



Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

TSGAC Webinar – Response to Submitted Topics and Qs / Open Q&A Session

May 14, 2015

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Tribal Self-Governance Advisory Committee

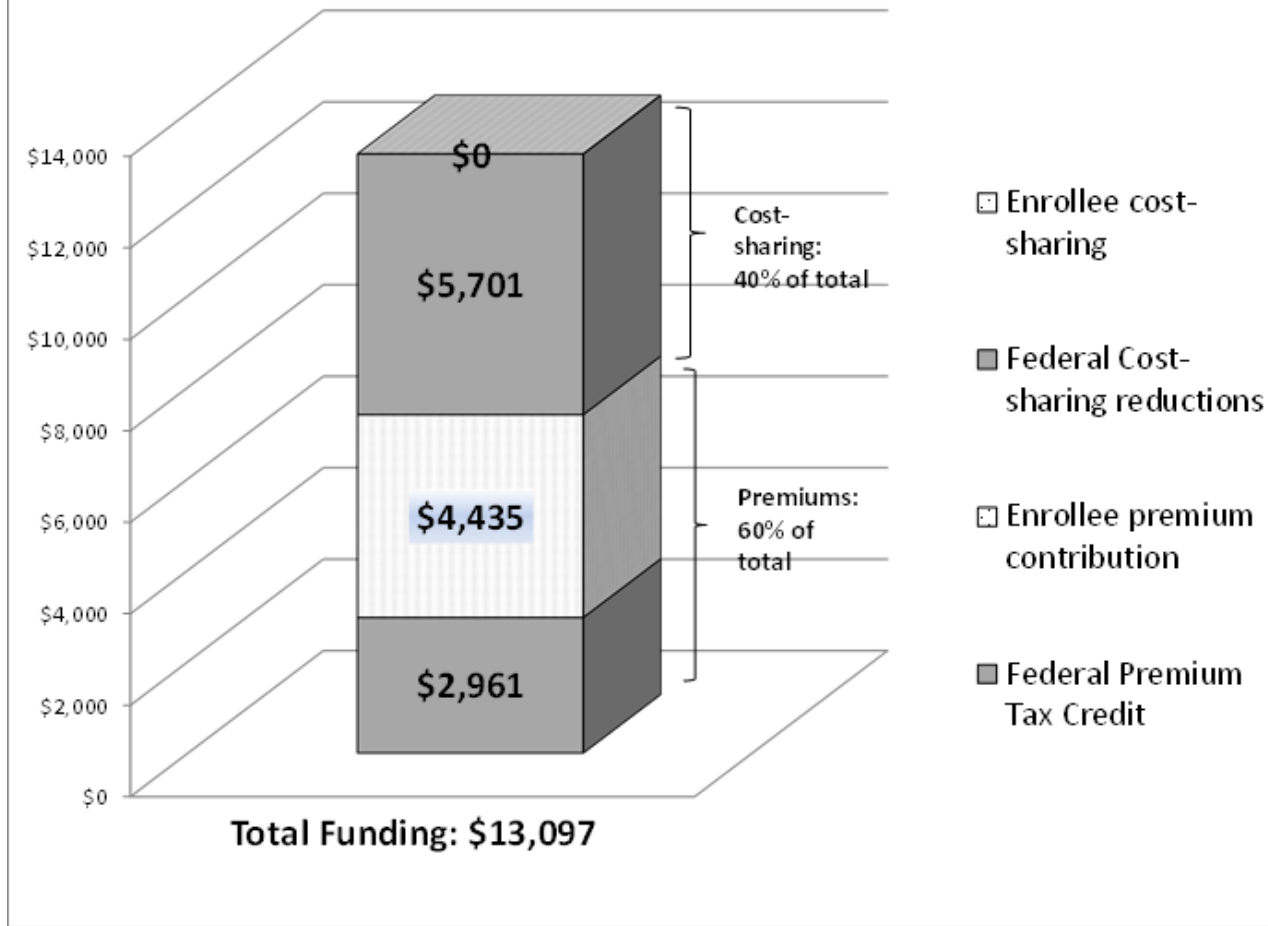
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Submitted Q's and Topics

1. Indian-specific cost-sharing reductions (CSRs)
 - How are Indian-specific CSRs intended to work
 - How does a Qualified Health Plan (QHP) know that a patient had a referral from an IHS or tribal facility
 - How to get QHPs to understand and comply
2. Strategies to maximize revenues through tribal sponsorship of beneficiaries through a Marketplace
 - Question of whether to cover all family members
 - Timing enrollment: what has the experience been with covering enrollees for a short period(s) of time
 - Distribution of costs / federal resources under Marketplace coverage



Source and Distribution of Funding for Marketplace Coverage, 2015
- American Indian or Alaska Native Family -
 Three-person household; annual income of \$69,265 (350% FPL)
 (bronze-level coverage; three Marketplace enrollees)



SOURCE: Analysis of Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the ACA's Health Insurance Marketplaces", September 2014, Issue Brief.



Issue 1: Indian-specific cost-sharing reductions

- **How are Indian-specific CSRs intended to work**
- **How does a QHP know that a patient had a referral from an IHS or tribal facility**
- **How to get qualified health plans (QHPs) to understand and comply**

Marketplace Enrollment → Revenue Cycle

- [Establish sponsorship program]
- Eligible person enrolls through Marketplace and secures coverage by paying insurance premium to QHP
 - “02” / “zero cost-sharing variation (100% - 300% FPL; dependent on premium tax credit eligibility)
 - “03” / “limited cost-sharing variation (any income; not dependent on premium tax credit eligibility)
- THO provides services to sponsored Marketplace enrollees
 - No cost-sharing charged AI/AN enrollee
 - THO bills QHP for 100% of agreed upon rate or under section 206 authority (not to deduct any cost-sharing amounts)
- For enrollees with “03” / “limited cost-sharing variation”, for services outside of THOs, THO provides “referral for cost-sharing” to AI/AN enrollee
 - No cost-sharing charged AI/AN enrollee
 - Non-THO provider bills QHP for 100% of agreed upon rate (not to deduct any cost-sharing amounts)
- THO tracks revenues received and follow-up with QHP as needed
 - If needed, THO sends written communications to QHP requesting correction to mis-application of cost-sharing protections
- THO tracks revenues received and follow-up with QHP again, if needed
 - If needed, THO files complaint through HICS (Health Insurance Complaint System)



Example of THOs Billings: Initial Payments 21% of Charges

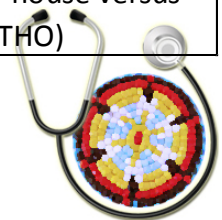
Example of Set of Charges Filed by One THO

		Percentage of Processed Effective Charges	Percentage of Reported Effective Charges
Insurance payments	\$775	26%	21%
Co-pay / deductibles	\$991	33%	27%
Adjustments / denials	\$1,195	40%	33%
Total processed	\$2,961	100%	
Not processed	\$707		19%
Total Effective Charges	\$3,668		100%



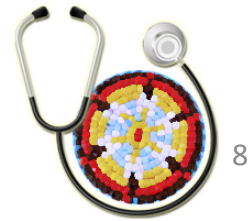
Issues

Common Impediments to Maximizing Revenues through Tribal Sponsorship		
	Issue	Considerations
1.	Reimbursement rates / Discount on charges	Rates subject to negotiation with health plan; consider use of Section 206 authority
2.	Application of deductibles	Not permitted
3.	Application of cost-sharing - general	Not permitted
4.	Application of cost-sharing - pharmacy	Not permitted
5.	Denied claims - prior authorization required	Process improvement needed; possibly over-restrictive formulary in chosen health plan
6.	Denied claims - non-covered services	Bariatric surgery; Hepatitis C medications; compare health plan coverage policies
7.	Plan payment to patient, not provider	Potential problem when I/T/U is out-of-network; process improvement needed, if occurring
8.	Billing cycle delays	Opportunities to reduce length of time to submit bills to health plans and to respond to health plan inquiries
9.	Length of time to identify and enroll individuals in Marketplace coverage	Unlike Medicaid, Marketplace coverage is not retroactive; need for proactive enrollment
10.	Scope of services at I/T/U	Consider which services are best provided in-house versus outside providers (other THO; non-THO)



Referrals

- Work with QHP on an agreed upon *process* for documenting a “referral for cost-sharing”
 - Requirements placed on a THO by QHP issuer should be no more restrictive (or burdensome) than is provided for in the CMS May 9, 2014, guidance document
 - The CMS guidance from 5/9/2014 is linked here [\[CLICK HERE\]](#)
- TribalSelfGov.org website Q&A on referrals
 - http://www.tribalsef.gov.org/NEWSGCE/healthcare/Blog_page/section_a_marketplace_home.html
- Sample 1: Single item or service referral
 - http://www.tribalsef.gov.org/NEWSGCE/healthcare/webinar_10/Referral_letter_Sample_1_generic_2015-04-14.pdf
- Sample 2: Combined single / comprehensive referral
 - http://www.tribalsef.gov.org/NEWSGCE/healthcare/webinar_10/Referral_Form_Sample2_Generic_Form_Indian_specific.pdf



Referrals

(See CCIIO 5/9/2014 Q&A)

- Required THO-supplied information
 - Identification information for patient receiving an item or service through referral (name of patient; date of birth of patient)
 - Name of the Indian health program (aka THO) issuing the referral under contract health services
 - Contact information for the THO issuing the referral
 - Date of the referral
- QHP-supplied service-specific information
 - Name and address of the provider delivering the item or service
 - Description of the item or service furnished through referral under contract health services
 - Date(s) the item or service was provided
- “We note that many of the required elements above may be contained in the referral itself, and recognize that often the referral will be obtained after the service has been provided.”
- Referrals can be issued after service provided



Importance of Filing Complaints

- Complaints, if not resolved with QHP, are to be filed with FFM through Health Insurance Casework System (HICS)
[45 C.F.R. § 156.1010]
 - **Call FFM Contact Center (1-800-318-2596) to register a complaint in HICS.**
 - There are timeframes established for QHPs to resolve complaints (72 hours; 14 days)
 - State-based Marketplaces to establish similar process
- CMS to track complaints and use aggregated complaints information as a tool for directing oversight activities in FFMs.
 - For example, if cost-sharing protections are applied incorrectly, file complaint through HICS.
- In contrast to complaints, “appeals” of coverage decisions (also referred to as “alternative benefit determinations”) are to directly with QHP using internal and external review process



Importance of Documenting Issues: QHPs Have 45-Days to Comply

- Under section 1402 (d)(2)(A) of the Affordable Care Act, no cost sharing should be imposed for services provided to Indians by Indian Health Providers.
- Subparagraph (B) states the issuer shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A). [SEE 45 CFR 156.430(g).]
- 45 CFR 156.410(c)(1)(i) dictates the **QHP issuer must refund the excess cost sharing “paid by the provider” (i.e., deducted from the payment to the provider) within 45 calendar days** of discovery of the improper application of these rules.
 - Other provisions apply if patient paid cost-sharing



Issue 2: Strategies to maximize revenues through tribal sponsorship

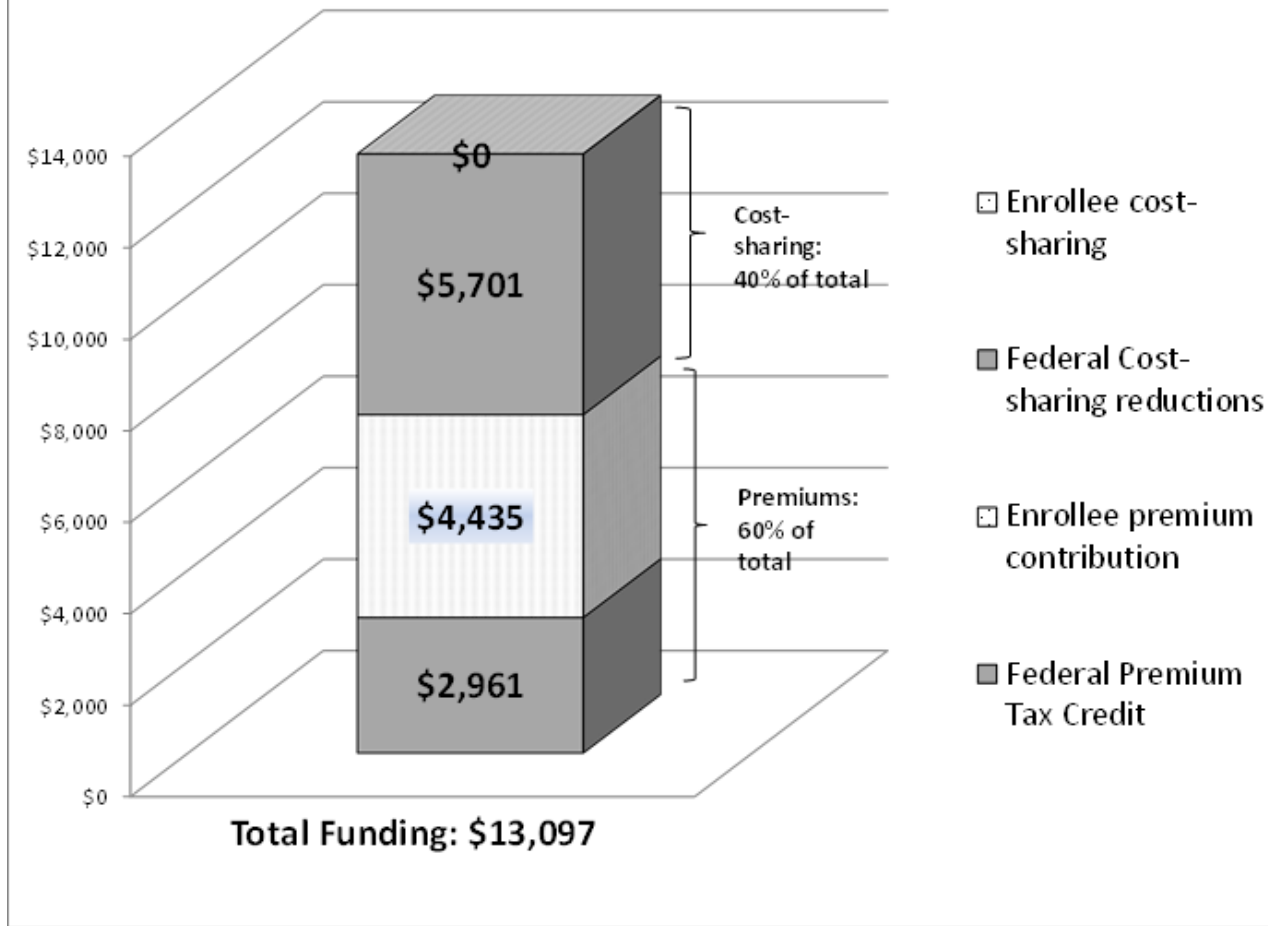
- When to cover the whole family
- Timing enrollment: what has the experience been with covering enrollees for short periods of time
- Distribution of costs / resources with Marketplace coverage

Marketplace Coverage

- Sponsoring tribal members through a Marketplace is a mechanism to convert a “fixed appropriation” to an “individual entitlement”
- Sponsoring tribal members through a Marketplace is a mechanism to shift risk from the Tribe to the Marketplace
- Using the Marketplace to cover tribal employees may be a mechanism to successfully reduce tribal employer health insurance costs AND provide greater access to health services at a lower cost to employees and their families
 - Potential for increasing resources for non-health insurance compensation for employees (*i.e.*, increase wages)
 - Opportunity to align premium sponsorship for uninsured THO patients with tribal employer use of Marketplace



Source and Distribution of Funding for Marketplace Coverage, 2015
- American Indian or Alaska Native Family -
 Three-person household; annual income of \$69,265 (350% FPL)
 (bronze-level coverage; three Marketplace enrollees)



SOURCE: Analysis of Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the ACA's Health Insurance Marketplaces", September 2014, Issue Brief.



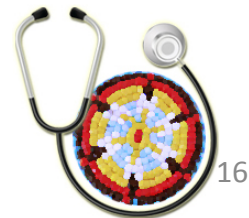
Issue 2 (continued): When to cover the whole family

Sponsorship of all eligible family members typically produces the greatest net revenues / savings to THO.

Marketplace Coverage: All-in?

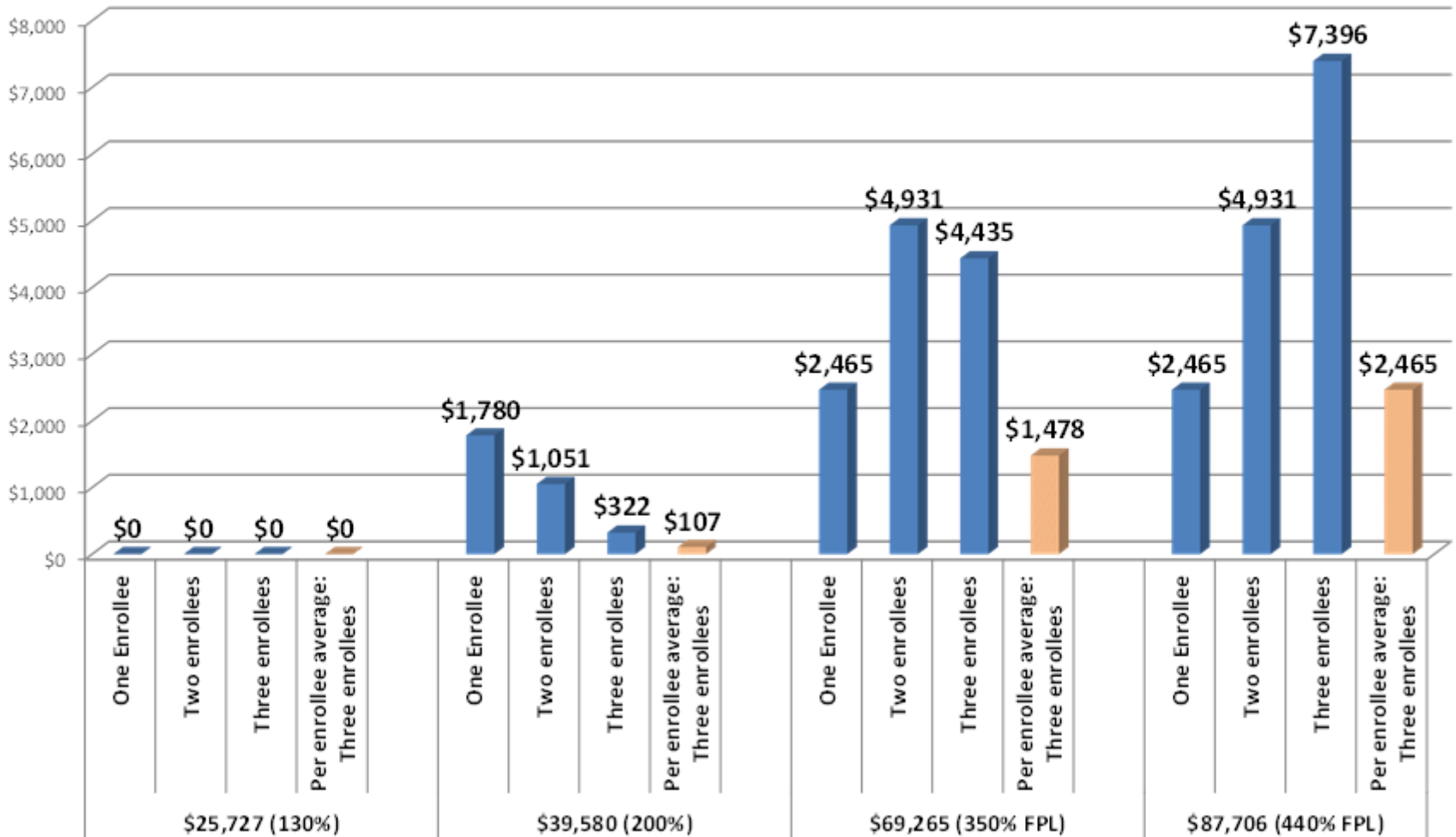
- Comparison of AI/AN family of three covered through Marketplace
 - All three family members (two adults; one child) covered through Marketplace
 - Two family members (one parent; one child) covered through Marketplace

All 3 Family Members Covered through Marketplace				50-year Old Parent Not Included in Marketplace Coverage			
Tax credit calculation: Family of 3 in Apache, Arizona				Tax credit calculation: Family of 3 in Apache, Arizona			
Income	\$48,825	(250% FPL)		Income	\$48,825	(250% FPL)	
Contribution %	8.05%			Contribution %	8.05%		
Family premium required	\$3,930			Family premium required	\$3,930		
Reference premium: 2nd lowest cost silver plan		\$3,025.68	27	Reference premium: 2nd lowest cost silver plan		\$3,025.68	27
		\$5,156.28	50			\$5,156.28	50
		\$1,833.24	child			\$1,833.24	child
Total reference premium	\$10,015.20			Total reference premium	\$4,858.92		
Tax credit amount:	\$6,084.79			Tax credit amount:	\$928.51		
Actual premium: lowest cost bronze		\$2,220.00	27	Actual premium: lowest cost bronze		\$2,220.00	27
		\$3,768.00	50			\$3,768.00	50
		\$1,344.00	child			\$1,344.00	child
Total premium	\$7,332.00			Total premium	\$3,564.00		
Apply tax credit	\$6,084.79			Apply tax credit	\$928.51		
Net household premium owed	\$1,247.21		- all 3 family members	Net household premium owed	\$2,635.49		- no 50 year old included
						\$1,388.28	- net higher cost



Total Household Costs for Marketplace Enrollment: American Indians and Alaska Natives, 2015

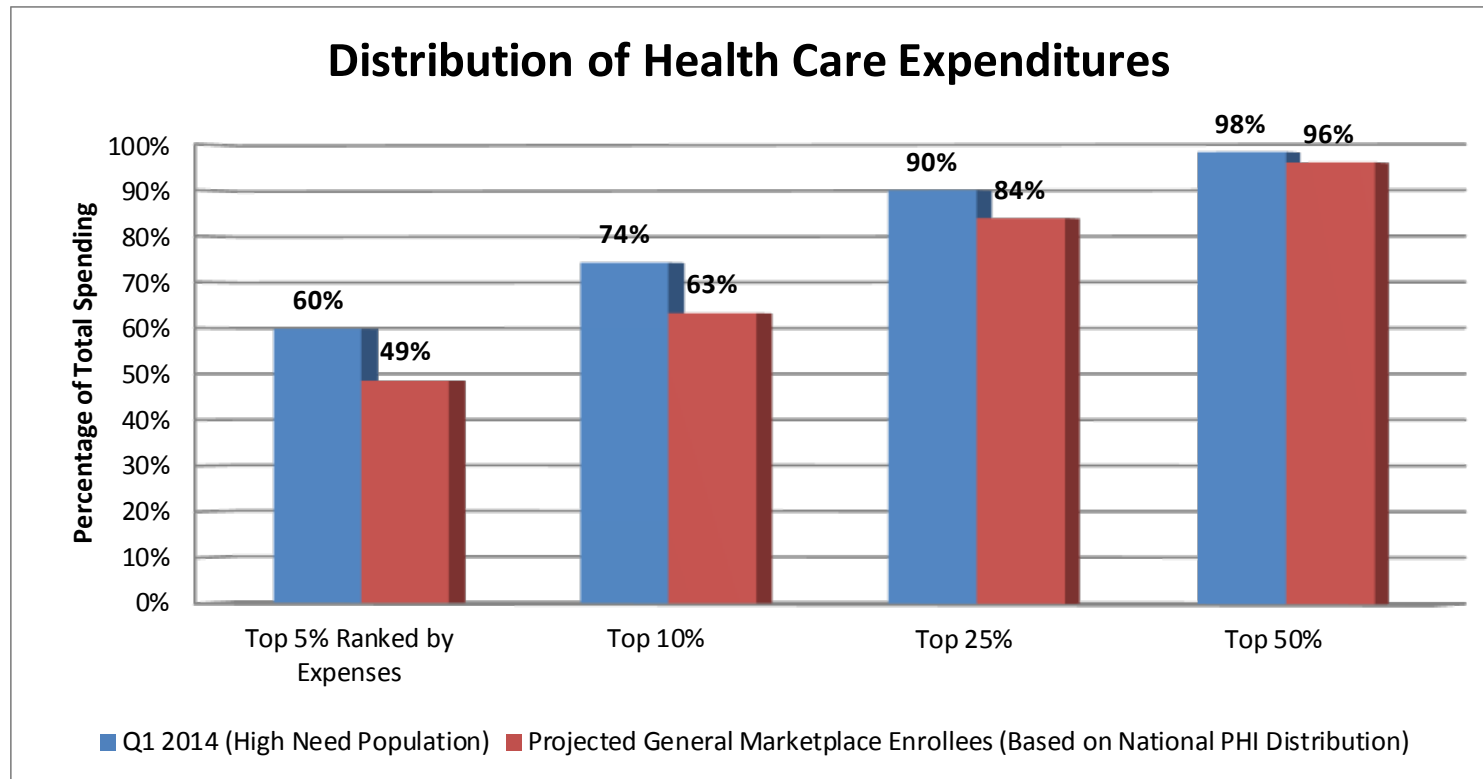
(family of 3; bronze-level coverage; by income; by enrollees; 40-year old non-smokers;
premiums and out-of-pocket costs)



Issue 2 (continued): What has the experience been with sponsoring enrollees for a narrow period of time in Marketplace

“Timing” enrollment through a Marketplace is not likely to maximize revenues / savings to sponsoring Tribe

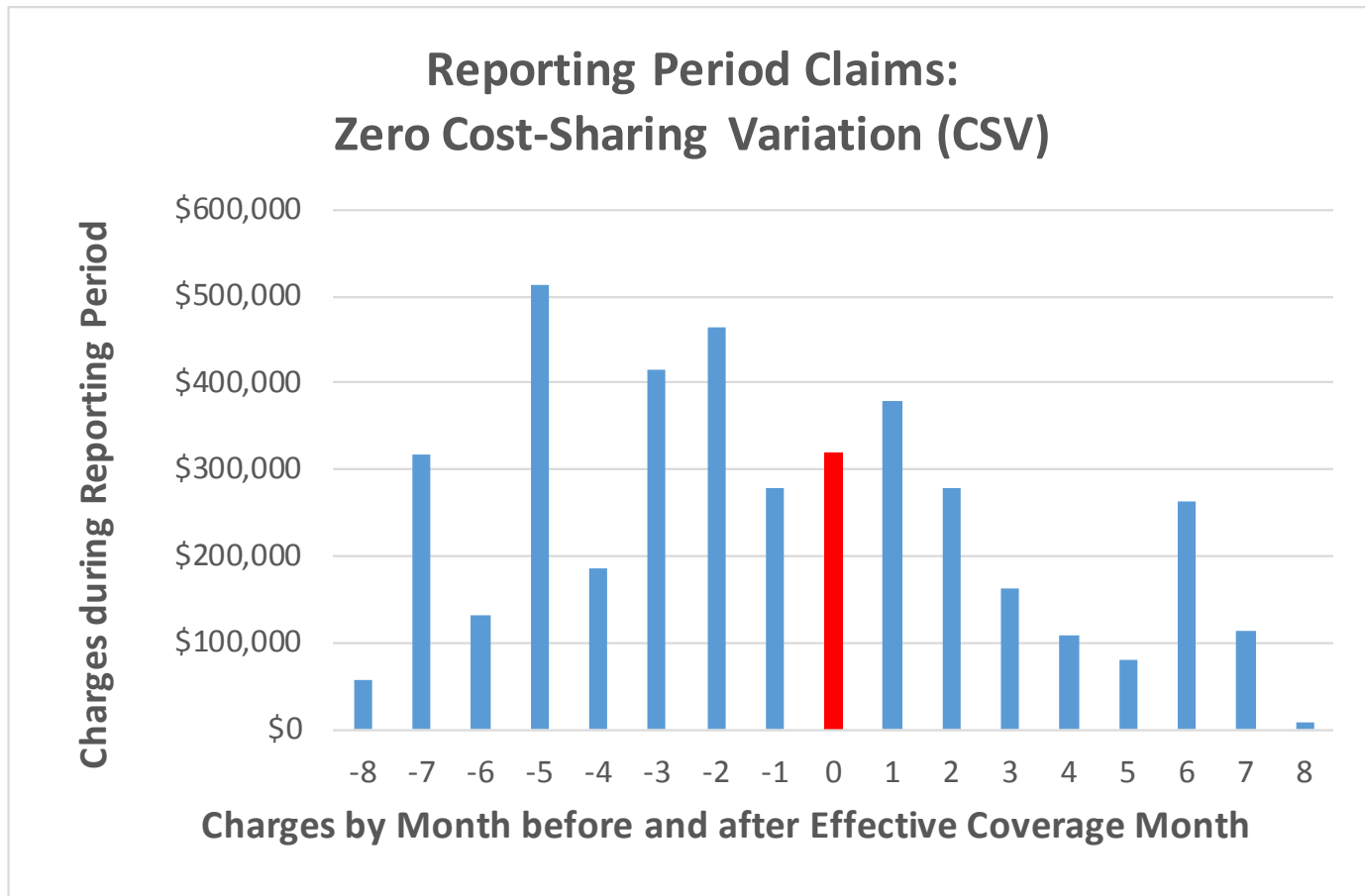
Even Pool of High Cost Enrollees Have an Unpredictable Use Pattern



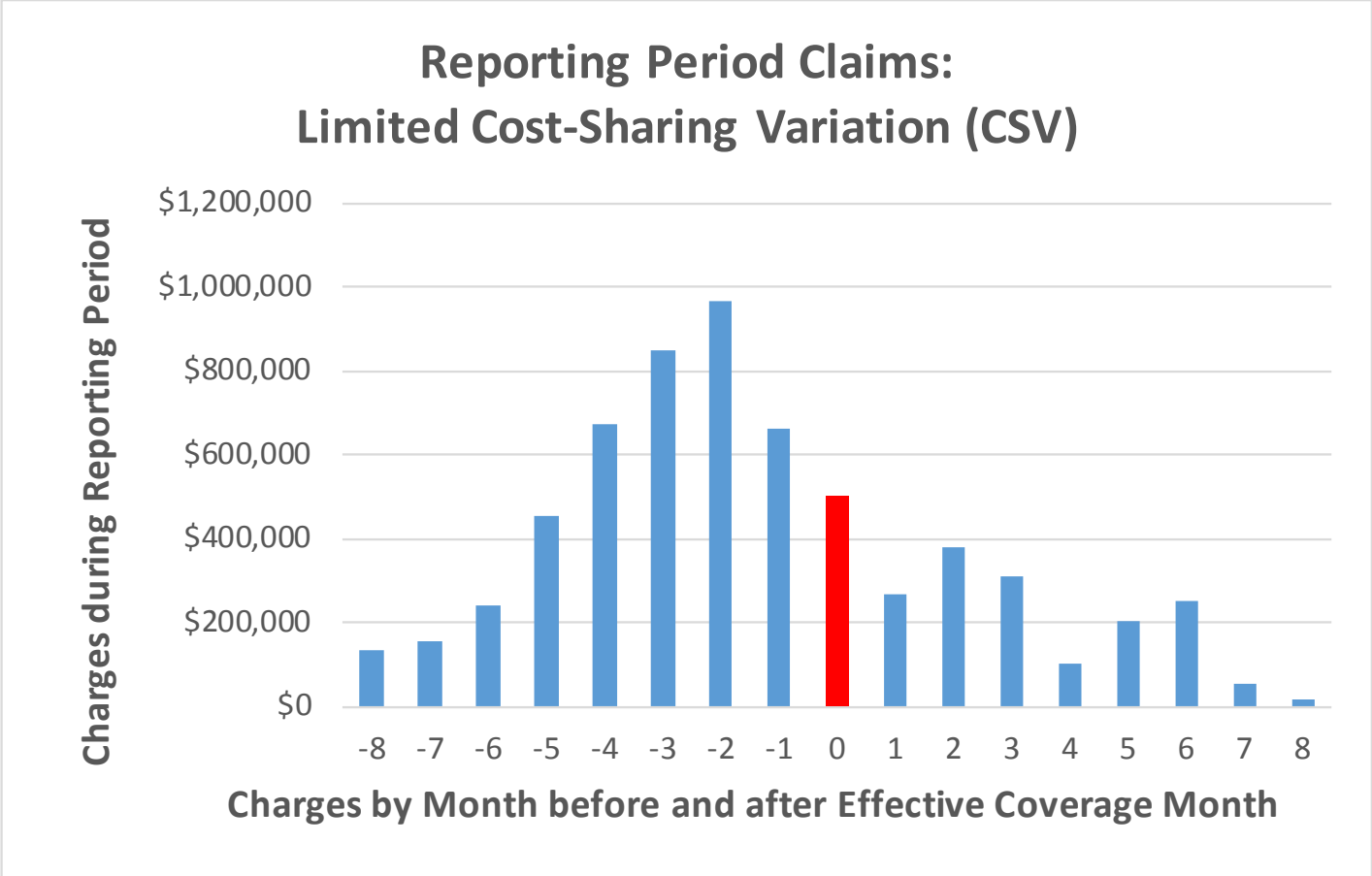
- 5% of enrollees generated 50% of costs
- 50% of enrollees accounted for 2% of costs



Marketplace Enrollment Requires More Extended Process (vs. Medicaid)



Enrollees under Limited Cost-Sharing Variation Shows Similar Pattern



**Issue 2 (continued): Distribution of costs / resources with
Marketplace coverage**

**Marketplace provides tremendous new resources to
meet health care needs of tribal members, and tribal
employees**

Distribution of Costs / Resources with Marketplace Coverage

- Data on following slides illustrate distribution of costs between enrollee and federal government for Marketplace coverage, for:
 - Range of household income levels
 - Individuals meeting definition of Indian under the Affordable Care Act (ACA)
 - Individuals NOT meeting definition of Indian under ACA
- Consider using Marketplace to meet employer requirement

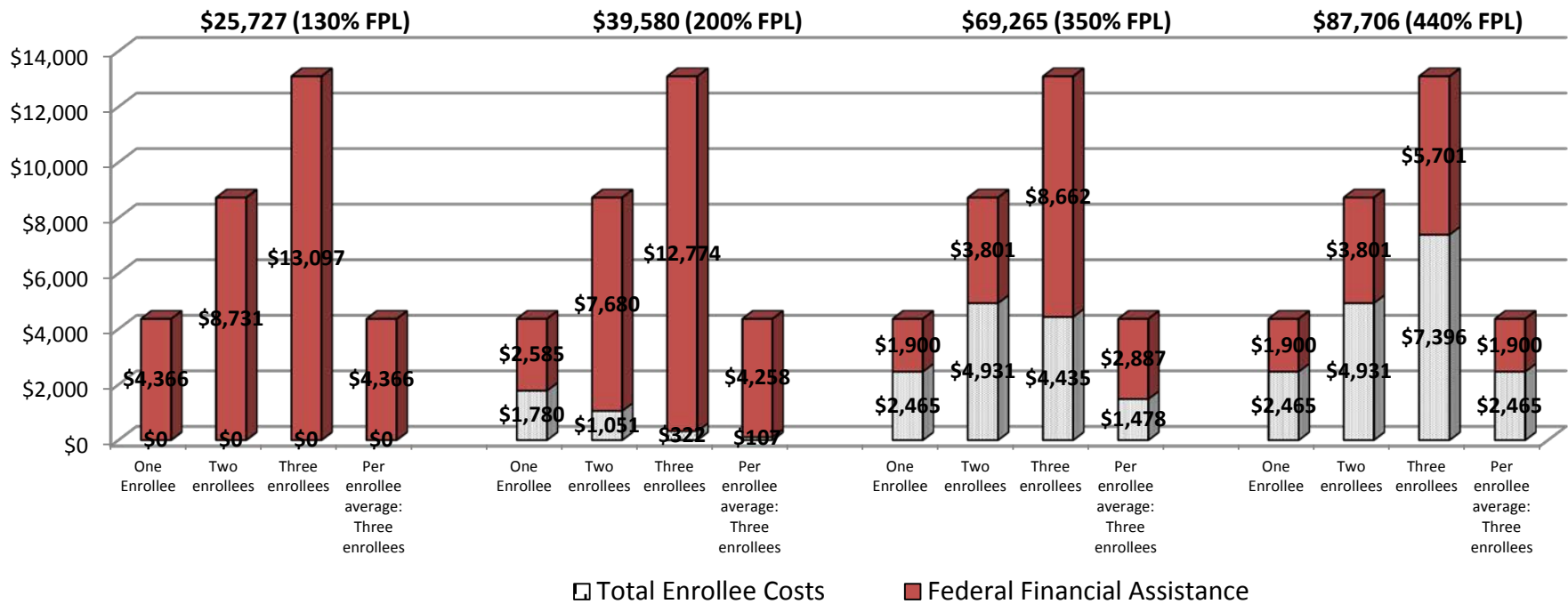


AI/AN enrollment in bronze-level plans: premiums and cost-sharing costs

Distribution of Funding - Marketplace Enrollment:

American Indians and Alaska Natives, 2015

(family of 3; bronze-level coverage; by income; by number of enrollees)



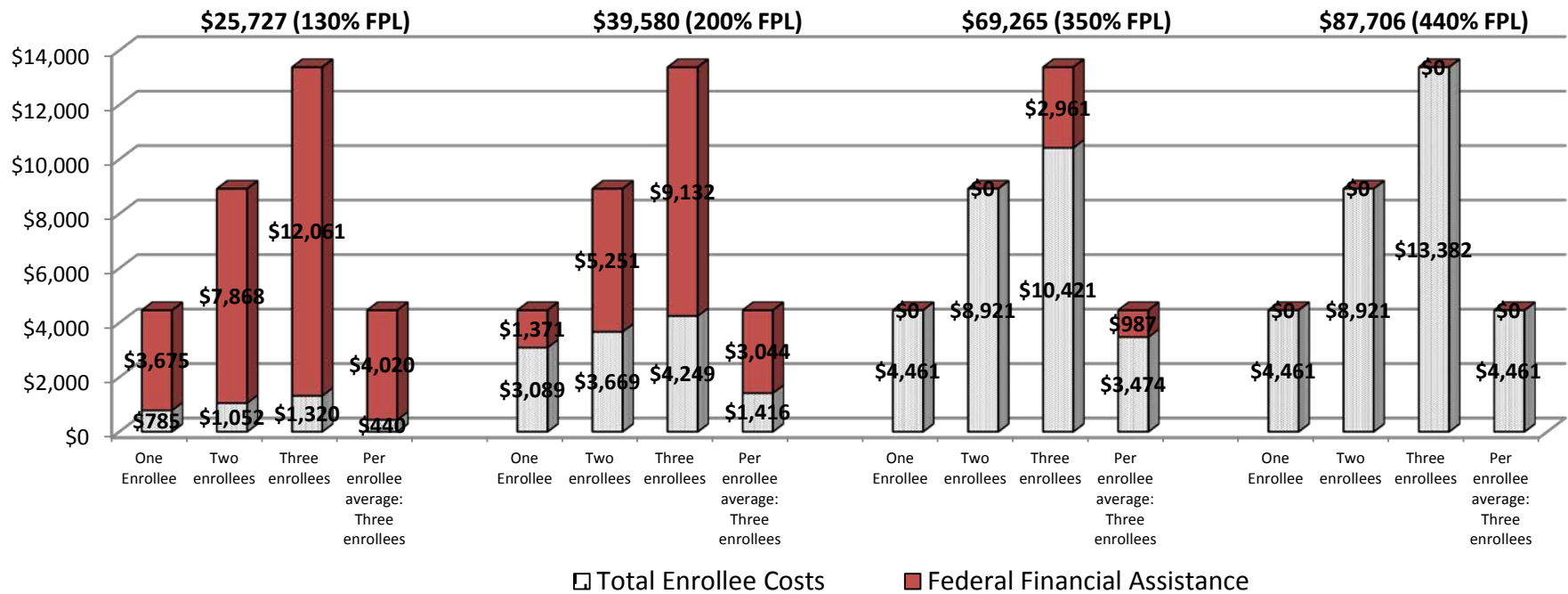
SOURCE: Analysis of Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the ACA's Health Insurance Marketplaces", September 2014, Issue Brief.



Enrollment in silver-level coverage: premiums and cost-sharing costs

Distribution of Funding - Marketplace Enrollment: non-"Member of Indian Tribes", 2015

(family of 3; silver-level coverage; by income; by number of enrollees)



SOURCE: Analysis of Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the ACA's Health Insurance Marketplaces", September 2014, Issue Brief.



Support tables to prior graphs: premium and cost-sharing costs

	Distribution of Funding - Marketplace Enrollment: American Indians and Alaska Natives, 2015															
	(family of 3; <u>bronze-level</u> coverage; by income; by number of enrollees in household)															
	\$25,727 (130%)				\$39,580 (200%)				\$69,265 (350% FPL)				\$87,706 (440% FPL)			
	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees
Total Enrollee Costs	\$0	\$0	\$0	\$0	\$1,780	\$1,051	\$322	\$107	\$2,465	\$4,931	\$4,435	\$1,478	\$2,465	\$4,931	\$7,396	\$2,465
Federal Financial Assistance	\$4,366	\$8,731	\$13,097	\$4,366	\$2,585	\$7,680	\$12,774	\$4,258	\$1,900	\$3,801	\$8,662	\$2,887	\$1,900	\$3,801	\$5,701	\$1,900
Total Funding	\$4,366	\$8,731	\$13,097	\$4,366	\$4,366	\$8,731	\$13,097	\$4,366	\$4,366	\$8,731	\$13,097	\$4,366	\$4,366	\$8,731	\$13,097	\$4,366

	Distribution of Funding - Marketplace Enrollment: Non-"Member of Indian tribe", 2015															
	(family of 3; <u>silver-level</u> coverage; by income; by number of enrollees in household)															
	\$25,727 (130%)				\$39,580 (200%)				\$69,265 (350% FPL)				\$87,706 (440% FPL)			
	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees	One Enrollee	Two enrollees	Three enrollees	Per enrollee average: Three enrollees
Total Enrollee Costs	\$785	\$1,052	\$1,320	\$440	\$3,089	\$3,669	\$4,249	\$1,416	\$4,461	\$8,921	\$10,421	\$3,474	\$4,461	\$8,921	\$13,382	\$4,461
Federal Financial Assistance	\$3,675	\$7,868	\$12,061	\$4,020	\$1,371	\$5,251	\$9,132	\$3,044	\$0	\$0	\$2,961	\$987	\$0	\$0	\$0	\$0
Total Funding	\$4,460	\$8,920	\$13,381	\$4,460	\$4,460	\$8,921	\$13,381	\$4,460	\$4,461	\$8,921	\$13,382	\$4,461	\$4,461	\$8,921	\$13,382	\$4,461

SOURCE: Analysis of Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the ACA's Health Insurance Marketplaces", September 2014, Issue Brief.

