ACA Grace Period Facts for Colorado

Colorado Insurance Commissioner Marguerite Salazar issued a bulletin in August clarifying carriers’ responsibilities in implementing the “90-day grace period” included in the Affordable Care Act (ACA). Many of the recommendations put forward by the Colorado Medical Society were included in the bulletin covering issues such as the information provided about a patient’s eligibility status and the timing of notification to physicians. It also clarifies the relationship between existing statute on eligibility verification and the grace period. CMS has provided the following summary of ACA grace period requirements and how they will be implemented under Colorado law.

Under the Affordable Care Act (ACA), if a patient who receives an advance premium tax credit (APTC) does not pay his or her health insurance premiums in full, he or she enters a 90-day “grace period.” During the first month of the grace period, the patient continues to have health insurance coverage, and the patient’s health insurer will pay claims for health care services provided to the patient during that time. However, if the patient enters the second or third month of the grace period, the health insurer may pend claims for services provided during that time. If the patient pays his or her premiums in full before the end of the grace period, the patient retains health insurance coverage for the second and third months of the grace period, and the insurer will pay the pended claims. But if the patient does not pay his or her health insurance premiums in full before the end of the grace period, the health insurer will not extend coverage for the second or third months of the grace period and will deny claims for services provided during that time. In this case, a patient is then responsible for paying the entire bill for services rendered during the second and third months.

Colorado law provides for a thirty-one (31) day grace period for those consumers with individual or small group health benefit plans who are not receiving APTC and who have missed a premium payment. Carriers must honor and pay claims incurred during the first month of the grace period regardless of whether the consumer is receiving the APTC or not. Grace periods do not apply to the payment of the first month’s premium.

The current statutes do provide some protections when patients are in the second and
third month of the grace period, as long as you use them proactively and within the timeframes laid out within each section.

**Eligibility Verification Is the Key**

- Each carrier must have one or more mechanisms in place for eligibility verification at the time services are provided, and regardless of the mechanism shall issue an eligibility verification code. C.R.S. 10-16-705(12)(a)(b)
- If you verify the patient’s eligibility within two business days prior to the delivery of services and the claim is paid, the carrier cannot take the money back. C.R.S. 10-16-704(4.5)(f)
- If at the time you verify eligibility the carrier determines that the patient is in the grace period and a premium has not been received, they may report that eligibility is contingent on payment of the premium due.
  - At the time you verify eligibility the carrier should be able to provide you with information concerning when the patient/policyholder entered into a grace period; the length of the grace period (APTC recipient vs. non-APTC recipient); which month of the grace period the policyholder is currently in; and the date upon which the grace period will expire and the policy will be cancelled.
- If you receive information from the carrier that coverage is contingent upon receipt of a premium, the hold harmless requirements of C.R.S. 10-16-705(3) do not apply and you may collect payment from the patient. C.R.S. 10-16-704(4.5)(g)(II)
  - This means that you may make arrangements with the consumer, prior to delivering services, to collect partial or full payment from the patient/policyholder. (If the policyholder pays all past-due premiums and the carrier pays the pended claims, you must refund all payments received from the consumer that exceed the patient’s responsibility, i.e. copayments, deductibles, and/or coinsurance amounts.)

**Notification**

Once a carrier receives a claim from a provider for a policyholder who is currently within a grace period, the carrier must send a letter to the provider no more than five business days after the receipt of the claim for services incurred during the grace period. The notice should contain the same level of detail as noted above concerning where the patient is within the grace period and when it will expire.

Note: Plans that are subject to Colorado insurance laws and regulations have “CO-DIO” noted on the insurance card.
How Much Do You Cost? Understanding Total Cost of Care

New healthcare cost reports detailing individual group, regional and state level total cost of care and resource use will be released in December of 2014 for physicians meeting certain attribution requirements.

Session objectives:
- Inform physicians about the CIVHC total cost of care and relative resource use measurement project using data from the Colorado All Payer Claims Database.
- Present draft templates and discuss the initial round of reports that will be provided to primary care practices with sufficient numbers of attributed patients in December 2014.
- Obtain feedback on report format and content. Identify types of information physician practices need to better understand their relative performance and identify opportunities to improve care and/or lower costs.
- Compare your cost and resource use to others in your area and across the state.

DATE: THURSDAY, NOVEMBER 20, 2014
TIME: Cocktail Reception - 5:30 PM; Dinner/Presentation - 6:00 PM
LOCATION: Cool River Cafe, 8000 E. Belleview Blvd., Greenwood Village
SPEAKER: Jonathan Mathieu, PhD - Center for Improving Value in Health Care (CIVHC)
RSVP: info@denvermedsociety.org no later than Monday, November 17th

Women Physicians’ Holiday Meet & Greet
Open House Soiree

Wednesday, December 3
6:00 PM to 8:30 PM

Inverness Hotel & Conference Center
200 Inverness Dr. W., Englewood

Cocktails &
Heavy Hors d’oeuvres

RSVP to info@denvermedsociety.org
No later than Tues., Nov. 25th at 3
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Acknowledgement
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Be Cybersecure: Protect Patient Records, Avoid Fines, and Safeguard Your Reputation

Cybercrime costs the U.S. economy billions of dollars each year and causes organizations to devote substantial time and resources to keeping their information secure. This is even more important for healthcare organizations, the most frequently attacked form of business.¹ Cybercriminals target healthcare for two main reasons: healthcare organizations fail to upgrade their cybersecurity as quickly as other businesses, and criminals find personal patient information particularly valuable to exploit.

The repercussions of security breaches can be daunting. A business that suffers a breach of more than 500 records of unencrypted personal health information (PHI) must report the breach to the U.S. Department of Health and Human Services’ Office for Civil Rights (OCR). This is the federal body with the power to enforce the Health Insurance Portability and Accountability Act (HIPAA) and issue fines. To date, the OCR has levied over $25 million in fines, with the largest single fine totaling $4.8 million.² A healthcare organization’s brand and reputation are also at stake. The OCR maintains a searchable database (informally known as a “wall of shame”) that publicly lists all entities that were fined for breaches that meet the 500-record requirement.³

If you think you may not be fully compliant with HIPAA privacy and security rules, consider taking the following steps:

- Identify all areas of potential vulnerability. Develop secure office processes, such as:
  - Sign-in sheets that ask for only minimal information.
  - Procedures for the handling and destruction of paper records.
  - Policies detailing which devices are allowed to contain PHI and under what circumstances those devices may leave the office.
  - Encrypt all devices that contain PHI (laptops, desktops, thumb drives, and centralized storage devices). Make sure that thumb drives are encrypted and that the encryption code is not inscribed on or included with the thumb drive. Encryption is the best way to prevent a breach.
- Train your staff on how to protect PHI. This includes not only making sure policies and procedures are HIPAA-compliant, but also instructing staff not to openly discuss patient PHI.
- Audit and test your physical and electronic security policies and procedures regularly, including what steps to take in case of a breach. The OCR audits entities that have had a breach, as well as those that have not. The OCR will check if you have procedures in place in case of a breach. Taking the proper steps in the event of a breach may help you avoid a fine.
- Insure. Make sure that your practice has insurance to assist with certain costs in case of a breach.

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References


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