KELLI BACK, ATTORNEY AND APMA CONSULTANT

Coverage Trends – Employer Insurance

PPOs – 52% of covered workers

HDHPs – 24 % of covered workers

HMO – 14% of covered workers

HMO/POS – 10% of covered workers

Indemnity – 1 % of covered workers

Self – insured

63% overall

83% of large firms (200 or more employees)

17% of small firms

Coverage Trends – Employer Insurance -- Higher Cost Sharing Obligations

- 81% of employer group plans feature an annual deductible
  - Average deductible for single coverage $1,318
- 68% have copayments
  - Average copayment for a specialist visit is $37
- 24% feature coinsurance
  - Average coinsurance amount for a specialist is 19%
- Capped financial responsibility: 98% have an out-of-pocket maximum

- Result: More financial risk for physicians
- Staff needs to be trained to talk to patients about their financial obligations

Grace Period

- For individuals receiving subsidies to purchase through the exchange (85%)
- Plans must offer a 90 day grace period for payment of premiums.
- Applies after the individual has paid one month of premiums.
- Days 1-30, the plan is responsible for covering costs.
- Days 30-90, plan <u>may</u> pend claims, if allowable under state law.

Grace Period – Practical Advice

- Know which plans are sold through the exchange.
- Nothing on card will indicate subsidy status.
- Find out how plans will notify you of grace period status.
- Cannot expect notification with regard to new or seldom seen patients.
- Confirm that a patient is not in grace period before furnishing expensive items or services.

Grace Period – Practical Advice

- Can't request payment up front when a member is in the grace period -- the hold harmless requirement applies until disenrolled.
- Can delay elective services where state law wouldn't prohibit.

Eligibility Churn under the ACA

- Initial estimates were that anywhere between 32-40 percent of Medicaid recipients would change eligibility in a year. Initial numbers appear lower.
- Creates continuity of care issues
- Particularly an issue for physicians who participate in Medicaid but not exchange plans or visa versa.

Prompt Payment

- What law/standard applies?
  - Insured employer group plans – state law
  - Self insured employer group plans
    - Contracted providers – Generally subject to contract terms
    - Non-contracted providers – ERISA
  - Individual plans – state law (generally)
  - Medicare Advantage
    - Contracted providers – subject to contract terms
    - Non-contracted providers – 30/60
  - Medicaid Health Plans – State Medicaid law.

Prompt Payment

- State laws vary
  - Different timeframes for payment of "clean claims"
    - May vary for paper and electronic claims
    - Generally between about 14 and 45 days.
  - Some require notice within a specific timeframe of any deficiencies in the claim.
  - Some specifically include a second deadline for paying the claim after receipt of missing information.
  - Generally, the clock is "reset" when a perfected claim is submitted.
  - Important to be familiar with state prompt payment laws. APMA has a compilation of all state prompt pay laws as Part of its State Reference Manual.

Questions?