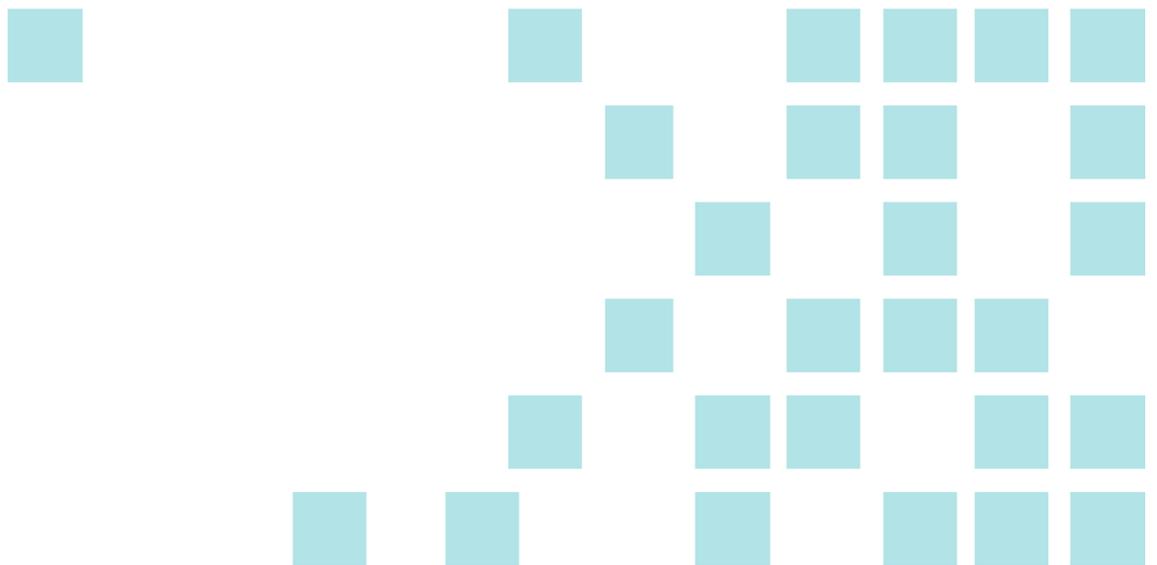


Administrative Inefficiency in Coordination of Benefits

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EXECUTIVE SUMMARY

Ineffective coordination of benefits (COB) – the process to determine how benefits should be applied for individuals with coverage from more than one payer– burdens the U.S. healthcare system with more than \$800 million in unnecessary administrative expense per year.¹ The healthcare coverage reforms of the Affordable Care Act (ACA), many of which became effective on January 1 of this year, have the potential to magnify the scope of the problem. While the country will benefit as fewer people remain uninsured, the coverage expansion that results will create more instances where COB becomes a concern.

Many aspects of the healthcare system complicate existing COB processes and create challenges. For example:

- Poor communication between various forms of payers, including those offering commercial and government-sponsored health plans, workers' compensation policies, auto coverage and others;
- Limitations with HIPAA transaction standards and incomplete industry implementation of administrative simplification operating rules; and,
- Numerous constituents involved in complex claims practices, including billing service providers, practice management systems and other intermediaries.

Inefficient COB processes generate significant administrative costs. These costs are manifested throughout the healthcare system and affect payers, providers and consumers. Providers today often do not have complete information necessary to submit transactions and do not know to whom they should be submitting them. Payers similarly do not have ready access to information about other potential payers. On the front end, providers and payers are not yet working together consistently – with patients and members – to ensure claims are first filed with the correct payer, leading to excess effort on the back end to correct those initial shortcomings.

CAQH, a nonprofit alliance of payers and trade associations that serves as a catalyst for industry collaboration on simplifying healthcare administration, recently conducted extensive research on the COB process, including input provided by commercial payers, providers, vendors and other key stakeholders. CAQH research estimates that ineffective benefits coordination results in more than \$800 million a year in administrative costs. Providers alone could save an estimated \$480 million annually with more efficient COB processes. Addressing these problems at the beginning of the benefits coordination process represents a significant opportunity for the entire healthcare industry. By working together to ensure claims involving COB can be processed correctly when initially filed, providers and payers can improve the patient experience while the healthcare system realizes millions of dollars in administrative savings.

¹ See full white paper for a discussion of sources and methods used in the research.

I. INTRODUCTION

The key players that process reimbursements in today's healthcare industry – providers, payers, and intermediaries – lack uniform and accurate data on which payers are potentially responsible to cover a healthcare expense. This lack of easily accessible uniform data leads to providers and payers reprocessing claims, consuming extra staff time and incurring external vendor fees to investigate whether additional payers are responsible for reimbursing a claim or, in the case of both commercial and public payers, whether they may have paid for a claim for which they are not responsible. Workers' compensation, auto and other payers lack basic interoperability with the healthcare transaction system. Significant back-end expense is incurred because of incorrectly routed COB claims. Addressing these problems at the beginning of the claims process represents a significant opportunity for the entire industry.

Exacerbating the COB challenge, beginning this year approximately 30 million uninsured Americans will obtain coverage, principally through expanded Medicaid eligibility or federally subsidized private health insurance sold on health benefit exchanges.² Many are expected to experience periods of multiple, overlapping coverage as they move in and out of the insurance exchanges and on and off of Medicaid eligibility.³ An individual will not generally be eligible for subsidized exchange coverage if eligible for Medicaid or employer sponsored insurance.⁴ However, for households with mixed coverage eligibility (and potentially overlapping coverage), the general expansion of coverage and the potential for frequent changes of coverage will present COB challenges for providers and payers in ensuring claims are correctly routed and that payments for any overlapping benefits are coordinated. Furthermore, current data collection techniques may not be effective in helping providers and payers keep accurate COB records for this population as exchanges themselves become additional data sources, overlapping in that role with commercial and public payers.

This paper describes the current COB landscape among private and public payers and identifies the work that must be done to improve COB. As highlighted, effective and sustainable solutions to current COB problems require collaboration among providers, payers and intermediaries. Only together can the different industry constituents improve the efficiency of the healthcare payment process in COB situations.

² The Congressional Budget Office and the staff of Congress' Joint Committee on Taxation estimate the ACA will cause the uninsured population to decrease by 30 million between 2014 and 2021. Cong. Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* tbl.3 (2012).

³ See Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228 (2011).

⁴ See Internal Revenue Code § 36B(c)(2)(B), 26 U.S.C. § 36B(c)(2)(B) (2012).

II. CURRENT COB LANDSCAPE

Several aspects of the current healthcare system must be understood to consider the COB challenge.

Commercial Health Insurance

The growth of two-wage-earner households in the 1950s increased the likelihood that individuals would potentially have more than one source of health coverage. Children, for example, might be covered by either of their parents' employers' plans. Adults might be covered as an employee by their own employer's plan and as a dependent under their spouse's employer's plan. It was during this period that payers began to recognize the need to better coordinate coverage when a single individual was covered under multiple forms of insurance. The insurance industry developed a set of guidelines on COB during the 1960s that it voluntarily included in policies.⁵ In 1970, the National Association of Insurance Commissioners (NAIC) adopted its first model regulation on coordination of benefits. State insurance regulators, who make up the membership of NAIC, have adopted some version of the model rule in 42 states, with NAIC updating the rule periodically, most recently in 2005, with another round of updates currently being considered.^{6,7}

Under the NAIC model regulation, general rules establish liability. One rule, for example, provides that when an individual is covered under one insurance policy as a primary subscriber and under a second policy as a dependent, the policy where the individual is the primary insured pays before the other policy. NAIC rules, however, do not explain how payers are supposed to identify other payers. Payers must collect information from providers, members or fee-based data-mining contractors.⁸ The data collection process itself has not been addressed by NAIC or other industry groups.

Medicare

Medicare has the most robust mechanism for coordinating benefits, known as the Medicare Secondary Payer (MSP) rules. Under federal law, Medicare is required to pay secondary to other coverage in most circumstances. For example, a group health plan of an individual's current employer or a spouse's current employer pays first if the employer has 20 or more employees. However, if the group health plan is retiree coverage, Medicare pays primary. Medicare is always secondary to workers'

⁵ See Thompson Publishing Grp., *Coordination of Benefits* ¶ 150 (2013).

⁶ Available here: <http://www.naic.org/store/free/MDL-120.pdf> (2005).

⁷ See Memorandum of NAIC's Actions taken at NAIC Spring 2013 National Meeting, http://naic.org/documents/committees_b_revised_coord_benefits_model_reg.pdf (last visited 7/1/13).

⁸ See, e.g., The Rawlings Group, COB Recovery Services, http://www.rawlingsgroup.com/cob_services.asp (last visited 1/26/13).

compensation, auto or liability insurance, and enterprises that self insure tort liability.⁹ The following diagram identifies primacy rules for some of the most significant Medicare populations.

Figure 1. Who Pays First for Common Medicare Situations

Medicare Beneficiary	Dual Eligible	Age 65 or Over and Employed	Age 65 or Over and Retired	Disabled
Other Coverage	Medicaid	Group Health Plan	Group Health Plan Retiree Coverage	Group Health Plan
Who Pays First	Medicare	Group Health Plan ¹	Medicare	Group Health Plan ²

¹ If the employer has more than 20 employees, the group health plan generally pays first. If the employer has fewer than 20 employees, Medicare generally pays first.

² If the employer has more than 100 employees, the group health plan generally pays first. If the employer has fewer than 100 employees, Medicare generally pays first.

Because Medicare pays secondary in many situations, it is important for Medicare to have reliable information on its beneficiaries' other coverage. As such, Medicare has employed many more techniques to identify and track other sources of coverage than have commercial health insurers. When individuals first apply for Medicare, they fill out a questionnaire describing other coverage. While this initial eligibility questionnaire parallels voluntary information gathering undertaken by private payers, Medicare has an advantage over other health coverage programs in its ability to access federal data sources and use the force of federal law to learn about other coverage. Medicare uses data from the Social Security Administration and the Internal Revenue Service to determine which of its beneficiaries may have coverage through an employer or a spouse's employer. Medicare then sends inquiries to employers to determine whether they offer a group health plan that might be primary to Medicare. Employers that fail to provide timely responses may be liable for a civil monetary penalty of up to \$1,000 per inquiry.¹⁰ Medicare imposes a \$2,000 per incident civil monetary penalty on physicians and other non-hospital suppliers that willfully and repeatedly fail to provide complete

⁹ Social Security Act § 1862(b)(2)(A), 42 U.S.C. § 1395y(b)(2)(A); Ctrs. for Medicare & Medicaid Services, Medicare Secondary Payer Manual, ch. 1 §§ 10.1, 10.4, 10.6 (87th rev. 2012).

¹⁰ Social Security Act § 1862(b)(5).

information on patients' other coverage on their Medicare claims.¹¹ Finally, group health plans, workers' compensation plans, liability insurers, and enterprises that self-insure tort liability are required to notify Medicare when claimants under their plans are eligible for Medicare. This reporting requirement is enforceable by penalties of \$1,000 per claimant, per day of noncompliance.¹² All this information is compiled by Medicare's COB contractor in the CMS Common Working File, a profile of other coverage for each Medicare beneficiary, which Medicare uses to process claims and determine whether other plans should be primary.

Medicaid

By law, Medicaid is the payer of last resort; it will not make payment if any other payer is liable. Medicaid agencies are required to take all reasonable steps to identify and recover payment from third parties liable for a beneficiary's care.¹³ In a 2006 survey of state Medicaid programs, an average of 13 percent of beneficiaries who had Medicaid coverage for the entire year reported having other coverage for some time during the same year. States reported significant problems identifying and verifying third-party liability and collecting from liable parties. Medicaid officials also noted they sometimes lacked legal authority to recover from third parties, often because a timely filing deadline was missed by the Medicaid agency.¹⁴

Because Medicaid is administered by the states, there is considerable variation in how Medicaid programs determine whether there is a third party that could be liable. In general, states collect information about other potential payers when the initial eligibility determination is made, verifying information through workers' compensation and other state databases.¹⁵ States also hire contractors for data mining and other services to determine whether any third-party recoveries can be made after a claim has been paid and may pay such contractors on a contingency basis.¹⁶ Private managed care organizations (MCOs) also play a role in most states' Medicaid programs. States will generally reduce capitation payments made to an MCO to take into account third-party liability for some claims. The Government Accountability Office (GAO) estimates that, although states have been able to save about \$5 billion a year in avoided payments by ensuring Medicaid is the payer of last resort, Medicaid ends up paying more than \$500

¹¹ *Id.* § 1862(b)(6).

¹² *Id.* § 1862(b)(7), (8).

¹³ Social Security Act § 1902(a)(25), 42 U.S.C. § 1396a(a)(25).

¹⁴ U.S. Gov't Accountability Office, GAO-06-862, *MEDICAID THIRD-PARTY LIABILITY: Federal Guidance Needed To Help States Address Continuing Problems* 10-16 (2006).

¹⁵ See generally 42 C.F.R. pt. 433 subpt. D (2012); Centers for Medicare & Medicaid Services, *Third Party Liability & Coordination of Benefits*, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Eligibility/TPL-COB-Page.html> (last visited 1/11/13).

¹⁶ See Medicaid Program; Recovery Audit Contractors, 76 Fed. Reg. 57808, 57809 (Sept. 16, 2011); see, e.g., HMS, *Coordination of Benefits*, <http://www.hms.com/our-services/coordination-of-benefits/> (last visited 1/26/13).

million per year toward claims for which it should not be liable, and then has to recover those sums from other payers.

HIPAA Transaction Standards

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructed the Secretary of Health and Human Services (HHS) to adopt standards for electronic healthcare transactions, and the standards have been progressively specified, adopted and updated since 2003. A significant limitation to these transaction standards, however, is that only health plans, providers and clearinghouses are subject to these rules. Certain types of healthcare intermediaries, such as practice management system vendors, as well as other types of payers potentially involved in a claim, such as for workers' compensation or automobile coverage, are not required to comply with HIPAA transaction standards.

Nevertheless, under HIPAA two different types of transaction standards are primarily relevant for COB: the eligibility verification transaction and its response (identified as the Accredited Standards Committee (ASC) X12 270 and 271 transactions, respectively) and the health claim transaction (identified as the ASC X12 837). Providers and health plans use the 270 transaction to verify whether an individual has coverage in a particular health plan; the health plan responds with a 271 transaction. The 837 transaction is used to file claims with a health plan and also has segments specified within it for a provider or a health plan to communicate to a secondary health plan the payment that has already been made by a primary health plan. While these transaction standards have the potential to standardize the format of information that is shared, they do not currently have the capability to govern how information should be routed, how quickly data must flow or what other related infrastructure requirements should be met. As a result, transaction standards are only effective if payers and providers have good information about all of the forms of coverage involved so that the transactions can be sent to the correct health plans.

Intermediaries

The complexity of claims procedures has led to the development of an industry of billing services, claims clearinghouses, practice management solution providers and other vendors that format and route eligibility and claims transactions between providers and health plans. When claims are incorrectly routed, specialized vendors are hired by private and public payers to identify and recover overpayments. The introduction of these additional "intermediaries" increases cost for providers, payers, and ultimately patients and employers.

Operating Rules for Administrative Simplification under Health Reform

Implementation of the HIPAA transaction standards has been incomplete, however, with providers and payers continuing to work on adoption nearly 10 years after the original implementation deadline. Even if adoption of the standards were universal, healthcare claims transactions in particular would remain complex. One source of complexity is that payers, even when the HIPAA transaction standards are used, have found it necessary to adopt lengthy “companion guides” and other proprietary business rules to address gaps caused by the relatively incomplete nature of the standards. The American Medical Association (AMA) estimates that its physician-members contend with 1,200 different companion guides published by payers.¹⁷

The ACA, enacted in March 2010, attempts to address the proliferation of payer-specific business rules in a section titled “Administrative Simplification.”¹⁸ The intent of the section is, among others, to eliminate the health plan-specific variations in implementation and the need for companion guides by authorizing the adoption of universal operating rules for the implementation and exchange of the transactions. The operating rules are intended to create nationally uniform expectations about content, process and infrastructure for use of claims-related transactions around such matters as timing, acknowledgments, system interoperability, patient identification issues, error resolution and security.

To satisfy the first wave of the ACA-driven operating rules, HHS adopted the CAQH Committee on Operating Rules for Information Exchange (CAQH CORE[®]) operating rules for eligibility and claim status transactions in July 2011¹⁹, and the industry is in the process of implementing these rules. While the rules now carry the force of the ACA mandate and HHS adoption, CAQH CORE is a voluntary multi-stakeholder initiative that predates the ACA. All CAQH CORE operating rules and the voluntary testing for CORE certification are decided upon by the multi-stakeholder CORE participating organizations.²⁰

Efforts to understand and improve COB must consider the current role and future objectives for transaction standards, operating rules and administrative simplification.

¹⁸ Affordable Care Act § 1104.

¹⁹ Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions, 76 Fed. Reg. 40458 (July 8, 2011).

²⁰ CAQH, CORE Participating Organizations, http://www.caqh.org/ben_participating.php (Feb. 2013).

III. THE COSTS OF COB TO THE U.S. HEALTHCARE SYSTEM

The key players that process reimbursements in today's healthcare industry – providers, payers and intermediaries – lack uniform and accurate data. And yet, payers are potentially responsible to cover a healthcare expense based on this data. Providers often lack complete information for submitting transactions, including who should be receiving the submission. Similarly, payers often do not have information about other potential payers. These challenges generate significant administrative costs throughout the healthcare system. Inconsistent collaboration between providers and payers– with patients and members – to ensure claims are first filed with the correct payer, results in shortcomings that require additional effort to address later in the claims process. These costs are manifested through the following examples:

Provider-Patient Interactions

- Patients are often the principal source of information on potential payers. Providers generally request all payer information from patients, on patient registration forms and by making copies of insurance ID cards. Patients may not have all of their insurance cards or information in their possession, however, or the cards they have may be out of date. Consequently providers may not submit claims to all appropriate payers.
- Patients who have additional insurance coverage through a spouse or other family member, or overlap between Medicare and other coverage, may not understand the importance of reporting all of their coverage sources and may not present their insurance cards or coverage specifics accurately or completely at the point of service.

Payer-Provider Interactions

- Because there is no comprehensive method to determine coverage and ensure that a claim is routed quickly and correctly, some payers and intermediaries may take inefficient actions in order to generate additional information. For example, some payers may pay claims fully upon initial receipt and then conduct follow-up activities to identify and reconcile any potential overpayments. In other cases, claims may be “pending” while other coverage is investigated.
- Despite the adoption of transaction standards, different payers may use the standards differently, resulting in incomplete transmission of information for COB determinations. Claims may need to be resubmitted or rerouted manually to reach the appropriate payer. The pending adoption of operating rules may diminish this friction point.
- Providers may fail to attach the primary payer's explanation of payment when submitting a claim to a secondary payer, requiring resubmission to the secondary payer.

- Some billing services may send duplicate claims to different payers in an effort to maximize initial payment and then work to return funds to the appropriate payers once the correct order of benefits is determined.
- Actual or perceived privacy and security barriers may impede efficient transfers of information among providers and payers; furthermore, payers and providers have been reluctant to share information they might consider proprietary.

Payer-Member Interactions

- When claims are adjudicated, payers may incur additional costs for ad hoc patient/member data requests – to verify, for example, whether an individual has other coverage that may be primary. After adjudication, both payers and providers may seek additional actions (reviews and appeals, respectively), which are further complicated when there are potentially multiple payers.
- Payers sometimes resort to sending surveys to their enrollees, or hiring contractors to do so, to ferret out sources of other coverage, particularly when evidence of other coverage might be in court files or other sources to which payers have limited access.

Payer-Payer Interactions

- When a potential payer is Medicare or Medicaid, special, complicated rules and requirements apply that may be onerous for other payers to meet.
- Delays in processing primary payments may inhibit secondary payers' abilities to accurately adjudicate claims. Different plans have different timely filing deadlines, and lags in processing primary claims may eliminate the ability of providers and patients to file secondary claims.
- Payers may abandon efforts to determine other liability as the information-gathering expenses mount.
- Complications arise when the need to coordinate benefits arises from a tort. A payer may identify diagnostic codes associated with an injury and seek to determine whether there may be third-party liability for the injury.

Extensive CAQH research conducted over the last two years, based on input provided by commercial payers, providers, vendors and other key stakeholders, has uncovered more than \$800 million in COB-related administrative costs. Sixty percent of COB costs relate to additional resources needed to handle administrative tasks, while the remaining 40 percent is spent on technology and vendors. The following figures detail the impact of these inefficiencies on providers and payers:

Figure 2. Provider Annual COB Costs

Repeated requests for COB information	\$0.5 million
Redone claims due to data errors	\$2.3 million
Excess time spent gathering COB information initially	\$45.8 million
Lengthy filing process for initial claim when payer information unavailable	\$91.7 million
High repeat bill rate	\$0.9 million
High denied bill rate from inaccurate/missing information	\$33.8 million
Slow bill preparation	\$91.7 million
Repeat routing of bill	\$0.3 million
Poor information on EOB, hindering secondary billing	\$187.5 million
Incorrect rejections or underpayments leading to repeated claims	\$16.9 million
Lengthy reconciliation effort	\$0.9 million
Lengthy appeals and claims inquiries efforts	\$11.0 million
TOTAL	\$483.3 million

Figure 3. Payer Annual COB Costs

Upfront information gathering by payers	\$36.7 million
Manual secondary billing	\$73.3 million
Ad hoc patient data gathering	\$45.8 million
Incomplete information provided to primary payer necessitating manual adjudication	\$55.0 million
Incomplete information on other payers and their payment responsibility	\$50.0 million
Primary claims that pend due to manual processing	\$60.0 million
Overpayments and adjustments	\$11.3 million
TOTAL	\$332.1 million

These estimates are based on costs to commercial payers and providers interacting with commercial plans. Additional costs are borne by Medicaid and Medicare to administer their respective coordination of benefits / third-party liability programs.

IV. OPPORTUNITIES FOR IMPROVEMENT

The millions of dollars spent on the COB process represent a call to action for payers, providers, employer sponsors of health coverage and policymakers to begin approaching COB seriously, in new ways, with new tools and infrastructure. Now is a particularly opportune and critical moment to address the issue. As the healthcare coverage system is about to welcome tens of millions more covered lives via the ACA, the issues of coordination and collaboration among providers, payers and vendors will become more acute.

CAQH's extensive study of COB suggests additional work can be done in several areas:

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- **Data Accuracy and Transparency**

As demonstrated in this paper, a central problem for efficient COB is the lack of complete, accurate data about potentially responsible payers for each claim. CAQH has launched an initiative that helps payers and providers consistently and accurately identify individuals with multiple forms of coverage. The solution also enables existing transaction standards, operating rules and claims processing infrastructure to work more effectively. Broad industry-wide adoption will accelerate the impact of this solution.
 - **Uniform Industry-wide Processing Approach**

In addition to improving data accuracy and transparency, an opportunity exists for providers, payers and other healthcare stakeholders to collaborate on a uniform industry-wide COB claims processing approach that builds on existing standards and operating rules. This approach to processing, similar to ACA-driven operating rule efforts, could align how the various players interact to coordinate benefits and provide a framework for how information should be exchanged, when it should be exchanged, how it should be processed and what results should be returned. The outcomes of this approach should improve the patient experience, reduce the need for paperwork, streamline the steps involved in fully adjudicating a COB claim across the applicable payers and accelerate the speed at which appeals are processed.
 - **Role of Intermediaries**

Today, claims clearinghouses, billing agencies and other intermediaries play a central role in claims processing and would need to be key partners in reforming COB. Intermediaries must have a seat at the table to work with the rest of the industry to ensure that improvements to the COB process are rapidly adopted by the provider community.
 - **Engagement with Public Programs**

Private industry and government programs must collaborate. As the largest payers, Medicare and Medicaid hold enormous sway and can help drive rapid adoption of industry-wide improvements. Uniform national resources and standards will facilitate accurate and timely processing of claims, for both public and private payers. States in particular have demonstrated they may lack the tools necessary to ensure Medicaid programs appropriately coordinate with other payers and would benefit from engagement with the rest of the industry.

Continued work in these areas, as well as others, can lead to significant administrative efficiencies that will benefit health plans, providers and patients through improved accuracy, timeliness and secure availability of coverage status information when processing claims. With reduced administrative costs and frustrations, provider resources are freed up, enabling more focus on patient care and leading to a better patient experience.

V. CONCLUSION

Challenges with coordination of benefits today arise from a lack of access to complete and accurate data about coverage, complicated and non-standard transaction processes and an environment where collaboration among diverse stakeholders is difficult. Focusing on remediating issues on the back end, after a claim has been submitted or even paid, causes more than \$800 million in annual administrative costs.

As this paper highlights, there is a path forward that leverages technology and industry-wide collaboration to enable improvement at the front-end of COB, prior to claim submission. While much of the necessary standards and infrastructure are in place, concerted action among industry stakeholders will be necessary to reduce administrative expenses and drive to a more functional healthcare system.

APPENDIX: METHODS

Figures 2 and 3 contain estimates of categories of provider and payer expenses that CAQH believes could be diminished by improving the efficiency of COB. These estimates are based on data collected for the CAQH U.S. Healthcare Efficiency Index, the industry experience of CAQH and its consultants, as well as public data sources on health claims transaction costs, including the following sources:

- Am. Med. Ass'n, *Standardization of the Claims Process: Administrative Simplification White Paper* (2009).
- Casalino, Lawrence P., et al., *What Does It Cost Physician Practices To Interact with Health Insurance Plans?*, 28 HEALTH AFF. W533 (2009).
- Milliman, Inc., *Electronic Transactions Between Payors and Providers: Pathways to Administrative Cost Reductions in Health Insurance* (2001).
- Milliman, Inc., *Electronic Transaction Savings Opportunities for Physician Practices* (2006).

ABOUT CAQH

CAQH is a nonprofit alliance of health plans and trade associations, serving as a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better experience for patients and caregivers.

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