

## Questions and Answers from Nov. 4 2013 ACNM/HRSA Webinar on the ACA and Midwifery

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Q1: Can I get a copy of the slides?

A1: The slides are available [here](#). A recording of the webcast, with audio presentation is [here](#). A list of the sources for the materials in the slides is [here](#).

\* Note of Correction –During the presentation on slide 21, Jesse Bushman indicated that the light color blue states were those that **are** moving forward with Medicaid expansion. In fact, the opposite is true. The light blue states are **not** moving forward with Medicaid expansion.

Q2: Are the benchmark plans offering any out of network coverage?

A2: Avalere health conducted a study of plans offered through marketplaces being operated by the Federal government as well as the marketplace run by the state of California. They found that nearly half of plans were HMO/Exclusive Provider Organizations, and half were PPO/Point of Service models. Assuming the other marketplaces run by states have a similar mix, it is safe to say that there will be plan options available that provide for coverage outside of a dedicated network, although such out of network care will almost certainly come at a higher cost. We have also heard consistent reports that marketplace plans are keeping their networks small in an effort to control costs.

Q3: Will women who qualify for insurance through the ACA during pregnancy automatically qualify for an entire year of insurance? Or will their coverage terminate after their postpartum visit as it presently does?

A3: This response presumes that the question concerns women qualifying for Medicaid. The short answer is that coverage will, in general, be available after the ordinary 60 day postpartum period. The real question is what the nature of that coverage will be. Unfortunately, the situation for coverage during pregnancy is exceedingly complex. In general, if a woman is pregnant when she applies for coverage, and her income falls at or below the threshold at which the state provides Medicaid coverage for pregnant women, she will be covered under a package of benefits that was defined before the ACA. It may be either full benefit Medicaid, or pregnancy-related Medicaid coverage, depending on her income and/or the specifics of the state's Medicaid plan. Further, if she has income above 100% of FPL she may also qualify for subsidized coverage through the health insurance marketplaces. Technically, she could have coverage under both Medicaid and the marketplace at that point, but practically speaking the systems needed to coordinate this coverage don't exist, so she is likely simply to be covered under pre-expansion Medicaid. If a woman is not pregnant when she applies for Medicaid, and her income falls below 138% of the Federal Poverty Level (FPL), then *if her state has opted to expand its Medicaid program*, she will be covered under the new "adult group" that was created under the Affordable Care Act (ACA). The benefit for this new adult group is based on the "essential health benefits," which differs from the pre-expansion benefit package. If she enrolls in adult group expansion Medicaid and later becomes pregnant, CMS has indicated that she should have the option of staying in the adult group, or moving to the pre-expansion benefit. This is an issue that has been [examined](#) by the Medicaid and CHIP Access and Payment Commission.

- Q4: If a woman becomes pregnant, and finds that a CNM birth or out of hospital birth is not covered, will she be able to change plans to obtain the type of birth she desires?
- A4: This answer presumes that the question refers to plans offered through the health insurance marketplace. In general, there is a single open enrollment period each year, during which an individual can make coverage changes. There are additional special enrollment periods as well that allow individuals to drop or begin coverage. These special enrollment periods include events such as loss of employer coverage, qualification or disqualification for subsidized coverage, or a permanent move. There is no special enrollment period for pregnancy. However, there is a special enrollment period in cases where the individual's enrollment "is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange." If the woman was told that there would be coverage for CNM attended or out of hospital birth and the plan subsequently says no to such a request, then this could potentially trigger this particular special enrollment period which would allow the woman to switch plans. The best option is to carefully examine available choices during an open enrollment period and choose accordingly.
- Q5: I have heard that midwifery services for birth or are going to be reimbursed at rates equal to physicians? Is this confirmed?
- A5: The ACA did mandate that Medicare pay CNMs at the same rate as physicians. Payments under Medicaid differ state to state based on each state's laws and regulations. Payments to midwives from plans offered through the health insurance marketplaces will be a contractual matter between the plan and the midwife and/or her practice and may or may not be at the same rate as physicians.
- Q6: If a state has a law in place requiring midwifery care which was enacted before ACA, will the law still apply to the plans in the exchanges?
- A6: Plans offered through the health insurance marketplace must offer a benefit package that is based on the benchmark plan selected by their state. In almost all cases, benchmark plans are subject to state coverage mandates. Because of this, presumably plans offered through the marketplace will reflect their state mandates. However, insurers do have the ability to substitute or actuarially vary benefits within each of the ten benefit categories defined in the essential health benefits package. It is not clear whether plans will use that flexibility to refuse to cover midwifery services. An anti-discrimination provision of the ACA has been interpreted to mean that plans are not required to accept all types of providers into their networks. Decisions about network adequacy will generally be made by states and are likely to reflect the processes they use for commercial carriers.
- Q7: My prior employer just notified its employees that it was cancelling their health care coverage. Are the HRSA folks noticing a trend toward this?
- A7: At the time of this writing it has become clear that many insurers are cancelling policies that do not meet requirements imposed by the ACA. The thinking behind this was that new plans would be available through the marketplaces or through employers would include more comprehensive coverage.

- Q8: If someone has medical problems - diabetes, heart disease will they pay more for a premium, than the same age person without health problems. How are they verifying the accuracy of applications?
- A8: No. Premiums cannot vary based on health condition. They can vary based whether the coverage is for an individual or family; rating area (a geographic designation); age; and tobacco use. Income information on applications is compared to data from the Social Security Administration and the IRS. If the data submitted as part of the application cannot be verified using IRS and SSA data, then the information is compared with wage information from employers provided by Equifax. If Equifax data does not substantiate the inputted information, the Marketplace will request an explanation or additional documentation to substantiate the applicant's household income.
- Q9: I am unclear how the pay scale works for the medal plans. It seems unfair that the more you make for an income the higher your premium will be which is not the case if you have insurance with an employer. Maybe I misunderstood what you said.
- A9: The key is that the higher your income, the smaller your premium subsidy will be, which also means that you pay a higher proportion of your income toward your share of the premium. The policy concept is that people with lower incomes can only afford to spend a small proportion of their income on healthcare, as most of their income will need to go to more basic requirements. Slide 47 shows this in the graphic on the left. The premium subsidy is tied to the second lowest cost Silver level plan in the marketplace through which the individual is applying. So, for example, a person making between 300-400% of the federal poverty level will only have to pay a premium that is equal to 9.5% of his/her income. The premium of the second lowest cost Silver plan will be compared to the income of the individual. If it exceeds 9.5% of his/her income, then the premium subsidy will be set at an amount that makes it so that the premium cost does not exceed 9.5% of the person's income. They may sign up for a lower cost plan, or a higher cost plan. In the former case, the premium subsidy may result in them actually paying less than 9.5% for their coverage, while in the latter case they may have to pay a higher amount. So choice of plan will impact beneficiary payment as well.
- Q10: What can be done to apply political pressure to the states that have opted out of the Medicaid expansion? How can midwives help correct this injustice?
- A10: The typical grassroots sorts of actions would be appropriate: calling, writing to, or personally visiting with your state representative and senators, and governor; partnering with other likeminded organizations/individuals to amplify your message; voting for lawmakers who are in favor of expansion. The key argument is around how much it will cost the states to expand. The federal government is paying for most of the cost of expansion, but states will ultimately be left paying for 10% of the ongoing costs of covering these individuals. Many states have been looking at whether that minimal cost is offset by providing the coverage, because it saves in things like bad debt incurred by hospitals, or other problems that occur for people without coverage that are paid for in other ways through public programs. Looking for those sorts of studies and using them in your advocacy efforts is a logical first step. A good analysis of what it will mean for coverage if states do not expand can be found [here](#).

- Q11: I thought ACNM worked with the Federal agencies to make sure CNMs would be covered. Is that not definite?
- A11: ACNM does speak with federal agencies on behalf of CNMs/CMs. In coalition with other advance practice nurses we have submitted a letter to HHS expressing concern over an interpretation of the anti-discrimination language of the ACA that could conceivably be taken to allow plans to exclude coverage for CNMs/CMs. Practically speaking, though, we expect insurers offering plans through the marketplaces to cover CNM/CM services in the same way that they do for their commercial products.
- Q12: We are still having difficulty at my practice getting ALL forms of contraception (especially IUDs) covered at 100%. Is there a resource to help our billing department get insurance companies to comply with different elements of the ACA - like 100% coverage of all contraception?
- A12: HRSA's guidelines for coverage of contraception are found [here](#). Keep in mind that these do not apply to grandfathered commercial plans (which are few in number) or to Medicaid. You should also look at FAQs 14, 15 and 16 [here](#). These documents can be used to discuss with plans the requirements that apply to coverage for contraceptives. Keep in mind that the items that are covered are those approved by the FDA, *as prescribed*, so there is no coverage for over the counter items. Further, the plan can charge cost sharing for items or services received out of network, or can impose cost sharing for a brand or non-preferred drug when a medically acceptable generic or preferred brand drug is available. Plan reimbursable amounts are a matter of contract between the plan and insurer. They may pay you less than your acquisition cost for an IUD, but as long as they cover it without cost sharing to the beneficiary, they are technically in compliance with this provision. Where they would run into trouble is if their low reimbursement effectively makes it impossible for the beneficiary to obtain the service. This would be grounds to complaint to officials at either a state marketplace, or the federally facilitated marketplace, depending on which entity is operating the marketplace and reviewing plan benefit designs.
- Q13: Should CNMs/CMs be meeting with insurance commissioners and/or others to advocate proper language/coverage of our services and for our patient's needs?
- A13: In short, yes! Each year the federal government will issue a "Letter to Issuers" outlining policies they expect plans to abide by. It is likely that they will also modify regulations pertaining to insurers on a regular basis. These events will provide an opportunity for ACNM and our members to provide input to policymakers regarding aspects of the ACA that are not working well for CNMs/CMs or the patients they serve. To the extent that insurance commissioners or other state policy makers have responsibility for and authority to make changes to policies in their specific states, they would clearly be appropriate subjects for advocacy efforts. ACNM's national office staff would be happy to assist our affiliates in such advocacy efforts.
- Q14: Do the problems with the website cause problems with enrolling by phone? In person?
- A14: ACNM staff contacted the call center for the federally facilitated marketplace and confirmed that customer service representatives there use the same system available to members of the public going to the [www.healthcare.gov](http://www.healthcare.gov) website. The call center representative verified that they have had significant problems enrolling people who call in. Consequently, we would expect to see problems with using either a phone or in-person approach.

Q15: When patients sign up for insurance on the marketplace web site, will there ever be a reason a patient will be denied health care insurance?

A15: The short answer is no. However, if they have affordable health insurance coverage through another source, such as an employer, they will not be able to obtain *subsidized* coverage. Further, those who qualify for Medicaid will be enrolled in Medicaid when they apply, rather than being enrolled in one of the marketplace plans (assuming their state Medicaid program does not use a premium assistance approach that actually allows them to enroll in a marketplace plan). Keep in mind that they must enroll during an open enrollment period, or pursuant to a special enrollment period for which they qualify. Outside of those timeframes and circumstances, they cannot apply.

Q16: What effect do you believe deductibles will have on health seeking behaviors, particularly for those individuals close to the poverty line? Am I wrong in reading that subsidies will cover premiums but not deductibles?

A16: A substantial body of research shows that cost-sharing modifies beneficiary behavior. Clearly, imposition of deductibles will cause people to self-regulate in terms of the amount of care they seek. That said, for people between 100% and 250% of the federal poverty level, there are subsidies for their cost-sharing. The cost-sharing subsidy is in *addition* to the subsidy for premiums available to individuals with income between 100% and 400% of the FPL.

Q17: Where can the information in regard to benchmark plan coverage be found? Please share your resources.

A17: Descriptions of benchmark plans are available [here](#). Keep in mind that the benchmarks are just that, benchmarks. They do not necessarily reflect the exact benefit package that will be offered by all plans in the respective marketplaces. This is because plan issuers have permission to vary their benefit, within certain limitations.

Q18: If you are in a birth center in a state that is not planning to expand Medicaid, will the ACA provision still cover birth center services for those at the normal Medicaid levels now (i.e., at or below FPL?)

A18: Assuming your state licenses or otherwise regulates birth centers and has implemented coverage for birth centers through a Medicaid State Plan Amendment, coverage for birth center services and the services of providers working in the birth centers, should be available under the pre-expansion Medicaid benefit.

Q19: How would you direct me as a midwife to educate Native Americans about their need for personal health care insurance? I personally have been printing off supporting information from CMS and those items sent to me via my government email administration and sharing this information with patients. I am commonly being told by Native American patients they "have insurance through IHS."

Can you please help me in assisting Native American women understand that "contract health - IHS health care monies" is not personal insurance and that Native American patient population groups need to obtain health care insurance?

Also, if I am incorrect in my thinking, the Native Americans are exempt from obtaining personal health insurance.

A19: [Part 2, Chapter 1](#) of the IHS Manual specifically indicates that there are limits to what the IHS can and will cover and that even when a Native American receives care through the IHS, he/she may be subject to costs arising from care they need that the IHS cannot provide.

The IHS has posted a good summary of the benefits of the ACA for Native Americans [here](#). In general, subsidies for Native Americans purchasing coverage through the health insurance marketplaces are richer than those for other populations.

You are correct that Native Americans will not be subjected to a penalty for failing to obtain minimum essential coverage.

Q20: What credentials do lactation counselors/consultants need in order for their services to be covered by the ACA? Are there universal standards for coverage between insurers? How can lactation counselors in private practice go about the billing or reimbursement process with their clients?

A20: The [HRSA guidelines](#) regarding coverage of breastfeeding support, supplies and counseling simply say that coverage without cost-sharing is available for “Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.” The HRSA guidance does not specify what a ‘trained provider’ is. Similarly, the [USPSTF guidelines](#) for coverage of services without cost sharing simply state that with regard to breastfeeding, “The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.” HRSA has provided a little more detail on this coverage requirement in an associated [FAQ document](#). Neither of these sets of guidelines provides any detail on how lactation consultants are credentialed, or how they would go about enrolling as providers with insurers, or billing for their services. Presumably, this would be worked out contractually with the plans.

Q21: Is there any plan to add maternity care provider shortage areas to the current primary care shortage areas? Often areas that need maternity providers cannot qualify for a National Health Services Corps position because they have plenty of primary care providers, but not enough OB providers including nurse-midwives. This would help improve maternal infant outcomes as well.

A21: ACNM is actively involved in a legislative effort to create a maternity shortage area designation. However, at this point there is not a legal requirement that such a designation be generated by the federal government and in our conversations with the agency that creates the currently required provider shortage designations they have indicated that, in addition to lacking the statutory authority to do so, they do not have the resources that would be required to do so.