

EMERGING ISSUES IN PRIVATE INSURANCE

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Emerging Issues

- Health Care Reform
 - Provider Non-Discrimination - Interpretation
 - Contracting
- Market Trends
 - Provider Consolidation
 - Alternative payment methodologies
- Medicare Advantage
 - Audits
 - Benefits
 - Network streamlining

Non-discrimination under ACA

- 42 U.S.C. §300gg-5(a) “A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.”

Non-discrimination under ACA

- Shall not require that a group health plan or health insurance issuer contract with any provider willing to abide by the plan or issuer's terms and conditions for participation.
- Shall not prevent a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

Applicability

- Applies to self-insured employee health benefit plans, group health insurance, and individual health insurance.
- Includes individual and small group products sold through the exchanges and to the Basic Health Plan.
- It would not apply to grandfathered plans, Medicaid or Medicare.

Guidance Regarding Non-Discrimination

- CCIO issued an FAQ stating that the Departments would not be issuing regulations addressing PHS Act section 2706(a) prior to its effective date.
- Said the statutory language of PHS Act section 2706(a) is self-implementing and the Departments do not expect to issue regulations in the near future.
- Group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law.

Guidance regarding non-discrimination

- To the extent an item or service is a covered benefit, and consistent with reasonable medical management techniques specified under the plan, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.
- This provision does not require plans or issuers to accept all types of providers into a network.
- This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

State Interpretation

- Colorado
 - Benchmark plan excluded chiropractic services and services of chiropractors.
 - Division of Insurance issues a memo concluding:
 - The exclusion listed in the EHB benchmark plan of “services provided by a chiropractor” is no longer a valid exclusion, as it discriminates against a provider acting within the scope of his/her license.
 - Carriers should clearly identify what services are and are not covered, and may not define the scope of coverage by reference to a specific provider type.
 - Carriers are not required to include all types of providers in their networks. Carriers may include any type of care provider (acting within the scope of their license or certification), including chiropractors, in their network to provide treatment or services that are part of the EHB package or other benefits as long as they maintain required network adequacy standards.

Health Care Reform: Contracting

- Podiatrists will need to consider whether they wish to participate in health plans offered through the exchanges or with Medicaid health plans.
- They will also look at their existing contracts to determine if they may already be obligated to participate in such health plans.

Network issues

- Using smaller networks of “most efficient” providers.
- Plans have already undergone review for network adequacy.
- States that have not opted to expand Medicaid may do so in the future.

Medicaid Expansion Benefits

- States can choose Medicaid benefits, Benchmark coverage or Benchmark equivalent.
- Any package must cover essential health benefits.
- Can choose different packages for different populations.
- Non-discrimination does not apply.

Market Trends

- Massachusetts as a model.
- Transition to alternative payment methodologies.
 - 3 largest commercial insurers in Mass have majority of commercial HMO members covered under global payments.
 - Bill passed in 2012 to increase efficiency and transparency.

2012 Mass. Legislation

- Requires commercial and state funded insurance programs to transition to alternative payment methodologies to the maximum extent feasible.
- Medicaid must move to 80 percent by 2016.
- Contracted rates must be made available on request to other providers with whom they've entered an alternative payment contract.
- Malpractice reform.

2012 Mass. Legislation

- Provider organizations will have to register with the state.
- Provider organizations taking on downside risk will have to be issued a risk certificate by the DOI.

Massachusetts

- Tiering – required the offering of a tiered network for the small group market.

Provider Consolidation

- Hospitals buying practices.
- Provider organizations accepting risk.
- Could affect referral streams.
- How are podiatrists faring in this environment?

Medicare Advantage

- 558 Medicare Advantage contracts.
- Over 14 million enrollees.
- Some pullback in rural areas.

Cause and Effect

- Payments decreases =
 - Increased pressure to ensure diagnostic data is captured.
 - Increases in cost sharing under the plans.
 - Increased utilization control mechanisms.
 - Desire to streamline networks.
- Quality provisions=
 - Increased focus on obtaining quality data.
- MLR requirement=
 - Focus on lowering administrative costs.

Medicare Advantage

- APMA has been getting questions regarding:
 - Coverage in instances in which there is concern that the plans are not covering the same benefits as Medicare FFS;
 - Termination from networks; and
 - Record requests/audits.

Termination

- MAOs are required to provide written notice of termination.
- MAOs are required to have a process for providers to appeal network participation decisions.
- As long as MAOs continue to meet network adequacy requirements, CMS has no authority to get involved.

Coverage

- Is it a payment issue or a coverage issue?
 - MAOs must cover at least the same benefits as FFS Medicare.
 - Not required to pay contracted providers the same as FFS Medicare.
 - May add utilization review requirements not present in FFS Medicare.

Termination

- Physicians may wish to send letter to their members.
 - If plan has out of network option, explain.
 - Provide entire list of other MAOs with which you contract.

Record Requests

- Is physician a network or non-network provider?
- What is the purpose for the request?
 - Diagnostic data?
 - Confirming services are medically necessary?
 - Other?
- If network, does contract provide for payment?

Record Requests

- Non-contract physicians may ask for payment for records provided for quality or diagnostic data purposes
- Like under FFS, when issue is medical necessity, physicians must furnish data or face denial.

Dual Eligible Demos

- Dual eligible demos are drawing both old and new players to the market.
- Fifteen states – CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI
- To the extent the state uses a managed care system, there may be facilitated enrollment in plans.
- Not technically Medicare Advantage plans but will operate under some of the same rules.
- Organizations with Medicare Advantage contracts are participating in the demos.

Questions?