Tiered Benefit Plans: in the Crosshairs

Neil M. Sullivan

by Neil M. Sullivan, Esq.

Tiered health benefits plans are plans that have more than one level of in-network benefit. Insureds have a financial incentive to use service providers in the first tier – usually through one or more of lower deductible, coinsurance or co-payment. They can get covered services from providers in the second tier, but at a higher out-of-pocket cost.

To some, tiered benefit plans are the future of health benefits – focusing services efficiently through a core team of service providers working together to increase quality while holding down costs. To others, they represent a triumph of backroom deals over best-practices medicine, with insurance bureaucrats wresting healthcare delivery decisions from doctors and their patients, and usurping the State's rightful oversight of the delivery system as those relegated to the second tier fight for survival.

As care becomes more directed, two issues become paramount – is the capacity in that first tier sufficient to provide the access advertised, and how were those providers selected?

The network adequacy dialogue that is now taking place in New Jersey was in some ways made inevitable by the Affordable Care Act. Traditionally, the levers to control prices of health insurance plans included plan design (what is and is not covered), cost-sharing (deductibles, copays and coinsurance), and reimbursement (how much is paid by the plan considering both price and volume). For individuals and small groups the ACA largely fixed the plan designs by defining essential health benefits and requirements for Qualified Health Plans, and the cost-sharing, by defining bronze, silver, gold and platinum plans primarily through application of varying cost-sharing. For insurers to differentiate their pricing in the marketplace this led to increased pressure on the third lever, and ratcheting down price and volume frequently meant deeper discounts and more tightly coordinating care through a winnowing of the networks.

Tiered networks have been around in New Jersey for the past few years, but the issue was pushed into overdrive when New Jersey's largest insurer made a major push in this direction with the introduction of Horizon's Omnia plan at the end of last year. Driving great volume to the first tier inevitably affects both the services received by a larger portion of the population and financial viability of those providers not in the first tier. How was this hierarchy determined? Horizon has generally responded that its process is proprietary.

State Network Adequacy Requirements

New Jersey saw its first tiered benefit filings while I oversaw the Office of Life and Health at the New Jersey Department of Banking and Insurance. Existing network adequacy requirements were the only regulatory tools available by which to approve or disapprove these plans. We held to the position that the first tier of the network had to meet the existing adequacy requirements. It would be misleading, it seemed to us, to market a plan as having an inexpensive first tier in an area where the first tier providers were geographically out of reach. It was not a popular position with the carriers filing the products, but the industry seems to have embraced it since. While I was at the Department I had occasion to discuss network adequacy issues with my peers in other states. I was struck by the number of states that did not have any network adequacy requirements set out in regulation, particularly for managed care plans of insurance companies.

For Health Maintenance Organizations, New Jersey's network adequacy standards are codified at *N.J.A.C.* 11:24-6.1 *et seq.* In summary they call for:

- a sufficient number of primary care providers,
- adequate numbers of specialists by type, each of which must be sufficient to ensure access within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or smaller service area; and
- an array of institutional providers meeting time and distance criteria.

For insurance companies other than HMOs, analogous requirements are found at *N.J.A.C.* 11:24A-4.10.

A small but very professional and diligent staff at the Department is dedicated to reviewing the submissions, and they are very thorough and very experienced.

However, historic network adequacy measures - including New Jersey's - are necessarily rough. They tend to count heads

continued on page 34

continued from page 33

by practice type, bricks and mortar buildings by accreditation type, and where those heads and buildings are geographically in relation to membership. This puts a premium on volume and proximity over quality, and doesn't factor in the reality that some practices are more limited than their specialty alone suggests. In the past, networks tended to be more inclusive than exclusive, and when nets are cast widely there is little risk that quality will be excluded or necessary subspecialties unavailable. As networks or tiers are established more narrowly, these issues loom larger. It is also true that changes in delivery model increasingly make time and distance standards less relevant. We saw this in New Jersey with the 2009 autism insurance reform. When individuals certified in behavior analysis are performing their activities in the patient's environment, how relevant is the mileage to their office? Similarly, when Medicare and other payers are supporting electronic means of communication between patients and providers, how important is geography for those services?

At the end of the day, health insurance purchasers are interested in whether they will be able to get quality services they need, when and where they need them. While historic measures may have served us well in the past, it is understandable we find ourselves in the middle of new policy discussions at the State and Federal levels concerning appropriate guardrails in this new emerging landscape. And it is appropriate that conversation expands from time and distance to encompass criteria for selection. Advocates on both sides have debated whether the designation 'Tier 1' in and of itself denotes higher quality, but there is no denying that when families are financially incented to receive their care within a narrow circle, there is a societal interest in how that circle was constituted.

It is also an economic reality that many providers rely on commercial insurance reimbursement levels to compensate for shortfalls in reimbursement for charity care and under-paying government programs. Tiering structures that could avoid providing that cross-subsidy by steering commercial patients to providers with more affluent patient bases could threaten the viability of safety-net providers. Even without reliance on the cross-subsidy, many care providers contracting with carriers agreed to price concessions in the expectations that patients would be steered toward them. Relegated to second-tier status, they now find those tiered plans steering patients to their competition.

NAIC Model

The National Association of Insurance Commissioners took up the issue on a national level and adopted a new "Health Benefit Plan Network Access and Adequacy Model Act" in 2015, to take on many of these concerns.

NAIC Models are instructive in that they generally represent the consensus thinking of the nation's insurance commissioners on the issue at hand, and therefore carry weight with many legislators and Insurance Departments. Of course any national network adequacy model must necessarily leave many of the specifics to local authorities – requirements that may work in populous New Jersey will surely be an impossible standard in states like Montana. Putting aside local issues, however, the 2015 Network Adequacy Model Act incorporates the following design elements:

- The definition of network adequacy affirmatively incorporates the obligation to include those providers who serve predominantly low-income, medically underserved individuals to meet adequacy standards;
- The Model places greater emphasis on the ability to get authorization for out-of-network providers at in-net work cost-sharing, if the specific sub-specialty is either absent from the network or otherwise not sufficiently available to a patient. This includes reporting requests for out-of-network access and carrier responses to the Insurance Commissioner, who can then better monitor network adequacy;
- Requiring carriers to file an adequacy plan with the Insurance Department, which would include use of telemedicine, out-of-network authorization processes, and the criteria for network selection;
- Transparency requirements, including participation status of hospital-based physicians, and cost ranges for those out-of-network; and
- A mediation process for disputed out-of-network bills for providers not selected by the patient.

CMS on Network Adequacy and Tiered Networks

The Centers for Medicare and Medicaid Services (CMS) has established network adequacy requirements that apply to Qualified Health Plans, which are generally plans that have been qualified to sell on the Federal Marketplace. These are codified at 45 CFR § 156.230. Under these rules, carriers are generally required to maintain adequate networks, which may be defined by state regulations. Carriers are more specifically also required to include a sufficient number of providers that serve predominantly low-income, medically underserved individuals (Essential Community Providers), maintain provider directories that are accurate and up-to-date, and provide continuity of care when providers leave the network. As in New Jersey, the current rules make no reference to tiering.

Interestingly, CMS sought input on possible additional standards when it proposed its "Notice of Benefit and Payment Parameters for 2017":

> "In the proposed rule, we solicited comments on a number of other network adequacy standards, including standards included in the work being done by the NAIC's Network Adequacy Model Review Subgroup. Our solicitation of comment included…

> Whether issuers should be required to make available their selection and tiering criteria for review and approval by HHS and the State upon request."

CMS did not act on the comments in finalizing the rule, but had this to say in the preamble on those two issues:

- "We encourage issuers to be more transparent about selecting and tiering criteria. We believe that transparency of selecting and tiering criteria would help enrollees and providers better understand how the issuer designed its network, which could help enrollees use the network more effectively and efficiently.
- "We are not implementing additional network adequacy related provisions at this time. Our intention is to give States time to adopt the NAIC Network Adequacy Model Act provisions and potentially reconsider this area in the future."

This suggests we may yet hear more from the Federal government on this issue.

The ACA's Prohibition on Non-discrimination

An intriguing unknown in all of this is the new and largely untested prohibition in the ACA on health plans' discriminating against licensed health care providers.

PHSA section 2706(a), as added by the ACA, says that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law." However, the section "shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer." It further provides that nothing in the section prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." Similar language is included in section 1852(b)(2) of the Social Security Act and HHS implementing regulations.

So the ACA prohibits discrimination in plan participation against any licensed practitioner, stops short of adopting an "any willing provider" standard in health plans, and permits varying reimbursement by quality or performance measures. The NAIC and CMS actions described above, both of which acknowledge the advent of tiered benefit plans, post-date this statutory requirement. It would therefore appear those bodies do not consider relegating some duly licensed providers to a separate tier with lower reimbursement as per se discriminatory under Section 2706(a). But an about-face on what the section does mean by the Departments responsible for implementation may be illuminating:

"Provider Non-Discrimination FAQs about the Affordable Care Act Implementation Part XV" published jointly by HHS, DOL, and the Department of Treasury on April 29, 2013, included the following in response to question 2 regarding this section of the law:

> "This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations."

Subsequently, the Senate Committee on Appropriations issued a report dated July 11, 2013 which criticized this section of the Departments' FAQs:

> "The goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State. The Committee is therefore concerned that the FAQ document issued by HHS, DOL, and the Department of Treasury on April 29, 2013, advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in reimbursement rates based on broad "market considerations" rather than the more limited exception cited in the law for performance and quality measures. Section 2706 was intended to prohibit exactly these types of discrimination."

The Departments accordingly pulled back in "FAQs about Affordable Care Act Implementation (Part XXVII)". It more directly quoted the section of the ACA, and provided the following Q&A:

"Q5. Does Q2 in FAQs about Affordable Care Act Implementation Part XV continue to apply?

No. Q2 in FAQs about Affordable Care Act Implementation Part XV, which previously provided guidance from the Departments on PHS Act section 2706(a), is superseded by this FAQ and notation will be made on the Departments' websites to reflect this modification."

While it remains to be seen how far this provision may be employed in challenging carrier network participation and tiering decisions, using criteria that go beyond performance and quality measures are clearly at greater risk of challenge.

Recent New Jersey Legislative Activity

Multiple bills have been introduced in the legislature in the wake of the launch of Horizon's Omnia plan, attempting to wrestle with this issue from different angles. These include re-

continued on page 36

continued from page 35

quiring inclusion of state hospitals in the highest tier, requiring actuarial value disclosure, and establishing a minimum actuarial value for the lowest tier (S296/A2329); freezing enrollment in current tiered plans until legislation and regulations are in place (S1934/A3558); requiring tiering placement based on cost and efficiencies, disclosing tiering criteria, and establishing an oversight monitor (S634/A887); requiring network adequacy to apply to the first tier and prohibiting conditional approvals (S635/A2328); and establishing a Task Force on Tiered Health Insurance Networks (S1512/A888).

Wherever these bills go, they have fostered a much-needed public dialogue on issues of network access and criteria for inclusion in a changing healthcare delivery environment.

About the author

Neil M. Sullivan is a Partner in the Health Care Practice Group at McElroy, Deutsch, Mulvaney & Carpenter, LLP. Mr. Sullivan served as the Assistant Commissioner for Life and Health at the New Jersey Department of Banking and Insurance from March 2010 to March 2014. McElroy, Deutsch Mulvaney & Carpenter has twelve offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware and Colorado. Neal can be reached at NSullivan@mdmc-law.com.

What's In Your Beach Bag?

NJ HFMA Members share their personal and professional reading picks

The Boys in the Boat - Daniel James Brown
Recommended by Lindsey Colombo

The Nightingale by Kristin Hannah. It is a phenomenal book about the reality of war in France during WWII.
Recommended by Lindsey Colombo

Zapp! The Lightning of Empowerment: How to Improve Quality, Productivity, and Employee Satisfaction, by William Byham and Jeff Cox. It is a great, easy read and applicable to any industry/role in business.
Recommended by Brittany Pickell.

Man's Search for Meaning by Viktor Frankl. It is an autobiography chronicling his experiences as an Auschwitz concentration camp inmate during World War II, and describing his psychotherapeutic method, which involved identifying a purpose in life. Something we all could use as we transcend the changing environment in our industry.
It is one of the best books I've ever read!
Recommended by Dave Alexander

In my beach bag – in between the jugs of sunscreen and big hat is a fascinating book *READY PLAYER ONE* by Ernest Cline. This book was a gift to me from Anthony Chiafullo which I just finished two weeks ago. It really brought back a lot of memories for me growing up in the video game culture – there are a lot of inside jokes as well as some references that will bring a smile to the reader. I would say it is along the lines of a funny, science fiction thriller set in a futuristic (and depressed) United States. Also I have heard that Steven Spielberg is making it into a movie for 2017. I have been reading more fiction as they are somewhat more enjoyable but for those that prefer non-fiction I would also recommend *Killing Patton* by Bill O'Reilly – I know it has been out for a while but well worth the read. And for readers that may have read *Blackwater* by Jeremy Scahill – I recommend *Civilian Warriors* by Erik Prince as a rebuttal to *Blackwater*. I would also like to thank Brian Herdman for his review of *The Martian* – still have not seen the movie because I do not believe it can live up to the book.
Recommended by Scott Besler