Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

The Center on
Health Insurance Reforms
Georgetown University Health Policy Institute

A COMPILATION OF ASSISTER QUESTIONS

As part of our Robert Wood Johnson Foundation-funded project providing technical assistance to navigators and assisters in five states, we have received a broad range of questions. This compilation includes a subset of those questions that may be of broader interest. As questions continue to come in, we'll send out semi-regular compilations.

The Navigator Resource Guide referred to throughout can be found at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/11/navigator-resource-guide-on-private-health-insurance-coverage---.html

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Student Health Insurance and Premium Tax Credits

Question: A man is covered by student insurance but it would cost $600 to add his wife. Would she be free to go to the marketplace and apply for a subsidy, or does student insurance work like employer insurance?

Answer: In terms of eligibility for the marketplace/Advanced Premium Tax Credits, student insurance works under a different set of rules than employer-based coverage. While student insurance is minimum essential coverage, you can be eligible for it and still be eligible for a Qualified Health Plan (QHP) with financial assistance. We have some FAQs on this in our Navigator Resource Guide, (see p. 85-88). Of course, if she wants to apply for a QHP outside of open enrollment she would need to meet the requirements for getting a Special Enrollment Period.

Stuck in a Non-ACA Plan

Question: We have a client who is pregnant and her policy doesn't cover pregnancy-related services. How is that possible if the Essential Health Benefits include maternity coverage? The representative who enrolled her in the plan in 2012 said there was nothing she can do to update her plan until open enrollment at the end of the year. She was told that there is no guarantee that pregnancy-related services would be covered since it could be considered a preexisting condition. Regardless, it would not be helpful because it wouldn't go into effect until Jan 1st, which is after her expected due date.

Answer: Sounds like she has an individual policy but it renewed in 2013 (i.e., Dec. 1, 2013 or earlier), which means it does not have to cover the essential benefits, including maternity care. If, however, the policy renewed on or after Jan. 1, 2014, then the insurer is required to cover maternity. Traditional individual health insurance policies are on a 12-month contract and renew on your anniversary date of purchase. If her plan renews in 2014 (even if outside open enrollment) she will have a 30-day window to find a new plan either on or off the Marketplace, and that plan must cover maternity as part of the Essential Health Benefits. She does NOT have to worry about pre-existing condition exclusions if she is buying a health insurance policy on or after Jan. 1, 2014, whether on or off the Marketplace. Those are prohibited.

90 Day Grace Period for Payment of Premiums

Question: Our feedback loop has been hearing about insured people not being listed as insured when their provider attempts to confirm coverage. When a person misses a payment and is in the 90-day grace period, is he considered covered? Or is the grace period simply an opportunity to catch up the premium without having to wait until the next Open Enrollment to enroll. So when the doctor calls to verify coverage, is it correct for the insurance company to say uncovered because one premium has been missed?

Answer: The 90-day grace period for non-payment of premium only applies (a) if the policyholder is receiving advanced premium tax credits and (b) if he/she has paid at least one month's premium. If both of those are true, the insurer cannot terminate coverage until the end of the 90-day grace period. However, the insurer only needs to pay

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claims for the first 30 days of the 90-day period. After that, the insurer can hold off paying any claims. If the enrollee doesn't pay premiums in full by the end of the 90 day grace period, s/he could be liable for payment of the health services in the 2nd and 3rd months if they don't catch up with their premium payments.

The insurer is supposed to let providers know if a policyholder's claims are being held until payment of premium. In such a case, a provider may choose not to provide care until the premiums are paid up. But the person is still technically enrolled in the plan until the end of the 90-day period.

Accessing Providers in Border Counties/States

Question: Is there any exception for individuals living in border counties (or cities) to see doctors in a neighboring state? We have an individual with lung cancer who sees a doctor in a county across the state line. He is eligible for a special enrollment period, but his oncologist isn't included in the network of the marketplace plan available to him. This situation applies to many other individuals who see providers out-of-state and out-of-network, since we are close to the borders of two states.

Answer: Your client and others in his situation may have a few options to consider. First, depending on the plan rules, he may be able to obtain care from the same providers but with higher cost sharing. If it's an HMO without any out-of-network coverage, that won't be an option. But the Summary of Benefits and Coverage (SBC) will tell him if the plan will pay for any out-of-network care and what his costs would be. Note, however, that the plan is not required to count his out-of-pocket costs for out-of-network care toward the annual limit on out-of-pocket costs; the SBC will provide details on that, too.

He can also appeal to the insurer to see if he can obtain care from out-of-network providers at in-network rates. That is one of the benefit denials or "adverse determinations" that can be appealed. You can find more about that process in the Navigator Resource Guide, FAQ # 262. He'll need his doctor's help to make this case. He should also report this to your state's Department of Insurance. Appendix C of the Navigator Guide includes a list of state Departments of Insurance websites. They may be able to help with the appeal and/or work something out with the plan. Regardless, they should know that the plan's network is not meeting needs of some enrollees in that area.

Finally, some states have "continuity of care" laws that require insurers to allow consumers to continue to see their providers under certain circumstances. However, there are typically limits to be aware of: such protections may apply only to certain individuals, for example, people with terminal illness or in the middle of an acute episode of care; it may be limited in duration, for example, 60 days of continued coverage; and it may apply only when a provider ceases to be in-network (rather than discovering, as above, that the provider was not in-network prior to the consumer's enrollment in the plan).

Medicaid Residency Rules

Question: A family just moved from another state, where they qualified for Medicaid. Their Medicaid coverage in that state is not accepted here, in their new state of residence. As a result of the move, the parents are currently unemployed. Would this family not qualify for MAGI Medicaid because of the new state's residency rules?

Answer: Residency is established even without a permanent address if the family intends to reside in a new state. For kids, the state of residency is where the parent resides.

<u>The federal definition of state residence is as follows (under 42 CFR §435.403):</u>
(h) Individuals age 21 and over. Except as provided in paragraph (f) of this section, with respect to individuals age 21 and over —
(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual is living and—
(i) Intends to reside, including without a fixed address; or
(ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed).

<u>If they don't intend to live in the new state, the state where they previously lived has an obligation to provide coverage to absent residents as follows, from the same federal rule above (42 CFR §435.403):</u>
(a) Requirement. The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in §431.52 of this chapter.

<u>§431.52 Payments for services furnished out of State.</u>
(a) Statutory basis. Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.
(b) Payment for services. A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions is met:
(1) Medical services are needed because of a medical emergency;
(2) Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his State of residence;
(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;
(4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.

(c) Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

Counting Social Security Benefits

Question: Does the Marketplace and Medicaid count Survivor's Social Security Benefits for a 15 year old when estimating income?

Answer: If the 15 year old earns income that meets the tax filing threshold ($6,100 in 2014) or has other unearned income over $1,000, then his/her income reported on taxes plus the non-taxable Social Security survivor benefits would count toward income. However, if the teen does not have sufficient income to be required to file taxes, the Social Security survivor benefits DO NOT count. For adults, it's different. Social Security income, including social security disability income (Social Security Disability Insurance, or SSDI, but not Supplemental Security Income, or SSI) is added to other taxable income for eligibility purposes.

Question: Is only the taxable amount of Social Security Retirement Income counted as income when looking at a person's 1040 tax form? The Social Security Income is $34,000.00, but the taxable amount is only $2,435.00, which brings down their adjusted gross income on the 1040 to $24,000.00. The client is retired, works part time and also gets a pension.

Answer: No, the non-taxable portion of Social Security Income is added back to line 37 of the 1040 (which includes the taxable portion of the Social Security retirement income) for his/her eligibility. In other words, all of the Social Security retirement income counts.

Same-Sex Couples and Eligibility for Premium Tax Credits

Question: A consumer recently asked if Marketplace plans have to treat same-sex marriages as able to enroll jointly no matter what state they live in. Related to this, if the employer of one spouse does NOT offer benefits to same-sex spouses, is the person able to get insurance on the marketplace as a family? Is there a difference if they are married vs. domestic partners?

Answer: Yes, same-sex married couples are able to enroll in the same marketplace plan. Under CMS Guidance, which can be found at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/frequently-asked-questions-on-coverage-of-same-sex-spouses.pdf, Marketplace plans must treat same-sex married couples as they would opposite-sex married couples. The federal rule does not require plans to cover domestic partners. Same-sex married couples may also apply for advanced premium tax credits (APTCs) as a household, regardless of what state they live in. CMS Guidance last fall, which can be found at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/marketplace-guidance-on-irs-2013-17.pdf, says for purposes of applying for APTCs, as long as the couple files jointly, they are eligible to apply for APTCs. It doesn't matter if their state recognizes same-sex marriage (because premium tax credits fall under the federal tax code).

However, states are permitted, but not required, to recognize same-sex couples who are legally married in other jurisdictions as spouses for purposes of Medicaid and CHIP. Since state recognition of same-sex marriages may affect Medicaid and CHIP eligibility determinations, and applicants must first be screened for Medicaid and CHIP eligibility before being considered for APTCs, then the state treatment of same-sex marriages may affect eligibility for APTCs. And, as always, APTC eligibility requires that a household have income above 100% FPL in non-Medicaid states and 138% FPL in Medicaid expansion states, with the exception of lawfully present immigrants who are eligible for APTCs under 100% FPL.

On the question of whether a spouse without benefits from the employer of a same-sex spouse can get APTCs if they don't have an offer of employer coverage, the answer is yes. Employers are free to define who is eligible for coverage as a spouse and many employers recognize same-sex partners for spousal benefits. The test for whether a same sex spouse is entitled to APTCs is the same as it would be for any other married couple: if the spouse is not eligible for benefits under the employer coverage, s/he is eligible to apply for APTCs. If the spouse is eligible for benefits under the employer coverage, then the affordability test would apply, looking at the cost of self-only coverage in the lowest cost plan.