

FoCUS Project

Financing and Reimbursement
of Cures in the US

RESEARCH BRIEF

2018F202v014

The heterogeneity of health care payers suggests that durable therapies need precision financing targeted to each payer segment. FoCUS participants have identified four payer segments for precision financing: self-insured employers and related organizations; health insurance plans and managed care organizations; Medicare; and Medicaid.

By **MIT NEWDIGS FoCUS Project**
16 February 2018

Accounting for Payer Organization Differences in Evaluating and Applying New Financing Mechanisms for Cures and Durable Treatments

Establishing Payer Organization Segments

The Financing and Reimbursement of Cures in the United States (FoCUS) project seeks to deliver an understanding of financial challenges created by durable therapies, leading to system-wide implementable precision financial solutions for the organizations obligated to pay for them. These organizations include self-insured and fully insured employers, health insurers and managed care organizations, unions and retirement systems, federal and state governments, and risk-bearing health care providers. Some of them are in the public sector and the rest in the private sector. They can be nonprofit or for profit. These organizations have different reasons why they pay for health care (e.g., social obligations, employee recruitment, member satisfaction), serve dissimilar populations that turn over at different rates, withstand acute and intense financial demands to different degrees, and use distinct payment

KEY TAKEAWAYS

1. Durable treatments will create acute and intense financial demands on health care payers
2. Current financing mechanisms were not designed to address these financial demands
3. The diversity of U.S. payer organizations can be grouped into four broad segments (detailed herein)
4. Precision Financing tools to enhance patient access to durable therapies must be tailored to the preferences, processes and constraints of each payer segment.

mechanisms. Any financing tools created for these organizations must account for their diversity.

The possible combinations of all the organizations and all the characteristics meaningful to financing mechanisms produce a byzantine and unwieldy maze of arrangements. To bring order to these arrangements needed to make financing mechanisms workable, FoCUS participants from various payer organizations entered this maze together, clinging onto Ariadne's Thread. Their aim was to aggregate payer

organizations into segments that would approach new financing mechanisms in roughly similar ways based on the form of the risk they take, the populations they cover, and their decision and business processes. They returned with four primary payer segments: 1) self-insured employers and related organizations, 2) health insurers and managed care organizations, 3) Medicare, and 4) Medicaid. Each of these segments is further comprised of distinguishable groups, and the more significant among these groups are identified in the individual segment descriptions below.

Self-Insured Employers and Related Organizations

Self-insured employers determine the health care services and products they cover, and they are exposed to the risks these costs generate up to the amount that triggers stop/loss provisions when they are in place. They make payments for these costs as they make payments for other costs to their businesses and have discretion on preferred methods. Self-insured employers can adapt to new financing mechanisms that work to their advantage as business operations, and that take into account their size and capabilities. They may be constrained by the payment systems of the benefits administrators that administer benefits on their behalf.

Some unions and retirement systems operate in the same way as self-insured employers in determining the health care services and products covered and in paying for them directly. These are the unions and retirement systems that provide health care coverage through funding that comes from member contributions or from negotiated agreements with companies or governments.

These organizations have considerable discretion to adapt precision financing for cures. Contractual agreements between organizations and unions, and certain laws and regulations governing state retirement systems, for example, can limit that discretion. And, like employers, these organizations vary in size and capabilities to a degree that will affect their interest in any given financing mechanisms.

Health Care Insurers and Managed Care Organizations

This segment includes the risk bearing products of health care insurers and managed care organizations such as fully insured employer sponsored health care

PAYER SEGMENTS	
<p>Employers</p> <p>Self-insured</p> <ul style="list-style-type: none"> • Fed / State Gov't Employee Plans • Union / retirement systems¹ <p><small>1 Unions / retirement systems provided funds for which they allocate to members and in this way resemble self-insured employers</small></p>	<p>Health Plans (Commercial)</p> <p>Commercial groups</p> <ul style="list-style-type: none"> • Individuals • Provider-based plans² • National • Regional <p><small>2 Provider-based plans refers to risk-bearing providers that are part of an insurance plan, and also risk-bearing providers with arrangements with insurers that makes them resemble provider-based plans</small></p>
<p>Medicare</p> <p>Fee for service</p> <ul style="list-style-type: none"> • Medicare Advantage • Part D Rx 	<p>Medicaid</p> <ul style="list-style-type: none"> • Fee for service • Managed Medicaid

plans and plans for people purchasing individual health care insurance policies (including through exchanges serving the Affordable Care Act). The organizations in this segment can be national in their reach or smaller regional companies covering all or just parts of individual states.

As they pay for the health care services and products their plans cover, these organizations have some discretion on the financing methods they can use. However, any precision financing tools for this segment would need to reflect the implications of these organizations' size, characteristics of the populations they cover and the clients they serve, and any relevant laws and regulations.

Current trends in health care payment reforms include shifting risk for health care costs to provider organizations. Depending on the arrangements made, provider organizations can become payers in effect, making new financing mechanisms potentially useful to them. Providers that take on these arrangements, however, can be part of an organization that is also a

health care insurer and when they are, they can be thought of as provider-based health plans. Other providers can have separate business arrangements with health care insurers, but these relationships can take on aspects of a provider-based health plan based on requirements insurers impose on the providers. Therefore, these types of these providers are grouped under health care insurers and face similar precision financing needs.

Medicare

The size and nature of its beneficiary population, and its role as a national and publicly funded health care coverage program distinguishes Medicare as a payer segment. Medicare pays for the health care services and products authorized under federal law. It pays directly for beneficiaries under fee for service options, and it pays indirectly through managed Medicare plans (i.e., Medicare Advantage). Medicare Advantage plans are operated mostly by national and regional health care insurers and managed care organizations. In the case of Part D plans, which only involve prescription drug coverage for beneficiaries in the fee for service option, other entities such as pharmacy benefit managers can operate them as well. While these plans serving in delegated roles for Medicare are given some discretion as health plans for Medicare beneficiaries so that they have room to compete for business, they still have to operate accordingly to Medicare rules and local state health plan legal and regulatory requirements.

Medicare beneficiary health care utilization patterns are well understood. While beneficiaries are migrating from the fee for service option to Medicare Advantage plans at a slow but steady rate (now a third of beneficiaries), the churn of beneficiaries among these plans is low. Thus, time horizons for beneficiaries in either option are significant and relatively stable. Precision financing mechanisms that could appeal to both fee for service and Medicare Advantage because they share many of the same influences and requirements, but they will still need to account for some of differences between them in their business processes, preferences, and legal requirements.

Medicaid

Medicaid is a distinguishable payer segment in large measure due to the financial constraints it's under. In each state, the programs compete with other vital services that are either mandated or obligated, and as

a result, are left with little room for discretion or expansion as may be needed to accommodate higher health care utilization or costs. The beneficiary population also distinguishes Medicaid when considering health care financing mechanisms because of the rapid rates at which they enter and exit the program, and because of the added host of challenges they face in achieving the therapeutic outcomes possible with any given treatment.

Comprising the Medicaid segment are the state management fee for service programs and the managed care organizations that function as delegated entities. National and regional health plans—nonprofit and for profit—operate the managed Medicaid programs. These plans agree to different types of risk arrangements that cover some products and services and not others. Prescription drugs and behavioral health, for example, may be carved out. As delegated entities, managed Medicaid take on many of the requirements and restrictions of the associated state Medicaid agency that could limit the precision financing mechanisms they could adopt. However, to the degree feasible, financing mechanisms that could be preferable for large, national, for profit managed Medicaid plans, may not be for small, regional nonprofit plans, or for fee for service programs in one state or another.