



Healthcare Exchange Must-Do's for Radiology

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AT A GLANCE:

- Are you in the right exchange plans?
- Are your patients really insured?
- Have premiums been paid?
- Procedures to protect the practice

EXECUTIVE SUMMARY

Although the healthcare exchanges/marketplaces opened for enrollment last October, there are still many unknowns about patient coverage, physician networks and how well the plans will work financially for providers.

Enrollment through the insurance marketplaces ended on March 31 and in mid-April, it was announced that over 8 million consumers signed up for insurance on the federal and state-based health exchanges ("marketplaces").

But there are still many unanswered questions:

- Did enough people sign up with private carriers to make it work?
- Did enough "young" people sign up?
- How many who signed up did so by enrolling in Medicaid?
- How many consumers are upset because they could not "keep their own doctor."

While the media and pundits have a field day discussing these points, this whitepaper concentrates on how the marketplaces affect radiology.

The next section highlights the current "must do's" for radiologists, including plan participation and the procedures needed to help patients and your practice make sure that a patient actually has coverage.

RADIOLOGIST "MUST-DO's" FOR INSURANCE EXCHANGES

The healthcare exchanges (marketplaces) got off to a rough start, with the highly visible problems on healthcare.gov and some of the state exchanges. A less visible but equally important barrier was (and may still be) consumer unfamiliarity with the workings of health insurance.

Although they got some media attention, little was said about the ACA's and insurance marketplaces' effect on radiology.

Two aspects of the exchanges significantly impact radiologists:

- Provider Networks – are you included?
- Understanding who is covered and insured and how to stay current with changes

Exchange Provider Networks

Just because a radiologist has a contract with an insurer does not mean he/she is a member of all their policy networks and just because a group practice has a contract with certain ACA plans, doesn't mean all the radiologists in the group are enrolled.

Individual radiologists and group practices must take the time to know which plans and networks they are participating in. Not doing so can leave radiologists "holding the bag" when the insurer denies claims for non-participation.

The ACA mandates that exchanges ensure a sufficient choice of providers. But how insurers went about adding and eliminating providers and hospitals from their ACA plans has been widely-criticized. In 2013, many insurance carriers sent their panel physicians a letter stating that if the physician did not "opt out" of a new ACA plan, it would mean they were automatically signed up to accept these new plans. Many radiologists did not receive the letter or did not authorize participation in the new plans, but were added anyway.

Other hospitals and physicians were left out of the plans without any notice from their insurers. Insurers say that narrowing hospital and provider networks is necessary to keep premiums down, shutting out many health care providers from plans they had previously been a part of. Patients who wanted to keep their providers had to switch plans, or patients had to change their physicians. In states with a small number of networks to choose from, some patients had to travel great distances to be seen by an in-network primary care physician, specialist or hospital.

As a response to the "I can't keep my own doctor," one aspect of the new proposed rule for 2015 (see below) is that health plan provider networks must contract with at least 30% of that area's "essential community providers" which include community health centers, HIV/AIDS clinics, and children's hospitals. The current rule is 20%. The rule also authorizes the federal exchanges to scrutinize their plans to ensure they have enough hospitals and specialists in various fields of practice.

CMS says the proposed rules would "encourage improved consumer protections regarding essential community providers, network adequacy, access to needed prescription drugs, and coverage of care during transitions." These rules are written for plans offered on the federal exchange but will also influence state-run exchanges and insurers in general.

At this point radiology are advised to assess how well current exchange participation (or lack thereof) is working and begin the process of negotiating participation for 2015. While insurers are likely to continue to focus on "narrow networks" to manage costs, the countervailing public and regulatory pressures mean that insurers may be more flexible for 2015 than in 2014.

It is important to note that many observers expect exchange participation to increase substantially over the next 2 years, including private exchange plans where most radiologists will want to participate. It's also worth noting that many exchange plans have private counterparts with the same insurer and it's critical to know if the practice is included in both or only one.

Are Your Patients Really Insured?

It is essential for a radiology practice to know which patients are covered under the insurance marketplace plans. But some patients enrolled in an exchange plan have the exact same insurance card as a person enrolled with the same insurance company who pays for a traditional plan!

In addition, even if a patient is enrolled in a health insurance exchange plan, it does not mean he/she is covered under the plan. Patients' payment for their premiums designate when their coverage begins. As an example, patients who paid their premiums and were enrolled on February 20 were not covered until April 1. Then there is the 90 day grace period.

Know Your Patients' Coverage

In an imaging center, by now staff should be trained on the insurance marketplace implications and have the necessary contacts and procedures in place (see below). For hospital-based radiologists, it is essential to know what your hospital has done to train admitting staff to obtain, confirm and pass on the most updated and complete insurance information.

In both cases, staff must be trained to assist patients who have insurance and enrollment questions. Some of the information they should have on hand includes:

- State exchange call center phone number and website
- Personal Assistance Sites available through the federal exchange at www.healthcare.gov
- Major insurance carrier websites and phone numbers

Understand the 90 Day Grace Period

Consumers who purchase exchange insurance with advance premium tax credits but fail to pay their premiums have a three-month grace period before termination from the plan. Health insurance issuers are obligated to pay claims for covered services rendered during the first month of the grace period. During the second and third months of the grace period, health insurance carriers may pend claims until the member has either paid the premiums owed or the grace period has ended. At the end of the grace period, if the member has not paid their premiums, claims may be denied.

Health plans must notify physicians when their patients have entered the 90-day grace period and that their claims are pended. Some carriers make additional information available when contacted to confirm eligibility, such as the "paid to date" through which the policy has been paid.

On March 6, 86 medical organizations submitted a [letter](#) to CMS Administrator, Marilyn Tavenner, requesting CMS revisit the 90-day grace period notification to physicians, as it places unnecessary financial burdens on medical practices. The letter urged CMS to require issuers to provide grace period information as soon as a patient enters the first month and when responding to eligibility verification requests. They also urged the agency to require issuers to assume full financial responsibility if they provide inaccurate eligibility information during the last 60 days of the grace period.

Check Patient Eligibility, Coinsurance, Deductibles and Copays at *each visit*

Given the circumstances, it is critical for imaging centers to check a patient's identification card and confirm eligibility at each visit. The same is true for hospital admitting offices, recognizing that emergency admissions are

an exception. Hospital-based radiology groups would do well to inspect the hospital's process. It's worth noting, as an additional complexity, that this patient population may move in and out of coverage or between private insurance and Medicaid.

Many major carriers have provider portals that can be very helpful to verify patient information and eligibility quickly. Some carriers provide an electronic version of the patient's insurance card to verify eligibility. In order to access these portals, registration is needed with a user name and password.

It is also true that some newly insured patients are not familiar with certain terms common in health insurance. For example, these patients may not understand the difference between the deductible, co-insurance and co-pay or may not understand how deductibles work. Therefore, wherever possible, radiologists should remind their patients to keep all of their paperwork and receipts from each exam and pharmacy visit. It's also not too basic to remind these patients to always carry their health insurance card.

Imaging centers should also be prepared to cover the following points. Hospital-based practices should do everything possible to have the hospital cover these points on their behalf:

- Explain cost-sharing information which can be found on many major insurers' websites. Cost-sharing varies widely, especially based on the plan category (bronze, silver, gold and platinum) and whether services are in or out-of-network.
- Discuss financial policies with patients as many of the exchange products have high deductibles and co-payments. Make sure patients understand your practice's policies, whether you collect the whole patient portion up front or if you offer payment options such as time-of-service discounts or payment plans.
- Work with patients who owe past due amounts to set up payment plans.
- Explain to patients in the "**grace period**," the importance of paying their premiums in order to have insurance coverage.

PROPOSED RULE: INSURANCE MARKET STANDARDS FOR 2015 AND BEYOND

On March 14, the Obama administration issued a proposed rule, the [Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond](#) which provides early guidance intended to promote affordable health coverage next year. [Per CMS](#), the rule "clarifies policies to improve consumer protections, stabilize premiums, and continue the common-sense approach to implementing key policies." Specifically, the rule will affect:

- Insurance exchange plans' provider networks
- Consumer access to quality information about plans
- Selection of plans in the Small Business Health Options Program(SHOP)
- Standards and state rules on enrollment navigators and other consumer assisters;
- Premium stabilization policies for 2015;
- Reinsurance and medical loss rations for insurers

The comment period ended on April 21, 2014 and CMS is expected to issue a final rule this summer.

CURRENT STATE OF THE MARKETPLACES

In 2011, the [Congressional Budget Office](#) (CBO) predicted that the ACA would increase the number of non-elderly with health insurance by about 32 million in 2016 and 34 million in 2021, leaving only 23 million nonelderly residents uninsured: one-third being unauthorized immigrants, who are not eligible to participate in Medicaid or the insurance Exchanges with another quarter eligible for Medicaid but not expected to enroll.

In preparing the February 2014 baseline budget projections (based on analyses performed in December 2013), the numbers changed. The CBO recalculated their numbers and [announced](#) that the insurance coverage provisions of the ACA would increase the number of nonelderly people who have health insurance by about 13 million in 2014, 20 million in 2015, and 25 million in each of the subsequent years through 2024, 9 million less than projected in 2011. They also predicted that about 31 million nonelderly residents of the US are likely to be without health insurance in 2024, 8 million more than the original projection.

The CBO also projected that under current law, 6 million people in 2014 would receive insurance coverage through the new exchanges and over time, more people are expected to respond to the new coverage options with enrollment to increase sharply in 2015 and 2016. Roughly 80% of those enrollees are expected to receive subsidies for purchasing marketplace insurance.

The enrollment extension, blamed on problems with the exchange websites, increased enrollment to the 8 million level. The 36 federal exchanges extended the enrollment period until midnight April 15 for consumers who could show they tried to enroll before midnight March 31. Most state-run exchanges also offered a grace period.

There are still many unanswered questions about the current enrollees. The 8 million figure only includes people who have completed applications for healthcare plans on the federal or state exchanges. It is unclear how many have made an initial premium payment: without payment the enrolled patient is not insured. HHS Secretary Kathleen Sebelius, quoting insurance industry officials, said an estimated 80–90 percent have made their first premium payment.¹

The administration has announced that 28% of enrollees are ages 18 to 34. Experts believe that closer to 40 percent of enrollees need to be between the ages of 18 and 34 to balance out sicker and older people on the marketplaces. Without such a balance, premiums could rise fast in some states.²

Detailed enrollment data is not yet available, so it's not clear how many of the 8 million people are gaining insurance for the first time. We also do not know how many of the 8 million signed up for Medicaid and not private insurance.

Certainly those who back the ACA are confident that over the next few years the enrollment will sharply increase and there will be enough young and healthy enrollees to make the exchange plans profitable. However, two factors will play out in the near future that could decrease the number of enrollees:

- Consumers may find their monthly payments too expensive and not pay their monthly premiums
- As state Medicaid agencies analyze financial and other data provided by the exchanges, they may continue to find what some states have already found: that a substantial number of applicants deemed eligible by exchanges did not meet state requirements because of inaccurate or incomplete data.³

¹ Viebeck, Elise, and Sink, Justin, "[ObamaCare Comeback?](#)" The Hill, April 1, 2014

² Ibid

³ Vestal, Christine, "[Next Steps for States, Health Insurance under the ACA,](#)" USA Today, April 3, 2014

It is too early to tell whether the ACA has improved health insurance coverage and lowered costs. It will be some time before accurate data can be gathered to answer these questions.

RESOURCES

Several resources are available to help radiologists and their staff set up best practice policies for working with patients. Particularly for collecting payments due from the patient for services not covered by their insurer and for grace period issues.

AMA - The AMA has published a nine-page [Step-by-step Guide to the ACA Grace Period](#), which is an extensive resource to help physicians know the right questions to ask insurers concerning how the practice will be notified of grace period status, physicians' rights with respect to payment, and recoupment and frequent issues that physicians raise about the grace period. They have also published "[Model Collection Policies for Grace Period Patients](#)," giving tips on how to handle patients who fall behind on their health insurance premiums.

CMS - You can also download copies of the following made available by CMS:

- [10 Things Providers Need to Know](#)
- [10 Things to Tell Your Patients](#)

The Department of Health and Human Services offers the following advice to verify a patient's coverage under an insurance exchange plan. If the marketplace in the state where the patient purchased insurance is run by the federal government, it is best to call the plan's customer service line. A list of all plans and their customer service numbers can be found in this [data base](#). Here's a [fact sheet](#) for using the data base. If you can't find the number, call the Marketplace Call Center (1-800-318- 2596).

If the marketplace in the state where the patient purchased insurance is run by the state, contact that state. To find the website for the state-run exchanges, select the name of the state in the box at the left hand side of the [healthcare.gov website](#).

BACKGROUND

The Patient Protection and Affordable Care Act (PPACA or ACA) was enacted in 2010 with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government. The ACA was projected to newly insure 30 million people over time.

To meet these goals, the ACA includes both individual and employer mandates, subsidies for lower income individuals and small businesses, expansion of Medicaid, and the state and federally-run health insurance exchanges/marketplaces.

The central goal of the ACA is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and the new Health Insurance Exchanges, or Marketplaces.

Insurance Exchanges were designed to provide a state-based competitive marketplace where individuals and small businesses would be able to purchase "affordable" and "quality" health insurance. But as events have unfolded, not all states have welcomed the opportunity to set up these Marketplaces. Only 16 states and the District of Columbia are operating under their own state-based marketplace, seven states created a partnership with the

federal government and 27 states defaulted to a Federally-facilitated Marketplace (FFM).⁴

More states participate in the Medicaid expansion program. The expansion covers individuals eligible for Medicaid under age 65 with incomes up to 133% of the Federal Poverty Levels. The federal government pays 100% of the costs for this expansion for the first three years and 90% after that. As of March 2014, 26 states and the District of Columbia have implemented or will implement Medicaid expansion in 2014, 5 states are debating it and 19 states have indicated they will not move forward, at least not this year.⁵

The Marketplaces are open to individuals making between 100%-400% of the federal poverty level who are not offered coverage through their employer. This group will receive some type of premium tax credit to help offset the cost of buying coverage.

Those who have job-based coverage but want to participate in an exchange plan can do so but if the job-based coverage is considered affordable and meets minimum value, the individual is not be able to get lower costs on premiums or out-of-pocket costs in the Marketplace.

Under the ACA, all Americans were to buy insurance by March 31 or face a tax penalty. Individuals are considered covered if they have Medicare, Medicaid, CHIP, any job-based plan, any plan a person bought themselves, COBRA, retiree coverage, TRICARE, VA health coverage, or some other kinds of health coverage. In 2014, the penalty is \$95 per person in a household or 1 percent of a person's income, whichever is higher, paid with 2014 income taxes in 2015.

Those who did not purchase insurance by March 31 must wait until next year's open enrollment to get insurance. Those eligible for Medicaid and the Children's Health Insurance Program can enroll at any time and those with a "qualifying event," such as moving to a new state, marrying, divorcing, having a baby or losing a job, may also apply for private coverage on the exchange at any time after March 31.

⁴ Kaiser Family Foundation, "[Marketplace Enrollment as a Share of the Potential Marketplace Population](#)," March 1, 2014

⁵ Kaiser Family Foundation, "[Status of State Action on the Medicaid Expansion](#)," 2014