

LIBRARIES and the
**AFFORDABLE
CARE ACT**

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Francisca Goldsmith

LIBRARIES and the **AFFORDABLE CARE ACT**

**Helping the Community
Understand Health-Care Options**



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Francisca Goldsmith worked in public and academic libraries, both in the United States and Canada, for more than 25 years, before moving into full-time library staff development consulting and instruction, much of which through California's IMLS-funded Infopeople Project. Most recently, that instructional work has focused on supporting public library staff and administrators in responding to community needs for access to health-care information, both related to Affordable Care Act policies and the changing technology landscape of health-care delivery in rural, immigrant, and other socially isolated communities. Her library experience and consulting includes frontline reference work, collection management, branch services management, and teen services development and advocacy. She has given many presentations on multiple literacies, serving underserved communities, and social media use for community and staff development. She earned an MS in Library and Information Sciences at Simmons College and has had a variety of advanced education experiences in support of her knowledge management and community advocacy work. This is her third book for ALA Editions.

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Acknowledgments

The past 30 years of my professional life have been dedicated to promoting literacy and information access through public library services, although not necessarily through public library buildings. In 2011, I was tapped by California's Infopeople Project to develop and present a series of health information evaluation workshops, funded by a grant to UC Davis by the US Department of Commerce's National Institute of Standards and Technology, addressing family support center health information providers (almost none of whom worked in or with whatever libraries were in or "near" these largely rural and isolated communities). In 2012, this on-ground series found library staff supplementation through an asynchronous series on Health and Wellness Competencies for non-medical library staff, which I developed under the guidance of UCLA's wonderful medical librarian Kelli Ham, supported by a grant from the US Broadband ARRA office. That opportunity was followed by an IMLS-funded project to develop and oversee an asynchronous learning series, again through Infopeople, on the Affordable Care Act and California public libraries. And that has led to a variety of contacts with OCLC's WebJunction project to inform its Health Happens in Libraries resource.

A lot of thank-yous are in order and offered warmly to: Kelli Ham of the National Network of Libraries of Medicine (Pacific Southwest Region); Infopeople's Eileen O'Shea; WebJunction's Liz Morris; ALA Editions editor Jamie Santoro, who jumped at the mildly floated idea that a guidebook fast was the support public libraries need; IMLS Director Susan Hildreth, who sees all the ways public libraries have an essential role in community health; Librarians Internet Index founder Carole Leita, who never stops asking the nitty-gritty questions that require more fact-digging; Canadian librarian friends who find privatized health insurance a community information nightmare they are happy not to have; and Alameda County Library's Gary Morrison and Richard Bray for their inspirational trailblazing into this whole Affordable Care and the community library thicket.

Finally, this book is dedicated to the memory of Joachim Goldsmith (1942–2013) who, in the Affordable Care Act, finally discovered a topic of discussion he and his little sister could pursue with shared enthusiasm.

Introduction

While the rollout of the 2010 Patient Protection and Affordable Care Act is regulated to unfold over a full decade, concentrated public attention began to scale up as media called attention to the upcoming health insurance changes taking effect between 2012 and the present. Many public library staff and administrators began to anticipate a challenge to their information role in communities large and small, urban and rural, well-endowed with information access and isolated from ready access to authoritative policy news. In other public library settings, opportunities to connect to communities were recognized and engaged with relative swiftness.

Notably, where the complex new policies and regulations were viewed as a challenge to effective and efficient library service, communities largely left the library alone as a resource. And, just as notably, this moved many library districts to a false perception that staff awareness and community guidance on this matter is a nonstarter.

Meanwhile, in those districts where staff investigated the ramifications of these health-care policy changes as they relate to the various sectors of their stakeholders—importantly, including those stakeholders who just aren't traditional library users—libraries did find essential and rewarding ways in which to build both community health and wellness capacity as well as enrich library access to previously invisible community sectors.

The purpose of the book here is to engage and encourage the awareness and service planning of public libraries in every state in supporting local community health. This book is intended to serve as a guide and library staff and administrator support toward your own local explorations and actions. There is no singular blueprint to offer or adopt. Instead, the chapters here provide conceptual matters to address locally with the knowledge and understanding only you can bring to the table.

The chapters are short, generous with bullet points for quick and ready reference, and include task lists to focus further your local planning and execution of health capacity building. In order to get all this to you so as to capture library service learnings from the initial open enrollment period of the Affordable Care Act—mandated health insurance marketplaces and in time for the open enrollment period beginning November 2014, ALA Editions and I are taking the unusual tack of providing an analytical table of contents and a question-based chapter guide, rather than a traditional index. The intention is to keep the text as up-to-date as print books can possibly be in this period when we can use on-demand printing.



The Affordable Care Act

Overview and Context

Legislation Facts and Texts

The federal Patient Protection and Affordable Care Act was signed into law by President Obama on March 23, 2010. The rollout of the many legislated changes it makes in both the financing of health care for American citizens and legal non-citizen residents, as well as access to preventive healthcare in the United States, will continue across a full decade. Health-care insurance marketplace exchange regulatory effects formulated under the Act took effect January 1, 2014, with the initial health insurance open enrollment period spanning October 1, 2013 to March 31, 2014. Other aspects of the Act went into effect earlier than the health insurance marketplace exchange portions, and other important aspects of the Act's changes in citizen and legal resident access to health care also went into force on January 1, 2014.

Current Text of the Affordable Care Act

The legislation (<http://housedocs.house.gov/energycommerce/ppacacon.pdf>) signed by President Obama marks the beginning of the work by policymakers to develop and document the regulations by which the legislation turns into supported actions. The US Department of Health and Human Services provides a plain language version of the Act on its site. The Key Features of the Affordable Care Act (www.hhs.gov/healthcare/facts/timeline/timeline-text.html) presents official policies, and assigns areas of responsibility for regulatory development, as well as the schedule of mandates that take effect each year between 2010 and 2015.

A Brief History of Affordable Health-Care Legislation in the United States

Providing accessible health care for Americans began its legislative history more than 100 years ago. The key dates and events along the way include:

1912	Former President Theodore Roosevelt called for national health care as an element of his failed campaign against Woodrow Wilson
1935	During President Franklin Roosevelt's first term, the Social Security Act received legislative approval
1962	President John Kennedy called for a national health-care plan but his proposal was defeated by two senatorial votes
1965	President Lyndon Johnson signed the Social Security Amendments that gave rise to Medicare and Medicaid programs
1974	President Richard Nixon called for national health care, at a time when there were 25 million uninsured Americans

Sitting presidents since Nixon oversaw regulatory changes affecting Medicare and Medicaid, as well as some health-care system reforms including emergency room access.¹ When the Affordable Care Act was signed in 2010, the number of uninsured Americans had risen to more than 45 million.

Affordable Care Act Synonyms and Editorial Names

The Patient Protection and Affordable Care Act is the official name of the legislation driving the policies and regulations we are discussing in this text. However, the plan it outlines has other names attached to it in public media, political platforms, and other non-legal venues. Those names include:

- ACA
- Affordable health care
- Health-care reform
- Obamacare/ObamaCare
- PPACA

While these terms can help you to uncover news and editorial items, they are not official legal names for the Act and the policies library service staff need to track. In this book we will refer to the legislation as the Affordable Care Act as do most official government sources at this point.

Roles of the Federal and State Governments

The policies and regulations arising from the Affordable Care Act address both health-care access and insurance reform. They include some protections guaranteed at the national, or federal, level as well as allowing for strategic and tactical decisions that are made at the state level. They also include federal regulatory directions that become the responsibilities of health consumers, the medical industry, and employers. Certain flexibilities are granted to state-level policy-making. What happens because of this cross-government oversight is that each state's specific policies and regulations vary in some essential ways.

At this time, 16 states and the District of Columbia have developed their own structures of government agencies and workforces to allow them to create state-level policies and regulations, and seven more are in the process of developing similar infrastructures. The remaining states, for now, have their access and compliance with the Act enabled and overseen by the Department of Health and Human Services and other federal agencies, as relevant. *State Decisions for Creating Health Insurance Marketplaces, 2014* (<http://kff.org/health-reform/state-indicator/health-insurance-exchanges>) provides a current overview of the degrees to which different states have implemented the insurance market reforms mandated by the Affordable Care Act.²

It is important to note that some aspects of the Act roll out without regard to whether a state has opted for state control of its market. These include:

- patient rights;
- funding for clinician education and availability;
- Internal Revenue Service (IRS) provisions relevant to health-care-related taxation; and
- textual clarity of health insurance policy presentations.

Federal Law

Under the Affordable Care Act, health-care consumers, health-care providers (including the pharmaceutical industry and pediatric dentists), employers, and health insurance carriers all have specific rights and responsibilities. No state may decrease the level of health-care access its residents are accorded by federal mandate. These federal mandates include:

- Those making less than 133 percent of the federal poverty line become eligible for Medicaid (or its state-administered equivalent) coverage of health costs.
- Rather than pre-existing conditions or other health needs-based qualifiers, the four determinants that may be used to calculate health insurance premiums are:

1. age;
 2. geographic location;
 3. tobacco use; and
 4. family size.
- Insurance premiums collected must be spent against costs incurred by those insured at an 80/20 ratio, with no more than 20 percent of the premium applied to the insurer's administrative costs and 80 percent applied directly to the health-care expenses of those they insure.
 - Small businesses are afforded tax credits for spending on health-care insurance for full-time employees.
 - Individuals (consumers) who can afford coverage that costs less than 8 percent of their income are mandated to enroll in a health-care insurance plan, or face penalty fines.

Let's clarify these rules. In the case of the four permitted determinants of health insurance cost, a state may choose to require fewer determinants. (In California, for instance, tobacco use is not utilized as a determinant.)

The insurance 80/20 rule applies to the aggregate of policyholders a carrier covers, so that an individual policyholder, who may enjoy markedly excellent health, will not find that 80 percent of what her insurer collects from her is spent on her own personal health-care needs. However, she cannot be overcharged for any demographic characteristic other than the four allowable determinants.

The age determinant differs in its divisions from traditional insurance rate age banding. There are only three age tiers permitted under the Act's qualifications:

1. Children
2. Adults 19 to 64
3. Adults 65 and over

This structure assures children as a class being afforded specific care rights, including pediatric dentistry, and older adults being moved into Medicare, according to its age class threshold.

Toward providing health-care protection to employees of small business employers, a variety of programs, policies, and various federal agency regulations are designed to create small business health insurance access. Together these provide tax credit offerings, policy management, and other features intended to enable small businesses to address their employees' health-care access prospects.

While those who can afford to purchase health insurance are mandated to do so—if they are not provided such coverage through their employer—many Americans who fall into the category of being able to afford coverage also have at least some employer-provided coverage already. They may need to add household members at their own expense, if the employer's package doesn't provide for family members. In any case, the "individual mandate," as this self-coverage is called, need not be purchased on a government exchange. If purchased privately, however, the

individual will not qualify for any subsidy just as an employer purchasing away from the exchange will not qualify for any tax credit for providing employee coverage.

Insurance Exchange (Marketplace) Types

The federal health insurance marketplace, which serves 34 states to some degree at this time, operates as an enrollment channel for consumers, as well as a vetting agency for insurance carriers. Each of the 17 state-level marketplaces operates according to a similar pattern. In some states, the state-operated exchange is entirely a governmental agency while others include nongovernment operatives appointed by the state executive (governor) or legislative body to perform part of the exchange's work.

It is essential for the local public library's service providers to understand which entity has oversight of the state's marketplace, as this information informs many access questions. Among the portfolios carried by some state marketplaces are the oversight of Medicaid distributions, COBRA management, and again, small business access.³ Following relevant announcements of dates, policy changes, and website outages requires sensitivity to whether local communities are affected.

Medicaid

The Affordable Care Act makes some changes in how Medicaid and the Children's Health Insurance Program (CHIP) coverage are provided to recipients. (In some states, the federal Medicaid program is undertaken through a state agency and may carry a different name.) The mission and tenets of these federally funded programs address the needs of residents who are eligible for health access subsidy assistance without having attained age 65 when Medicare becomes available.

Outcomes Already in Place

Regulations arising from the Act that have been in place before the health-care insurance marketplace mandate went into effect include:

- new rights to free preventive care;
- coverage of preexisting conditions for children under 19;
- changes in annual and lifetime limits on health insurance policy coverage;
- new Small Business tax credits for employers with 50 or fewer full-time equivalent (FTE) employees that provide health-care insurance to employees as a benefit;
- reduction of health insurers' profit margin (medical loss ratio);

- public reporting of hospital performances and electronic health record replacement of paper billing to reduce health-care costs; and
- expansion and modernization criteria for the primary health-care workforce.

You can refer to Key Features of the Affordable Care Act Year by Year (www.hhs.gov/healthcare/facts/timeline/timeline-text.html) for links to details in plain language, FAQs, and other information about the regulations surrounding each of these and other outcomes of the Act.

Among changes already in effect that likely have bearing on many community members as they undertake health-care planning are:

- coverage options for dependent children under the age of 26;
- reforms in consumer prescription costs;
- coverage of preventive health-care visits;
- coverage of a preexisting medical condition, regardless of age (as of January 1, 2014);
- mental health benefits; and
- substance abuse treatment benefits.

Insurance Enrollment

The initial enrollment period for insurance purchased in the marketplace opened October 1, 2013, and was mandated to remain open for six months, until March 31, 2014. Each year, in November, a new open enrollment period allows anyone to change plans (<https://www.healthcare.gov/what-key-dates-do-i-need-to-know/#part=1>). To buy insurance through an exchange outside open enrollment periods, the consumer must qualify for special enrollment access due to a qualifying life event such as moving to a different coverage region, marrying, a divorce, a family increase or decrease, or job change that affects previously held coverage.

There are several areas in which fines will be applied for failure to access appropriate health insurance coverage. These penalties will be phased in for both individuals and employers over a number of years. At this time, planned penalties for employers are being renegotiated.

There is no penalty for acquiring health insurance from a source other than the government-established marketplace. The marketplace regulates what insurance carriers must provide, but consumers may shop elsewhere for insurance policies.

Who Is Affected by the Enrollment Requirement?

Only those who need health insurance, access to Medicaid (or its equivalent state program), or the opportunity to make line-by-line comparisons of the insurance

plans available in a consumer's geographic district must enroll for health-care coverage via the government marketplace. However, virtually everyone in your community is affected by aspects of the Affordable Care Act that touch on the marketplace's availability. The affected include:

- community members who need to pursue faith-based, tribal status or other exemptions from health-care coverage;
- residents new to the area served by local health-care provider networks, including those arriving from another state or a different area of a large state;
- those whose family or economic circumstances have changed within the past 90 days;
- residents who have changed employers;
- residents who seek COBRA coverage;
- insurance agents and brokers, and certified in-person assistance counselors;
- local health access support providers serving underserved segments of the population, including those with primary language needs other than English and those serving in isolated rural areas; and
- public library staff who need to understand enrollment access questions as well as information for anyone about the Act's dynamics as they relate to library space, equipment, and information services.

Recognizing Local Needs

In July 2013, the Institute for Museum and Library Services announced a matter of policy.⁴ Unlike law, policy calling on the 17,000 public libraries in the United States to serve as Affordable Care Act access points has the force of an ethical mandate, rather than a government regulation. Public libraries provide a local face to government rules and resources. As professional information evaluators and providers, our services to our local communities position us to communicate, provide technology access and literacy resources, and serve as a physically sited forum for other service providers. We can use our community knowledge and professional assets to work with those in each local community who may be impacted by Affordable Care Act legislation.

How is your community learning about Affordable Care Act-related health-care changes? How have you learned them yourself? If you have employment-related health-care insurance for yourself and your family, you may not have been tuned into the details of the Affordable Care Act's specifics. Or you may have been involved in political discussions with friends and family members based on what you and they are hearing in a wide range of media channels. These are the same likely sources of information members of your community have used.

Members of your community (and you!) also may be reading documentation that has been arriving from their (or your) current coverage provider. Community

members who already have ongoing communications with various health-care access providers, such as Medicaid, and/or local health support agencies may be receiving regular communications. Insurance agents and brokers are another source of information on which community members may be relying. All of these are valid sources of information. Yet, any one of them is an incomplete source. The ethical mandate given public libraries requires us to provide access to any element of information needed by a community member seeking improved understanding of Affordable Care Act policy matters.

Access to health-care information includes overcoming any of a variety of potential barriers that may present themselves in your community, or to segments of it.

Library staff need to possess a clear understanding of their roles in linking their community to the most appropriate resources to fulfill the need for authoritative Affordable Care Act information. In many communities, this also means:

- making available public access computers with the appropriate software to perform health research and complete online forms;
- providing time and space to complete online forms thoughtfully;
- performing linguistic and culturally competent reference interviews; and
- building partnerships with social services agencies.

Project Management and Staff Awareness of Affordable Care Act News

You may want to consider taking the following actions to best serve the local community:

- Identify lead staff to assess local information access needs in the community.
- Ensure the ongoing upkeep of technology that the community may need in order to enroll in government programs and perform health and health-care related research.
- Locate and document information to supply to community members if they need more help than the library can provide.
- Proactively collect and share on a frequent and ongoing basis new information published at the federal or state level that changes any features of the Act's effects on your community.

In the following chapters, we will explore how to approach the many information demands made on your library by the Affordable Care Act and the policy statement that public libraries serve as an access point to health-care information. In order to optimize your use of this guidebook, you will find that each chapter ends with questions and tasks, usually comprising information to gather and consult in order to apply best practices to your local situation.

CHAPTER ONE: Questions and Tasks



- ✔ Have you bookmarked the links to the Affordable Care Act legislation mentioned in this chapter for quick access by public service staff throughout your library?
- ✔ Are you aware of your library's current policy concerning open access and reference provision standards?
- ✔ Do you know the name under which Medicaid functions in your state and what level of government administers it to residents?
- ✔ Make sure that your governing body—board, trustees, city or county supervisors—is aware of the public library's role in providing access to information about and enrollment in the Affordable Care Act's legislated health coverage access structures.
- ✔ Is staff aware of the library's policies concerning the types and level of support the library provides in the enrollment process?

NOTES

1. *New York Times*, "A History of Overhauling Health Care," www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIMELINE.html?_r=0.
2. See appendix A of this book for the most current overview of state insurance marketplace sites and other discriminating state-level details of implementation.
3. Ibid.
4. Institute of Museum and Library Services, "IMLS and Centers for Medicare and Medicaid to Partner with Libraries," www.ims.gov/ims_and_centers_for_medicare_and_medicare_services_to_partner_with_libraries.aspx.