Health Exchanges 2014: Navigating Medicaid and Managed Care Contracts, Maximizing Coverage and Reimbursement

WEDNESDAY, FEBRUARY 5, 2014

1pm Eastern  |  12pm Central  |  11am Mountain  |  10am Pacific

Presenting a live 90-minute webinar with interactive Q&A

Today’s faculty features:

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Health Insurance Exchanges: A Brief Overview

Presented by Kathrin E. Kudner
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February 5, 2014
Overview

• PPACA provided for the establishment of health insurance Exchanges for individuals and small employers
  – 3 options: State operated; Federally facilitated (FFE); Federal/state partnership
  – Hybrids permitted – State for small group; FFE for individuals

• Coverage provided through Qualified Health Plans (QHPs) and network of providers

• Premise was that the Exchanges will provide avenue for the uninsured and underinsured to obtain coverage, permit comparison of plans, increase access to coverage, and reduce cost by increasing competition among plans
Options for Exchanges

• Federally facilitated exchange (FFE)
  – “Health Insurance Marketplace”
  – DHHS responsible for all Exchange functions
  – 26 States

• State operated Exchange
  – State controlled subject to PPACA requirements
  – Greatest flexibility for States
  – 16 States (California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont and Washington)
Options for Exchanges (cont’d)

• Federal/State partnership exchange
  – Viewed as potential transition to State based Exchange
  – DHHS required to retain overall authority but greater State involvement
  – 6 States (Arkansas, Delaware, Illinois, Iowa, New Hampshire, and West Virginia)

• Hybrid exchange
  – State for small group or SHOP; FFE for individuals
  – New Mexico and Utah
Exchange Functions

- Federal/State coordination with State continuing traditional regulatory role (e.g., licensure, solvency)
- Facilitate eligibility and enrollment
- Certify and provide oversight of QHPs
  - Controversial plan by DHHS to block QHPs with rate hikes from Exchange
- Assess provider network adequacy
- Operate website for QHP comparison
- Provide consumer technical assistance and support
- Collect and report data
QHPs

- Generally, insurers, HMOs, PPOs
- Certified to participate in Exchanges
- Must cover essential health benefits, limit amount of cost-sharing, and provide all PPACA customer protections
- Plans may vary
  - Bronze, Silver, Gold or Platinum coverage tier based on level of cost sharing required
  - Network of providers
  - Coverage out of network
- Catastrophic coverage
  - Available to those under 30 years of age or who meet 1 of 13 “hardship exemptions”
Implementation: A Rocky Start

• Healthcare.gov went live October 1, 2013
  – State Exchanges went live at varying times
• Immediately experienced technical glitches
  – No or difficult access
  – Personal information not uploading accurately
  – Higher volume than expected
  – QHPs not receiving information needed to enroll
• State Exchanges seem to be operating more smoothly, except…
Strafford Webinar

“Health Insurance Exchanges”

February 5, 2014

Jackie Selby
jselby@ebglaw.com
New Claims Payment Issues

- Some exchange members who do not pay their premiums on time may be entitled to services for 3 months (grace period)
  - insurers may terminate after 3rd month of non-payment but may deny/adjust claims for months 2 and 3
  - need to bill member?

March

April

May
New Claims Payment Issues

- Incorrect eligibility information or incorrect cost share information is likely and will lead to insurers denying/adjusting more claims retroactively
  - need to bill member or other insurer (COB)?
New Claims Payment Issues

• Incorrect cost sharing subsidy calculations is likely and will lead to insurers adjusting more claims retroactively
Members with cost sharing subsidies and fixing mistakes in cost sharing reductions

• No notice is required to providers regarding which enrollees receive cost-sharing subsidies, but some payers use different names for such products so you may be able to identify such members that way. However, federal regulations address how payers must handle miscalculations of cost-sharing reductions:

• **45 CFR § 156.410(c): Improper cost-sharing reductions.** (1) If a QHP issuer fails to ensure that an individual assigned to a plan variation receives the cost-sharing reductions required under the applicable plan variation, taking into account §156.425(b) concerning continuity of deductibles and out-of-pocket amounts (if applicable), then the QHP issuer must notify the enrollee of the improper application of any cost-sharing reduction within 45 calendar days of discovery of such improper application, and refund any resulting excess cost sharing paid by or for the enrollee as follows:

(i) If the excess cost sharing was paid by the provider, the **QHP issuer must refund the excess cost sharing to the provider within 45 calendar days of discovery of the improper application.**
Fixing mistakes in calculating cost sharing reductions

• 45 CFR § 156.410(d)(4): If, pursuant to a reassignment under this paragraph (d), a QHP issuer reassigns an enrollee from a less generous plan variation (or a standard plan without cost-sharing reductions) to a more generous plan variation of a QHP, the QHP issuer must recalculate the enrollee's liability for cost sharing paid between the effective date of eligibility required by the Exchange and the date on which the issuer effectuated the change, and must refund any excess cost sharing paid by or for the enrollee during such period as follows:

  (i) If the excess cost sharing was paid by the provider, the QHP issuer must refund the excess cost sharing to the provider within 45 calendar days of discovery of the improper assignment.

• 45 CFR § 156.410(c)(2): If a QHP issuer provides an individual assigned to a plan variation greater cost-sharing reductions than required under the applicable plan variation, taking into account §156.425(b) concerning continuity of deductibles and out-of-pocket amounts (if applicable), then the QHP issuer will not be eligible for reimbursement of any excess cost-sharing reductions provided to the enrollee, and may not seek reimbursement from the enrollee or the applicable provider for any of the excess cost-sharing reductions.
New Claims Payment Issues

- Members may be more likely to not pay their coinsurance and deductible amounts later or to not pay for services that are denied as not covered if they cannot afford it or if they are not used to having insurance.
  -- harder to collect
Thus...

There will be more reconciliations with insurers, more member responsibility and “uncollected debt” will likely increase for providers.
Options For Providers

• What are provider’s options under the law?
Options For Providers

• What are provider’s options under its contracts with insurers?
Ask Insurers to flag those members who have not paid their premiums when you check their eligibility.

- Provider still has obligation to provide services
- Member may end up paying premium.
Add provision to agreements allowing you to terminate your participation in exchange products if your uncollected debt exceeds $X or X%
Ask Insurer to provide notice of premium nonpayment when check eligibility

Add Right to Term From Exchange Network?

Ask Insurer to share in increased uncollected debt in exchange products -- add indemnification provision to agreement
Restrict payers from applying lower rates for exchange products to other (non-exchange) products

-- add requirement to get your consent before doing so
It will be easier to bill for services later if authorization and credit/debit card info is collected at point of service.

- Analyze hold harmless language may apply as to when you actually collect.

- Get Member’s Credit/Debit Card at POS?

- Tighten Language In agreement to “Lock In” specific Exchange Products?

- Ask Insurer to provide notice of premium nonpayment when check eligibility

- Add Right to Term From Exchange Network?

- Ask Insurer to Share in Increased Uncollected Debt
Some providers are helping individuals pay their premium

– CMS discouraging

– Legal Issues (see Kathy’s slide)
Access Health CT – The Exchange

• Scope of Duties
  ▪ Administer the HIX for qualified individuals and employers
  ▪ Survey individuals, small employers, and health care providers on health care coverage issues
  ▪ Certify, recertify and decertify health benefit plans as Qualified Health Plans (QHPs), consistent with CT and HHS guidelines
  ▪ Build and operate the new health insurance “marketplace”; enroll individual and groups during PPACA-designated periods. Key duties:
    - Operate a toll-free consumer assistance hotline
    - Maintain an Internet website with a standardized format for presenting health benefit options
    - Screen applications to determine eligibility for Medicaid, state or other public insurance programs
    - Enroll individuals in public programs and QHPs
    - Provide a calculator to help consumers determine their actual cost of coverage with/without applicable federal premium tax credits and cost-sharing reductions
    - Publish other information related to QHPs and Access Health CT (incl. administrative costs, survey findings, etc.)
### The Insurance Landscape

#### Insurance Coverage 2012

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<td>Private – Employer Sponsored</td>
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| Grand Total             | 3,588,886 | 100%

Source: Thompson Reuters

### CT Uninsured: 344,000

**Opportunity**
- 120,000 Medicaid eligible
- 176,000 subsidy eligible
- 48,000 direct buy opportunity

**Gender**
- 57% men
- 43% women

**Ethnicity**
- 55% Caucasian
- 25% Hispanic

**Location**
- 80% in (counties)
  - New Haven
  - Hartford
  - Fairfield
The Competitors

• The Qualified Health Plans – Individual Market
  ▪ HealthyCT
  ▪ Connecticare
  ▪ Anthem Blue Cross & Blue Shield

• The QHPs – SHOP Exchange
  ▪ HealthyCT
  ▪ Anthem Blue Cross & Blue Shield
  ▪ UnitedHealthcare

• Off-Exchange Competition
  ▪ The above, plus
  ▪ Cigna
  ▪ Aetna
QHP Requirements

• Be licensed and in good standing to offer health insurance in Connecticut

• Offer, on Exchange, at least one plan:
  o At the “silver” coverage level - covering 70% of the cost of essential health benefits
  o At the “gold” coverage level - covering 80% of the cost of essential health benefits

• Charge the same premium rate for each plan whether offered:
  ▪ On or off the Exchange
  ▪ Directly by the carrier or through an insurance producer
Contracting Woes: What to Watch For

• Different fee schedules based on point of enrollment
  ▪ What the law allows: benefit plans offered by QHPs on the Exchange are the same but premium rates, networks and fee schedules can be different
  ▪ The impact on providers:
    o Many insurers have lower reimbursement for services rendered to patients who purchased coverage on the Exchange
    o Carriers can steer members into lower cost plans and “drop” high-risk/high-cost patients
    o Added complexity when it comes to coverage and billing

• Different networks for benefit plans sold on the Exchange
  ▪ What the law allows: health plans must have statewide coverage to become a QHP but they can offer different networks for on- and off-Exchange products
  ▪ The impact on providers:
    o Confusion – by patients and practices regarding participation in specific plans
    o Disruption of physician-patient relationships
    o Insurers can retract claims payments for services rendered if the individual/employer does not pay
    o Providers must recoup charges from their patients
Contracting Woes: What to Watch For

• The grace period for “on-exchange” enrollees
  ▪ What the law allows: individuals and groups, once effectuated, have 90 days to pay past due premiums; the period is 30-days off-Exchange
  ▪ The impact on providers:
    o Patients have coverage during the grace period
    o Insurers can retract claims payments for services rendered when they don’t receive payment
    o Providers must recoup charges from their patients

• Changes in the law
  ▪ What the law allows: standard periods and deadlines for enrollment
  ▪ The reality: deadlines and initial payment grace period readjusted; causing new challenges for initial (January 1) invoicing and marketplace confusion
  ▪ The impact on providers:
    o Patients who enrolled for January 1 may have entire month to pay
    o Pent up demand likely resulting in high utilization of services in January
    o Insurers can retract claims payments if the individual/employer does not pay
    o Providers must recoup charges
HealthyCT’s Mitigation Approach

• Product
  ▪ Standardization of individual and small group products sold on- and off-Exchange

• Contracting
  ▪ Same network for all products

• Reimbursement
  ▪ Same fee schedule for most services
  ▪ New payment methodologies, including incentives for designated Patient-Centered Medical Home practices and practitioners; supports focus on chronic disease management

• Education and Outreach
  ▪ Provider training and proactive outreach
  ▪ High-touch approach

• Customer Service
  ▪ Extension of payment deadlines until January 17; accompanied by letter and telephone campaigns to increase collections
  ▪ Outreach to providers with known cases
  ▪ High touch approach; especially during critical December 2013 / January 2014 time period
What Providers Can Do

• **Product**
  - Understand the new products and the implications for patients and the practice
  - Take an eyes wide open approach to both major contract provisions and “nuances”

• **Network**
  - Know which networks they’re participating in; they may be product-specific
  - Understand how patients purchased their coverage; it can impact whether they are in or out
  - Take extra steps – work with patients and carriers – to refer patients to in-network providers

• **Reimbursement**
  - Identify the impact, on reimbursement, of Exchange vs non-Exchange coverage
  - Seek opportunities for additional payment; ex. ACO participation, PCHM designation, other incentives
  - Negotiate with carriers for compensation of services that deliver convenient, high-touch and appropriate contact (e.g. email)

• **Education**
  - Take advantage of carrier training sessions for providers and staff
  - Be sure staff reads carrier bulletins and take appropriate steps
  - Understand how carriers will educate members regarding their coverage

• **Customer Service**
  - Hold them to required notifications regarding covered enrollees who enter payment grace periods
  - Establish and monitor expectations regarding access to medical management, provider relations and customer service assistance
  - Refer patients to carrier resources (websites, customer service, plan documents)
Other Issues Related to Exchanges

- Enrollment
- Provider networks and access
- Medicaid and CHIP
- Premium assistance for Medicaid eligible
- Provider subsidies on the Exchanges
- Security on the Exchanges
Enrollment

• Enrollment by 2/15/14 for coverage by 3/1/14
• Open enrollment ends 3/31/14
• Proposed open enrollment for 2015 from 11/15/14 to 1/15/15
• Special enrollment
  – Triggers include loss of eligibility for other coverage, change in marital or dependent status, exhaustion of COBRA, loss of eligibility for Medicaid or CHIP, error in enrollment or eligibility
  – States have flexibility to expand special enrollment options
Enrollment (cont’d)

• QHPs in FFE may accept premium payments after 1/1/14 for coverage retroactive to 1/1/14 (States set own rules)
• May enroll in Medicaid or CHIP at any time, subject to State rules
Provider Networks and Access

- Evolving networks and out-of-date online information
  - Consumers learning after enrollment that their providers not part of network
  - Providers not sure if in the network
  - Potential CMS reaction – if provider was in network as of enrollment, treat claim as in network

- Too narrow networks
  - By type (e.g., mental health providers; FQHCs)
  - Particularly for low cost plans

- Changes in prescription drug coverage
  - Non-covered drugs and changes in medical management
Medicaid and CHIP

- Medicaid Plans and CHIP are not available on the Exchange
- Exchanges do have role in determining eligibility for Medicaid and CHIP (also eligibility for tax credits and cost-sharing reductions)
- Medicaid
  - State Medicaid agencies choose whether Exchange will only assess Medicaid eligibility or accept applications
- Concern about gap in care between Medicaid eligibility and coverage on Exchange
  - What is the role of providers?
Premium Assistance for Medicaid Eligible

- Two options:
  - States may implement premium assistance by electing option in Medicaid State Plan, or
  - DHHS will consider Section 1115 demonstration waiver to implement PPACA Medicaid expansion through premium assistance
    - Proposals from Arkansas, Iowa and Pennsylvania
- Options differ in enrollment, duration, target populations, and level of evaluation/follow up by DHHS
Provider Subsidies on the Exchange

• Key Question: May health care providers assist their current or future patients to pay the cost of premiums/cost sharing amounts on the Exchange?
  – What about pharmaceutical manufacturers providing coupons for enrollee cost-sharing?

• Essentially an anti-kickback statute analysis
  – Is the QHP or Exchange a federal health program?
  – Is the subsidy/cost sharing reduction federal health care dollars?
Provider Subsidies on the Exchange (cont’d)

- Debate continues – No clarification
  - 10/30/13 – Letter from Secretary Sebelius to Rep. McDermott – QHPs not subject to federal anti-kickback statute
  - 11/7/13 – Letter from Sen. Grassley to Secretary Sebelius and Attorney General Eric Holder – Concerns about potential exemption of QHPs from federal anti-fraud provisions
  - 11/20/13 – Letter from National Organization for Rare Disorders to DHHS - Expressing concerns about subsidies
  - 12/4/13 – Letter from National Health Council to Secretary Sebelius and Office of Inspector General – Seeking clarification for direct assistance to patients

- Keep State anti-kickback laws in mind
Security on the Exchange

- Concern expressed about security of personal information required to enroll in Federal Marketplace and State Exchanges
- Complex system to secure
  - DHHS as central data hub with connection to other Federal and State agencies
- Exchanges required to have privacy and security policies
- QHPs subject to HIPAA and HITECH and more stringent State laws
Security on the Exchange (cont’d)

• 1/10/14 - House of Representatives passed the “Health Exchange Security and Transparency Act” — would require DHHS to notify any affected person within 2 business days of any possible breach of a Federal or State Exchange

• Only a few breaches reported but generally one user obtaining access to another user’s data, distribution of user data to wrong user or “recycled” usernames
  – 10/13 – Highly publicized breach of Vermont Health Connect – one user obtained access to another user’s data