

January 8, 2014

## UNDERSTANDING AND MONITORING NEW INSURANCE COVERAGE ISSUES

### AT A GLANCE

#### **At Issue:**

The *Patient Protection and Affordable Care Act* (ACA) has changed the way people access and pay for insurance coverage through private insurance, Medicaid and the Children's Health Insurance Program (CHIP). According to the Department of Health and Human Services, about 6 million additional Americans had health insurance on Jan. 1 as a result of the ACA. This included about 2 million enrollments through the Health Insurance Marketplaces and about 4 million through Medicaid and CHIP.

While health care providers, federal and state government agencies, and other stakeholders have been preparing for this launch for nearly four years, many experts expect there to be some confusion and uncertainty as newly-covered individuals begin to seek care. This Member Advisory highlights potential situations that may occur and suggests how you can respond. In addition, the AHA has developed a [form](#) that you can use to document issues and concerns your hospital or health system is experiencing. The Centers for Medicare & Medicaid Services has asked the AHA to collect feedback from across the country and share your concerns directly with the agency so that it can help to resolve the issues encountered by hospitals and health systems.

#### **Our Take:**

At this time, we expect a slow ramp up of activity at hospitals after newly-insured patients have engaged with their physicians and specialists. However, some patients may have put off needed but elective care until they could obtain coverage. These individuals may contact hospitals to schedule appointments, diagnostics, or procedures without having their insurance cards, identification numbers, or documentation of benefits even though they signed up for coverage by the enrollment deadline and paid their premium.

**Hospitals have worked through coverage issues with patients and insurers for many years and have processes in place to assist patients with enrollment issues. However, this year hospitals need to be even more diligent in training front line staff and working with insurance companies and the Marketplaces to verify patient eligibility, determine benefits and networks, and advise patients on their financial responsibilities under their plan. For those patients whose eligibility cannot be confirmed at the point of service, hospitals need to be able to advise patients of their options, including how to get coverage or how to find out if they qualify for charitable care programs. Most importantly, hospitals need to ensure that patients are able to get needed care during this transitional period.**

#### **What You Can Do:**

- ✓ Share this Member Advisory with your senior staff and frontline teams, particularly those in the areas of coverage eligibility and patient financial services.
- ✓ Monitor the situation daily, especially during first couple months.
- ✓ Review your policies and procedures and make sure you have contact information for key partners, including insurance companies, Healthcare.gov or your state Marketplace, and your state Medicaid agency.
- ✓ Use the feedback [form](#) to share issues with AHA that are affecting your hospital.

#### **Further Questions:**

If you have questions, please contact Jeff Goldman, vice president for coverage policy, at (202) 626-4639 or [jgoldman@aha.org](mailto:jgoldman@aha.org). In addition, please complete the feedback [form](#) and email it to [coverage@aha.org](mailto:coverage@aha.org).

January 8, 2014

## **UNDERSTANDING AND MONITORING NEW INSURANCE COVERAGE ISSUES**

### **BACKGROUND**

The *Patient Protection and Affordable Care Act* (ACA) has changed the way people access and pay for insurance coverage through private insurance, Medicaid and the Children's Health Insurance Program (CHIP). According to the Department of Health and Human Services (HHS), about 6 million additional Americans had health insurance on Jan. 1 as a result of the ACA. This included about 2 million enrollments through the Health Insurance Marketplaces and about 4 million through Medicaid and CHIP. Most experts expect both of these numbers to continue to rise through the end of March.

While health care providers, federal and state government agencies, and other stakeholders have been preparing for this launch since 2010, there will likely be some confusion and uncertainty as newly-covered individuals begin to seek care. This Member Advisory highlights potential issues that may occur and suggests how you can monitor the situation. In addition, the AHA has developed a [form](#) that you can use to document issues and concerns your hospital or health system is experiencing. The Centers for Medicare & Medicaid Services (CMS) has asked the AHA to collect feedback from across the country and share your concerns directly with the agency so that it can help to resolve the issues encountered by hospitals and health systems.

### **AT ISSUE**

During the enrollment process, the federal government extended key enrollment deadlines several times. It also asked insurance companies to accept enrollments through the end of 2013 and to accept the first premium payment through the middle of January. The latter point is important because enrollment generally does not become effective, meaning the enrollee is not covered, until the first premium payment is received.

While the final dates for enrollment and premium collection vary by state and insurance company, in many cases, enrollments were accepted up to Dec. 31, 2013, and the final date for collection of the first premium has been extended as late as Jan. 15. Some insurers may even accept Jan. 1, 2014 enrollments as late as the end of January with benefits retro-active to Jan. 1. Therefore, insurance companies will need extra time to process the late enrollments, and collect the premiums before they can verify coverage.

At this time, we do not expect a deluge of activity for elective procedures at hospitals, but rather a slow ramp up after patients have engaged with their physicians and specialists. However, some patients may have put off needed but elective care until they could obtain coverage. These individuals may contact hospitals to schedule appointments, diagnostics, or procedures without having their insurance cards, identification numbers, or documentation of benefits even though they signed up for coverage by the enrollment deadline and paid their premium. In some cases, enrollments and premium payments may be lost or misplaced, adding to the potential confusion. Moreover, some patients may have chosen to remain uninsured.

### ***Important Areas of Focus***

**Eligibility.** Hospitals routinely verify eligibility of insurance. For several weeks or months, it may be difficult to verify insurance coverage due to the processing of applications and the loading of records into insurance systems. Contacting the patient's insurance company directly or working with the applicable state or federal Marketplace can help resolve eligibility issues.

In some cases, you may not be able to verify eligibility and will need to work with the patient on appropriate care plans and financial strategies. When the opportunity is available, recommend that patients who do not yet have their new insurance cards bring a copy of any enrollment confirmation communications from the Marketplace and/or their health plan. Some patients also have been successful in calling their new health plan to obtain their group health plan number. Many health plans have made temporary insurance cards available online. Qualified Health Plan (QHP) issuers have anticipated potential problems and have established processes to resolve issues. **We recommend you contact the insurance companies in your market to learn more about these processes.**

Meanwhile, under Medicaid's new "presumptive eligibility" regulations, hospitals can temporarily enroll patients in Medicaid coverage at the point of service with a few basic pieces of information such as income and household size. This not only will help patients get connected to needed health coverage, but also will help hospitals receive payment for services provided before a full Medicaid determination is made. A hospital can elect to make such determinations without regard to whether the state chooses to expand its Medicaid program or has an established presumptive eligibility program. Hospitals interested in making presumptive eligibility determinations should work with their state Medicaid agencies and state hospital associations. You also can refer to the AHA [Special Bulletin](#) and use the web-based toolkit.

**Benefits.** It is important to know what services are covered under the patient's plan as well as the patient's financial responsibilities. These include copays, coinsurance and deductibles. Note that many low-income enrollees in Marketplace QHP products will qualify for reduced cost sharing. Please review the AHA [Member Advisory](#) on New Insurance Market Reforms and Hospital Bad Debt for more information about cost sharing reductions.

It also is important to get specific benefit and cost share information directly from the health plan. In some cases that information may not be available until enrollments are processed and premiums are paid. You may need to refer to your charitable care and private pay policies and procedures in order to advise patients of their obligations. If a patient has his or her enrollment confirmation available, you can look up the benefit details for that plan on the Marketplace to counsel the patient on potential out-of-pocket costs. However, only the QHP issuer can provide specific coverage information to individuals.

**Networks.** It may be difficult to verify which providers are in-network versus out-of-network. This is important as patient financial responsibilities can be much higher in out-of-network offices or facilities. Health plans often offer products that use different networks, meaning that the network of one Blue Cross Blue Shield product may not match that of another. **For example, you may be able to verify that a patient is enrolled in a Blue Cross Blue Shield plan, but you will still need to verify the product and the network to accurately inform the patient of his or her options.**

**Financial Considerations.** In some cases, insurance coverage will be new and patients may not fully understand their financial obligations and how that is impacted by their benefits and provider network. For elective care it is important that patients have as much information available to them as possible to make care determinations. Recognizing that this may not be possible in the early stages of coverage, it may be necessary to provide needed care and work out payment afterwards. It might be helpful to contact major insurers and clearinghouses with whom you do business in order to clarify how these types of situations can be best handled. Patients will need to understand any financial risk they are taking before care is rendered. **Your business office also will want to carefully review any claims denials. If claims were automatically denied because the patient's enrollment was not fully processed at the time the service was provided, those claims should be resubmitted.**

### ***Resources Available***

To assist patients and providers, CMS has posted resources that can help address questions related to coverage, network providers, premium payment, copayments, cost sharing and other issues. **In addition, consumers who signed up for coverage through [HealthCare.gov](https://www.healthcare.gov) can find information related to their health plan by logging into their HealthCare.gov account or by contacting the Health Insurance Marketplace call center at 1-800-318-2596. Please share this number with your staff and patients.**

Below are links to several CMS factsheets available to assist consumers and providers with plan specific information.

- [What you should know about provider networks](#)
- [Contacting your health plan's customer service phone number](#)
- [What to know about seeing your doctor](#)
- [I signed up, but don't have health coverage. What should I do?](#)
- [Getting emergency care](#)

- [What to know about getting your prescription medications](#)
- [Appealing your insurer's decision not to pay](#)
- [What you should know about early renewal of health coverage](#)

## **NEXT STEPS**

We encourage you to provide feedback on our [form](#) so we can share it with CMS. CMS has asked for rapid feedback so that it can follow up with other health care stakeholders to remove any barriers to needed care.

Please fill out the feedback form and describe significant obstacles to care or coverage that are related to the issues discussed in this Advisory. There are instructions on the template to help speed up issue resolution with CMS. Email the completed form to [coverage@aha.org](mailto:coverage@aha.org). We also encourage you to use this form to communicate success stories when problems are resolved or averted.

We also encourage you and your staff over the next several months to monitor key points of patient interaction to ensure a smooth transition of patients, some of whom may have pent-up demand for health care services. In particular we encourage you to monitor the volume of:

- Non-emergency services and procedures;
- Calls to your managed care and patient financial services areas;
- Patient complaints or problem escalations;
- Calls to insurance issuers and their response time;
- Private pay billings; and
- Uncompensated care or charity care

It also is important for your hospital to consider developing or updating detailed contact sheets for the insurance carriers in your local market to help ensure prompt resolution to patient questions. You also may consider asking insurance carriers for detailed information on the network composition of their various benefit plans so that you can help inform patients of their in-network versus out-of-network options.

## **FURTHER QUESTIONS**

If you have questions, please contact Jeff Goldman, vice president for coverage policy, at (202) 626-4639 or [jgoldman@aha.org](mailto:jgoldman@aha.org).