"CREEPING AROUND PITFALLS ON THE WAY TO SCARY SAVINGS!" – HOW TO AVOID HORROR WHEN IMPLEMENTING COST CONTAINMENT SCHEMES!!!

THE PHIA GROUP

EMPOWERING PLANS

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THE 411 ON THE FAQ – IS RBP DOOMED?

Intro:

May 2, 2014 FAQ

- Any portion of the reference based price (the "maximum payable amount" as defined by the RBP plan) that a member pays should indeed count toward any MOOP limit, but any amount above the plan's allowed amount does not need to be counted toward the MOOP limitation; provided the plan uses a **reasonable** method to ensure that it offers adequate access to quality providers.

- Ex. If plan covers 75% of the RBP payable amount and the participant pays the remaining 25%, the 25% counts against the MOOP; but any amount charged by the provider in excess of the RBP (and balance billed to the patient), would not apply.

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THE 411 ON THE FAQ – IS RBP DOOMED?

Intro:

Concern – Does the recent October 10, 2014 FAQ XXI eliminate Reference Based Pricing ("RBP")

Industry Feedback – "It doesn't apply to us" through "We're doomed!"

Consensus – RBP is not dead, but we need to tread carefully...

- Emphasis on Provider Relations
- Emphasis on Participant Education
- Emphasis on Intent vs. Effect of the FAQ

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THE 411 ON THE FAQ – IS RBP DOOMED?

Intro:

- Emergency Balance Goes Toward MOOP
  - Automatically provide information regarding pricing structures
  - Upon request:
    - List of services to which RBP applies
    - List of providers that will accept a negotiated price above the reference price for each services
    - Info on process & data used to ensure adequate number of providers accepting the referenced price meet reasonably quality standards

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THE 411 ON THE FAQ – IS RBP DOOMED?

Defining Reference Based Pricing

- Three RBP Programs
  - Network with Underlying Carve Out – Fixed Prices for Fixed Procedures
  - Hybrid – RBP with Underlying Network
  - Pure – RBP with No Network; Possibly Direct Contracts

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THE 411 ON THE FAQ – IS RBP DOOMED?

Defining Reference Based Pricing

- "If a large group market coverage or self-insured group health plan has a reference-based pricing structure, under which the plan pays a **fixed amount** for a particular procedure…"

- Appears to refer directly to a plan the California Public Employee's Retirement System ("CalPers") Plan, which has a PPO but pay a single, fixed amount, for particular services, to in-networks providers (below the negotiated price).

- Goal of FAQ? – Prevent plans that have negotiated rates with in-network providers from imposing fixed, reference based payments for certain services, on those providers.

- Classic RBP isn't "Fixed" – Medicare payment systems vary payment by provider and are based on an individual provider's costs, clinical factors such as complications, and extremely difficult acute-care cases.

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THE 411 ON THE FAQ – IS RBP DOOMED?

Scope of Impact – Intended or Unintentional

- Scope seemingly meant to be limited to scenarios wherein a payer has executed a network agreement with providers, but identifies a particular service to which it applies a fixed, lesser, reference based payable rate.

- FAQ – repeatedly hints that to be an RBP Plan within purview of FAQ Review – must have:
  - fixed prices, for certain services; and,
  - a network

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THE 411 ON THE FAQ – IS RBP DOOMED?

Target, or Collateral Damage?

- Agencies seem fixated on options for patients that involve no balance billing
  - So target network plans; (albeit small networks)…
  - But condone Plans that potentially expose patients to balance billing every time? (No network)
    - If not a target now, will be soon!?!?

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THE 411 ON THE FAQ – IS RBP DOOMED?

“Network Verbiage” – When A Network Isn’t

- FAQ indicates that its scope extends only to plans utilizing networks, where it references “network adequacy.”

- "... providers that accept the reference-based price as the only in-network providers and excludes or limits cost-sharing for services rendered by other providers is using a reasonable method to ensure adequate access to quality providers at the reference price…”

- The FAQ seems to envision RBP plans with “networks” of providers that accept the reference-based price; and exclude the cost-sharing for services rendered by other providers.

- How do we avoid creating networks, but also proceed under the assumption that RBP plans must secure reasonable access for patients; enabling their ability to secure quality care without fear of balance billing?

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THE 411 ON THE FAQ – IS RBP DOOMED?

"Network Verbiage" – When A Network Isn't

- A network is different than maintaining a list of "safe-harbor providers" that accept a reference-pricing method.

- RBP plans need to identify valuable non-monetary consideration to incentivize provider cooperation, without setting up a so-called network; with a fixed set of rules and compensation schedules.

- The Interim Final Rule (to which the FAQ applies):

  - "... refer to providers both in terms of their participation (participating provider) and in terms of a network (in-network provider)."

  - The Secretary's formal definition of "Network plan" from the 45 C.F.R. § 144.103, states:

  - "... the financing and delivery of medical care are provided through a defined set of providers under contract with the issuer."

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THE 411 ON THE FAQ – IS RBP DOOMED?

To "Accept", or Not to "Accept"

- "...providers that accept the reference-based price..." -and- "...an adequate number of providers that accept the reference price..."

- Does it mean "providers that accept the reference-based price from one or more payers, in general..." or, "providers that accept the reference-based price from this particular plan or payer?"

- If "providers that accept the reference-based price" actually means "providers that accept the reference-based price from one or more payers, in general," then (given the fact that most providers accept Medicare+0% from CMS as payment in full), a plan paying Medicare+40% can say, "Not only do most providers accept Medicare+40%, they usually accept less!"

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THE 411 ON THE FAQ – IS RBP DOOMED?

To "Accept", or Not to "Accept"

- Most RBP plans pay a percentage of Medicare—usually somewhere between 120% and 180%. A very substantial percentage of Medicare patients (96%) report having ready access to physicians who accept Medicare.
    - Source: The Henry J. Kaiser Family Foundation, Medicare Patients' Access to Physicians: A Synthesis of Evidence (Dec. 10, 2013), http://kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/ (last visited Oct. 19, 2014).
- More than 4,800 hospitals around the country accept Medicare patients.
    - Source: Data.Medicare.gov, https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/xubh-q36u (last visited Oct. 19, 2014)

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THE 411 ON THE FAQ – IS RBP DOOMED?

It's All About the MOOP

- Most demanding interpretation of the FAQ indicates that amounts balance billed to patients in excess of the reference based price would NOT be counted toward the MOOP, if the plan uses a reasonable method to ensure that it offers adequate access to quality providers, who accept the RBP amount as payment in full, from this particular payer.
    - So, is RBP plan choosing not to follow FAQ "illegal"? – NO!!!
    - But amounts balance billed by providers in excess of reference based price (paid by the plan) WILL be counted toward MOOP
    - FAQ irrelevant if RBP plan administrator can manage an RBP plan and avoid having their participants be balance billed $6.6K/$13.2K

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THE 411 ON THE FAQ – IS RBP DOOMED?

It's All About the MOOP

- What You Need to Succeed!
  - Competent patient advocacy process
  - Balance billing response procedure
  - Centers of excellence incentivized to accept RBP as payment in full
- But remember - $6.6K/$13.2K MOOP limit impacts provider incentive to negotiate
- Assignment revocation impact weakened

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THE 411 ON THE FAQ – IS RBP DOOMED?

Recap – What Have We Learned?

- RBP as we know it - still possibly below the legislative radar;
- But RBP adopters should see this as evidence of the legislative intent …
- Design program to ensure access to providers that will accept (formally) the referenced based benefits, while avoiding a network?

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THE "SKINNY" ON MINIMUM VALUE PLANS

Minimum Value Plans - Experts up in arms … But mum is the word from the Regulators – For Now!

- Does Your Plan Offer Minimum Value?
  - Figuring Out the Calculator – You Can Do What?!??!
    - Providing minimum value with no hospital coverage!?
  - Not the Only Way!
    - Utilize an actuary to determine when plans contain non-standard features
    - Plans can use the design-based safe harbor checklists

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THE "SKINNY" ON MINIMUM VALUE PLANS

Minimum Value Plans ("MV Plans")

- Potential Implications
  - By the employer stating that a plan meets both the affordability and minimum value requirements of the Employer Mandate, employees will not qualify for a subsidy on the Marketplace (Federal or State).
  - Employers should use a good faith interpretation of the IRS guidance, as the IRS is the agency that will levy the tax penalties for employers that do not comply with the Employer Mandate.
  - Potential liability for lawsuits under ERISA if employers do not perform their due diligence and give information to their employees that is correct.
  - **If the Administration does make revisions to the MV Calculator before the end of the year, it is not clear that there will be any protection/transitional relief to employers who used the old calculator for their 2015 Skinny/Minimum Value plan. Employers should also note that any new guidance issued may affect the MV calculations for all plans.**

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DIALYSIS CARVE-OUTS & THE MEDICARE SECONDARY PAYER ACT

Dialysis Hot Button Issue:

Question – Can a plan reimburse Medicare premiums to its participants?

Issue – Vendors and experts vary in their opinions...

Answer – Depends on risk aversion and willingness to deal with the consequences if wrong!

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DIALYSIS CARVE-OUTS & THE MEDICARE SECONDARY PAYER ACT

Please... Stop...

- Dialysis Carve-out Language Specific to End-Stage Renal Disease (“ESRD”) or Medicare Enrollees Only
- Violates the Medicare Secondary Payer Act (“MSPA”)
- The Balance Billing Conundrum

Quality Incentive Program

- The Medicare ESRD Quality Incentive Program ("ESRD QIP") Applies as of January 1, 2015
- Dialysis Facilities will Receive a Total Performance Score (“TPS”) based on its performance.
- TPS will Adjust Amounts Paid by Medicare.
- “Medicare+” For Dialysis? Need To Know The Facility's TPS
- SPD Needs to Be Open
- Need Good Source of Data

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DIALYSIS CARVE-OUTS & THE MEDICARE SECONDARY PAYER ACT

Medicare Premiums Reimbursed ... Okay?

- The MSPA prevents discrimination based on ESRD status and prohibits incentivizing enrollment in Medicare; [the ant kickback law ("AKL")]

- The AKL statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.

- The question... Can a Plan include financial incentives, such as reduced cost-shares and Medicare premium payment, for beneficiaries who have ESRD to apply for Medicare coverage?

- The immediate response... This is a differentiation of benefits in violation of the MSPA, "takes into account" the beneficiary's Medicare eligibility and ESRD diagnosis, and violates the AKL.

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DIALYSIS CARVE-OUTS & THE MEDICARE SECONDARY PAYER ACT

Medicare Premiums Reimbursed ... Okay?

- Complicating matters... The HHS Inspector General posted on November 14, 2013 OIG Advisory Opinion No. 13-16 regarding a health insurer's proposal to pay the Medicare Part B premium costs for Medicare-eligible individuals with ESRD

- "This advisory opinion is issued only to the requestor of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity."

- "Requestor would offer to pay the Medicare Part B premiums for every Group Enrollee with ESRD who qualifies for, and wishes to enroll in, Medicare..."

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DIALYSIS CARVE-OUTS & THE MEDICARE SECONDARY PAYER ACT

Medicare Premiums Reimbursed ... Okay?

- "The Requestor certified that in no case would it pressure, require, or otherwise unduly influence or coerce Group Enrollees with ESRD to enroll in Medicare Part B."

- "The Proposed Arrangement clearly is intended to influence Group Enrollees with ESRD to enroll in Medicare Part B; indeed, the subsidy is contingent on such enrollment."

- "We recognize that the Proposed Arrangement likely would result in increased costs to the Medicare program, particularly once the Coordination Period expires and Medicare becomes the primary payor."

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DIALYSIS CARVE-OUTS & THE MEDICARE SECONDARY PAYER ACT

Medicare Premiums Reimbursed ... Okay?

- "However, any increased costs to the Medicare program would result from a Group Enrollee's decision to enroll in Medicare Part B—an entitlement program for which the Group Enrollee with ESRD qualifies."

- "Bearing in mind that Group Enrollees with ESRD are entitled to Medicare benefits, for a combination of the following reasons, we conclude that the Proposed Arrangement presents a minimal risk of fraud and abuse."

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DIALYSIS CARVE-OUTS & THE MEDICARE SECONDARY PAYER ACT

Medicare Premiums Reimbursed ... Okay?

- "We express no opinion regarding whether the Proposed Arrangement would violate: (1) CMS's regulations at 42 C.F.R. § 411.102(a)(1)(i), which prohibits a group health plan from taking into account the ESRD-based Medicare eligibility or entitlement of any individual who is covered or seeks to be covered under the plan, and 42 C.F.R. § 411.102(a)(1)(ii), which prohibits a group health plan from differentiating in the benefits it provides between individuals with ESRD and other individuals covered under the plan, on the basis of the existence of ESRD, or the need for dialysis, or in any other manner; or (2) the Medicare Secondary Payer provisions at section 1862(b) of the Act, as amended, or its implementing regulations."

- Yet, the Advisory Opinion states that it is addressing "... individuals with End-Stage Renal Disease ("ESRD") who are enrolled in a group health plan offered by the insurer"

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