


*Understanding Private Payers &
Maximizing Private Payer
Reimbursement Strategies:
Understanding the Process*



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Private Commercial Payers

- The private commercial market is much different than traditional Medicare
- Medicare Advantage plans, on the other hand, *are* part of the commercial payers and represent an important market for many companies
- Coverage and reimbursement for the private payers is defined by the individual insurance plan (including the Medicare Advantage plans) and/or by the employer group

Private Commercial Payers



- Coverage and reimbursement also varies by the type of plan (HMO, PPO, etc.)
- State rules and regulations also vary by the type of plan (e.g., in some states there is no balance billing for HMO products)

Commercial Payers

Insured Plans

- In an insured plan, an employer contracts with the insurer to provide coverage for its employees
 - The employer may opt to add certain additional benefits not in the standard plans offered by the insurer (e.g. rider coverage) or they may stick with one or more generic options offered by the insurer
 - Insurers generally offer a wide variety of plans including HMO (no out-of-network coverage); PPO (out-of-network coverage is allowed for a higher copay); and POS plans (members decide on a service-by-service basis whether to use in-network providers or go out-of-network)
 - Each of these plans may have several different options based on copay and deductible levels

Commercial Payers

Insured Plans

- There are State regulations that govern insured plans but they typically focus on ensuring that consumers have the right to a variety of protections such as the right to appeal coverage denials, minimum stays for maternity cases, direct access to OB/Gyn services, and coverage of certain allied professionals
- Insurers have a lot of leeway in designing their benefit plans including coverage and reimbursement decisions

Commercial Payers

Self-Insured Plans

- In a self-insured plan, the employer pays for its employee health care costs out of a fund that is set aside for this purpose
- Employers may contract with an insurance company to administer the plan
- Self-insured plans are regulated by the US Department of Labor (under the ERISA statute)
- State laws do not apply and, therefore, self-insured plans have even more discretion in designing benefits

Commercial Plans

Union Funds

- Union Health and Welfare Funds provide coverage for an estimated 30 million workers and dependents plus millions of retirees
- Many of these funds purchase coverage from the commercial payers (i.e. insured plans) while others use the commercial payers to administer their benefits
- In either case, this is a large potential market which needs to be addressed either directly or through the commercial payers

Commerical Payers Coverage Process

- There are many similarities in how the commercial payers make decisions regarding new technologies and devices
- In most cases, the process is under the direction of a committee chaired by one of the corporate Medical Directors
- The decision-making process is based on clinical issues; what to pay is a separate analysis addressed after the coverage decision is made by a separate committee

Generic Components of the Coverage Process



- Virtually all payers require FDA approval before consideration of a new technology or device
- All payers require that there be literature documenting the safety and efficacy of the technology

Generic Components of the Coverage Process



- Most payers use outside assessment companies as part of their process
 - Hayes (A to D rating system)
 - Blue Cross Blue Shield Technology Evaluation Center (criteria based review)
 - International organizations (e.g. NHS-Great Britain, CCOHTA-Canada)

How is the review process initiated?



- Requests for coverage determinations can be made by patients, providers or manufacturers
- Most requests come from providers

How is the review process initiated?



- A decision to conduct a review is generally made after at least 3 requests have been received, and/or:
 - if the new device/technology is related to a high utilization service or disease
 - If the new device will significantly reduce other medical care costs
 - If the internal person is aware of the importance of the new device

What is the process and how long does it take?

- Generally, the committee responsible for technology assessment will begin their review by consulting one of the outside assessment companies
- The payer may supplement the information from the assessment company with their own literature review
- Many payers will have outside clinical consultants review the data

What is the process and how long does it take?



- A number of payers speak directly to the researchers to ask questions
- Staff recommendations are then made to the committee for final determination

Examples of criteria used to approve a new technology



- FDA approval
- Improvement of health outcomes
- Independent scientific evidence
- At least as efficacious as current alternatives

What is the process and how long does it take?



- The time it takes for the process to be completed varies by payer and by the specific technology being addressed; on average it ranges from 1 month to 6 months
- If the situation involves a specific patient, a case-by-case determination can be made quickly and paid prior to corporate approval of the device
- In the case of national payers, coverage decisions are generally made at the corporate level rather than in the regions

What happens once a decision is made to approve a new device?

- After a decision is made to approve a new device or technology, it may be referred to an implementation committee to put the new policy into place
- Implementation issues include decisions on how to reimburse for the new device or procedure, claims processing, coding and utilization management and/or quality assurance guidelines

What happens once a decision is made to approve a new device?

- Reimbursement decisions are made by the reimbursement or finance area and are totally separate from the coverage committee
- Reimbursement may be based on current fee schedules for similar technologies or procedures
- The payer may also review Medicare payment levels if it has already been approved by Medicare

What happens if a decision is made not to cover the device?

- Generally, under state law, a patient or his or her designee can appeal a decision not to cover a device or new technology to the State Department of Insurance
- Depending on the urgency of the situation, the appeal may be expedited
- The specific regulations and process vary from State to State

*Approaching the Commercial
Market*



Approaching the Commercial Market



- Initial efforts should be targeted at the top health plans in the country
 - UnitedHealthcare
 - Wellpoint/Anthem
 - Aetna
 - Health Net
 - Blue Cross Blue Shield
 - Kaiser

How can the manufacturers support the coverage determination process?

- The best way to influence the coverage process is to:
 - Ensure that independent research is available to the payers and the independent assessment companies
 - “Spoon feed” the Medical Directors - you should provide them with copies of all the relevant literature; don’t assume they will seek it out on their own
 - Market to providers who can, in turn, stimulate the payers

*How can the manufacturers
support the coverage
determination process?*

- Manufacturers play an important role in communication to and education of the providers
- Payers will simply send one notification of a new coverage policy which may never even be read by the physician
- Manufacturers can augment this process through their own marketing efforts

Next Steps



- Identify nature of coverage and reimbursement issues
- Develop target list of payers
- Initiate discussions with payers
- Develop creative strategies to motivate the physicians
- Educate providers