Health Insurance Exchanges: Practical Implications for Dermatologists

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Practice Points

- Health insurance exchanges aim to broaden access to needed health care services.
- Policies purchased through health insurance exchanges may provide coverage for major illnesses and preventive care but often carry substantial deductibles.
- Fee schedules for exchange policies may vary based on negotiations between providers and the new health plans.

The Patient Protection and Affordable Care Act (PPACA) of 2010 established health insurance exchanges to facilitate the purchase of health insurance by individuals (through individual exchanges) and by small businesses with 2 to 50 full-time equivalent employees (through the Small Business Health Options Program [SHOP]). As of May 28, 2013, 17 states have opted to run their own marketplaces; the rest are either fully or partly run by the federal government.[1] Policies purchased through these marketplaces will be effective on January 1, 2014. Recently, President Barack Obama delayed the implementation of SHOP until 2014.[2]

At the core of PPACA, the individual mandate requires uninsured individuals to either obtain a qualified health insurance plan or pay a tax. Individuals covered by Medicare, Medicaid, or an employer-based group insurance plan may continue to hold their existing policies, provided the plan meets the new federal requirements that will go into effect on January 1, 2014; however, certain groups are excluded from paying the tax from the individual mandate, including those who are incarcerated, American Indians who are covered through the Indian Health Service, undocumented immigrants, those with religious objections, individuals who earn less than 8% of the cost of the least expensive plan, and those with incomes below the tax filing threshold.[3]

Any individual or family can purchase insurance through the health insurance marketplace, either a state or federal exchange. Individuals making 100% to 400% of the federal poverty level will receive federal subsidies through advance tax credits based on income level.[4] Individual premiums within each state district will vary based on age (up to 3 times higher premium costs for seniors) and smoking status (up to 1.5 times higher for smokers). Preexisting medical conditions and health status will not be factors in determining eligibility or premiums.[4]

As of December 2013, implementation of the individual exchanges has been rocky (both federal and state-run exchanges), leading to lower enrollment than originally projected by the Obama administration. These issues stem from Web site glitches and incomplete public understanding; the Congressional Budget Office, however, projected that 7 million Americans may obtain individual health coverage through the exchanges by the end of 2014, so it is important for dermatologists to understand the practical aspects of these new health insurance plans.[5]

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The PPACA established new health insurance policies that cover 10 sets of benefits, including ambulatory care, emergency care, hospitalization, maternity and newborn care, mental health, prescription drugs, rehabilitative services, laboratory services, preventive and wellness services, and pediatric services.[6]

Many dermatologists are familiar with 80/20 medical plans wherein the insurer covers 80% of the charge for rendered services under a fee schedule and based on *Current Procedural Terminology* (*CPT*) codes. Traditional Medicare plans cover 80% of the cost of a given *CPT* code after a yearly deductible, which has been set nationally at $147 for Medicare patients in 2014.[7] Policies sold through the individual insurance exchanges will now fall into 4 tiers based on the portion of eligible expenses paid by the insurance company: bronze, 60/40 plan; silver, 70/30 plan; gold, 80/20 plan; platinum, 90/10 plan; catastrophic coverage, which can only be purchased by individuals younger than 30 years and those who are unable to purchase the least expensive plan available in their area.[8]

A 2011 article in *Dermatology World* examined Massachusetts dermatologists' experiences with the Massachusetts Health Connector Web site (http://www.mahealthconnector.org), which has been in place as the state's health insurance marketplace since 2007.[9] Although the health reform law enacted in Massachusetts later became the model for reform nationwide, the state's marketplace may not be a true model for the nation, as the state's demographics include many more students who generally are younger and healthier and obtain health care coverage through institutions.[9,10]

A look at issues related to the Massachusetts Health Connector marketplace, including fee schedules, deductibles, and contractual issues, may be useful for physicians. With regard to the marketplace, Mary E. Maloney, MD, University of Massachusetts, Worcester, said:

> The [Massachusetts] Health Connector may be a panacea for catastrophic health events for individuals, but it is not a panacea for general ambulatory care and not for preventive services. Deductibles have skyrocketed (under the Health Connector). The only insurance that is reasonably affordable (under the Connector) has a deductible of $3000 to $5000. I'm not aware that we have encouraged people to go to the doctor (for preventive services through the Connector). Even coverage for medications may not occur until after a deductible has been met (oral communication, November 2013).

According to Paul Wetzel, executive director of the Massachusetts Academy of Dermatology, "The patients are being encouraged to ask how much it will cost to do the procedure (prior to receiving one in a physician's office). But in many cases, the patient doesn't know that he has a large deductible until he's there, and the patient either has a larger deductible or this procedure is not covered" (oral communication, November 2013).

A physician's participation in these new insurance plans is effectively a matter of whether or not he/she has a contract with the insurance company for that plan. Some insurance companies are automatically adding physicians who are already contracted under their existing networks, while others are contracting on a case-by-case basis with providers who are interested in participating. The terms of these contracts can be as long as 2 years with limited opportunities for the provider to exit, suggesting lean networks with limited provider panels to hold down financial risk to the insurance company. Correspondingly, long wait times may result.

Fee schedules also vary widely, from near-Medicaid levels to those comparable to commercial insurance. Exchange policies also will carry a grace period of 3 months wherein an individual can maintain coverage even if he/she does not pay the monthly premium. The insurer will hold payment for services rendered after 30 days of delinquency until the individual pays his/her premium. Physicians essentially will then be serving as creditors; therefore, tracking ongoing premium payment becomes vital.[11]

Because the new health insurance marketplaces are complex, it is vital for dermatologists to understand applicable fee schedules, deductibles, and portions met, as well as whether a patient's current policy is valid.

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