

Making Health Care Reform Work for Montanans

Webinar 2 for marketplace assistors

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What we'll cover today:

- Montana specific information on Medicaid and Healthy Montana Kids eligibility
- American Indian ACA benefits
- Montana specific privacy laws
- Unlicensed producer activity and the consequences
- Background information on plan design structure and how to choose a plan
 - Deductibles and other cost-sharing
 - Financial and health considerations
 - Network Adequacy
 - Prescription drug formulary
 - Summary of Benefits and Coverage
- Multi-State Plans
- Autism and Mental Health Parity
- Stand-alone dental plans
- How to help people who aren't eligible

MEDICAID AND HEALTHY MONTANA KIDS ELIGIBILITY

Montana Department of Public Health and Human Services

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Medicaid Coverage Groups

- In order to be eligible for Medicaid an applicant must fit into one of the following coverage groups:
- Family Related
 - Family
 - Healthy Montana Kids Plus
 - Pregnancy
 - Healthy Montana Kids (CHIP)
- Aged, Blind, and Disabled (ABD)
 - Aged (65 or older)
 - Blind
 - Disabled
 - Must be determined blind or disabled using SSA criteria

Income Standards

- ACA standards are based on a household size of 4

Family	\$916/month	\$5,436/year
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HMK Plus	\$2,806/month	\$33,672/year
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Pregnancy	\$3,120/month	\$37,440/year
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HMK (CHIP)	\$5,122/month	\$61,466/year
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- Aged, Blind Disabled standard

\$710/month for an individual

\$1066/month for a couple

New to Medicaid

- No more resource test for Family Related Medicaid programs.
- Income calculations are based on IRS Tax code
- Filing Units are based on IRS Tax code
- Note: resource and income standards and calculations do not change for Aged, Blind, and Disabled programs

- Please encourage applicants to apply through the FFM at healthcare.gov
- The FFM offers real-time eligibility along with other affordable health care options if the applicant is ineligible for Medicaid.

Questions?

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ACA PROVISIONS FOR AMERICAN INDIANS & ALASKA NATIVES

ACA Provisions for American Indians & Alaska Natives

The ACA includes provisions relevant to American Indians and Alaska Natives (AI/ANs) purchasing 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;
- If an AI/AN is enrolled in a QHP and receives services directly from IHS, Indian tribe, tribal organization, urban Indian organization or through the Contract Health Service program, the individual will not have to pay any cost sharing for those services;
- The marketplace will provide special monthly enrollment periods for AI/ANs; and
- Indians who are eligible for IHS are exempt from the individual responsibility penalty

Tribes Paying Premiums

- The Marketplace may permit Indian tribes, tribal organizations, and urban Indian organizations 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.

Verification of Indian Status

- If an applicant attests that he or she is an Indian, the Marketplace must verify Indian status.
- The applicant has 90 days following an attestation on an application to provide proof of tribal membership.

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MONTANA PRIVACY LAWS

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 with enrollment in a marketplace.
- 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.
- Violations of this law may lead to penalties—up to a \$25,000 for each violation.
- You may only disclose PPI to entities/individuals when it is required to complete an insurance transaction.
- 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, even with other navigators, CAC's or producers, unless that person “needs to know” in order to carry out job duties.

Illegal Disclosure of PPI

Includes, but is not limited to:

- The following are examples of failing to secure PPI:
 - Your laptop is stolen. It does not have appropriate safeguards and the PPI is compromised.
 - If there is any breach of computer security, that breach must be reported to all individuals whose PPI was compromised immediately, even if no misuse of that information has occurred. Law enforcement should be informed.
 - You leave file drawers or desk drawers containing PPI unlocked. You leave papers out in the open on your desk and others are able to view them such as janitors, repair persons, etc.
- 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.

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 to the CSI any suspicious activity

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UNLICENSED PRODUCER ACTIVITY AND THE CONSEQUENCES

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.
- 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 (who 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 from 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 certification revoked.

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PLAN DESIGN STRUCTURE & HOW TO CHOOSE A PLAN

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 \$5000 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?
 - NOTE: Some plans have copayments for office visits 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 specialty drug?
 - 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" to obtain more detail about cost-sharing arrangements in each plan.

Network adequacy

- A new network adequacy law in Montana is effective October 1, 2013. Most “network-type” health insurance plans, including dental and vision, sold in Montana are “PPO” plans.
 - The consumer’s cost-sharing (i.e. deductibles, coinsurance, co-payments and maximum out-of-pocket) is increased if he/she seeks coverage from “out-of-network” healthcare providers. Consumer cost-sharing is substantially reduced or even eliminated (for preventive services) if that consumer seeks healthcare services “in-network.”
- The new law says that a provider network is “deemed” adequate if it includes 90 % of the hospitals and 80 % of the healthcare providers in the state.
- Below that threshold percentage, the commissioner may “determine” a network to be adequate.

Network Adequacy cont.

- Below that level, a maximum differential is applied: no more than 25 % cost-sharing difference that the consumer pays for out-of-network services.
- The commissioner will disapprove a network plan as “misleading” if there is no viable network.
- Cost-sharing differences between in and out-of-network are significant—as much as four times higher. Consumers should always check the insurer’s list of in-network providers before they choose a health plan.
- Many of the benefits of the ACA are based on “in-network” costs only.

Essential Community Providers

- The definition of essential community provider is a provider that serves predominantly low-income, medically underserved individuals.
- Marketplace issuers must offer provider contracts to all Indian health clinics
- The CSI has identified a list of essential community providers based upon the needs of Montanans—posted on the website.

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 \$1500 to \$6000
- Higher deductibles may be combined with much lower other types of cost sharing, such as coinsurance and copayments.
- Some benefits are paid “pre-deductible,” i.e. preventive services.

Silver Plans Continued

- Sometimes copayments are “pre-deductible.”
- Sometimes the out-of network cost-sharing is much higher in one health plan and lower in another issuer’s plan.
- Consumers should be advised to evaluate all cost-sharing options carefully, so they understand how the plan works before they purchase it.
- The “SBC” can help with that understanding.
- The “same” actuarial value does not mean standardized cost-sharing parameters.

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MULTI-STATE PLANS

Multi-State Plans

- Montana’s marketplace has a “multi-state” issuer offering multi-state health plans (MSPs) in the marketplace.
 - BCBSMT is the “multi-state” issuer.
- This plan is substantially similar to other BCBSMT health plans offered in the marketplace.
- One difference is that this health plan is under contract with the federal office of personnel management (OPM)

Multi-State Plans

- OPM reviews these plans, in addition to the review that the CSI conducts.
- The MSP is somewhat more regulated because of its contractual relationship with OPM.
 - Consumer complaints about the MSP plan are still referred to CSI. The CSI still approves forms, network adequacy and rates for these plans.
 - If there is a request for an external appeal from a consumer on a claim denial, that appeal must be referred to OPM.
 - OPM has their own external review process for MSP plans.
- This MSP has the same out of state “blue card” provider network as other BCBSMT non-MSP products

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MENTAL HEALTH PARITY

Mental Health Parity and Addiction Equity Act

- This federal law requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or addiction disorder benefits are no more restrictive than what is applied to physical illness generally.

Mental Health Parity and Addiction Equity Act, Cont.

- Formerly (since 2008) this law applied to large employer group health plans only.
- In 2014, it will apply to all individual and small employer group health plans also.
- The dollar limits in the Montana insurance code for mental health and chemical dependency are preempted by operation of federal law.

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AUTISM COVERAGE

Autism Coverage

Coverage must include:

- Habilitative or rehabilitative care that is prescribed, provided or ordered by a licensed physician or psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore to the maximum extent practicable, the functioning of the covered child;
- Medications;
- Psychiatric or psychological care; and
- Therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist.

Autism Coverage, cont.

- Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including applied behavior analysis, also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.
- Applied behavior analysis must be provided by an individual licensed by the behavior analyst certification board or is certified by DPHHS as a family support specialist with an autism endorsement. This therapy may be limited to children under the age of 18.

Autism Coverage, cont.

- Coverage for treatment of autism spectrum disorders may be limited to medically necessary treatment that is offered in connection with a treatment plan from a qualified physician.
- The dollar limits for autism coverage are preempted by operation of federal law.
- Montana' Autism statute provides protections for both employer group and individual market health insurance

STAND-ALONE DENTAL PLANS

Pediatric Dental Benefits

- Dental and vision benefits for children under age 19 are a required part of the essential health benefit package.
 - These benefits must be the same as those offered in the federal employee plan.
- Lifetime and annual dollar limits cannot be applied to pediatric dental and vision benefits.
- Not all health plans sold inside the marketplace offer embedded pediatric dental benefits—some 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 (QDP).

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 \$700/individual and \$1400/family.
- 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.

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WHAT TO TELL PEOPLE WHO AREN'T ELIGIBLE

Individuals who Fall into the Gap

- This “gap” refers to individuals who have income below 100 % of FPL, but do not qualify for traditional Medicaid or CHIP. These are the individuals who would have been covered by Medicaid expansion.
- There is no premium assistance available to these individuals, including most low-income childless adults.
- You may refer those individuals to federally qualified health clinics (see the website for the Montana Primary Care Association www.mtpca.org). At those clinics, individuals are able to receive primary health care on a sliding scale, with fees as low as \$10.
- These clinics may also provide access to certain prescription drugs at little to no cost, particularly for chronic diseases like high blood pressure.
- There are also “free clinics” available in some communities.
- American Indians may receive care at Indian health services for no charge.

KEY TAKE AWAYS TO REMEMBER

Who should you turn to when there are questions/issues:

Call or email the CSI, if a consumer has a complaint, question or issue concerning the conduct of:

- an insurer, including but not limited to: insurer-related enrollment issues, rating issues, claims not paid or not paid in a timely manner internal or external appeals of claims denials
- A producer, including but not limited to: unlicensed activity, misrepresentations, delays in submitting applications, or any other type of complaint
- General questions about how any type of insurance works

Call or email the FFM, if a consumer has a complaint, question or issue concerning:

- the marketplace website;
- A navigator or CAC (although the CSI will monitor those complaints also)
- Eligibility for premium assistance tax credits or other types of assistance:
 - Including questions relating to income projections
 - Appeals of eligibility determinations for tax credits
 - Affordability waivers (exemptions)

KEY TAKE AWAYS, CONT.

- Call or email DPHHS/Medicaid division:
 - Issues relating to Medicaid claims or providers
 - Issues relating to Medicaid eligibility

NOTE: ALWAYS advise individuals to apply through the marketplace portal, even if they believe they are Medicaid or HMK eligible. This practice may avoid significant technical delays later on.

Questions?

Call 1-800-332-6148

Or visit www.csi.mt.gov

www.montanahealthanswers.com