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PHIA
GROUP**


EMPOWERING PLANS

A Network by Any Other Name


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PGCReferral: May 2017's Most FAQ

- Does Cal COBRA (i.e., California COBRA) apply to a large self-funded employer that has multiple office locations, including an office in California?
- If a Massachusetts employer has an approved general leave of absence in their handbook with a specific duration, can this general leave be utilized to address leaves required by employers in Massachusetts, including Domestic Violence, Small Necessities, jury duty, and/or ADA, or does the employer need to list each type of leave specifically?
- How do the non-discrimination rules under Section 1557 work in tandem with the preventive care guidelines to pay certain services at 100%? For example, there are a number of services on the USPSTF A and B Recommendation list that are gender specific. Would it violate Section 1557 to cover a bone density screening for a woman over the age of 65 at 100% but to cover for the same screening at deductible/coinsurance for a man over the age of 65?



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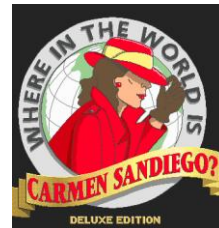
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Where Is The Senate Bill?



- **The Senate Bill Is Shrouded In Secrecy**
 - No public hearings. Only private meetings involving ~12 senators.
 - Sen. Rand Paul (R-Ky) asked, "[W]ill you send me a copy?"
 - This is unusual.
 - This is a risky political move.
- **Why Does This Matter For Our Industry?**
 - Key stakeholders are not involved in the process.
 - Might not be a chance to voice opposition.
 - Polling shows AHCA is deeply unpopular.
- **...An Outline Leaked To The Press.**



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Better Care Reconciliation Act of 2017 (“BCRA”)



- Discussion Draft Release Just 2 Hours Ago
- What’s In It?
 - Repeals the individual and employer mandate.
 - Elimination of EHBs?
 - Preserves protections for those with pre-existing conditions.
 - Medicaid expansion phased out starting in 2021 (also cut Medicare budget).
 - No penalty for those with breaks in coverage (unlike AHCA).
 - Age-based subsidies preserved.
 - Delays Cadillac Tax until 2026.
 - Changes 1332 Requirements – redefines what counts as offering “affordable coverage.”
 - Many ACA taxes repealed (on investment income, healthcare CEOs, tanning, medical device)



What’s Not In It?



(b) SUNSET OF ESSENTIAL HEALTH BENEFITS REQUIREMENT.—Section 1937(b)(5) of the Social Security Act (42 U.S.C. 1396n–7(b)(5)) is amended by adding at the end the following: “This paragraph shall not apply after December 31, 2019.”.

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When To Expect A Vote



- “It’s like having a baby,” said Senate Majority Whip John Cornyn (R-TX). “It’s not here yet, but it’s coming.”
- A public copy and CBO are not expected until days before the vote
- Senate Minority Leader Chuck Schumer (D-NY) wants all-Senate meeting next week on healthcare
- Senate Maj. Leader Mitch McConnell (R-Ky) wants a vote as soon as July 4th recess, but no later than July 31st
- Rs have 52 seats → can only lose 2 senators (VP Pence is the tie-breaker)





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Alternative Provider Arrangements



- **Up-front transparent pricing**
 - Not always the lowest prices – but there's value in transparency
- **Subscription-based direct primary care (DPC)**
 - Some limited, some virtually unlimited
- **Value-based pricing**
 - A step in the right direction...

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Alternative Provider Arrangements



- Accountable Care Organization
 - It's not just benefit plans that coordinate
- Medical tourism: domestic or international
- On-site clinics, telemedicine, "centers of excellence"



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Reference-Based Pricing



...as explained by Arnold Schwarzenegger




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Reference-Based Pricing







“Commando”

ALL providers reimbursed at reference price


No contracts...no mercy.





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Reference-Based Pricing







“Junior”

Physician-only network, with RBP for facilities


This OB won't BB.





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Reference-Based Pricing







"The Terminator"

Direct contracts with certain providers


Balance-billing can be terminated.





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Reference-Based Pricing







"The T1000"

Narrow network underlying RBP


Balance-billing can be terminated...more.





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Reference-Based Pricing



“Twins”


Direct primary care
underlying RBP

*Money talks, and
balance-billing walks.*



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Reference-Based Pricing



“Predator”

Applying RBP to only
certain high-cost services

*Get to the medically
necessary choppah!*



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Direct Contracting



- Single-provider contracting
 - Can be very useful in certain geographical areas
 - High claims dollars can help incentivize a contract
- Direct contracting & RBP: like cookies and milk
- Many contracts → “informal” narrow network
- What about a “formal” narrow network, though?
 - Careful of state network formation laws!



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Avoiding the Creation of a Network...



- This can happen “accidentally”
- Some TPAs amass lots of contracts...the intuitive thing is to lease access to other entities.
- State laws include credentialing, “any willing provider,” taxes...



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...But...Requiring the Creation of a Network?



➤ ACA FAQs, Part 31 – Question #7 (May 2016)

- If a non-grandfathered large group market or self-insured group health plan has a pricing structure in which the plan pays a fixed amount (sometimes called a reference price) for a particular procedure, **but the plan does not ensure that participants have adequate access to quality providers that will accept the reference price as payment in full**, is the plan required to count an individual's out-of-pocket expenses for providers who do not accept the reference price **toward the individual's MOOP limit?**



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...But...Requiring the Creation of a Network?



➤ Answer: YES.

- “A plan that merely establishes a reference price without using a reasonable method to ensure **adequate access to quality providers at the reference price** will not be considered to have established a network for purposes of PHS Act section 2707(b).”
- “...a non-grandfathered plan that utilizes **reference-based pricing (or similar network design)** may treat providers that accept the reference based-price as **the only in-network providers** for purposes of determining what counts towards an individual's MOOP limit as long as the non-grandfathered plan uses a reasonable method to ensure that it provides **adequate access to quality providers at the reference-based price.**”




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Ensuring the Plan Document Supports the Model




- PLAN LANGUAGE!
- PLAN LANGUAGE!
- Oh, and... **PLAN LANGUAGE!**










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Analyzing other Contracts to Avoid Conflicts



- Check your PPO contract!
 - Does it allow direct contracting?
 - Does it allow the plan to pay non-network claims at 100%?
 - Does it prohibit negotiation with in-network providers?
- Check your ASA (or ASO agreement)!
 - Does it support medical tourism?
 - How does it treat price transparency?
 - Will the claims administrator help patients shop around?

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Incentives: Employer vs. Plan?



- Phia story: Phia employee and spouse got gastric bypass surgery; they received check for \$4,300 by consulting with HR to find lower-cost, high-quality providers
 - Price difference between providers was \$9,000 per surgery!
- Incentives should generally be paid by employer
- Language should support the program and be as specific as possible without handicapping employer
 - Even though paid by *employer*, language should be in *SPD*



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Biggest Pains in the Industry



- Dialysis
- Air ambulance
- Specialty drugs
- Excessive & egregious out-of-network charges



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The Big Heist



“The Big Heist will transform the public's understanding of healthcare's problems/fixes.”

A nation divided over how to manage healthcare. Some byproducts of that include:

- Johns Hopkins: medical error estimated to be 3rd leading cause of death
- Dialysis charges exceeding 1,500% of Medicare
- Air ambulance flights billed at \$700,000
- 63% more incur over \$50,000 in drug claims per year than in 2014



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