ACA Stakeholder Meetings
Frequently Asked Questions

In partnership with Connect for Health Colorado, the Department of Health Care Policy and Financing convened a series of meetings on March 18, April 29 and May 29, 2013 with stakeholders to discuss the issues related to the movement between public and private coverage through these new programs. The following questions were raised during the series of stakeholder meetings.

ELIGIBILITY

Will a client who is moved to Medicaid because of the IEVS interface have to fill out a new application?
Connect for Health Colorado will not be using the IEVS interface for periodic redeterminations. Therefore, they would not be moving to Medicaid from Connect for Health Colorado due to an IEVS interface.

Will a client automatically go off of Connect for Health Colorado and have a gap in coverage?
There will be communication between Connect for Health Colorado and Medicaid to ensure correct transitions. We are anticipating there will not be a gap in coverage, except for very unique circumstances, as people move from Connect for Health Colorado to Medicaid. However, there is a possibility there may be a gap in coverage when individuals move from Medicaid or CHP+ to Connect for Health Colorado. Qualified health plans do not begin until the carrier receives the first payment of the monthly premium. If a consumer pays this premium between the 1st and the 15th of the month, coverage begins the first of the next month. If the consumer pays the premium between the 16th and 31st, the coverage will begin the first of the following month. For example, premium is paid December 15th, coverage begins January 1st. Premium is paid December 16th, coverage begins February 1st.

How will the client be notified of the change, and will he/she have enough time to apply for other coverage? How can the new navigators know enough to help these clients?
Connect for Health Colorado will not be using the IEVS interface for periodic redeterminations. Marketplace customers must report to Connect for Health Colorado any change in circumstance that may affect their eligibility, including a change in income. If a change is reported to the Marketplace, we will re-run eligibility based on the new information provided by the consumer. If the re-determination results in the consumer becoming newly eligible for Medicaid or CHP+, then the Marketplace and the State would notify the consumer of the new determination. The Marketplace would discontinue any premium tax credits and cost sharing reductions, and the consumer would dis-enroll from his/her QHP. All changes become effective the beginning of the following month from when they are reported to the Marketplace and the carriers. The date that the change was reported would be considered the application submission date for Medicaid/CHP+. If Medicaid approved, coverage begins the beginning of the month of date of submission. If CHP+ approved, coverage begins from the date of submission. Our customer

support network (Health Coverage Guides, agents/brokers, Customer Service Center Representatives) will be trained on all of these policies this summer.

Could we consider income on a yearly basis rather than month to month since so many are seasonal or self-employed with great swings in yearly income?
The Centers for Medicare and Medicaid Services (CMS) gave states an option to use projected annual income. The Department has not currently adopted this option but is evaluating the possibility of adopting it in the future.

How do Presumptive Eligibility (PE) sites fit into real-time eligibility determinations for Medicaid and the Marketplace?
Consumers will have the option to apply for a real-time eligibility determination instead of applying for PE. However, PE sites will not be going away as there will always be families that need immediate assistance.

Will we backdate Medicaid for the expansion population?
Medicaid can be backdated up to 3 months prior as with other populations. However, backdating cannot be prior to January 1, 2014 for the expansion population.

What happens if a client is found eligible for Medicaid but does not verify self-attested information in 45 days and the open enrollment period for the Marketplace ends? Does that individual lose the opportunity to get coverage?
Verification of income is not required in order for an eligibility determination to be made. If they attest an income limit above Medicaid standards, they will be sent to the Marketplace. The applicant will be responsible for enrolling in coverage during the open enrollment period.

What does 'real time eligibility' mean to the client? Does the client get a client number right away? How long would it take for the doctor to know?
The consumer will know upon submission of a completed online application if they are eligible for Medicaid or CHP+. They will have their Medicaid ID number and case number. It will take up to 2 days for the doctor to obtain the eligibility information. For the Marketplace, consumers will be able to complete an application, see what programs they are eligible for, how much of the Advance Premium Tax Credit they can use upfront to reduce their premium, compare plans side-by-side, select and enroll in a health plan. In order for coverage to begin in a qualified health plan, the consumer must make the first month’s premium payment to the selected health plan carrier.

If someone applies for coverage and is offered a subsidy but was eligible for Medicaid in the retrospective months, could the client receive the retrospective Medicaid coverage?
Yes, if someone meets all of the eligibility criteria for Medicaid they are able to obtain Medicaid coverage up to 3 months retrospectively from the date of application, regardless if they are now eligible for a subsidy. However, backdating cannot be prior to January 1, 2014 for the expansion population.

It sounds like the Department is relying heavily on the real time eligibility (RTE) determinations. What is the contingency plan for folks who cannot be RTE - will that take 45 days to process? Federal regulations still require 45 days for applications to be processed. Let's say someone applies on March 15 and does submit the verification documentation needed, but the applications still takes 45 days to process and it's determined they are eligible for APTC but the open enrollment period is closed - is that the same outcome as if they did not submit verifications? Will they need to wait until the next open enrollment period?
As long as Connect for Health Colorado receives a determination and the application was submitted during the open enrollment period, the consumer would be enrolled after the first month's premium payment is received by their selected health plan carrier. The effective date of coverage is dependent on when the application and first month's payment is submitted during the month.

Has HCPF determined how many current Medicaid households are "excepted" from IEVS and will require manual verifications?
Based on ACA rules, IEVS will be modified to align with Federal regulations and provide a reasonable compatibility check. Within these regulations consumers, will be provided the opportunity to provide a reasonable explanation (such as losing a job) which will mitigate the number of consumers discontinued due to IEVS.

Will an application through Connect for Health Colorado that turns out to be Medicaid go to the local DHHS to be processed like a PEAK application does now?
Applications through Connect for Health Colorado will be interfaced over to HCPF to determine if they are Medicaid eligible. Those that are Medicaid eligible will be enrolled through the interface. After the eligibility determination is made and someone is eligible for Medicaid or CHP+ a link to PEAK will be presented for the consumer to apply for additional state benefits and get connected with the State website to report future changes.

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How will the subsidy provided to a client be repaid by the client when a churn occurs? For instance, when a client moves from a 90% subsidy to only a 40% subsidy or from subsidy to Medicaid?
The Advance Premium Tax Credit (APTC) is paid directly to the health plan from the federal government. Connect for Health Colorado customers whose income increases or decreases should report the change to the Marketplace to have the APTC for the rest of the year appropriately adjusted to avoid having to pay back excess advance payments to the IRS when they file their taxes. All tax credit reconciliation will occur between the customer and the IRS at the time of tax filing. When someone moves from being APTC to Medicaid eligible he/she will not have to repay the tax credit as long as the change in circumstances was reported within 30 days from the event.

Is pediatric dental coverage a required essential health benefit?

The Marketplace is required to offer pediatric dental benefit to all consumers, but consumers are not required to purchase the pediatric dental benefit within the Marketplace. If a plan chosen by the customer does not include pediatric dental coverage and there is someone identified in the application seeking coverage under the age of 19, then a pop-up window will be displayed to the applicant telling him/her to consider buying separate pediatric dental coverage.

Will a client be able to compare benefits provided by the different plans in the Marketplace before enrolling?
Yes, the consumer will be able to compare plans side-by-side, and sort and filter plans based on different factors prior to selecting a health plan.

What happens if services were used within those conditional 90 days of eligibility and the individual was ultimately determined ineligible for that Marketplace plan? Will services used still be covered from that time period?
The eligibility that is being verified is for the Advance Premium Tax Credit (APTC) and cost sharing reductions (reduced co-pays and deductibles). If after the 90 days the individual is ineligible for those benefits because requested documentation was not submitted in the timeframe, he/she is still enrolled in the health plan but will have to pay the full amount of the premium each month and the plan's standard cost sharing requirements. As long as he/she is enrolled in their plan and paying the premium, the health plan will continue to cover the services in accordance with the deductible, co-pays and co-insurance identified in the contract. The APTC will not have to be paid back during for the previous 90 days.

How will payment be accepted for the Marketplace? It is my understanding that the first payment can be made with a card but after that a check must be used. How will people without checking accounts make payments?
For individuals and families, payment options will vary based on the health insurance carrier they select and their preference. Some health insurance carriers may allow cash, check, debit or credit cards, while others may only allow checks. The Marketplace will facilitate the initial payment to the carrier, but the payment is processed by the carrier and handled directly with the applicant after initial enrollment.

I have visited the Connect for Health Colorado website and seen the calculator for benefits. Will there be any way to add the "basic" level of benefits to the calculator?
Connect for Health Colorado plans to provide consumers with tools to help them compare health plans. This includes ways to estimate costs and benefits.

If someone loses a job and is offered COBRA, could that person choose a Marketplace plan instead? Would the client have to wait until open enrollment to apply?
Individuals who lose employer-sponsored coverage may apply and enroll in a health insurance plan outside of the open enrollment period due to the loss of minimum essential coverage and see if they qualify for financial assistance. Individuals do not have to accept COBRA and will be able to choose a health plan through Connect for Health Colorado either during open enrollment or through a special enrollment period.

What outreach activities are occurring in rural areas? You mentioned billboards and light rail advertisement in the metro area - anything similar in the rural areas?
Connect for Health Colorado has been conducting outreach in rural areas since the summer of 2012 through staff and partners. The Western Slope Outreach Coordinator has been conducting meetings every week from Steamboat Springs to Durango, including many meetings and presentations in rural areas. Another Outreach Coordinator is meeting with groups in southern Colorado and the San Luis Valley, including attending health-related fairs and community events. Our outreach statewide will intensify this summer and include attending community events and working with Assistance Sites to implement creative targeted initiatives. We will sponsor and participate in the Pedal the Plains bike race that will go through many eastern plains towns in September, and will identify other opportunities to create awareness of the new marketplace. We also have been advertising in newspapers statewide, including in towns such as Montrose, and in rural radio stations. The advertising campaign will include rural communities and will complement the partnerships we are establishing.

In the Marketplace, will there be a required generic formulary?
Federal regulations for qualified health plans (QHPs) in health insurance marketplaces require them to cover at least one drug in each drug class and category OR as many drugs in each class and category as the Benchmark plan covers (whichever is greater). QHPs are not required to cover a specific list of generics – they just have to offer a certain number of drug options.

How will we link uninsured patients who are newly eligible for insurance coverage with the providers they already have relationships with?
The Connect for Health Colorado Customer Service Center will be developing processes, procedures and training to advise customers to contact their current provider to see what types of health insurance they accept before shopping and enrolling if they want to keep their current provider. Connect for Health Colorado is also building a provider directory into the shopping experience so customers can sort plans based on whether or not their provider is in the plan network if that is a priority for them.

When undocumented individuals file taxes at the end of the year but don't have insurance, will they be penalized?
According to federal regulations, individuals who are not lawfully present in the U.S. are not subject to the requirement to have health insurance.