Navigating ACA Eligibility and Benefits Enrollment for the Uninsured

Prepared For:

hfma® tennessee chapter
healthcare financial management association

Chamberlin Edmonds®
an Endean company

This information is confidential. Due to the continual developments regarding ACA, the information detailed in this presentation is accurate as of 10/1/13.
Objectives

• Introduce Chamberlin Edmonds and Emdeon

• Present an overview of the ACA and the specific areas of focus related to self-pay eligibility and enrollment

• Highlight the specific impact of the ACA changes to hospitals

• Discuss the considerations and risks regarding your readiness to address the new ACA challenges

• Present Chamberlin Edmonds ACA preparations and solutions
Affordable Care Act
ACA Policy Highlights

1. Medicaid expansion
2. State by state choice
3. Health Insurance Marketplaces/Exchanges
4. Streamlined process
5. Navigators/Certified Application Counselors/In Person Assistance Personnel
6. Presumptive Eligibility
Expanding Medicaid & State Options

- State option to expand Medicaid programs which increases the number of eligible recipients
- States can opt in at a later date
- Decision is made by the legislative and executive branches of the individual state governments
- Alternative models are evolving
  - The Arkansas model (CMS approved)
    - Accepting federal funding
    - Target the same population of individuals
    - The program is provided via an insurance model; not the expansion of Medicaid

Streamlining the process for the expansion population:

- No medical disability requirement
- No asset test / income test only
- 0 – 138% FPL (technical 5% income disregard)
- No face to face appointment required
Key differences for Opt in vs. Opt out States

- **Opt in states**
  - All childless adults up to 138% of the FPL
  - Applying for SSI on disabled patients still provides value to the patient and some value to the hospital, but not needed to gain standard Medicaid coverage
  - An opt-in state may choose to tighten Medicaid eligibility requirement to shift part of the population to the Exchange or Marketplace.

- **Opt out states**
  - Federal funding of Medicaid remains the same
  - Disability remains the only option for childless adults with incomes at or below 100% of FPL
  - An opt-out state might choose to tighten Medicaid eligibility for adults due to revenue constraints
  - States may decide to opt-in late in the game resulting in more changes to address for hospitals

- **Decisions are evolving continually**
  - 26 states have opted-in (includes DC)
  - 21 have opted-out
  - 4 states are still in debate
  - Tennessee, Pennsylvania and Indiana are interested in a slightly different model; Arkansas "Premium Assistance for Medicaid"
State Participation in Medicaid Expansion

- **Opt-in at this time**: WA, OR, MT, ND, ME, VT, PA, MI, NY, MA, CT, MD, DE, NV, CA, UT, CO, KS, MO, IL, IA, IN, OH, WV, VA, SC, NC, FL, AL, GA, TN, AK, HI
- **Opt-out at this time**: HI, AK, WY, SD, NE, KS, MO, IL, IA, IN, OH, WV, VA, SC, NC, FL, AL, GA, TN
- **Debate ongoing**: RI, NH
Affordable Insurance Exchanges

• Competitive private health insurance markets through the creation of Affordable Insurance Exchanges
• Launches October 2013 - provides ‘one-stop shopping’ for affordable coverage
• Uninsured individuals over the 138% FPL should use exchanges
• Limited enrollment – only during open enrollment period
  ▪ October 1, 2013 – December 31, 2013 – Preliminary enrollment period
    – If completed by December 15th, coverage will begin on January 1, 2014
  ▪ January 1, 2014 – March 31, 2014 – Bonus enrollment period
    – No retro coverage, begins the month after enrollment

Three types of public exchanges

- State based exchange
- State partnership exchange - Illinois
- Federally facilitated exchange
State Participation in the Exchange

- **Federal exchange (27)**
- **State-based exchange (17 including DC)**
- **Planning for partnership exchange (7)**

Source: www.healthcare.gov, July 2013
Key Functions of Assistance Personnel

- All functions require:
  - Up to 30 hours training
  - Testing
  - Certification & Recertification
  - Disclosure of any potential conflicts of interest
  - Agree to comply with standards
  - Act in the best interest of the applicant

- Exclusions:
  - Persons who are paid by QHP for enrollment
Streamlined Exchanges

All states will be utilizing the Health Insurance Exchange to enroll people in Medicaid and the subsidized insurance products.

- Web portals
- Simplified application and electronic submission
- Ease of access – available online and in person
- Applications will be able to be taken by phone – no face to face meeting is required
- Electronic verification of income and citizenship is accepted
- No asset test needed for MAGI Medicaid programs (other than disability and long term care)

Insurance under the ACA

- Patients can only enroll during Open Enrollment period – Oct ‘13 – March ‘14
- Insurance becomes effective beginning of the month after enrollment for those that enroll 1st – 15th, beginning the following month for those that enroll 16th – 31st.
Delivered on multiple devices - CEA’s Advocate Technology Application ensures your hospital has access to the data it needs through bi-directional integration to the portals and your HIS system.

1. Gain integrated access to the data your hospital needs
2. No double data entry
3. Complete performance reporting and tracking
4. Audit management trail

Federal Data Hub

• Eligibility Results
• User data

Patient/Performance Data

Hospital HIS System

Demographics

CEA PACE System

Real time

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Premium Tax Credits in Insurance Marketplaces

Eligibility for premium assistance.

• Eligibility for premium assistance:
  
  ▪ Must be a part of a tax-filing unit (individual or family - must file)
  ▪ Must enroll in a marketplace plan
  ▪ With household income at or above 100% of FPL, but not more than 400% of the FPL (household income is measured by Modified Adjusted Gross income (MAGI))
  ▪ Must be lawfully residing in the US and not be incarcerated (to receive premium assistance or to even buy on the marketplace)
  ▪ Citizen family members or family members of an incarcerated individual may access the marketplace and receive premium tax subsidies

• Must NOT be eligible for “minimum essential coverage” including but not limited to Medicaid, Medicare Part A, CHIP, Tricare, employer sponsored plans

• If employer coverage is not affordable (would exceed 9.5% of household income) or does not provide minimum value (covers less than 60% of total allowed costs), then individual or family can access the marketplace and receive premium subsidies
Premium Tax Credits in Insurance Marketplaces

• The amount of the premium tax credit will vary depending on household income and the amount of the premium.

• The amount of the premium is based on enrollee’s age, the price of medical goods or services in a geographic area, the breadth of the provider network, how out of network services are provided, drug formularies and prior authorization requirements and other factors.

• The amount paid by the enrollee is capped as a percent of household income.

• The premium credit provided to enrollees is calculated off the premium for the second lowest “silver” plan in the relevant marketplace (families can use that $$ to buy any plan).
Maximum Percentage of Income

Measured by FPL to go toward premium contributions.

Source: Congressional Research Service – Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) July 31, 2013
### Monthly Required Premium Contributions

*Contributions based upon family size, and if premium credits were available in 2013.*

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*Applicable percentages

**SOURCE:** Congressional Research Service – Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) July 31, 2013
How Federal Subsidies to Purchase Private Insurance Work

Premium Tax Credits
(available to people with income between 100 and 400% FPL)

APPLICATION
Person applies for premium tax credit and cost-sharing reductions during exchange open enrollment periods. Income verification via the HUB or with most recent tax returns or other documentation of income (e.g. pay stubs).

Applicant must elect to receive the premium tax credit in advance.

PAYMENT
Premium tax credit is paid in advance on a monthly basis directly to the health plan. Payment amounts are based on income, with an individual expected to pay between 2 and 9.5% of income toward premiums and the tax credit making up the difference.

Cost-Sharing Reductions
(available to people with income between 100 and 250% FPL)

PAYMENT
Cost sharing reductions mean that plans pay a greater amount of the covered costs, taking that burden off of the enrollee. The cost sharing subsidies are paid directly to the plan.

RECONCILIATION
When the person files a tax return for the actual year in which he/she received the tax credit, underpayments or overpayments are reconciled (overpayments are capped based on income).

SOURCE: NASTAD, Health Reform Issue Brief, June 2013
Presumptive Eligibility

The final federal regulations governing Presumptive Eligibility were released July 5, 2013. Attention now turns to the states to promulgate guidance and standards for implementation and oversight. Early discussions lead us to believe the following are likely scenarios.

- Hospitals will be able to ask the state for certification as a ‘qualified entity’ to do Presumptive Eligibility for pregnant women, children and caretaker adults categorical Medicaid eligibility groups
- At state option, Presumptive eligibility may be available for the adult expansion group and even disability based groups
- Medicaid enrollment utilizing Presumptive Eligibility will be available while a patient is receiving care from the hospital
- Hospitals will be able to bill based on Presumptive Eligibility determination
- Patients will be able to verbally attest to their income
- Patients will be required to complete their application by following up via the Medicaid or Exchange portal or other application modality and provide any necessary documents
- Hospitals may lose the ability to enroll patients presumptively if adequate follow-up to a complete application is not done
Optimal Process for New Hospital Presumptive Eligibility Opportunity

**Single streamlined application is an application that anyone can fill out for health coverage. It can be done in-person, online, or on the phone. The application connects the individual and their family to Medicaid, CHIP, insurance affordability programs, or individual and family coverage.**

**Source:** Enroll America | Best Practices Institute
Detailed Process Flow for Presumptive Eligibility

CEA’s experience providing services in states that permit this functionality today would indicate this process will be close to the Go Live process in January, 2014.

**Day One**
- CEA interview patient
- CEA completes form for presumptive Medicaid for MAGI only categories
- CEA sends completed form to Medicaid
- CEA continues to interview patient for “Full Medicaid” application

**Week One**
- Medicaid receives presumptive application and processes same
- Patient Medicaid number is received by CEA
- CEA notifies hospital billing with change in financial indicator
- Hospital bills Medicaid

**Audit Phase**
- Hospital receives notice of audit – remote or onsite
- CEA prepares reports associated with:
  - Applications taken for Presumptive
  - Application completed for Presumptive
  - “Full Medicaid” applications completed
  - Patients approved / denied for Medicaid
What is CEA Doing to Prepare?

• A dedicated ACA team
  ▪ Ongoing meetings with key customers
  ▪ Researching daily regarding developments and implications of same
• Cook County 1115 waiver experience
• Certified Application Counselor & Application Organization
  ▪ CMS
  ▪ Several state Exchanges
• Updating/expanding application software & delivery methods

Our Goals

• Stay abreast of the evolving regulations related to eligibility benefits and enrollment
• Interpret the regulations and help our customers understand what they need to do to be ready
• Identify key risks and considerations
• Develop products and services to address the evolving requirements of the ACA
C.E.A. Today

- Full service eligibility and enrollment provider specializing in federal, state and local assistance programs
- Over 1,200 employed professionals
  - ~80% are directly involved in taking and resolving applications
    - 88% degreed professionals
    - 43% bilingual
- Headquartered in Atlanta, GA with over 370 customers in 34 states
  - Unique perspective gained from experience with diverse customer base (safety net, academic teaching, community & systems)
  - Extensive experience with major urban safety-net systems (Jackson Health, Cook County Health & Hospital System, Parkland Health & Hospital System, Denver Health, Boston Medical Center, UMDNJ)
- In 2013, we will:
  - Submit approximately 350,000 applications
  - Recover more than $1.4 billion in cash remittances for hospitals
  - Generate over $130 million in cash payments to patients
  - Contact agencies over 510,000 times in pursuit of approvals
  - Scan/digitize over 10.4 million pages to facilitate efficient communication, faster cycle times and reduce paper use and associated costs
  - Become a multi-state Certified Application Organization and certify patient-facing staff as Application Counselors
  - Successfully integrate with both the state and federal marketplaces
Quality, Referenceable Customer Base

*CEA works with a wide spectrum of provider types throughout all regions of the United States.*

**Broad Spectrum of Providers**
- Single-site hospitals, healthcare systems and integrated delivery systems
- Academic medical centers (~25%)
- Large urban safety net hospitals/healthcare systems (~20%)
- Not-for-profit hospitals
- Medicaid managed care organizations
  - Over 1 million lives under contract
- State/municipal governments
  - Winner of The National Association of Counties’ Achievement Award

**Premier Customer Base**

Our Strategic Partner

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Questions/Comments