FUNDAMENTALS OF MANAGED CARE AND RECENT TRENDS

Presented by the American Bar Association Health Law Section, Young Lawyers Division and Center for Professional Development
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This publication accompanies the audio program entitled “Fundamentals of Managed Care and Recent Trends” broadcast on February 11, 2016 (event code: CE1602FMC).
The Fundamentals of Managed Care and Recent Trends

Presentation Outline

Today's Outline

1. Speaker Introductions
2. General History and Evolution of Managed Care
3. Legal and Contracting Issues Affecting Managed Care Arrangements
4. Health Care Reform and its Impact as a Catalyst of Change to Managed Care
5. Future Trends in Managed Care
6. Q & A
Speaker Introductions

Speakers

• Brian Benjet, Partner, DLA Piper LLP (US), Philadelphia, PA

• Christina Hage-Steiner, General Counsel, HealthyCT, Wallingford, CT

Moderator

• Ardith Bronson, Of Counsel, DLA Piper LLP (US), Miami, FL

History & Evolution of Managed Care

General History and Evolution of Managed Care in the U.S.
History and Evolution of Managed Care

- The Rise of Health Insurance
  - Early Efforts
    - 1929 Blues established first plan; other cooperatives and clinics followed
    - 1933 Dr. Sidney Garfield provided care on a prepaid basis to construction workers
    - 1940s (post WWII) Kaiser developed programs
    - 1950s Rise in health insurance coverage
    - 1965 Medicare and Medicaid created
    - 1973 Federal HMO Act
    - 1974 ERISA

- 1980s Escalating health care costs
- 1990s Growth in managed care
- 2000s Trends towards PPO and high deductible consumer-directed plans
- March 23, 2010 PPACA signed into law
- 2015 Accelerated Industry Consolidation
### Who are the Players?

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<th>The Payors – Private</th>
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<td>Indemnity Insurance Companies</td>
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<td>Employer (ERISA) Plans (ASO and Insured)</td>
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<td>Risk Bearing Provider Networks</td>
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<td>Consumer-Driven Health Plans</td>
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### Who are the Players?

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<th>The Payors – Governmental</th>
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<td>Medicare</td>
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<td>Traditional Medicare</td>
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<td>Part A (Hospital)</td>
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<td>Part B (Physicians and Suppliers)</td>
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<td>Medicaid (MediCal in California)</td>
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<td>Other Federal Programs (CHIP, TRICARE, FEHBP, etc.)</td>
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<td>Other state, county and municipal programs</td>
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<td>Exchange/Marketplace plans</td>
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</table>
### Who are the Players?

**Providers**
- Physicians and other individually licensed practitioners
- Suppliers (DME, Home Health, Pharmacy, etc.)
- Hospitals and other licensed facilities (ASCs, IDTFs, etc.)
- Other provider entities/organizations (surgical assistants, freestanding emergency centers, etc.)

**Intermediary Organizations**
- IPAs
- PHOs
- Provider Networks
- ACOs
- Management Services Organizations
### Who are the Players?

- **Other Organizations Involved in Outsourced Management and Administration of Products**
  - Pharmacy Benefit Managers (PBMs)
  - Utilization Management (UM) Organizations
  - Administrative Services Only (ASO)
  - Third Party Administrators (TPAs)

- **Beneficiaries/Subscribers**
  - Individual consumers
  - Employers and Employer Groups (large and small)
  - Co-ops
Legal and Contracting Issues Affecting Managed Care Arrangements

Legal Issues that Affect Managed Care Arrangements

- **ERISA**
  - Employer-sponsored plans “exempt” from many state laws
- **State Insurance Regulation**
  - Prompt payment
  - “Clawback” statutes of limitation
  - Any willing provider
- **Out-of-Network Reimbursement and Fee Forgiving**
### Legal Issues that Affect Managed Care Arrangements

**Liability Considerations**
- Medical decision-making
- Utilization review
- Indemnification

**Antitrust**
- “Messenger model”
- New clinical integration models
- DOJ guidance

### Legal Issues that Affect Managed Care Arrangements

**Referral Restrictions**
- Federal Anti-Kickback Statute
- Safe Harbors (42 CFR 1001.352(t), (u))
- State “all-payer” kickback laws

**Stark**
- Lesser issue in managed care arrangements
- Applies to physician-owned entities
- State “mini-Stark” laws
Managed Care Contracting Issues

• Provider discounts rates
  • In exchange for:
• Payer steerage of members to provider
• Sounds simple BUT:
  • Multiple externalities exist
    – ERISA
    – State laws
    – Payer policies and procedures
• Out of network considerations are different

Top 9 Contract Issues

1. Amount of discounts/payment rates
2. Parties to the contract/affiliates
3. Member steerage
4. Amendments
<table>
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<th></th>
<th>Top 9 Contract Issues, cont’d</th>
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<td>Under/overpayments resolved</td>
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<td>Future issues/new services &amp; technology</td>
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<td>8.</td>
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<td>Medicare/Caid managed care required provisions</td>
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**Health Care Reform and Managed Care**

Health Care Reform and its Impact as a Catalyst of Change to Managed Care
## What is Health Care Reform?

- History and Development of Health Care Reform in the United States
- Federal Reforms
  - The Affordable Care Act / Obamacare
- State Reforms

## Key Provisions of ACA Affecting Plans

- Individual Mandate
  - The Requirement to Have Coverage
- Employer Requirements
  - The Requirement to Offer Coverage
- Expansion of Public Programs
  - Medicaid
  - CHIP
- Premium and Cost-Sharing Subsidies to Individuals
- Premium Subsidies to Employers
Key Provisions of ACA Affecting Plans

- Changes to Private Insurance
  - Annual Limits banned completely starting in 2014
  - Coverage for dependents
  - Market Rating Reforms/Premium Rate Reviews
  - Medical Loss Ratio
  - Preventive Services
  - Changes back and forth related to small versus large group definitions

Exchanges

Consumer facing materials from the federal government refer to them as “Marketplaces”
Exchange Types
State vs. Federal Exchange Activities

- States have chosen which activities are managed at the state level and which activities they want the Federal government to manage.
- Majority of states chose federally-facilitated or partnership exchanges, although a number of state-based also exist.

State-based Exchange
State operates all Exchange activities; however, State may use Federal government services for the following activities:
- Premium tax credit and cost sharing reduction determination
- Exemptions
- Risk adjustment program
- Reinsurance program

State Partnership Exchange
State operates activities for:
- Plan Management
- Consumer Assistance
- Both
State may elect to perform or can use Federal government services for the following activities:
- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination

Federally-facilitated Exchange
HHS operates; however, State may elect to perform or can use Federal government services for the following activities:
- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination

State Exchange Map

State Health Insurance Marketplace Types, 2016

NOTES: This map displays the marketplace type for the individual market. For most states, the marketplace type is the same for the small business, or SHOP, marketplace; however, AR, MS, and UT operate State-based SHOP Marketplaces.
SOURCE: State Health Insurance Marketplace Types, 2015, KFF State Health Facts:
http://kff.org/other/state-indicator/state-health-insurance-marketplace-types/
Exchange Enrollment

Exchange Functions: Plans

- Marketplace/Distribution Channel
- Functions:
  - Certify Qualified Health Plans (plans sold on exchange) and Essential Health Benefits
  - Rate QHPs participating on Exchange
  - Determine eligibility and enroll participants
- Prohibitions:
  - Cannot prohibit non-exchange market
  - Cannot impose regulatory or premium price controls (although some Marketplaces are looking to be active purchasers)
### Exchange Functions: Consumers

A *marketplace and support network* for individuals and small employers to:

- **Compare** information regarding cost and quality
- **Shop** features of plans containing the same base benefits
- **Determine** eligibility for federal financial assistance (premium subsidies)
- **Call, text or sit down** with someone for help
- **Enroll** in a plan

### Key Provisions of the ACA Affecting Managed Care Arrangements for Providers

- **Delivery System Reforms**
  - Focus on coordination of care, improved quality and reduced costs
  - Value-based purchasing
  - Bundled Medicare payments
  - ACOs
  - Penalties for excessive readmissions and “never events”
  - Development of a Center for Medicare/Medicaid Innovation
Essential Health Benefits

- On November 9, 2015, the Centers for Medicare & Medicaid Services (CMS) released the final 2017 essential health benefits (EHB) benchmark plan for each state. A summary of benchmark plan coverage and the supporting plan document, as well as a list of how many prescription drugs are covered in each United States Pharmacopeia (USP) category and class were posted.
- The benchmark plan can be found at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html

Key Provisions of the ACA Affecting Managed Care Arrangements for Providers

- Medicare and Medicaid Payment Changes
  - Reduced DSH payments
  - Enhanced payments to rural hospitals, additional payments to primary care physicians and expanded 340B drug discount programs
  - Formation of Independent Payment Advisory Board
- Wellness and Prevention
  - $12.9 billion to be invested in prevention and wellness
  - Preventive services with zero cost sharing by patient
## Key Provisions of the ACA Affecting Managed Care Arrangements for Providers

- **Quality, Disparities and Comparative Effectiveness**
  - Pay-for-reporting to move financial incentives from volume to quality
  - Movement to value-based purchasing incentive program
  - Extension of PQRI to affect Medicare payment to physicians
  - Penalties for hospital-acquired conditions
  - National quality improvement strategy to include patient safety research to promote adoption of best practices

- **Regulatory Oversight and Program Integrity**
  - Extension of RAC program to Medicare Parts C and D, and Medicaid
  - New transparency and disclosure provisions
  - Fraud and abuse provisions
  - New community benefit reporting requirements for nonprofit hospitals

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## Future Trends in Managed Care

Future Trends in Managed Care
### Effect of Reform on Physicians and Other Providers

- **Specific**
  - Expand office-based ancillary services (short term)
  - Expand use of mid-level providers (PA and APN)
  - Expand use of technology (telemedicine, EMR, etc.)
  - Consider alternative practice models (mergers, virtual groups, etc.)
  - Partner with insurance companies
  - Partner with or become employed by hospitals
  - Establish direct contracts with employers for internal and outside clinics
  - Go “off the grid” and opt out – Concierge Practice options

### New Arrangements in Payor and Provider Payment Relationships

- Traditional fee for service
- Shared risk arrangements
- Global payments (a form of shared savings)
- Bundled payments (involve hospitals and physicians)
- Pay for performance
- Accountable Care Organizations
  - Can utilize any of payments above
- Patient Centered Medical Home
  - Typically more global payment
New Arrangements in Payor and Provider Payment Relationships

CONVERGENCE / ALIGNMENT

Providers Buying Payors & Payors Buying Providers

Historical relationships

• The interests of payors and providers have historically been at odds:
  – Providers
    • Provide patient care
    • FFS – more care provided, more money to be made
    • Generally less focused on cost of care
  – Payors
    • Pay for care
    • Generally focused on lowering costs (e.g., denials, audits)
New Alignment: Clinical

- **Preventative care** rather than “reactive” care
  - Decrease volume/utilization by getting in front of it
- **Coordination of care**
  - Care plans
  - Care coordinators
- Sharing **historical clinical/outcome data** to improve quality of care
- Focus on **patient-centered** care

New Alignment: Administrative

- Payors can **relieve administrative burden** on providers
  - have infrastructure already built
  - have IT capability
- Gives providers **more time and resources** for patient care
New Alignment: Economic

- **Transparent** payment terms
  - defined up front
- Shift towards **Pay-for-Performance (P4P)** payor contracting
  - E.g., pay more for care plans
- Using **bundled** payments
  - Similar to DRG approach
- Must drive **quality** and **efficiency** to maximize reimbursement under health reform
- **Shared savings**

Mergers Galore!

- Three significant mergers announced in 2015
  - Aetna/Humana
  - Anthem/Cigna
  - Centene/Health Net
- End result- 3 major payors (United, Anthem and Aetna)
- Continuation of a trend since the passage of the PPACA
  - Aetna/Coventry
  - Cigna/Healthspring
New Arrangements in Payor/Provider/Employer Relationship

- Accountable Care Organizations
  - Medicare ACO numbers decreasing
  - Private payer ACO numbers increasing
- Patient Centered Medical Home
  - Primary care providers managing care, instead of payer
- Onsite Employer Clinics and Wellness Programs

Consumer Cost Transparency

- Health Plans Cost Estimator Tools
  - Real-time member responsibility
  - Current network provider charges and geographic average
  - Quality designations
- Other Publicly Available Tools
  - Fair Health Consumer Cost Lookup
  - HCCI Transparency Initiative
- CMS Release of Provider Payment Data
Consumer Cost Transparency

• Impact
  – Provider price variances available
    • 60% to 200% based on one study
  – Consumers making more cost-conscious health care decisions
  – Considerations for employers in plan design

Questions?

Questions, Answers, & Discussion