HMO Oversight and Its Relationship to Delivery System Performance

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Who Regulates Health Insurance Products?

DOH	DFS
Limited to HMOs, (including PHSPs)	Fee-for Service (indemnity plans), POS, PPO, EPO, HDHP HMO – commercial benefits and financial health

Delineation of Responsibilities for HMOs

DOH

- Fiscal Solvency/Reserves: MMC
- Capitalization Requirements: MMC
- Provider contract approval: Prior approval - all HMOs
- Monitoring and Oversight: Annual surveys, focused review, ongoing reviews of key areas: all HMOs
- Fraud and Abuse: Limited to MMC with between 10,000 and 60,000 members

DFS

- Fiscal Solvency/Reserves: Commercial MCOs
- Capitalization Requirements: Commercial MCOs
- Provider contract approval: None
- Monitoring and Oversight: Fiscal audit once every three years: Commercial only
- Fraud and Abuse: MCOs with 60,000 or more members enrolled

Laws and Policies Affecting Insurance Coverage and Payment

Medicaid Managed Care Model Contract

- Enrollment and disenrollment inpatient coverage
- Benefit coverage
- Authorization and appeal process

HMO Only (PHL, SSL)

- Out-of-network access, transitional care
- Provider rights, credentialing
- 15-month claim filing (MA, FHP, CHP) for non-par providers

HMO and Indemnity Contracts

- Prompt pay law
- Pre-existing conditions
- Overpayment recovery
- Utilization Review
- External Appeal
- Adverse reimbursement change
- Benefit coverage Commercial
- Credentialing limited to Art 48 products

Self-Funded Plans and ERISA Pre-emption

- As more companies become self-funded, impact of State oversight becomes more limited.
  - Provider protections diluted
  - Member protections less defined
    - Article 49 Appeals and External Appeal

Enrollment in Self-Funded vs. Insured Employer Sponsored Health Insurance

Based on the Urban Institute's HIPSM modeling for 2010:

- 9,671,000 New Yorkers have employer-sponsored coverage.
- Approximately 4,293,924 NY employees are covered by self-funded plans (approximately 44%).

Health Insurance Coverage for the Nonelderly in New York (2011)

Employer	9,603,000	57%
Employer (HNY)	65,000	0%
Non-Group	32,000	0%
Non-Group (HNY)	113,000	1%
Medicaid/CHP	4,067,000	24%
Uninsured	2,724,000	16%

Adapted from "Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State," Urban Institute Health Policy Center (March 2012).

Who Bears the Most Risk?

- Risk is assumed largely by:
  - Self-funded business
  - State/Federal Government
  - Insurance carriers for large group commercial market

Financial Stability

- HMO market
  - 10NYCRR 98-1.11 – Operational and Financial requirements for HMO's
    - Contingent Reserve requirements
    - % of net premium income for the calendar year
    - Increasing amount until 12.5% with some special rules for HMOs forming after 2011

Transfer of Risk by MCO to Provider

- HMO agreements are reviewed for transfer of risk from HMO to provider
  - Level 1: Contracts with providers or IPAs based on FFS arrangements, including with-holds and bonuses up to 25% of the payment to the provider
  - Level 2: Contracts transferring risk to providers or groups of providers for a specific service they directly provide with the provider accepting all *medical risk* for that service

Transfer of Risk by MCO to Provider (cont'd)

- Level 3: Contracts that transfer broader risk to providers (multiple services provided directly, inpatient hospitalization, or FFS with withholds or bonuses greater than 25%)
- Level 4: Contracts that transfer risk to IPAs for a single or multiple services.
- Level 5: Contracts falling under risk level 3 or 4 that include services not provided directly (out-of-network services).

11 NYCRR 101 – Regulation No. 164

- Standards for Financial Risk Transfers Between Insurers and Health Care Providers
  - Permits transfer of risk in prepaid, “capitation” arrangements
  - Applies to HMO/Provider (IPA) arrangements

ACOs and Risk

- Different ACO scenarios:
  - ACO contracts with insurer/HMO and provides clinically integrated services for capitated payment: No insurance license required.
  - ACO contracts directly with health care purchaser and receives FFS payment with shared savings: No insurance license required.
  - ACO contracts directly with health care purchaser and receives capitated payment: Insurance license may be required.

Considerations for Delivery System Performance: Financial Stability

- Whether applicant plans to accept risk now or in the future
  - In what context?
    - Insurance model (IPA, Medical Group)
    - ACO
    - Other
  - What financial resources are available?
    - Will parent or affiliated organization bear risk for providers?
  - What markets does the provider “play” in?
    - Medicare, Medicaid, Commercial
    - Percentage of the market in each of the above categories

Considerations for System Performance: Access to Care

- HMOs required to submit network through HCS
  - Reviewed for accessibility using time/distance standards, choice
  - Lack of access to network provider requires out-of-network access.
- Other Managed Models PPO, EPO
  - Networks are not reviewed for adequacy
  - OON access, but risk lies with member for payment
- Exchanges will require network submissions, but may not include an analysis for adequacy

Considerations for Delivery System Performance: Cost and Quality

- Integrated systems have great potential to improve quality.
- May yield systems that can deliver care more efficiently and improve quality more cost effectively.

Considerations for Delivery System Performance Cost and Quality

- Risk that the delivery system may wield market power to:
  - Increase costs resulting in increased insurance premiums (affecting employers, government or individual purchasers of health insurance)
  - Decrease access by reducing competitors
- Lack of competition and shifting of risk could adversely affect quality.

Questions ?