or APRN and the same cost sharing should apply; i.e. a co-payment. Also the same types of preauthorization.

Insurers may not apply additional scrutiny to the payment of mental health claims. This is known as a “non-quantitative treatment limitation.” For instance, insurers may not:

- Require that every type of mental health out patient treatment be “pre-authorized;” or
- Require that treatment providers provide an excessive amount of justification for ongoing treatment such as out patient therapy.

Habilitative Services

HABILITATIVE AND REHABILITATIVE CARE DEFINITIONS

Habilitative:

Coverage will be provided for habilitative care services when the covered person requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) other services for people with disabilities. These services may be provided in a variety of inpatient and/or outpatient settings as prescribed by a Physician.

Rehabilitative

Coverage will be provided for rehabilitative care services when the covered person needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because a the Covered Person was sick, hurt or disabled. These services will include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) psychiatric rehabilitation. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

HABILITATIVE SERVICES, CONT.

- **Autism**—State mandate specifically includes “applied behavior analysis” treatment for children up age 18. [Mont. Code Ann. 33-22-515]
- **Downs Syndrome:** New in 2016, also includes speech therapy, occupational therapy, physical therapy and “intensive behavioral intervention” for covered children up to age 18. [Mont. Code Ann. 33-22-139]
 - Prescribes visit limits “up to” a certain number—52 or 104.

Pediatric Dental Benefits

- Dental and vision benefits for children under age 19 are a required part of the essential health benefit package.
- Lifetime and annual dollar limits cannot be applied to pediatric dental and vision benefits.
- No individual health plans sold inside the Montana marketplace offer embedded pediatric dental benefits—all are “9 ½ plans.”
 - A “stand-alone” pediatric dental plan must be sold with the 9 ½ health plan in order to make the package complete.
 - These plans are known as a certified stand-alone “qualified dental plans” (QDPs).
 - Some small employer group plans now have imbedded pediatric dental.

Pediatric Dental Benefits

- There are numerous stand-alone dental plan options offered in the marketplace. Sometimes those plans are combined with adult dental coverage, which are allowed to have annual dollar limits.
- Pediatric dental must have a “high” (85 %) or “low” (70 %) actuarial value and offer a maximum out-of-pocket of \$350/one child and \$ 700/two or more children.
- Pediatric dental rates may be “underwritten,” which means that sometimes the rate shown is “guaranteed” (not subject to underwriting) and sometimes the rate is subject to change (underwritten)—the rate may go up after the application is evaluated by the QDP.

Stand Alone Qualified Dental Plans (QDPs)

- None of QDPs sold in Montana have an “adequate” network
- The CSI has allowed two dental insurers to have a small cost sharing differential between in-network and out-of-network services.
- Consumers should be prepared to pay the out-of-network cost, including balance billing because very few dentists will sign network contracts.

Student Health Insurance

- **Student health plan coverage is considered “individual” coverage,** except that the rates are different than the rest of the individual market AND enrollment in the health plan is contingent upon maintaining student status.
- An offer of student health plan coverage is **NOT** a barrier to receiving tax credits on the exchange.
 - All university students have access to a student plan—in fact, the terms of their enrollment requires them to have coverage.
- Exchange coverage may be cheaper than student plan coverage (which currently is at a “gold plan” level), especially for students under age 21; or
 - If the student has income amounting 138% or more of FPL; or
 - If the individual prefers less generous coverage—bronze or even catastrophic coverage.
- Some students may be eligible for Medicaid expansion coverage.

Retiree Health Insurance

- Individuals who have retired before the age of 65 do not have to accept their retiree coverage and may enroll in the exchange and receive tax credits, if eligible.
- For instance, the state retiree coverage is quite expensive and those retirees may seek marketplace coverage.
 - BUT the marketplace coverage is different and may be less generous.
 - State retirees have a one-year period that will allow them to “go back” to the state plan—after that they may not return, even after they turn 65.
- The decision to switch can be complicated and involves financial decisions that may require advice from a licensed professional.

Over 65-year-olds

- Who are Medicare eligible may not enroll in individual coverage—on or off exchange.
 - Refer them to an insurance agent or SHIP counselor
- Depending on the plan type chosen, Medicare supplement insurance may provide lower cost-sharing than Medicare Advantage plans, BUT Medicare supplement is NOT guaranteed issue, except during the 6 month period after turning 65 (there are a few exceptions).
- Medicare Advantage has an open enrollment period every year: Oct. 15 to Dec. 7

Incarceration and Health Insurance

- If a person is “incarcerated,” he or she cannot buy private insurance, on the marketplace or otherwise.
 - Incarceration means serving a term in prison or jail; or in Montana, a pre-release center.
 - It does not mean probation, parole or in jail pending trial—not yet convicted.
- Upon release, the person becomes eligible for coverage and will have an SEP—60 days
- No individual penalty can be assessed during the period of incarceration
- When a person has been charged with a crime, but not convicted they may:
 - access the marketplace and keep individual coverage
 - be eligible for Medicaid

ACA Provisions for American Indians & Alaska Natives

The ACA includes provisions relevant to American Indians and Alaska Natives (AI/ANs) who are enrolled members of federally recognized tribes and who purchase coverage in the Marketplace, including:

- AI/ANs with household incomes below 300 percent of the federal poverty level who are enrolled in a Qualified Health Plan (QHP) offered through the individual Marketplace will not have to pay any cost-sharing;
- AI/Ans who qualify for \$0 cost-sharing may seek healthcare services anywhere. They do not need referrals from IHS

American Indians & Alaska Natives (cont.)

- The Marketplace will provide special monthly enrollment periods for AI/Ans who are enrolled tribal members; and
- All Indians who are eligible for IHS are exempt from the individual responsibility penalty
- Indian tribes, tribal organizations, and urban Indian organizations are allowed to pay the QHP premiums for qualified individuals, subject to terms and conditions set by the Marketplace.

Definition of Indian

- In relation to special monthly enrollment periods and \$0 cost-sharing, Indians must show proof of tribal membership
- That proof will consist of uploading, scanning or mailing a tribal membership card, or other electronic means to prove membership
- The exemption from the individual responsibility requirement does not require tribal membership—anyone who qualifies for Indian Health Services is exempt; but they must obtain and exemption letter for IHS.

Verification of Tribal Membership

- Only enrolled members of federally recognized tribes can receive the benefit of \$0 cost-sharing and monthly enrollment periods
- Proof of tribal membership must be received by the Marketplace within 90 days of insurance taking effect
 - Upload a tribal membership card
 - Mail copy of the membership card
 - Electronic tribal membership lists
- Healthcare.gov will only accept uploads as PDFs, not JPEGs
- **Most smart phones save images as JPEGs**
(If you use a smartphone to obtain a digital copy of your tribal membership card, you will need to convert it to a PDF)

Renewal Notices

- Scrutinize renewal notices because there are many significant benefit changes, and large rate increases.
- Some of these notices advise of “product withdrawal.”
- Existing plans (or a substitute plan) will be “auto-renewed” if the covered person takes no action and their tax credits will be continued at the same level—until the IRS updates its information.
 - If a product withdrawal, a substantially similar plan will be chosen by the issuer to replace the old plan.
- Tell individuals who did not buy plans in the Marketplace last year that they may be eligible for tax credits if they go to healthcare.gov.

*****IMPORTANT:** If an individual changes their health plan choice, they should notify their insurer, even though the Marketplace is supposed to do that

Update Information

- **Consumers need to update their financial information on the Marketplace website even if they want to keep their current plan;** this is one of the best ways to ensure that Medicaid expansion eligibility has been determined and/or the correct tax credit amount is received.
- Tax credit amounts are based on the cost of the 2nd lowest silver plan.
- Insureds will receive renewal notices from companies around November 1, including specific instructions on what to do if they want to keep the plan or change plans.
 - Some will receive notices that say the plan is no longer offered and they will be enrolled in another “similar” plan. Many times the benefits are significantly different.

Problems with Documentation Verification Regarding Income or Citizenship Status

- Coverage may be terminated if citizenship documentation is not submitted or is inadequate.
- Income documentation issues could result in loss of tax credits **but may not result in loss of coverage; the FFM may not terminate coverage for this reason either!**
- Insurers in Montana still have a duty to provide adequate notice of termination or a change in premium.
- **Report problems to the CSI!**

Protected Personal Information

- Social security numbers, personal financial information, protected health information and other identifying personal information may be exposed when an assister is helping an individual enroll in a health plan.
- This kind of information, including even name and address and birthdates, is known as “protected personal information”—PPI.
- Any person assisting with enrollment in the Marketplace has a legal duty to protect PPI.

You Must Protect and Secure PPI

- There are various state and federal laws that require the protection of PPI. We are focusing on the Montana law.
- Montana has the adopted the Insurance Information and Protection Act (IIPPA), which complies with the federal minimum privacy protections contained in the Graham Leach Bliley Act (GLBA).
- This Act applies to Certified Application Counselors and Navigators, as well as insurance producers.
- You may only disclose PPI to entities/individuals when it is required to complete an insurance transaction (such as an FFM application).
- All other disclosures require a written authorization from the individual.

Protected Personally Identifiable Information (PPI)

- Names
- Addresses
- Places of employment
- Incomes
- Credit histories
- Various account numbers
- Social security numbers
- Dates of birth
- Information contained on income tax returns
- Health information

Illegal Disclosure of PPI Includes, but is not limited to:

- **Careless disclosure:** accidentally leaving PPI where unauthorized individuals can see it;
 - Paper in a waste basket or on a desk
 - Leaving information visible on a computer terminal where others can see it
- **Oversharing**
 - Mentioning details of another individual's PPI in casual conversation with friends, family or neighbors.
 - All privacy laws require that the "minimum necessary" information be disclosed only to those authorized to receive it--Do not share PPI, unless that person "needs to know" in order to carry out job duties.
 - Navigators and CAC's are **not allowed** to keep PPI in their possession any longer than it takes to successfully assist with the enrollment of that individual in Marketplace coverage.
 - This information cannot be used for any other purpose, without the consent of the individual.

Fraud and Intentional Misuse of PPI – Criminal Acts

- Intentional misuse
 - Using another individual's PPI for private gain is a crime, which will be prosecuted by the commissioner's office or other law enforcement.
 - That crime can be punished by fines and jail sentences.
- **GUARD AGAINST FRAUD AT ALL TIMES**
 - Certified assisters must report to the commissioner's office any suspected misuse of PPI, including information about individuals who "pose" as legitimate assisters and are not properly certified.
- **WARN INDIVIDUALS NOT TO GIVE THEIR PPI TO INDIVIDUALS WHO ARE NOT CERTIFIED ASSISTERS AND LISTED ON THE COMMISSIONER'S WEBSITE.**
 - Immediately report any suspicious activity to the CSI

Do Not Engage in Unlicensed Activity

- Only licensed health insurance agents are allowed to “sell, solicit, or negotiate” insurance, which means that CAC’s and navigators may NOT:
 - receive compensation for “selling” a health plan,
 - “urge a person to buy” a particular health plan, or
 - “offer advice to a prospective purchaser concerning the substantive benefits, terms or conditions” of a particular health plan.

Do Not Engage in Unlicensed Activity

- CAC'S and Navigators may provide “enrollment assistance,” which includes:
 - helping a consumer navigate the marketplace website, and
 - Assisting with completion of the uniform application that determines a person's eligibility for Medicaid, HMK, premium assistance tax credits or cost-sharing reductions.
- Beyond that, CAC's and Navigators may only explain the decision-making points that an individual should consider when choosing a plan.
- CAC's and Navigators **MAY NOT**:
 - **recommend certain health insurers or health plans over others.**
 - offer financial advice or tax advice, especially to employers.

CONSEQUENCES OF UNLICENSED ACTIVITY AND CONFLICTS OF INTEREST

- A person who acts as an insurance producer without a license (sells, solicits or negotiates insurance, even without compensation from an insurer), may be subject to significant fines imposed by the insurance commissioner, or even criminal penalties.
- **Navigators and other types of assisters may not receive any compensation of any type of insurer. Such compensation creates a conflict of interest.**
- Navigators who receive any kind of compensation from any type of insurer, including “in-kind” compensation, will have their Navigator license revoked.

Navigators

- Exam requirement at Pearson Vue Center
- Time requirement for fingerprint/background check
- Continuing Education Requirement of 10 hours every 24 months
 - Check your certification expiration date
 - Courses must be MT approved CE through CSI
- producerlicensing@mt.gov
- Jeannie Keller, jkeller2@mt.gov

Questions?

1-800-332-6148

www.csimt.gov

www.MontanaHealthAnswers.com

 **@CSILindeen**

 **Commissioner Monica J. Lindeen**