Big Changes in 2016 to Marketplace Plans

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We all just went through what is one of our favorite seasons of the year; no, we aren't talking about the Holiday Season (although it is one our favorite times of the year), we are talking about Open Enrollment Season. And while we have grown accustomed to Open Enrollment questions from our patients for employer-sponsored plans, as we enter the 3rd Open Enrollment season for "Obamacare", there was a tidal wave of new questions as we once again we are see dramatic changes to and questions about the health plans listed on the Marketplace (FKA the Exchange) for individuals who do not get insurance through their employer, or Medicare or Medicaid. Couple that with questions and complexities around the state of Illinois' rapid migration to managed Medicaid, and the increasing popularity of Medicare Advantage plans, and one can conclude that we are now seeing the real transformative impact of changes in the U.S. health insurance models.

The focus of this article is Marketplace/Exchange product updates. The first two years of experience on the Marketplace has not been great for many health insurance companies. Many experienced significant losses and are withdrawing from markets, increasing premiums, and eliminating many products for the 2016 Open Enrollment Period. The average rate increase on existing policies was 17% in Illinois, with many premium increases in the 30-40% range. Additionally, many major insurers, including Blue Cross (BCBS) and United Healthcare (UHC), have introduced a variety of "Narrow Network" plans for 2016. This continues a market trend proven successful in 2015 by Land of Lincoln Health, a pioneer in 2014 with the introduction of the Narrow Network (or Private Label) model.

There are two (2) reasons Narrow Networks are emerging as a hot new health plan model:

1. Eliminating "high cost" providers from the network lowers the overall premiums for the products/networks they are removed from, and
2. Narrow Networks keep referrals to those providers in the network who have demonstrated higher quality and/or have agreed to various provisions to support Accountable Care and Population Health Management initiatives.

The concept of a Narrow Network has been around for awhile. In Illinois, an example of that would be the Blue Advantage HMO, which was introduced over a decade ago as a lower cost version of HMO Illinois. It was lower cost because it did not include certain hospitals and health systems whose costs drove premium prices up. Removal of those providers from the network resulted in lower premium amounts for employers and in turn employees/patients. So the driving thrust of the Narrow Network trend was pricing.

Today's version of Narrow Network is also premised on price and cost reductions, but is also premised on improvement in "Quality" and medical cost management. Several 2016 Narrow Network products are exclusive to a specific provider network (often a "clinically integrated network" or "CIN"), or have higher benefits and lower out of pocket costs if you receive services from the narrow network of

providers. These Narrow Networks promise lower costs and higher quality because physicians, hospitals and other care providers in the Narrow Network have agreed to certain contract terms that support the Narrow Network's Population Health Management (PHM) initiatives. By keeping patients in the Narrow Network, providers can better collaborate on care coordination, and often enjoy additional reimbursement via Contract Incentives.

Movement in the Marketplace: Highlights of Chicago-area health plan changes

The Illinois Marketplace enrollment has grown to nearly 300,000 as we enter Open Enrollment 2016. That number is expected to increase, perhaps dramatically, as employers increasingly seek alternative plan options to save money on their employee benefit costs (including the emergence of "Private Exchanges" which are expected to penetrate the market in 2017-2018). Below are a few examples of what's happening in the Marketplace/Exchange plan options in Illinois for 2016:

- Introduction of two (2) plans with the Advocate Health Care network as the core network: The "Blue Direct" plan from Blue Cross, and the "AETNA Whole Health Chicago" from AETNA Health.
- Continuation of Land of Lincoln Health Preferred Network products, Tiered Network plans, where members have less out of pocket for accessing providers in the "Tier 1" category.
- Elimination of "The Blue PPO" by Blue Cross. Blue PPO is the largest BCBSIL network, and it will no longer be sold to individuals and families who buy plans on and off the Exchange. People currently enrolled in Blue PPO will be automatically enrolled in the "Blue Choice Preferred PPO" with only 78 hospitals compared to the more than 200 hospitals in the Blue PPO network. Notably, several high profile Chicago area hospitals and healthsystems are not in Blue Choice, including Advocate Health Care, Northwestern Medicine, Rush University Medical Center, and NorthShore University HealthSystem and University of Chicago Medicine. This has significant implications to patients, and to physician practices that are in network for Blue Choice Preferred PPO, but now find that their affiliated hospital will be out of network.

The Impact to Physician Practices and Health Care Providers:

There are three (3) immediate potential impacts to physician practices and other healthcare providers that need to be considered in Narrow Network and Exchange products/contracts:

1. Increasing Bad Debt and Patient A/R
2. Impact to referral patterns
3. Administrative requirements, complexity and added costs to administer

Let's discuss each of these in more detail:

Increasing Bad Debt and Patient A/R: Marketplace products routinely have Deductibles $3,000-$6,000 per individual, and $6,000-$12,000 per Family and this is for In Network providers. Many patients with these low cost plans do not have the financial resources to pay these Deductibles, nor the hefty Co-Insurance amounts. As a result, Patient Bad Debt, Aged A/R, and Cost to Collect have skyrocketed in the first 2 years for these plans. Providers are increasingly implementing more aggressive "upfront" payment policies for patient liability (often referred to as "Point of Service" collections). For example, collect outstanding balances/portions of at time of service/registration, and collecting co-payments for

today's visit today at time of service/registration). Additionally, many plans have Maximum Out of Pocket exposure exceeding $10,000-$20,000.

Impact to Referral Patterns: Typically, any given physician practice has any given number of established referral relationships in place, where they routinely refer to certain physicians in certain specialties, driven by your comfort in knowing that physician's clinical excellence and responsiveness to you and your patient. Historically, most physicians and most hospitals were in most health plan networks. Increasingly, across Narrow commercial networks, Medicare Advantage Risk Networks, and the emerging Medicaid Networks, one must be increasingly attentive to whom one is referring, as these networks are getting smaller and more contained, in fact limiting your choice and your patient's choice of whom you can refer. As if it wasn't complex enough, the introduction of Narrow Networks and Micro Networks exponentially increases the complexity of referring patients to the right "in network" providers. Couple this with "Tiered Products", "Private Label" and "EPO" product models, and it is clear that one of the more difficult jobs in the healthcare industry today for Hospitals and Medical Groups is managing payor contracts (especially at the "front end" of Registration/Admission, and tying to the "Back End" to ensure appropriate payments and collection of patient liabilities).

There are also implications to not being in these new network models; specifically, (a) if a physician or other healthcare provider has to change referral patterns for certain products, they may increase re-direction of referrals for other products, and (b) if you accept a referral for a patient in a limited network, and/or you refer a patient to a non-network provider, you could face financial penalties and expose your patient to greater out of pocket expenses.

In a seemingly unprecedented move, one of the largest healtsystems in the U.S. (BJC HealthSystem, St. Louis, MO) made national news by initiating a public communications effort designed to tell patients NOT to come to BJC if BJC and their affiliated physician were Out of Network with the patient's insurance plan. They have made it a policy that Out of Network patients must pay in advance with a credit card for elective services.

There is no clear "one size fits all" strategic approach to a Managed Care Contracting Strategy for Exchange/Marketplace products, or Medicaid HMOs or Medicare Advantage plans. For some, you need to be "all in" to ensure alignment with your referral base and patient base. For others, you can be "selective", like BJC and others referenced in this article. Either way, the single most important thing you can do is understand what's going on so you can better position your organization for what's coming in 2016 and beyond.