Surviving Covered California – Tip Sheet #4

May 21, 2014

Covered California reports that nearly 1.4 million individuals have enrolled in exchange plans, which significantly surpasses original targets, making it critical that physicians and their staff know what to expect from these products. This tip sheet is the fourth in a CMA series titled, "Surviving Covered California." Prior tip sheets are available in CMA's Exchange Resource Center at www.cmanet.org/exchange.

To help answer some of the more common questions, the California Medical Association (CMA) offers this fourth tip sheet to assist physician practices in surviving this major change in health care.

1. **How can I identify whether an exchange patient is in months two or three of the grace period?**
   As mentioned in last month's tip sheet, enrollees who receive federal premium subsidies to help pay their premiums are entitled to keep their insurance for three months after they have stopped paying their premiums. Insurance ID cards for exchange enrollees do not indicate whether the enrollee is subsidized. Current enrollment trends, however, predict that 88 percent of those with exchange coverage will be subsidized and receive the three-month grace period. In other words, those with a Covered California logo on the ID card will most likely will have the three-month grace period.

   In the first 30 days of the grace period, federal law requires plans to pay for services incurred, but in months two and three of the grace period plans can pend and deny claims. So it will be extremely important that practices verify eligibility on all exchange patients, ideally on the date of service, or as near the time of service as possible. If the patient is in months two or three of the grace period, the health plan should indicate that coverage is inactive or otherwise suspended.

   CMA queried Anthem Blue Cross, Blue Shield of California and Health Net, which account for approximately 75 percent of the total Covered California enrollees, on exactly what to look for in eligibility verification to identify patients who are in months two and three of the grace period. They report the following:

Plan Name	Grace Period Eligibility Status Indicator (Days 31-90 of grace period)
Anthem Blue Cross	"Inactive pending investigation"
Blue Shield of California	"Pended"
Health Net	"Eligibility suspended"

   Unsubsidized exchange patients and those with a mirror product are not entitled to the 90-day federal grace period, rather they only receive the 30-day grace period called for under state law.

2. **What are my options if a patient presents with inactive coverage on account of the grace period?**
   Practices should have policies in place regarding how they will handle patients who are in months two or three of the grace period. Patients should ideally be made aware of this policy in advance. If a patient's eligibility verification comes back indicating his or her coverage is not active, the practice should treat the situation as they would any other patient who has had a lapse in coverage. For non -emergent services, patients may be given the option to either pay cash at the time of service or reschedule to a later date

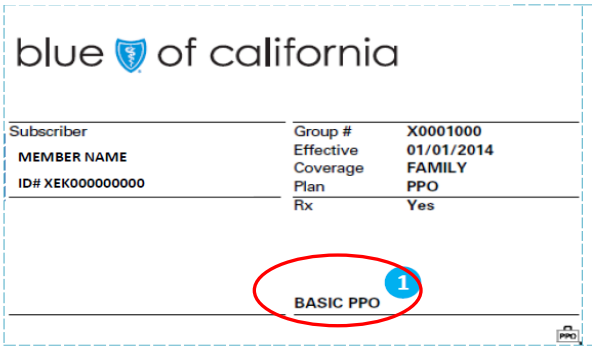
when their coverage is effective. The office policy should include how patients will be triaged to determine whether their condition is emergent or urgent and the policy should be approved by the physician.

3. **How can I identify the off-exchange, or "mirror," products that are sold outside of Covered California but utilize the narrowed exchange provider networks?**
Practices must review patient ID cards and eligibility information closely to identify whether the practice is in or out of network for that particular plan. Every plan offered in the exchange must also be offered outside of the exchange, using the same provider network. Confusion around these off-exchange products, also called "mirror" products, has resulted in a number of practices unknowingly seeing patients out-of-network for products that use a narrowed exchange provider network, as these ID cards will not have the Covered California logo. The issue is specific to just Anthem Blue Cross and Blue Shield of California, because they are the only two plans offering narrowed networks.

Blue Shield mirror products (bought off of the exchange but utilizing the exchange provider network) will list one of the following product names on the patient ID card:

- Basic PPO/EPO
- Enhanced PPO/EPO
- Get Covered PPO/EPO
- Preferred PPO/EPO
- Ultimate PPO/EPO.

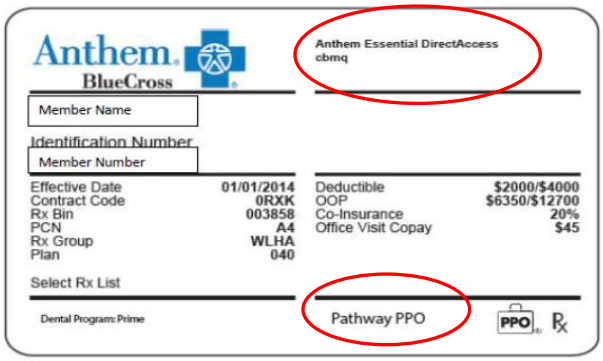
Sample Blue Shield ID Card



Anthem Blue Cross mirror products (bought off of the exchange but utilizing the exchange provider network) will list "**Pathway**" (network name) on the bottom of the card. The product names for mirror products, which appear on the top of the ID card are:

- Anthem Core DirectAccess (EPO/PPO)
- Anthem Essential DirectAccess (EPO/PPO)
- Anthem Essential Guided Access (HMO)
- Anthem Preferred DirectAccess (EPO/PPO)
- Anthem Premier DirectAccess(EPO/PPO)
- Anthem Premier Guided Access (HMO)

Sample Anthem Blue Cross ID Card



Click here for a detailed list of exchange and mirror product names.

If you see these product or network names on the Anthem Blue Cross or Blue Shield of California patient ID cards, it indicates the patient only has access to the narrowed exchange network. Again, these are the only two plans currently offering narrowed networks. The other nine plans generally offer their full network to exchange and mirror product patients.

Given the confusion and varying product/network names, CMA submitted a letter to Peter Lee, Executive Director of Covered California, and the Exchange Board of Directors, recommending Covered California

develop new requirements of plans to clearly identify mirror products on patient ID cards, among other things.

4. **What options are available for Covered California/mirror product patients who are having trouble finding in-network providers and/or facilities to provide care?**
   CMA has received a number of complaints about patient access to care issues, mainly in the narrowed networks offered by Anthem Blue Cross and Blue Shield of California. In fact, in a recent CMA survey of physicians' experiences with exchange plans, more than half of physician respondents indicated that they have experienced difficulties finding an in-network physician or hospital to which they can refer their Covered California patients.

   Patients who are having trouble finding an in-network physician or facility are encouraged to file a complaint with the Department of Managed Health Care's Help Center at (888) 466-2219. When calling, patients should indicate they have a Covered California plan and cannot find an in-network physician/facility that is reasonably accessible.

   In addition to contacting the health plan, we ask that physicians and practice staff who are experiencing difficulties finding in-network providers notify CMA of the issue so that we may raise it with Covered California and the appropriate regulator. Issues may be submitted to our physician helpline at (888) 401-5911 or economicservices@cmanet.org.

5. **Still have questions?**
   Visit CMA's exchange resource center at www.cmanet.org/exchange. At the resource center, you can download CMA's comprehensive exchange toolkit, "CMA's Got You Covered: A Physician's Guide to Covered California, the state's health benefit exchange," as well as a number of other CMA exchange resources. CMA members and their staff also have **FREE** access to our reimbursement helpline at (888) 401-5911 or economicservices@cmanet.org.