"Managed Care": "Back to Basics"
Context, Structures, Regulation, Developments

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Some Macro Context

- $1.7+ trillion health care sector, 15.3% of GNP, projected to $3.4 trillion in 2013
- Sources of health care coverage
  - 56% employer-based
  - 12% Medicare
  - 13% Medicaid (Medi-Cal) and other public programs
  - 5% Private and individual
  - 15% Uninsured
- Annual premium increases in employer-sponsored coverage:
  roller coaster from 18% in 1989 to 0.8% in 1996 to 13.9% in 2003, 11.2% (11.4% in CA) in 2004
- CA HMO premiums lower than national, PPO rates higher than national
  - (mo’ly $792 vs. $721 for fam in HMO grp plan; PPO $981 vs. $851)
- Actual consumer out-of-pocket costs relative to employer contribution down from 40% in 1970 to about 16% today – tho actual consumer costs continue to rise
- Costs rise more slowly in CA
- ½ of personal BK’s are health care cost-related
Macro: Spending

- Health care spending per capita up 69% from 1993 to 2003, outpacing inflation and wage growth, slight slowing (7.7% increase 2003-2004 vs. 9.3% 2002-2003)

- Spending distribution
  - 30.7% hospital
  - 22.0% physician and clinical services
  - 10.7% prescription drugs
  - 10.3% dental/other professional
  - 9.0% nursing home/home health care
  - 7.1% administration
  - 10.2% other
  - Highest increase in admin (13.2%) and prescription drugs (10.7%)
Managed Care

- Comprehensive health care services arranged through systems of contracted networks of providers, for set periodic payment, “full” assumption of risk by MCO, with distinct mechanisms of care coordination, quality assurance
- Rules and conditions apply, both public and private. Closely regulated, mostly at state level, with patient-protection the motif.
- “capitation” compensation system of rates negotiated with providers, either groups or individually: note inherent tensions
- mc entity typically bears the financial risk for provision of services needed: “full financial risk on a prospective basis” (KK and federal HMO Act)
“Managed Care” (cont’d)

- Found in both private and public sectors
- Some member “co-payment” or “co-insurance” typically required, by benefit
- Predominant if not dominant mode of delivery of health care services
Contrasted with “Traditional Care”

- Freedom of choice: for patients re providers and for providers re services
- “usual and customary” “fee for service” billing to insurer, which pays, with the patient making up some difference (typically 80/20 split)
- Impossible to predict medical costs
- Provider incentive is to order services, a serious cost-driver
- More autonomous physician practices, “cottage industry” model
Emergence of Managed Care

- Ross-Loos staff model, late 20’s
- Henry Kaiser and Dr. Garfield, dams and shipyards, 30’s and 40’s: service the workers, with NP plan and medical groups, emphasis on coordination, integration and quality of care
- Birth of the Blues, “California Physician Services”, late 30’s, judged not insurance (1946 Garrison case) (Anthem not yet met)
- CA AG regulation as “charitable organizations”
- Medicare and Medicaid in mid-60’s lead to cost explosion
- CA’s Knox-Mills Act of1965
- 1973 federal HMO Act first major regulation, with standardization and even seed money for development (42 U.S.C. Section 300e)
Emergence of Managed Care (cont’d)

- CA’s prepaid Medi-Cal program and scandals (early to mid-70’s)
- ERISA (29 U.S.C. Section 1001 et seq.) in 1974
- Knox-Keene Health Care Service Plan Act of 1975 (H&S 1340 et seq.)
- Shift from non-profit to for-profit structures in early ’80’s
- CA statutory policy encouraging innovative negotiated provider structures (1982) (see Insurance 10133.6, B&P 16770, H&S 1373.9)
- Indemnity premiums sky-rocket in late 80’s, health care expenditure annual inflation rate 15+, employers turn more to mc
Managed Care Today: Ubiquitous in CA, some major forms:

- “commercial”
  - HMO’s (aka “hcsp’s” in CA per KK): the core model
  - Preferred Provider Organizations ("PPO’s")
    - Exclusive Provider Organizations ("EPO’s")
  - “consumer-driven health plans”/”defined care”
  - “discount plans”
  - “purchasing pools”, “marketing cooperatives” (e.g., CalChoice, PacAdvantage)
Managed Care Today: Ubiquitous in CA, some major forms: (cont’d)

- Public
  - Medi-Cal mc programs
  - Medicare Advantage
  - Local Initiatives, County Organized Health Systems
  - Workers’ Comp programs: Health Care Organizations, Managed Provider Networks (both are in the private sector)
  - Healthy Families Program, Health Kids Program
Managed Care: Market Penetrations

- National:
  - HMO peaks near 80M in 1999, in 2004 68.8M; PPO 109M in 2004
  - Combined HMO and PPO:
    - Medicare: 12.47%
    - Medicaid: 60.3%
    - Commercial: 91.2%
- State: HMO highs: CA (48%), CT (39.1%), MA (37.4%), RI (31.6%); lows: ND (0.3%), MS (0.4%), WY (2.2%), AL (2.8%)
Managed Care: Big Fish, Consolidation

- Total 2004 MC Enrollment (HMO, PPO, EPO, POS):
  - Anthem/WellPoint, 28M
  - Aetna U.S. Healthcare, 13.6M
  - United Health Group, 10.8M
  - Cigna HealthCare, 9.9M
  - Kaiser Foundation Health Plans, 8.4M
  - Followed by HealthNet (7.3M), Humana (7.0M), Coventry (3.1M), Pacificare (3.0M)

- Total by HMO only
  - Kaiser (8.9M), United HG (3.8M), WellPoint (pre-merger) (3.8M), Aetna (3.5M) Health Net (3.4M)
Some California Consolidation
“Go Where You Wanna Go, They Do What They Wanna/Wanna Do”

Traditional Indemnity

Employer
Or
Individual

Premium

Insurer

Each collects patient $ share

("Sick")

Doctors*
(ANY)

& Maybe Orders
-Lab
-Hospital
-Etc.
(ANY)

Bills ffs

Each bills ffs

Pays

> or to a “PPO” for lower patient share
> or to an “EPO” for even lower patient share
> in both PPO & EPO, negotiated rate for docs & in some for hospitals
> In a “POS”, pay more to go outside of network

*
“It’s All In The Game”

HMO/HCSP

Employer

Or

Individual

(pmpm) fee

HMO

Contracts with, at another pmpm fee

Patient copay or coinsurance

“Member” sick, goes to “PCP”

Hospitals

Doctors*

PCP gets ok for specialist or non-physician services

Labs

Ambulance

Etc.

Individual

Medical Groups

IPA’s

*POS option in most plans
Some Important MC Provider and Other Elements

- Medical Groups, full and specialty
- Independent Practice Associations (“IPA”), full and specialty
- Hospitals
- Labs
- Administrative Services companies
- Pharmacy Benefit Management companies
- Physician Practice Management companies
- Accountants and lawyers and solicitors
- Etc.
Who’s In Charge? Laws and Regulators (Note: 40 states’ regulation of insurance and hmo’s is housed in same department)

- HCSP’s: Knox-Keene Act (H&S 1340 et seq.), Department of Managed Health Care.

A “health care service plan” is “any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.” (H&S 1345(f)(1)); 48 “full service”, 59 “specialized.” Some key features:
“basic health care services” (physician, hospital, lab, home health, preventative, emergency, hospice) and numerous others “mandated”

Opportunity for Independent Medical Review (“IMR”)

“quality assurance”

Fiscal soundness of plans: “tangible net equity” requirements

Provider solvency standards

Detailed regimen for “small employer groups” and for “Medicare supplement” plans

Specialty plans licensed too: dental, mental, chiro, ambulance, etc.

Very detailed regulation by DMHC, through regs, “Director’s Opinions”, bulletins, “material modifications” or “amendments” of licensure documents, ad hoc directives

Tenor of KK provisions has shifted from broad to very detailed and prescriptive
Who’s In Charge? More Laws and Regulators

- Federal HMO Act (42 U.S.C. Section 300e), U.S. Department of Health and Human Services (“DHHS”), Centers for Medicare & Medicaid Services (“CMS”)
  - plans that want to contract with CMS for federal mc programs must secure qualification
  - comprehensive scheme similar to KK, but preempts KK counterparts
  - elements include conditions of participation, quality assurance, grievance handling, claims payment and so forth
  - some overlap with ERISA, HIPAA (see below)
- Medicare Advantage Program (formerly Medicare+Choice), CMS
  - Managed care plans, PPO plans, private FFS plans, specialty plans
And More Law and Regulators

- Medi-Cal prepaid health plans (W&I 14081 et seq.), Department of Health Services ("DHS")
- Local county systems for Medi-Cal eligibles
  - "Local Initiatives" (W&I 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96), DHS
  - "County Organized Health Systems" (W&I 14087, et seq., H&S 101675, Managed Risk Medical Insurance Board)
  - "Healthy Families Program" (Insurance 12693) and "Healthy Kids Program"
- Geographic Managed Care Plan (W&I 14089)
Workers’ Comp mc structures, Division of Workers’ Compensation, Department of Industrial Relations

- Medical Provider Networks (Labor 4616 et seq.; emergency regulations): brand new, employer-oriented mc “lite”
- Integrated Care (Labor 3201.5 et seq.): open-ended mc possibilities through labor-management negotiations
- “Pre-designation” (Labor 4600(d)): member can choose his/her regular plan doctor for “occupational care” needs
- Health Care Organizations (Labor 4600.5 et seq.): earlier attempt to bring mc to workers’ comp
And More…

- Indemnity “mc” through PPO’s and EPO’s (Insurance 740 et seq., 10133(c)), Department of Insurance: not much “mc”, mostly network restrictions
- Purchasing Pools: aggregating purchasing power, e.g.’s:
  - Pac Advantage (for small groups), public HIPC spin-off
  - CaliforniaChoice Program (small and large groups) (Insurance 10820(i) as a “marketing cooperative”)
  - PBGH Negotiating Alliance (big employers)
  - “purchasing alliances” (Insurance 10800 et seq.), few takers

- Carves out from state regulation an “employee welfare benefit plan” run by an employer, establishes protections for participants
- Requires plans to provide participants with plan information about plan features and funding
- Establishes fiduciary responsibilities for those who manage and control plan assets
- Requires plans to establish a grievance and appeals process for participants to get benefits from their plans
And More ERISA…

- Gives participants the right to sue for benefits and breaches of fiduciary
- Preempts state laws that “relate to” an ERISA plan
- Murky, much of its “content” divined through litigation and case law
Health Insurance Portability and Accountability Act of 1996 (codified in various sections of Titles 18, 26, 29 and 42 U.S.C.; “HIPAA”)

Intent is to improve the portability of coverage in individual and group insurance/hmo markets and group plan coverage provided in connection with employment. Some intended features:

- Limits pre-existing condition exclusions
- Prohibits enrollment and premium discrimination based on health status
- Provide credit for prior coverage
...And More HIPAA

- Guarantee availability of coverage of employees of “small employers” and renewability of coverage in both large and small group markets
- Assure confidentiality of personal health information, including electronic
Some Market Dynamics Affecting Manage Care

- The cost-benefit ratios of U.S. health care system
- Cost-drivers, such as prescription drugs and new technologies
- Aging population, “baby-boomers”
- Revolts against managed care, HMO enrollment down, PPO up
- Push for greater cost-shoauldering by patients: “skin in the game” (organs?)
  - Higher co-payments and deductibles
  - “Consumer-driven health plans”
  - “Defined” benefit plans
Some Market Phenomena Affecting Manage Care (cont’d)

- Mandated services
- The uninsured, leading to suggestions of “universal coverage”, “single-payor”, mandated coverage by employer, mandated coverage period
- “discount plans”
- “pay for performance”
- Medicare provider rates about 80% of private, Medi-Cal 50%
- Lack of vision or consensus about how to “fix it”
Some Good Websites for Information

- CA Department of Managed Health Care: [www.dmhc.ca.gov](http://www.dmhc.ca.gov)
- CA Department of Insurance: [www.insurance.ca.gov](http://www.insurance.ca.gov)
- Integrated Healthcare Association: [www.iha.org](http://www.iha.org), which includes scores of links
- California Healthcare Foundation: [www.chcf.org](http://www.chcf.org)
- Health Affairs: The Policy Journal of the Health Sphere: [www.healthaffairs.org](http://www.healthaffairs.org)
- Health Lawyers Weekly: [www.healthlawyers.org](http://www.healthlawyers.org)
- Medicare Program: [www.medicare.gov](http://www.medicare.gov)
Questions???