

THE NEW NORMAL: Helping Patients Navigate the Changing Insurance Landscape

HEALTH CARE REFORM AND THE SPREAD OF HIGH-Deductible PLANS CAN MEAN CONFUSION FOR PATIENTS – AND UNCERTAINTY FOR YOUR PRACTICE.



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Our practice has recently seen a major increase of patients coming into our office with new health care coverage purchased through the insurance exchanges or revamped policies provided by their employers. Many of these plans have high deductibles and large out-of-pocket costs. High-deductible health

plans (HDHPs) are nothing new; small employers and individuals have used HDHPs as safety net coverage for years, often paired with a health savings account. With the Affordable Care Act (ACA) now in full swing, however, HDHPs have become more common because they provide the minimum required health care benefits but at a low-cost premium.

About the Author

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In addition, with the last-minute influx of people trying to buy coverage through the insurance exchanges in recent months to comply with the law, many insurance companies had to scramble to get those applications processed, premiums credited, and coverage in place. As a result, you may have patients showing up saying they have coverage but with no insurance card or other proof of insurance. If you think understanding deductibles and coinsurance in the new health care market is difficult for physicians and their staffs, try to imagine what patients who have never had private health insurance are going through. Only 14 percent of American adults with health coverage understand deductibles and other key concepts of insurance plans, according to one study.¹ More patients with health care coverage is a good thing, but not understanding how insurance works can be costly for you and your patients.

What's changed?

High deductibles are commonly used with preferred provider organization plans, but they can also be used by health maintenance organizations or point-of-service plans. HDHPs, also known as consumer-driven health

ter cuts, and ongoing increases in overhead. Considering that there are only so many ways to collect money from patients, you and your practice managers must come up with plans to take control of the situation and keep your practices financially viable – and here's how.

Learn what the new plans are and how they work

Knowing what services an insurance plan covers and how it pays for those services is a good strategy to use to keep your cash flow healthy. Under all level plans, preventive care services (e.g., annual physicals, mammograms, and cancer and diabetes screenings) provided in-network are covered at 100 percent with no out-of-pocket costs from the patient. Knowing this, practices should encourage patients to get these services done, especially during the first part of the year when new deductibles are beginning and practice cash flow is slow.

Plans sold on the exchanges are broken down by “metal” level (Platinum, Gold, Silver, and Bronze) depending on the level of coverage, although each level covers the same minimum essential health benefits. Platinum plans pay 90 percent of a patient's allowed

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plans, charge lower monthly premiums in exchange for higher deductibles and higher out-of-pocket limits.

HDHPs typically have had deductible amounts of \$1,000 to \$2,000 per year and office copayments of \$5 to \$35 or coinsurance of 10 percent to 20 percent of the charges allowed by the plan. Maximum out-of-pocket costs have been in the \$5,000 range for an individual policy. But these costs are rising. Individuals who have purchased HDHPs from a state or federal health insurance exchange have discovered that they must pay out-of-pocket costs of up to \$6,350 before their insurance pays anything for their medical care. If they have a family, they may have to pay nearly \$12,700 themselves.²

Besides the obvious financial difficulties this rise in costs may present for patients, it creates practice management challenges as well. The responsibility for collecting payments is increasingly shifting from insurance companies to medical practices, which already are struggling with stagnant medical reimbursement, Medicare seques-

charges once the patient's deductible is met, leaving the patient responsible for the remaining 10 percent. Gold plans pay 80 percent. Silver and bronze plans, the most popular plans thus far, pay 70 percent and 60 percent, respectively.

It is important to note that even if a physician has a contract with an insurance company selling insurance plans on a health care exchange, those plans may possibly not include the physician as an in-network provider and the patient may not have out-of-network benefits. This is one of the most frequently reported problems we've experienced in our practice with policies purchased on the exchange. Patients often neglect to check the participating provider lists when signing up for insurance, and the error isn't found until the patient comes in for a visit. Patients and physicians can look on the HealthCare.gov website to see what physicians are in-network with the patient's plan, as well as what services that plan covers, if there are any out-of-network benefits, and the plan's drug formulary. ➤

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Have a written payment policy in place

A payment policy lets your patients know what you expect of them financially and what they can expect from you (see “Sample financial agreement”). Your payment policy should address things like the following:

- How are copayments and deductibles handled? (In our office, copays are due at each visit.)
- How are uninsured patients or non-covered services handled? (Payment is due in full at the time of service.)
- Do you offer discounts for uninsured patients? (We provide a 30 percent discount if the patient pays at the time of service.)
- How are patient balances and delinquent accounts handled? (Any account over 90 days past due may be sent to collection and the patient discharged from the practice.)
- Do you charge for things like missed appointments, filling out forms, or medical management over the phone? (Yes, yes, and yes.)

This is a short list of things that should be included in your written payment policy. Once your policy is in place, have each patient read and sign it and then keep a copy in the patient’s chart. You should review your policy annually and revise as needed.

Know what your patients’ benefits are before they come in for a visit

Forewarned is forearmed. When patients call to make an appointment, ask if their insurance has changed. This will give you time to call and verify coverage and benefits or look the information up online. Websites like Availity.com, HealthCare.gov, as well as individual insurance company websites list information on what the patients’ plans cover as well as their deductible, copay, and other out-of-pocket expenses. These reports are printable and can be attached to each patient’s superbill, giving the cashier at checkout proof that the patient has coverage and what the patient owes before he or she leaves the office. Remember, it’s always easier to collect pay-

ment for service at the time of service than it is 30, 60, or 90 days later.

Take advantage of certain service codes to increase cash flow

The Initial Preventive Physical Exam (IPPE, G0402), also known as the “Welcome to Medicare” exam; the initial annual wellness visit (G0438); and subsequent annual wellness visits (G0439) are not subject to patient deductibles and have no out-of-pocket expenses for the patient.³ The “Welcome to Medicare” visit is a one-time service that must take place within 12 months from the date the patient is eligible for Medicare. For a newly enrolled beneficiary, the IPPE is not a routine physical but an introduction to Medicare and covered benefits that focuses on health promotion and disease prevention and detection to help beneficiaries stay well. Patients who have been on Medicare for more than a year and have not received the “Welcome to Medicare Visit” are eligible for the annual wellness visit. Both visits have specific guidelines that include developing a personal prevention plan. During the visit, the provider must establish or update the individual’s medical and family history, a list of the individual’s current medical providers, a current medication list, and a record of height, weight, body mass index, blood pressure, pulse, and respiration. It also includes a cognitive impairment screening and establishes a screening schedule for the next five to 10 years. The patient is then provided personalized health advice and referrals to health education or other preventive services. After the initial annual wellness visit, the patient will then be eligible for a subsequent wellness visit annually.

Transitional care management services apply to Medicare or Medicare Advantage patients whose medical conditions require complex medical decision-making while transitioning from different levels of care and care facilities. For more on how to use these codes see “Transitional Care Management

■ High insurance deductibles are leaving some patients confused and practices financially vulnerable.

■ Preventive services often don’t involve out-of-pocket costs for patients and are good for cash flow.

■ Practices should develop written payment policies that patients must review and sign.

SAMPLE FINANCIAL AGREEMENT

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

- 1. Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
- 2. Patient payment:** All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.
- 3. Forms:** There is a \$15 fee for completing FMLA, sick leave, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed. There is also a \$5 fee for any forms that need to be faxed instead of mailed.
- 4. Registration:** All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
- 5. Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.
- 6. Uninsured patients:** We offer a 30-percent discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action.
- 7. Credit and collection:** If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient and possibly immediate family members from the practice. You will at that time be notified by regular and certified mail that you will have 30 days to find alternative medical care. During that 30-day period our physicians will be able to treat you only on an emergency basis.
- 8. Phone management fee:** There will be a \$20 charge for managing and treating a minor acute illness (e.g., cold, flu, or sinus congestion) over the phone. The phone management fee will not be billed to your insurance and is your full responsibility.
- 9. Missed appointments:** Our policy is to charge \$50 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X _____ Date _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Helping our patients understand their financial obligations up front and develop strategies to help them pay their bills over time can help to prevent high uncollectable balances and bad debt write-offs.

Services: New Codes, New Requirements,” *FPM*, May/June 2013, <http://www.aafp.org/fpm/2013/0500/p12.html>.

Educate your patients on their benefits

Because patients will be paying much higher out-of-pocket expenses, patient education regarding their benefits is vital. Use the insurance coverage and benefit printout previously discussed as a teaching tool to help your patients understand their benefits and their responsibilities. Many have bought policies based solely on whether they can afford the monthly premiums. Most don't understand what is or isn't covered or when their plan pays for it. This becomes most evident when a patient shows up at your office after receiving a bill for services because their deductible is unmet. If you have a patient who is having difficulty understanding his or her benefits, help the patient figure out the nuances of his or her policy. If you don't have the answers, consider asking your staff to call the insurance company on the patient's behalf or talk to an insurance broker who might have more specific knowledge of the policy. Although it is ultimately our patients' responsibility to know what their benefits are, practices must be knowledgeable of their coverage as well so we can steer them in the right direction and help them get the most out of their benefits. Taking the extra time will pay off in the long run because you won't be spending hours on the phone with insurance companies untangling eligibility issues after the patient has been treated or filing appeals for claims that were denied because the patient didn't understand what his or her plan did or did not cover.

Set up a payment plan before services are rendered

Because of higher out-of-pocket costs for patients, our practice is doing a lot more one-on-one financial counseling. It may be a good

idea to set up a payment arrangement with patients before services are rendered, especially for higher-cost procedures. Remember that most patients with high-deductible plans purchased through the exchanges are receiving a subsidy to help them pay for their premiums, and they qualified for that subsidy because they have a lower income. It may be difficult for them to meet their financial obligations. Helping our patients understand their financial obligations up front and develop strategies to help them pay their bills over time can help to prevent high uncollectable balances and bad debt write-offs. This could include automatic credit or debit card authorizations each month or at each visit. Most patients want to pay what they owe; helping them to do so with dignity works for both the practice and the patient.

Send claims every day

The sooner you get your claims processed, the faster you get paid. Also, once the claim is processed and the charges are credited toward the patient's deductible, you can bill the patient. If a patient owes a balance due to an unmet deductible, I always attach a copy of the insurance explanation of benefits (EOB) with our statement. The EOB is proof that we sent in the claim, it was processed and credited toward his or her deductible, and the amount owed is correct. Also, I don't wait until the end of the month to send out these statements. When I post the payment, I print the statement and send it that day. I've found that getting statements in the patient's hands as soon as the claim is processed helps speed up the turnaround time for payment.

Run a claim file check every month

In addition to sending out claims daily, it's important to run regular reports to see if your claims are being processed, and if not, why? You can run a claims file check a few different ways: In your billing software program there

■ Acquaint yourself with your patients' health plans to know what is and isn't covered.

■ Explain to patients how their policies work to help them – and you – get the most from their benefits.

■ Offering payment plans to patients can ensure you get paid in a timely manner, especially for more expensive procedures.

should be a report called “unprocessed or open claims.” This report will pull up all claims that have not be processed or paid in a 30-, 60-, or 90-day range. If you use a clearinghouse to submit your claims, it may have this feature as well. Many clearinghouses “scrub,” or check, your claims before sending them on to the insurer. If something is wrong with the claim, the computer will kick the claim out and put it in a retrievable unprocessed claim file, many times giving you the exact reason why it was rejected and what to do to fix it.

Another way is to run a manual check of your accounts. Pull your schedules dated 90 days out. Go to each patient’s account and see if his or her claim for that date of service has been paid. It’s more time-consuming to do it this way, but if your billing software doesn’t have the capability to pull the outstanding claim reports, this is probably your best alternative.

I check outstanding claim reports monthly. Sometimes it’s an easy fix, and I can just resubmit the claim. But sometimes it’s not, and I need to call the insurance company to either verify coverage or find out why the claim has not been processed. Running the report monthly helps ensure I resubmit claims before the time filing limit is up.

Ask for payment

Copayments are always due at the time of service as are payments for services that aren’t covered by the patient’s insurance but which they’ve elected to have anyway. If the patient does not have insurance, you should collect payment in full or your discounted amount before he or she leaves. On the other hand, if the patient has a deductible and you don’t know how much the patient has already paid toward it, you are better off sending a claim to the insurance company first and then billing the patient once the claim is processed.

Giving patients a choice is always a good thing, but there must be limits. If you ask a patient, “Do you want to pay that today?” their answer will more than likely be “no.” But if you say, “Your copayment is \$50. How would you like to pay for that today?” your chances of getting paid are much better.

If you have a patient who is notorious for skipping out on his or her copay (e.g., goes to get a checkbook from the car and doesn’t come back), ask for the copay the next time he or she

checks in. Always be discreet when asking for payment ahead of time as you never want to embarrass your patient in front of a full waiting room. Dealing with a deductible is more difficult this way because you can’t be sure what his or her charges will be, but the copayment is usually the same amount for any level of office visit. While some practices collect copays up front, our patients have generally complained when we have tried to do this, and the vast majority of them pay on time anyway.

Be flexible

This is an uncertain time for everyone in the health care industry. Rules and regulations change, sometimes daily. Health care providers have been exposed to the bureaucracy of the health care industry for many years. Now there are patients who will be entering the health care system for the first time. It’s important to be flexible and considerate with our patients, helping them understand and maximize their benefits.

Take the time to sit down with your patients who have questions about their coverage. It is your practice’s responsibility to be a resource for your patients when it comes to managing their benefits, and most patients will be appreciative when you take the time to help them with their coverage. It’s a win for the patients who now understand how their coverage works and are getting the most benefits they can. It’s also a win for your practice as, once your patients understand their benefits, they become more willing to pay their portion. This increases your cash flow and helps your practice stay viable. **FPM**

1. Loewenstein G, Friedman JY, McGill B, et al. Consumers’ misunderstanding of health insurance. *J Health Econ*. 2013;32(5):850-862.

2. Six things to know about deductibles in the health insurance marketplace. Health Insurance Blog. <https://www.healthcare.gov/blog/6-things-to-know-about-deductibles-in-the-health-insurance-marketplace>. Accessed March 17, 2014.

3. Medicare.gov. Preventive visit & yearly wellness exams. Available at: <http://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html>. Accessed April 8, 2014.

■ Sending claims quickly after visits gets you reimbursed faster.

■ Regularly check on overdue claims to see if the problem is with the insurer, the patient, or your office.

■ Ask for copayments and other fees at the time of service.

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