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

A Law Review Q&A

As implementation of the Affordable Care Act (ACA) continues to move forward, attention has begun to shift toward key insurance reforms—including the development of health benefit exchanges—that will impact the health care landscape in 2014. While the structure and design of products within state exchanges and the federal exchange have clear implications for health plans and employers, provider organizations should not overlook the effect on existing agreements with payers.

Most of the health plans that will be offered on the exchanges will be managed care plans covered by hospital and other provider agreements. As a result, hospitals and health systems should start reviewing existing managed care participation agreements today to determine if they will apply to exchange products, say **Jackie Selby** and **Jane Kuesel** from the firm **Epstein Becker Green**.

In this edition of the Law Review, Selby and Kuesel offer insight for provider organizations preparing for the launch of state and federal insurance exchanges.

1) What is the timeframe and schedule for developing health benefit exchanges under the ACA?

Following an extension from **HHS**, the most significant near-term deadline for developing health benefit exchanges is on Dec. 14, 2012, at which time states are required to submit a declaration letter to operate a state-based exchange. For states choosing to run their own exchange, a blueprint application must also be submitted by this date detailing the state's readiness to perform exchange activities and functions. States electing to partner with the federal government to run their exchange are required to offer declaration letters and blueprint applications by Feb. 15, 2013.

By Jan. 1, 2013, HHS will make a determination if those state-based exchanges that have filed are far enough along to be functional in time for a Jan. 1, 2014 start date. HHS may grant either approval or a conditional approval.

While states that do not pursue a state-based exchange or federal-state partnership will have a federally facilitated exchange established by HHS, they may learn from this experience and transition to a state-based exchange or federal-state partnership in a subsequent year.

Although there remain some states that have yet to make a decision, as of Dec. 4, 2012, eighteen states have declared their intent to establish a state-based exchange, and have invested substantial time and resources—including federal grant money—to get their exchange up and running.

2) How much progress has occurred on the state and federal level in the implementation of HHS' regulations?

There have been five groups of proposed federal regulations relating to the exchanges that have been recently released: essential health benefits, actuarial value and accreditation; wellness programs for group health plans; health insurance market rules; establishment of the multi-state plan program for exchanges; and notice of benefit and payment parameters for 2014. While these federal regulations promise to impact pending insurance exchanges, **CMS** has confirmed that more guidance will be forthcoming. In particular, additional clarity is needed regarding what the federally facilitated exchange will look like, and more details involving how it will operate.

3) What key provisions under the health insurance exchange rules will impact provider organizations?

Even though there have been recent rules around benefits on the insurance exchange, including a description of the four "metal" levels insurers may offer (bronze, silver, gold and platinum), it is not yet clear which insurance issuers or health plans will offer products on the exchanges, how pricing will occur, what insurance products will be offered, what networks for such products will look like, and if such health plans intend on negotiating new rates for those products.

Because important questions remain, hospitals and health systems should monitor the developments at both the federal level and state level. If a state hasn't decided whether they will run their own exchange, hospitals in that state should know this by the December deadline. At that point, providers should start identifying which of the health plans they contract with will participate in an exchange in those states, whether it is a state-run exchange, federal-state partnership, or federally facilitated exchange.

4) In order to prepare for state exchanges, what steps should hospitals and health systems take today to analyze existing managed care agreements?

Providers should look at their existing agreements with health plans that they expect will offer a qualified health plan on the exchange, since the term of many current agreements address or contain provisions that extend into 2014. In particular, hospitals and health systems should determine if they are already obligated to participate in new commercial products the plans offer, whether the plan has the right to change the type of product they participate in or the rates paid for those products, whether the health plan is permitted to unilaterally amend the agreement with respect to these products, and whether the provider has a right to opt out of new products.

Providers should also focus on some of the key definitions their agreements, including benefit plans, products, and the rate attachments for such products. In addition, providers should review any mention of tiered products (e.g. different tiers of providers based on member co-pays), the right for the plans to have limited networks for certain products and whether the provider can be excluded, and any restrictions on collection of member cost-share. Lastly, providers should look at how the contract addresses continuity of care for members who may switch between Medicaid and commercial exchange products. All of these provisions should be reviewed carefully prior to responding to health plan amendments that involve new rates for products offered on the exchange.

While providers should begin today analyzing their own existing agreements in preparation for the insurance exchanges, a lot of relevant factors aren't clear yet—including pending state and federal law developments. These factors will push negotiations with managed care plans related to exchange products into next year. Hospitals and health systems should plan for a very busy first three quarters of 2013 with respect to health plan agreements and how they cover future insurance exchange products.

The Advisory Board Company
2445 M Street NW | Washington DC 20037
P 202.266.5600 | F 202.266.5700
advisory.com