KEEPING THE THIRD-PARTY REVENUE STREAM AFLOAT *AFTER* MEDICAID UNWINDING

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AGENDA

- Medicaid Unwinding Overview
- Unwinding Strategies & Activities
- Patient Outreach & Education
- Patient Screening Options
- Marketplace Overview
- Insurance Enrollment
- Areas of Focus
- Discussion
- Outcome

MEDICAID UNWINDING

Kaiser Family Foundation estimates approximately 20 million individuals gained Medicaid coverage during the three-year period, between February 2020 and March 2023.

It is further estimated around 17 million individuals could lose Medicaid coverage beginning April 2023 as many are no longer eligible and others are still eligible but face some type of barrier in getting renewed.

The State of Oklahoma has approximately 314,000 individuals that have had continuous Medicaid eligibility during the public health emergency but are truly ineligible for coverage. Of this number, it is expected that 13% are Alaska Native/American Indian SoonerCare members!

MEDICAID UNWINDING (CONT.)

In Oklahoma, April 1st, 2023, is when the unwinding process began for members that will be losing Medicaid coverage and no longer auto renewing. There will be phases of the Unwinding process that will go through December 31st, 2023. Oklahoma HealthCare Authority will send out a series of letters to members that will be losing coverage specifying the dates and why they will be losing coverage. There will be a total number of 4 letters mailed to each member losing their health coverage.

Some examples of the individuals losing coverage will be:

- Adults that are no longer categorically related meaning they aged out or became disabled through Social Security and could qualify for ABD through DHS and/or Medicare.
- Individuals that are now over income due to **high annual household** incomes.
- Individuals that have moved out of state.
- Information has not been updated (undeliverable address, phone number, etc.)

MEDICAID UNWINDING (CONT.)

There are approximately 153,000 Tribal members enrolled in Oklahoma Medicaid aka SoonerCare.

There are more than 40,000 members scheduled to lose SoonerCare during the unwinding that will end December 31, 2023.

During the Pandemic, members were auto renewed automatically so that there would not have a lapse in coverage, and they would have continuous coverage. This process prevented member's applications from being terminated based on changes in household information, therefore resulting in a high number of members losing coverage now as the unwinding process unfolds.

Many on Medicaid have children that will remain eligible and covered under Medicaid, even if the adults in the home lose coverage.

WHERE TO GO FROM HERE?

PLANNING BEGAN EARLY ON!

- Medicaid has sent updates that the Public Health Emergency (PHE) would be ending and will provide updates as they became available.
- Preparation began for the Unwinding process, committees were formed, data was examined to determine the number of patients that were potentially affected, staffing considered, and patient outreach was discussed.
- We had multiple discussions with the State to see if they could/would provide us with a list of everyone that would be "unwinding" so we could get started.
- And we started………… the State provided us with our first list.
  - The list consisted of members seen in the last 2-years that showed Choctaw Nation as the Primary Care Provider (PCP).

PLANNING BEGAN EARLY ON! (Cont.)

- The State's list was reviewed, and preparation began.
  - We quickly realized that this list could not possibly be **ALL** of our Medicaid enrolled and eligible members because the list was ***way too short!*** We discovered that we had a lot of patients that do not have Choctaw Nation listed as the PCP.
  - Many could have been seen at different clinics outside of Choctaw Nation and had their PCP changed to that clinic.
  - Many may not have a PCP listed at all.
  - We needed to locate all the members in our database to figure out if and when they could possibly be losing coverage.
- Back to the State to see if they could re-run our member enrollment roster and see if we could get a better list.

SUGGESTIONS *and* OPTIONS *on the* DATA

- Oklahoma has provided I/T/U providers the benefit of a Tribal Administrative Match payment aka TMAM.
- The intent of the TMAM is to contract with tribal enrollment partners to receive reimbursement for accepting and processing new and renewed applications for SoonerCare.
- Because of the TMAM, a quarterly report is submitted to the State using their requested formatting, listing each patient's enrollment information along with other specific criteria. The State then verifies the information and pays Choctaw Nation for the verified applications.
- We went back to the State and asked if they could match the Medicaid patient population in our database using this existing TMAM reporting format to get us better data for the impending unwinding activities related to our entire population.

SUGGESTIONS *and* OPTIONS *on the* DATA (CONT.)

Be careful what you ask for! The new list included almost 29,000 patients within our health system.

- Approximately 5,200 patients did not show active coverage with OK Medicaid and the list was sent to the Registration department to have the chart data verified to ensure the data didn't just need to be updated. e.g., demographics such as address, date of birth, Social Security number, etc.
- Approximately 6,900 patients were marked by the state as being affected by the unwinding process. These cases were assigned to Patient Benefit Coordination staff to begin the task of contacting the patients to update their Medicaid application. If they were denied or no longer qualified, they would go through a screening process to search for other third-party resources and obtain any other changes or coverage that needed to be added or their charts.
- Our goal is to make sure that we update all Medicaid cases to reflect accurate, up to date information.

REMEMBER: From the beginning of COVID in 2020 until the fall of 2022, most Medicaid cases auto-renewed and had zero to minimal updates made to their Medicaid files.

UNWINDING OUTREACH Excel INTERACTIVE PATIENT LIST

Snapshot of the interactive Excel Unwinding Patient spreadsheet.

- The Patient Benefit Coordinator’s individual patient assignments are along the bottom.
- The Status column has a drop-down box to allow for quick documenting by staff.
  - 1st call, 2nd attempt to call
  - Mailed letter (unable to contact via phone)
  - Non-working phone and/or address
  - Completed
- Each status is color coded to quickly identify.

Excel Updated PHE Patient List in TMAM Template Unwinding

A10 | 1st attempt made

	A	B	C	D	E	F	G	H	I	J	K	
1	STATUS	Member ID	Applicant's Social Security Number (SSN)	Applicant's Last Name	Applicant's First Name	Middle Nan	nt's Gend	Applicant's Date of Birth MM/DD/YYYY	PHE Unwind Date	Coordinat	Outcome	Comments
2	1st attempt made											
3	2nd attempt made											
4	Mailed letter											
5	Non-Working Phone & Address											
6	Completed											
7	New											
8	Asked for Callback											
9	Called 4+ times and Mailed Letter											
10	1st attempt made											

Drop-down: Mailed letter; 1st attempt made; 2nd attempt made; Non-Working Phone & Address; Completed; New; Asked for Callback; Called 4+ times and Mailed Letter

Rows 20–29: 1st attempt made

Sheet tabs: Baylee, Mary, Kendra, Hosanna, April, Amy, Kelsey, Cindy, Ashley, Christie, Debbie, Lacy, Krystal, Macey, Selena, Teagan, Tiffany, DO NOT USE Status Tab, DO NOT USE COMPLETED

UNWINDING OUTREACH Excel INTERACTIVE PATIENT LIST (Cont.)

Snapshot of the interactive Excel Unwinding Patient spreadsheet.

- The patient's demographics were listed to help the Patient Benefit Coordinators locate the chart and the information within the State's on-line enrollment system.
- The Outcome Status column also has a drop-down box to allow for quick documenting by staff.
  - Updated & Recertified
  - Over income
  - Does not want to renew
  - Moved out of state
  - Enrolled/Current ACA coverage
  - Has other insurance coverage
  - DHS case/Referred to DHS
- Each status is color coded to quickly identify.

Excel Updated PHE Patient List in TMAM Template Unwinding

	STATUS	Member ID	Applicant's Social Security Number (SSN)	Applicant's Last Name	Applicant's First Name	Middle Nam	nt's Gend	Applicant's Date of Birth MM/DD/YYYY	PHE Unwind Date	Coordinat	Outcome	Comments
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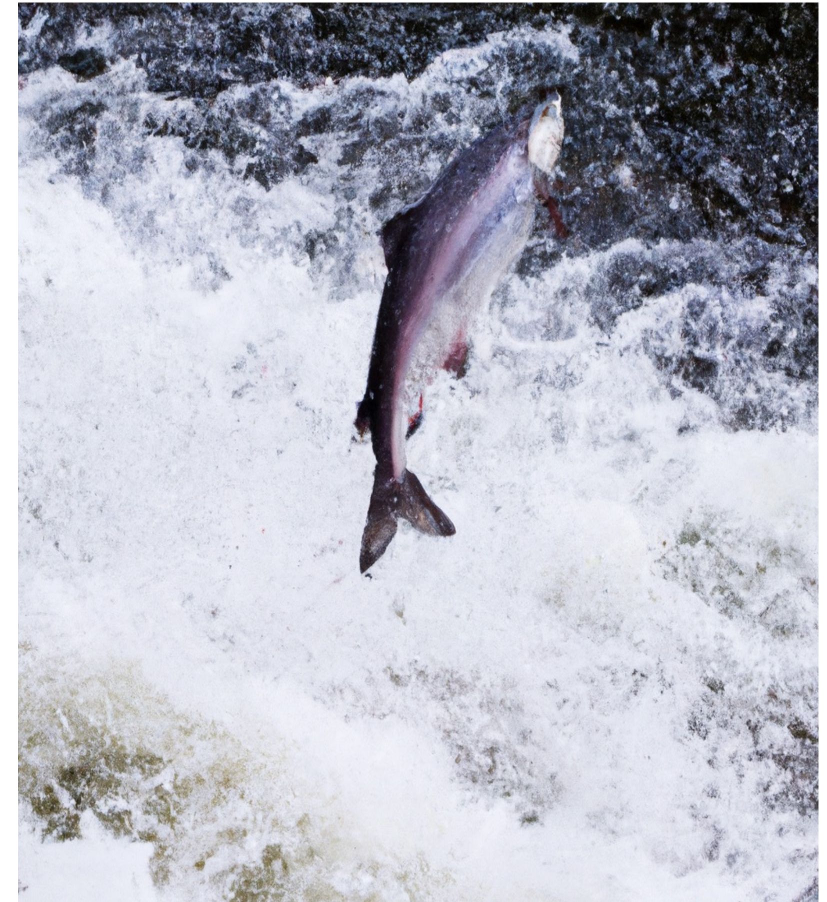
25	1st attempt made											
26	1st attempt made											
27	1st attempt made											
28	1st attempt made											
29	1st attempt made											

Outcome drop-down: Updated & Recertified; Over Income/Denied; Did not want to renew; Moved Out of State; Enrolled/Current ACA Coverage; Has other Insurance coverage; DHS Case/Referred to DHS

Sheet tabs: Baylee, Mary, Kendra, Hosanna, April, Amy, Kelsey, Cindy, Ashley, Christie, Debbie, Lacy, Krystal, Macey, Selena, Teagan, Tiffany, DO NOT USE Status Tab, DO NOT USE COMPLETED

"OUR" MEDICAID UNWINDING ACTIVITIES

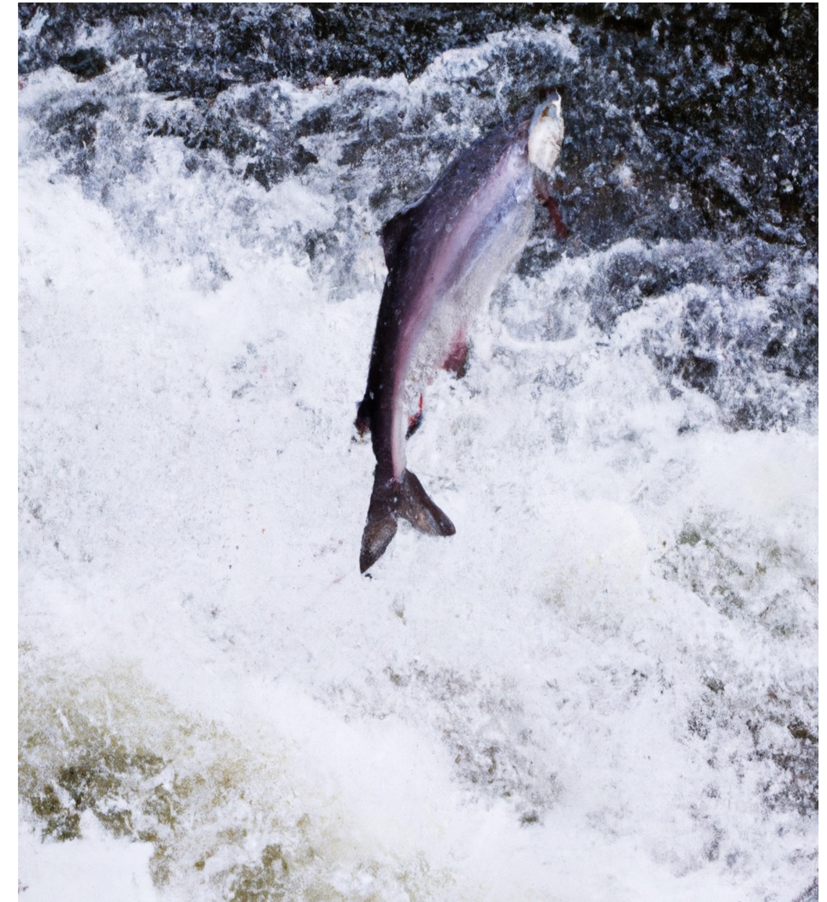
- The active list that was given to the Patient Benefit Coordinators was an interactive Excel list housed on an internal SharePoint site.
- The staff were assigned groups of patients to begin contacting from the Excel list separated by months. The list had drop-down columns that could be changed as each patient's status was updated.
- Management could pull reports from the Excel file and report to Leadership on the renewals, terminations, referrals to other insurance screening, etc.
- Other important data such as open, terminated, unable to contact, etc. was included in the list. This continues to be a focus as the unwinding activities continue!



"OUR" MEDICAID UNWINDING ACTIVITIES (Cont.)

In addition to the active list, we immediately began other means of patient outreach.

- A Postcard was developed and mailed out to Medicaid households letting them know an Update was Required on their SoonerCare case and to take action to call the State or one of our Patient Benefit Coordinators to avoid termination.
- Over 15,000 postcards were mailed out in October of 2022 AHEAD of the State's unwinding activities that begin in the Spring of 2023.
- Patient Registration was advised to send every single patient that had Medicaid insurance to a Patient Benefit Coordinator for screening and/or updates.
- A campaign was also published via Social Media encouraging patients to contact the State and/or a Patient Benefit Coordinator.
- Choctaw Nation has a health system app for Smartphones. Messages were blasted via the app to contact a Patient Benefit Coordinator to avoid insurance termination.



POST CARD-UNWINDING OUTREACH

The snapshot provided, is an example of the Postcard that was sent out to over 15,000 individuals in our health system in October 2022.

UPDATE REQUIRED FOR SOONERCARE CASES

The Oklahoma Healthcare Authority

will soon require all SoonerCare recipients to update their information to continue coverage.

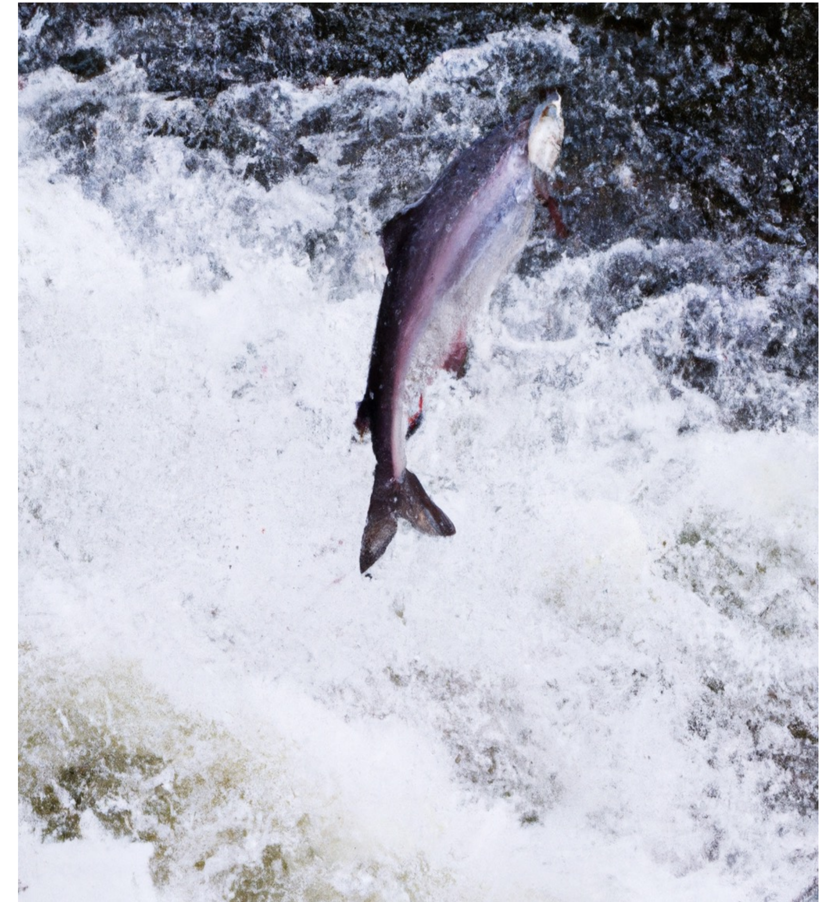
Contact a Patient Benefit Coordinator

at your local Choctaw Nation Health Clinic to update your information to avoid termination or lapse in coverage.

Choctaw Nation Health Services

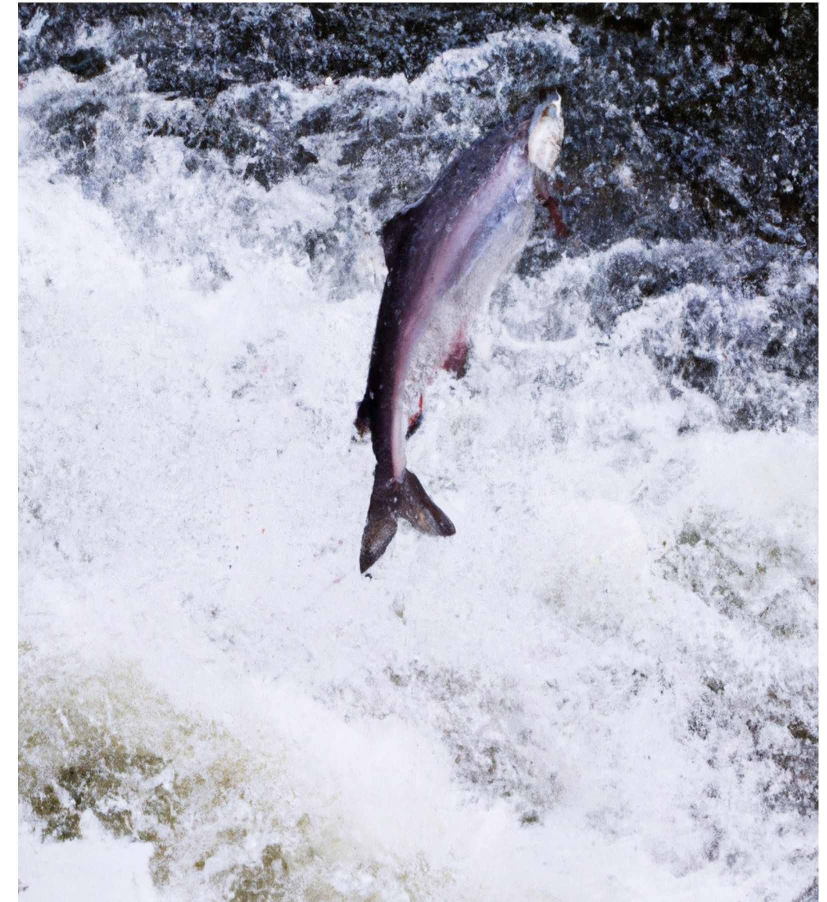
"OUR" MEDICAID UNWINDING ACTIVITIES (Cont.)

- Posters (similar to the Postcard) were distributed in and around Pharmacy and Patient Registration areas.
- As the unwinding activities progressed and the State provided the unwinding timeline, another Postcard was mailed out in April 2023. Approximately 11,000 were sent out this time!
- Fliers were distributed in ***all*** outbound prescriptions filled with the same message. The fliers had a QR code that could be scanned to link to the benefit coordinator website and contact information.
- Choctaw Nation also has a newspaper publication. Articles were run in the Bisknik to help get the unwinding word out.
- Any patient that had an email listed in their chart also received email blasts regarding Medicaid unwinding.
- Outreach events, including senior lunches, Choctaw Nation community center events and community events were attended by benefit coordination staff to provide information and education to the community.



"OUR" MEDICAID UNWINDING ACTIVITIES (Cont.)

- Staff training was/is very important!
  - Periodic emails listing completion rates, uninsured statistics.
  - Bi-monthly Webex meetings to discuss updates, reminders and other tips to keep the staff in the loop.
  - Standards/quotas put in place to ensure that the workload is handled timely during the unwinding.
  - Face-to-face Medicaid training. We also invited the State to attend to help field questions regarding updates.



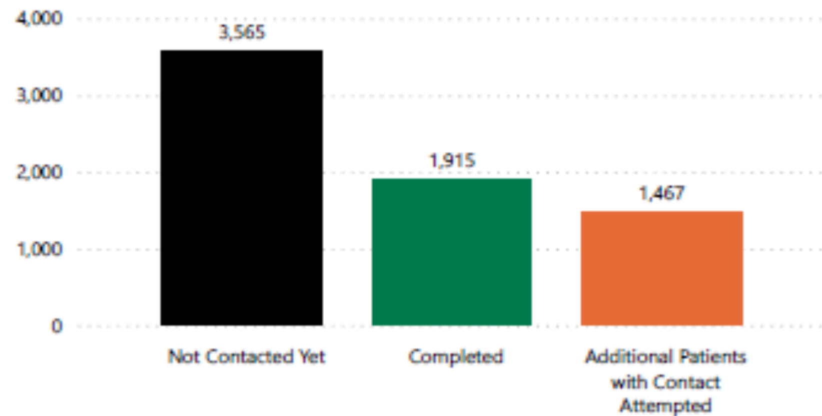
"OUR" CURRENT MEDICAID UNWINDING STATS

Total Patients Identified

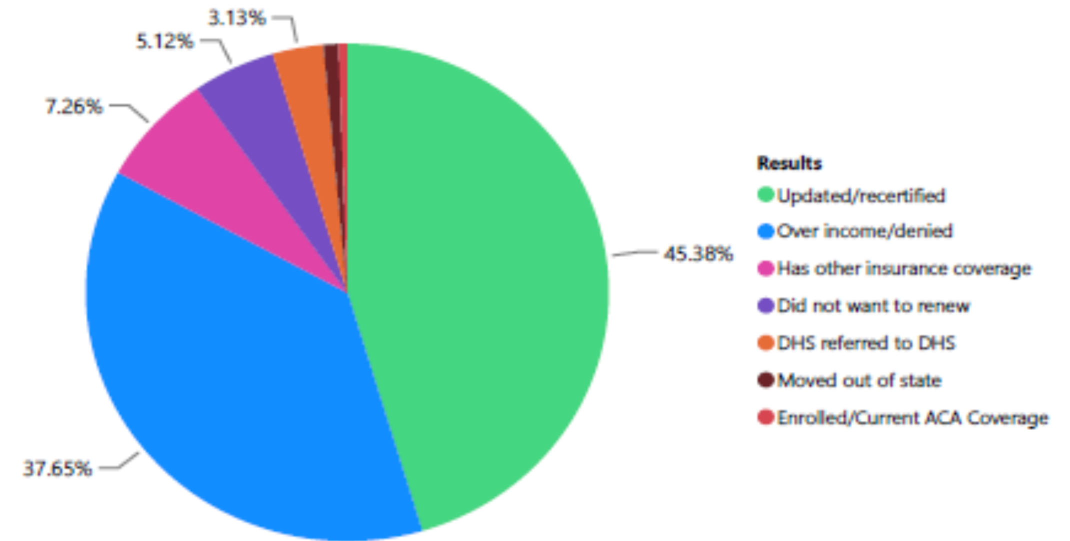
6,947

Medicaid Unwinding

Unwinding Results By Status - June 2023



Outcome Completed Status - June 2023



**These stats were reported at the June 2023 Leadership Meeting

REVENUE *by* PAYER CLASS

The snapshot of the revenue listed by payer class clearly demonstrates how important Medicaid unwinding activities are for our health system!

PLAN FOR THE FUTURE

PLANNING

Identify your patients that have Medicaid and identify the targeted termination date.

Build an internal network to work through the list.

MARKETING

Educate Educate Educate!

Apply, Update, Re-apply and Renew

The public health emergency is over. Medicaid resumes the one-year enrollment effective date just like before.

TARGETED PATIENT CONTACT

Coordinate the unwinding list(s) with your Patient Benefit Coordinators to call, mail letters, educate the office staff, physicians, nursing staff, and the community!

STRATEGY

Not everyone will re-qualify for Medicaid benefits. All other patients need to be screened for alternative resources such as employer insurance or ACA/Marketplace plans.

INITIATE PLAN

Patient screening and alternate insurance enrollment is critical in protecting your third-party revenue stream as well as ensuring your patients have health insurance protection.

AREAS OF FOCUS

Unwinding Goals

- Identify any/all patients that are enrolled in Medicaid.
- Work with your State Medicaid Agency to see if they can provide you with a listing of all the AI/AN individuals that will be unwinding.
  - Ask your State Agency to provide you with a listing of your patients that are about to lose coverage.
  - Many will provide you with a listing that can be filtered by month of coverage loss.

Unwinding Goals

- Develop an “unwinding” schedule and begin patient contact with the first to term and move down the list based on the month the coverage will end.
- Contact patients by phone, mail, email, robo-calls, fliers, Social Media, other means of patient contact to update Medicaid profile and/or screen for alternate insurance plans.

CLARIFY ANY MYTHS TO YOUR PATIENTS

Bad Information

Many individuals have heard that EVERYONE will be losing Medicaid coverage.

Myth: Not everyone will lose Medicaid coverage. Medicaid has reviewed the last information that was added to the individual's profile.

Many could be losing coverage due to outdated or incorrect information. A quick update; addition of paystubs, household information, etc. may renew them!

Rumors

Patients comment that they don't want to update their Medicaid profile with the State because if they do, they will get cancelled.

Myth: Medicaid has been on auto-renewal for the last three years. Many will remain eligible, the individual's demographics, employment information, household status needs to be updated. It's all OUTDATED.

Just Don't Care

There are individuals that have been auto-renewed for three years and should NOT have Medicaid benefits anymore. These individuals may have even tried to terminate their coverage and it auto-renewed again and again, so they gave up trying to correct the coverage.

SOMETHING TO THINK ABOUT!

The Medicaid coverage could be terminating for something as simple as a Social Security card! It's been three years since many of these cases have been formally updated.

BENEFITS TO RENEWING *or* COMPLETING NEW MEDICAID ENROLLMENT

- Increases a patient's access to medical care.
- Improves health disparities and rural areas.
- Supports IHS, Tribal and Urban health care programs.
- Maximize fiscal resources.
- Reduces/eliminates Referred Care dollars spent.
- Many Indian health care systems receive a Medicaid all-inclusive aka flat rate for services provided.
- Many states have expanded Medicaid benefits to include many individuals that otherwise would not have insurance benefits.

DID YOU KNOW?

There are members that will be unwinding due to no longer being categorically related because of aging out, becoming disabled, and/or obtaining Medicare. These patients will be screened for OK DHS Medicaid coverage. If the members meet qualifications, they will go through DHS for their coverage.

There are also Medicare Savings Programs that could be available if the members meet the income qualifications. These programs can help pay for Part A and Part B premiums and lower drug cost.

These patients are also screened for our Tribal Premium Assistance (sponsorship) programs that are available to qualified tribal members that utilize our health services.

DID YOU KNOW? (CONT.)

If/when an individual loses Medicaid, this opens a Special Enrollment Period (SEP) within the insurance world?

Because of the SEP, that individual and/or family can enroll in the employer health plan (if they work where insurance is offered)!

The SEP gives the individual and/or family **60-days** to enroll in the employer sponsored insurance plan. If they wait beyond the 60-day time limit, they must wait until the employer has their open enrollment activities to be able to enroll. This could cause the individual and/or the family to remain uninsured for an extended period of time.

DID YOU KNOW? (CONT.)

If the individual and/or family does not have access to an employer sponsored insurance plan OR if the insurance is too costly for their budget, the Marketplace should be considered.

The Marketplace offers special provisions to Native Americans that many other individuals can not take advantage of!

- Native Americans can enroll in the Marketplace anytime during the year.
- Many qualify for immediate tax credits that lower the monthly cost of the premiums, so the plan is either FREE or low-cost.
- Some may qualify for limited cost-sharing plans and have the deductibles, co-payments and/or co-insurance waived if the income is between 300%-400% of the Federal Poverty Level and a referral from the Indian Health Care provider.

DID YOU KNOW? (CONT.)

The Marketplace offers complete coverage plans that are beneficial to the patient as well as the clinic/facility!

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Pregnancy, maternity, and newborn care. (both before & after birth)
- Mental health and substance use disorder services. (includes behavioral health treatment, counseling & psychotherapy)
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.
    - Adult dental and vision coverage **ARE NOT** essential health benefits.

MARKETPLACE COVERAGE aka ESSENTIAL HEALTH BENEFITS

- **Outpatient Care:**
  - Doctor's visits
  - Same-day surgery
  - Home health care *and* hospice
- **Emergency services:**
  - Trips to the emergency room
  - Ambulance service
- **Prescription drugs**
- **Laboratory Services:**
  - X-rays
  - Blood tests

- **Nursing home care**
- **Hospitalization**:
  - Doctor's care
  - Surgeries
  - Medications
  - Tests
  - Room *and* board
- **Mental health/substance use disorder services:**
  - Behavioral health treatment, e.g. therapy *and* counseling
  - Mental *and* behavioral health hospitalization
  - Substance use disorder treatment

- **Rehabilitative/Habilitative services/devices:**
  - Services (physical therapy, speech therapy, etc.)
  - Devices (walkers, crutches, body braces, etc.)
- **Pregnancy/maternity care:**
  - Pregnancy care
  - Childbirth
  - Newborn care
- **Child health care:**
  - Dental care
  - Vision care
- **Additional benefits:**
  - All plans must also cover the following at no additional charge:
  - Breastfeeding support *and* counseling
  - Equipment, including a breast pump

ESSENTIAL HEALTH BENEFITS (Cont.)

The Marketplace insurance also offers **FREE** preventive services that can help stop disease and other health problems or detect illnesses early when treatment is likely to work best!

Marketplace plans are required to cover preventive services such as:

Adults:
- ✓ Alcohol counseling
- ✓ Blood pressure tests
- ✓ Cholesterol screening
- ✓ Depression screening
- ✓ Diabetes screening
- ✓ Immunizations
- ✓ Obesity counseling
- ✓ Osteoporosis screening
- ✓ Mammography
- ✓ Stop smoking programs

Children:
- ✓ Autism screening
- ✓ Behavioral assessments
- ✓ Fluoride supplements
- ✓ Immunizations
- ✓ Lead screening
- ✓ Vision screening

COVERED SERVICES UNDER *the* MARKETPLACE INSURANCE PLANS- PRE-EXISTING CONDITIONS

ALL Marketplace plans **must** cover treatment for pre-existing medical conditions.

NO Marketplace insurance plan can reject, charge more or refuse to pay for essential health benefits for any condition an individual had before the insurance coverage started.

Once the individual is enrolled, the plan can't deny coverage or raise the premium rates based on the patient's health condition(s).

Pregnancy- is covered from the day the plan becomes effective.

- The insurance plan can not reject or charge an individual more because of a pregnancy related diagnosis.
- Once the individual is enrolled, the pregnancy and childbirth are covered from the day the plan starts.

AFFORDABLE INSURANCE COVERAGE

The monthly premium costs are based on annual income.

There are immediate tax credits for those with income between the income range listed on the current year Federal Poverty Level (FPL) income guidelines.

- The amount of the tax credit depends on the annual income and the size of the family.

If an individual qualifies for an immediate tax credit, that credit will reduce the monthly premium payment to an affordable monthly amount.

TWO TYPES *of* COST SHARING REDUCTIONS FOR NATIVE AMERICANS/ALASKA NATIVES

ZERO COST-SHARING INCOME 100%-300%

Individual does not pay:

- ✓co-payments
- ✓deductibles
- ✓co-insurance

When getting care from an Indian Health care facility OR when getting essential health benefits through a Marketplace plan from a network "outside" provider.

LIMITED COST-SHARING INCOME ABOVE 400%

Individual does not pay:

- ✓co-payments
- ✓deductibles
- ✓co-insurance

When getting care from an Indian Health care facility.

REQUIRES a Tribal Referral form prior to getting essential health benefits through a Marketplace plan from a network "outside" provider to avoid having to pay the above costs!

WHAT IS A PREMIUM TAX CREDIT?

Helps individuals afford health coverage purchased through the Marketplace (ONLY).

Eligible to those that have incomes between 100% and 400% of the Federal Poverty Level (FPL) based on family size.

Individuals can choose how much of their credit to use, to apply towards their monthly premiums, up to the maximum amount they qualified/eligible for.

It must be reconciled at the end of each year when the Federal income tax return is filed. The Marketplace will mail out a 1095-A form each January letting the individual/family know the monthly premium cost minus any tax credits used and the number of months the coverage was in effect.

To receive the tax credit, an individual must file taxes.

- Married individuals **MUST** file a joint tax return.

PREMIUM TAX CREDIT (Cont.)

The individual **MUST** be aware that the amount of the premium tax credit taken in advance may impact the amount they owe in taxes or the amount they receive as a refund when filing the Federal tax return.

If the individual's family size or income projection turns out to be higher than projected during enrollment, it may change the eligibility for the tax credit for what was pre-determined at enrollment AND additional taxes may owed when filing the tax return.

If the individual's family size increases or income projection turns out to be lower than what was pre-determined the individual could get money back or receive a larger refund for the year when filing the Federal return.

It is vital that the individual keep the Marketplace account updated and the income as close to "true" as possible to prevent any tax issues when the Federal income tax return is filed.

INCOME GUIDELINES…WHAT COUNTS

- Salaries
- Tips
- Alimony
- Retirement/Pension income
- Investment income
- Rental income
- Unemployment compensation
- RailRoad Retirement benefits

- Wages (not including pre-tax contribution to retirement, childcare, transportation, or medical care)
- Net income from self-employment or business (amount they take in minus their business expenses)
- Social Security payments, including disability BUT not Supplemental Security Income (SSI)
- Other taxable income like prizes, awards and gambling winnings

INCOME GUIDELINES……WHAT DOESN'T

- Child support
- Gifts
- Supplemental Security Income (SSI)
- Veterans' disability payments
- Workers' compensation
- Proceeds from loans, like student loans, home equity loans or bank loans

REPORT CHANGES IN CIRCUMSTANCES

Changes in circumstances can affect the eligibility for a premium tax credit:

- Eligibility for a tax credit due to the change but not eligible on initial enrollment.
- Amount of tax credit could vary up or down depending on the change.

Reporting changes **timely** will ensure the proper amount of the credit and prevent issues during tax season.

MARKETPLACE

Anytime an individuals circumstances change, they must report those changes **within 30 days**. This will ensure that the correct financial assistance (tax credits) are applied, and that the individual(s) do not owe money when filing the tax return because the wrong amount was applied all or part of a year.

The individual could/would be eligible for new or different financial help, or free or low-cost coverage through Medicaid/SoonerCare or Insure Oklahoma versus the Marketplace.

EXAMPLES *of* CHANGES IN CIRCUMSTANCES

- A move, change in residence address.
  (Moves outside of the state would mean a complete change of plans!)
- Household income changes. (Raise in income, bonus, new job, loss of working work hours, etc.)
- Family size changes. (married, divorced, pregnancy, death, child born, child ages out, etc.)
- Become qualified for other health insurance. (through employer plan, Medicare, Medicaid, VA, etc.)

EXAMPLES *of* CHANGES THAT MUST BE REPORTED

- Changes in immigration status. (VISA expires or isn't renewed)
- Enrolls, becomes eligible for Medicaid, Medicare Part A Part B or Medicare Part C.
- Becomes incarcerated or released from incarceration.
- A change in plan for filing your Federal income tax return for the year of getting Marketplace coverage. (e.g., getting to claim new dependents or no longer getting to claim a dependent-every other year as a child)

MARKETPLACE ENROLLENT GUIDELINE

If an individual (or family member) is offered employer insurance **AND** they decide to turn it down or the individual terminates the plan for whatever reason (too expensive, employer told them they didn't need it because they were "Native American") ……..they can enroll in a Marketplace plan **BUT**

…….. they **will not** receive advance premium tax credits (to reduce the monthly premium costs) as well as the cost-sharing reductions (deductibles and co-payments/co-insurance waived).

Exception: If premium cost is over 9.12% of their household income individual or family member may still qualify for advanced premium tax credits.

INDIVIDUALS WITH MARKETPLACE COVERAGE AGING INTO MEDICARE

Medicare (Part A) is considered to be minimum essential coverage; therefore, those aging into Medicare **cannot** continue their enrollment with a Marketplace plan.

If an individual already has Medicare, they do not qualify for Marketplace enrollment. There is no need for someone on Medicare to do anything further.

Those with a Marketplace plan reaching age 65 (or becoming eligible due to a disability) will need to terminate the Marketplace plan. The Marketplace plan termination date needs to be the day before Medicare eligibility begins.

CHOOSING MARKETPLACE *OVER* MEDICARE

If an individual has a Marketplace plan **and** decides they would rather keep that plan and NOT enroll in Medicare, they will have to face some serious issues regarding their healthcare! The individual drops Medicare Part A and Part B coverage:

- They will lose the premium tax credits and cost-sharing reductions in the Marketplace!
- If the Marketplace doesn't immediately "catch it", down the road they will owe additional taxes for the amount of the tax credit received during the time they had Marketplace insurance and eligible for Medicare.
- By cancelling Medicare, when they decide they want/need it later there will be a late Medicare enrollment penalty; they would only be able to enroll from January 1 – March 31; and their Medicare coverage would not start until the first day of the following month!
- Medicare late enrollment penalties will apply. 10% for every year they should have had Medicare but didn't.

DID YOU KNOW?

Native Americans **cannot** have the Medicare Part B late enrollment penalty waived. The late enrollment penalty is 10% for every year an individual could have had Medicare but didn't.

The only penalty that can be waived is for Part D!

PATIENT SCREENING BARRIERS

- Some of the patients have not been seen recently in one of the clinics so the address, phone number(s), next of kin and/or emergency contact information is outdated.
- Many patients have moved on from having the Medicaid coverage and don’t feel like it’s a priority to spend the time on the phone or face-to-face to be screened and/or enrolled in insurance.

PATIENT SCREENING BARRIERS (CONT.)

- Often **“we”** have a sense of urgency to find the patient insurance, but it is not a priority for the patient, so they don’t have the same passion or concern.
- Members that are over income and cannot continue with Medicaid and are offered insurance through their employer, but they opted out of the insurance.
  - NO tax credits available so another form of insurance is not affordable.
  - We strongly encourage our patients to utilize the SEP (Special Enrollment Period to enroll in health benefits to not be without coverage.

THE VALUE *of* HEALTH INSURANCE

Provides greater **access to medical care**!

Compliments care the patient receives from Indian Health care.

Provides **insurance coverage outside of Indian Health** in the event the patient has traveled away from an Indian Health facility, lives outside of the service area, OR needs medical care that an Indian Health care facility cannot provide.

Reduces the patient's out-of-pocket costs associated with medical expenses received outside of an Indian Health care facility.

Increases third-party revenue for Indian Health care providers, which in turn increases the services that can be performed.

- **Reduces the Referred Care dollars spent** each year and allows for those dollars to be stretched to help more patients!

WHY WOULD NATIVE AMERICANS/ALASKA NATIVES NEED *or* WANT HEALTH INSURANCE?

Reduces the out-of-pocket costs associated with medical expenses received outside of an Indian Health care facility.

Provides medical providers outside of Indian Health in the event the patient has traveled away from an Indian Health facility, lives outside of the service area, OR needs medical care that an Indian Health care facility cannot provide.

Special enrollment provisions/protections for Native Americans through the Marketplace: income between 100%-300% of the Federal Poverty Level (FPL) means ZERO cost sharing! No out-of-pocket expenses like deductibles, co-payments and deductibles!!! AND Native Americans can enroll in a Marketplace plan anytime during the year versus only during open enrollment.

Native Americans have **special protections under Medicaid** and could receive any premiums and/or co-payments refunded.

Provides **greater access to medical care**!

Compliments care the patient receives from Indian Health care.

PREMIUM TAX CREDIT

IRS HANDOUT

We have a variety of patient handouts to help patients understand the Marketplace.

If the patient that has questions, it's always a good idea to provide them with a handout to take home.

This IRS handout discusses tax credits, reducing monthly premiums and reporting changes!

August 2023

PREMIUM TAX CREDIT

Affordable Care Act
Individuals and Families

Report changes to the Marketplace as they happen

IMPORTANT REMINDER ABOUT ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT

If you or anyone in your family purchased health coverage through the Marketplace and decided to have advance payments of the premium tax credit paid in advance to your insurance company to lower your monthly premiums, it is important to report life changes to the Marketplace when they happen.

The Marketplace computes your advance credit payments by estimating the premium tax credit you will be allowed when you file your tax return for the year. The Marketplace uses information about your family composition and projected income that you provide when you enroll in coverage to estimate your credit. When you file your return you must reconcile – or compare – your advance credit payments with the actual premium tax credit you are allowed. If your advance credit payments are more than your premium tax credit, you must increase the taxes you owe by all or a portion of the difference.

Reporting life changes as they happen allows the Marketplace to adjust your advance credit payments. This will help you avoid a smaller refund or unexpectedly owing taxes when you file your tax return.

CHANGES YOU SHOULD REPORT TO THE MARKETPLACE INCLUDE:

- Birth or adoption
- Marriage or divorce
- Moving to another address
- Changes in household income and size
- Gaining or losing health care coverage or eligibility
- Other changes affecting income, including lump sum payments
- Incarceration or release from incarceration

These changes may also open the door for the Marketplace special enrollment period, during which time you can purchase health coverage through the Marketplace.

Find out more about the premium tax credit, and other tax-related provisions of the health care law at IRS.gov/aca.

Find out more about the Health Insurance Marketplace at HealthCare.gov.

Publication 5152 (Rev. 5-2016) Catalog Number 66535G Department of the Treasury Internal Revenue Service www.irs.gov

KNOW *the* PATIENT'S INSURANCE NEEDS

Tips on helping the patient find a plan that works best:

- Will they be expecting a lot of doctor visits or needing regular prescriptions?
- Will the be needing to see a specialist outside of the local area?
- Does the patient see providers across the state line?
- Is it a house divided Native American/non-Native American?
- Does the patient file taxes and qualify for a tax credit?
  - Will they be able to get the deductibles and co-payments waived OR will they be responsible for the out-of-pocket costs?
  - Will the patient qualify/need a Tribal Referral form.. BCBS insurance relationship only.
- Does the patient need dental work? If so, how quickly some plans make you wait.

WHAT COUNTS AS INCOME MARKETPLACE HANDOUT

Our Patient Benefit Coordinators have been given copies of this handout in the event a patient has questions on income when screening for Marketplace insurance coverage. These publications are **FREE**!

August 2023

What counts as income on my Marketplace application?

When applying for or updating your Marketplace application on HealthCare.gov, we'll ask you to enter your income.

- If you have income below a certain amount, you may qualify for different programs or get help paying for health coverage. We need to know about your income to see what you qualify for.
- Your application may be pre-filled and show your income for the year. We get this information from a consumer reporting agency, and we'll ask if you'll make the same amount next year. Or, we may ask you to estimate what you think you'll make.
- If you think your income will be different than previous years, we'll ask if you expect changes or a different kind of income that you didn't get before.
- If aren't sure about your income or how it will change, enter your best guess or select "I don't know." You'll need to update your application if something changes later. It's important to update your income because changes may affect the coverage or savings you're eligible for.

When adding your income, include income from:

- Jobs. Visit HealthCare.gov/help/income-from-your-job.
- Self-employment. Self-employment income is the net income a person earns from their own trade or business. Net income is the amount left after you've subtracted your business expenses. For more information, or to find out what expenses you can deduct, visit HealthCare.gov/help/add-other-income and see the "Self employment income" section.
- Social Security (taxable and non-taxable).
- Retirement.
- Pensions.
- Unemployment.
- Capital gains.
- Investments.
- Rental or royalty.
- Farming or fishing.
- Alimony.
- Other taxable income, including canceled debts, court awards, jury duty pay, cash support, and income from gambling, prizes, or awards.

When you're adding your income, don't include money you get from:

- Child support.
- Gifts.
- Supplemental Security Income (SSI).
- Veterans' disability payments.
- Workers' compensation.

You'll also answer questions about deductions. You should include:

- Alimony you pay.
- Student loan interest you pay.
- Educator expenses if you're a teacher and pay for supplies out-of-pocket.
- Moving expenses if you're moving to live much closer to your job.
- Contributions to your individual retirement account if you don't have a retirement account through a job.
- Tuition costs for school if you pay for the costs out-of-pocket and deduct them on your tax return.
- Other deductions you can take on the front of your IRS form 1040.

You shouldn't include these deductions:

- Charitable donations.
- Home mortgage interest.

For more information:

- Visit HealthCare.gov/help/add-other-income.
- Visit HealthCare.gov/help/income-deductions.
- Call the Marketplace Call Center at **1-800-318-2596**. TTY users can call **1-855-889-4325**.

You have the right to get Marketplace information in an accessible format. You also have the right to file a complaint if you feel you've been discriminated against. Visit CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users can call 1-855-889-4325.

Health Insurance Marketplace

MARKETPLACE APPLICATION CHECKLIST

- Who needs to apply within the household?
- Home and/or mailing address for everyone applying for coverage.
- Information about everyone applying for coverage, e.g., Social Security numbers and birth dates.
- Information about filing taxes, e.g., single, married, etc.
- Employer and income information for every member of the household, e.g., pay stubs or W-2 forms.
- The best estimate of what the household income will be for the current year or the upcoming year. (depending on the time of enrollment)
- Policy information of any existing health plans.
- Knowledge of job-based insurance plan (if applicable) to verify if "affordable".
- Notices from current Marketplace plan that include plan ID, if previous year coverage.
- Documents needed for uploading, e.g., CDIB, Tribal membership, birth certificate, income, etc.

APPLICATION CHECKLIST MARKETPLACE HANDOUT

This handout is a great reminder for those that need to gather personal information before completing a Marketplace application!

These publications have been developed for everyone and are FREE!

August 2023

Marketplace Application Checklist

When you apply for or renew your coverage in the Health Insurance Marketplace, you'll need to provide some information about you and your household, including income, any coverage you currently have, and some additional items.

Use the checklist below to help you gather what you need to apply for coverage.

- ☐ Information about your household size. Figure out who in your household should apply before you start your application. Visit **HealthCare.gov/income-and-household-information/household-size** for help figuring out who needs coverage.
- ☐ Home and/or mailing addresses for everyone applying for coverage.
- ☐ Information about everyone applying for coverage, like addresses and birth dates.
- ☐ Social Security Numbers.
- ☐ Information about the professional helping you apply (if you're getting help completing your application). Visit **HealthCare.gov/help/whos-helping-me-complete-my-application** for more information.
- ☐ Document information for legal immigrants. Visit **HealthCare.gov/help/immigration-document-types** for more information.
- ☐ Information on how you file your taxes.
- ☐ Employer and income information for every member of your household (for example, from pay stubs or W-2 forms—Wage and Tax Statements). Visit **HealthCare.gov/income-and-household-information/income** to learn more about what types of income to include and not include.
- ☐ Your best estimate of what your household income will be in 2018. Visit **HealthCare.gov/income-and-household-information/how-to-report** for help estimating your income.
- ☐ Policy numbers for any current health plans covering members of your household.
- ☐ A completed **"Employer Coverage Tool"** for every job-based plan you or someone in your household is eligible for. (You'll need to fill out this form even for coverage you're eligible for but don't enroll in.) Visit **HealthCare.gov/downloads/employer-coverage-tool.pdf** to view or print the tool.
- ☐ Notices from your current plan that include your plan ID, if you have or had health coverage in 2017.

Stay up-to-date about the Marketplace. Visit HealthCare.gov to get email or text updates that will help you get ready to apply or renew.

You have the right to get Marketplace information in an accessible format. You also have the right to file a complaint if you feel you've been discriminated against. Visit CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users can call 1-855-889-4325.

Health Insurance Marketplace

CMS Product No. 11686
Revised September 2017

Medicare & the Health Insurance Marketplace

The Health Insurance Marketplace, a key part of the Affordable Care Act, is a way for individuals, families, and employees of small businesses to get health coverage.

If I already have Medicare, do I need to do anything?

No. Medicare isn't part of the Marketplace. If you have Medicare, you're covered and don't need to do anything about the Marketplace.

The Marketplace doesn't affect your Medicare choices or benefits. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO), you don't have to make any changes.

Note: The Marketplace doesn't offer Medicare Supplement Insurance (Medigap) policies or Medicare drug plans (Part D).

Does Medicare coverage meet the requirement that all Americans have health insurance?

If you have Medicare Part A (Hospital Insurance), you're considered covered and won't need a Marketplace plan to meet the requirement. Having Medicare Part B (Medical Insurance) alone doesn't meet this requirement.

Can I get a Marketplace plan in addition to Medicare?

No. It's against the law for someone who knows that you have Medicare to sell you a Marketplace plan. This is true even if you have only Part A or only Part B.

If you want coverage to supplement Medicare, visit Medicare.gov to learn more about Medicare Supplement Insurance (Medigap) policies. You can also visit Medicare.gov to learn more about other Medicare options, like Medicare Advantage Plans.

Can I choose Marketplace coverage instead of Medicare?

Generally, no. As noted on the previous page, it's against the law for someone who knows you have Medicare to sell you a Marketplace plan. However, there are some situations where you can choose Marketplace coverage instead of Medicare:

- You can choose Marketplace coverage if you're eligible for Medicare but haven't enrolled in it (because you would have to pay a premium, or because you're not collecting Social Security benefits). If you're eligible for premium-free Part A but choose Marketplace coverage over Part A, you won't be eligible for help paying your Marketplace plan premiums.
- If you're paying a premium for Part A, you can drop your Part A and Part B coverage and get a Marketplace plan.

Note: If you get premium-free Part A, you can't drop Medicare without also dropping your retiree or disability benefits (Social Security or Railroad Retirement Board). You'll also have to pay back all retirement or disability benefits you've received and all costs paid by Medicare for your health care claims.

Before making either of these choices, there are 3 important points to consider:

1. If you enroll in Medicare after your Initial Enrollment Period ends, you may have to pay a late enrollment penalty for as long as you have Medicare.
2. Generally, you can enroll in Medicare only during the Medicare General Enrollment Period (from January 1– March 31). Your coverage won't begin until July 1 of that year.
3. If you get premium-free Part A after already having Marketplace coverage, you won't be eligible for help paying your Marketplace plan premiums.

What if I become eligible for Medicare after I join a Marketplace plan?

If you have coverage through an individual Health Insurance Marketplace plan (not through an employer), you should end your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. Once you're considered eligible for Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you might have to pay back the help you got when you file your taxes. Contact the Marketplace at least 15 days before the date you want your Marketplace coverage to end. Usually, you'll want your Marketplace coverage to end the day before your Medicare coverage starts.

Note: You can keep your Marketplace plan after your Medicare coverage starts. However, once your Part A coverage starts, any tax credits and reduced cost-sharing you get through the Marketplace will stop.

If I have Medicare, can I get health coverage from an employer through the SHOP Marketplace?

Yes. Coverage from an employer through the SHOP Marketplace is treated the same as coverage from an employer group health plan. If you're getting health coverage from an employer through the SHOP Marketplace based on your or your spouse's current employment, Medicare Secondary Payer rules apply. Visit Medicare.gov to learn more about how Medicare works with other insurance.

If I'm getting health coverage from an employer through the SHOP Marketplace, can I delay enrollment in Part B without a penalty?

Yes. You can delay enrollment if you're getting health coverage from an employer through the SHOP Marketplace based on your or your spouse's current employment. You have a Special Enrollment Period for Part B without penalty:

I have Medicare coverage due to ESRD. Can I drop my Medicare coverage and choose a Marketplace plan?

Generally, no. Once you apply for Medicare, your Medicare coverage will end one year after you stop getting regular dialysis or 36 months after a successful kidney transplant. However, you may withdraw your original Medicare application. You would have to repay all costs covered by Medicare, pay any outstanding balances, and refund any benefits you got from Social Security or the Railroad Retirement Board. Once you've made all of the repayments, the withdrawal will be processed as though you never had Medicare at all.

Can I get a stand-alone dental plan through the Marketplace?

In most cases, no. If the Marketplace in your state is run by the federal government, you won't be able buy a stand-alone dental plan. If your state is running its own Marketplace, you may be able to buy a stand-alone dental plan, if one's available.

Is prescription drug coverage through the Marketplace considered creditable prescription drug coverage for Medicare Part D?

While prescription drug coverage is an essential health benefit, prescription drug coverage in a Marketplace or SHOP plan isn't required to be at least as good as Medicare Part D coverage (creditable). However, all private insurers offering prescription drug coverage, including Marketplace and SHOP plans, are required to determine if their prescription drug coverage is creditable each year and let you know in writing. Visit Medicare.gov for more information about creditable coverage.

Can I get help paying for my Medicare costs?

- If you need help with your Part A and B costs, you can apply for a Medicare Savings Program. Call your state Medical Assistance (Medicaid) office. To get their phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you need Extra Help to pay for Medicare prescription drug costs, visit socialsecurity.gov/i1020 to apply, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Where can I get more information?

- Call Social Security at 1-800-772-1213 for information about Medicare enrollment. To learn more about Medicare coverage and plan choices, visit Medicare.gov, or call 1-800-MEDICARE.
- If you have family and friends who don't have health coverage, or if they want to explore health plan options, tell them to visit HealthCare.gov.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users should call 1-855-889-4325.

This handout might be very useful when talking with patients who are aging into Medicare (or will in the near future) and have active Marketplace plans!

American Indian and Alaska Native Trust Income and MAGI

Q: What is Modified Adjusted Gross Income (MAGI)?

A: MAGI is your adjusted gross income, as determined for federal income tax purposes, with certain types of income added in and subtracted out.

Q: What is the purpose of MAGI?

A: MAGI is used to determine an individual's eligibility for premium tax credits and cost sharing reductions for Qualified Health Plans purchased through the Health Insurance Marketplaces. MAGI is also used to determine eligibility for families and children coverage groups in Medicaid and the Children's Health Insurance Program (CHIP).

Q: Are there special rules for calculating MAGI for American Indians and Alaska Natives (AI/ANs)?

A: Yes. MAGI is based on taxable, adjusted gross income reported to the Internal Revenue Service (IRS). Because some types of income specific to AI/ANs are non-taxable, this income is excluded when determining eligibility for Marketplace tax credits, cost sharing reductions, Medicaid, and CHIP. Certain additional types of AI/AN income are excluded when determining eligibility for Medicaid and CHIP, even though they might be taxable. This means that your MAGI might be slightly higher for the purposes of Marketplace assistance than it is for Medicaid eligibility.

Did you know?

You m... qualify for lower cost ...

Q: What types of AI/AN income are generally exempt from MAGI?

A: The following categories of income are generally excluded from an AI/AN's MAGI:

- Distributions from Alaska Native Claims Settlement Act (ANCSA) Corporations and Settlement Trusts
- Distributions from trust/reservation property
- Income from property and rights related to hunting, fishing, and natural resources
- Income from the sale and use of cultural/subsistence property
- Student financial assistance provided by the Bureau of Indian Affairs and/or a Tribe
- Income that falls within the IRS General Welfare Doctrine
- Any other income that is non-taxable according to federal law or IRS guidance

You should contact your Tribe if you are unsure whether a certain type of income is exem...

Q: Income exempt under the "General Welfare Doctrine" is excluded fr... What is the General Welfare Doctrine?

A: Payments made under social benefit programs for the promotion of general welfare may ... gross income under a concept known as the general welfare doctrine. This applies only t... payments out of a welfare fund based upon the recipient's need, and not as compensatio... When distributions to tribal members are made equal (per capita) and not based on need, ... fall under the general welfare doctrine. Benefits payable regardless of the financial status, ... background, or employment status of the recipient may be included in gross income of rec...

Q: Is my tribal gaming per capita payment excluded from MAGI?

A: No. Gaming per capita payments are taxable and must be included in your MAGI.

Q: The list of AI/AN income includes distributions and payments from activities on trust property. Does that property have to be located on a reservation for the income to be excluded from MAGI?

A: No. This income is exempt from MAGI so long as it is derived from property that is held in trust by the federal government, subject to federal restrictions, located on an Indian reservation or within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior.

Q: How do I list AI/AN income on the application for Marketplace health insurance, Medicaid, and CHIP?

A: When filling out an application for health insurance in the Marketplace, you will be asked to list your taxable income. You should provide the same income that you report to the IRS when you file your federal income tax. Do *not* include AI/AN income that the IRS exempts from taxation as part of your taxable income.

- In Appendix B of the Marketplace application, you will be asked to list certain types of AI/AN income that you previously included in Step 2 of your application. Even though this income is taxable, it still may be excluded from MAGI for the purposes of Medicaid and CHIP eligibility. You are asked to list this type of income on Appendix B to make sure that it is not counted toward your MAGI as part of the Medicaid and CHIP eligibility determination.
- If you don't have these types of income, just put a zero on the application after the questions in Appendix B. If you do have this type of income, list what kind you have and how much of it you receive.
- Do not list any per capita income from gaming in Appendix B, as it is taxable and included in MAGI.

Q: Who should I contact for help when filling out the Marketplace appli... my exempt AI/AN income?

A: You should contact your Tribe or the enrollme... organization, or urban Indian organization. Yo... State's Marketplace or at Healthcare.gov. If so...

Specific Types of AI/AN Exempt Income

Below are some specific types of AI/AN income that may be excluded from your MAGI when determining eligibility for Medicaid, CHIP, and the tax credits and cost sharing reductions in the health insurance Marketplace. Please note that these are just examples and that this list is not exhaustive.

Distributions from ANCSA Corporations and settlements trusts

- Cash distributions from an ANCSA corporation or settlement trust
- Stock or bonds issued by or acquired from an ANCSA Corporation
- A partnership interest distributed by an ANCSA Corporation, as well as subsequent partnership distributions
- Land or an interest in land (including land or an interest in land received from an ANCSA Corporation as a dividend or distribution on stock)

www.healthcare.gov/tribal

- Payments from funds held in trust by the Secretary of Interior for an Indian tribe, including interest and investment income accrued while such funds are held in trust and initial purchases made with such funds

Income derived from property and rights related to hunting, fishing, and natural resources

- Profits from the sale, lease, or harvest of mineral, timber, and other such resources
- Income derived from hunting, fishing, gathering, and harvesting fish, wildlife, and plant resources pursuant to federally protected rights, including off-reservation rights

Income from the sale and use of cultural or subsistence property

- Earnings from ownership interests and usage rights to items that have unique religious, spiritual, traditional, or cultural significance that support subsistence or traditional lifestyle
- Materials such as the sale of sage or sweetgrass for use in a healing or spiritual ceremony
- The sale of artwork, pottery, or jewelry with cultural or religious significance
- Crafts made by AI/ANs from fish and wildlife resources taken for personal or family consumption
- Proceeds of subsistence fish and game

Student financial assistance provided by the Bureau of Indian Affairs

- Student financial assistance provided under programs in Title IV of the Higher Education Act of 1965
- Grants from the Bureau of Indian Education's Higher Education program

Payments that are exempt from federal income taxation under federal statute

- Per capita shares distributed to Indians pursuant to the Indian Tribal Judgment Funds Use or Distribution Act (25 U.S.C. § 1401 *et seq.*), including interest and investment income earned on Judgment Funds while under administration
- Distributions from certain federal settlements, such as the *Cobell v. Salazar* class action settlement and some payments under the *Keepseagle v. Vilsack* settlement

Income excluded under the General Welfare Doctrine

- Housing assistance
- Education assistance
- Programs serving elders and individuals with disabilities
- Cultural and religious programs
- Transportation programs
- Disaster relief
- Payments used to help establish AI/AN-owned businesses on or near a reservation

Contact Info:

Questions? Give us a call
1-800-318-2596
TTY: 1-855-889-4325

...healthcare.gov/tribal @CMSGov #CMSNativeHeal...

What Native American income counts and doesn't count.

MARKETPLACE KEY TERMS/DEFINITIONS

Premium: The amount an individual must pay for health insurance or plan. Sometimes an employer can pay all or part of the premium costs. Typically, the premium is paid monthly but can be paid quarterly or even yearly.

Premium Tax Credit: A tax credit can help an individual afford coverage purchased through the Marketplace. These credits can be used immediately to help lower the monthly premium costs.

Deductible: The amount an individual would owe for health care services under an insurance plan before the insurance or plan begins to pay. The deductible may not apply to all services. The individual must pay out-of-pocket their share aka the deductible amount before the insurance will pay their share of the covered services.

Pre-existing Condition: A health problem the individual had before the date the new health coverage starts. Health insurance companies cannot refuse to cover individuals or charge more in monthly premiums due to pre-existing conditions. They also can’t charge more due to the individual's sex (more for a woman than a man).

MARKETPLACE KEY TERMS/DEFINITIONS (Cont.)

Essential Health Benefits: The things that must be covered by the insurance plan offered in the health insurance Marketplace.

Cost-sharing: The share of costs covered by the insurance that the patient will owe out of pocket. This includes deductibles, co-insurance and co-payments. Native Americans who enroll in a zero or limited cost-sharing plan are exempt from "most" cost-sharing.

Qualified Health Plan (QHP): An insurance that is certified by the Marketplace, provides essential health benefits and follows established limits on cost sharing.

Co-payment: A fixed amount an individual would be responsible for when a service is received. The amount could vary depending on the type of service received. Example: $25 co-pay for an office visit, $75 co-pay for an ER visit or $950 for inpatient. This would be the patient's responsibility up-front when the service was provided.

MARKETPLACE QUICK FACTS

Even people eligible for Indian Health services need insurance. Health insurance covers many things Indian health care programs do not provide. With health insurance individuals can:

- Go see specialists or providers outside of their respective Tribal service area.
- Get health care for covered services without Indian Health Purchased Referred Care authorization.
- Get health care when they are away from home in the event of an accident or health care emergency need.

Many will pay little or NOTHING for the health insurance if their income falls between 100%-300% of the Federal Poverty Level income guidelines. ZERO cost sharing for Native Americans who enroll in a Bronze level plan when the insurance is used.

MARKETPLACE QUICK FACTS (Cont.)

Native Americans with health insurance can continue to get health care services with their current Indian Health care providers AND/OR get health care services elsewhere. Having insurance adds an additional benefit and allows the individual to have choices in their health care. Indian Health providers will also GLADLY accept health insurance. Billing these plans allows the additional revenue to contribute back to the health programs currently in place.

Native Americans do not have to wait to sign up! There is no open enrollment limitations for Native Americans like the general public has to abide by.

MARKETPLACE QUICK FACTS (Cont.)

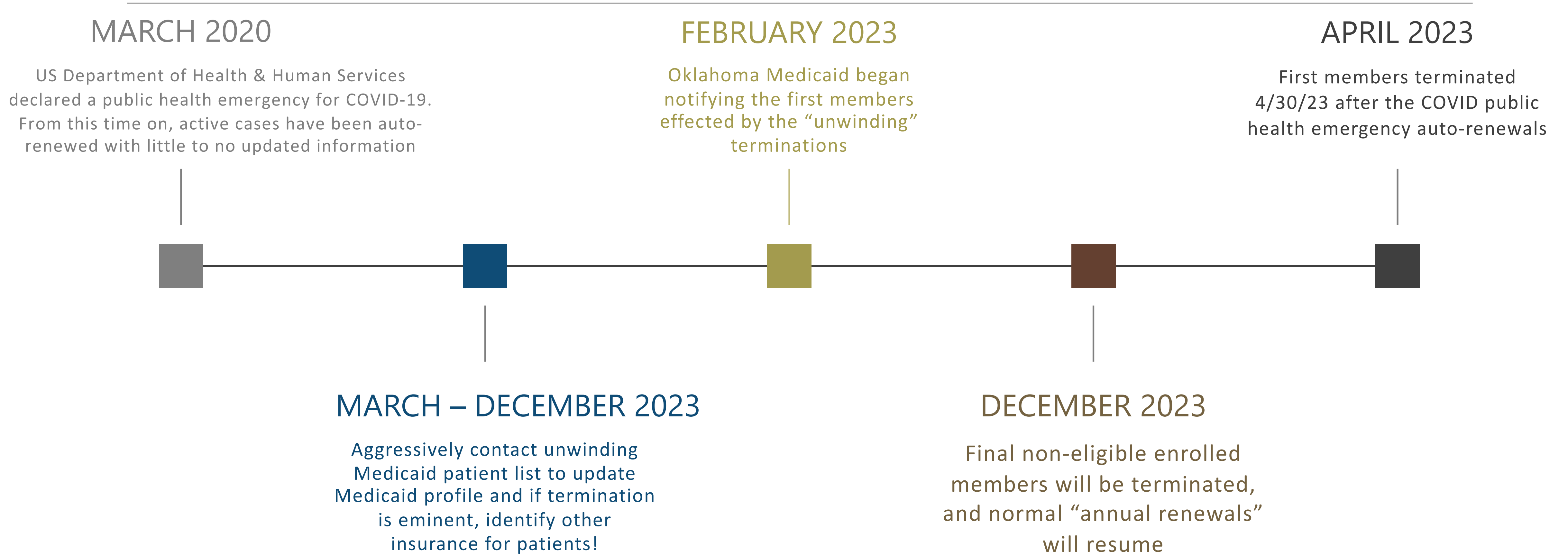
Even though health care is a treaty right, Native Americans should still consider having insurance. Indian Health providers work within yearly budgets approved by Congress and does not receive enough funding to meet all the health needs of American Indians and Alaska Natives.

This is why some Indian Health providers do not offer certain services and others may. Some services may not even be available during certain times of the year due to funding/budget issues.

Historically, the Indian Health Congressional funding only meets about half the need, so enrollment in insurance helps expand health care services. Patients with insurance provides additional revenue into the health care system.

Patients with health insurance may find that they are away from an Indian Health facility and become ill, the insurance is a safety net and/or compliments their Indian Health care.

MEDICAID UNWINDING TIMELINE

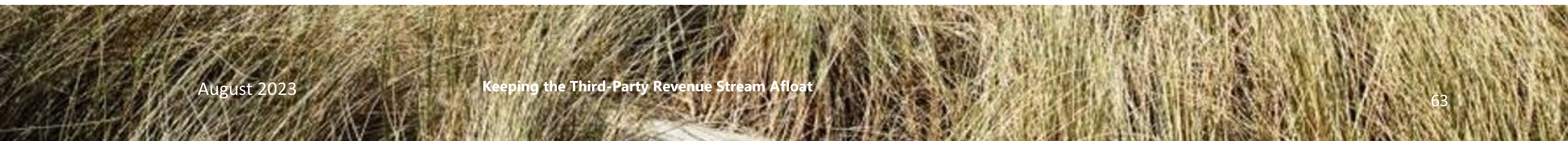


SUMMARY

Patient screening processes and insurance enrollment is vital for any health system and the all-important third-party revenue stream.

Studies have found that having any type of “gap” in insurance coverage and being uninsured create significant risk factors that lead to patients not receiving preventative health care services which in the long range, creates a sicker population. Lack of health insurance is linked with a wide range of serious health consequences; such as being severely ill when diagnosed and unable to receive life-saving care timely and have a poorer survival rate.

The same studies show that individuals that kept continuous health insurance were at a significantly lower risk of healthcare issues such as flu or pneumonia. This same survey group that received other preventive services such as mammograms, pap smears, colonoscopies and other preventive services had less comorbidities because chronic medical conditions were identified early, were treatable and these individuals had a higher health outcome and longer life expectancy.



Thank you

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