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Tips for Providers: Managed Care Contracting Under Health Insurance Exchanges

Almost 56 million Americans are currently uninsured. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act or ACA) seeks to drastically reduce this number by creating state-based and regulated marketplaces—"Exchanges"—that will offer millions of qualified individuals and small employers access to affordable private health insurance coverage. In essence, beginning in October 2013 and through the first open enrollment period ending in March 2014, qualified individuals and small employers will be able to select health insurance plans from an online portal, similar to booking an airline flight. Exchanges will make purchasing health insurance easier and more comprehensible by helping qualified individuals and small employers shop for, select from and enroll in one of a variety of affordable private health plans that fit their needs.

The majority of health insurance plans that will be offered on the Exchanges will be managed care plans with networks of health care providers such as hospitals and physicians. Consequently, providers must understand the impact of Exchanges and prepare accordingly. Most importantly, providers should review their existing provider agreements with managed care organizations to determine, among other considerations: if the existing agreement applies to the new product being offered by the managed care organization on an Exchange; whether amendments to the agreement are required; what services will be covered by Exchange-based products; and at what rate and fee schedule such services will be covered (and provided).

Specifically, providers should follow these tips when reviewing existing contracts and/or entering into new contracts with managed care organizations for Exchange-based products.

- **Determine Whether the Existing Provider Agreement Covers the New Product.** Whether an existing provider agreement will apply to new, Exchange-based products will generally depend on how certain terms are used and defined in the existing provider agreement. Specifically, providers should review the definitions of terms such as "Plan," "Benefit Plan," "Product" and "Line of Business." If only specific products are covered by the relevant defined terms, either by specific name or type, then the existing provider agreement will

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probably not apply to Exchange-based products and an amendment would be necessary before this could become the case. In contrast, an existing provider agreement will likely cover Exchange-based products where such terms have expansive definitions applicable to all commercial products offered by the managed care organization during the term of the agreement. It is also important that providers review the existing provider agreements for provisions giving the managed care organization the ability to exercise discretion in provider selection for new commercial products.

- **Decide Whether an Amendment Is Both Necessary and Sufficient.** An amendment to an existing provider agreement may be necessary and sufficient to include a new Exchange-based product. Depending on the language of the provider agreement, the managed care organization may be able to unilaterally amend the agreement. In some cases, however, the provider has authority to object to such an amendment. Thus, providers should carefully review amendment provisions within their existing provider agreements. If an amendment is not possible (or possible but not preferable), providers may consider entering into new provider agreements with managed care organizations to address Exchange-based products. Either way, a mutually clear understanding is critical.

- **Agree on the Scope of Exchange-Based Products.** It is important that providers agree with managed care organizations about the specific services, or benefit levels, that will be covered under Exchange-based products. Even more significant are fee schedules and rates. Providers should carefully review proposed fee schedules and rates to ensure that they are acceptable from the provider's perspective. If a new Exchange-based product is covered by an existing provider agreement, providers should be aware that the fee schedule and rates attached to that provider agreement will likely govern the new Exchange-based product as well.

- **Agree on Data Collection and Auditing Protocol for Exchange-Based Products.** One of the major goals of the ACA is to ensure a tighter nexus between payment for services and quality of care. To this end, providers and managed care organizations will need to strike the proper balance among protection of provider-specific proprietary information and transparent, effective quality-based assurance mechanisms. Developing common preordained guidelines for data collection and audits within the bounds of Exchange rules—even if this requires additional addenda or amendment—is well worth the investment on the front end to avoid frayed relations on the

back end.

- **Review Provisions Enabling Provider to Seek Repayment.** Although new enrollees in Exchange-based products will have insurance coverage, they still may be required to pay a sizeable portion of their medical bills under their new insurance plan. Accordingly, providers need to review provisions of its provider agreement relating to seeking payment, or prepayment, of copayments, coinsurance and deductibles from Exchange-based enrollees, as well as provisions pertaining to the collection of bad debt.
- **Improve Lines of Communication, Be Patient and Be Flexible.** Exchanges present managed care organizations and providers with a whole host of known, and unanticipated, challenges. It is important that providers develop liaison relationships with particularly knowledgeable individuals at the provider and managed care organization levels to efficiently address these challenges in a mutually acceptable fashion.
- **Evaluate Miscellaneous, Potentially Relevant Contract Terms.** In addition to the above, providers should carefully assess expiration, automatic renewal and termination provisions in both new and existing provider agreements. In many cases, agreements or applicable law will require 60-day notice provisions, for example, prior to termination of an agreement. Providers should also be aware that provider agreements for Exchange-based products may impose certain federal and/or state-based regulatory requirements on providers potentially inapplicable to other products. In many cases, Exchange-based products must include very specific elements and a managed care organization may need to restructure or readjust existing agreements to technically comply (and participate). Providers should be cognizant of the rules governing the Exchanges in which they participate.

The Health Care team at Reinhart Boerner Van Deuren s.c. is available to assist you with any of the aforementioned proactive measures. Please feel free to contact your Reinhart attorney, Larri Broomfield or any other member of Reinhart's Health Care team to discuss any questions or concerns related to your organization.

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