THE PHIA GROUP

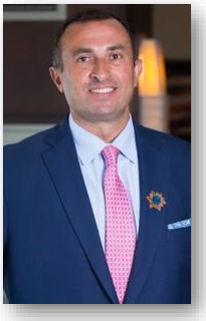
EMPOWERING PLANS




To Pay, or Not to Pay…
The Guide to Handling Claims, Denials, and Appeals




Today's Speakers



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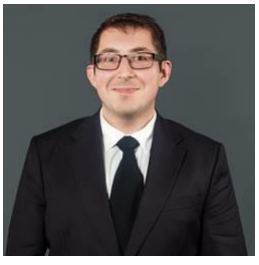
Check Out Our Podcasts

In this groundbreaking episode, **Pat 'the Man' Santos** – our silent producer, is silent no longer! Listen (if you dare) as he grabs the mic and goes toe to toe with our hosts.

Learn of his daring escape from mediocrity, journey of self-awareness, and eventual role with The Phia Group. This is the one you've been waiting for. ***Don't miss it.***



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A Special Shout-Out!

Special Shout-Out to Chris Chapman

of

MERITAIN HEALTH
An Aetna Company

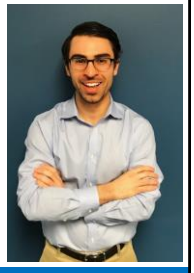
Chris is an avid fan of our webinars and podcasts!

Thanks for listening!

Faces of Phia

Ulyana Bevilacqua, Supervisor, Phia Group Consulting - Ulyana is an expert in drafting and reviewing Summaries of Benefits and Coverage (or SBCs). Ulyana has not only drafted numerous SBCs, but also educated a huge number of TPAs, brokers, and health plans regarding SBC and other compliance matters. In addition to SBCs, however, Ulyana has exhibited particular expertise in plan drafting; as The Phia Group's consulting division continues to expand, Ulyana's expertise has earned her a well-deserved supervisory role, where she provides crucial support, guidance, and assistance to The Phia Group's plan drafting team.

Corrie Cripps, Consultant II, PGC Internal Process Auditor - Corrie wears two hats: she not only tackles the difficult tasks of drafting and editing various employers' plan documents, but she also serves as an Internal Process Auditor, ensuring that The Phia Group's consulting division operates at maximum efficiency. As one of The Phia Group's preeminent experts in federal law compliance, Corrie helps our clients maintain plan documents that are not only compliant, but which also adequately contain costs.



Andrew Fine, Lead Intake Specialist – As Lead Intake Specialist, Andrew is responsible for tracking client requests, ensuring that team members meet deadlines, and verifying that our deliverables align with our clients' needs. Andrew utilizes targeted data to identify ways that The Phia Group can maximize efficiency and improve our processes in general. Andrew employs an individualized, hands-on approach to his intake and business development processes, designed to deliver consistent client satisfaction.

Overview

- Problem, Purpose, Process
- Last Month's PGC FAQs
- Political Update
- Claim Adjudication
  - Discretion
  - Fiduciary Duties
- Communication: Explanations of Benefits
- Appeals
  - Who Can Do What?
  - Questionable Denials & Lawsuits

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 is the Save American Workers Act, and what is its current status?**
  - H.R. 3798 - *The Saving American Workers Act of 2017*
  - Viewed by many as the first step in abolishing the employer mandate
  - Would change full-time threshold from 30 hours to 40 hours
- **Can a plan cover independent contractors (1099)?**
  - ERISA definition of "employee welfare benefit plan"
    - May bring the plan outside the purview of ERISA
  - Accidental MEWA?
  - COBRA considerations
  - Consider the stop-loss implications!

Last Month's PGC FAQs

- **Can a self-funded plan exclude all specialty drugs?**
  - Short answer: Yes
  - Longer answer: Lots of considerations for this one!
  - Essential Health Benefits, minimum value, grandfathered status, giving proper notice, health factor discrimination, §1557 discrimination, PBM contracts…
- **Is a medical provider time-barred from balance-billing a patient after one year?**
  - What? *No*.

Political Update

Surprise Balance Bills

President Trump: "We're determined to end surprise medical billing for American patients**"**

- What are They? (Balance Bills vs. Surprise Balance Bills)
- Why are They Being Targeted? (Bi-Partisan Support)
- Sample "Solutions" (Issue: They all Rely on Billed Charges)
  - Harvest the Money Tree
  - Play Ball
  - Sit Down and Make a Deal, Dammit!

Political Update

Surprise Balance Bills

The Crux of the Issue About the Issue: "Lawmakers aim to address the often-exorbitant amounts patients are asked to pay out of pocket**"** **(**https://www.npr.org/sections/health-shots/2019/05/09/721783170/trump-throws-support-behind-fix-for-surprise-medical-bills-but-hurdles-remain**)**

"Fair Rate" Solution (a/k/a Benchmarking**)** – No Support as Long as Providers Believe (and/or Lawmakers Believe) there is a Rationale Behind the Prices

- Payers Won't be Incentivized to Negotiate Fair Rates
- Private Payers Offset Medicare, Medicaid, and Uninsured
- Physicians Won't Operate out of Facility on OON or ER Basis

Political Update

Washington State … Public Option is NOT Single Payer (*Yet*)

Washington state has passed a law designed to give all consumers – starting in 2021 – a new, "public option" health insurance plan, to compete with the private marketplace (via the State's online "Health Benefit Exchange").

The state will contract with private health insurers to administer the plans, but will control the terms to manage costs.

To keep premium and deductible costs down, the new plans will cap total provider and facility reimbursement rates at **160% of Medicare**.

Political Update

Washington State … Public Option is NOT Single Payer (*Yet*)

Democratic state Rep. Eileen Cody, who sponsored the House version of the public option bill, said:

"**It's the first time that anybody has put a rate cap on a plan and tried to make sure that those people who are buying insurance don't have to pay so much.**"

Uh, *excuse me*?

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Political Update

Washington State … Public Option is NOT Single Payer (*Yet*)

Some Pushback:

"We worry that this could distort the market," said state Sen. Steve O'Ban, the ranking Republican on the Senate's Health and Long Term Care Committee.

O'Ban raised the specter that doctors might drop Medicaid patients "to make it work financially to participate in this plan with the lower reimbursement rates."

No word on Balance Billing, or raising rates paid by private payers?

Claim Adjudication

Discretion

- Most SPDs provide the Plan Administrator with discretion to interpret the terms of the SPD
- SPDs are long – but without the ability to interpret them, they'd need to consider *every possible scenario*
- Courts have iterated that discretion is crucial to affording deference to the Plan Administrator's opinion on review!
- Without discretion, the court doesn't "trust" the Plan Administrator's decision, but instead performs its own review from scratch *(or "de novo")*

Claim Adjudication

Discretion

Discretion is not synonymous with independence, though:

> Discretion is a way of *interpreting* an existing set of rules – not making up the Plan Administrator's *own* rules!

Example of discretion: A plan's "hazardous activities" exclusion lists **skydiving, bungee jumping, and rock climbing** as examples.

Without discretion: Those are the *only* hazardous activities

With discretion: The Plan Administrator can populate a list of what fits in with the language and the Plan Administrator's intent

Fiduciary Duties

Courts and regulatory bodies are constantly restating the basic fiduciary duties involved in plan administration:

- Acting solely in the interest of plan participants and beneficiaries, with the exclusive purpose of providing benefits;
- 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

Acting solely in the interest of plan participants and beneficiaries, with the exclusive purpose of providing benefits

Real Example:

The Plan Administrator's cousin operates an ASC, and an employee visits that ASC.

The Plan Administrator decides to decline to apply a particular plan exclusion, and pay the claim anyway – even though it is not technically payable pursuant to the Plan Document.

That payment was made to benefit the Plan Administrator's cousin, rather than to benefit the plan and its participants.

Fiduciary Duties

Carrying out their duties prudently

Real Example:

The Plan Administrator reviews an appeal but negligently fails to consider all pertinent facts.

The Plan Administrator is presented with information but ignores some of it, and unreasonably renders a claim determination based on only partial information.

Fiduciary Duties

Following the plan documents (unless inconsistent with ERISA)

Real Example:

The Plan Administrator learns that a particular patient has a history of drug-seeking behavior.

To combat abuse, this employer decides to set an annual dollar limit on coverage of certain drugs for that patient…

…but that limitation is not written anywhere in the Plan Document.

Fiduciary Duties

Holding plan assets (if the plan has any) in trust

Real Example:

An employer collects contributions from enrolled employees, but combines (or "commingles") them with the employer's general assets rather than keeping them separately in trust.

Subsequently, a creditor seizes some of the employer's assets. Those assets include some employee contribution amounts, which should be *plan* assets rather than employer assets, and therefore *not* subject to the employer's creditors.

Fiduciary Duties

Paying only reasonable plan expenses

Real Example:

A claims administrator's fees are paid by the health plan's assets rather than by the employer directly.

The CFO of the administrator is a good friend of the Plan Administrator, and the CFO asked the Plan Administrator if she would give the CFO a loan.

Instead of loaning the CFO money from her own personal assets, or even corporate assets, she gave the loan from the plan's assets, and couched it as an additional payment to the administrator.

Explanations of Benefits

29 CFR §2560.503-1: "Manner and content of notification of benefit determination"

(i) The **specific reason** or reasons for the adverse determination;

(ii) Reference to the **specific plan provisions** on which the determination is based;

(iii) A description of any **additional material or information necessary** for the claimant **to perfect the claim** and an explanation of why such material or information is necessary;

(iv) A **description of the plan's review procedures and the time limits applicable to such procedures**, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

Explanations of Benefits

"In the case of an adverse benefit determination by a group health plan…"

(A) If an **internal rule, guideline, protocol, or other similar criterion** was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request….

- Oddly, this seems to contemplate that health plans *are* permitted to utilize "internal" policies, which are not written within the Plan Document…
- But who polices or verifies that those "internal" policies are in fact established policies, and not just made up on the fly?

Explanations of Benefits

"In the case of an adverse benefit determination by a group health plan…"

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- This is designed as a system of checks and balances
- It is not enough for a Plan Administrator to claim to rely on some medical review – but the contents of that review must be made available

Appeals

Real Case Study:

- A self-funded health plan denied a claim after the Plan Administrator determined that that the services rendered were not appropriate
- The member called customer service and was told that she could appeal, but the Plan had already made its decision
- The member spoke to some doctors and received two written opinions on the propriety of the services; the Plan Administrator reviewed them but did not afford them any weight
- The PACE (independent fiduciary) determined that the Plan Administrator was required to consider those opinions, and ultimately determined that the claim should in fact be paid

Appeals

Among other things, a plan must:

- Provide claimants the opportunity to **submit written comments, documents, records, and other information** relating to the claim for benefits;
- Provide that a claimant shall be provided, **upon request and free of charge,** reasonable access to, and copies of, **all documents, records, and other information relevant to the claimant's claim for benefits**.
- Provide for **a review that takes into account all comments, documents, records, and other information** submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals

***Who* Can Appeal?**

- Difference between a medical provider appealing on its own behalf, and appealing on the member's behalf, as Personal Representative
- Assignment of Benefits (Ron's favorite topic!)
  - The provider's rights become equal to the patient's rights with respect to submitting bills and receiving payment
- "[T[he assignment is only as good as payment if the provider can enforce it" *(N. Jersey Brain & Spine Center v. Aetna)*

Questionable Denials

Cigna v. Humble Surgical Hospital

- Cigna withheld certain payments due to Humble to account for Cigna's perceived billing improprieties and fraud
- Humble countersued and was ultimately awarded $13M in damages – including $2.3M for fiduciary breach

Mason v. FedEx

- After Aetna (as TPA) denied a short-term disability claim, the court found a conflict of interest
- Court: FedEx "has an obvious incentive to hire a Claims Administrator that minimizes benefits awards."

Questionable Denials

Schultz v. Aetna Life Ins. Co.

- Insurer denied claim despite evidence from its own doctor that the claim might not be deniable
- All the discretion in the world still won't allow a fiduciary to ignore relevant information

Pac. Shores Hosp. v. United Behavioral Health

- In denying a claim, the Plan relied on telephone conversations and ignored hospital records
- Court: Plan violated fiduciary duty! Insurer has a responsibility to examine all relevant facts when adjudicating claims

Lesson: Discretion is the right to *interpret* rules – not to *ignore* them

Thank You

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June 20th at 1:00pm EST
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