Narrow Network Offerings - Market and Contracting Implications

This Roundtable is brought to you by the Accountable Care Organization Task Force
(a joint endeavor of all sixteen AHLA Practice Groups).

May 20, 2013 · 12:00 - 1:15 pm (Eastern)

Presenters

John Foley
Vice President for Health Services • Anthem Blue Cross and Blue Shield of Wisconsin • Milwaukee, WI

Tracey L. Klein, Esquire
Attorney and Shareholder • Reinhart Boerner Van Deuren SC • Milwaukee, WI • tklein@reinhartlaw.com

Gerald W. Frye, CLU, ChFC, RHU, REBC, CASL
President • The Benefit Services Group Inc. • Pewaukee, WI • gerald.frye@bsg.com

Moderator

Paul Van Den Heuvel, Esquire
Associate General Counsel • Marshfield Clinic • Marshfield, WI • vandenheuvel.paul@marshfieldclinic.org
Roundtable Outline

- Overview of Anthem Blue Cross and Aurora Health Care Narrow Network Arrangement
- Legal Implications to Narrow Network Arrangements
- Benefit Design and Data Considerations
- Panel Discussion/Q&A
ANTHEM BLUE CROSS
AURORA HEALTH CARE
NARROW NETWORK ARRANGEMENT
EASY ACCESS TO A QUALITY NETWORK OF DOCTORS AND HOSPITALS
What’s Blue Priority?

Accountable Care Organization network offering from Anthem Blue Cross and Blue Shield built around Aurora Health and other outstanding providers in southeast Wisconsin.

Financial Risk Sharing
Quality Benchmarking
Patient Management Collaborations

High Quality Health Care
Goal of Blue Priority

- Measurable Quality
- Affordable Care
- Integrated Care
- Excellent Patient Experience
Care Coordination

Aurora’s Fully Integrated Health Care Delivery System
Blue Priority

Network Access + Care Coordination = Financial Predictability
Aurora ready
Aurora Health Care

- The state’s largest health care provider system
- Serves 31 counties in 90 communities
- 17 hospitals
- Over 150 clinics
- More than 1,400 doctors
- State’s largest home care provider
Why worked

- Two Willing Parties
- Share Different Perspectives
- Situation Resolution Experience
- Mutual Respect
- Marketplace Need
- Trust
- Long Term Relationship
- WHIO Data

AMERICAN HEALTH LAWYERS ASSOCIATION
Care Management

**Population Health Management**
- Analyze claim data
- Review for medical necessity
- Support on-site nurse case mgmt
- Triage to other interventions

**Individual Care Management**
- Disease management
- Care coordination
- High risk conditions
- Behavioral health management

**Insurer & Employer**
- Physician
Management

Preventive Health & Wellness

Acute Care

Right Care.
Right Place.
Right Time.

Continuum of Care

Patient Safety
On-Site Nurse

Referral Source & Liaison
- Convenient access
- Appointment scheduling
- Provider recommendations
- Home visits for at-risk

Care Coordination
- Chronic diseases
- High risk conditions
- 1:1 visits
- Self-management plans
- Disease coaching

Wellness
- HRA coaching
- Blood pressure screenings
- Wellness program participant
PREDICTABILITY

(COST x UTILIZATION) + OUTCOMES = HEALTH COSTS
Financial Predictability

Efficiencies & cost savings

- Keeping healthy healthy
- Electronic medical record
- Care & disease management
- Integrated Care Model
- Preventive care
- Episode of care analysis
- Appropriate interventions
- Focus on quality
Financial Predictability

Volume

Value

Collaboration

Quality & Outcomes

Shared Savings

Health Care Spending

Savings

ACO Launch
THE RISE OF NARROW NETWORKS
Why?

- More than half opt for Narrow Network if premium reduction is at least 10%
  "Hospitals Forge New Deals With Insurers,"

Overview

• What is a Narrow Network?
• Examples of Narrow Networks
• Affordable Care Act ("ACA") Implications
• Legal and Regulatory Considerations
WHAT ARE THEY AND WHAT DO THEY DO?

NARROW NETWORKS
The Basics

- **Narrow Network**: An arrangement between an insurer and a select, smaller group of providers in an attempt to control resources and steer payments to less costly providers.

- In some ways, resembles 1990s Classic HMO model.

- Classic HMO model lost favor with public and employers because of lack of choice and/or lack of access to adequate care in late 1990s.

- In response to spiraling health care costs, insurers have developed Narrow Networks for employers seeking low cost options without sacrificing quality.

- Success of these products dependent not just on lowering the per unit price or controlling utilization, but in providing care coordination and management of population health.

- Narrow networks will offer price points that are less than open access PPOs. On average, insurers expect premiums to be 5-10% lower.
THE BASICS (cont.)

- Tiered Provider Networks or High Performance Networks. Employees pay different cost-sharing rates for different tiers of provider.
- Tiered networks are part of a larger movement to sensitize employees to the real cost of health care.
- Patients will face higher out-of-pocket costs if they don't go to the top tier of providers.
  - In contrast to narrow networks that remove providers from the network and do not cover any charges from them, tiered networks put some providers in lower tiers and force patients to pay higher out-of-pocket charges for them.
  - Both narrow and tiered networks rate hospitals and physicians based on both quality and efficiency.
How it works

- Integrated insurer/system profiles providers and designates a provider network best able to control costs and provide quality care
  - Increasing UR
  - Reducing unit cost
  - Reducing usage
  - Better care management
  - Adheres to specialty specific practical protocols
  - Monitoring of specific quality metrics, such as 30-day readmission rate and hospital complication rate
  - Goal is to lower premiums and attract low-risk members
  - Fuels consumerism by providing transparency
EXAMPLES
Former Oakland Athletic (pictured as a Yankee) Eric Chavez is the prototypical Moneyball success story.

He is one of the highest regarded players of the last decade because of his sustainable, consistent performance across numerous facets of the game.
Performance networks with aexcel (Aetna)

- Amy Oldenburg, Aetna

- Quality comes first when selecting providers for tiered networks—Then we select according to cost offering

- Aexcel-designated specialists:
  - Are part of Aetna's network
  - Meet industry-accepted practices for clinical performance
  - Meet Aetna’s efficiency standards – To become Aexcel specialist, physicians meet Aetna’s standards for clinical performance using naturally-recognized standards, such as National Quality Forum, National Committee on Quality Assurance, specialty specific metrics

- Data is paramount – Aetna uses data to develop tiered networks and adjust its benefit tiers/provider assignments/inclusions—narrow networks only as good as tracking data supporting them
  - Members can choose specialists from 12 categories without a referral
  - If use out-of-network specialists, higher out-of-pocket costs
BCBS CALIFORNIA

- BCBS-CA has developed a narrow network that includes Patient Centered Medical Home ("PCMH") for patients with chronic conditions
  - Cancer
  - Diabetes
  - ESRD/chronic kidney disease
  - Heart failure
- Members who choose to participate in PCMH receive lower out-of-pocket costs
- PCMHs reflect an additional means of cost savings with the goal of increased quality
HEALTHNET/BANNER

- After reviewing data on Arizona providers, HealthNet contracted exclusively with Banner Health

- Employers selecting ExcelCare will have a premium savings of about 20% when compared to the most popular PPO option

<table>
<thead>
<tr>
<th></th>
<th>Statewide HMO</th>
<th>Silver Network</th>
<th>Bronze Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs</td>
<td>13,166</td>
<td>7,500</td>
<td>1,900</td>
</tr>
<tr>
<td>Specialists</td>
<td>38,900</td>
<td>16,490</td>
<td>3,950</td>
</tr>
</tbody>
</table>
LOWE'S/PEPSICO

- Lowe's contracts with Cleveland Clinic
- Under the contract, Lowe's will fly any employee to Cleveland Clinic for cardiac surgery
- Lowe's pays for travel, hotel and meals
- Cost expected to be the same as if employee received care with local network
- PepsiCo has similar arrangement with Johns Hopkins
INOVA

- Embarked on strategic planning process and determined need for an Inova health plan
- Five major players in Missouri insurance market – no dominant player, but Blues the most dominant
- Knew they needed an insurance partner—started with a provider-owned insurance company, but chose Aetna after RFP process (good network, longstanding business partner)
- Inova brings the capital, Aetna brings the members—50/50 joint venture
- Joint venture entity just received insurance license in Virginia
- Partnership will participate on the health insurance exchange
INTANGIBLES OF PICKING RIGHT PARTNER

In *Moneyball*, Oakland GM Billy Beane passed on Prince Fielder because he did not adequately consider the limitations of his assumptions with adequate creativity.

If you don't think about a Narrow Network as creatively as Inova, you run the risk of losing similar opportunities at the ground floor.

**NB:** Fielder went on to sign a historic contract with the Detroit Tigers some years later.
Ridgeview Connect – A community health network strategy

- Ridgeview Medical Center is a community-based health system 30 miles southwest of Minneapolis.
- Developed private health exchange.
- Narrow network consisting of Ridgeview "Friends & Family".
- Insurance exchange portal.
- Leverage Ridgeview low cost position.
- Essentially establishes narrow network by contract with Medica Health Plan and using health insurance exchange portal for price/quality comparisons.
- Contracts with Medica Health Plan as an insurance partner.
SCOTT & WHITE HEALTH PLAN

- Scott & White Health Plan is the insurance arm of a six-hospital system
  - Plans to pursue new entrants to the health insurance marketplace on HIX through provider-owned insurance company
  - Views new insurance markets as an opportunity to expand their primary business, which is health care
  - Relies on narrow network to channel patients to their own facilities
  - Gain more business in their primary business (health care) because of lower insurance premiums
SMART E NETWORK

- Developed by Imagine Health and Towers Watson in Metro Chicago
- Building custom networks for large employers
- Smart E Network offers discounts to employers for seeking care at a select number of hospitals and physician groups
- Towers Watson in the midst of two-month feasibility study with five metro Chicago employers with 5,000 each
- Annual savings of $1,500 per employee per year projected
- Out-of-pocket costs projected to be ½ of traditional open access PPO
aca and narrow networks

ACA IMPLICATIONS
HEALTH INSURANCE MARKETPLACE BASICS

• Enrollment - Premium subsidies and tax credits
  • Most people with incomes under 138% of poverty. For people with somewhat higher incomes (up to 400% of poverty), ACA provides tax credits that reduce premium costs. People with incomes up to 250% of poverty also are eligible for reduced cost sharing (e.g., coverage with lower deductibles and copayments) paid for by the federal government. The premium tax credits and cost-sharing assistance will begin in 2014.
  • The amount of the tax credit that a person can receive is based on the premium for the second lowest cost silver plan in the exchange and area where the person is eligible to purchase coverage. A silver plan is a plan that provides the essential benefits and has an actuarial value of 70%.
  • The amount of the tax credit varies with income such that the premium that the premium a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income.
NARROW NETWORKS AND HEALTH INSURANCE MARKETPLACES

- Health insurance marketplaces will initially provide coverage to individuals.
- Cost and quality metrics will be vary transparent on health insurance marketplace portals.
- Only qualified health benefit plans ("QHP") can be sold in the health insurance marketplaces.
- The essential health benefits package offered QHPs must include specific coverage categories and certain cost share standards.
- QHP must include benefits over the 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- Provider networks must contain a sufficient number and type of providers to ensure services reasonably available without delay, including mental health and substance abuse.
- Premium ratio cap 3:1.
- Federal and State regulators will be looking at plan design to ensure that consumers receive adequate care.
CONSUMERS AND NARROW NETWORKS

• All plans must meet new coverage standards under healthcare reform so differentiation will be on network price and quality
• Consumers will likely find premiums most important factor in choosing QHP
• Provider-owned health insurance plans can set their own prices while typical insurers will have to negotiate new rates or live within existing commercial rates
• Provider-owned health insurance plans will not face barriers that inhibit new entrants into commercial insurance market
But IT'S NOT AN HMO, really

“Very scary, Jennifer—does anyone else have an H.M.O. horror story?”
BUT IT'S NOT AN HMO, REALLY

- Lessons learned from the 1990s (Google "HMO horror stories") but...
- Competition in health benefits marketplace moves the focus for employers and consumers from expansive networks in open access PPO plans to lower premium and out-of-pocket costs for plans using a narrow or tiered network
- Old models of managed care sought to limit utilization; new models offer more sophisticated tools to keep costs low and enhance quality
- Mixture of motives and penalties
  - Gift cards
  - Reduced premium
  - Cooking classes
  - Wellness initiatives appealing to consumers
  - Additional premium for smokers
drafting and organizing compliant networks

LEGAL CONCERNS
LEGAL CONCERNS

• Any Willing Provider ("AWP") – state laws
• Antitrust
  ■ Network design
  ■ Contracts/agreements
• Insurance regulation
• Consumer practices
• Contractual design
• Employee benefit design
ANY WILLING PROVIDER

- Any willing provider laws
  - Scope and applicability varies by state
  - General premise is that any provider capable of meeting plan requirements must be allowed into the network
  - Largely a response to those 1990s "HMO horror stories"

- MI and MN had AWP laws but abandoned them
- WI (Wis. Stat. 628.36 et seq. and IL (215 ILCS 5/370h) remain in place with respect to non-pharmaceutical providers
ANTITRUST

• Price fixing: Multiple parties employed in network development avoid *per se* illegal actions with
  - Exclusionary partners
  - Division of markets
• Get to a Rule of Reason analysis through integrated new product development
  - Financial integration
  - Clinical integration
ANTITRUST – NETWORK DESIGN—MULTIPLE PARTIES

- Identifying right mix of providers within your ACO for the Narrow Network
  - Geographic
  - Specialty (be wary—cost savings evaporate outside tier and network)
  - Reimbursement rate

- Exclusivity (30% primary service area safety zone)
  - Share
  - Viable alternatives?
  - Physician income sources?


- See generally FTC Staff Advisory Opinions (2002-Present), available at www.ftc.gov/bc/healthcare/industryguide/opinionguidance.htm
CONTRACTUAL DESIGN

- Contract vs. joint venture
- Responsibility for initial and ongoing capitalization
- Branding
- Administration issues
- Premium levels and product design, including employee benefit design
- Responsibility for regulatory approvals
- Confidentiality and exclusivity
- Key terms for provider contracts
- Term/Termination
- Dispute resolution
- Geographic scope of project
- Prohibited procedures
- IT expense cost/other extraordinary expenses
EMPLOYEE BENEFIT DESIGN
ISSUES

- Coverage that is affordable in individual, small and group markets
- Out of network design
- Out of pocket limits/deductible limits
- Groups not required to provide mandated essential coverage
- Steerage mechanisms/guarantees
- Incentive pools for providers
- Data transparency
- Tiers – prices + volume
- P4P
- Care coordination instead of pre-authorization
Insurance regulatory issues

- Check state law – do you need an insurance license to sell insurance?
- Many hospital systems stop short of getting insurance license in lieu of joint partnership
- Inherent conflicts of interest in some cases for systems that do provide insurance
- One example: Multistep transaction involving insurance company and in-house reinsurance arm in Cayman Islands – averts state licensure requirements.
CONSUMER PRACTICES

- CA and NY Lawsuits regarding fraud - quality as basis for selection
- 2008 Voluntary Patient Charter Agreement
- American Medical Association guidance on challenging profile
  - Compare data referenced in report with actual claims/chart
  - Valid reasons for practice variation
  - Margin of error
  - AMA poster on unfair physician measurement systems
- Quality must remain paramount and metrics transparent
  - 2007 NY settlement for basing Narrow Networks purely on cost rather than quality, as marketed
BENEFIT DESIGN AND DATA CONSIDERATIONS
Rethink Network Composition

- New focus on “gated” and narrow network products
- Directed choice helps ensure improved outcomes
- Physicians not meeting outcome measures “culled”
- Improved patient satisfaction; easier decisions
The Paradox of Choice

- Too many choices cause distress, regret
- Fewer choices aids decision-making
- Greater satisfaction when the choice is narrowed

Source: The Paradox of Choice, Why More is Less, Barry Schwartz
Episode Treatment Groups (ETGs)

MPC = Major Practice Category

ETG = Episode Treatment Group

Base ETG − 524

Detailed ETG − 1500+

+ 4 Levels of Severity

Based upon:
Member demographics,
Episode complications,
Episode comorbidities, and
Complication and comorbidities interactions
Getting to Root Causes

### Major Practice Category (22)
- Cardiology
- Chemical dependency
- Dermatology
- **Endocrinology**
- Gastroenterology
- Gynecology
- Hematology
- Hepatology
- Infectious diseases
- Isolated signs & symptoms
- Late effects, environmental trauma & poisonings
- Neonatology
- Nephrology
- Neurology
- Obstetrics
- Ophthalmology
- Orthopedics & rheumatology
- Otolaryngology
- Preventive & administrative
- Psychiatry
- Pulmonology
- Urology

### ETG Base Class (524)
- Cystic fibrosis
- Dehydration
- **Diabetes**
  - Endocrine disease signs & symptoms
  - Female sex gland disorders
  - Gout
  - Hyper-functioning adrenal gland
  - Hyper-functioning parathyroid gland
  - Hyper-functioning thyroid gland
  - Hyperlipidemia, other
  - Hypo-functioning adrenal gland
  - Hypo-functioning parathyroid gland
  - Hypo-functioning thyroid gland
  - Lipidoses (Gauchers Disease, Fabry Disease, Mucolipidosis I-III)
  - Male sex gland disorders
  - Malignant neoplasm of adrenal gland
  - Malignant neoplasm of pancreatic gland
  - Malignant neoplasm of parathyroid gland
  - Malignant neoplasm of pituitary gland
  - Malignant neoplasm of thyroid gland
  - Non-malignant neoplasm of adrenal gland
  - Non-malignant neoplasm of pancreas
  - Non-malignant neoplasm of parathyroid gland
  - Non-malignant neoplasm of pituitary gland
  - Non-malignant neoplasm of thyroid gland
  - Non-toxic goiter
  - Nutritional deficiency
  - Obesity

### ETG (1,500+)
- Diabetes, w/o complication, w/o comorbidity, w/o surgery
- Diabetes, w/o complication, w/o comorbidity, with surgery
- Diabetes, w/o complication, with comorbidity, w/o surgery
- Diabetes, w/o complication, with comorbidity, with surgery
- Diabetes, with complication, w/o comorbidity, w/o surgery
- Diabetes, with complication, w/o comorbidity, with surgery
- Diabetes, with complication, with comorbidity, w/o surgery
- Diabetes, with complication, with comorbidity, with surgery
- **Diabetes, with complication, with comorbidity, with surgery**
Optimization with Good Data

Plan Criteria
Reward Program

Plan Sponsor
Risk Pool

Prevalence
Frequency
Episode
Severity
Patient
Risk

Participants’ Behavior

Health Status
Lifestyle
Medical Systems Usage

Employer Plan

MPC - 22

Base ETG - 524

Detailed ETG – 1500+

+ 4 Levels of Severity

Member demographics,
Episode complications,
Episode comorbidities, and
Complication and comorbidities interactions

Provider and
Patient

Critical Pathways
(EBM) Evidence-based Medicine
Sequence and timing of care
Adherence
Compliance

Navigation

Provider Action

Proprietary and Confidential
Provider Quality and Efficiency

Source: UnitedHealthcare
Cost vs. Discount

**Physician A**
- $100 office visit
- $120 x-ray
- $85 medication
- No-cost follow-up call to check compliance

Treatment Timeline for Episode of Care—2 Weeks, Total Cost: **$525**

**Physician B**
- $80 office visit
- $100 x-ray
- $85 medication

Treatment Timeline for Episode of Care—3 Weeks, Total Cost: **$3,645**

**RETURN TO HEALTH**

**DIAGNOSIS: Pneumonia**
Efficiency/Quality Matrix

High Quality Achievements
Low Efficiency

High Quality Achievements
High Efficiency

Low Quality Achievements
Low Efficiency

Low Quality Achievements
High Efficiency

Greater Efficiency

Community Average

Number 1

Number 2

Number 3

Number 4

Number 5

Number 6
Network Selection: Be Careful

No one health system is best at everything

<table>
<thead>
<tr>
<th>Major Practice Categories</th>
<th>EPISODES</th>
<th>HS 1 Utilization Ratio</th>
<th>HS 2 Utilization Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive &amp; Administrative</td>
<td>1,581</td>
<td>1.06</td>
<td>1.14</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>1,495</td>
<td>0.97</td>
<td>1.37</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1,506</td>
<td>0.82</td>
<td>0.53</td>
</tr>
<tr>
<td>Orthopedics &amp; Rheumatology</td>
<td>1,449</td>
<td>1.00</td>
<td>1.08</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>1,095</td>
<td>0.78</td>
<td>0.94</td>
</tr>
<tr>
<td>Dermatology</td>
<td>883</td>
<td>0.94</td>
<td>0.84</td>
</tr>
<tr>
<td>Cardiology</td>
<td>713</td>
<td>0.94</td>
<td>1.02</td>
</tr>
<tr>
<td>Grand Total</td>
<td>11,331</td>
<td>0.98</td>
<td>1.02</td>
</tr>
</tbody>
</table>
Market Level: Quality Compliance & Cost Efficiency

Protocol Compliance/Cost-Efficiency Matrix
PANEL DISCUSSION AND QUESTIONS AND ANSWERS
Narrow Network Offerings—Market and Contracting Implications © 2013 is published by the American Health Lawyers Association. All rights reserved. No part of this publication may be reproduced in any form except by prior written permission from the publisher. Printed in the United States of America.

Any views or advice offered in this publication are those of its authors and should not be construed as the position of the American Health Lawyers Association.

“This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought”—from a declaration of the American Bar Association