

## **Cost Savings through Innovative Plan Design**

By Ron E. Peck, Esq.

At my office, I promote a slogan of: “Your rights are only as good as your plan language.” All too often, clients of mine (which largely consist of self-funded benefit plans and their third party administrators), will wait for a conflict to arise, and bank on their status under the Employee Retirement Income Security Act of 1974 (ERISA) to protect them. Regardless of whether an attack is coming in the guise of a disgruntled plan participant, underpaid healthcare services provider, State insurance commissioner, or personal injury attorney, my clients always think that they can adapt their procedure to meet their needs on that day.

Nothing could be further from the truth.

### **YOU'RE AN ERISA PLAN... SO WHAT?**

When my clients cry “ERISA” into the face of every conflict, I respond, “You are an ERISA plan... so what?” A little known fact is that all benefit plans offered by an employer are ERISA plans, unless they fall under one of a few categories that can apply for exemption from ERISA. The benefit of being a private, self-funded plan is not the application of ERISA. Rather, the benefit of being a private, self-funded plan is the pre-emption of State insurance laws.

What does that mean?

A private insurance carrier, which collects premiums in exchange for providing insurance coverage to a group of employees, must meet both the requirements of ERISA and the State insurance laws in effect for each State in which the carrier issues policies. For the larger insurance companies out there, that can mean adjusting your practices up to 50 times! Ouch.

A private, self-funded benefit plan, however, is able to apply one uniform benefit plan, nationwide, without adjusting its terms on a State by State basis. That is the purpose of ERISA preemption against State laws... It allows the Plan to enforce the terms of its benefit plan document nationwide, without having to worry about each State's special, unique laws.

Take note of that last sentence... ERISA preemption “allows the Plan to enforce the terms of its benefit plan document.” In most Federal Circuits we avoid State laws and other pesky rules only when those rules are disclaimed in writing. As a result, if your benefit plan document fails to address something in writing ahead of time, you may be forced to obey restrictive State laws and equitable doctrines that you otherwise could have avoided... had you disclaimed them in writing.

So now that we've proven the veracity of my slogan, "Your rights are only as good as your plan language," we need to address how to ensure your plan document is top-notch.

### APPLYING MURPHY'S LAW

For many, plan document drafting may seem rather boring and analytical. I disagree wholeheartedly! In my opinion, "Pre-Emptive Creativity" is the key to successful plan document drafting. What does that mean? To write a strong plan document, you cannot simply address applicable laws, requirements, and issues that have occurred in the past. In addition to those mundane matters, you must also dare to think outside the box! I've learned in my time to always apply Murphy's Law – if it can go wrong, it probably will. As you draft... ask yourself... what can possibly go wrong? Then, draft language which would address such a scenario.

Allow me to provide an example. A plan document includes a classic exclusion – one which excludes from coverage injuries arising from the commission of a felony. A plan participant is driving home from a party, is intoxicated, and hits a tree. The participant is seriously injured. Driving while intoxicated, however, is usually not a felony (unless it is a repeat offense, or another person is injured). As a result, since the Plan restricts the exclusion to felonies, the claims must be paid. To make matters worse, the stop-loss policy covering the Plan excludes all illegal acts. So, the Plan not only pays the claims, but it cannot obtain reimbursement from its reinsurance carrier.

Why did the Plan only exclude felonies? I have asked many of my clients that very question, as too many of them fail to exclude illegal acts which are not felonious. One and all, they provide the same response. They do not want to be forced, by their plan language, to deny claims arising from basic speeding, jay-walking, and other "illegal acts" that we all commit every day.

This decision – to limit an exclusion to felonies, in order to avoid excluding charges arising from jay-walking – is the very definition of "overkill." In this scenario, like so many other plan drafting scenarios, a little creativity goes a long way. How about an exclusion which states that: "All charges for services and supplies, arising from or during the commission of any illegal act, which – if convicted – could result in any period of incarceration, is excluded." Language like this (1) does not require incarceration to occur, (2) captures the "nasty" misdemeanors like DUI/DWI offenses, but (3) preserves benefits for those of us that think 10 miles over the limit should be taught in driver's education classes.

Again – sometimes a little creativity and language which actually expresses your intent, will go a long way. Not convinced? How about another example...

The Department of Labor (DOL) issued a requirement that exclusions include an exception for injuries arising from incidents of domestic abuse. In response, most benefit plans added to their documents language which was tacked onto the end of their

exclusions, which says, “This exclusion will not apply if the injury arises as a result of an act of domestic abuse.”

In one particular case, a client sought to exclude claims based on their illegal act exclusion, when a husband came home, and broke his hand whilst beating his wife. The illegal act exclusion included the exception described above. The abuser’s attorney read the language, and rightly stated that the injury did indeed arise from an act of domestic abuse. The Plan was required to pay the claims.

Instead, had the language expressed the actual intent of both the DOL and the Plan... that injuries due to being the victim of domestic abuse (note the use of the word “victim”) are excepted from the exclusion, they would have been able to exclude the abuser’s claim.

These are just some examples of situations where preemptive creativity could have saved the Plan some money.

Other examples of situations where the Plan wants to do one thing, but the language says something else, include medical tourism. Many plans are now considering allowing their participants to travel to other countries to seek treatment. These plans contract with vendors specializing in this process, and even amend their plan documents to describe how the process will work. Unfortunately, many of these plans forget to remove from the exclusions the language which excludes from coverage any treatment received outside the United States!

### EXPRESS YOURSELF!

Thus far, we have proven that the plan language must express the intent of the Plan. The plan document, however, represents more than an opportunity to express the Plan’s intent. It is also the Plan’s opportunity to clearly describe how it is constituted, who has what responsibilities, and which laws apply. In other words, the plan document should include language which clearly states that it is self-funded within the purview of ERISA, and that State law contrary to the terms of the plan document are preempted. It should clearly state that the Plan Administrator is the fiduciary, as envisioned by ERISA, and has complete discretionary authority to interpret the terms of the Plan, and make all administrative decisions based on evidence available to it.

This, then, gives the Plan Administrator an opportunity to tell the world what standards it applies in its discretion. Don’t leave anything to chance! Define terms such as Experimental and/or Investigational, Medically Necessary, Usual and Customary, Reasonable, Clean Claim, Maximum Allowable Charge, and Excess Charge(s).

Of particular importance is the concept of Usual and Customary (U&C). I’ve seen benefit plans that define U&C as the equivalent of 90% of the charge amount or 100% of amount charged by an in-network provider. This type of definition takes the power to review the charge and pay an appropriate amount out of the hands of the Plan Administrator.

Some Plans try to limit a provider's discretion, by defining Usual and Customary as the common amount accepted by other providers in the area. I call this type of definition the "classic" U&C. What's wrong with the "classic" U&C? We've developed the concept of "The U&C Garage."

People have come to accept that, in some areas, every mechanic in town has agreed to overcharge for their services. If every mechanic in town is overcharging, the "amount commonly accepted by the service provider in the area" (and thus, U&C, per the plan terms), is still excessive! Relying on other providers in the area to keep prices fair is a bad idea.

Furthermore, you may also run into a situation where a provider is the only provider in town. If that is the case, and U&C is defined by what providers in the area charge, you have now given that single provider the power to determine what U&C will be.

When stating that providers in the "area" will be examined, express an intent to expand the "area" to include a representative cross section, large enough – in the Plan Administrator's discretion – to provide a true basis for comparison. In addition to an "expanding area," give the Plan Administrator the ability to consider other parameters for defining U&C as well. List in the definition of U&C, the fee that the provider most often receives, Medicare cost to charge ratios, average wholesale prices, manufacturer's retail pricing (MRP), actual cost to the provider, and Medicare reimbursement rates.

The Plan is not required to pay any one of these amounts in particular, however, it should be able to examine them all when determining what the U&C amount should be.

Another important term which is often overlooked is the definition of a "Clean Claim." A Clean Claim should be one that includes relevant details adequate to determine whether a claim is payable by the Plan.

PPO network agreements often impose a deadline upon a Plan, requiring the Plan to pay claims within a certain number of days after receiving a clean claim. Those agreements go on to define a clean claim as merely one that adequately completes a HCFA or UB form. The Plan, however, more often than not can't determine whether a claim is payable, in accordance with the terms of the Plan, based solely on the information they receive on a HCFA form.

Medicare defines a clean claim as one in which there is "No defect, impropriety, lack of required substantiating documentation or particular Circumstance requiring special treatment that prevents timely payment," 42 C.F.R. § 422.500. The Plan should also require all necessary details to actually process the claim per the Plan terms, before the deadline begins to run.

WHAT ONCE WAS LOST IS NOW FOUND

One field of plan document preparation which is near and dear to me has to do with claim recovery. My career in benefit plan services began with subrogation and claim reimbursement.

I have found over the years that the major issue Plans face when considering third party payers is a lack of understanding regarding the purpose of the provisions, and what certain terms truly mean. Coordination of Benefits, for instance, is meant to ensure that when a primary source of funds is available to pay claims, the proper party pays first. It is important to assert a right to pay secondarily to any and all potential payers.

Remember, however, that this provision is meant to coordinate with available funds. I have encountered scenarios where a client will exclude a certain amount in claims, equivalent to a no-fault medical payments amount required by law to cover all automobiles in their State. So, for instance, if the law requires cars to carry \$5,000 in medical payments coverage (available to pay medical bills regardless of who was at fault for the accident), the Plan will deny the first \$5,000 in claims. The Plan in that scenario, fails to consider whether the medical payments coverage was exhausted on medical bills that were never sent to the Plan. Or, perhaps the vehicle in question was a motorcycle, and in that State, motorcycles aren't required to carry medical payments coverage.

Plans must be better prepared to deal with coordination of benefits situations on a case by case basis, rather than apply a single "carve out" approach.

At this time, it is important to understand the difference between "subrogation" and "reimbursement."

We in the industry use the term "subrogation" to define both subrogation and reimbursement. The truth is, however, that third party recoveries result from reimbursement more than 90% of the time.

Subrogation literally means "Stepping into the Shoes" of the insured. Subrogation occurs when the Plan pursues a claim directly against the third party that caused a loss, in the name of the insured. This can only be done if and when the insured chooses not to pursue the claim themselves. Rarely, if ever, is a claim worth pursuing ignored by the insured. If a plan participant doesn't want to pursue a claim, 9 times out of 10, it isn't worth pursuing at all, and subrogation makes no sense.

Reimbursement is the avenue we most often take to recover funds. It, as the name suggests, consists of the plan participant pursuing a claim against the party that caused the loss, recovering money, and reimbursing the Plan.

Reimbursement is much more preferable than subrogation. As a result, when I see plan language which states that the Plan is "automatically subrogated," I cringe. I know that the Plan actually means to say that they automatically have a "right" to subrogate, and automatically have a "right" to reimbursement... but all too often, they fail to say what they mean! (That, by the way, should be a theme which is obvious to you by now).

As it relates to subrogation and claims recovery, many terms and provisions are required to be included if the Plan wishes to enforce any rights to reimbursement. First and foremost, the Plan should clearly state that if a third party is responsible for the injury OR PAYMENT OF THE CLAIMS (these two third parties are not always the same), the Plan may – but is not required – to pay the claims. The Plan then goes on to state that if the plan participant wishes claims to be paid, they must – in exchange for this payment – acknowledge and obey the terms of the Plan.

The Plan should then go on to state that once claims are paid, an equitable lien is established on the Plan's behalf. Furthermore, the plan participant is obligated to hold funds in a constructive trust. Disclaim rules such as the common fund doctrine (which purports to have the Plan reduce its lien for an attorney's fees and costs) and the made whole rule (which states that the Plan may recover nothing until the plan participant is fully compensated for all of their losses).

Take it further, and address what will happen if the plan participant fails to cooperate, such as an offset provision. "Offsetting" allows the Plan to deny future claims (even if they are unrelated to the incident from which the subrogation rights spring), until the claims which are denied equal the amount owed.

Address situations where the patient is a minor, or deceased, or bankrupt. As mentioned earlier, you can only enforce rights which are expressed in writing; it is wise to be creative, and cover all of your bases.

Similar in nature to subrogation and reimbursement is the Plan's Right of Recovery. This right is often (wrongfully) limited to the coordination of benefits provision. It is the place where the Plan expresses a right to pursue refunds of claims which are overpaid. The Plan should ensure that this provision applies to the entire Plan (not just the coordination of benefits section), addresses any and all types of overpayments, and allows the Plan to pursue both the entity which was paid as well as the entity on whose behalf payment was made.

#### NEVER EVENTS – NEVER? HARDLY EVER.

In general, the industry has decided that a Never Event is one which results from identifiable, preventable, and serious medical errors. We know that about 98,000 patients die each year due to errors, and that between the years 2002 and 2004, CMS paid more than \$9.3 billion in claims caused by medical errors. These days, benefit plans don't want to pay providers to fix their own mistakes. Yet, how can a plan document exclude such errors?

Believe it or not, but we advise our clients that it is imprudent to address "Never Events" in their plan documents. There is no concrete definition of what a Never Event is at this time. Furthermore, complications do occur which should not be considered a Never Event, but may still be held up if "Never Event" language makes it into the plan

document. This results in confusion regarding what a “Never Event” actually is. Further complicating matters is the nightmare scenario where a benefit plan, whose document excludes “Never Events,” pays claims arising from a complication, and seeks reinsurance reimbursement. The Plan doesn’t think the incident is a Never Event, however, their reinsurer does.

Rather than utilize a strict “Never Event” exclusion, we advise instead limiting claims eligible for payment to reasonable services. In defining what “reasonable” is, we look at the basis of the charge, rather than the cost. So, for instance, if amputation of a right-leg usually costs \$10,000, and a provider does it for \$5,000, we can all agree the price is very fair, and meets our definition of what is usual and customary (see above). If, however, the surgeon was supposed to amputate the left leg... not the right leg... no matter how little the provider charges, the service itself is unreasonable and should not be paid for by the Plan.

By testing claims for reasonableness and medical necessity, rather than just testing the price for U&C or excluding Never Events, the Plan Administrator has the discretion to determine what is a covered service, and what is not, without worrying about stop-loss conflicts.

#### TO NETWORK, OR NOT TO NETWORK? ... THAT IS THE QUESTION.

Too often, conflicts arise between providers, participants, plans and TPAs, due to a PPO network agreement. In a nutshell, one of two entities will sign a network agreement on behalf of the payer – the TPA or the benefit plan.

If a TPA signs the agreement as a payer, they expose themselves to liability for unpaid bills. Providers which are only paid a portion of their bill (by the Plan) will come after the TPA for the rest. The TPA will claim they are not the plan sponsor and have no access to the Plan funds. The TPA will say that the plan document doesn’t allow the Plan to pay the entire bill, despite the PPO contract’s existence. The provider, in turn, will respond by saying they don’t care about the Plan, or the Plan’s money. They want the TPA to pay, because the TPA signed the network agreement. They will sue the TPA, and they will win.

PPO networks are set up to provide benefit plans with access to discounts. As such, the benefit plan... not the TPA... should be signing the agreement. After all, it’s the Plan’s money, isn’t it?

If the Plan signs the agreement, however, we must look at the conflict between the plan document and the classic PPO agreement.

Most PPO agreements require quick payment. Most plan documents require the collection of accident reports, details, etc. to process claims. Most PPO agreements won’t allow claims to be reduced to match U&C rates. Most plan documents limit

available funds to U&C rates. These are just some examples of the inherent contradictions existing between the Plan and the PPO agreement.

The bottom line is this – A plan administrator is also a fiduciary. As a fiduciary, the Plan Administrator has a legal obligation to manage Plan assets prudently, and in strict accordance with the terms of the benefit plan document.

No third party contract can require a party to breach their fiduciary duty, and still be valid or enforceable. That being said, one could argue that the plan administrator breaches their fiduciary duty if they sign anything which contradicts the terms of the Plan.

As a result, plan administrators would be wise to review network agreements and ensure that the agreement never requires them to pay claims in excess of those allowed by the Plan.

Furthermore, the plan document should include language which addresses disgruntled providers, and confronts the matter of balance billing. That brings us to...

#### CONSIDER ASSIGNMENT OF BENEFITS AS CONSIDERATION

Based upon my understanding of contract law, a contract consists of three things: Offer, Acceptance, and an Exchange of Consideration. In the context of a provider / patient relationship, the provider offers to treat the patient, and the patient accepts said offer. The treatment is in and of itself the consideration supplied by the healthcare provider. In exchange, the provider accepts monetary compensation as payment.

This leads into the next issue, which relates to how billing is accomplished. With every other form of insurance, claims are processed in the same fashion. First, the insured suffers a loss. Next, the insured reports the loss to the insurer. Next, the insurer assesses the damages, and provides compensation to the insured, with said compensation equivalent to what the insurer feels is the fair market value for the loss, based upon industry accepted parameters. Finally, the insured either uses the compensation to address the loss or not. How the insured uses the funds is of no concern to the insurance carrier.

In the realm of healthcare, health insurance carriers are charged vastly different amounts for the same service by similar providers practicing within less than a mile from each other. These medical service providers even charge different entities different amounts for the same service. Moreover, the insurance carrier is expected to pay these varied charges in full, regardless of what the carrier believes is the actual, fair value of the loss.

Consideration is an interesting topic. Rarely do people clash over an offer, or acceptance of that offer. More often than not, controversies and conflicts arising from a failed contract arise due to the issue of consideration. Failure to provide goods or services “per the contract,” and failure to pay for goods and services, is a failure to provide consideration. Failure to deliver what was promised is failure to deliver adequate

consideration per the terms of the agreement, and is by far the most common issue giving rise to a “breach of contract.”

Consideration literally is: “What I am giving to you, and what you are giving to me.”

Consideration comes up when we examine how a healthcare service provider is compensated for treatment rendered to a plan participant.

We know that, as the system is currently constituted, a provider will provide treatment to a patient, and that patient will – in exchange for said services – assign their right to file a claim with the insurance carrier or benefit plan, to the provider. This process is known as an “assignment of benefits”.

The insurance carrier or benefit plan will then forward payment directly to the provider. If the benefit plan administrator or insurance carrier determines that the amount charged exceeds the amount available, they will (sometimes) pay to the provider less than the billed amount.

Sometimes, the provider will accept said payment and consider the matter closed in full. More often, however, the provider will deposit the payment, and pursue the patient for the remainder. This is called “balance billing.”

In my mind, however, this is not only balance billing... It is theft! It is a prime example of “having your cake and eating it too.” The provider enjoys all of the benefits of billing the insurance carrier or benefit plan (deep pockets, timely payment), but also rests assured that – should the insurance carrier pay less than the billed amount – the provider can balance bill the patient as well!

Billing an insurance carrier has value above and beyond the money received.

I propose that when a patient offers their right to obtain benefits from their insurance, that assignment of benefits is in and of itself consideration in full, exchanged for services and treatment. It is my theory that an assignment of benefits is thus not a form of access to consideration, and rather, is the consideration itself.

As such, I advise my clients to state in their plan document, that assignment of benefits is accepted as consideration in full, and if the provider feels that the assignment of benefits is inadequate consideration for the services rendered, they may not accept said assignment of benefits, may not bill the Plan directly, and must bill the patient. The patient, meanwhile, will be the only party with a right to submit a claim to the Plan.

One might ask why a medical service provider would ever choose to accept an assignment of benefits in lieu of the right to bill a patient for 100%. The reasons why assignment is still an attractive option are many.

First, there is the certainty of payment. Next, there is promptness of payment. If the provider bills the patient, the provider must pursue said patient for payment. This entails debt collection activities, unearned interest on unpaid bills, costs of pursuit, and extreme administrative costs inherent in the billing of many individual billable parties. Compare that to a scenario where the number of billable parties is reduced to a much smaller group of insurance carriers. These carriers are much more likely to pay than individual patients (eliminating debt collection costs). These insurers will pay promptly as well, meaning the funds will find their way into the provider's account quickly and efficiently. Finally, the carrier's pockets are no doubt deeper than the patient's, should a dispute arise or a substantial amount be due.