Untested waters

Marketplace means decisions for doctors

BY AMY LYNN SORREL It got off to a really rough start, but the federal government launched the insurance marketplace under the Affordable Care Act (ACA) on Oct. 1. And physicians could encounter their own challenges if they are not vigilant in their business practices with the health plans in the marketplace that take effect Jan. 1, Texas Medical Association officials say.

Topping the list is widespread physician uncertainty about whether having existing contracts with insurers means they're already included in an exchange network. Right after that is a federal rule that jeopardizes physician payments if patients with subsidized marketplace coverage don't pay their premiums. Exchange regulations give those patients three months to pay their premiums and allow health plans to deny or later recoup payments from doctors for services provided to patients who end up delinquent.

That risk is a big factor in Texas Oncology's decision to hold off on participating in any exchange plans, at least for now. But it's not the only factor.

"If we assume care for a patient and start rendering services, and if in another month or two that patient isn't able to make a premium payment and loses coverage, Texas Oncology has already committed to a course of costly treatment," only to see payments recouped, said Chris Henderson, executive director of payer and public health relations for the statewide cancer group, the largest in Texas.

For cancer patients, treatment tends to be a long-term commitment that also requires an adequate referral network of hospitals and other specialists — something Texas Oncology says it doesn't see among the health plans participating in the marketplace. That puts doctors in a tricky situation if they don't have privileges at the participating hospitals, for example. Nor is it clear how cancer care is covered, and the Medicaid-based payment rates most exchange plans offered to Texas Oncology wouldn't cover the group's business costs.

"At this time, there are too many unknowns," Mr. Henderson said. "We want to be able to treat all patients who need us. But we at least want to make an informed decision about whether the risks [of joining exchange plans] are tolerable. We have to make sure we are here to take care of the next generation of patients."

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For similar reasons, Austin Regional Clinic (ARC) has been selective about the exchange plans the multispecialty clinic decided to join. Thus far, that number is less than a handful.

Most insurers that approached the group were unbending in their take-it-or-leave-it payment offers that fell below the non-exchange rates it receives, "and that's not the way we've done business historically," ARC founder and Chief Executive Officer Norman Chenven, MD, said. "It's a business calculation, like any other. We [physician practices] only have so many seats on the plane, and you want to fill them, but you don't want to fill them all with very low payments."

Moreover, ARC has yet to get a grasp on the different types of exchange plans, like high-deductible plans, and how the benefit structures affect patients' care options and practices' ability to collect money.

"This is a new thing. It's going to evolve. Things will go wrong, but then they will be corrected. So it behooves us to go slowly and learn as we go so that we can figure out how best to provide services to members of exchange products for their good and ours," Dr. Chenven said.

Texas physicians are not alone: Uncertainty surrounding the insurance marketplaces has 40 percent of physician practices nationally still evaluating whether to participate in exchange plans, according to a Medical Group Management Association (MGMA) survey conducted in September just before the marketplace launch. The research included responses from more than 1,000 medical groups that represent upwards of 47,500 individual physicians. Read the full survey at http://bit.ly/1c8YWzh.

Meanwhile, a good number of physicians, like Austin ophthalmologist Dawn Buckingham, MD, remain uncertain whether their contracts already include them in an exchange network because not all carriers are reaching out to them. "I

"A lot of things are out of our control, so at this point we are going to sit tight for a few months and let things develop."

don't know if I'm in the exchange or out, and you can't even tell based on the complexity of these contracts." And for smaller practices like hers, "it is a huge drain on our resources to try and evaluate these contracts."

That, along with the prospect of losing money due to the 90-day grace period, "makes me disinclined to participate" in the exchange, the chair of TMA's Council on Legislation added. "We [physicians] are trying to take care of people, and in the end, we are left holding the bag and a big bunch of debt. You can't practice like that."

As physicians brace for the impact of the new marketplace on their practices, "the bottom line is doctors will have to be vigilant about their contracts and about tracking patients and payments for exchange plans, and it may be difficult at first," cautioned TMA Vice President of Medical Economics Lee Spangler.

Norman Chenven, MD

Dan McCoy, MD

Dawn Buckingham, MD

Decisions

ACA requires most individuals to have health insurance by 2014, and states must set up health insurance exchanges — now referred to as marketplaces — as another avenue for purchasing coverage. Gov. Rick Perry chose not to authorize a state-based marketplace, so Texas defaulted to a federally run program. (See "Ready, Set, … ?" August 2013 *Texas Medicine*, pages 49–53.)

When it opened Oct. 1, there were about a dozen different insurance companies in the Texas marketplace selling roughly 100 different plans across the state, according to a TMA analysis. (See "Texans' Choices of Marketplace Health Insurers," opposite page.) The marketplace could see an influx of more health plans as they become qualified.

That means physicians have decisions to make, Mr. Spangler says. Exchange plan participation is voluntary, so physicians must independently decide whether to opt in or, in some cases, opt out. Because insurance carriers take different approaches to forming networks for exchange plans and notifying doctors about those choices, physicians must closely evaluate their existing contracts and any new offers they receive.

TMA continues to research the different health plan networks offered. In general, insurance carriers are forming so-called "narrow" exchange networks with fewer physicians and providers than those outside the marketplace so they can offer patients more affordable premiums.

Mr. Spangler says some insurers are using existing network contracts with physicians; others are forming new networks for the exchange plans.

When insurers use their existing network contracts, physicians may be notified by the insurer, but that is likely to be an exception rather than the rule. That is because many managed care contracts don't require insurers to provide any notification. Physicians will have to inquire about their status for themselves by contacting the insurer. Physicians who don't want to participate in the exchange plans must opt out. However, not all insurance contracts allow physicians to opt out of the various health plans they offer, in which case the physician has to decide whether to keep or terminate the entire contract.

In still other situations, particularly with new networks, doctors may get notice of new contract offers or amendments to existing contracts to opt into a marketplace plan.

While some carriers have created new networks, they may apply to only one type of exchange health plan, Mr. Spangler adds. That means "doctors could be in-network for one health plan and not another. There's no guarantee all plans [under a single insurer] will use the same network."

TMA has fielded calls from physicians inquiring about their contract options in exchange plans. TMA advises physicians to call insurers to find out if they are included in any exchange networks if they are unsure about their current contract terms and if carriers participating in the exchange have not contacted them.

Also, payment rates under the various exchange plans could differ from those under existing contracts. Mr. Spangler pointed out that exchange plans operat-

ing within the marketplace are private, commercial plans, not government-run plans, which means "there is no [national or statewide] exchange fee schedule." Physicians' individual, privately negotiated contracts determine payments, and "joining exchange plans may change doctors' payer mix and practice revenues," he said.

With Medicaid managed care companies now selling commercial health plans in the Texas marketplace, physicians also should evaluate their Medicaid contracts to find out if they agreed to provide services to exchange patients through those contracts and if the managed care plans use Medicaid payment rates for their new exchange products.

A pair of new laws that TMA helped pass this legislative session will help physicians evaluate exchange contracts. As of September, under Senate Bill 822, TMA's "silent PPO" legislation, health plans must allow physicians to separately evaluate the various networks and fee schedules they sign up for and to object and opt out if they choose. Under Senate Bill 1221, which took effect in June, insurers must warn doctors who currently accept Medicaid managed care and Children's Health Insurance Program rates that they may be agreeing to those same rates for those managed care plans' commercial exchange products. The law also requires Medicaid managed care plans to obtain a physician's permission to add new products to the contract.

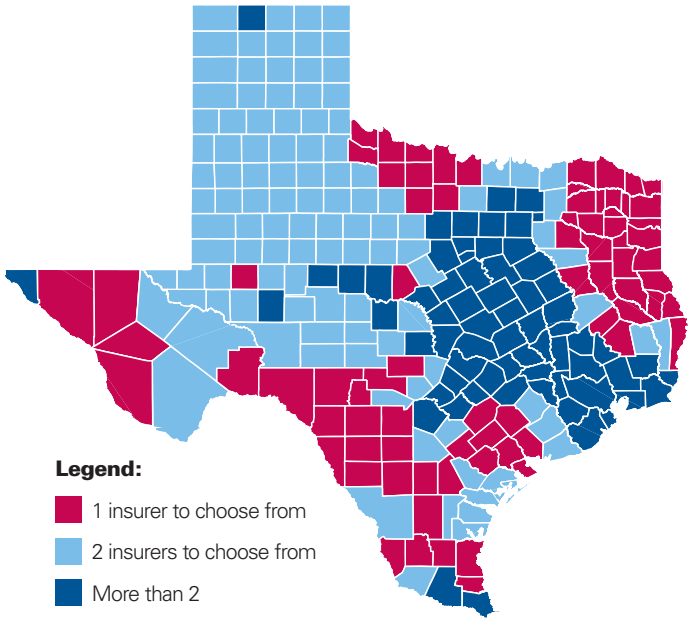
Contract confusion

Both Texas Oncology and ARC, for example, already participated in most major health plans in Texas before the launch of the exchange. Because not all of those insurers explicitly invited Texas Oncology to join their new marketplace networks, the group was combing through its contracts and contacting carriers to find out how to opt out of the exchange plans. All of ARC's existing contracts require insurers to renegotiate with the group before including it in any new products or networks. Some payers never approached the group; others came back with lower fee schedules, which ARC declined. On the other hand, 27 percent of respondents in the MGMA

Texans' choices of marketplace health insurers

The insurers listed below were participating in the Texas marketplace as of Oct. 1. Keep in mind that a single insurer may offer multiple different health plan products. In terms of contacting those insurers to find out whether your practice is included in a marketplace network, you must follow the guidelines of each insurer, as your practice may already have an assigned network contact. Some insurers, for instance, assign representatives to each region of the state, and that information is typically available on the insurer's website.

- Aetna
- Ambetter from Superior Health Plan
- Blue Cross and Blue Shield of Texas
- Cigna Health and Life Insurance Co.
- Community First
- Community Health Choice
- Firstcare Health Plans
- Humana Health Plan of Texas
- Humana Insurance Co.
- Molina Healthcare of Texas
- Scott and White Health Plan
- Sendero Health Plans



survey said they are participating in the exchange because their existing contract terms required them to participate in all of an insurers' products under so-called "all products" clauses.

Because a number of Dr. Buckingham's contracts include such clauses, the six-physician practice, Eye Physicians of Austin, faces the prospect of renegotiation in order to opt out of certain exchange plans.

"To me, my hands are tied, and they are making me jump off of a plank I don't want to jump off of. And it's an expensive process, and it interrupts patient care," she said.

Meanwhile, it remains unclear to what extent Texas exchange plans cover out-of-network benefits. At minimum, federal rules require marketplace plans to cover out-of-network emergency care and to pay the plan's "usual, customary, and reasonable" rate, the median amount it pays to in-network providers, or Medicare rates for the same service, whichever is greater.

Blue Cross and Blue Shield of Texas (BCBSTX) Chief Medical Officer Dan McCoy, MD, says the insurer continues to build exchange networks and began sending physicians contract notices in August 2012 to solicit participation. Aetna says it is notifying all providers about their ability to opt in or out of its exchange networks. It encourages doctors "to check before they refer patients, since the networks for [exchange] products are different than the 'traditional' networks."

Molina Healthcare is a Medicaid managed care plan now offering a commercial health plan on the exchange. In forming that network, Chief Financial Officer John Molina said the insurer "really tried to build a marketplace network based on our existing Medicaid network." In general, physicians have to opt in, and those who already contract directly with the health plan would sign an amendment to do that, for example. The company is communicating those options to physicians via phone calls, letters, and face-to-face visits.

Some insurers are holding off: One of the nation's largest carriers, UnitedHealthcare, is not participating in a majority of state marketplaces, including Texas. The carrier told *Texas Medicine* it is in only a dozen exchanges. Only one-third of those are exchanges for individual insurance; the majority are exchanges for small business insurance.

"We are simply taking the time to carefully evaluate and better understand how the exchanges will work to ensure we are best prepared to participate meaningfully in their development and continue to provide the service our current customers and members have come to expect," a United representative said.

Humana declined *Texas Medicine*'s interview request. Cigna did not respond.

None of the insurers *Texas Medicine* spoke to would comment directly on payment rates.

The Blues' Dr. McCoy said its rates vary by provider, geography, and cost of care.

Molina views its marketplace plan "more as a Medicaid-like program versus a commercial-like program. It's fair to say we have tried to structure our payments more along the lines of what we see reflected in the patient population," Mr. Molina said.

The health plans also reiterated that their networks had to meet specific adequacy requirements before joining the marketplace.

The Centers for Medicare & Medicaid Services (CMS) says it is enforcing those standards, and insurers are required "to maintain a network that is sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delay." Texas Department of Insurance officials say that in Texas, CMS also relies on state network adequacy standards in reviewing health plans' exchange applications. Any plans sold in Texas, in or out of the exchange, must follow state insurance regulations, such as prompt pay.

90-day notice

As for the 90-day grace period, "from a pragmatic perspective, for someone trying to run a business, holy mackerel!" Dr. Chenven said. "It's hard to figure how that cannot be a problem, so I have to be cautious as I dip my toe in the water," he said.

The grace period is triggered once a patient with subsidized marketplace coverage misses a premium payment. Instead of immediately terminating the policy, health plans must give the patient 90 days to catch up. 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 Texas law requiring prompt payment of claims submitted at any point in the grace period.

Federal regulations require exchange plans to notify affected physicians "as soon as is practicable when an enrollee enters the grace period, since the risk and burden are greatest on the provider." This includes whether the enrollee is in the second or third month of the grace period and the names of all individuals covered by the policy. The notice also must tell doctors the health plan may ultimately deny payment.

CMS officials did not directly respond to *Texas Medicine*'s inquiries on whether or how they would hold health plans accountable for appropriately notifying and paying physicians during the 90-day window. CMS said that during the last two months of the grace period, individuals can still receive care, but they are asked to either bring their insurance premiums up to date or pay providers directly. Patients whose health coverage lapses after the grace period could face a tax penalty for not maintaining their health insurance coverage.

The rules mean "doctors will have to check eligibility regularly and throughout treatment" when it comes to exchange plans, Mr. Spangler emphasized.

TMA officials were concerned about insurers' ability to timely update eligibility records even before the rocky launch of the marketplace. The association is working with carriers to ensure they notify physicians of patients in the grace period as soon as possible. It also remains unclear whether physicians can use standard electronic eligibility verifications to find out if patients are

in exchange plans or in the grace period, or whether doctors will have to make separate inquiries via phone or insurers' websites.

Because Texas is in a federally run marketplace, participating health plans also rely on the government to a large extent to receive records on new enrollees. At press time, that process was the subject of bipartisan congressional scrutiny due to what the Obama administration acknowledged were serious technical problems. Health plans also must look to the federal government to receive the subsidy payments for eligible patients.

Health plan practices vary

Physicians, meanwhile, should expect differences in how insurers will provide the grace period notifications and in how they will identify patients with marketplace coverage. At the TMA 2013 Fall Conference in October, the Council on Socioeconomics asked carriers to standardize those processes.

The Blues and Molina, for example, told *Texas Medicine* they will use electronic eligibility verification systems, such as web portals and Availity, to notify doctors of patients in the grace period. Doctors also can call their customer service centers. Aetna said its "current eligibility process" will tell doctors if a patient is delinquent.

Blues representatives told TMA that Blues patients' insurance cards will display certain colored letters to differentiate exchange versus non-exchange coverage. Aetna insurance cards will say "QHP" to indicate patients are in an exchange plan, and Molina also plans to identify exchange plan members.

To avoid the risk of nonpayment, the Blues and Aetna also encourage physicians to check exchange patients' eligibility and benefits before treatment.

"That's true for products on and off the exchange. It's also true for any service physicians perform in their practices," the Blues' Dr. McCoy said. "These risks existed before [the marketplace], and with all the changes going on right now, it's very important for practices to be proactive."

Specifically, the Blues plan will notify physicians when a member is in the grace period and the date through which the premiums are paid.

"We are going to do everything we can to help make this a good experience for doctors participating in the network," Dr. McCoy said, adding that he is "confident" the insurer's tools will provide the most up-to-date information available.

Rather than holding or denying claims filed during the grace period, the Texas Blues will pay doctors, he says. "We have a very good track record of working with our members to make sure they get their premiums paid." If that doesn't happen within 90 days, however, BCBSTX will cancel the patient's membership consistent with ACA guidelines and seek recovery of payment for services in the second and third month of the grace period. The insurer will notify doctors of those recoupments through an explanation-of-benefits (EOB) notice if patients don't follow through in paying their premiums.

Similarly, Aetna said "any claims submitted for a service date after 30 days of delinquency by a patient will result in an EOB to the provider saying the claim is being pended because the member is in a delinquent status."

At press time, the federal government and insurers had not said how many patients signed up for insurance through the Texas marketplace and how many were eligible for subsidies and therefore the grace period. Earlier this year, the Texas Health and Human Services Commission estimated that up to 2.4 million Texans — roughly 40 percent of the state's uninsured population — could be eligible for exchange subsidies.

Molina acknowledged that as a Medicaid managed care plan branching out into the exchange, a large portion of its members are likely to be subsidy eligible and subject to the grace period. But Mr. Molina does not expect it to be a big issue "because we feel the vast majority of patients will be Medicaid eligible."

Texas Oncology's Mr. Henderson said, "I don't think there's one single thing that

Hey, Doc: TMA answers your patients' marketplace questions

"Hey, Doc," TMA's multimedia patient education campaign about the Affordable Care Act (ACA) health insurance marketplace, provides your patients with no-nonsense answers to their top questions about the law. Since Oct. 1, people who brave the computer glitches can buy insurance from the marketplace to comply with ACA's "individual mandate," which requires everyone to be covered next year.

TMA's "Hey, Doc" will continue to provide pertinent, objective, and timely content each week on video, on the Internet, and in the news media. To keep up with the program or to refer your patients, go to www.texmed.org/heydoc/.

There you will also find resources for your practice, including handouts for your patients, and the latest information TMA has gathered on the marketplace networks.

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