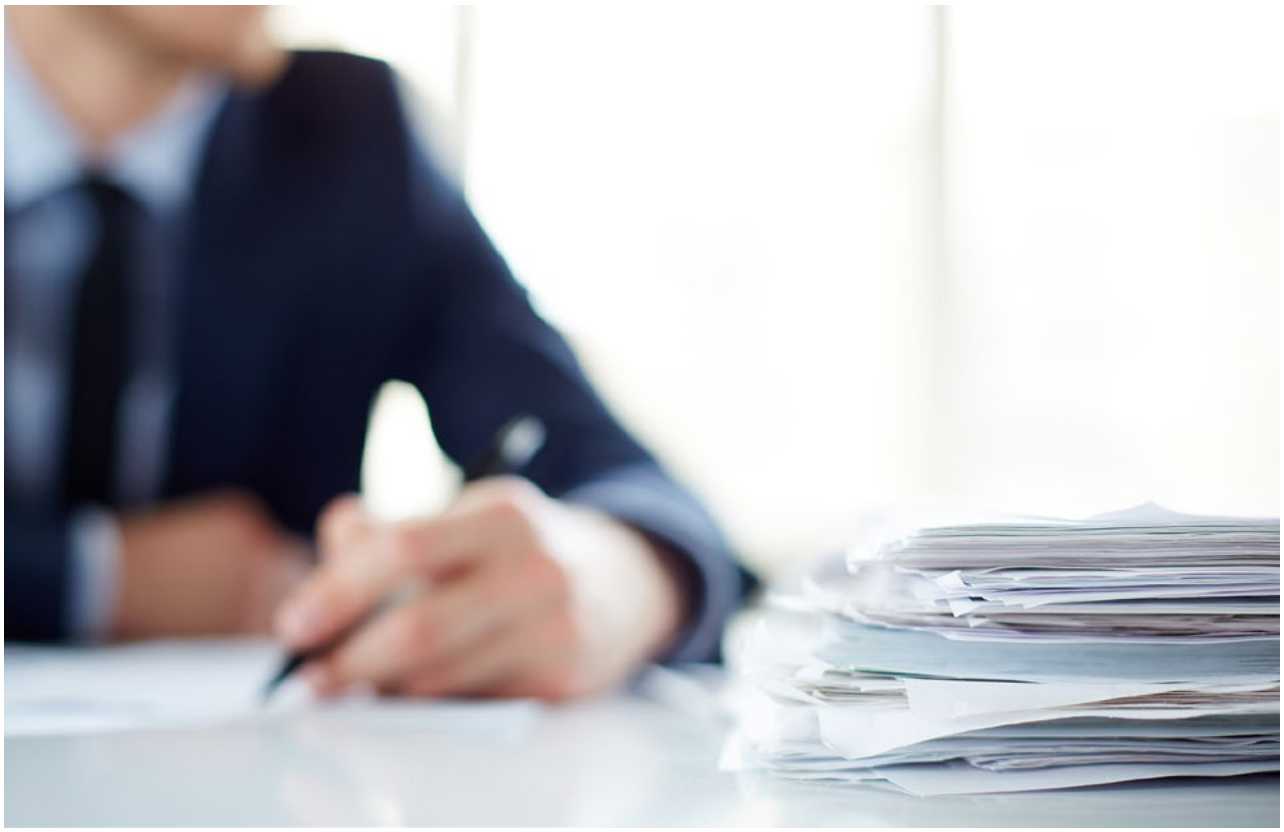


A ROSE BY ANY OTHER NAME...

Written By Ron E. Peck

The year is 2009. You are busy serving as a claims administrator for a self-funded health plan, on a lovely Monday morning in March.

On this day, a couple appeals roll into your office. In one instance, a claim was denied due to a lack of medical necessity. Nothing was paid; the claim was denied in full. In the other instance, the appeal relates to an out-of-network provider's bill.

The original claim that was submitted for payment exceeded $30,000. At the time, the applicable benefit plan paid an amount it calculated to be "usual and customary" (or "U&C"); the process it applies when determining a maximum allowable payment when there is no pre-existing contractual rate.

In the first case, the provider is filing an appeal, arguing that the treatment did meet the plan's definition of medical necessity.

In the second case, the provider is filing an appeal arguing that the plan's calculation of U&C is flawed.

In both cases, less than 100% of billed charges was paid. In both cases, the reduced payment (or no payment) constituted an adverse benefit determination.

In both cases, the provider – deeming itself to be a beneficiary of the plan (a completely separate discussion for another day) – has exercised its right to file an appeal. In both cases, per the terms of the plan document and applicable law, the plan will have a fixed number of days to review the appeals and issue a decision… In both cases, they can uphold the original decision, or overturn the original decision and pay something additional.

In both cases, if the decision on appeal is to uphold the original decision, the beneficiary may then choose to appeal again (if a second appeal is available), and once the appeals are exhausted, seek to appeal the matter externally to a court of law.

A year later, the "Affordable Care Act" (or "ACA") was enacted in two parts: The Patient Protection and Affordable Care Act (signed into law on March 23, 2010) and The Health Care and Education Reconciliation Act (of March 30, 2010).

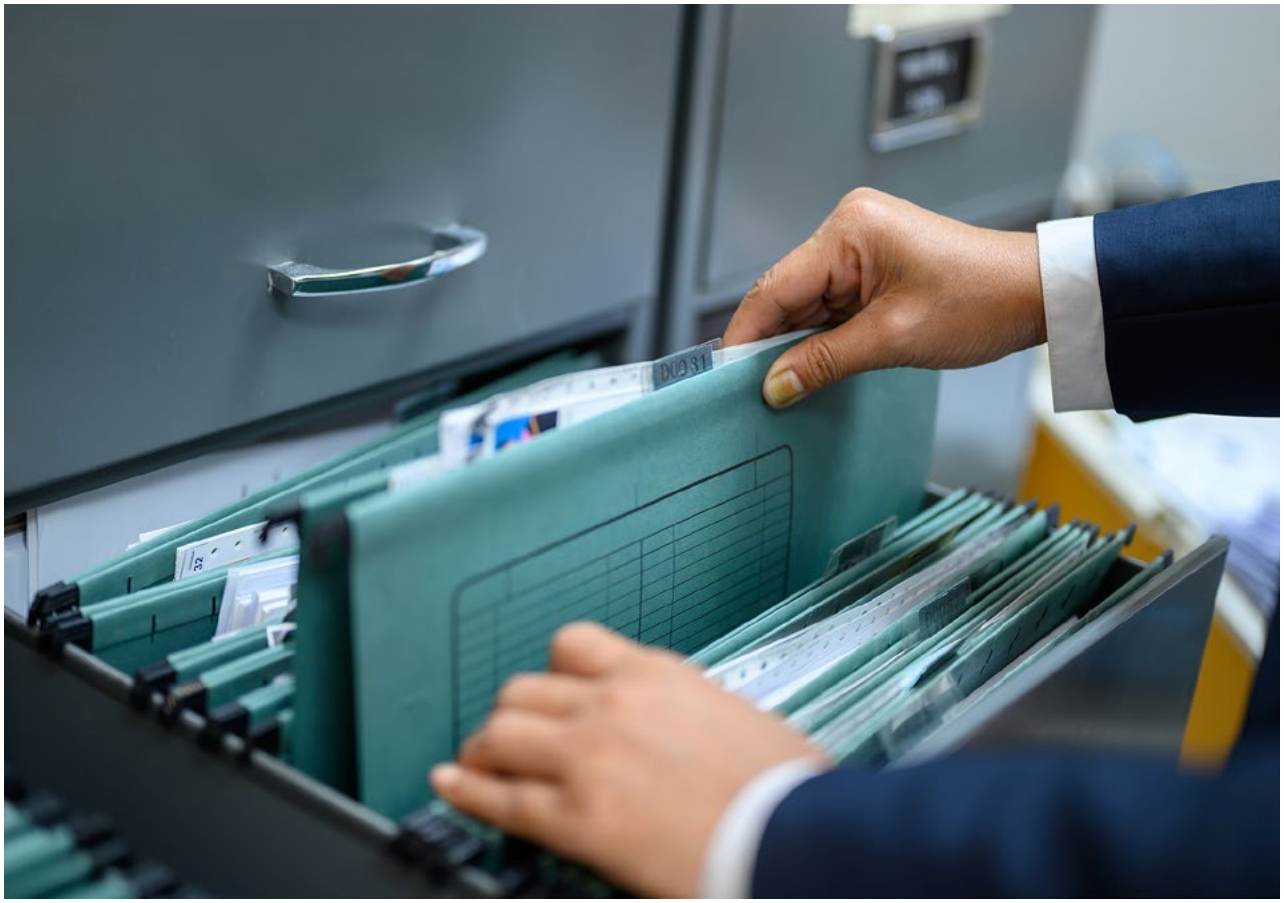
With the passage of what we call ObamaCare, rights to appeal were greatly strengthened. New rights were bestowed upon beneficiaries, while new obligations were simultaneously imposed upon plans and carriers.

Strict timelines were bolstered by law, and access to binding external appeals before independent review organizations (or "IROs") were legislated.

As providers and patients became more aware of these added rights and opportunities to push back against adverse benefit determinations, the number and complexity of appeals grew.

Both in response to denials and reduced payments, plan sponsors and administrators soon came to appreciate how important a well-organized and defensible appeals process truly is.

They also came to realize how risky it is to make claims payment decisions and handle appeals without outside analysis. Indeed – any seemingly arbitrary decision could, upon review, result in the decision maker being slapped with penalties for having breached their fiduciary duty.



Thus, it was that both external review of appeals and protection against fiduciary liability found new value in the eyes of payers. So it was, for more than a decade…

On Dec. 27, 2020, The No Surprises Act (or "NSA") was signed into law as part of the Consolidated Appropriations Act of 2021. Amongst the many interesting rules and changes so introduced, the NSA seeks to prevent providers from balance billing patients in specific instances.

With that in mind, we are forced to wonder, when a patient can't be held responsible for a balance, what – then – becomes of the balance? Is the provider forced to waive it? Is the applicable plan or carrier required to pay it? Something in the middle?

Indeed, telling providers not to bill patients was the easy part; deciding who pays what to whom – less so. The rule attempted to address this by stating that providers and payers would first be forced to negotiate.

Sadly, whomever devised this plan has apparently never negotiated before, since – any experienced negotiator knows – when entering a negotiation, you set a "cap" or maximum amount you are willing to pay (or accept).

That amount is in turn based on numerous factors. Some important – if not the most important – factors are how likely you are to "win" if a matter can't be resolved amicably, how much you'd win, and what it would cost to win.

The rule went on to explain that if a matter can't be negotiated, it will proceed to arbitration. The arbitrator – applying "baseball arbitration" rules – will need to pick between two offers; one made by the payer, and the other made by the provider. There can be no "middle ground" selected by the arbitrator.

The issue, again, is that – until we know what rules or parameters the arbitrator will use to determine who "wins," then no one knows who arbitration favors or how much to offer.

Without knowing what happens if a balance is NOT settled, we can't enter negotiations with a plan; without knowing what happens in arbitration, we can't engage in independent dispute resolution with a plan. This left us clamoring for more information.

Recently, we received an answer. On September 30, 2021, the Departments of Health and Human Services, Labor, and Treasury, along with the Office of Personnel Management, released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II."

Here, they made clearer their stance on the use of objective pricing metrics – such as Medicare rates – and gave us some additional information to help us calculate how much is likely to be deemed the proper payment by an arbitrator.

Rather than delve more deeply into that aspect of the rule, however, I seek not to address the rules and parameters likely to determine how pricing disputes will be resolved, and rather, I seek to highlight one glaring issue… What happens to appeals?

Recall, back on that sunny Monday in 2009 when you received those two appeals? Recall how those appeals were handled in accordance with the terms of the plan document and law? It was so simple, back then… Any reduced payment would be deemed an adverse benefit determination and would be eligible for appeal.

Skip to 2021, and here we find ourselves dealing with a true issue – what is appealed, and what is not? What adverse benefit determination must be appealed, and which triggers the NSA?

Certainly, some adverse benefit determinations clearly fall into the bucket of appeals. If a claim is denied outright – regardless of network status – because the service was (for instance) cosmetic, not medically necessary, and thus excluded by the plan… the provider, if they believe the payer to be mistaken, should appeal the denial.

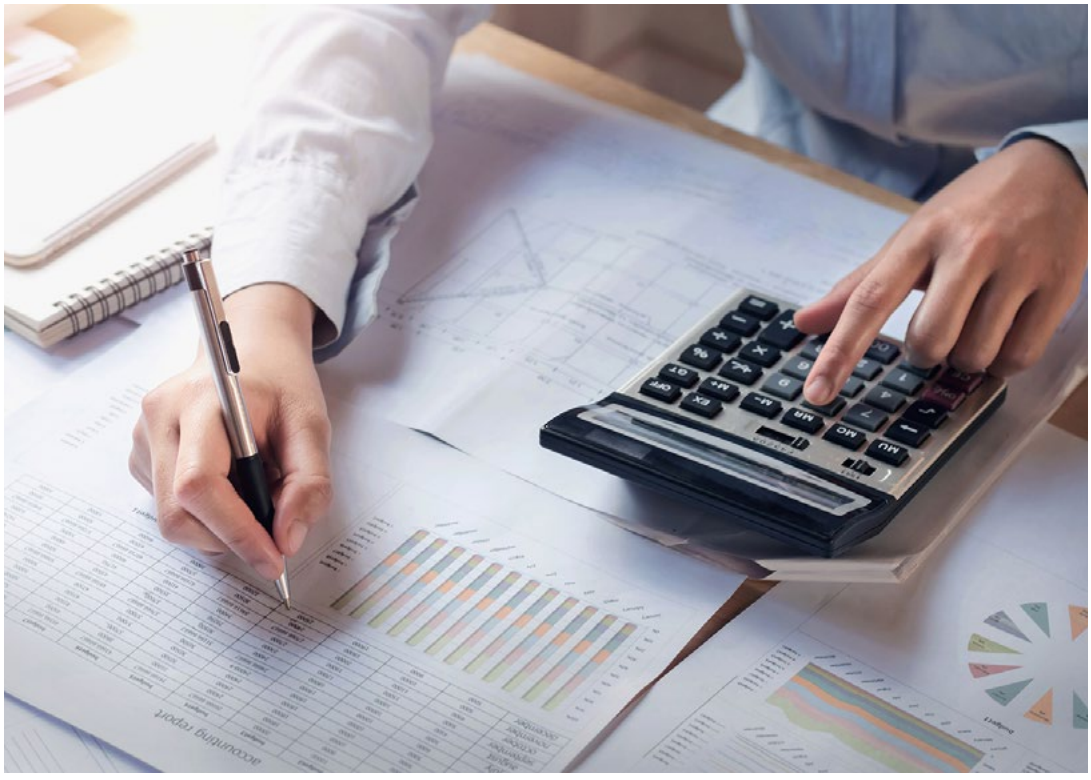
Likewise, looking at a situation that seems to fall cleanly under the NSA umbrella, an out-of-network specialist, providing services at an in-network facility, that treats a plan member… only to have their bill be paid based on a percent of Medicare rates (and leaving a balance behind) is the type of scenario envisioned by the NSA.

If this provider believes that the plan didn't misapply the terms of the plan document and agrees that the amount paid by the plan matches the maximum allowable amount as defined by the plan document, then – we believe – this balance would not be eligible for appeal, and rather, would need to be disputed per the NSA.

Yet… not all claims fall so neatly into these buckets. What if a claim, submitted by such an out-of-network specialist (at an in-network facility), is denied in part due to a plan exclusion (such as experimental and investigational), and the remainder is paid using a Medicare-based pricing methodology?

Is one part (the denied part) of the claim appealed, whilst the other part (the reduced payment) is disputed under the NSA? Does this happen simultaneously? What if the denied portion of the bill is overturned, and paid – using the aforementioned Medicare-based pricing methodology?

Must this be disputed anew, or added to the other disputed payment? What if the provider is willing to accept a payment based on a percent of Medicare rates, is pleased to accept the percent of Medicare described in the applicable plan document, but believes the plan simply miscalculated the Medicare-based amount to which that provider is entitled? Is that clerical error grounds for an appeal, or dispute?



This represents just the tip of the iceberg, when dissecting the breadth and scope of adverse benefit determinations. The variety of reduced and denied payments we routinely handle in our office would shame Baskin Robbins and their mere 31 flavors.

With the creation of an alternative means to challenge a plan's payment now being established by the NSA, in addition to the appeals process, we can expect an increase in appeal volume (as providers seek to trigger the NSA but mistakenly submit an appeal), complexity (as the players attempt to parse out what should be appealed, and what should trigger the NSA), and confusion (as matters go from an appeal of unpaid claims to a dispute over reduced payments of the same claim, following an overturned denial).

In addition to creating ambiguity and confusion regarding which disputed adverse benefit determinations trigger the NSA versus those that are eligible for appeal, so too does this also create more opportunity for conflict between benefit plans and their stop-loss carriers.

Once, stop-loss carriers only needed to suspend reimbursement while a matter proceeded through an appeals process. Now, stop-loss carriers will struggle to keep an eye on the claims as they bounce back and forth between appeals and NSA disputes.

Furthermore, while most stop-loss carriers agree to reimburse payments their policyholders are forced to pay (following an appeals process and order issues by an IRO or court of law to overturn an adverse benefit determination), will those same carriers also agree to cover additional payments made during an NSA negotiation period? Following independent dispute resolution and arbitration?

Adding to this quagmire, is the plan administrator's fiduciary duty. Plan administrators have learned over time to handle appeals in strict accordance with applicable law and the plan document. The terms of the plan document regularly dictate what is payable, and how much is payable.

Now, are these plan administrators authorized to pay something additional during the NSA's requisite "negotiation period," without exceeding the authority granted to them by the plan document and Employee Retirement Security Act of 1974 ("ERISA")?

Would an additional payment during negotiations constitute a payment in excess of the maximum allowable amount, and thus, constitute a breach of their fiduciary duty?

In summary, it is safe to say that these new regulations and laws will increase the number of entities that may file appeals and broaden the scope of issues about which appeals may be filed, as well as complicate the process applicable to handling adverse benefit determinations and appeals.

Additionally, the other "dispute resolution" procedures established by law – separate and distinct from formal appeals – will result in confusion regarding which conflicts are meant to be appealed, versus those that should now be handled via an alternative methodology.

As these rules and regulations continue to be released, we will continue to learn more. Hopefully, which claims fall into which lane – appeals versus disputes – will further crystalize. In the meantime, benefit plans and those that service them would be well advised to revisit their current appeals process.

Ensure the process clearly defines what can be appealed, when, and how. Retain objective third parties to provide a de novo review of adverse benefit determinations and share liability for complicated decisions. Establish a process by which matters can be transferred to or from the appeals process if and when it is determined a matter should be appealed, or negotiated via the NSA.

Finally, stay abreast of the changing rules to ensure compliance. Meanwhile, communicate with your stop-loss carrier to confirm what they need – before, during, and after both appeals and NSA based disputes – as well as define what is covered, when, and what documentation is required. Together, we can overcome these new complexities, and hopefully emerge with a system that works. ■

Ron E. Peck has been a member of The Phia Group's team since 2006. As the Chief Legal Officer at The Phia Group, Ron has been an innovative force in the drafting of improved benefit plan provisions, handled complex subrogation and third party recovery disputes, healthcare direct contracting and spearheaded efforts to combat the steadily increasing costs of healthcare.

Considered to be not only one of the nation's top ERISA lawyers, Attorney Peck is also viewed as one of the nation's premier self-funded health plan consultants and health benefits attorney; lecturing at and participating in many industry gatherings including but not limited to The National Association of Subrogation Professionals ("NASP") Litigation Skills Conference, Society of Professional Benefit Administrators ("SPBA"), the Health Care Administrator's Association ("HCAA"), The Health Plan Alliance, and Self-Insurance Institute of America ("SIIA").

Ron is also frequently called upon to educate plan administrators and stop-loss carriers regarding changing laws and best practices. Ron's theories regarding benefit plan administration and healthcare have been published in many industry periodicals, and have received much acclaim. Prior to joining The Phia Group, Ron was a member of a major pharmaceutical company's in-house legal team, a general practitioner's law office, and served as a judicial clerk. Ron is also currently of-counsel with The Law Offices of Russo & Minchoff.

Attorney Peck obtained his Juris Doctorate from Rutgers University School of Law and earned his Bachelor of Science degree in Policy Analysis and Management from Cornell University. Attorney Peck now serves as The Phia Group's Chief Legal Officer, and is also a dedicated member of SIIA's Government Relations Committee.