Managed Care

What people should know

Health Insurance – or is it?

- Fully-insured
- Self-funded
- Discount plans

What is out there?

- Major medical expense-incurred
- Indemnity
- Limited benefits medical aka Mini-Meds

- What is your coverage?

Focus Today

- Major medical expense incurred
- Also called Health Benefits Plan

Features you have heard of…

- Deductible
- Coinsurance
- Copayment

Approaches to cost sharing

Cost Sharing applied to…

- A patient receives care and a bill for the care.
- Example $100

Back in time

- Old deductible and coinsurance plan
- Maybe a $50 deductible then 80% coinsurance
- UNKNOWN: Allowed Charge

Limit to cost sharing

- Out of Pocket (aka OOP)
- Maximum Out of Pocket (aka MOOP)

- BUT neither OOP nor MOOP address the problem patients faced

Allowed Charge

- Reasonable and Customary (R&C)
- Usual and Customary (U&C)
- Usual and Prevailing (U&P)

- Etc. etc.
- PHCS/ Fair Health/Medicare

Benefit calculation

- Billed Charge = $100
- Allowed Charge= $ 90

$90

-$50

$40 x 80%= $32

Patient pays $50+$8+ $10=68

Where did the $10 come from?

- Balance billing
- The difference between Billed Charge and Allowed Charge
- Patient Responsibility!!!

Balance Billing Liability

- The HUGE unknown
- For the $100 service, maybe not a big deal
- What if the charge for the service is $10,000?

Patient Protection Needed

- Managed Care Plans provide the protection

Key Definition

- “Managed Care Plan means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangement with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan.” (NJAC 11:24A-1.2)

Defining terms within the definition

- **Health benefits plan**

  Benefits for hospital and medical expenses or provision of hospital and medical services

Think of major medical expense incurred

Defining terms within the definition

- **Participating Provider**

  Provider under contract with a carrier or its contractor or subcontractor that has agreed to provide services or supplies for a predetermined fee or set of fees

  (i.e negotaited rates)

Managed Care Plan Alphabet

You have probably seen

HMO

PPO

POS

EPO

- What do they mean????

HMO

- Health Maintenance Organization

  Referral model

  Direct/Open access model

PPO

- Preferred Provider Organization
- Network
- Non-Network
- No referrals

POS

- Point of Service

- Note: it may be HMO-POS or Insurer POS
  They are not the same!

EPO

- Exclusive Provider Organization
- Similar to HMO; generally no referrals required

Back to the definition

- Explicit Standards

- Carrier credentialing process
- Starting to see “Tiers”

Incentives?

- Patient incentives
  - Benefit design
  - No balance billing
  - Claim submission made easy

Perception is not always reality

Fear factor

Responsibility for patient care

No is easier than yes

Referrals = Mother May I?

Practice of medicine

The bottom line $$$

Protections

- Network adequacy
- Out of plan exceptions
- Emergency care

Adverse Benefit Determination

- Denial
- Reduction or termination
- Maybe it is a pre-ex
- Maybe it is experimental or investigational

What is pre-ex?

- Various definitions depending on plan
- N/A under age 19
- A thing of the past come 2014

Utilization Review …aka…

- Pre-approval or prior approval
- Pre-certification

- Whose job is it?
- Who can be penalized?
- Maximum penalty (assuming medically necessary)

Medical necessity

Sample definition

Services or supplies provided by a recognized health care Provider that the Carrier determines to be:

- necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
- provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
- in accordance with generally accepted medical practice;
- not for a Member's convenience;
- the most appropriate level of medical care that a Member needs; and
- furnished within the framework of generally accepted methods of medical management currently used in the United States.

More on medical necessity

- Who decides?
- What if a patient/provider disagrees?

Not the final word

Appeal rights

- Strong under NJ law
- Further strengthened under Federal law

Resources at NJDOBI

- Office of Managed Care 609-777-9740
- Call Center 609-292-7272
- DOBI Website
  http://www.state.nj.us/dobi/index.html
- Reform Website
  www.state.nj.us/dobi/reform.htm
- My contact 609-633-1882 ext 50302
- Ellen.derosa@dobi.state.nj.us