

Should You Accept Insurance Exchange Coverage?

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Practice Points

- Many private practitioners remain ambivalent about participating in the new Health Insurance Marketplace plans under the Patient Protection and Affordable Care Act. Problem areas include lower reimbursements, high deductibles and/or co-pays, and the infamous 90-day “grace period.”
- Small practices will have to balance the additional administrative and regulatory burdens and lower remuneration against the need to remain competitive.
- It may take years to evaluate the overall effect of public and private exchanges on private practices and on the American economy in general.

According to the Obama administration on April 1, at the end of the first enrollment period 7.1 million previously uninsured Americans now have health insurance through the Health Insurance Marketplace under the Patient Protection and Affordable Care Act (PPACA).¹ Exchanges are online marketplaces that individuals without access to conventional private, government-sponsored, or employer-provided insurance can use to obtain subsidized coverage from competing private health care insurers. It remains unclear how this influx of newly insured patients will affect private practice health care practitioners.

For many private practices, particularly solo offices and small groups, the increased patient load comes at a substantial price in the form of increased administrative and regulatory burdens and lower remuneration. For each plan, new and unfamiliar paperwork must be completed, and each patient's insured status must be verified. Most exchange

plans reimburse at a lower rate than conventional private insurance, and many have disturbingly high deductibles and co-pays. A majority (perhaps as many as two-thirds) of hospital networks on the exchanges are “narrow or ultra-narrow,” according to one report.² My impression, based on conversations in recent weeks with colleagues in my state (New Jersey) and around the country, is that a substantial percentage of physicians in small practices remain reluctant to participate in at least some of the exchange plans being offered to them.

In some cases, refusal is not an option. Private insurers often include an all-products clause in their provider contracts. That is, if you sign up to participate in any of their plans, you must accept all the products that they offer, including exchange policies. A few states have outlawed such clauses.³ It is important to be aware of all the problematic aspects of insurance exchange coverage and to use any and all available measures to neutralize them.

Verification of Coverage

Your staff will probably spend a considerable amount of time verifying coverage. The Centers for Medicare & Medicaid Services' Web site has a Qualified Health Plans section (<http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html>) where you can verify the

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coverage and effective date. The verification process varies based on the patient's plan: state or federal government. If your state has a federal-run marketplace, you may have to call the plan's customer service desk to verify coverage. A database of health plan contact numbers is available online (<http://1.usa.gov/11YOVqZ>). You also can find contact information for state-run plans on the Centers for Medicare & Medicaid Services Web site (<http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html>).

Grace Period for Premiums and Patient Nonpayment

A potentially bigger headache is the infamous "grace period."⁴ The PPACA mandates that patients purchasing policies through government-run exchanges who receive federal subsidies have 90 days to pay their insurance premiums. During the first 30 days of nonpayment the patient's health insurer is required to continue paying claims; however, in the next 60 days payments can be withheld. If the premium remains unpaid at the end of the grace period, the patient loses the coverage, and any payments withheld during the last 60 days become the patient's responsibility.⁴ Therefore, it becomes the provider's responsibility to collect payment. If patients are unable or unwilling to pay the insurance premiums, what are the odds that they will be able or willing to pay direct invoices from physicians and hospitals? Hospitals and large multispecialty clinics are apparently resigned to absorbing such losses as a necessary business expense, but small practices with much shallower pockets can scarcely afford to do so on a regular basis. One way to moderate this risk is to ask if the premium has been paid when contacting the carrier for verification that the patient is insured. White House officials⁵ and insurers^{6,7} estimate that 10% to 25% of patients who have enrolled online have not paid their premium invoices.

Financial advisors recommend having lines of credit, upfront payment plans, and various other forms of special financing to reduce the chances that nonpaying patients will leave you holding the bag.⁸ A better approach, in my view, is to adopt a policy that I have recommended for years: Get a credit card number from each patient at the first visit; keep it on file; and bill any withheld payments, along with patient-owed portions of covered payments, to the card as they arise. My staff asks every patient to sign a simple authorization form stating that he/she is aware of our policy and granting permission for us to submit such charges. Hotels, rental car companies, and hospitals have done the same for decades, and physicians should too.

One consultant has suggested an even less conventional strategy for dealing with some patients with unpaid premiums: pay the premium yourself. In select cases (eg, large outstanding balances, complicated surgeries, Mohs micrographic surgery involving several layers), spending a few hundred dollars to cover the premium to collect thousands of dollars in outstanding claims makes good sense.⁹

Higher Deductibles

Another problem is the trend toward higher deductibles, which has only been exacerbated by the exchanges. Public exchange plan options are labeled platinum, gold, silver, bronze, or catastrophic to differentiate their levels of coverage, with platinum having the best coverage and highest premiums, and catastrophic the worst coverage and lowest premiums.¹⁰ In general, the worse the coverage, the higher the co-pay and deductible; the cheapest plans may have deductibles as high as \$4000.¹¹ By requiring patients to authorize use of a credit card, physicians will be better equipped to deal with those with the cheaper plans and higher out-of-pocket costs.

Private Exchanges

To complicate matters further, there also are private exchanges, which are created by private sector companies and therefore are not part of the PPACA. They offer no government subsidies and no grace period. Employers looking for a lower-cost alternative to conventional private coverage may offer their employees a set amount of money for insurance and then direct them to a private exchange where employees can select various options based on the employer's payment.

Conclusion

The overall effect of public and private exchanges on private practices and on the American economy in general may not be known for several years. A recent editorial in the *Wall Street Journal* suggested that the exchanges have already had a substantial negative influence on the gross domestic product.¹² Nonetheless, it is already clear that exchanges are going to change the way millions of Americans choose their health insurance and how they use their benefits. Private practitioners will have to monitor these changes closely in the coming years.

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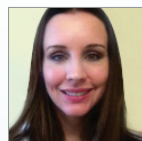
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