MOVING ON

Adjusting for Healthcare Reform

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WHO ARE YOU?

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Overview

Elements of Reform

Commonwealth Care

Benefit Plans & Self-Funding

PPO Conflicts

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Elements of Reform

The vast scope of the Patient Protection and Affordable Care Act and the related Health Care and Education Reconciliation Act enacted in March 2010 (collectively, “PPACA”) has captured widespread attention with its array of new obligations.

Several of the provisions affecting group health plan sponsors take effect immediately or in the near future.

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Elements of Reform

- Elimination of lifetime and annual limits (Sec. 2301 - immediate)
- No pre-existing condition exclusions (Sec. 2301 - immediate)
- Extending dependent coverage until age 26 (Sec. 2301 - immediate)
- On 7/1/12 plan members may leave to buy into “the exchange”
- Employers may term plans and pay 8% of payroll per EE into “the exchange”
- Starting 1/1/2014 – All citizens must have minimum coverage through themselves or employers

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Elements of Reform

- For the first 10 years, it will cost ~ $100 billion a year (the yearly cost of the Iraq War)
- Will increase the cost of health insurance
- Tax increase on high income people and businesses
- Cuts in Medicare
- No incentives for primary care physicians
- New levels of scrutiny

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Elements of Reform

Kaiser Foundation:

- NBC News and Wall-Street Journal survey
  - Repeal is supported by 51%
  - 39% feel repeal is unacceptable
- Bloomberg Survey
  - 47% want repeal / 42% do not
- CNN Survey
  - 26% want to make changes to law
  - 23% want to keep the law as is
  - 47% want to repeal the entire law

Repeal of law would require Republican Senate majority

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Elements of Reform

There is some possibility for revision addressing specific portions of the law

Popular Reform

- Require States to set up special plans so that people with major health problems can still get health insurance;
- Prohibit insurance companies from denying coverage based on pre-existing conditions;
- Addition of more prescription drug benefits for people on Medicare

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Elements of Reform

There is some possibility for revision addressing specific portions of the law

Less Popular Reform

- Mandates which allow children up to age 26 to remain on their parents' policies;
- Insurance exchanges;
- Elimination of lifetime caps;
- Taxing of companies that provide especially generous health insurance plans to employees

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Elements of Reform

Very Unpopular

- Mandate that requires everyone to have health insurance
- Governors from several States have filed a lawsuit in Florida that challenges the reform on constitutional grounds
- Virginia federal judge recently found that portion of the health care law to be unconstitutional; see *Commonwealth of Virginia v Sebelius*, VAED 3-10-cv-00188
- Justice Department expected to challenge the judge's findings and opinion contradicts other court rulings finding the mandate to be constitutionally permissible

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Elements of Reform

- It's all about risk, and adjusting benefits and rates accordingly… Mandates and regulations that limit medical underwriting will eliminate the insurance marketplace and decimate the industry
- Cost of providing a benefit plan is poised to jump by 11% in 2011 - increase of $1,000 per covered EE over 2010 premiums
- Employers feel they will be better served by dropping coverage, offering salary increases to employees, and paying governmental fines in lieu of rising premiums for private plans

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Elements of Reform

- Employee Retirement Income Security Act of 1974 (“ERISA”) Appeal Guidelines
  - What are they?
- New appeals procedure – If you are not subject to ERISA claims procedures you soon will be (or something like it)
  - Uniform appeals and administration standards will be implemented
- Plan review
  - You must provide external review of decisions if asked (Independent Review Organizations aka “IRO”)

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Elements of Reform

- NAIC Uniform Model Act provides that an approved IRO must have no Conflict of Interest (COI) influencing its independence and the IRO should be random
- How neutral will the IRO really be?
  - The plan is paying the IRO for its decision which is binding not only on the benefit plan but also on the provider and the claimant
- Plans are required to contract with at least 3 IROs and rotate claims assignments
- IROs cannot receive incentives based on likelihood of denial of benefits
- If IRO wants to continue to work with the plan, they may want to keep their client satisfied which could result in an unspoken COI

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Elements of Reform

- Will IROs be required to adhere to strict deadlines required by PPOs and stop loss carriers? If requirements are not met due to IRO review, what entity is liable?

Binding Federal External Review Processes and Contradicting Language Regarding Discretionary Authority and Deference

- Typical ERISA plan document language states the plan has sole discretionary authority

- Federal external review process states the IROs decision will become the final binding decision

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Elements of Reform

- There has been a renewed focus in our industry on wellness and disease prevention
- Many employers are working to reduce employee illnesses and health care costs through preventive care programs and employee education
- Patient education and disease management are taking center stage as insurers look to bend the cost curve
- Many employers are addressing preventive health by expanding health education programs to their employees

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Elements of Reform

- Wellness programs are subject to HIPAA
  - Basic principle is nondiscrimination
  - Cannot charge different rates to workers based on health conditions

- To avoid violation, wellness must comply with specific requirements
  - Wellness program rewards cannot exceed 20% of cost of coverage
  - The program must be designed to promote health or prevent disease
  - The program must permit people to qualify at least once a year
  - Program has to be available to all similarly situated employees
  - Materials must disclose alternative standards/waivers are available

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Elements of Reform

Two laws muddied the "wellness waters"

- PPACA
- GINA

PPACA

- Encourages employers to develop wellness programs – Increases incentives to 30% for EEs in wellness programs or meeting health targets.

- Created $200 million, five-year program to provide grants to small employers that implement workplace wellness programs.

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Elements of Reform

GINA I

- Undermined ability of wellness program to provide individual-specific health advice by preventing access to EEs genetic & family medical history.
- Prohibited plans from collecting genetic info to provide discounts in return for targeted activities.
- Resolving the Contradiction -

  GINA's "Interim Final Rules" suggested 3 ways:

  1) Eliminate Incentives, and/or

  2) Stop Collecting Genetic Info.

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ELEMENTS OF REFORM

3) Genetic info can only be used in accordance with the following rules…

- Employer *could* collect genetic info if EE provides **written authorization**.
- Only EE and licensed professional can receive identifiable info re results.
- Employer can see aggregate terms that don't disclose ID of specific EEs.
- Congress made it clear that GINA I was not the final ruling.

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Elements of Reform

GINA II

- The program must be voluntary. The employer neither requires the disclosure of info nor penalizes those who choose not to provide it.
- Offer optional GINA section, clearly stating that completing questionnaire seeking genetic info is purely optional and that any reward offered will be provided whether that portion is completed or not.
- Incentives offered to all qualifying workers - not just those who answered the genetic questions indicating risk for that disease.

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Elements of Reform

- 5 ways to implement financial incentives under PPACA:

  1) Differential premiums — better choices reflected in lower premiums.
  2) Differential EE contribution rates — reflected in lower EE premiums.
  3) Differential deductibles — rewarded by lower deductibles.
  4) Differential cost-sharing — rewarded with lower EE cost-sharing.
  5) Differential deposits to personal care accounts — better choices are rewarded with larger deposits to HSAs or HRAs.

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Elements of Reform

What is “The Exchange?”

- A State-based American Health Benefit Exchange and Small Business Options Program (“SHOP”)
- Exchanges administered by a governmental agency or non-profit organization through which individuals and small businesses (up to 100 employees) can purchase qualified coverage
- Federal evaluation of State Exchange implementation in 2013
- State Exchanges begin on January 1, 2014
- Will allow private carriers to offer policies across state lines, so long as they meet certain requirements
- Prices will likely be controlled through subsidies, and risk pools will grow as these carriers expand their coverage

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Elements of Reform

What is "The Exchange?"

- Plans must meet quality and coverage standards
- There will be different "value" levels based on coverage
- Free choice vouchers equal to employer contributions may be offered by employers rather than employer purchased coverage

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Elements of Reform

The "Exchange" and the "Public Option"

Rather than implement a governmental plan, a "public option" will likely be included in the exchange

It will likely drive private insurance from the market because it will be underpriced relative to its cost

Government is large enough to limit what it is required to pay to healthcare providers, and control costs internally (see Medicare and Medicaid)

Issues are:
(1)Can the government sustain such a benefit plan, charging bargain basement premiums without looking to the taxpayers for assistance?
(2)Will the "best of the best" want to practice medicine when their revenue is being forcibly controlled

If a public option fails to develop, even a governmentally regulated marketplace consisting of private policies, underwritten by private carriers, may be unable to sustain itself – see Massachusetts…

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Commonwealth Care

- Massachusetts State law requires all residents to provide proof of insurance, or they will be fined
- Individuals who cannot obtain coverage through employment may access what is called “the connector plan” or “Commonwealth Care”
- Individuals access numerous private policies of insurance through the connector plan

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Commonwealth Care

- Insurers must offer certain mandated benefits, and cannot do so for more than a certain, capped rate
- Insureds are responsible for payment of their own premiums, but employers can pay employee's premiums using that employee's wages pre-taxation
- At first, plan was a great success
  - It resulted in a spike in the number of people with coverage

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Commonwealth Care

- Two negative side effects:
  - Providers do not want to deal with the administrative "red-tape" when submitting bills to "connector plan" policies
    - Covered patients are either being refused care, or experiencing severe delays
  - Each year legislators have increased the number of mandated benefits, but have refused to raise the premium cap
- Carriers have since been forced to file lawsuits against insurance commissioner to obtain approval to raise premiums

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Commonwealth Care

- BCBS of MA and 5 other local, not-for-profit health plans and the MA Assn. of Health Plans filed legal action against MA Division of Insurance
- Complaint seeks a court trial and immediate injunction that would prevent the Division of Insurance from implementing or enforcing its decision to disapprove premium rates
- Slowing the unacceptable rise in premium increases will only happen when we lower the costs, which drive those premiums…

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Benefit Plans & Self Funding

Benefit plans can be funded in one of two ways - Insurance is either purchased or self-funded

The difference between insurance and self-funding has to do with risk:

- Employers that purchase insurance pass the risk of loss onto their insurance carrier
  - If someone is seriously injured, and medical expenses exceed premiums, the insurance carrier pays the difference
  - If no one is seriously injured, the insurance carrier keeps the premiums and wins the gamble
  - Regardless, the employer simply pays premiums
- A self-funded plan pays its own claims, and merely hires a third party administrator to process claims with the benefit plan sponsor's money
- The risk of loss is on the sponsor… not an insurance carrier

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Benefit Plans & Self Funding

- Employers are not limited to two choices - dropping coverage and paying fines or paying more for private coverage; self-funding – remains a great option for employers
- Personalization and cost-efficiency of self-funding looks advantageous compared to government run exchanges that limit personalized options and increase costs
- Projections already suggest that while fully insured carriers will increase costs by 30% to 50% over the next 4 years, self-funded plans will see a much slower rise in costs - 5% to 10% during the same length of time
- While it has always been true that large companies are ideal for self-funding now small and mid-size employers are self-funding in record numbers
  - PricewaterhouseCoopers reported that self-funding by smaller companies has jumped by as much as 20% between 2008 and 2010

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Benefit Plans & Self Funding

Claims Processing

- New emphasis placed on how claims are processed
- Administrators have seen many courtroom losses attributable to sloppy claim adjudication
- Administrators are beginning to update their claims payment procedures and are more cautiously proceeding with claim review, as well as detailed notices of adverse benefit determinations

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Benefit Plans & Self Funding

Fiduciary Duty

Plan Sponsors (known as Plan Administrators) have a fiduciary duty to administer their benefit plans in strict accordance with the terms of their benefit plan documents.

Failure to prudently manage the plan assets and adhere to the terms of the plan document expose plan administrators to claims of breaching their duty, and being sued by their plan members.

As such, plan administrators are questioning everything, pinching pennies, and exposing plan participants to the costs benefit plans once took on the chin.

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Benefit Plans & Self Funding

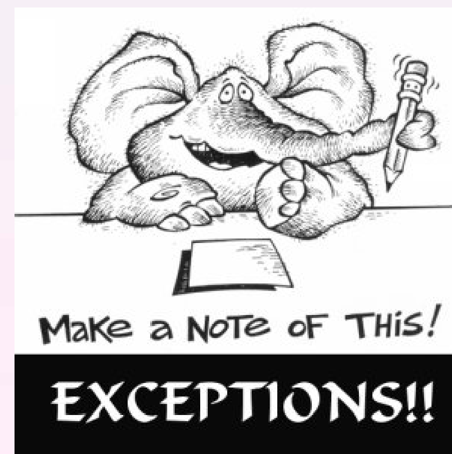
Plan Language… Plan Intent:

Exclusions

- Felonious Acts vs. Illegal / Criminal Act
  - DUI example
- Workers Compensation vs. Occupational Injury
  - Ranch example
- Eligible Charges
  - U&C vs. PPO

“Exceptions” to the Exclusions:

✓ Result of Domestic Abuse
✓ Suffers from a Medical Condition



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BENEFIT PLANS & SELF FUNDING

Usual and Customary

The Plan Has the Discretionary Authority to Decide if a Charge is Usual & Customary

- Medical Necessity is Determined by Other Providers in the Area.
- Classic: Plans Limit U&C to Charges Roughly Equivalent to Those Charges Billed by Similar Providers, Providing Similar Services, in a Similar Locale
- Recent Trend: Other Pricing Benchmarks (MSRP, CMS, Usual Pricing Regardless of Payer by Provider)

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Benefit Plans & Self Funding

Reasonableness:

The Plan Has Discretionary Authority to Decide if Services and Procedures are *Reasonable*

(What's the difference between U&C and Reasonable?)

- Plans Only Pay For Services or Supplies Necessary for Treatment.
- Fees Must Comply With Generally Accepted Billing for Unbundling.
- Treatment of Errors That are Clearly Preventable, are Not Reasonable.

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Benefit Plans & Self Funding

Tier 1 – Certain Never Event That is Clearly Preventable

- Example: Surgery Performed on the Wrong Body Part

Tier 2 – Less Certain Never Event Due to Facts of Case

- Example: Diabetic Coma

Tier 3 – Least Certain Never Event Associated With the Original Treatment

- Example: Post-Operative Infection

Unlisted Never Event

- Provider Errors Not Recognized
- Example: Infant Discharged to the Wrong Person

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BENEFIT PLANS & SELF FUNDING

What is "Stop-Loss"?

Gaps in coverage

- Charges in excess of the usual and customary ("U&C") amount are excluded
- Plan defines U&C based upon what other providers in the area charge
- Reinsurance policy defines U&C based upon average wholesale, MSRP, CMS pricing, etc.

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PPO Conflicts

Pay per the PPO or Stop- Loss…

A Rock and a Hard Place

SPD & Stop Loss → TPA & Plan ← PPO & Provider

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PPO Conflicts

PPOs once delivered real value to benefit plans …

- Plan participants have since demanded that PPOs be expanded to include all providers…
- Exclusivity of "in-network" status is gone
- Networks lost their bargaining chip

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PPO Conflicts

What has *Baylor* done? (The last straw)

- The PPO agreements have always been written for the fully insured marketplace, even though the TPA isn't a payor
- TPAs are no longer signing PPO agreements as payors and having plans take on the risk of liability if a claim is underpaid to a provider, under a PPO contract or if payment is made late
- Some of largest health insurers are chopping away at their massive networks, and developing smaller networks of physicians and hospitals
- By shrinking their networks to include only a few providers – making them "exclusive" again, premiums are dropping by up to 15%!

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PPO Conflicts

Alternative options to PPOs?

- Does the TPA protect the plan against the network provider, and honor the PPO terms… or… does the TPA enforce the terms of the plan document, even if it means breaching the network agreement?
- Does the plan forgo its right to review the claims to secure what it hopes to be a fair discount, or does the plan audit the claims and ensure only covered amounts are paid?

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PPO Conflicts

- Transparency under health care reform is making access to real data better than ever
- Number of vendors providing detailed information to assist in determining usual and customary rates, as well as the wholesale price and invoices for implants
- Detailed pricing information along with revamped plan language is making the option of utilizing cost plus pricing instead of a basic PPO program a much more popular alternative
- Many vendors are peddling services to plans - services that grant plan administrators access to millions of lines of data against which claims can be compared and bills can be audited

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PPO Conflicts

- Other options involve payment based upon Diagnosis Related Groups ("DRG"); Medicare-Plus, whereby a plan pays what CMS pays, plus a set percentage

- Some are dropping networks altogether and utilizing out of network pricing for all, based upon MSRP, retail pricing, wholesale costs, actual costs to the provider, amounts charged by other providers for the same service, amounts charged by this provider to other payers, etc.

- Plans will do even more to ensure that everyone (provider, network, and carrier) knows how they handle claims before they are received

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PPO CONFLICTS

AOB is consideration… feel free to return the check!

In Exchange for Providing Services, the Provider has Two Options:

1) Bill the insured for services and the insured is responsible for payment.
   - Insured submits the bill to insurer, and the insurer compensates the insured for the fair market value of their loss.

2) Provider accepts from the insured – as consideration in full for the medical services provided – an assignment of benefits.
   - Provider only entitled to what the insurer determines is the fair market value of the loss, exactly as the insured was only entitled to the fair market value of the loss.

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Conclusion… The "Unknowns"

- How much will health care reform backlash affect implementation?
- What will be the specifics of various implementing regulations?
- Will the economy pick up steam or not?
- What will insurance companies do based on the rules and requirements imposed on them throughout health reform?
- Will they leave the health market? Is it possible that the health insurance business will be unprofitable by 2014?

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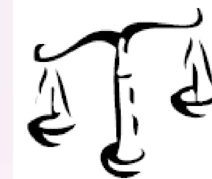

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