

Providers with Health Plans



For member health care systems and hospitals with health plans, the American Hospital Association (AHA) supports CEOs and their teams by addressing their advocacy needs, engaging their leadership to help shape policy and advocacy positions, and providing key resources.

Working for Providers with Health Plans

Engaging Providers with Health Plans

Providing Key Resources

History

- 1929 – Justin Ford Kimball, vice president at Baylor University’s School of Medicine, develops the first hospital care prepayment plan after learning that some Dallas teachers cannot pay their hospital bills
- 1933 – AHA helps to promote the development and growth of these plans, known as Blue Cross Plans, resulting in 16 Blue Cross Plans with 35,000 members across the United States
- 1937 – AHA organizes the Hospital Service Plan Commission
- 1939 – Blue Cross symbol signifies that health plans with this designation met certain standards
- 1960 – Blue Cross Association replaces the AHA Commission and begins to operate independently of AHA
- 1972 – AHA and Blue Cross Association divide into two separate organizations
- 1982 – The Blue Cross Association merges with the Blue Shield Association (pre-paid physician plans) and becomes the Blue Cross and Blue Shield Association

During the 1980s, managed care gained favor by health insurers as a way to channel patients into HMO and PPO networks and, in theory, to more effectively manage the cost of care.

By the 1990s, some health care systems and hospitals, believing they were best able to *manage* care, began to purchase or build their own health insurance plans. A decade later, many health care systems and hospitals divested these plans, explaining that the insurance function was not in alignment with business goals and strategies.

Today

Today's health care marketplace features increasing consumer choice, more transparency of cost and quality information about health insurance products and health care services, closer alignment between health care systems/hospitals, physicians and providers along the continuum, and greatly improved information technology as compared with earlier decades. These features, along with other factors, have created a favorable environment for increasing the number of health care systems and hospitals that solely or jointly own health plans.

- *Sole ownership* includes health plans that have been in the market 30+ years, as well as those that have recently received health insurance licenses.
- *Joint ownership* includes health plans with two partners/owners where the health care systems or hospitals maintain active involvement in the health plan. It also includes health plans with three or more partners/owners where the health care systems or hospitals do not generally participate in the health plans' daily activities.

In all cases, there is a range of what provider owned health plans offer – from covering just one market segment (e.g., Medicaid or Medicare) to a full portfolio of health plan offerings. Health care systems and hospitals that own health plans have the infrastructure and ability to communicate, collaborate, measure and evaluate across provider and payer domains, giving them increased opportunity to improve health outcomes and the consumer experience while decreasing the cost of care. As the health care market continues to evolve, there are increasing innovations and examples of health care systems and hospitals partnering with provider health plans and non-provider health plans to offer health insurance products in local markets.

Working for Health Care Systems and Hospitals with Health Plans

AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, judicial matters, and with the media and consumers. These advocacy efforts address a broad array of issues of importance to all AHA members. More specifically, on behalf of member health care systems and hospitals with health plans, AHA has advocated to address issues in the following areas:

Health Care Coverage

- **Effect Highest Level of Scrutiny for Proposed Health Insurance Acquisitions:** AHA is working to ensure that the recently proposed acquisitions involving four of the five major national health insurers achieve the highest level of review. Detailed analyses has been provided to the Department of Justice and AHA officials have testified before Congress

numerous times explaining why the acquisitions would decrease competition and adversely impact patients and providers.

- **Fight Escalating Drug Prices:** In conjunction with the Campaign for Sustainable Rx Pricing, AHA has raised awareness with legislators, policymakers and the media of how rising prescription drug prices are putting a strain on the entire health care system.
- **Review Center for Consumer Information and Insurance Oversight (CCIIO) Rules:** AHA monitors and comments on benefit and payment rules that affect the health care marketplaces and emerge from CCIIO, including “skinny” plans, network adequacy, eligibility, enrollment and “essential health benefits.” CCIIO is charged with helping implement many reforms of the Affordable Care Act and oversees the implementation of the provisions related to private health insurance. CCIIO also works with states to establish new health insurance marketplaces.
- **Support Third-Party Premium Payments:** AHA supports third party payment of premiums for individuals to ensure broader health insurance coverage. AHA continues to seek clarity on whether it is considered a conflict of interest to have the health system/hospital’s foundation pay the premiums for individuals electing the health system/hospital’s own health plan. Third-party payment programs are a type of affordability program and third-party payments from private and nonprofit foundations can only be made based on an enrollees’ financial status and must cover the full plan year.
- **Recommend Health Plans Pay Claims during 90-Day Grace Period:** In a joint letter to the Centers for Medicare & Medicaid Services (CMS) from AHA, the Federation of American Hospitals (FAH) and the Association of American Medical Colleges (AAMC), we asked that health plans, not providers, be responsible for paying claims during the full 90-day enrollment grace period. Consumer protections in the Affordable Care Act (ACA) allow subsidized exchange enrollees a 90-day grace period before termination for unpaid premiums where claims for days 1-30 are paid by the health plan and providers are at risk for the remaining 60 days.
- **Ensure Hospital Coverage in Health Plans:** AHA worked successfully with the Department of Health and Human Services (HHS) to ensure that health plans in 2016 and beyond do not exclude hospital inpatient coverage. Large employers are required to offer employees an affordable health plan that meets or exceeds the “minimum value threshold” of covering at least 60 percent of expected costs. Reports had indicated that health plans meeting the threshold excluded or had minimal inpatient hospital coverage. CMS responded swiftly to AHA and stopped the proliferation of these types of plans. AHA will continue to engage on this issue as CMS looks to develop further guidance.
- **Monitor Activity on Private Health Insurance Exchanges:** AHA is monitoring employer and consumer activity related to high-deductible health plans. Employers are increasingly shifting more costs to employees and limiting employer contributions to health insurance premiums to a fixed dollar amount. In addition, private health insurance exchanges offer employees additional health insurance options but require employees to make difficult trade-offs between upfront premium costs versus coverage, cost-sharing levels and provider access.
- **Mitigate Impact of Cadillac Tax:** AHA is proactively working with businesses and unions to mitigate the impact of the ACA’s “Cadillac” tax. The “Cadillac” tax is an excise tax on high-cost employer coverage that will be collected starting in 2018.

Public Health Insurance Exchanges Coverage Enrollment

- **Continue to Grow Enrollment 3.0:** AHA is working again with hospitals in a grassroots effort to enroll as many Americans as possible in health insurance plans. AHA also has advocated for hospitals to receive real-time data indicating the patients' type of health coverage as well as their financial responsibilities. Set up by the ACA, the federal exchanges were designed to provide health insurance in an accessible and transparent marketplace for individuals and small groups. (See AHA Enrollment Toolkit in Resources section.)
- **Supported State Subsidies:** AHA filed a friend-of-the-court brief with the Supreme Court in the *King v. Burwell* case in support of states being allowed to keep the subsidies for those enrolled in their states through the 37 federal exchanges – representing 7 to 8 million people across the country. The Supreme Court ruled in favor of the states keeping the subsidies in June 2015.

Medicare Advantage

- **Reverse Proposed CMS Cuts:** AHA sent an Action Alert to members in March 2015 with Medicare Advantage plans to ask their House of Representatives member to sign a House letter to direct CMS to reverse proposed Medicare Advantage cuts. AHA also hosted a call to receive input for AHA's comment letter sent to CMS.
- **Evaluate Stars Quality Ratings Program:** AHA is using a technical advisory group to discern which measures and thresholds should be in place for the Medicare Advantage Stars Quality Ratings Program. Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to Medicare health and prescription drug plans. One to five stars are given to health plans based on five categories: staying healthy, managing chronic conditions, ratings of health plan responsiveness and care, health plan member complaints and appeals, and telephone customer service.

Medicaid Managed Care

- **CMS Proposed Rule on Managed Care for Medicaid and CHIP:** AHA proactively advocated for changes to the Medicaid managed care program such as the need for health plan medical loss ratio requirements, provider network adequacy standards and strategies for quality improvement. Many of these recommendations were included in CMS's proposed rule, released in the summer of 2015, that is intended to modernize the Medicaid and CHIP managed care regulations. The proposed rule attempts to more closely align Medicaid managed care with Medicare Advantage and private insurance, particularly private insurance sold in the Health Insurance Marketplace. AHA worked with member hospitals with Medicaid health plans in developing comments submitted to CMS in July 2015.

Provider Networks and Services

- **Provider Network Adequacy:** AHA participated in a year long process with a National Association of Insurance Commissioners (NAIC) workgroup to revise NAIC's Network Adequacy Model Act of 1996. AHA successfully recommended including language in the

revised Model Act to address “surprise bills”, updated provider directories, and definition of tiered networks. CMS is expected to use many of NAIC’s recommendations to inform their own regulatory work on provider network adequacy.

Relationships with Other Organizations

- **Collaborate with National Organizations:** AHA works with national organizations to drive positive change in federal policies to facilitate and promote high quality health care coverage. Liaison relationships are maintained, for example, with the NAIC, Association for Health Insurance Plans and the National Business Group on Health.
- **Partner with State Hospital Associations:** AHA works directly with state hospital associations to improve the quality of health care coverage.

Engaging Leaders from Health Care Systems and Hospitals with Health Plans

Health care system and hospital leaders with health plans help shape key advocacy activities and policy positions and share resources of particular interest to both provider and health plan executives through their active involvement in many forums as described below.

- **Executive Roundtable:** Chaired by Jim Hinton, president and CEO, Presbyterian Healthcare Services, and AHA immediate past chairman, this roundtable invites health care system and hospital member CEOs, health plan CEOs, and the executive teams to meet with AHA executives to provide their guidance to AHA on the policy agenda for members with health plans, as well as on specific and time-sensitive health care issues impacting health care providers *and* health care insurers.
- **Leadership Briefing Series:** CEOs and members of the executive teams from health care systems and hospitals with health plans share their perspectives and experiences related to challenges and opportunities they are encountering in the field on conference calls and identify areas where AHA can help.
- **Health Plan Workgroup:** AHA member systems and hospitals with health plans are invited to share recommendations and guidance on specific legislation or regulation impacting provider health plans. Topics may include Medicare Advantage, narrow networks and public exchanges.
- **Action Alert Calls:** AHA invites members to participate on Action Alert Calls to address key issues when immediate input or contact with their legislators is needed to impact an issue related to provider health plans.

Providing Key Resources

AHA provides member executives from health care systems and hospitals with health plans numerous resources to support performance improvement, optimal health outcomes and increased customer satisfaction as shown below.

Health Care Coverage

- **Coverage Matters Website:** AHA's Coverage Matters webpage, (<http://www.aha.org/advocacy-issues/initiatives/coverage/index.shtml>), provides resources and the latest news about the state of subsidies available through the Health Insurance Marketplaces.
- **Enrollment Toolkit:** The AHA releases an annual toolkit to support hospitals' efforts to help consumers enroll in the Health Insurance Marketplaces. The kit contains links to key resources from the AHA and other national and local organizations, as well as case examples from hospitals on their enrollment efforts. In addition, the AHA continues to update its "Get Enrolled!" webpage (www.aha.org/getEnrolled) with resources to help hospitals connect their communities to increase coverage.



Provider Plan Data, Research, Best Practices

- **Policy Reports and Analyses:** AHA research reports examine key issues to inform the policy-making process. These include the *TrendWatch* series, a periodic AHA publication that reports on the latest trends affecting health care systems and hospitals and have focused on topics such as increasing consumer choice in coverage and care and telehealth.
- **Research:** AHA partnered with the Navigant Center for Healthcare Research and Policy Analysis to conduct research and explore how provider-sponsored health plans may be distinguished from non-provider sponsored health plans across several areas including access to care, quality and financial performance. The white paper and webcast are available at www.aha.org/research.
- **Health Plan Best Practices:** Health plan best practices, culled from a variety of published resources as well as from interviews with provider insurer leaders, highlight specific unique best practices and key competencies – within the health plan and across the provider and health plan business units. (*under development*)
- **AHA Publications:** *Hospitals & Health Networks* and *Trustee* magazines and AHA's Great Boards newsletter have featured articles on provider health plans including the articles below:
 - Kamp P; Stockard R. Today's Provider-Sponsored Health Plans: What Board Need to Know. Great Boards. Fall 2015: 4-6. <http://www.greatboards.org/newsletter/2015/provider-sponsored-health-plans-fall15.pdf>
 - Vesely R. Resurgent provider-owned plans show promise. Trustee web exclusive, June 9, 2014. http://www.trusteemag.com/display/TRU-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/TRUWebExclusives/2014/WebExclusive0614-provider-owned-health-plans
 - Morrison I. Risky business: health systems become insurers. H&HN Daily, May 6, 2014. <http://www.hhnmag.com/display/HHN-news->



article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Daily/2014/May/050614-morrison-health-insurance

Consumer Price Transparency Guides and Websites

- **Price Shopping Consumer Website:** As the prevalence of high-deductible health plans grows, more health care shoppers are price sensitive and willing to use fewer brand name drugs and visit lower cost venues. Aetna, Humana and United Healthcare partnered with the Health Care Cost Institute, an organization that uses private health insurance claims data to analyze cost trends and created a consumer website that makes price ranges and average reimbursement for services available for consumer reference.
- **Price Transparency Toolkit:** The AHA developed *Achieving Price Transparency for Consumers: A Toolkit for Hospitals*, to provide resources for hospitals to assess their current price transparency efforts, as well as case examples and sample price transparency tools. It can be found at: <http://www.ahacommunityconnections.org/tools-resources/transparency.shtml>.
- **Consumer Guide on Health Care Prices:** The AHA contributed to a Healthcare Financial Management Association (HFMA) guide, *Understanding Health Care Prices: A Consumer Guide*, to help consumers understand where to get answers to their questions about health care prices, compare prices among providers, and manage their out-of-pocket costs. A copy of the report can be found at <http://www.hfma.org/Content.aspx?id=22306>.

