

# Minimizing Legal Exposure for Potential Consumer-Directed Health Plan Liability

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# The New Paradigm



Benefit Dollars



Patient as the  
consumer



Patient Advocacy and  
Information



Providers

# What is a Consumer Driven HealthCare?

*A Consumer Experience*



*A Consumer Moment*



# Empowerment

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Creating a consumer experience through:

- Knowledge
  - Relevant, credible information
  - Delivered in a timely manner
  - In a user friendly format
  - Given proactively, not reactively
- Tools
  - Creating Price/Quality Transparency
  - Acting as an Advocate

# Accountability

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Creating a consumer moment using financial consequences:

- Engaging members at key decision points (consumer choice portals):
  - Plan design selection/open enrollment
  - Provider selection (point of service)
  - Pretreatment
  - Treatment

## Proactive Planning . . .

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- Reasonable cost sharing absent financial hardship if a member becomes ill or injured
- Balancing the “4 C’s” of health benefit plans
  - Cost
  - Coverage
  - Choice
  - Contributions
- Employees engaged in making decisions regarding plan and benefit trade offs

# Employee Choice

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- Employees have individual needs
- Choice of medical benefit design
- Consumer driven health care plan as an option, not replacement
- The consumer driven health care market is dynamic, with new options emerging and old options evolving
- Migration plans allow for controlled movement into CDHPs and require planning for employee communication issues

# The Consumer Experience

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- The consumer experience encompasses all of the touch points that the plan has with the member
- It begins during open enrollment and is defined by every interaction

# The Consumer Experience

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- Common touch points include:
  - Open enrollment
  - Provider selection
  - Claims submission
  - Utilization review
  - Disease management

# The Consumer Experience

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- Consumer driven plans often utilize web sites that provide additional resources such as:
  - Benefit descriptions
  - Claim status
  - Benefit balance reporting
  - Health content
  - Prescription drug interactions and alternatives
  - Provider quality ratings
  - Procedure cost information
  - Health assessments

# High Deductible Health Plans

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## Issues to consider:

- Income levels of employees
- Benefits strategy, particularly as it relates to providing choice to the employees
- Ability to effectively communicate with employees on an ongoing basis

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# Characteristics of Current Provider Contracting Market

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- The Cause

- Provider consolidation
- Negotiating leverage
- “Must have” status
- Reduced discounts

- The Effect

- Tiered network
- Incentive compensation
- Tightening of open enrollment

# Provider Market Differentiation

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- Products and Services
- Price/Service
- Location
- Specialty
- Customer Segment
- Quality

SOURCE: Daniel & Douglas & Norcross  
Daniel Fell

# Payor-Provider Paradigm Shift

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- Quality and affordability
- Financial interests and incentives
- Multiple benefit plans and designs
- Shifting burden of provider collections

# Changes on the Horizon for Providers

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- Moving from operational interface (UR; precertification) to financial interface (more akin to traditional indemnity insurance)
- Not can you provide the service, but how much will you be paid and from whom is it collected
- From negotiated rates to market rates
- Doing what you say rather than saying what you do – demonstrated quality care
- Stratification of care based on ability to pay – baseline care versus concierge care

# Allocation of Responsibilities

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- What does the hospital control?
- What does the physician control?
- What does the health plan/plan sponsor control?
- What does the patient control?

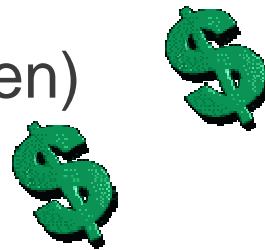


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# Types and Categories of Tiering

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- Types of tiering
  - Quality (consultant driven)
  - Total cost of care
  - Price (broker driven)
- Categories of tiering
  - Multiproduct organization
  - Service line



# Tiering Factors and Placement Criteria

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- Unit Price
- Average cost
- Type of facility (community/academic medical center)
- Quality measures
- Negotiation
- Service portfolio
- Geographic access
- Physician alignment
- Marketplace demand

## Effect of Tiering on Cost/Quality Characteristics

High Quality High Cost	Elite Level Patients
High Quality Low Cost	Attract Patients Over Lower Quality Providers
Low Quality Low Cost	Cost Conscious Consumer
Low Quality High Cost	Only attracts patients under non-tiered benefit plan (gets same rate as those with better quality/lower cost)

# Consumer/Provider Reluctance

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## Objections to Tiered Programs

- Continuity of care
- Lack of adjustment for case mix or severity of illness
- Teaching programs
- Tertiary care
- Misdirection of patients to lower-quality/overcrowded providers
- Access to care/lack of lower tier providers
- Confusion based on inconsistency - Plan A lower tier/Plan B higher tier
- Disassociation of hospitals and physicians

# Pay for Performance

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- Compensation model that rewards providers for quality with payments embedded as part of baseline reimbursement and bonus awards on top of regular reimbursement
- Payments focused on and tied to effective, efficient, safe and patient-centric care
- Challenges of differentiating between quality of reporting data and actual performance upon which the data is based (i.e. the teaching to test syndrome)

# Pay for Performance

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- Tied to contract negotiations
  - Carrot not stick – no penalty for opt-out
- Can include both financial and non-financial incentives (publicly disclosed rating, elimination of prior authorization requirements, selective network inclusion)
- Need to distinguish between performance and expectations
- Triggers need to be clear and unambiguous, valid, reliable, efficient to collect and report
- Categories can be based on structure/operations, process/protocols, and outcomes
- Separating hospital from physician performance
- Statistical sampling errors
- Confusing volume for quality

# Types of Pay for Performance

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- Bonus for targets
- Awards for improvements
- Add-ons for performance (variable fee schedule model)
- At risk adjustments – next year's rates tied to prior year performance

# Liability Issues & Concerns

# Theories of Liability

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- Plan sponsors generally free to design features of medical plan as settlor function.
- Implementation of the plan, however, is a fiduciary function.
- Breach of fiduciary duty for failure to prudently select healthcare providers in the plan, misleading statements in employee communications, harmful silence
- Breach of fiduciary duty for failure to disclose discounts, rebates and provider incentives
- Breach of fiduciary duty for misinforming and misleading participants about eligibility and enrollment requirements

# Theories of Liability

- Level of care and due diligence in selecting source and content – what is the standard of care?
- Providing information is a fiduciary, not ministerial, function – fiduciary breach
- A substantial likelihood that the information would mislead and result in a less than informed decision
- “Knew or should have known” test for reliance
- Pecuniary interest (costs) v. patient best interest (quality)
- Bad information – fraud, misrepresentation



## Sources of Liability

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- Poor provider quality data but retention in network
- Breach of pricing confidentiality
- Failure of consumers to fully understand value of differing treatment modalities
  - A CT is more expensive than an x-ray but is the x-ray an equivalent diagnostic tool?
- Benefit designs that lead people not to get care
- Discrimination against lower wage employees

## Sources of Liability - Continued

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- Usability of data
  - The reasonably prudent person test
- HIPAA Privacy violations (wrong person retrieves voice mail/e-mail) – invasion of privacy
- Failure to maintain adequate patient decision support infrastructure
- Informed consent as to price/quality trade-offs
- Reliability of provider quality data/sampling error

## Sources of Liability - Continued

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- Lack of equal access to information (the “Digital Divide”)
- Literacy and cognitive capabilities
- Culture and language
- Patient as consumer

# The Thresholds of Liability

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- Choosing the plan
- Using the service
- Managing the care

# Potential Process Points of Liability

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- Understanding the information
- Knowing what information is applicable
- Knowing which factors are relevant
- Processing and interpreting information
- Weighing choices against risks
- Differential provider selection decisions
- Differential medical treatment decisions

# Minimizing Legal Exposure

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- Accurate and thorough communication to employees
- Update plan documents and summary plan descriptions
- Disclaimers about oral misrepresentations
- Compliance with federal and state privacy laws
- Careful negotiation of contracts – indemnification, limitation of liability
- Insurance protection
- Compliance with HIPAA nondiscrimination rules and Americans with Disabilities Act in plan design and administration