

Providers: Do Your Managed Care Participation Agreements Apply to New Insurance Exchange Products?



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As enacted in the Patient Protection and Affordable Care Act (ACA), states are required to have established operational health benefit exchanges by Jan. 1, 2014, or the federal government will implement one for them. These exchanges will allow individuals¹ and small businesses² to buy health care coverage, and

¹ Individuals can purchase a qualified health plan through an American Health Benefit Exchange (which is generally referred to as an “exchange”).

² Small businesses will access a Small Business Health Options Program (which is referred to by the ACA as a “SHOP Exchange”). The SHOP Exchanges will assist qualified small employers with enrolling their employees in qualified health plans offered in the

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are expected to add approximately 30 million currently uninsured people to the health insurance market.

Most of the health plans that will be offered on such exchanges will be managed care plans with networks of participating providers. Thus, the resulting new business will be covered by hospital, physician and other provider participation agreements with such managed care plans.

Hospitals, physicians and other providers of health care services should start reviewing their commercial managed care participation agreements to determine whether they will apply to exchange products when implemented, especially if the term of the agreement is evergreen or ends after Jan. 1, 2014.³

Enrollment in exchange products begins in October 2013, but health plans will likely submit their applications to offer products on these exchanges, including a listing of their provider networks for such exchange products, beginning in early 2013. Therefore, health plans need to know which providers will be participating in those networks by early 2013.

Providers should also ask the managed care plans that they contract with whether they intend to offer

small group market in their state. A state may offer both an exchange and a SHOP Exchange through one exchange.

³ Note, too, that Medicaid coverage is likely to be expanded in most states; providers should also monitor upcoming changes that may affect any provider participation agreements that include Medicaid or Medicaid managed care.

products on the exchanges and follow state and federal law developments establishing such exchanges.

A Typical Participating Provider Agreement

A typical participating provider agreement with a managed care plan lists the “benefit plans” or “products” in which the provider will participate under the terms of the agreement, and usually delineates fees or rates based on the line of business (commercial, Medicare Advantage, Medicaid) and type of benefit plan within that line of business (HMO, PPO, etc.).

Determining whether an agreement will apply to exchange products, especially if the term of the agreement is evergreen or ends after Jan. 1, 2014, will typically depend on how the following terms are used and defined in such agreement:

- “Benefit Plan” or “Benefit Program;”
- “Product;”
- “Line of Business;”
- “Payer” or “Payor;” and
- “Member” or “Customer.”

If the relevant defined terms in an agreement apply to all the commercial products offered by the managed care organization during the term of agreement, then exchange products should be covered. If only specific products are covered (either by name or type), then the agreement may not automatically apply to exchange products offered by such managed care organization.

A Primer on Key Definitions Related to Exchanges

The ACA uses definitions related to exchange products that likely do not match definitions in many providers’ managed care agreements.

For example, some agreements use the term “health plan” to mean the managed care organization. This can be confusing because the ACA uses the term “health plan” and “qualified health plan” to mean the “benefit plan,” and “health insurance issuer” to mean the managed care organization. To avoid confusion with the ACA, this article uses the term “managed care organization,” instead of “health plan.”

The following are some of the key definitions that providers should know as they analyze their managed care agreements:

■ “Health insurance issuer” is broadly defined by the ACA as an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a state, and that is subject to state law that regulates insurance, but excludes a group health plan.⁴

⁴ Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148 § 1301(b)(2).

■ “Qualified health plan” or a “QHP” is defined by the ACA but allows states great flexibility to determine the types of benefit plans to be offered on exchanges.⁵

■ “Product” has yet to be defined, but its definition is expected in future regulations.

■ “Essential health benefits” under the ACA must cover at least the following general 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 and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).⁶

■ “Platinum,” “gold,” “silver” and “bronze” categories of QHPs are defined under the ACA as having a certain percentage of benefits, compared to the full level of benefits. This is done by comparing the actuarial value of the benefits, not the out-of-pocket costs, coinsurance or other measures. A platinum level plan provides benefits actuarially equal to 90 percent of the full actuarial value of the benefits provided under the plan. The gold level provides 80 percent, while the silver level provides 70 percent and the bronze level provides 60 percent.⁷

Analyzing Provider Agreements

Providers should be aware of several important points as they analyze their agreements.

First, many providers’ managed care agreements do not automatically apply to all future products that the managed care plan may offer, such as a QHP offered on an exchange. As a result, providers should check to see if their agreements have a negotiated provision that covers participation in all new products.

Second, many hospital and other facility or system agreements include specific provisions that address the managed care plan’s ability to offer new products, “tiered” products or limited network products. Often, these provisions give the managed care plan the ability to decide whether to include a provider in such products or specific tiers of such products. Providers should review these provisions to determine if they will cover exchange products as well.

Third, fee schedules and rate attachments should also be reviewed to determine what benefit plans or products are covered by the rates.

Fourth, many agreements list the benefit plans to which they apply in a separate attachment. Such attachments can be very generic (listing all “commercial” or “Medicare Advantage” products) or very specific—naming product by name—and should be carefully reviewed.

⁵ *Id.* at § 1301(a).

⁶ *Id.* at § 1302(b).

⁷ *Id.* at § 1302(d)(1).

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Finally, the amount that the member is responsible to pay under an exchange product may vary greatly. For example, while a platinum-level QHP covers 90 percent of the actuarial equivalent of the full level of benefits, a bronze-level QHP provides only 60 percent of the full level of benefits—a third less.⁸ That may translate into greater numbers of patients who have to pay a significant portion of their medical bills, even though they “have coverage.”

The provider should review its provider contract provisions permitting it to seek payment—and clarifying an ability to seek prepayment—of copayments, coinsurance and deductibles from patients in certain plans. Provisions governing the collection of bad debt should also be reviewed to ensure that they give the provider the flexibility to collect from patients, as appropriate.

Following Developing Laws on Exchanges

As of Aug. 4, 2012, governors of 13 states, with nearly one-third of the U.S. population, have sent letters to the Obama administration indicating that they intend to set up exchanges. Complete applications are due Nov. 16, 2012, just 10 days after the presidential election. Federal and state officials and health policy experts expect that the federal government will run the exchanges in about half of the 50 states.⁹

⁸ The bronze level is the minimum level of benefits required to avoid the tax penalty under the ACA.

⁹ See Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. Times, Aug. 4, 2012.

Most of the state exchanges, however, do not define the types of QHPs or benefit plans that will be offered.¹⁰ States may also impose terms impacting rates to be paid by health insurance issuers for exchange products.

If a state elects not to implement an exchange, a “federally facilitated exchange” (FFE) will apply. The state may also partner with an FFE to perform some of the administrative or operational functions.

By way of comparison, Massachusetts has had a commercial health insurance exchange in place called “Health Connector.” Many managed care organizations in Massachusetts had to modify certain provider agreements when they offered exchange products to address such products and rates specifically.

Conclusion

Providers should review the relevant provisions in their managed care agreements and follow state and federal law developments regarding exchanges closely. Developments are likely to occur rapidly over the next year or so.

¹⁰ For example, Connecticut’s health insurance exchange board has just selected a mandatory benefit plan that takes a popular HMO product in the state and adds additional benefits that the HMO product does not offer (such as prescription drug coverage and pediatric dental and vision services). The HMO product chosen also offers benefits beyond essential health benefits (such as in-vitro fertilization treatments and special autism care). See Ana Radelat, *Connecticut’s Health Exchange Board Determines Basic Coverage*, Conn. Mirror, July 27, 2012.