Wyoming’s
CHANGING
HEALTHCARE LANDSCAPE
How the Affordable Care Act’s Insurance Exchange May Affect the Work of Wyoming’s Physicians

BY RON FEEMSTER

With the rollout of the Affordable Care Act’s insurance marketplace into its sixth month, insurance companies, patients and physicians are wondering how much has changed in Wyoming. What does the new health insurance exchange mean for the medicine in the state? So far, the answers are “everything” and “nothing.”

Let’s take “nothing” first. Even with more than 5,000 people enrolled in ACA-approved plans since Oct. 1, there is no telling how many of Wyoming’s estimated 85,000 uninsured people have purchased coverage.

“A lot of the people who signed up for insurance may have had insurance already,” said Tom Hirsig, director of the Wyoming Department of Insurance. “They may have found a better plan with more benefits on the exchange. Or they may have found a cheaper plan because of the subsidies. But there is no way to know if they are newly insured. We just don’t have that data.”

Hirsig expects to see a trickle of relevant data after the open enrollment period ends on March 31. The Centers for Medicaid and Medicare Services (CMS) release data once a month. But many details about demographics and the uninsured are missing.

“It’s going to take time,” he said. “But it is working very well. The original rollout was not very good, but we are not getting the calls we used to get. No one is calling us and saying they can’t get on the exchange or they can’t get insurance.”

Nor is there enough evidence to show whether people buying insurance on the exchanges are those whose treatment might lead to uncompensated care for hospitals and clinics around the state. The Department of Insurance knows how many people have bought policies. And they know that most policies are bronze and silver plans. But they do not know how many buyers received large subsidies. This latter number could provide an indicator of how many financially needy people are being covered.

Another very important demographic—young healthy people who pay premiums but are unlikely to make sizeable claims—is not broken out in the reports that Hirsig sees from CMS. The data for healthcare.gov belong to the federal government.

To assess the true impact of the new healthcare law on Wyoming may take two years, Hirsig estimates. The state and the insurance companies may not understand the impact of the law until they have a much bigger set of enrollment and claims data.

Which brings us to the “everything” assessment. Perhaps for the first time, the way is open for everyone of moderate income in Wyoming to purchase health insurance. Although the premiums are higher in Wyoming than in any other state, the cost of insurance is based on a percentage of income for people who earn less than 400 percent of the federal poverty level. In 2014, that 400 percent comes to $46,680 for an individual and $95,400 for a family of four.

Under that limit, the cost of insurance is calculated as a percentage of income, not as a fixed price. This does not necessarily make insurance affordable for everyone, but it may herald a new era of expanded access to care.

“The law is designed to make it possible for more people to get insurance,” said Hirsig. “If you get a subsidy, insurance is not any more expensive in Wyoming than it is in other states.”
According to a Gallup Poll published at the end of January, 53 percent of all uninsured Americans said they planned to buy insurance. These are not Wyoming numbers, which may differ simply because the state has been more opposed to the Affordable Care Act and President Barack Obama than the country as a whole. Nationally, 38 percent of the Gallup respondents said they would be more likely to pay the penalty—the tax according to the Supreme Court—than purchase insurance.

Overall, the percentage of uninsured in Wyoming may be slightly lower than in the United States as a whole. Most estimates put the number of uninsured in the state at about 83,000. That is around 14 percent of the 583,000 people living in the state, according to the 2013 Census Bureau estimate. Nationally, Gallup reported in early January that 16 percent of Americans were uninsured.

“In a lifetime of selling insurance,” said Hirsig, “I have been amazed at people’s attitudes about risk. There are people who just don’t want to buy insurance. Some people just do not see the magnitude of risk they face.”

Profits and the ACA

Many of the new plans under the ACA—primarily the bronze plans and the catastrophic plans available to people under 30—have high deductibles that patients must meet before any insurance reimbursement kicks in. When patients are newly insured—and especially when they have little experience with health insurance—they may not understand the deductible. Many practices may have problems collecting from these patients. In this way, again, nothing has changed. Collection is already a headache for many small practices and clinics.

“Some people can only afford the policies with higher deductibles,” said Amy Hayes of The Office Assistant, LLC, a company that manages billing and reimbursement for many solo practitioners and clinics around the state. “We are seeing some $2,500 deductibles. We are sending out more patient bills. The concern is that we are going to have to continue to rebill those patients or that we may not collect at all.”

This is not a new problem, but it is one that Hayes sees getting worse under the ACA. “I really think it will increase unless clinics are proactive about verifying eligibility at the time of scheduling and informing the patient that they have a deductible and they need to pay at the time of treatment,” she said.

The big issues are verification and communication. Providers need to understand their patients’ coverage and communicate the patients’ responsibility before the first visit. “If they don’t verify, there will be people who have a $200 office visit and can only pay $10 a month, even with insurance,” Hayes said. “That’s a long time to wait to get paid.”

Although the problems of immediate payment are most pressing, the ACA does reduce some of the long-term risk factors for practices in Wyoming. The fairly low annual limits and the lack of lifetime limits reduce providers’ and hospitals’ exposure to catastrophic losses.

“The upside is there is less risk of getting no payment forever and ever, amen,” Hayes said. But that is a long-term upside. Hayes sees practices in the state focused on the coming weeks and months. When the regulatory climate changes, she suggests, physicians must think first about how to continue to practice effectively and still make a profit.

“My clients are more concerned about the immediate situation,” Hayes said. “How will we mitigate the issues in the short run while providing quality care?”

Trusted Messengers

One thing providers can do is help patients—especially self-paying patients—educate themselves about insurance.

“There is a big population out there that has never had coverage,” said Tracy Brosius, operational director of the Wyoming Institute of Population Health. Brosius oversees a network of navigators who help consumers become informed about the insurance available under the Affordable Care Act. “Or maybe they have had coverage on a job and lost it. But they have never bought insurance for themselves before.”

Brosius noted that many people are likely to buy a policy based on the lower premium, and forget about the out-of-pocket costs until it is too late.

“They see that the premium is $50 less,” Brosius said. “But they don’t think about the $6,000 in out-of-pocket costs that may come with that lower premium.”

Some providers are clearly sending their patients to meet with navigators. Physicians are the most trusted messengers when it comes to healthcare, Brosius said, and patients mention them when they come in to talk about insurance.

“Patients come to navigators and say, ‘My doctor said to come here,’” Brosius said.

“Doctors have a huge amount of influence. They can make sure that people understand their medical condition and what their risks are. This will help them be a better educated consumer.”

Over the past six months, even before the grants to train and deploy navigators kicked in, Brosius and her staff reached out to the provider community to find the self-payers.

“There is no magic list of people,” Brosius said. “We asked hospitals, mental health centers and family practice clinics to help us identify people.”
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Once they had a list, Brosius and her staff organized informational meetings for patients. They sent out 1,500 personalized invitations to self-payers in Laramie County. A similar group in Casper sent out even more, Brosius believes. The results were mixed. Many of those people came to learn about the plans. But some never responded.

The navigators are busy now, but Brosius expects the pace will pick up even more in March, as the end of open enrollment approaches. People who want to buy insurance on the exchange must do so by March 31. Those who are not covered by March 31 must pay the tax penalty prescribed by Congress.

The education process will not stop at the end of March, however. According to healthcare.gov, a new open enrollment period is slated to begin Nov. 15, 2014 for insurance coverage that begins Jan. 1, 2015. That enrollment period will be shorter than this year’s, ending on Jan. 15, 2015.

“We expect to do a great deal of work to prepare for that shorter open enrollment period,” Brosius said.

In the meantime, Brosius and her colleagues hope that providers will encourage patients to be proactive and buy insurance. Some people are well informed but somehow stop short of actually purchasing a policy.

“Some people come to us and have done all of their homework,” Brosius said. They may know what they need but still not commit to a plan. “In some cases,” she said, “a provider could intervene to help them over the edge.”
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More Patients
In the long run, the Affordable Care Act is likely to increase the number of patients seeking treatment in Wyoming. Preventive care will be covered for free under all ACA policies, so more patients are likely to book more appointments.

Less likely to increase is the number of physicians in the state. Recruiting is notoriously hard in Wyoming. With more work for the same number of physicians, the organization of practices and even larger medical communities may have to change. Some close observers of the Wyoming medical community are understandably skeptical of Accountable Care Organizations in such a sparsely populated state.

“It relies on a critical mass of patients to get things accomplished,” said Nicholas Dray, a partner at the law firm Dray, Dyekman, Reed & Healey. “ACOs are features of the ACA intended to create efficiencies in the delivery of care. But you need 5,000 people on Medicare. That can be hard to achieve in Wyoming.”

On a more local level, physicians may choose to become more like managers of a practice that distributes work to qualified colleagues.

“Not every patient needs to see the physician,” said Phyllis Sherard, executive administrator of the Wyoming Institute of Population Health. “Physician-led teams can deal with the shortages by using mid-levels. Physician assistants and nurse practitioners can deliver care working at the top of their licenses.”

Patient-centered medical homes are thriving in Casper, Cheyenne, and Fort Washakie on the Wind River Indian Reservation. By tracking patients’ medical conditions and care, physicians concentrate their resources on people who need it the most, even if they have to treat more patients than ever before.

Changes in practice have begun in Wyoming already, even if changes in insurance coverage are hard to identify. When slow, long-term change begins in the state’s medical community, it might be tempting to see nothing new. But that may not last. In a couple of years, everything might be different.

Ron Feemster covers healthcare for WyoFile, a non-profit online news service in Wyoming.