A Passion for Subro Newsletter

October 2009

Dear Reader,

Over the past few years we have sent emails regarding important industry events relating to subrogation, ERISA, and the healthcare industry as a whole. Beginning this month, we will be emailing a monthly newsletter focusing on many of the innovative practices here at The Phia Group as well as diverse industry issues you won't find anywhere else.

This month we are also proud to announce our first ever event - The Phia Group Forum - Boston 2010. In honor of The Phia Group's 10th Anniversary, we are hosting a conference at the historic Omni Parker House Hotel June 10th and 11th 2010. Based on the initial responses, we are expecting hundreds of attendees and representatives of the industry, ranging from TPAs to MGUs and beyond. We are promising to deliver unique seminars led by the industry's best and brightest speakers. The focus of the conference is on client savings and I have proposed a theme which reflects our Boston roots "A Revolutionary Passion for Savings". If you

The Phia Group Forum - Boston 2010
Learn more

The Phia Group, LLC
www.phiagroup.com

The Law Offices of Russo & Minchoff
www.russominchofflaw.com

The personal subrogation blog of Attorney Adam V. Russo
www.passionforsubro.com

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Questions/Comments
If you have any questions or comments about this newsletter, please email us at
newsletter@phiagroup.com

love it or hate it, let me know – please!

Over the next few months, we will debut a new level of services. Based on feedback from our clients, The Phia Group will launch innovative services to meet plan needs and maximize savings. It is an exciting time for our entire staff as we continue to grow during these tough economic times.

I hope you enjoy this inaugural edition and I look forward to receiving your feedback concerning the newsletter's layout, topics and any issues of preference on past or upcoming newsletters. Thank you and enjoy.
Sincerely,

Adam V. Russo, Esq.
Co-Founder

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The Phia Group Case of the Month

By Melanie Yates
Vice President of Operations

In this, our first of many "Case of the Month" articles, we review some of the more interesting scenarios with which we have dealt, and share some of our successes.

This incident took place in our backyard, on a small New England road. The plan participant was walking to work when a vehicle, owned and operated by a local corporation, hit him at a cross-walk.

The Phia Group was involved immediately, and asserted our client's rights against the vehicle's insurance coverage. Unfortunately, the funds were limited and damages were severe, both for the benefit plan and the participant. The funds were therefore quickly exhausted.

Rather than consider the matter concluded, however, The Phia Group continued to monitor the situation and determined that a law suit against the owner of the vehicle was viable. Working with the participant, The Phia Group was able to advance the matter, place all interested parties on notice, and work with the opposing counsel to reach a satisfactory settlement. The Phia Group played an active role throughout the proceeding and aided in its resolution without sacrificing the benefit plan's right to reimbursement; recovering nearly $700,000.00.

The Form 5500 Advisory – URGENT!

By Jennifer M. McCormick, Esq.

Many of the self-funded benefit plans The Phia Group services, and our clients administer, are sabotaging their own right of reimbursement by completing and filing faulty Form 5500's.

According to the Department of Labor, "Each year, pension and welfare benefit plans generally are required to file an annual return / report regarding their financial condition, investments, and operations. The annual reporting requirement is generally satisfied by filing the Form 5500 Annual Return / Report of Employee Benefit Plan and any required attachments.

The Form 5500 Series is an important compliance, research, and disclosure tool for the Department of Labor, a disclosure document for plan participants and beneficiaries, and a source of information and data for use by other Federal agencies, Congress, and the private sector in assessing employee benefit, tax, and economic trends and policies. The Form 5500 Series is part of ERISA's overall reporting and disclosure framework."
http://www.dol.gov/EBSA/5500MAIN.HTML

Unfortunately, we often face many plaintiffs' attorneys who seek to limit or eliminate a benefit plan's rights will ask us to provide them with a copy of that benefit plan's Form 5500. Often, we retrieve the Form 5500 only to discover that Line 9 indicates the Plan is funded through

"Insurance" and only through "Insurance." The plaintiff's attorney will then argue the Plan is NOT self-funded, and is in fact insured. Based on the Form 5500, that attorney is right!

The Department of Labor advises us that, when completing Line 9, you should "Indicate all the proper Funding and Benefit Arrangements on Form 5500, Lines 9a and 9b. The "Funding Arrangement is the method used for the receipt, holding, investment, and transmittal of plan assets prior to the time the plan actually provides benefits. Be careful to indicate all the applicable Funding and Benefit Arrangements." http://www.dol.gov/ebsa/form5500tips.html

Line 9 offers options which include "Trust" and "General Assets of the Sponsor." Self-funded benefit plans are Trusts, funded with the General Assets of the Sponsor, so why aren't they indicating that on their Form 5500's? Please review your Form 5500 filing procedures, and the procedures of all self-funded benefit plans you encounter, and ensure that both the "Trust" and "General Assets of the Sponsor" boxes are marked.

The Phia Group's Healthcare Reform Update

By Ron E. Peck, Esq.

If you are not aware that healthcare reform is afoot, you simply aren't paying attention. As the hottest of hot topics, the question is not whether we will see reform, but rather, when we will see it and what form it will take.

In the past, Adam Russo and I, as well as other members of The Phia Group team, have joined the debate. We have attended various conferences, met with our legislators, participated in lobbyist efforts, and kept you updated regarding developing stories.

At a recent event, a poll was taken among the audience. The question asked was whether the crowd believed a healthcare reform bill would pass before the end of the year. Over 60% of the crowd believed we would see no such law take affect.

Speaking of votes, the 60% of "doubters" may wish to reconsider their ballot, given the upcoming elections. Currently there are 123 seats (77 democrats, 46 republicans) in the House of Representatives and 20 seats (12 democrats, 8 republicans) in the Senate which are coming up for election and – by all accounts – will be the subject of a competitive race.

Historically, the President's party sees a drop in representation come mid-term elections. This well known statistic likely has the Congressional Democrats anxious to get their ideas in writing

and passed, before it is too late. Senate leaders are aiming to begin the floor debate on health reform, including key procedural votes, during the week of October 19.

House leaders have been meeting with the House Democratic Caucus. Their goal is to craft a single plan that can be presented for votes. The Congressional Budget Office has advised that the proposed plans will result in a coverage increase for legal, nonelderly residents, from 83 percent coverage today to more than 90 percent by 2019. This growth in coverage, however, comes with a price tag in excess of $800 billion.

In summary, we are concerned by two major issues. First, some of the proposals are troubling. Second, the conspicuous absence of certain topics from the discussion is disturbing.

Regarding some of the ideas floating around Capital Hill, there have been several proposals.

The dreaded "Public Option" – which would drive private insurance out of business by offering Americans more coverage for less cost, reduce the quality of healthcare by under-compensating healthcare providers (coverage will be based on Medicare rates or bargain-basement negotiations), and rely upon steadily increasing tax dollars to remain viable – has been replaced in many proposals by less objectionable ideas.

For instance, some are promoting the National Health Insurance Exchange, whereby private and public plans would offer coverage (which meet government set minimum mandates), and be offered to consumers through a "connector" similar to the Massachusetts Connector Plan. Of course, those of us living in the Commonwealth of Massachusetts have seen the cost of this program sky-rocket, as unreasonable mandates continue to be attached to the plan by special interest groups.

Our industry has expressed concerns that the Senate Finance Committee's "America's Healthy Future Act" (as presently constituted) could significantly harm Employer-Based Health Benefit Plans in many ways. There are no regulations limiting movement between plans, and nothing to prevent a costly exodus from efficient coverage to a public plan. This massive shift to a public plan which was originally meant only to protect the uninsured, will cost tax payers billions and limit customization and flexibility on the part of benefit plans. Facing requisite mandates and rising costs, plans coming within the purview of the public exchange will be incentivized to focus on profits rather than innovation, and will be forced to share those costs with employers and plan beneficiaries.

Looking next at what is missing from the conversation, what are we doing about provider

pricing and transparency? What are we doing about mark-ups, inefficiencies of process, and frivolous lawsuits? For instance, between 2002 and 2004 CMS (on behalf of Medicare and Medicaid) paid billions to fix preventable errors. Inefficiencies and unfair billing practices are surely resulting in soaring healthcare costs. Yet, not once have we heard reference to mandates which would impose restrictions on pricing and reduce costs by incentivizing efficiency.

Pricing by healthcare professionals are often reactive to costs. Why not examine those costs? For instance, consider malpractice insurance; I would argue that reform limiting which suits can be filed and requiring an objective expert panel determine whether a malpractice suit has merit, prior to allowing suit, would reduce costs and prevent doctors from "over-treating" to avoid said suits.

The Congressional Budget Office recently considered medical malpractice reforms that would place a $250,000 cap on non-economic damages, limit punitive damages, and other limitations which would, they estimate, reduce total national healthcare spending by more than $11 billion in 2009, reduce federal spending by more than $40 billion, and reduce all premiums paid for health benefit coverage by at least ten percent.

This is just one example of "a non-insurance" issue affecting the cost of healthcare. If Congress and the President stepped back and looked at the entire healthcare picture – starting with the patient (patient education initiatives, physical education in schools, preventative treatment, etc.), providers (cost regulations, transparency, free-market competition), and trial lawyers (malpractice reform and regulation), instead of strictly demonizing the insurance (who only joins the party at the end of the game) – they could cut costs, provide better healthcare, and avoid this upheaval altogether.

Thoughts on the American Association of Preferred Provider Organizations Pacific Regional Chapter 2009 Educational Forum

By Ron E. Peck, Esq.

Nine days have passed since I was soaking up the Arizona sun in lovely Tucson. The only thing more interesting than the blue skies, mountainous terrain, and dry heat was the discussion taking place in the Hilton "El Conquistador" resort's "Coronado" conference room. In that room, an esteemed panel took it upon themselves to expose the conflict that has festered in darkness, existing between medical service providers, health insurance carriers, third party administrators, benefit plans, and PPO

networks.

John Rivers, CEO and President of the Arizona Hospital Association spoke for the physicians and hospitals. Todd Archer, President of Mutual Assurance Administrators and HCAA member provided the TPA perspective. Benton Davis, Regional Vice-President of United Health Care, offered a view from the fully funded insurance carrier's world. Finally, Adam Russo was more than happy to address the conflicts between providers, administrators, and plans, when PPO payment instructions conflict with the terms of the applicable plan documents.

John got the ball rolling by explaining that, in the past, providers were more concerned with large insurance carriers avoiding bills by claiming the submission was never received. This conflict is not particularly sophisticated; it is a basic "he said / she said" dispute. The provider would claim the bill was sent the carrier would advise it hadn't been submitted. Unlike this simple clash of yore, today's conflicts are much more sophisticated.

A big problem then arises from the complete lack of innovation on the part of the billing entity, and the lack of incentive to be innovative. Why should providers develop new technologies and procedures to properly bill various entities when they can simply raise rates and demand payment outside the terms of the applicable document by

enforcing a PPO agreement they feel “trumps” the plan or policy?

These days, every payer implements unique rules and providers are hard pressed to understand them all. As far as they are concerned, when a hospital provides a service, they expect to be paid at the rate they arranged ahead of time. The purpose of PPO agreements, as far as they are concerned, is to simplify the process and ensure they get paid what they think they deserve. Getting what they deserve, however, is easier said than done when large carriers and Medicare pay bargain rates. To ensure the bottom line closes in the black, they will manipulate their numbers to ensure they are compensated – somehow, by someone.

Size matters. The bigger your pool of patients, the more negotiation power you have, and the burden is shifted to the little guys.

Furthermore, as far as providers are concerned, a convenient and familiar billing process is as important as the amount paid. In fact, some doctors would rather there be a single payer nationwide, even if they are paid less for their services, they need only concern themselves with a single billing process. The result is that many providers actually prefer large insurers despite the lower rates involved.

This is why they hate the TPA, self-funded benefit plan, stop-loss carrier, and PPO network confusion. They truly don't have a grasp on (1) what is covered, and (2) how much is available. When providers and PPOs refer to a TPA as a payer, those of us in the industry recoil – we know that TPAs process claims using the sponsor's money, and thus, the sponsor is the payer. Indeed, we're confident they are referring to TPAs in such a manner with malicious intent. The truth is, many simply don't understand how the relationship is structured. The network is dealing with the TPA, not the benefit plan sponsor; they want someone to be responsible for seeing their claims paid, and so they target the party seated in front of them – the TPA.

The bottom line is that the sheer number of players involved is driving providers mad. They will not accept whatever terms we slide before them because to do so is to risk payment. There are not enough billing staffers employed, and the hassle factor is quickly becoming a bigger issue than profit margins. Thus, as far as they are concerned, the issue orbits around who pays and how; not how much.

Todd Archer picked up the ball where John left off. Todd explained that TPAs are like quarterbacks: usually they don't call the plays; they are bound by the playbook (aka the plan document). Sometimes, quarterbacks need to

improvise, but always they represent the team's interests as they manage all the other players on the field. And, like a quarterback, if anything goes wrong, TPAs are the ones that get sacked, finding themselves on their butts.

TPAs are blamed by each party when another party slows the process. They are at the mercy of the billing entities, paying entities, and administrative red-tape strung between them. Meanwhile, each party thinks the TPA has far more power to control the direction of proceedings than it actually does.

For instance, plan sponsors think they are immune to regulations that affect insurance policies. This is not always true. On the other side, providers think benefit plans must cover all services insurance carriers are responsible for, per State regulations. Likewise, not always true. The TPA, more often than not, is stuck in the middle.

TPAs need to focus on getting claims paid timely, and correctly. Unfortunately, these two tasks almost always conflict. While it is true that the plan sponsors have a right to dictate what is covered, how much is available, and how it is paid, TPAs must also appease brokers by providing competitive network rates. Again, they face two contradicting tasks.

Finally, TPAs need to deal with provider lack of technology mentioned above. When TPAs are receiving paper bills, or providers are misinformed as to when complete, adequate claims have been received, delays occur.

TPAs are also concerned by the advent of things like "never events" and fraud. As far as they are concerned, discounts are supposed to equate to a payment less than what they would pay without a discount offer. TPAs and their vendors have identified the tricks implemented by providers, to inflate charges, and unbundle these inflations. The issue is then, do providers have a right to demand the PPO rate, or the amount the Plan – and its TPA – feel is available per the plan document?

Add to this the fact that stop-loss carriers will not reimburse a plan if that plan has failed to examine the provider charges with a fine tooth comb (woe be the plan, and its TPA, that simply pays what the PPO charges), and you see why Plans are concerned and defensive.

Benton Davis then spoke, and explained that even large carriers have substantial self funded interests. He feels there is not enough cooperation, given that all of the parties involved will bear the costs of these inefficiencies. If a plan pays the PPO rate, which may exceed the amount actually payable, that plan will go fully

funded, lean on Medicare, or simply dissolve. The result is future payments to the provider decrease substantially, or disappear entirely. The key is to simplify how plans cover charges, and make the billing process more efficient. We must, Benton advised, empower physicians to update their practices, but also incentivize them to do so by increasing pricing regulations and transparency – thus creating competition. As for the Plans, there are too many variations in the standard of care, usual and customariness, etc. By clarifying what is covered, and how much is available, ahead of time, providers have a goal – to reduce costs so that the amount available will be enough to keep the provider's enterprise profitable.

Even Medicare needs to get in line and aid in the pricing stability. The key? Education, competition, uniformity, technology – for providers, patients, payers and administrators. Adam closed the game by discussing the conflicts between PPO agreements, and the plans that dictate how (and how much) administrators can pay.

When a PPO agreement calls the TPA "payer" and states that the TPA is the plan fiduciary, with authority to determine what the plan means, what the plan covers, and what the plan can and cannot do, it exposes serious ignorance. Anyone that has picked up a plan document in their life knows the plan sponsor 1) is the fiduciary, 2) has

the final say, and 3) those powers (listed above) belong to it – not the TPA. Yet, based on this misconception, the PPO network agreements go on to state that should a claim go unpaid, the TPA is responsible to resolve the amount due. Indeed, as Adam eloquently expressed the issue in a nutshell, you simply cannot enforce either the terms of the Plan document, or PPO agreement, without violating the other.

The solution, according to Adam, is to educate providers and networks with regard to the relationship between parties, and update PPO agreements to state the Plan will pay (through the TPA) only the amount allowed in accordance with the Plan. If providers feel more is due, they will have to balance bill the patient and deal with the negative publicity. The philosophy that a PPO agreement is a guarantee of payment, entirely separate from the Plan, is erroneous and must be changed. Based on ERISA, contract law, and fiduciary duties, Plans cannot be forced to pay more than the Plan document allows, and TPAs cannot be held responsible for that fact.

In conclusion, I feel each entity has valid concerns. The opinions voiced do not actually conflict, and rather, all point toward the same issues. There is a lack of education, and there is too much confusion arising from infinite levels of variation. Everyone must sacrifice a little, in order to resolve this conflict. PPOs must

acknowledge the limitations placed on Plans and TPAs. TPAs must be more efficient and willing to make tough decisions. Plans must be willing to reduce variations and accept a little more uniformity in coverage. Providers must supply adequate information, be more patient, and accept that Plans will only pay what their terms allow. Finally, no one can treat another entity unfairly, and expect to receive anything but contempt as a result. Pricing transparency and uniform billing practices will eliminate the need for plan audits, and second guessing, and ensure consistent, timely payment.

The Phia Group Employee of the 3rd Quarter 2009

Jamie Calder

Jamie Calder started her career with The Phia Group in November 2007 and currently serves as a Claim Recovery Specialist III.

Jamie obtained a Bachelor of Science Degree from Bridgewater State College where she majored in Psychology and also acquired a Paralegal Certificate from Boston University.

She enjoys working for The Phia Group as she is able to learn about the developments of new case law and practice putting them into action. Jamie is looking forward to continuing her strides and

expanding her knowledge in the subrogation industry. In the near future, Jamie hopes to become a Certified Subrogation Recovery Professional (CSRP).

In her spare time, Jamie enjoys spending time with her family, friends and puppy Max.

Congratulations Jamie!

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