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PERSPECTIVES

Editor's Note: MGMA does not endorse any solutions put forth in this column. We urge readers to explore the legal issues — federal, state and local — that might arise from a particular course of action. We encourage members to share their perspectives on issues and would like to note the importance of ensuring efficient collections on the front end of all patient visits. Many industry experts have expressed concerns about the high-deductible nature of many ACA insurance exchange products. Get tips on collections at mgma.org, and download our ACA insurance exchange resources at mgma.org/aca.

Member perspectives on the ACA insurance exchange grace period

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Grace periods associated with the use of health insurance exchanges that are part of the Patient Protection and Affordable Care Act (ACA) might cause a significant shift in practice revenue as more patients enroll. In practice, the grace period translates to an extended line of credit offered to qualified health plan (QHP) patients and allows them to establish an account receivable (receive care now, pay for it later). These extensions could have extreme consequences for medical practices with regard to discounted payments for services rendered and obtaining payments later in the fiscal year.

During a recent meeting in Texas, several practice administrators shared fears about the practical implications of the ACA health insurance exchanges. These professionals had several patients who had purchased their health insurance through the exchanges when they opened for business. "We experienced this situation when claims were not processed as usual and hit our 60-90 day [accounts/receivable] bucket," says one practice administrator. "As a result, we contacted our managed care plans to discuss how claims were held without any mention of it in our contract."

To protect practice revenues, administrators are employing various tactics from developing electronic communication systems with payers to creating new tracking methods for patients whose active insurance cannot be verified.

"Patient coverage status is verified by our staff prior to any medical procedure that involves high cost to the practice and therefore helps with this issue," says one Texas-based practice administrator. "While time-consuming and expensive to the practice, this step is necessary so we know the patient's coverage status prior to the procedure."

Another practice administrator, who also asked for anonymity, says he has "inundated the health plan with emails and other correspondence to finally establish an internal protocol, specific to our practice that informs us of patients entering grace periods via email until the payer is able to better formalize its notification process. Collaboration with our managed care representative was important."

- Listen to a recent NPR piece about the ACA health insurance exchange grace period with commentary from Anders Gilberg, MGA, senior vice president, MGMA Government Affairs: mgma.org/npr-aca-exchange.
- Insurance exchange essentials toolkit: mgma.org/insurance-exchange-essentials
- ACA LEARN, mgma.org/aca

The issue

QHP enrollees who use a premium tax credit to purchase their credible coverage on the health insurance exchange get a 90-day grace period of continuation of QHP benefits, which begins once a monthly premium payment deadline is missed. This grace period extends to family members even if a partial monthly premium payment is made.[3] An

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enrollee may take advantage of the full grace period (up to three months), pay delinquent premiums to the QHP in full, and the pending claims held during the last 60 days of the grace period are then processed by the QHP and not returned to the medical practice for self-pay collections, according to *Federal Register* documents. In Texas, practice administrators are reaching out to payers with questions (and say that so far they are not getting a timely response or any response) and researching adjustments to their revenue cycles to protect reimbursement and ensure future viability.

Although the idea of permitting QHP beneficiaries to miss premium payment dates initially affects the exchange health plan's receipt of monthly premiums, the extension of benefits and alteration of claims processing protocols possess serious revenue cycle implications for medical groups as outlined in the timeline chart (Figure 1, available online at mgma.org/insurance-exchange-timeline), which shows how grace period status might be difficult for practice professionals to discern during the first and second periods. Any services provided in Periods 2 and/or 3 (or after day 30) might be deemed uncovered services by a QHP because the patient was delinquent on monthly premium payments beyond 90 days; however, due to the grace period status, a patient might continue to appear covered by the health plan throughout the duration of the entire 90-day period.

"The health insurance exchange grace period in its current form has already started to affect our insurance verification process and revenue cycle management," says CJ Cannaday, CMPE, MGMA member, director of clinic operations for a private surgical practice in north Austin. "We are currently having great difficulty attempting to verify ACA health insurance exchange products, including products held with the major carriers. Carrier responses to insurance verification are typically limited to 'claims status,' and customer service representatives are unable to speak to the fact of whether or not the patient is delinquent and/or current on their QHP benefits payments. Two

Summary of 90-day grace period for insurance exchange participants[2]

I have heard that medical groups across the country are realizing that the 90-day grace period associated with health insurance exchange products translates to a 300% increase of their reimbursement timelines in addition to inherent costs related to the grace periods.

Qualified health plan (QHP) enrollees who use a premium tax credit to purchase their credible coverage on the health insurance exchange get a 90-day grace period of continuation of QHP benefits, which begins once a monthly premium payment deadline is missed, as outlined in the following table:

Table 1: Summary of the ACA grace period provision

Grace period time frames	Description of events	Benefits permitted by ACA to QHP beneficiaries
Period 1 Day 0–30	QHP enrollee becomes delinquent on a healthcare exchange plan monthly premium payment.	QHP continues to process and pay the medical provider for services rendered.
Period 2 Day 31–90	QHP enrollee continues to remain delinquent on consecutive monthly premium payments, continuation up to the three-month premium period.	QHP may hold all claims for processing/payment.
Period 3 Day 91 and beyond	QHP enrollee consecutive monthly premium payments remain delinquent.	QHP returns unprocessed claims from Day 31 (first day of the second month) forward, informing the medical provider that the policy has been terminated and such charges are now deemed "self-pay."

major carriers that we have spoken with in the last couple of weeks specifically stated that they have no way to promptly notify us when payments are missed and that they do not have access to the parts of the system that would let them give us information on the patient's payment status. The health insurance exchange products are indeed a huge liability for our practice."

Lack of timely insurance notification

Relations, communication and collaboration between medical organizations and health plans are not always amiable, and practice processionals use various ways to obtain accurate information from plans, including:

- Phone call to customer service
- Email to customer service
- Fax sent to the claims department
- Healthcare plan's online provider portal/website (or other platforms)
- EDI and other claims remittance practices
- Direct communication (phone call, email, fax) to a group's managed care representative
- Regular mail
- Indirect communication via the state department of insurance

As a result, the federal government is relying on effective and timely communication between both parties to notify medical practices when a patient enters a QHP grace period.[3] Unfortunately a specific time frame is not stipulated, which might allow the QHP to interpret how promptly it notifies practices of a grace period and by what communication.[1] This allows for potential delays in provider notification of a patient being put on a grace period or moving into the second or third time frames (Table 1), which might jeopardize revenue.

Unfortunately, the "glass-half-empty" view of such enrollee benefits must also be evaluated to capture the true effect of the grace period. There have been reports that some patients are failing to pay and then paying QHP premiums to maintain a grace period status that meets the QHP beneficiary's deliberate intentions.[4] For instance, a QHP beneficiary could schedule expensive medical procedures or services during the 30-day portion of the grace period, or adversely select coverage for upcoming periods of high healthcare service utilization, and then drop the QHP credible coverage once the necessary services are obtained. At this point, the patient (previous QHP beneficiary) might simply accept the ACA's penalties (tax) for not possessing credible health coverage, now that the system has been accessed and necessary medical services or procedures have been provided under the assumption of credible QHP insurance coverage.[4] Although the federal government does acknowledge such avenues for corruption, it has yet to establish or accept any of the suggestions provided to prohibit such actions.[3]

Line of credit demonstrations

Figure 1 further demonstrates the effect of extended lines of credit using a typical process of care (office consultation, outpatient surgery and follow-up appointment). Several assumptions help demonstrate the effect of granting an ongoing line of credit from each grace period while notification of grace period entry and continuation status are unknown to the medical practice throughout the entire patient care episode.

Date of service (DOS) #1 (office consultation) and #2 (outpatient surgery) fall within the first 30 days of the grace period, so the services will be processed and paid by the QHP. However, it should be noted that the most expensive service in this patient care episode (outpatient surgery) could occur during Days 31-90 of the grace period, which creates an additional financial burden for the medical practice because the QHP may

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MGMA has sent two letters — in July 2013 and March 2014 — to the Centers for Medicare & Medicaid Services (CMS) regarding the ACA grace period.

A significant revenue cycle implication of the health insurance exchange was summarized by Susan Turney, MD, MS, FACP, FACMPE, MGMA president and chief executive officer, in a letter to Marilyn Tavenner, RN, administrator for CMS (July 2013):[1] "In an effort to pursue equitable healthcare stakeholder benefits for insurance exchange policy holders, the ramifications of such alteration to qualified health plan processing methods will directly affect the medical group practice's ability to effectively manage its revenue cycle, net operating income, and possibly implicate treatment patterns in an adverse manner." Read the letters: mgma.org/cms-cycle-letter and mgma.org/medicare-advantage-rule.

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hold all claims received during this time period. As a result, services rendered might not be processed or paid if the beneficiary remains delinquent on premium payments. Labeled accordingly, all services provided during this "danger zone" time frame retain a high probability of not being processed or paid by the QHP and potentially being returned to the medical practice after Day 90 for self-pay collection processes from Day 91 forward.

The practice is potentially extending its collection period from an average 35- to 45-day payment period[5] to 150-plus days, as demonstrated by red bars under the timeline (Figure 1). It is crucial to note that such initiations of lines of credit in this example begin on Day 45 (date the practice should have been paid via electronic remittance if all monthly premiums were up-to-date). This is almost a 300% increase of the possible reimbursement timeline with these inherent costs related to such grace period provisions:

- An increased probability of nonpayment from the patient once the 90-day grace period has expired
- Potential processing or payment by the QHP (if the patient catches up on late premiums), which occur later than the 45-day electronic claim remittance period[5]

As a result, professionals need to adjust budgeting practices to involve future estimates of cash flows stalled or subject to self-pay bad debt expense (after Day 90). To protect revenue cycle management, medical group practice administrators are making adjustments to temper the consequences of the grace period.

Several administrators discussed the possibility of using an electronic notification system process to identify patients who are in various grace periods and reduce the financial risk of scheduling expensive treatment episodes. Medical groups have already suggested or enacted electronic communication methods with QHPs to include indemnification if the QHP fails to correctly notify the medical practice of a patient entering a grace period when such electronic notification procedure is enacted.[6] Ultimately, the ability to protect a practice and ensure high-quality patient care requires an additional step in the revenue cycle process. ■

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Notes:

1. Turney, S. (July 2013). Concerns regarding 90-day grace period in Affordable Care Act exchanges. Letter addressed to the Administration of the Centers for Medicare & Medicaid Services. Retrieved from: mgma.org/WorkArea/DownloadAsset.aspx?id=1374940&kc=wac.
2. MGMA Washington *Connexion*. (August 21, 2013). What practices need to know as ACA exchange implementation continues. Email listerv: MGMA calls for a moratorium on meaningful use penalties.
3. *Federal Register*. (2013). Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. Retrieved from: federalregister.gov/articles/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans#h-167.
4. HUB International. (2012). Unraveling the Supreme Court's PPACA Ruling: What does it mean for Plan Sponsors? Retrieved from: hubinternational.com/uploadedfiles/dev_site/products/employee_benefits/healthcare/post%20supreme%20court%20ruling%207.3.12.pdf.
5. Texas Medical Association. (2003). Summary of SB 418 Prompt Pay Legislation. Retrieved from: texmed.org/Template.aspx?id=3171.
6. New Jersey Provider Protections for the ACA Grace Period Provision. Fox Rothschild LLP. Retrieved from: foxrothschild.com/newspubs/newspubsArticle.aspx?id=15032391557.

ONLINE EXCLUSIVE

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Our May/June Member Experience article examined the potential impact of the ACA insurance grace period; here is a timeline that describes what reimbursement could look like under the grace period.

Figure 1: Reimbursement timeline