CHCS Center for Health Care Strategies, Inc.

TECHNICAL ASSISTANCE BRIEF

Charity Care Organizations as Navigators: Considerations for Guiding Consumers toward the Best Coverage Options

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The Affordable Care Act (ACA) ensures that consumers receive assistance to understand and maintain health insurance coverage. State-based insurance marketplaces must establish navigator programs to connect consumers to coverage options.[1] The federal government is supporting consumer assistance in states using its marketplace model. Those participating in a partnership marketplace will work together with the federal government to provide consumer assistance.

In each of these marketplace models, charity care programs can play a key navigator role.[2] In some cases, charity care programs are serving in a formal "navigator" capacity. Yet even those not officially serving as navigators are likely to assist consumers within their communities in understanding new eligibility options and obtaining access to health insurance. Individuals previously uninsured may require assistance in understanding basic insurance terms and cost-sharing. Because there are multiple coverage options, navigators need to be well versed in the continuum of coverage that the ACA creates. After the initial enrollment period ends, navigators can help ensure that individuals retain coverage, especially when circumstances or income changes (e.g., marriage, child birth, loss of employment).

The Center for Health Care Strategies (CHCS) developed this resource, through support from Kaiser Permanente Community Benefit, to aid navigators based in charity care programs in helping consumers obtain and maintain appropriate coverage. It details key considerations for helping individuals apply for coverage and includes: (1) a decision-making flow chart that highlights potential coverage options; and (2) a detailed enrollment process chart. While the information outlined is geared toward charity care programs, it is relevant to anyone serving in a navigator role.

IN BRIEF

The Affordable Care Act requires the establishment of navigator programs to connect consumers to coverage options in state-based marketplaces. Consumer assisters -- including navigators, certified application counselors, and in-person assisters -- can function via charity care organizations. Whether or not they serve in an official "navigator" capacity, these organizations can play an important role in helping individuals ensure continuous insurance coverage.

The Center for Health Care Strategies (CHCS) developed this resource with funding from Kaiser Permanente Community Benefit to help charity care programs serving as navigators. It provides guidance to charity care organizations in both state-based and federally facilitated marketplace environments. While the information is geared to charity care programs, it can inform anyone serving in a navigator role. A companion ***Health Insurance Options Reference Guide*** offers at-a-glance details about Affordable Care Act options for charity care programs.

Helping Individuals Apply for Coverage: Key Considerations

Navigators in charity care organizations will need to understand a range of issues to guide individuals to the appropriate coverage option(s). Following are key tips for navigators that are discussed in this document:

- Evaluate household size, status, and eligibility criteria to properly assess coverage options for which the individual is eligible;
- Understand the health needs of an individual to identify the most suitable coverage options and build health literacy by educating newly insured individuals about their coverage; and
- Help individuals who are facing life changes, including loss of income or change in family status, to maintain insurance coverage and avoid care gaps.

Made possible through support from Kaiser Permanente Community Benefit.

1. Evaluating Household Size, Status, and Eligibility Criteria

To advise on coverage options, navigators need to determine household income and size. Generally, a taxpayer's household includes the individuals for whom he/she claims a deduction for a personal exemption. A taxpayer may claim a personal exemption deduction for: self; spouse; and dependents, including children and other relatives who meet certain requirements.[3] An individual is not eligible for subsidized coverage if he/she has access to affordable basic job-based coverage that meets minimum standards; or public health coverage, including Medicaid or Medicare.

Navigators should inquire about other relevant information, including citizenship and immigration status. Legally present immigrants with incomes below 100 percent FPL who are ineligible for Medicaid may be eligible for advance premium tax credits (APTCs) to purchase coverage on the marketplace.[4] Certain categories of immigrants are eligible for Medicaid coverage without being subject to the five-year waiting period.

Exhibit 1 provides a flow chart that CHCS developed to assist charity care program staff in walking through coverage options with consumers. The chart details the various coverage options an individual or family might be eligible for depending on personal circumstances such as income, existing minimum essential coverage, medical need and/or disability. In a state that has decided to expand Medicaid eligibility, a greater number of individuals will be eligible for coverage through Medicaid if their income falls below 138 percent of the FPL.

Exhibit 2, adapted from Families USA, outlines the steps in the enrollment process as well as the issues that navigators should be prepared to provide assistance with at each step.[5] Navigators can use this planning tool to help guide consumers in completing enrollment applications.

Primer: Explaining the Concepts

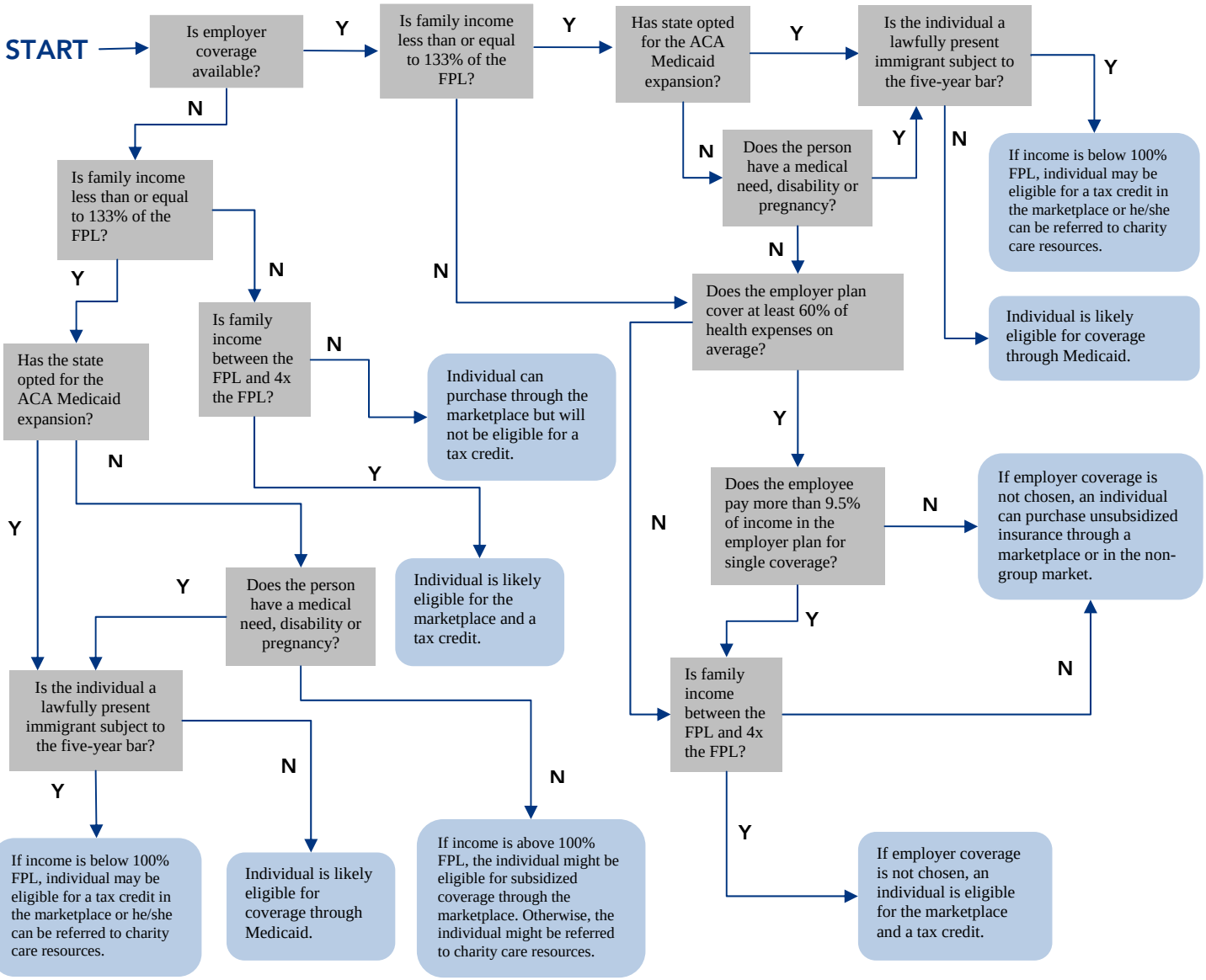
Premium Tax Credits: Federal tax credits that will help subsidize the cost of purchasing a qualified health plan (QHP) on the marketplace. Individuals are eligible for a tax credit if they: (1) enroll in a QHP; (2) have projected annual income between 100 and 400 percent FPL; (3) lack access to other coverage that meets minimum essential coverage standards; and (4) plan to file a tax return and are not claimed as a dependent on someone else's tax return. The tax credit can be received in "advance" when purchasing a plan (known as advance premium tax credit) or when a tax return is filed (known as premium tax credit).

Minimum Essential Coverage: Basic health coverage that meets minimum affordability and minimum value standards (below). For example, this can include policies in the individual market; job-based coverage; and other forms of public coverage such as Medicaid, Medicare, CHIP, and TRICARE.

- **Affordability**: A plan is considered affordable if the person is required to contribute eight percent of his/her income or less toward the plan.
- **Minimum Value**: Job-based coverage meets minimum value standards if it pays for 60 percent of the benefits covered by the plan. Individuals must pay no more than 40 percent of costs out-of-pocket (e.g., co-pays, deductibles).

Cost-Sharing Reductions (CSRs): CSRs are available to those who: meet the eligibility criteria for a premium tax credit; anticipate annual household income below 250 percent FPL; and enroll in a silver plan.

Exhibit 1: **Coverage Options Flowchart***



After determining if an individual is marketplace or Medicaid eligible, consider the following items to select an appropriate plan:

- Does the consumer have specific health care needs (i.e., disabilities, chronic illnesses, mental health and substance use, long-term care, prescriptions, vision, dental) or require additional services and supports? Are those health needs met by the selected plan? For Medicaid, is the person considered to be medically frail?
- What is the maximum amount of money a consumer might have to pay out-of-pocket for specific services? What is the expected household contribution? How does this vary depending on the plan selected?
- How do certain characteristics including family size, age, and geography impact the cost of the benchmark plan and the subsequent premium tax credit received?
- Is the household eligible for cost-sharing reductions based on the family's income?

*The Basic Health Program has been excluded as a coverage option because it cannot be implemented until January 2015. It is an optional coverage program for individuals between 139-200% FPL and allows states to cover legal immigrants with income below 138% FPL who have been in the United States less than five years.

Exhibit 2: **Potential Areas to Provide Consumer Assistance during the Enrollment Process***

Enrollment Process Steps	Areas Where Consumers May Need Help
1. Learning what coverage is available	▪ Getting information about coverage options, how to apply, and how to obtain assistance. ▪ Understanding insurance affordability programs to the extent needed to determine whether the applicant or a family member may be eligible (premium tax credits and cost-sharing reductions for qualified health plans, Medicaid, CHIP, and the Basic Health program) .
2. Enrolling in public coverage	▪ Completing supplemental sections of the application or forms to apply for Medicaid based on a disability, need for long-term care, or high medical costs. Ensuring successful completion of the enrollment process if applications are transferred to a state Medicaid or CHIP agency for a final eligibility determination. ▪ Understanding premium and/or cost-sharing requirements. ▪ Selecting a plan and coordinating plan choices among individuals in the same household.
3. Gathering the necessary information to apply	▪ Providing information on all family members who are part of the household for the purpose of filing taxes. ▪ Identifying recent or expected changes in income or family size to provide the most accurate projection of income and family size for the current tax year. ▪ Collecting information on employer-sponsored coverage and its affordability by using the lowest-cost plan the employer offers. ▪ Gathering and submitting approved forms of documentation within deadlines when information cannot be verified through data matching and self-attestation is not allowed.
4. Reviewing eligibility determinations	▪ Understanding coverage options available to individuals. ▪ Appealing an eligibility determination that appears to be incorrect. ▪ Obtaining information about Medicaid coverage for emergency medical assistance and/or charity care organizations providing free or low-cost care if a member of the applicant's household is a non-citizen. Lawfully present immigrants with income below 100% FPL who are ineligible for Medicaid can qualify for APTCs.
5. Deciding the advance amount of premium tax credits to take, if eligible	▪ Understanding the tax credit reconciliation process, the potential tax liability, and the implications for how taxes are filed. ▪ Assessing how much, if any, of the premium tax credit to take in advance to minimize the risk of repayment. ▪ Understanding when and how to report changes in income and family size.
6. Selecting a qualified health plan (QHP)	▪ Understanding plan features, such as premiums, cost-sharing, and plan differences. ▪ Comparing costs under different coverage tiers based on eligibility for tax credits and cost-sharing reductions. ▪ Comparing plan benefits package, provider networks, prescription drug coverage, or other features that are important for the individual. ▪ Enrolling in a stand-alone vision or dental plan, if needed. ▪ Coordinating plan choices among individuals in the same household.
7. Obtaining an exemption from the individual mandate, if eligible	▪ Obtaining exemptions from the individual mandate if coverage options are unaffordable, or for other allowable reasons.

*Adapted by CHCS from Families USA. *Preparing Navigator and Other Assisters to Meet Consumer Needs: Appendix 1*. Accessed at: http://www.familiesusa.org/resources/tools-for-advocates/preparing-navigators-tool-kit/appendix-1.html.

2. Building Access to Services by Increasing Health Literacy and Matching Health Needs with Coverage Options

It is expected that the uninsured gaining coverage through various ACA options beginning in January 2014 will have higher rates of delayed or unmet health care needs, including chronic diseases, mental illness, and substance use disorders.[6,7] Becoming eligible for insurance coverage does not guarantee access to health care services. In many cases, newly eligible individuals may not have had health insurance previously, thus may not be familiar with how insurance works and how to get the services they need. Understanding an individual's health needs will allow the navigator to identify the coverage options and plans that best meet those needs. Navigators based in charity care programs can play a critical role in improving health literacy by educating newly insured individuals about their new coverage, specifically their benefits and provider networks, and helping them access needed services. Following is a high-level description of marketplace and Medicaid benefit options as well as provider options and cost issues to assist navigators in guiding consumers.

Marketplace and Medicaid Benefit Options

Marketplace qualified health plans (QHPs) will cover 10 essential health benefits (EHBs), including:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services; and
- Pediatric services, including oral and vision care.

Under most coverage options, however, dental and vision benefits for adults are available in stand-alone plans sold separately. Individuals interested in purchasing these additional benefits will need to be guided through the selection of a stand-alone plan.

If possible, charity care programs offering navigator support might catalogue information about the EHB plans in their communities, including limitations on scope, amount, duration, and any prior authorizations for medically necessary services. Since pharmacy services and prescription drug coverage will likely be a concern for newly eligible individuals, navigators might try to inventory information about drug coverage policies and formularies for local EHB plans. If navigators are unable to provide this information, they can help connect individuals to their plans to better understand available benefits.

States participating in the Medicaid expansion for adults between the ages of 19-64 with incomes below 138 percent FPL must offer an alternative benefit plan (ABP) that includes the 10 EHBs. Those identified, or who self-identify, as medically frail can choose between the ABP and traditional Medicaid. The medically frail definition includes those with: (1) disabling mental disorders; (2) chronic substance use disorders; (3) serious and complex medical conditions; (4) a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; and/or (5) a disability determination based on Social Security criteria or state plan criteria. In many states, the standard Medicaid benefit package will be more comprehensive than the ABP benefit package; while in others, the benefits will be nearly identical. If individuals meet certain

state-specific requirements, they may be eligible for other waiver programs such as long-term services and supports.

Provider Options and Cost Implications

Primary care and specialist provider networks and plan costs -- including household premiums, deductibles, and cost sharing -- will have an impact on consumer plan choice. Navigators can help newly eligible individuals understand their provider options and translate relevant terms, e.g., premiums, deductibles, and cost sharing.

For most individuals newly eligible for Medicaid, costs will be minimal. In the marketplace, consumers will have the option of selecting from a range of metal levels (i.e., platinum, gold, silver, and bronze) with varying out-of-pocket costs. If an individual is eligible for premium tax credits and cost-sharing reductions, navigators can help clarify the amount of the credit and/or reduction and the overall affect his/her out-of-pocket costs and tax filing implications.

Charity care programs serving as navigators can help enrollees identify and select providers that meet specific health, language, and geographic needs. For continuity of care, individuals should be encouraged to keep their current providers, assuming that the providers meet the quality and certification requirements imposed by the marketplace.

Information on an in-network primary care physician (PCP) and on exceptions to care, including receiving out-of-network care, may be complex concepts for newly insured individuals. Charity care programs serving as navigators can clarify the information and help answer questions. The navigator can provide instructions about making appointments with PCPs and how the referral process works for specialists. Individuals should be made aware of restrictions around access to out-of-network care.

Since behavioral health services are also likely to be important for many in the newly eligible Medicaid population,[8] charity care programs serving as navigators may seek to document the extent of behavioral health coverage in their areas. Navigators might also seek out information about programs for individuals with other chronic health issues, including health homes, case, and disease management services. Other important services that might be available through new coverage options include: interpreters; non-emergency medical transportation; preventive care; and family planning. Finally, navigators might gather information about the customer service and complaint process for eligibility determinations and service denials to assist consumers as necessary.

Those coordinating resources for navigators might develop a handout that inventories locally available resources, services, and programs, including program descriptions, websites, and phone numbers. Navigators can provide the locally tailored information to consumers who are interested in learning more about additional programs and services in their communities.

3. Maintaining Coverage through Income and Life Changes

Roughly 30 million of the estimated 96 million indiividuals gaining coverage through the Affordable Care Act, will move between coverage options from one year to the next, often referred to as "churning."[9] Adults who switch health insurance coverage have reduced odds of having a usual source of care and report delaying care.[10] To prevent gaps in coverage when income or circumstances change (e.g., marriage, child birth, loss of employment), navigators should be prepared to help consumers enroll in another coverage option and understand the details of the new insurance/plan.

Individuals whose eligibility shifts between Medicaid and the newly established marketplaces will face differences in benefits, premium levels, and cost-sharing responsibility. In addition, differences in plans, provider networks, and gaps in eligibility status could result in a lack of care coordination and exacerbated chronic conditions. Navigators can educate consumers about the timely need to report life changes. By reporting changes promptly, the marketplace will have time to adjust the APTC to the right level, which will reduce the chance that an individual will have to pay back a portion of the APTC. If navigators obtain information during the enrollment period that might indicate a potential income change, they can help minimize the time an individual is not covered.

Yearly renewal periods may pose significant barriers to retaining coverage, both for marketplace and Medicaid enrollees, especially if additional supporting documentation is required that is not reported through data matching with the federal data hub. The ACA attempts to minimize the burden on consumers by requiring marketplaces and Medicaid/CHIP to pre-populate forms provided during renewal. Navigators can potentially assist consumers responding to redetermination notices and ensure that they retain coverage during renewals. The redetermination notices will outline renewal timeframe and information that consumers must provide for renewal. Individuals found eligible for Medicaid will undergo renewal 12 months after January 1, 2014 or 12 months from the date of application. Annual renewal in the marketplace will take place 12 months from enrollment.

Conclusion

Given their extensive experience with the uninsured and underinsured, charity care programs are well positioned to assist individuals gaining coverage through the ACA's health insurance marketplaces and Medicaid. As evidenced by the information above, navigators can play a critical role in ensuring the immediate and long-term success of this major change in the U.S. health care system. Even so navigators based in charity care organizations will continue to have to locate free or low-cost health services for the millions of US residents who will remain uninsured after the ACA is fully implemented.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex needs.

This resource is a product of the *Charity Care Affinity Group*, a CHCS initiative made possible through Kaiser Permanente Community Benefit. CHCS is convening charity care programs across the country to share best practices to serve the uninsured population in 2014 and beyond. For more information, visit www.chcs.org.

Endnotes

[1] Navigators are required to: (a) maintain expertise regarding the marketplace; (b) provide information to consumers in a fair, accurate, and impartial manner; (c) facilitate QHP selection; (d) refer consumers to other resources; and (e) provide information in a culturally diverse and linguistically accessible manner.
[2] The term navigator is used in this document as a catch-all terminology for all of the various assister roles/programs.
[3] A person may be a dependent even if he/she files a tax return as long as he/she does not claim his/her own exemption.
[4] Legal immigrants with incomes less than 138 percent FPL and in the United States for less than five years will qualify for the Basic Health Program, if a state decides to adopt this option.
[5] Adapted by CHCS from Families USA. *Preparing Navigator and Other Assisters to Meet Consumer Needs: Appendix 1*. Accessed at: http://www.familiesusa.org/resources/tools-for-advocates/preparing-navigators-tool-kit/appendix-1.html.
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