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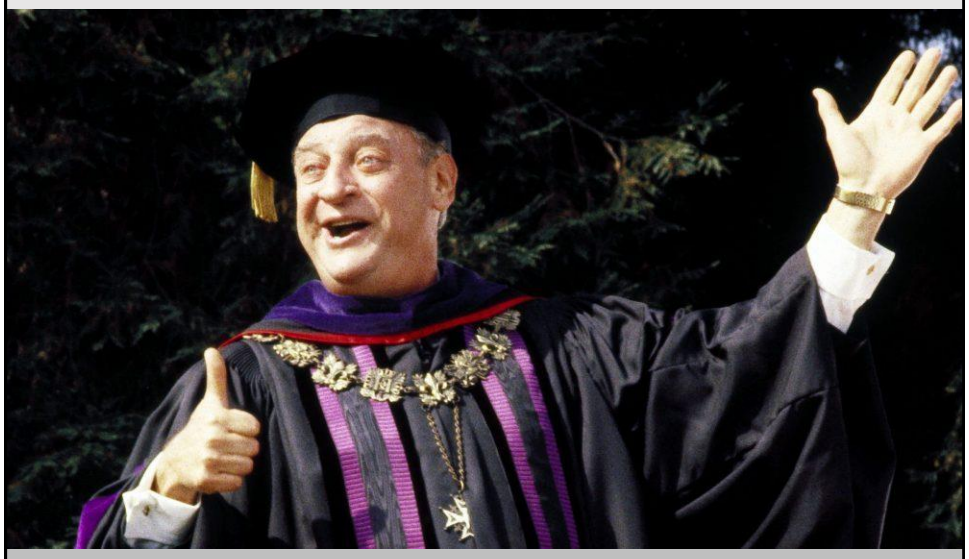
EMPOWERING PLANS

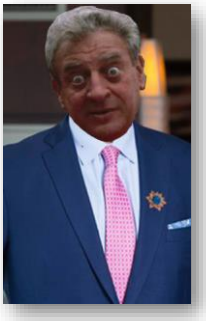



Back to School:
2020 Renewals



Today's Speakers



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Thanks for listening!

Patient Defender

With **Patient Defender**, the typical worries about balance-billing are extinguished. This innovative service protects the patient by providing them independent legal counsel, and protects the Plan by ensuring its members are represented by industry leading attorneys.

- **Proactive & Defensive Litigation and Negotiation Strategies**
- **Patient and Plan Consent Ensures No Conflict of Interest**
- **A PEPM Fee Guarantees an Attorney is on Retainer**
- **Attorneys Represent Patient Directly in Efforts to Resolve Balance-Billing**
- **The Phia Group Continues to Protect the Plan**
- **Patient Defense Can Be Added to Any Type of Plan**

Please contact Tim Callender at tcallender@phiagroup.com or 781-535-5631 if you are interested in learning more.

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PACE Certification Coming Soon

PACE® CERTIFICATION

The PACE® Certification program will educate you using 3 distinct chapters of information:

Chapter One
Explore the ins and outs of self-funding while learning about its risks and rewards. This chapter will transform any individual into a self-funding pro.

Chapter Two
Take a deeper dive into the laws that apply to self-funded plans. We cover it all, from federal preemption to adverse benefit determinations and appeals.

Chapter Three
Explain what PACE is, what PACE does, and how it's obtained, implemented, and utilized.

PACE® Certification was released on August 1, 2019!

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A Special Shout-Out!

Special Shout-Out to Dale Sagen

of

Berkley
Accident and Health
a Berkley Company

Dale is from Cleveland and is a big Indians fan!

"Berkley Accident and Health has a large office in Marlborough, MA so it is always fun to hear Adam's take on the Tribe deep in Red Sox territory near where a lot of my coworkers live."

Thanks for listening!

Overview

- **Problem, Purpose, Process**
- **Last Month's PGC FAQs**
- **Compliance**
- **Fiduciary Duties**
- **The Opioid Crisis**
- **Stop-Loss**
- **PBMs**
- **Adverse Benefit Determinations**

Problem, Purpose, Process

The Problem – Health Care Costs Too Much and The Price is Increasing; Employers are Forced to Offset Costs Through Higher Co-Pays and Deductibles

Our Purpose – To **Make Health Benefits Affordable** for Employers and Employees

Why? – Because **Hard Working Americans Deserve Access** to High Quality, Affordable Healthcare

Last Month's PGC FAQs

- What do we need to know about Rx manufacturer assistance?
  - Effective 1/1/20, CMS released new rules regarding counting manufacturer assistance toward OOP maximums
    - *"amounts paid toward cost sharing using any form of direct support offered by drug manufacturers to enrollees to reduce or eliminate immediate out-of-pocket costs for specific prescription band drugs that have an available and medically appropriate generic equivalent are not required to be counted toward the annual limitation on cost sharing"*
  - The rule does not address manufacturer assistance in any situations other than when a name brand drug is received instead of an available, medically-appropriate generic equivalent

Last Month's PGC FAQs

- Can we double our subrogation strength by using *both* equitable subrogation *and* contractual subrogation?
  - Not really…
  - Distinction between "contractual" and "equitable" subrogation:
    - Contractual = by operation of a *contract* (NOT the SPD)
    - Equitable = by operation of *equity,* or *law*
  - **Contractual rights are NOT preferable**! (Boo State Court)

Last Month's PGC FAQs

- Can we double our subrogation strength by using *both* equitable subrogation *and* contractual subrogation?
  - Equitable subrogation involves the argument to that you should reasonably be entitled to seek reimbursement because it's "fair" or "reasonable" (a more difficult and complex argument to sell)
    - Enforced in Federal Court under ERISA
    - That's why it should be written in the SPD.

And speaking of subrogation…

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Last Month's PGC FAQs

- Let's talk about Michigan's impending PIP waiver law.
  - As of 7/1/2020, MI residents can choose to forego PIP coverage if they have other accident-related coverage (i.e. a self-funded health plan)
  - If you have Michigan plans, you should keep this in mind!
  - Be aware: if a Michigan plan *does* cover auto accidents, members will be allowed to *opt out* of PIP, which removes the self-funded health plan's ability to coordinate benefits with PIP!

What do you need to *do* about this?

No SPD changes are necessary to comply, but plans may choose to alter benefits in light of this new PIP waiver option.

Compliance: Yeah, You Still Need It

- **New employment laws are being passed all the time!**
  - The group should check to see if its state has updated any laws or regulations that might impact the health plan, handbook, etc.
    - Example: MA paid family leave
- **Is the group planning on using any new vendors or services?**
  - Ensure that contracts, implementation, and compliance checks are all finished well in advance
  - Ensure that the TPA either can implement the new services easily, or makes the group known well in advance of renewal

Compliance: Yeah, You Still Need It

- **Has the SPD been updated? Make sure you notify *everyone*!**
  - Members, broker, TPA, network, stop-loss…
  - Different but potentially terrible ramifications of leaving anyone out of the loop
- **As of "the first day of the next plan year," is the plan going to implement carve-outs?**
  - Regulation: "a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries."
  - Example: dialysis carve-outs (usually not used until *needed*)

Compliance: Yeah, You Still Need It

- **COB/Eligibility audits**
  - CMS is never happy when they find COB issues down the road
  - Many TPAs start this a few months before renewal
- **What is IRS Notice 2019-45, and how does it affect our plans?**
  - In an HDHP, only preventive care can be paid at 100% prior to the deductible being met – or else patient cannot contribute to HSA
  - Notice 2019-45 expands the list of what can *be* considered preventive care pursuant to the IRC's HSA rules
    - Note: distinction between "preventive care" for the purposes of *this* Notice, and for the ACA. Very different purposes!
    - An HDHP is not *required* to add these services to its list of preventive services covered at 100% before deductible, but may choose to

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Fiduciary Duties

Remember the core duties:

- Acting **solely in the interest of plan participants** and their beneficiaries and with the **exclusive purpose of providing benefits** to them;
- Carrying out their duties **prudently**;
- **Following the plan documents** (unless inconsistent with ERISA);
- Holding plan assets (if the plan has any) in **trust**; and
- Paying only **reasonable plan expenses**.

Fiduciary Duties

- **Following the plan documents** (unless inconsistent with ERISA);

This has proven to be the toughest one for many plans and TPAs!

- SPDs can never be long enough to encompass *every* possible claim and appeal situation
- Employers sometimes design their benefits without realizing the ramifications of those benefits; it's very tempting to create exceptions and other rules on the fly
- TPAs are plan allies – but still potentially responsible for "just following orders"

The Opioid Crisis: What You Need to Know

According to a 2017 HHS study:

- 11.4 million people misused prescription opioids
- 2 million people misused prescription Opioids for the first time
- An estimated 130+ people died from opioid related drug overdoses
- 42,000 overdose deaths in 2016 (40% were prescribed)

HHS attributes at least some of this misuse to pharmaceutical companies that reassured the medical community that patients *would not become addicted*…

…so doctors didn't hesitate to prescribe them.

http:www.hhs.gov/opiods/about-the-epidemic/index.html

The Opioid Crisis: What You Need to Know

- About 40% of people addicted to opioids are covered by private health insurance
- Costs of treating addiction:

  2004 - $300 Million ($3 per person increase to annual of health coverage for large employers)

  2016 - $2.6 Billion ($26 per person increase to annual cost of health coverage for large employers; 900% overall increase)

The Opioid Crisis: What You Need to Know

So… what now?

- **Education**
  - Check for overpayments! Review the records!
  - Check your (de-identified) claims data for utilization
- **Avoidance**
  - Plan design & wellness incentives
    - Incentivize lower-cost pain management
      - Acupuncture
      - Chiropractic
      - Physical therapy
  - Ensure that providers are following CDC treatment guidelines

Stop-Loss Policies: Run-In, Run-Out, Run-Around

Run-In: "*x*/12" (Where *x* is more than 12)

- Claims incurred during the 12 months comprising the policy period and preceding *x*-12 months

Run-Out: "12/*x*" (Where x is more than 12)

- Claims incurred during the 12 months of the policy period and paid within the next *x* months

Paid: (usually just called "Paid")

- Claims paid during that policy period, but incurred *any* time (essentially, unlimited run-in)

Incurred/Paid: "12/12"

- Claims must be both incurred and paid during the twelve-month policy period

Stop-Loss Policies: Run-In, Run-Out, Run-Around

Common issue:

- A catastrophic claim is incurred and filed in late December, and policy period ends December 31 with no run-out
- The plan's TPA scrambles to pay it, and either:
  - *Pays it timely without review*, which could result in a partial or complete stop-loss denial based on the claim specifics, or
  - *Takes the time to review but ultimately pays it late*, which could result in a denial based on the end of the policy period.

- On renewal, the plan could purchase a policy with run-in coverage (for instance a 15/12 – three months of run-in) – but of course by then, the new policy may already have been purchased

Stop-Loss U&C: Another Year, Another Exclusion

When it's time to renew with stop-loss, consider whether the plan's needs have changed.

Common stop-loss U&C definitions include:

- Prevailing charge in the area for the same services
- An amount deemed reasonable by the carrier
- A pre-set percentage of Medicare

Note the conspicuous absence of references to PPO rates

Note the lack of deference to the Plan's determinations

Note the implied ability to engage an independent auditor

Stop-Loss U&C: Another Year, Another Exclusion

Common scenario:

- The plan incurs a claim for $200k, paid at the contracted 10% primary network discount ($180k)
- Once submitted to stop-loss, the carrier performs its own audit, and returns findings that the policy's U&C caps this claim's allowable at $47k – under spec – so there's no reimbursement

- Plan's argument: We know the 10% discount is meager, but this was an in-network claim; we had no choice but to take that 10% discount

- Some carriers are receptive to the group. Others…not so much.

PBMs

All self-funded health plans are getting hit hard by Rx spend. Just ask any plan's **broker**!

Take a look at yours and your clients' data.

- Check the spend

- Check the PBM contract terms

- See if there are other options (spoiler alert: *yes, there are*)

Adverse Benefit Determinations

According to ERISA, they must contain (among other things):

- *an explanation of the reason for the denial,*
- *the specific plan provisions applicable in deciding the denial, and*
- *a description of any additional material or information necessary to perfect the claim (including an explanation of why such information is necessary).”*

There are also important deadlines to follow!

It’s never a bad time for a review of internal claims and appeal handling procedures!

Thank You

Join us for our next free webinar:
September 17, 2019 at 1:00pm EST
www.phiagroup.com/media/webinars

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