

Session One – Overview of the Affordable Care Act and Third Party Payers

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HEALTHIER COMMUNITY



Session Overview

- Introduction – Public Health Delivery meets Health Care Delivery Financing (Insurance)
- The Affordable Care Act and Public Health –
- Review the types of “insurance” payers– and how they are “regulated”
- The Commercial Insurance Market in Washington with emphasis on Qualified Health Plans, Individual and Small Group Market
- Introduction to *Essential Health Benefits* – Emphasis on Preventive and Screening services
- *Essential Community Providers* – Including Local Health Jurisdictions
- Where to go for help – Grievance and Appeals; Consumer/Provider Complaints
- Helpful Links
- Questions and Answers

Introduction – Concepts to Keep in Mind

- Health insurance, including Managed Care Medicaid is a financing mechanism that Local Health Jurisdictions (LHJs) should use to maximize their funding
- Just as LHJs are not always familiar with health issuers (carriers) - health issuers are not familiar with LHJs –
- The Affordable Care Act (ACA) implementation is difficult – and health issuer's staff still don't understand the LHJs and the services you provide– You know more about the Public Health System and what is required than the issuer's representative



Poll Question:

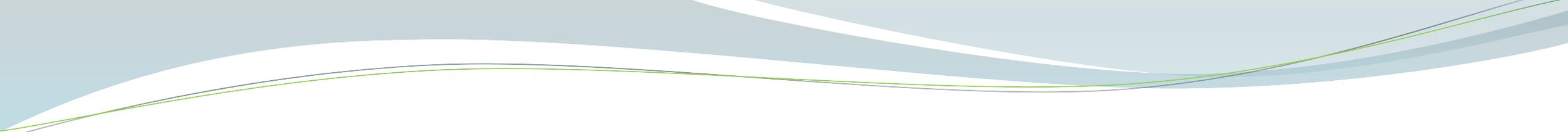
Are you currently billing health plans (private and public)?

The Affordable Care Act (ACA) and Public Health

- The ACA has a strong emphasis on prevention and improving the health of the population – and will impact Public Health in 3 major ways:
 1. Expansion of the Insurance Mechanism – reducing the number of uninsured and providing greater opportunities for reimbursement for clinical services
 2. Fosters new health care delivery models emphasizing improving health outcomes – which should integrate public health principles of population health evaluation and improvement
 3. Greater opportunities for expansion of public health services beyond prevention and screening

The Affordable Care Act (ACA) and Public Health – Expansion of the Insurance Mechanism

- The ACA requires individuals to have health insurance and removes some of the old barriers to coverage
 - Issuers may no longer deny coverage to sick people –pre-existing conditions can't be used to deny coverage
 - Medicaid Expansion means more low income individuals or families (at or below 138% of the federal poverty level (FPL)) qualify for Medicaid – see:
http://www.hca.wa.gov/hcr/me/documents/ME2014_Fact_Sheet.pdf
 - Premium tax credits and cost sharing reductions help reduce the premium and out-of-pocket costs for low income insureds in the commercial market (between 139 and 400% of FPL)
- The expansion of the insurance coverage may result in LHJs treating more insured patients – enhancing the chance for payment for services given to LHJ patients, or the patients may receive screening and prevention services from their primary care physician



Poll: Are you serving more insured clients?

The Affordable Care Act (ACA) and Public Health – Fosters new integrated delivery models

- The Public Policy intent of the ACA is to increase health care coverage, contain or at least reduce the growth of health care costs and improve health care outcomes
- The current system of paying fee for service is viewed as unsustainable
- Issuers and providers are actively engaged in developing integrated delivery systems that provide financial incentives to improve quality and health outcomes
- The ACA provides opportunities for partnerships between the Public Health System that prior to the ACA was dependent on government funding and the Clinical Health Delivery System that is primarily funded through the insurance financing mechanism
- LHJs providing clinical services for prevention and screening can be an important part of the delivery system – and receive insurance payments

The Affordable Care Act (ACA) and Public Health – Opportunities for Public Health

- Bottom line – get paid for what you do
- Opportunities to expand services because insurance payments are available to pay for services
- Provide expertise in evaluating changes in health status at the population level to measure health outcomes and access to critical health services

To do this - LHJs and Public Health leadership need to push for inclusion in the health issuer's networks

Types of “insurance” Payers – and who is in “charge”

- The Insurance financing system is made up of many different systems – and although our focus will be on the “Commercial” insurance market it is important to understand the various types
- When troubleshooting problems or trying to understand requirements one of the first questions you need to ask is “what type of insurance does the patient have?”
- The following charts outline some of the most common types of health coverage

Chart of Various Types of “Insurance” Programs

“Insurance” Program	Description	Who Regulates or Controls?
Commercial Insurance – Inside the Exchange	<p>The health benefit plans known as Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs) available for individuals and small groups (<50) through the Health Benefit Exchange (HBE.) These are fully insured products that must comply with the state insurance code and the Affordable Care Act (ACA.)</p> <p>Coverage for enrollees who do not qualify for Medicaid – but may be eligible for tax credits and cost sharing reductions if under 400% FPL</p>	<ol style="list-style-type: none"> 1) The OIC must approve the health benefit plans and regulates the issuers 2) The Health Benefit Exchange Certifies the QHPs and QDPs for Washington
Commercial Insurance – Outside of the Exchange	All fully insured individual, small group and large group insurance products sold outside of the HBE.	<ol style="list-style-type: none"> 1) The OIC enforces state and federal law 2) Federal Government establishes ACA requirements through rule making but delegates enforcement to OIC
Managed Care Medicaid “Apple Health”	Program for low income for individuals – including children at or below 138% FPL	<ol style="list-style-type: none"> 1) Health Care Authority – provides primary oversight 2) OIC licenses the companies and approves provider contracts

Chart of Various Types of “Insurance” Programs – cont.

“Insurance” Program	Description	Who Regulates or Controls?
Self Funded or Self-Insured Employer Group	Health Insurance program where the employer assumes the risk for the claims. Not subject to state insurance mandates – but does need to comply with ACA and federal mandates. May be administered by an Issuer that processes claims and provides access to networks. Sometimes called “ERISA” plan or “ERISA exempt” -	<ol style="list-style-type: none"> 1) Federal Department of Labor 2) OIC <u>does not</u> have authority
Medicare and Medicare Advantage	Program primarily for individual’s over the age of 65 and certain disabled persons including individuals with End-Stage Renal Disease	<ol style="list-style-type: none"> 1) Federal Government through HHS/CMS 2) OIC does not regulate Medicare or Medicare Advantage plans
Medicare Supplement or Medi-Gap Insurance plans	Insurance products designed to “supplement” or provide payment for the cost sharing amounts not covered by Medicare	<ol style="list-style-type: none"> 1) OIC
Labor Plans or “Taft Hartley Trusts”	Insurance products that may or may not be fully insured. Are subject to collective bargaining. Subject to ACA and Federal Department of Labor Requirements	<ol style="list-style-type: none"> 1) OIC if fully insured 2) DOL if self -insured

Commercial Insurance Health Benefit Plans

- The ACA has different requirements depending on whether the insurance is individual, small group (< 50 employees) or large group.
- The ACA also has different rules for plans that were issued before March 23, 2010 (grandfathered) or after March 23, 2010 (non grandfathered)
- Most individual and small group health benefit plans in Washington are non-grandfathered – and so were changed in 2014 to include the following:
 - Provide all Essential Health Benefits
 - Issuers can't deny coverage or benefits based on a pre-existing condition
 - Issuers can't cancel coverage due to health condition
 - Issuers must provide access to Essential Community providers that provide services to low income and medically underserved populations – if the product is a Qualified Health Plan (QHP) purchased through the Health Benefit Exchange
- Maximum out-of-pocket for Essential Health Benefits – limited to \$6,250 for individual and \$12,500 for family in 2014. Goes up to \$6,600 and \$13,200 in 2015



Poll: Do you provide essential health services in your clinic?

Essential Health Services

The 10 categories of health services that must be covered in all non-grandfathered individual and small group products beginning in January 2014

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. Laboratory & imaging services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

Preventive and Wellness Services

- Under the ACA, private health plans (including large group and self-insured plans) must provide coverage for a range of preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services
- The ACA requires private plans to provide coverage for services under four broad categories: **evidence-based screenings and counseling, routine immunizations, childhood preventive services, and preventive services for women**
- Issuers will provide coverage for evidence-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) – as the list change over time – the benefits will change
- Many of the services may be available from LHJs

Preventive Services and Screenings for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk

Preventive Services and Screenings for Adults cont.

- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella

22 Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk

22 Covered Preventive Services for Women, Including Pregnant Women cont.

- **Contraception** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- **Domestic and interpersonal violence** screening and counseling for all women
- **Folic Acid** supplements for women who may become pregnant
- **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women

22 Covered Preventive Services for Women, Including Pregnant Women – cont.

- **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-woman visits** to obtain recommended preventive services

26 Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Blood Pressure** screening for children
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

26 Covered Preventive Services for Children - continued

- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Hematocrit or Hemoglobin** screening for children
- **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella

26 Covered Preventive Services for Children - continued

- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Vision** screening for all children



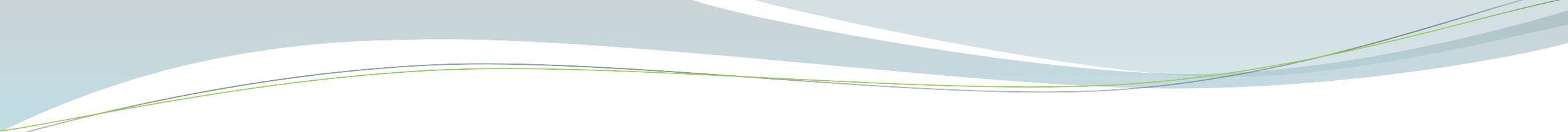
Poll: Are you an essential community provider?

Essential Community Providers -

- The ACA requires that issuers that offer individual or small group Qualified Health Plans in an exchange contract include Essential Community Providers (ECPs) in their networks
- Essential Community Providers are providers that serve predominantly low-income, medically underserved populations
- In Washington State – The Insurance Commissioner defines and Essential Community Provider under WAC 284-43 -221:
"Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to Medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes:
 - (1) Hospitals and providers who participate in the federal 340B Drug Pricing Program;*
 - (2) Disproportionate share hospitals, as designated annually;*
 - (3) Those eligible for Section 1927 Nominal Drug Pricing;*
 - (4) Those whose patient mix is at least thirty percent Medicaid or Medicaid expansion patients who have approved applications for the Electronic Medical Record Incentive Program;*
 - (5) State licensed community clinics or health centers or community clinics exempt from licensure;*
 - (6) Indian health care providers as defined in WAC [284-43-130](#)(17);*
 - (7) Long-term care facilities in which the average residency rate is fifty percent or more eligible for Medicaid during the preceding calendar year;*

Washington Definition of Essential Community Provider WAC 284-43-221 cont.

- 8) School-based health centers as referenced for funding in Sec. 4101 of Title IV of ACA;*
- (9) Providers identified as essential community providers by the U.S. Department of Health and Human Services through subregulatory guidance or bulletins;*
- (10) Facilities or providers who waive charges or charge for services on a sliding scale based on income and that do not restrict access or services because of a client's financial limitations;*
- (11) Title X Family Planning Clinics and Title X look-alike Family Planning Clinics;*
- (12) Rural based or free health centers as identified on the Rural Health Clinic and the Washington Free Clinic Association web sites; and*
- (13) Federal qualified health centers (FQHC) or FQHC look-alikes.*



Poll: Do you know how to file an appeal with the Office of the
Insurance Commissioner?

Grievance and Appeals -

- The ACA requires that consumers be allowed to appeal health issuer's decisions
- The law applies to individual and group health insurance products created after March 23, 2010 (non-grandfathered plans)
- The health issuer must have an internal appeals process and provide information to insureds on how to file an appeal when the issuer makes an “adverse benefit determination”
- If the insured exhausts their internal appeal process – they have the right to ask for an external review by an independent party – not employed by the health issuer
- In Washington – the insured may use an Independent Review Organization – and the findings are binding on the Insurance Company
- The Washington state Office of the Insurance Commissioner has helpful information on their website about the appeal process at: <http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/>
- Providers may file appeal on the behalf of their patients if appointed as “personal representatives”

Where to go for Help

- Issuer Provider Relations

Most issuers will assign a provider representative for you to contact. You can also call the health issuer's customer service unit and they frequently have dedicated lines for providers

- Office of Insurance Commissioner

The OIC's Consumer Advocacy hotline: 1-800-562-6900 or file an "on-line complaint" at: <http://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/>

Even if the OIC does not have jurisdiction – their consumer advocates can often provide helpful advice

- Health Care Authority (Medicaid / Apple Health)

1-800-562-3022

<http://www.hca.wa.gov/medicaid/provider/Pages/index.aspx>

Helpful Links to more Information

- Insurance Commissioner's Web Site:
www.insurance.wa.gov
- Health Plan Finder – Washington's Health Benefit Exchange
<http://www.wahbexchange.org/>
- Topical Fact Sheets dealing with ACA issues from Federal Government
<http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html>
- Glossary of Terms under the ACA"
<https://www.healthcare.gov/glossary/>
- HRSA Guidelines for Women's Preventive Services Guidelines:
<http://www.hrsa.gov/womensguidelines/>

Helpful Links to more Information - continued

- Kaiser Family Foundation Fact Sheet on Preventive Services

<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8219.pdf>

- Web site providing link to “Non-exhaustive list of Essential Community Providers” and other resources

- <http://www.cms.gov/cciiio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>

- Information on how consumers can file an appeal

- <http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/>

Questions?

- Questions may also be sent to Carri Comer at carri.comer@doh.wa.gov or (360) 236-4004

Carri Comer

Washington State Department of Health

Strategic Operation Lead for Health Systems Transformation and Innovation

Appendix No. 1 Glossary of Common Terms

Center for Consumer Information and Insurance Oversight:

The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many reforms of the Affordable Care Act, the historic health reform bill that was signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance. In particular, CCIIO is working with states to establish new Health Insurance Marketplaces

Cost Sharing:

The amount of the health care expense that is paid by the insured but does not include the premium. Typically there are three types of cost sharing:

- Deductible – A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the issuer starts to make payments for covered medical services. Plans may have both per individual and family deductibles.
- Co-Insurance - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.
- Co-Payment -A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The issuer is responsible for the rest of the reimbursement. There may be separate copayments for different services. Some plans require that a deductible first be met for some specific services before a copayment applies.

Essential Health Benefits:

A set of health care service categories that must be covered by certain plans, starting in 2014.

The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.