

# National Indian Health Board

## Health Insurance Overview

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# Health Insurance Basics Overview

- Explanation of Health Insurance for AI/AN
  - How it works
  - Options for Health Insurance in the Private Market
  - Additional Health Coverage Options
- Health Insurance Terminology and Information

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# Overview of Health Insurance

- For AI/AN consumers, health care can be accessed through the Indian Health system, job-based health insurance plans, or they can buy insurance themselves from an insurance company.
- If AI/AN consumers have to buy insurance on their own, many kinds of private health insurance policies are for sale. Different kinds of policies can offer very different kinds of benefits and can limit consumers' access to some doctors, hospitals, or other providers.
- The kinds of benefits and which care providers consumers' policies cover can make a big difference in their costs and the quality of care they get if they become ill.

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# IHS is Not Health Insurance

- IHS provides many health care services, but it does not cover all health care needs.
- Often IHS does not provide specialty care due to lack of resources or funding.
- AI/AN consumers should check to see if their local I/T/U clinic is included in their health insurance provider network, also known as “in-network providers.”

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# Options for Health Insurance in the Private Market for AI/AN: At-A-Glance

Health Insurance  
Inside the  
Marketplace

Health Insurance  
Outside the  
Marketplace

Job-Based  
Insurance

Insurance Under a  
Parent's Policy

Tribally-  
Sponsored Health  
Insurance



# Common Health Insurance Terminology and Information

- Some IHS, Tribal, and Urban (I/T/Us) may be known by many different names, familiarize yourself with the local facilities within the Indian Health System.
- Likewise, it is important to know the appropriate state-based names for Medicaid, Medicare, and the Children's Health Insurance Program (CHIP) within the State.

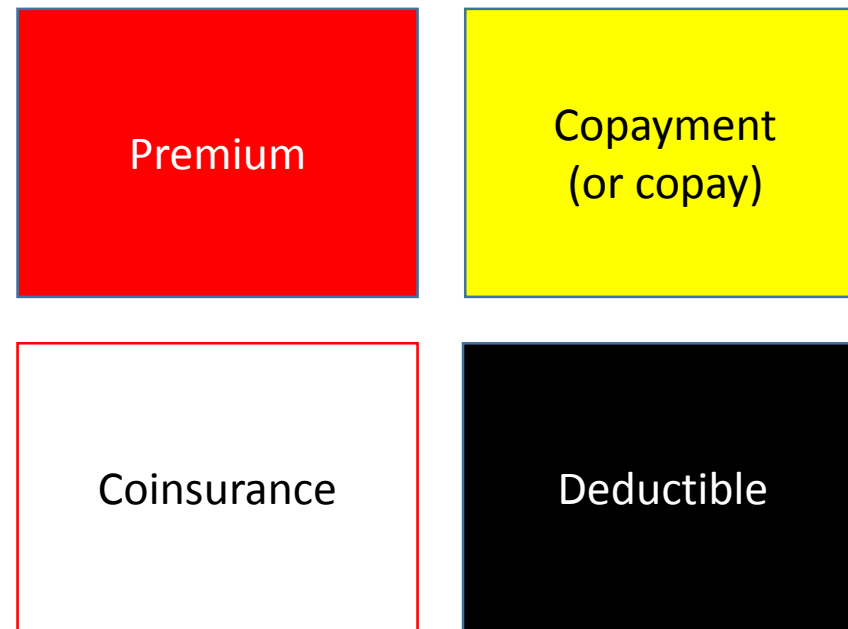
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# Common Health Insurance Terminology and Information: At-A-Glance

**Cost Associated with Health Insurance:** AI/AN consumers with the right health coverage, need to make sure they understand the terms related to health insurance costs.



# Common Health Insurance Terminology and Information

- **Premium:** Premium is the amount that must be paid to a health insurance company for a health insurance plan. Consumers and/or their employers usually pay it monthly, quarterly, or yearly.
- **Copayment (or copay):** Copayment is a fixed amount (e.g. \$15) consumers pay for a covered health care service, usually at the time of service. The amount can vary by the type of covered service, such as seeing a doctor, filling a prescription, or going to the emergency room. Remember that copays for in-network providers are typically lower than for out-of-network providers. IHS will continue to not charge copayments for services.

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### Copayment Plans

These are not deductible health insurance plans. Set copayments are established for covered benefits.

## Health Insurance Plans

### Low to Mid Range Deductible Plans

These Low Deductible Health Plans and mid-range Deductible Health Plans often include some benefits such as office visits and prescription drug coverage before the deductible is reached.

### High Deductible Health Plans

These High Deductible Health Plans (HDHP) usually offer the lowest premiums. Often, they are not qualified so you can open a Health Savings Account or other so be able to deduct qualified medical expenses from your federal taxes.

# Common Health Insurance Terminology and Information

- **Deductible:** Deductible is the amount that a consumer owes before the health insurance plan begins to pay. For example, if a consumers' deductible is \$1,000, the plan won't pay anything until the consumer has met his or her \$1,000 deductible for covered health care services. Some health care services may be covered by the health plan even if the consumer hasn't met the deductible. Premiums and copays don't count toward the deductible.
- **Coinsurance:** Coinsurance is a consumers' share of the cost of a covered health care service, calculated as a percent of the amount allowed by the health plan for that service. A consumer pays coinsurance plus any deductibles that are owed. For example, if the health insurance plan's allowed amount for an office visit is \$100 and a consumer has met his or her deductible, the coinsurance payment of 20% would be \$20. The health insurance play pays the rest of the amount owed.

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# What Services Does my Health Insurance Benefit include?



# Benefit Highlights

OUT-OF-AREA 90/10 PPO					
Deductible*	<b>Benefit Band</b>	<b>UPMC Health Plan, PHCS, and MultiPlan Network** (ind./family)</b>		<b>Out-of-Network** (ind./family)</b>	
	<b>Hourly Rate</b>				
	<b>A</b> below \$14.43	\$200/\$400		\$800/\$1,600	
	<b>B</b> \$14.43 - \$28.84	\$300/\$600		\$900/\$1,800	
	<b>C</b> above \$28.84	\$400/\$800		\$1,000/\$2,000	
Coinsurance	<b>UPMC Health Plan, PHCS, and MultiPlan Network</b>		<b>Out-of-Network</b>		
	Your responsibility	10%		40%	
	UPMC	90%		60%	
Out-of-Pocket Maximum	<b>Benefit Band</b>	<b>UPMC Health Plan, PHCS, and MultiPlan Network** (ind./family)</b>		<b>Out-of-Network** (ind./family)</b>	
	<b>Hourly Rate</b>				
	<b>A</b> below \$14.43	\$1,000/\$2,000		\$3,000/\$6,000	
	<b>B</b> \$14.43 - \$28.84	\$1,500/\$3,000		\$3,500/\$7,000	
	<b>C</b> above \$28.84	\$2,000/\$4,000		\$4,000/\$8,000	
Copay Services	<b>Service</b>	<b>UPMC Health Plan, PHCS, and MultiPlan Network</b>			
	PCP Sick Visit	\$20			
	Specialist/Urgent Care Visit	\$40			
	Emergency Room Visit	\$100			
Prescription Drugs	<b>30-day supply</b>		<b>90-day supply</b>		
	Generic	\$15		\$30	
	Preferred Brand	\$40		\$80	
	Non-Preferred Brand	\$80		\$160	
Employee Contributions (Per-Pay)		<b>Full-time, biweekly</b>	<b>Full-time, monthly</b>	<b>Part-time &amp; Job Share, biweekly</b>	<b>Part-time &amp; Job Share, monthly</b>
	Employee Only	\$41.54	\$90.00	\$114.46	\$248.00
	Employee and Child(ren)	\$78.46	\$170.00	\$217.38	\$471.00
	Employee and Spouse	\$101.54	\$220.00	\$281.54	\$610.00
	Employee and Family	\$108.92	\$236.00	\$300.92	\$652.00

\* The deductible has been designed to assist employees at all levels so everyone can afford health care coverage. A snapshot of your UPMC base pay-rate (effective two weeks prior to Open Enrollment) determines the deductible and out-of-pocket maximum Benefit Band that applies to you for the following year.

\*\* Assumes all Take a Healthy Step requirements have been met and \$1,000 individual/\$2,000 family credit applied toward the deductible.

# Marketplace Basics Overview

- Introduction and Explanation of the Marketplace
- Qualified Health Plans (QHP)
- Essential Health Benefits
- Eligibility & Enrollment

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# Introduction to the Marketplace

- The Marketplace is a resource where AI/AN consumers, families, and tribal businesses and entities can learn about their health coverage options, compare health insurance plans based on costs and benefits, choose a plan, and enroll in health insurance.
- The insurance plans offered in the Marketplace are called qualified health plans (QHPs). The Marketplace certifies each QHP that is sold in a state. The certification of a QHP means that the plan provides a comprehensive benefits package (known as essential health benefits), follows limits on cost-sharing for consumers, and meets other Marketplace requirements.



# How the Marketplace Works



## Create an account

First provide some basic information. Then choose a user name, password, and security questions for added protection.

## Apply

Starting October 1, 2013 you'll enter information about you and your family, including your income, household size, and more.

Visit [HealthCare.gov](http://HealthCare.gov) to get a checklist to help you gather the information you'll need.

## Pick a plan

Next you'll see all the plans and programs you're eligible for and compare them side-by-side.

You'll also find out if you can get lower costs on monthly premiums and out-of-pocket costs.

## Enroll

Choose a plan that meets your needs and enroll!

Coverage starts as soon as January 1, 2014.



NEED HELP NAVIGATING THE MARKETPLACE?  
CALL (215)355-2121 OR LOG ON TO  
[WWW.TOTALBENEFITS.NET](http://WWW.TOTALBENEFITS.NET)



CMS Product No. 11671  
June 2013

- The Marketplace also provides information on programs that help AI/AN consumers pay for coverage, including ways to save on monthly premiums and out-of-pocket costs. It also provides information on programs such as Medicaid and the Children's Health Insurance Program (CHIP).
- The Marketplace can be a one-stop online shopping site where individuals or small businesses (50 employees or less) can purchase private or public health insurance coverage.
- Consumers can do online comparison-shopping and look at a variety of plans with different benefits and costs.



# Health insurance marketplace

Enrollment starts in October 2013

## Important tip:

If you meet the criteria, you might be able to get a subsidy or tax credit to help you pay for your health plan.

ABC Health Insurance



## New choices when shopping for health insurance

A health insurance marketplace (also known as exchanges) is run by the state or federal government. Each health care company available at the marketplace offers their own set of plans which include a basic set of essential health benefits. Consumers and small businesses can compare plans side-by-side and pick the plan that works for them.

The marketplace is a new way to shop, compare and buy plans.

We can pick the plan that fits us by choosing from four levels of coverage from different health care companies.

 **Platinum**

 **Silver**

 **Gold**

 **Bronze**

The bronze plan costs less, but when you get care you pay more. You pay more for the platinum plan, but it costs less when you get care.

XYZ Health Insurance



123 Health Insurance



# Consumer Assistance Entities

- Navigators
- Non Navigators assistance personnel (also known as in-person assistance personnel)
- Certified application Counselors (CAC'S)
- Agents and brokers



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# Assistance through the Marketplace

	<b>Navigators</b>	<b>Non-Navigator assistance personnel</b>	<b>Certified Application Counselors</b>	<b>Agents and Brokers</b>
State-based Marketplace	Yes	Optional for states	Yes	Optional for states
State Partnership Marketplace	Yes	Yes	Yes	Yes, if state permits it
Federally-Facilitated Marketplace	Yes	Yes	Yes	Yes, if state permits it

# Training and Certification Required

	<b>Navigators</b>	<b>Non-Navigator assistance personnel</b>	<b>Certified Application Counselors</b>	<b>Agents and Brokers</b>
State-based Marketplace	State training & certification (state may choose to use federal training)	State training & certification (state may choose to use federal training)	State training & certification (state may choose to use federal training)	State training & certification (state may choose to use federal training)
State Partnership Marketplace	Federal training & certification, which may be supplemented by the state	Federal training & certification, which may be supplemented by the state	Federal training & designation of organizations, which may be supplemented by the state	Federal training & registration
Federally-Facilitated Marketplace	Federal training & certification	Federal training & certification	Federal training & designation of organizations	Federal training & registration

# Premium Tax Credits

- Premium tax credits may be available through the Marketplace for consumers that aren't eligible for other health coverage programs. These tax credits can lower consumers' monthly premium in a qualified health plan through the Marketplace. These premium tax credits are administered through the IRS and the Marketplace.
- The premium tax credits can be applied in two different ways:
  - The value of the tax credit be paid directly to the health insurance company and immediately lower monthly premiums. This is known as the "advance premium tax credit." Any amount of advance premium tax credit paid in advance are adjusted on consumers' tax returns at the end of the year
  - The consumer may also receive the premium tax credit as a refund when they file their federal income taxes.
- Premium tax credits are based on the cost of the second lowest silver plan available to the consumer. These tax credits can be applied to bronze plans, if the consumer is a member of a federally recognized tribe.
  - Please be aware that this premium tax credit can be greater than the cost of premiums in bronze plans – resulting in a "free plan." If this occurs, consumers will need to create a contract with the appropriate insurance company to ensure that they are covered.



Number of people in your household

		1	2	3	4	5	6
Private Marketplace health plans	You may qualify for <b>lower premiums on a Marketplace insurance plan</b> if your yearly income is between...  <i>See next row if your income is at the lower end of this range.</i>	\$11,490 - \$45,960	\$15,510 - \$62,040	\$19,530 - \$78,120	\$23,550 - \$94,200	\$27,570 - \$110,280	\$31,590 - \$126,360
	You may qualify for <b>lower premiums AND lower out-of-pocket costs for Marketplace insurance</b> if your yearly income is between...	\$11,490 - \$28,725	\$15,510 - \$38,775	\$19,530 - \$48,825	\$23,550 - \$58,875	\$27,570 - \$68,925	\$31,590 - \$78,975
Medicaid coverage	If your state <b>is</b> expanding Medicaid in 2014: You may qualify for <b>Medicaid coverage</b> if your yearly income is below...	\$16,105	\$21,707	\$27,310	\$32,913	\$38,516	\$44,119
	If your state <b>isn't</b> expanding Medicaid: <b>You may not qualify for any Marketplace savings programs</b> if your yearly income is below...	\$11,490	\$15,510	\$19,530	\$23,550	\$27,570	\$31,590

# Premium Tax Credits

- Eligibility Requirements for Premium Tax Credits
  - In order to qualify, consumers must file federal income taxes annually. In order for a married couple to qualify for this tax credit, they must file their federal income taxes jointly.
  - Consumers need to have household incomes of at least 100% but no more than 400% of the FPL.
  - Consumers have to enroll in a qualified health plan through the Marketplace. Please note that in areas where direct enrollment is occurring, consumers are still eligible for premium tax credits.
  - Consumers must also be ineligible for minimum essential coverage through public programs (Medicaid/CHIP) or from their employers.
- Eligibility for premium tax credits is determined when consumers apply or seek for an eligibility determination for programs to help lower their costs, and if they are found eligible to enroll in a qualified health plan in the Marketplace. Enrollment assisters should ensure that consumer are aware of the price differences and how premium tax credits will lower their costs.



# Premium Tax Credits

- Tax Implications of Advance Premium Tax Credits
  - While consumers may choose to have their tax credits paid directly to the appropriate health insurance company, they will be responsible for reconciling payments on their federal income tax returns at the end of the year.
    - Consumers that make more than expected at the time they applied for the premium tax credit will need to **repay** the extra amount when they file their annual federal income tax return.
    - Consumers who make less money than expected at the time they applied for the premium tax credit can receive additional tax credits on their federal income tax returns.

# Why Does Household Income Matter?

(All FPL statistics are for contiguous 48 States, excluding AK/HI)

People in Family	100% FPL (in household income)	138% FPL (Medicaid Expansion)	200% FPL (CHIP)	300% FPL (Zero Cost Sharing Plan)	400% FPL (APTC)
1	\$11,670	\$16,105	\$23,340	\$35,010	\$46,680
2	\$15,730	\$21,707	\$31,460	\$47,190	\$62,920
3	\$19,790	\$27,310	\$39,580	\$59,370	\$79,160
4	\$23,850	\$32,913	\$47,700	\$71,550	\$95,400
5	\$27,910	\$38,515	\$55,820	\$83,730	\$111,640
6	\$31,970	\$44,119	\$63,940	\$95,910	\$127,880
7	\$36,030	\$49,721	\$72,060	\$108,090	\$144,120
8	\$40,090	\$55,324	\$80,180	\$120,270	\$160,360
Additional Persons	\$4,060	\$5,603	\$9,020	\$12,180	\$18,040

Household Income does matter for  
determining Premium Tax Credits or  
Medicaid

Please refer to [www.cbpp.org](http://www.cbpp.org) for  
more information concerning  
Determining Households

# Information Verification

- If a consumer chooses to apply online, the system will generate a series of real-time questions related to their personal information.
  - Questions are similar to loan applications or credit report requests.
  - Note that the Marketplace does **not** ask individuals for their credit report.
- If a consumer is unsuccessful in validating their identity, they will be directed to contact the call center directly.
- Consumers unsuccessful in validating their information over the phone will be able to complete an application but will have to confirm their identity by mailing or uploading the requested documents on the online system.

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# Income Verification

- Consumers' applications must match information from the Hub before eligibility for health coverage, premium tax credits, and cost-sharing reductions is determined.
- The verification process occurs in real-time if the information can be verified immediately online. If additional information needs to be submitted, it may take longer.
- The fastest way for any individual to have their income verified is to go through the online process. Paper and call center verification will take more time, both in regards to an initial response and if additional information is necessary.
- Federal Data Services Hub is used by the Marketplace to verify consumers' information. It pulls information about consumers from other federal agencies like the IRS and SSA.

## **What are the cost sharing exemptions for American Indians and Alaska Natives?**

A: If you enroll in a qualified health plan offered through the Marketplace, you may qualify for savings on cost sharing (e.g., copays, coinsurance, deductibles, and other similar charges). If you are a member of a federally recognized tribe and your household income is at or below 300% of the federal poverty level, you will have no cost sharing for services covered by the health plan you choose in the Marketplace. Regardless of your household income and your enrollment in the Marketplace, there is no cost sharing if you continue to receive services from your Indian health care provider or through a Contract Health Service authorized referral.

There are also cost-sharing exemptions under the Medicaid program for enrolled individuals who receive services directly from the IHS, an Indian Tribe, tribal organization, or urban Indian organization or through a Contract Health Services authorized referral.

**NOTE:** Even if you are not a member of a federally-recognized tribe and your household income is below 250% of the federal poverty level, you may be eligible for reduced cost-sharing if you enroll in a Silver Plan through the Health Insurance Marketplace.

# ELIGIBILITY AND ENROLLMENT

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# Marketplace Eligibility & Enrollment for Indian Country

- **Enrollees Must:**
  - Live in its service area, and
  - Be a U.S. citizens or national, or
  - Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
  - Not be incarcerated



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# Eligibility Determination: Application Process

- Marketplace applications request the following information:
  - Basic contact information
  - Financial assistance (opt in or opt out)
  - Names of individuals seeking coverage
  - Personal information for each applicant (name, DOB)
  - Income information
  - Information regarding access to other health coverage
  - Family structure
- Members of federally recognized Tribes that are eligible to enroll in a health plan through the Marketplace will need to provide documentation demonstrating their membership in a federally recognized Tribe.
- Consumers that need more time to produce supporting documents may request additional time to submit the documents.

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# Eligibility Determination: Medicaid and CHIP

- In states where the Marketplace (FFM) assesses Medicaid and CHIP eligibility, consumers will have their account transferred to the Medicaid/CHIP agency for final eligibility determination. States will then notify the Marketplace of the final eligibility determination.
- American Indians and Alaska Natives applying for coverage through Medicaid or CHIP may need to provide documentation of Indian status or eligibility for services from an Indian health provider.
- Acceptable documentation includes:
  - A document issued by a federally recognized Tribe indicating Tribal membership
  - An enrollment card
  - A certificate of degree of Indian blood issued by the Bureau of Indian Affairs
  - A Tribal census document
  - Any document indicating affiliation with the Tribe

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# Eligibility Determination: Receiving Notice from the Marketplace

- The Marketplace will directly send consumers about their eligibility decision.
  - Paper applicants will receive a notice in the mail
  - Online applicants will receive their eligibility notice online
  - Consumers may also contact the call center directly and provide information in order to receive their eligibility over the phone and receive an application ID for completing enrollment in a Marketplace plan
- Eligibility results will show consumers what QHPs they are eligible for, the amount of their PTC, and any cost-sharing reductions

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# Eligibility Determination: Cost-sharing Reductions

- For all consumers, if household income is below 250% of the federal poverty level (FPL), they may be eligible for reduced cost-sharing if they enroll in a **silver** plan through the Marketplace.
- Members of a federally recognized Tribe:
  - If household income is at or below 300% of the FPL, they will have no cost-sharing for essential health benefit services covered by the health plan in the Marketplace.
- Note: There is no cost-sharing for individuals that are members in federally recognized Tribes or if they are I/T/U eligible if they continue to receive services from an Indian health care provider.

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# Enrollment Dates

- Annual Open Enrollment Period
  - Following the initial open enrollment period, consumers will be able to select QHPs or change QHPs through the Marketplace on an annual basis
  - For Coverage beginning in 2015, the open enrollment period will be from November 15, 2014-February 15, 2015
  - Note: members of federally recognized tribes may change health plans once a month and will be able to obtain health coverage outside of the open enrollment period
  
- Medicaid and CHIP Enrollment Period
  - Enrollment in CHIP and Medicaid is available all year and is not limited to the open enrollment period for the Marketplace. Eligible consumers may enroll in these coverage programs at any time during the year.

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# Effective Dates of Coverage: Marketplace

- If a consumer selects a QHP between the 1<sup>st</sup>-15<sup>th</sup> day of the month and pays the premium by the date specified by the health insurance company, coverage will begin on the first day of the following month.
- If a consumer selects a QHP between the 16<sup>th</sup> and the last day of the month and pays the premium by the date specified by the health insurance company, coverage will begin on the first day of the second following month.
- These dates are applicable for members in federally recognized Tribes outside of the open enrollment period as well.

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# Plan Selection and Enrollment: Premium Payment Options

- Assistors may not help consumers enter their payment information (credit card number, bank account numbers).
- Encourage consumers to enter their own financial information to ensure safety and protection.
- Consumers that do not have bank accounts may make payments through alternate methods as permitted by their health insurance company.
- Consumers should contact their health insurance company directly on alternate methods of payment.

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# Marketplace Plans

- When viewing plans on [www.healthcare.gov](http://www.healthcare.gov), there are a number of filters and sorting tools that can be used to narrow the plans for consumers.
- As enrollment assisters, you should help consumers compare plans using the side-by-side comparison tool and note the differences in categories for medical care, prescription drug coverage, and the availability of medical management programs.
  - Filtering and Sorting Tools on [www.healthcare.gov](http://www.healthcare.gov):
    - Premium price range
    - Out-of-pocket maximum
    - Cost-sharing reduction
    - Annual deductible
    - Availability of coverage across several states
    - Plan type
    - Category of coverage
    - Dental coverage
- **Always review the summary of benefits.**
- **Make sure you understand the benefit structure of co-pays, deductibles, and co-insurance if the incur any of these costs.**

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# Summary of Benefits

## Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Spouse | Plan Type: PPO

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.\[insert\]](#) or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	<b>\$500</b> person / <b>\$1,000</b> family Doesn't apply to preventive care	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other deductibles for specific services?	Yes. <b>\$300</b> for prescription drug coverage. There are no other specific <b>deductibles</b> .	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers <b>\$2,500</b> person / <b>\$5,000</b> family For non-participating providers <b>\$4,000</b> person / <b>\$8,000</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See <a href="#">www.[insert].com</a> or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-800-[insert] or visit us at [www.\[insert\].com](#).

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.\[insert\]](#) or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146



Plus catastrophic plan offering for individuals younger than 30/ financial hardship

$$\text{Actuarial Value}^{**} = \frac{\text{Total Expected Payments by Health Plans for EHBs}}{\text{Total Costs of EHBs for the Standard Population}}$$

# 10 Essential Health Benefits

Ambulatory Patient Services

Prescription Drugs

Emergency services

Rehabilitative & Habilitative Services and  
Devices

Hospitalization

Laboratory Services

Maternity & Newborn Care

Preventive & Wellness Services and  
Chronic Disease Management

Mental Health & Substance Use Disorder  
Services, Including Behavioral Health  
Treatment

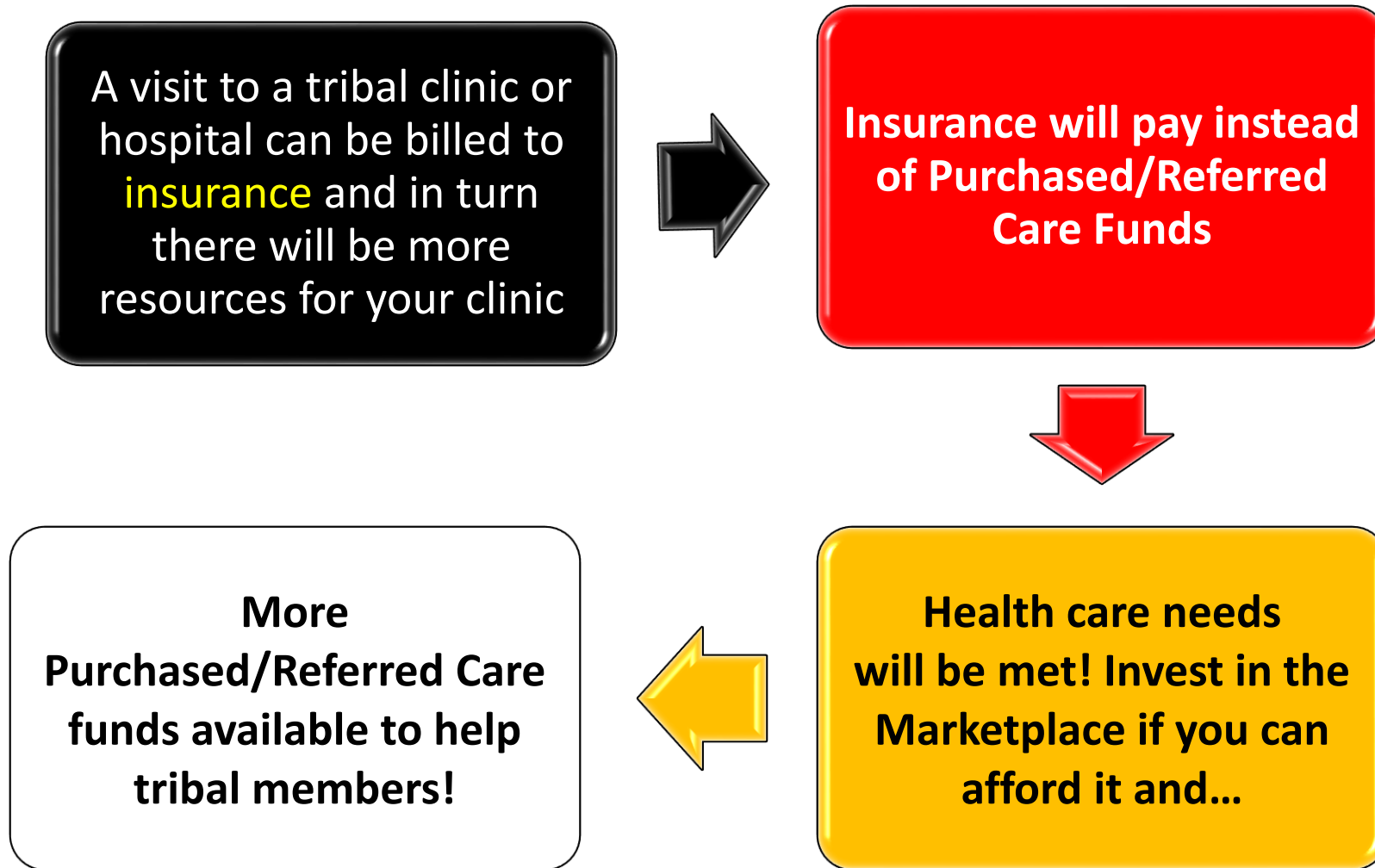
Pediatric Services, including  
Oral & Vision Care

# Plan Selection and Enrollment

- Consumers will not be able to receive benefits until they have selected a plan, made their first monthly payment, and the payment has been received by the health insurance company.
- Factors affecting plan availability:
  - Completion and processing of the application
  - Residency
  - Current health coverage
  - Age
- Factors affecting costs
  - Age
  - Geographic Location
  - Individual/Family Enrollment
  - Plan Category
  - Tobacco use
    - Issuers can charge up to 50% more for monthly premiums based on “regular tobacco usage.”
    - Tobacco use for ceremonial or religious purposes does not constitute as regular tobacco use.
- Factors that cannot affect premiums
  - Women can no longer be charged more than men for the same health policy
  - Your health status is not taken into account when rates are set – policies in the Marketplace must cover treatment for pre-existing conditions
  - Consumers should contact their health insurance company directly on alternate methods of payment.



# What are the Benefits of Enrolling in Health Insurance?



# Special Enrollment Periods and Effective Dates

- Special enrollment periods generally last for 60 days from the date of the qualifying event
- Qualifying circumstances for special enrollment periods:
  - Change in status as an American Indian or Alaska Native
  - Loss of minimum essential coverage
  - Termination of job-based coverage
  - Change in job-based coverage
  - Marriage, divorce, birth, pregnancy, or adoption
  - Change in income
  - Enrollment error
  - Change in citizenship or qualifying immigration status
  - Violation of a contract by a health plan
  - Gain or loss of eligibility for premium tax credits or cost-sharing reductions
  - Relocation or change in address
- Generally, coverage will begin on the same timeline as the initial enrollment period. However, in the case of marriage, or if a qualified consumer loses minimum essential coverage, coverage becomes effective on the first day of the following month and in the case of birth or adoption, coverage is effective on the date of the event.

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# Annual Redetermination in the Marketplace

- Starting in September 2014, the Marketplace will automatically reassess the eligibility of all qualified consumers that were determined eligible in the previous year. Any changes in coverage or eligibility will be effective on January 1, 2015.
  - If the Marketplace application included a request for financial assistance in paying for health coverage and a consumer agreed to allow the Marketplace to re-check this data annually, the Marketplace will check their income data (this will come from the IRS and the SSA). These individuals will be sent a notice summarizing their eligibility for the upcoming year – individuals should review this notice and notify the Marketplace if there is anything incorrect in the notice.
  - For consumers that do not allow the Marketplace to re-check their data annually, the Marketplace will send consumers a notice but will not be able to see if they will remain eligible for programs to help lower costs. If those consumers want to receive or continue receiving financial assistance, they will need to contact the Marketplace.
- Medicaid and CHIP agencies will redetermine consumers' eligibility for their programs on an annual basis.

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# The Marketplace and Medicaid/CHIP

- AI/AN are screened for Medicaid and CHIP eligibility when they apply for coverage through the Marketplace. Depending on the state, the Marketplace will either assess or determine their eligibility for coverage.
  - Assessment: Consumers assessed as eligible should be informed by the enrollment assister that their application will be sent to the appropriate state's Medicaid/CHIP agency for a final eligibility determination.
  - Determination: Consumers determined as eligible for Medicaid/CHIP will be notified directly by the Marketplace and they will then be given the option to enroll in a Medicaid/CHIP plan.

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# Key Points to Remember

- Members of a federally recognized Tribe or those eligible to receive services at IHS are exempt from the individual responsibility payment.
- Consumers are screened for Medicaid and CHIP eligibility when they apply for coverage through the Marketplace.
- AI/AN enrolled in Medicaid and are eligible to and do receive care at and IHS, tribal 638 or urban Indian Health will not have premiums or deductibles.
- Members in federally recognized tribes have the ability to change their enrollment status in Marketplace plan once a month.
- Members in federally recognized tribes are able to apply all tax subsidies to Bronze or Silver plans. Bronze plans may provide sufficient coverage at a lower rate than Silver plans.

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# KEY POINTS TO REMEMBER

- More American Indian/Alaska Natives will have access to affordable health care
- A small business or an individual consumer can find a plan that fits their budget
- Many will be eligible for low-cost or free health care
- Invest in the marketplace and save purchased and referred care funds



Questions?

Thank you!

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