Providers & Health Insurance Exchanges
Implementation in the Context of Health Reform
HFMA Lone Star Chapter East Texas Institute

April 18, 2013

ECG Management Consultants, Inc.

For 40 years, ECG has served as a trusted adviser to some of the nation’s leading healthcare providers.

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- We have a strong team of experts to assist you with managed care contract evaluation and negotiation.

ECG is committed to delivering smart and practical resolutions to critical issues, on time and within budget, across the spectrum of healthcare organizations.
I. Introduction

Key Objectives

Today’s presentation and discussion will illuminate many outstanding questions about health exchanges and serve as a forum for innovative ideas to prepare for this new insurance product.

• The implementation date of January 1, 2014, for state health exchanges is fast approaching, and providers need to understand the potential impact to their hospital, hospital system, or medical group.

• Our learning objectives for today include the following:
  – Review the legislative background and structural models for the state health exchanges and the implications associated with each.
  – Understand how to evaluate the health plan activity in your state and market.
  – Discuss how best to establish market-competitive rates and contract terms.
  – Further understand the impact of pricing on the exchanges and the potential impact on profitability.
  – Determine the best approach for structuring the managed care contracts and the key language considerations.
  – Evaluate potential shifts in payor mix associated with expanded coverage and the introduction of tiered and narrow network products.
  – Prepare your organization in terms of the operational impact.
II. Health Exchange Background

Development Rationale

Exchanges are designed to be one-stop marketplaces for consumers to find an affordable insurance plan that best meets their health needs.

- **State Control** – Exchanges can operate as part of an existing state agency or office (operated by the state), as an independent public agency (quasi-governmental), or as a nonprofit entity (nonprofit).
- **Qualifying Health Plans** – Exchanges will provide guidance to consumers regarding qualified coverage.
  - **Clearinghouse** – All qualified health plans (QHPs).
  - **Advisory Purchaser** – Selected health plans and/or negotiation of premiums.
- **Purpose** – Exchanges are intended to do the following:
  - **Competition** – Increase competition and choice to provide the leverage for small businesses and individuals who need to purchase insurance.
  - **Transparency** – Foster transparency whereby consumers can compare price, coverage, and quality.
  - **Comparison** – Facilitate shopping and enrollment in the coverage that best meets their health and financial needs.
  - **Coordination** – Coordinate eligibility for private as well as premium assistance plans.

*States choosing to operate their own exchanges have the flexibility to decide what resources to include in their state exchanges.*

II. Health Exchange Background

Key Exchange Dates

There are several key dates related to state health exchanges that providers need to know, including the initial start date of January 1, 2014.

- **State exchanges established throughout 2011 and 2012.**
- **October 1, 2013:** Enrollment begins for exchanges.
- **January 1, 2014:** All states open exchanges.
- **January 1, 2015:** All states must be financially self-sustaining through state funds and fees. Exchange cannot be supported with general fund money.

- **March 23, 2010:** ACA passed.
- **March 23, 2011:** Federal government begins awarding state grants to establish exchanges.
- **December 16, 2011:** Federal government releases proposed essential benefits.
- **January 1, 2013:** Federal government must be notified by state that it will operate exchange. If state does not show sufficient progress or chooses not to offer one, the federal government will operate the exchange.
- **January 1, 2017:** Companies with more than 100 employees can be accepted into exchange. State can limit to 50 employees until January 1, 2016.
II. Health Exchange Background

*Population Served by Exchanges*

- The Affordable Care Act (ACA) created two distinct exchange types: the American Health Benefit Exchange and the Small Business Health Options Program (SHOP) Exchange.

- Some states will operate them separately, while others will operate them as a single entity.

**Population Groups**

- Individuals and Families
- American Health Benefit Exchange
- SHOP Exchange
- Small Businesses

II. Health Exchange Background

*Size of Employers in SHOP*

<table>
<thead>
<tr>
<th>Employer Size</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 50</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>51 to 100</td>
<td>State Option</td>
<td>State Option</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>More than 100</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>State Option</td>
<td>State Option</td>
</tr>
</tbody>
</table>

- Department of Health and Human Services has recently proposed delaying the required opening of SHOP exchanges until 2015.

- Small businesses will still be able to get insurance through the exchange, but state will have the option to limit that to one choice, instead of multiple plans in 2014.

## II. Health Exchange Background
### Federal Coverage Requirements

*There are 10 essential health benefit (EHB) categories that all exchange products must include. Benefits within these categories are not mandated by the ACA.*

<table>
<thead>
<tr>
<th>Benefit Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Patient Services</td>
</tr>
<tr>
<td>Emergency Services</td>
</tr>
<tr>
<td>Hospitalization</td>
</tr>
<tr>
<td>Maternity and Newborn Care</td>
</tr>
<tr>
<td>Mental Health, Substance Abuse, and Behavioral Health Treatment</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Rehabilitative Services and Devices</td>
</tr>
<tr>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Preventive and Wellness Services and Chronic Disease Management</td>
</tr>
<tr>
<td>Pediatric Services, Including Oral and Vision Services</td>
</tr>
</tbody>
</table>

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## II. Health Exchange Background
### Coverage Requirements and Tiers

*Exchanges will have five tiers of coverage to choose from.*

- An exchange must offer a plan choice in each of the five categories, which are based on the actuarial value of the plan.
- The actuarial value is the average share of covered health expenses reimbursed by the plan for the typical population, with the remaining coverage being the member’s responsibility.
- In a given state, a participating payor must offer at least one Platinum or Gold plan.
- The plans must provide the 10 EHB categories in total, as defined by CMS. However, states can require a higher level of benefits.

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For example, a Gold plan would cover the equivalent of $2,000 for an average patient’s $2,500 in annual medical expenses. Higher coverage requires higher premiums.
II. Health Exchange Background

Coverage and Subsidy Support by Income Level

- **Eligible for Medicaid** [If State Expands Program] (0% to 133% of FPL)
- **Eligible for Health Exchange Subsidy** [Sliding Scale Subsidy as Tax Credit] (133% to 400% of FPL)
- **Eligible for Cost-Sharing Support** (100% to 250% FPL)

### Percentage of Federal Poverty Level (FPL)

<table>
<thead>
<tr>
<th>Description</th>
<th>100%</th>
<th>133%</th>
<th>200%</th>
<th>250%</th>
<th>300%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual¹</td>
<td>$11,490</td>
<td>$15,282</td>
<td>$17,235</td>
<td>$22,980</td>
<td>$28,725</td>
<td>$34,470</td>
</tr>
<tr>
<td>Family of Four¹</td>
<td>$23,550</td>
<td>$31,322</td>
<td>$35,325</td>
<td>$47,100</td>
<td>$58,875</td>
<td>$70,650</td>
</tr>
<tr>
<td>Insurance Premium Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Percentage of Income²</td>
<td>2.0%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>6.3%</td>
<td>8.1%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>


### Income by FPL Percentage Level

**The ACA has created three programs to eliminate incentives for “cherry picking” behavior from payors and ensure that plans compete on the basis of quality and service, not on attracting the healthiest individuals.**

- **Risk Adjustment** – A permanent, deficit-neutral, program will provide payments to plans that attract higher risk populations by transferring funds from plans with the lowest risk individuals.
  - Intended to reduce or eliminate premium differences among plans based solely on risk selection.
  - All non-grandfathered plans in the individual and SHOP are subject to this adjustment, inside and outside of the exchange.
- **Reinsurance** – A transitional program will help stabilize premiums for coverage in the individual market in the event that individuals who gain coverage during the first three years of the exchange operation (2014 – 2016) have higher cost needs.
  - All plans, self-insured group plans, and TPAs on their behalf, will make contributions to support reinsurance payments.
- **Risk Corridors** – A transitional program to protect against uncertainty in rate-setting in the first several years of the exchange.
  - A mechanism for sharing risk and savings between the federal government and the QHP will ensure that plans costs are within 3% of initial cost projections.

II. Health Exchange Background
Exchange Subsidy Eligibility

- Any individual who does not have employer-offered insurance can buy it on the exchange.
- The ACA provides a subsidy based on the Silver-level premium (geography-specific); this is considered the benchmark product.
- Some states have already specified that the subsidy would go to the insurer and appear as a discount on the policy.
- The target is for individuals to pay no more than 9.8% of income.
- Enrollees in a Gold or Platinum plan are responsible for premium costs above the benchmark.
- The ACA also states that the federal government will select at least two multistate carriers available in every state and every exchange.
- An exchange subsidy will also be available to small groups of fewer than 25 with average FTE annual wages of less than $50,000.

III. State Health Benefit Exchanges
State Decisions for Creating Health Exchanges

III. State Health Benefit Exchanges

A Summary of the Status by State

<table>
<thead>
<tr>
<th>Count</th>
<th>Status</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 States + DC</td>
<td>Established state-based exchange.</td>
<td>CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT, VT, WA.</td>
</tr>
<tr>
<td>7 States</td>
<td>Planning to pursue a state/federal partnership exchange.¹</td>
<td>AR, DE, IA, IL, MI, NH, WV.</td>
</tr>
<tr>
<td>26 States</td>
<td>Defaulted to federal exchange.</td>
<td>AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, ND, NE, NH, NJ, OH, OK, PA, SC, SD, TN, TX, VA, WI, WV.</td>
</tr>
</tbody>
</table>


¹ Under a state/federal partnership exchange, states can choose to operate certain plan management functions, certain consumer assistance functions, or both. In addition, a partnership state can elect to conduct Medicaid and Children’s Health Insurance Program (CHIP) eligibility determinations. The federal government fills the remaining responsibilities. Source: www.kff.org/healthreform/upload/8213-2.pdf.

III. State Health Benefit Exchanges

Establishment of the EHBs

States can choose from a range of existing insurance plans to serve as the EHB benchmark for the state. Insurers are required to offer benefits that are “substantially equal” to the benefits in the benchmark plan.¹

Options

- **Small Group Insurance** – Select from the three largest small group insurance products in the state.
- **State Employee Options** – Select from the three largest state employee health plan options.
- **Federal Employee Options** – Select from the three largest federal employee health plan options.
- **HMO Option** – Select from the largest commercial HMO plan sold in the state.

State Benchmark Plan Selections

- **Alaska** – Small Group; BCBS of AK Alaska Heritage Select Envoy, PPO.
- **Washington** – Small Group; Blue Shield Regence Innova, PPO.
- **California** – Small Group; Kaiser Small Group, HMO.
- **Oregon** – Small Group; PacificSource-Preferred CoDeduct Value, PPO.
- **Texas** – Small Group; BCBS of TX- BestChoice, PPO.
- **Nevada** – Small Group; Health Plan of Nevada (UnitedHealthcare) – POS C-XV-500-HCR.

¹ The EHB benchmark does not define the cost sharing for these benefits; that is defined by the metal levels, defined later in this section. If the benchmark plan does not have a benefit in a given category, the state will identify the benefit. The costs for benefits mandated by the state beyond these benchmarks must be deferred by the state.

On February 13, 2013, California announced the Standard Benefit plan designs.

- Platinum and Gold plans have no deductible and a physician’s office visit will be $25 (Platinum) and $45 (Gold).
- Silver plans will have $2,000 deductibles, a $45 physician’s office co-pay, and an additional $500 deductible for medications.

### Covered California Benefit Plan Outline

<table>
<thead>
<tr>
<th>Plan</th>
<th>Variation</th>
<th>Out-of-Pocket Max. by Type</th>
<th>Actuarial Value</th>
<th>Deductible (Medical/Brand Drug)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Coinsurance/Co-Pay/HSA/Cata.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platinum</td>
<td></td>
<td>$4,000/$4,000/88%</td>
<td></td>
<td>$0/$0</td>
</tr>
<tr>
<td>Gold</td>
<td></td>
<td>$6,400/$6,400/78%</td>
<td></td>
<td>$0/$0</td>
</tr>
<tr>
<td>Silver</td>
<td>Individual</td>
<td>$6,400/$6,400/$6,400/69%</td>
<td>72%</td>
<td>$2,000/$500</td>
</tr>
<tr>
<td>Silver</td>
<td>SHOP</td>
<td>$6,400/$6,400/$6,400/69%</td>
<td>72%</td>
<td>$1,500/$500</td>
</tr>
<tr>
<td>Silver</td>
<td>100% to 150% of FPL</td>
<td>$2,250/$2,250/95%</td>
<td></td>
<td>$0/$0</td>
</tr>
<tr>
<td>Silver</td>
<td>150% to 200% of FPL</td>
<td>$2,250/$2,250/88%</td>
<td></td>
<td>$500/$50</td>
</tr>
<tr>
<td>Silver</td>
<td>200% to 250% of FPL</td>
<td>$5,200/$5,200/74%</td>
<td></td>
<td>$1,500/$500</td>
</tr>
<tr>
<td>Bronze</td>
<td></td>
<td>$6,400/$6,400/60%</td>
<td>59%</td>
<td>$5,000</td>
</tr>
<tr>
<td>Catastrophic</td>
<td></td>
<td>$6,400/$6,400/60%</td>
<td></td>
<td>$6,400</td>
</tr>
</tbody>
</table>


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1 The Silver HSA plans have an integrated deductible of $1,500 for both medical and brand drug costs. The Bronze has a $4,500 integrated deductible.
IV. Expected Market Impact

Current Health Coverage Distribution – Population

Within the state of Texas, there are over 6 million uninsured people who are likely to flow into the exchanges. The additional insured patients could represent a strong opportunity, depending on your location.

Source of Healthcare Coverage by State – 2011 (Millions)¹

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>AK</th>
<th>CA</th>
<th>TX</th>
<th>NV</th>
<th>OR</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>149.35</td>
<td>0.36</td>
<td>16.68</td>
<td>11.48</td>
<td>1.29</td>
<td>1.86</td>
<td>3.32</td>
</tr>
<tr>
<td>Individual</td>
<td>15.41</td>
<td>0.02</td>
<td>2.24</td>
<td>0.97</td>
<td>0.14</td>
<td>0.14</td>
<td>0.36</td>
</tr>
<tr>
<td>Medicaid</td>
<td>50.67</td>
<td>0.09</td>
<td>7.07</td>
<td>3.95</td>
<td>0.26</td>
<td>0.56</td>
<td>1.03</td>
</tr>
<tr>
<td>Medicare</td>
<td>39.99</td>
<td>0.05</td>
<td>3.72</td>
<td>2.49</td>
<td>0.34</td>
<td>0.55</td>
<td>0.83</td>
</tr>
<tr>
<td>Other Public</td>
<td>3.85</td>
<td>0.03</td>
<td>0.32</td>
<td>0.32</td>
<td>0.05</td>
<td>N/A</td>
<td>0.18</td>
</tr>
<tr>
<td>Uninsured</td>
<td>48.61</td>
<td>0.13</td>
<td>7.32</td>
<td>6.14</td>
<td>0.59</td>
<td>0.56</td>
<td>0.96</td>
</tr>
<tr>
<td>Total</td>
<td>307.89</td>
<td>0.69</td>
<td>37.37</td>
<td>25.34</td>
<td>2.68</td>
<td>3.81</td>
<td>6.71</td>
</tr>
</tbody>
</table>


Uninsured individuals represent a higher percentage of the total population in Texas compared to the national average.

Source of Healthcare Coverage by State – 2011¹

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>AK</th>
<th>CA</th>
<th>TX</th>
<th>NV</th>
<th>OR</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>49.0%</td>
<td>51.8%</td>
<td>44.6%</td>
<td>45.3%</td>
<td>48.4%</td>
<td>48.7%</td>
<td>49.6%</td>
</tr>
<tr>
<td>Individual</td>
<td>5.0%</td>
<td>3.1%</td>
<td>6.0%</td>
<td>3.8%</td>
<td>5.3%</td>
<td>6.4%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>16.5%</td>
<td>14.4%</td>
<td>18.9%</td>
<td>15.6%</td>
<td>9.7%</td>
<td>14.8%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Medicare</td>
<td>13.0%</td>
<td>7.3%</td>
<td>10.0%</td>
<td>9.8%</td>
<td>12.7%</td>
<td>14.5%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Other Public</td>
<td>1.2%</td>
<td>4.9%</td>
<td>0.9%</td>
<td>1.3%</td>
<td>1.7%</td>
<td>N/A</td>
<td>2.8%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15.8%</td>
<td>18.4%</td>
<td>19.6%</td>
<td>24.2%</td>
<td>22.1%</td>
<td>14.9%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Percentage of All Employers Offering Insurance</td>
<td>51.0%</td>
<td>39.2%</td>
<td>50.5%</td>
<td>47.1%</td>
<td>55.2%</td>
<td>47.8%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Businesses With Fewer Than 50 Employees Offering Insurance</td>
<td>35.7%</td>
<td>23.2%</td>
<td>37.9%</td>
<td>28.4%</td>
<td>35.8%</td>
<td>34.1%</td>
<td>32.4%</td>
</tr>
<tr>
<td>Businesses With 50 or More Employees Offering Insurance</td>
<td>95.7%</td>
<td>94.0%</td>
<td>93.4%</td>
<td>92.3%</td>
<td>97.0%</td>
<td>95.2%</td>
<td>94.4%</td>
</tr>
</tbody>
</table>

IV. Expected Market Impact

Public Sentiment

A recent study by The University of Chicago explored the levels of knowledge about health insurance reforms for Covered California.

- An overview of the study is presented below.
  - The study identified important influencers on the decisions to shop for an insurance plan in the new marketplace as well as interest in enrollment.
  - Researchers conducted 412 in-depth, in-person, one-on-one interviews in October and November 2012.
  - Of the participants, 75% were uninsured, and 25% were privately insured.
  - In the study, 75% of participants were employed.
- Survey findings described the level of knowledge about exchanges and reform.
  - There was a low level of general knowledge.
  - Participants had considerable confusion about how exchanges function.
  - Less than 50% of respondents could identify a specific trait about exchanges and health reform.
  - Of the respondents who had some knowledge, most mentioned mandatory participation, universal coverage, and reduced healthcare costs.

Source: Getting California Covered, NORC at the University of Chicago, December 18, 2012.
IV. Expected Market Impact

**Individual Exchange Incentives and Penalties**

- Any individual who does not have employer-offered insurance can buy it on the exchange.
- The ACA provides a subsidy based on the Silver-level premium (geography-specific); this is considered the benchmark product.
  - The target is for individuals to pay no more than 9.8% of income.
  - The subsidy is a tax credit.
  - Subsidy-eligible enrollees in a Gold or Platinum plan are responsible for premium costs above the benchmark.
- The individual penalty for no coverage is the greater of $695 per family member or 2.5% of income (to be phased in by 2016).

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**Small Employer Coverage**

The second source of exchange patients is the small employer market. Employers have a couple of options to provide coverage.

- SHOP participants will be able to designate a single plan and benefit tier for their employees, allowing the employees to choose the plan.
  - (e.g., everyone picks a plan from the Silver tier)
- Alternatively, employers can contribute toward the premium and allow employees to choose the benefit tier (e.g., employer pays $4,000 per year of the premium, employees pick any plan they want in any tier).
- The small employer insurance market will be fundamentally changed by exchanges, but these employers typically have a relatively poor understanding of exchanges.

These options are subject to the SHOP being in place. As noted earlier, HHS has proposed to initiate the SHOP exchange in 2015.
IV. Expected Market Impact

Employer Response

"Some Small Businesses Choose to Self-Insure"
– March 14, 2013

• Some small employers are choosing to become self-insured, “a practice more typical of large employers”.
• Employers choosing to self-insure combine it with a low per worker stop-loss (e.g., $10,000 - $20,000) and take reinsurance to cover catastrophic losses.
• By self-insuring the employer can avoid some of the benefit restrictions and coverage requirements of the exchanges thereby lower costs.
• For employers with younger and relatively health work forces it could be a possible solution.
• However, educating employees on what is included in the coverage is critical.
• Also removing younger healthy workers from the total risk pool works against the concept of spreading risk over a large population.
• Some employers may see insurance coverage as a competitive advantage to recruit and retain the best workers.

Source: http://www.usatoday.com/story/money/business/2013/03/14/some-small-businesses-choose-to-self-insure/1988481/

V. Provider Financial Impact Factors

Based on the current projections, the volume of exchange patients can be large enough to have an impact on your hospital’s financial performance.

• Population Shifts – The exchange category will include some previously uncovered patients and will “cannibalize” some existing commercial business. In addition, an increase in the Medicaid population is anticipated.
• Premiums – The premium levels are likely to be relatively high. This uncertainty could have an impact on the health plan participation and the type of patients attracted to these products.
• Network Participation – Payors that want your system in the network will seek either to add the product to existing contracts or to initiate new contracts just for the impacted population.
• Kaiser Effect – How much volume will be lost to Kaiser if you do not participate?
• Utilization Impact – Utilization for an exchange population is unclear.
V. Provider Financial Impact

Impact on Current Payor Mix

One step in preparing for the exchange will be to understand the reimbursement impact of a shift in payor mix from one category to another.

- The ACA and the introduction of exchanges will shift your payor mix.
- Depending on the value of the exchange category contracts, the delicate balance of cost shifting may be disturbed.
- This impact can be profound if the exchange population is large enough or if you do not negotiate to ensure that exchange-related contracts maintain a sufficient margin.

V. Provider Financial Impact

Projections for Potential Payor Mix Changes

Analyzing the impact of payor mix changes will depend on several key assumptions.

Analysis Steps

- Develop a current status view – revenue and profitability by payor.
- Project anticipated payor mix changes.
  - How much volume will shift to the exchanges?
  - How much additional Medicaid?
- Project anticipated reimbursement.
  - Sensitivity analysis on the range of reimbursement possibilities.
  - Percentage of current Medi-Cal (e.g., Medicaid + $X) or commercial rates (e.g., commercial – $Y).
- Determine potential impact on profitability.
- Negotiate rates for exchange products based upon how much of a profit drop you can tolerate.
  - Discuss market-competitive rates with the payors.
V. Provider Financial Impact

**Physician Contracts**

Contracting for physician risk will be critical to aligning incentives for utilization management as well as generating positive margins.

- **High Physician Alignment** – Systems that include a significant number of physicians should also be concerned with professional fee contracting for exchange products.
  - Physician contracts for exchange products could be both partial-risk (i.e., at risk for physician spending only) and full-risk arrangements (i.e., at risk for both physician and facility spending).
  - Your alignment with specialty physicians (financial, technological, and operational) will also largely dictate your ability to take on more physician risk.
- **Low Physician Alignment** – Organizations that have low to moderate alignment among physicians would focus on case rates and bundled payment approaches, while those with high levels of alignment can enter into broader shared-savings or global reimbursement contracts.
  - Reimbursement targets for physician services should mirror those on the hospital side, as close to commercial rates as possible.
  - It is important to also consider reimbursement under current utilization levels versus future utilization, which is expected to be lower based on care coordination efforts.

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V. Provider Financial Impact

**Revenue Shift Example – Balanced Payor Mix**

In this example, revenue is shifting between payor categories. Given the respective margins, the organization’s profitability moves from $2.10 million to ($3.35) million.

**Revenue Before and After Health Exchange – Balanced Payor Mix**

(Dollars in Millions)

<table>
<thead>
<tr>
<th>Payor Type</th>
<th>Profit Margin</th>
<th>Pre-Exchange</th>
<th>Post-Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Revenue</td>
<td>Percentage</td>
</tr>
<tr>
<td>Medicare</td>
<td>0%</td>
<td>$52.00</td>
<td>52.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-45%</td>
<td>18.00</td>
<td>18.0%</td>
</tr>
<tr>
<td>Commercial</td>
<td>40%</td>
<td>27.00</td>
<td>27.0%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>-20%</td>
<td>3.00</td>
<td>3.0%</td>
</tr>
<tr>
<td>Exchange</td>
<td>-10%</td>
<td>0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$100.00</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
V. Provider Financial Impact

Revenue Shift Example – High Commercial Payor Mix

With a high commercial payor mix, if a sufficient number of small group employers shift toward exchanges (lower provider reimbursement), profitability will be negatively impacted.

Revenue Before and After Health Exchange – High Commercial Payor Mix

(Dollars in Millions)

<table>
<thead>
<tr>
<th>Payor Type</th>
<th>Profit Margin</th>
<th>Pre-Exchange</th>
<th>Post-Exchange</th>
<th>Profit Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>0%</td>
<td>$40.0</td>
<td>$40.0</td>
<td>$0.0</td>
</tr>
<tr>
<td>Medicaid</td>
<td>+45%</td>
<td>10.0</td>
<td>11.0</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Commercial</td>
<td>40%</td>
<td>45.0</td>
<td>35.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>+20%</td>
<td>5.0</td>
<td>2.0</td>
<td>(3.0)</td>
</tr>
<tr>
<td>Exchange</td>
<td>+10%</td>
<td>9.0</td>
<td>9.3%</td>
<td>(0.6)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$100.0</td>
<td>$97.0</td>
<td>$3.0</td>
</tr>
</tbody>
</table>

In this example, $10 million in commercial revenue, which is 22% of the commercial volume, moves to the exchange at lower rates of reimbursement. Total profit margin drops 38%.

V. Provider Financial Impact

Disproportionate Share Payments

Historical Approach

Based on Percentage of Medicaid Patients

Future Approach Starting 2014

Based on Percentage of Uninsured Patients

- The revised disproportionate share (DSH) payment methodology under Medicare will coincide with the introduction of health exchanges.
- The new methodology will no longer consider the percentage of Medicaid patients; instead, the DSH will be calculated based on the number of uninsured patients you care for.
  - The number of uninsured patients will be mitigated, significantly in most areas, by the expansion of Medicaid and the introduction of health exchanges.
  - The individual mandate for coverage and the removal of denial for preexisting conditions are expected to ensure that over 95% of the population will have coverage.
- Consequently, DSH adjustments are expected to be reduced compared to historical funding levels at hospitals.
VI. Payor Response

Contract Questions

• What types of contracts will your organization be offered from the payors?
  – Plans are likely to continue to use existing reimbursement structures.
• What other approaches might payors in the exchange take?
  – In many markets, payors are building narrow networks to care for exchange patients.
  – Narrow networks may include non-exchange patients.
• Will your competitors be contracting for exchange patients?

VI. Payor Response

Pricing Approach Options

<table>
<thead>
<tr>
<th>Medicaid Rates</th>
<th>90% of Medicare Rates</th>
<th>100% of Medicare Rates</th>
<th>135% of Medicare</th>
<th>5% to 10% Discount From Commercial Rates</th>
</tr>
</thead>
</table>

Example Options for Developing Contracting Rates

<table>
<thead>
<tr>
<th>Contracting Rate Approaches</th>
<th>Basis for Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution Margin</td>
<td>+/-10% of the commercial rate for a given payor’s contribution margin.</td>
</tr>
<tr>
<td>Percentage of Medicare</td>
<td>+/-10% of the commercial rate for a given payor as percentage of Medicare.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basis for Rates</th>
<th>Aggregate Commercial Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor-Specific</td>
<td>+/-10% of the aggregate average commercial contribution margin.</td>
</tr>
<tr>
<td>+/-10% of the aggregate average commercial rates as percentage of Medicare.</td>
<td></td>
</tr>
</tbody>
</table>
VI. Payor Response

Medicaid Products

- Medicaid plans will participate on the exchange so patients exceeding 133% of the FPL can continue with the same insurance provider by switching to another product.
- Continuity of care will be maintained for the patients moving to and from the exchange and a commercial product.
- Payors anecdotally estimate that as many as 50% of Medicaid/exchange patients will have changes in eligibility each year.

Providers must be concerned with patients in low income or unstable jobs situations “churning” between exchange products and Medicaid.

VI. Payor Response


- To keep rates down, payors are pressing providers for discounts.
- In return for discounts, providers are part of a smaller network.
- Providers receive more health exchange patients due to small networks.
- Tenet Healthcare Corporation.
  - Signed three contracts for narrow or tiered networks.
  - Granted discounts of less than 10% for 15 hospitals, which is approximately 30% of Tenet’s hospitals.
  - Discounts were from Blue Cross and Blue Shield plans.
- Premiums are the most important factor in consumer's choices.
- More than 50% of the patients opt for a narrow network if it costs 10% less than an equivalent plan.
- Blue Shield of California – Preferred network with 40% to 45% of a traditional PPO network.
- WellPoint – Rates at close to Medicare.
- Aetna – Rates between Medicare and commercial.
VII. Preparing Your Organization
Payor Strategy

There are a number of tasks that your system can proactively perform to stay ahead of the curve in responding to health exchanges.

- Proactively negotiate and contract with payors for the exchange products.
- Understand that payors may want to include the new products in existing agreements.
  - Structure your agreement to reduce the potential for add-on products (e.g., exchange products) at will.
  - Focus on freestanding agreements for the exchange products so that reimbursement for that population can be isolated.
  - If an amendment is necessary, add an amendment term clause.
- Evaluate the likely response of your competitors.
- Determine your preferred pricing strategy for these products.
  - Medicare plus rates.
  - Commercial rates.
  - Adjusted commercial rates.
  - Narrow-network rates.

VII. Preparing Your Organization
Contract Tactics

As another commercial product, exchange-based products can be approached like any other contract negotiation. Your current rates should be used as the basis for the exchange rates.

- Understand that payors may have the contractual ability to include the new products in existing agreements at current rates.
- Exclude exchange products from commercial narrow networks to avoid having exchange patients reimbursed under lower rates reserved for the narrow-network population.
New Contract Considerations

• Allows greatest flexibility for the provider.
  – Ability to negotiate rates.
  – Flexibility to limit the term.
• Provider can clearly specify the exchange participants (e.g., individuals and small groups only).
• Does not interfere with your current HMO and PPO agreements.

Given the uncertainty of pricing, the levels of participation, and the potential migration of commercial business to the exchange, providers need flexibility to negotiate rates and exit the contract if necessary.

VII. Preparing Your Organization
Contract Scenarios

Review your contract language regarding the ability of the payors to add products, and determine whether the contract delineates all contracted products.

<table>
<thead>
<tr>
<th>Scenario A – Base Agreement Allows Addition of New Health Plan Products</th>
<th>Scenario B – Base Agreement Needs to Be Amended</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Payor can add exchange product(s) automatically.</td>
<td>• Payor can only add exchange products with a signed hospital contract amendment.</td>
</tr>
<tr>
<td>• Payor can only add an exchange product with your approval; approval is not to be unreasonably withheld.</td>
<td>• Hospital can now negotiate new rates for the exchange.</td>
</tr>
<tr>
<td>• Payor may not need to provide you with notice of a new product.</td>
<td>• Amendment can include specific termination clause – avoids termination of all products (HMO, PPO, Medicare Advantage).</td>
</tr>
<tr>
<td>• Existing contract rates apply.</td>
<td>• Allows you to decline participation in the exchanges.</td>
</tr>
<tr>
<td>• If rates are low, you have a problem – should you terminate the entire contract?</td>
<td>• Should you negotiate a new stand-alone contract for the exchange?</td>
</tr>
<tr>
<td>• If rates are high, you are in a good position.</td>
<td></td>
</tr>
</tbody>
</table>
VII. Preparing Your Organization

Contract Strategy, Language and Operational Challenges

- **Patient Identification Cards** – How will patients be identified at the time of registration and how will payment be impacted?
- **Product Definitions** – Contract needs to specify clearly that the rates are for a Health Exchange patients only.
- **Existing Product Becomes the New Health Exchange Products** – Payor selects an existing product to be the health exchange product then requests a lower contracted rate. If a new contract is not agreed to then the current product is terminated by the payor.
- **Related Entities** – Can other owned or affiliated organizations access the health exchange contract rates?
- **Other Payors** – Can other payors access the rates?
- **Product Offering Off the Exchange and On the Exchange** – Should the contract language clarify this point?
- **Payor Filings** – Payors are filing hospitals as being in network at current contract rates without informing the providers.
- **Narrow Networks** – Are Payors filing your organization as a provider being in the network while developing a narrow network with your competitors?

VII. Preparing Your Organization

Key Considerations

Deciding to participate in a payor’s health exchange product network is a unique decision for each organization. “Why would I do this?”

<table>
<thead>
<tr>
<th>Good Conditions for Participation</th>
<th>Participation Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Safety net hospital.</td>
<td>• Inability to negotiate rates at near commercial rates.</td>
</tr>
<tr>
<td>– High uninsured patient population.</td>
<td>• Volume exceeds what was expected, and the lower rates impact profitability.</td>
</tr>
<tr>
<td>– High Medicaid population.</td>
<td>• Difficult to identify health exchange patients at registration, which leads to payment reconciliation issues.</td>
</tr>
<tr>
<td>• Potential for establishing a narrow network at the expense of your competitors.</td>
<td>• Payor uses lower health exchange rates to pay for other products.</td>
</tr>
<tr>
<td>• Potential for additional volume that adds to contribution margin.</td>
<td>• Commercial payors could shift groups to lower-paying rate schedules.</td>
</tr>
<tr>
<td>• Small discount off of current commercial contract rates.</td>
<td>• There could be operational confusion.</td>
</tr>
<tr>
<td>• Limited term – 1 year.</td>
<td></td>
</tr>
</tbody>
</table>
VIII. Open Discussion

Our Speaker

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