How to Navigate Health Exchanges

MAXIMIZE REIMBURSEMENTS AS THE EXCHANGES ROLL OUT

By Steve Selbst, Susan Charkin, and Regina Vasquez

In October 2013, the national health insurance exchanges launched – creating a significant change for medical practices. Many practices were left wondering how to navigate these exchanges to maximize reimbursements.

First, it is important to have a basic understanding of the structure of the health exchanges – that is, what is consistent across all exchanges (federally run and state run) and what is unique and, therefore, inconsistent. As of the time of this writing, there were 16 states that have implemented state run exchanges. The remaining 35 exchanges (including Washington DC) are either run by the federal government or in a partnership with the federal government.

Whether the state or federal government runs the exchanges, there are some very clear common features across all exchanges and all plans:

- Each state offers the exact same plans (features and structure): catastrophic, bronze, silver, gold, and platinum.
- Each of these plans has the same percentage of payor coverage: catastrophic will provide for 60 percent coverage; bronze, less than 60 percent; silver, 70 percent; gold, 80 percent; and platinum, 90 percent.
- Each plan includes doctor visits, prescription drugs, hospitalization, maternity and newborn care, and preventive care elements.

Still, there are many inconsistencies in the plans, including:

- Which payors choose to participate in a particular state's exchange
- The premiums established by each payor
- The benefit plans (catastrophic through platinum) that the payors choose to offer
- The products established for the exchange plans
- The physician reimbursement associated with exchange plans

The current trend in healthcare exchange enrollment indicates that the vast majority of individuals currently enrolled in state exchange plans qualify for expanded Medicaid coverage and are accessing policies with reimbursement rates equal

or close to state Medicaid rates. This could potentially have a significant impact on a practice's revenue and margins.

There are a range of questions you and your practice may be experiencing related to the exchanges, including:

- How do I know if I have an option to contract with a payor's exchange product or opt out of an exchange product?
- How can I validate if my practice is already in an exchange product?
- What are my exchange product reimbursement rates and do they differ from my current contracted rates?
- With enrollment problems, why would we assume that there will be accurate systems and business processes in place to track premium payments for exchange-based policies/plans, benefit eligibility, and deductible amounts paid to date?
- Can I collect from the insurance company if a patient in an exchange plan misses premium payment(s) or has terminated or changed their plan choice in the exchange?

Here, then, are answers to those questions.

HOW DO YOU KNOW IF YOU HAVE AN OPTION TO CONTRACT WITH A PAYOR'S EXCHANGE PRODUCT? HOW DO YOU VALIDATE PARTICIPATION?

The answer varies. First, whether you participate in a state run exchange or a federally run state exchange, you can go to healthcare.gov to figure out the plans that are in place in your state. Once on the site, follow the questions about coverage for a family to get to the options available. If you are in a state run exchange, this site is now integrated into your state's website and will transition you during your answers to the qualifying questions.

Figure 1 shows a partial result of navigating healthcare.gov for a selected county in the state of North Dakota to find plans for a family including "you, your spouse, and children." You immediately get the results for all payors and plans that are part of the exchange, along with the estimated premium payments based on the query.

Now that you have identified the plans, you can go to the website of the payor that offers the plan(s) to determine whether or not a physician or practice is a participating provider in the plan. In the example, you would visit the Blue Cross Blue Shield of North Dakota's website and search for a physician or practice by name.

FIGURE 1

Narrow your results	Plan	Estimated monthly premium for You, your spouse, and your children
Your answers	**BlueEssential 100 6350** Blue Cross Blue Shield of North Dakota PPO | Catastrophic	**$558.50**
Coverage type Individual & Family	**Simplicity $6,350** Sanford Health Plan HMO | Catastrophic	**$559.26**
Coverage Medical	**Simplicity $5,000** Sanford Health Plan HMO | Bronze	**$636.24**
Location ND - Burke	**BlueDirect 70 4000** Blue Cross Blue Shield of North Dakota PPO | Bronze	**$672.72**
Who needs coverage You, your spouse, and your children		
Insurance company Blue Cross Blue Shield of North Dakota Sanford Health Plan		

WHAT WILL MY REIMBURSEMENT BE FOR THIS EXCHANGE PRODUCT?

If you have determined that your practice is participating, the reimbursement will likely be the same as your current contracted fee schedule for the plan product in which the patient is enrolled. The difference, operationally, is that exchange products have patient copayments that vary based on the beneficiaries' selected exchange product. For example, a patient who has a PPO catastrophic plan may have more than a 40 percent copayment, while a patient who has a platinum plan in the same exchange product may have only a 10 percent copayment. This means that you and the practice staff will need to have both the business processes and systems in place to track the variance of copayments required from patients based on their plans. You will need to track the details for each patient and ensure the appropriate copayment is

collected from the patient and that the payor pays its portion of the contracted rate. Since the exchange plan copayments, deductibles, and coinsurance requirements will vary based on the exchange plan type, it is imperative that your practice team puts the appropriate systems in place to ensure that patient payments are accurately collected.

Since payors that participate in the plans need broad physician networks in support of the exchange plans, if you work at a specialist's office, you may be able to use an agreement to participate in an existing or new exchange plan product as leverage in a contract negotiation or re-negotiation of an existing payor agreement. Generally you have the options to opt in or out of a state exchange plan product. In some cases, a large payor automatically pays contracted practices the same contracted rates as its standard PPO plans. However, it is still important for practices that are auto enrolled in the exchange plans, at the usual PPO rates, to verify benefits and collect copayments, deductibles, and coinsurance payments according to the terms of the state-based plan since these payments vary for all plans, from catastrophic to platinum.

Some states have new payor products being put in place with new and, in some cases, lower fees for service reimbursements from the usual commercial products offered in the individual or small-business markets, both in and outside of the exchanges. We have seen one such scenario in Texas. In this case, in order to complete a re-negotiation of an existing agreement, a payor required, in exchange for an increase on an existing PPO fee schedule, that a practice participate in a new exchange plan, which paid significantly less than the PPO plan being negotiated and was to be offered both inside and outside the exchange in the coming year. If faced with a similar situation, it is imperative that you determine the financial effect of choosing to participate in the new product by understanding the estimated population of people who may choose this new plan both on and off of the exchange. It is important to ask questions such as, "How and to whom is this new plan going to be marketed – to individuals and employer groups?" or "Will this new plan be incentivized at brokerage firms?"

Once properly armed with information, you may have an opportunity to leverage your agreement to participate in the new product to help achieve increases in your existing agreement.

To protect against unexpected and undesirable outcomes, such as discovering that you are unknowingly participating in an exchange plan at low reimbursement rates, it is best to take a methodical approach to determine your status as it relates to each of your payor contracts and the plans covered by each contract. First catalog all of your key commercial payor contracts. Create a list of the payors and the plans/products in which you are contracted. Then, as described above, go to the website in your state to determine the payors that are offering plans on your state exchange, by payor, and then by product. Next determine if you are already listed as a participant in those plans by reviewing your contract documents or researching on each payor's website which plans are shown as being accepted by your practice. Last, validate the fee schedule that is in place when you service exchange-based patients.

Many payors have sent or will be sending written correspondence to communicate their procedures for your exchange

AFFORDABLE CARE ACT BY THE NUMBERS

85% The number of people in the ACA marketplaces receiving federal subsidies to help them pay for their insurance.

(Source: The New York Times, *"Understanding the Rate Increases for Health Care Plans," June 5, 2015)*

10.2 million

The number of people who paid for their ACA plan coverage as of March 31, making their enrollment official.

(Source: CNBC, "10.2M Paid for Obamacare Plans this Year: Govt," June 2, 2015)

> In some cases, not responding could mean that your practice is automatically enrolled in a plan or automatically opted out.

participation. Read all correspondence carefully and respond appropriately. In some cases, not responding could mean that your practice is automatically enrolled in a plan or automatically opted out. In other cases, you have to respond before the noted deadline in order to opt in or out.

WITH ENROLLMENT PROBLEMS, WHY WOULD WE ASSUME THAT THERE WILL BE ACCURATE SYSTEMS AND BUSINESS PROCESSES IN PLACE TO TRACK PREMIUM PAYMENTS FOR EXCHANGE-BASED POLICIES/PLANS, BENEFIT ELIGIBILITY, AND DEDUCTIBLE AMOUNTS PAID TO DATE?

It is critical that your billing and practice management systems be equipped to handle the business rules related to exchange patients, such as the 90-day grace period, and to ensure that each claim is tracked and paid per your contracted rate. While the payors and the exchanges have their systems, it is best that you rely on your own systems to ensure timely payments and accuracy of payments.

CAN I COLLECT FROM THE INSURANCE COMPANY IF A PATIENT IN AN EXCHANGE PLAN MISSES PREMIUM PAYMENT(S) OR HAS TERMINATED OR CHANGED THEIR PLAN CHOICE IN THE EXCHANGE?

One of the potential "gotchas" of administering patients who are in exchange plans is the 90-day grace period rule. That rule states that patients in exchange plans who are receiving subsidies are given 90 days to catch up on their premiums once they miss a payment. Federal rules allow health plans to pay, hold, deny, or later recoup payment of claims for services incurred in the second or third month of that window if patients are delinquent on their premium payments. However, insurers must pay physicians for services provided to a patient in the first 30 days of the grace period, and insurers still must comply with state law requiring prompt payment of claims submitted at any point during the grace period.

For patients who are not subsidized, the termination policy, including grace periods and payor/provider responsibilities, reverts to the laws and regulations in the state in which the patient purchased their exchange-based plan. The issue, therefore, is a practice management matter. It will be incumbent on your practice to verify, prior to delivering services each time, that patients with exchange-based plans are current on their premium payments and not in a grace period due to nonpayment. It would also be prudent to verify that previous claims have been paid in a timely manner. If not, you may have to potentially collect the full amount of reimbursement (both payor and patient portions) directly from the patients. This increases the risk of larger amounts of outstanding accounts receivable and lost revenue due to inability to collect after services are rendered.

> One of the potential "gotchas" of administering patients who are in exchange plans is the 90-day grace period rule.

Have a Plan

There are many considerations for your practice when looking at participation in a new or existing product offered by a payor on the health insurance exchanges. It is important that you do research and have a clear plan in place for how to work with exchange-based patients to ensure timely reimbursement and payment of outstanding balances. ■

Steve Selbst is the CEO of Healthcents. He leads the business operations, including contracting and reimbursement analysis. He is the inventor of RevolutionSoftware and leads the development and delivery of the "Blue Print for Success" Payor Contracting Class.

Susan Charkin MPH, is the founder and president of Healthcents and leads client strategy and new business development. Charkin's background includes more than 15 years of experience in senior contracting positions.

Regina Vasquez is the vice president of accounts and operations with Healthcents. She has more than 10 years of contracts negotiations and project management experience, plus five years of experience working as an ancillary professional in a hospital postpartum unit.