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Self-Insured Health Plan Claim Transparency:

Winning by Compliance - How the State Health Benefits Plan Can Save $1 Billion Per Year.

EXECUTIVE SUMMARY

The New Jersey State Health Benefits Plan (SHBP) and the School Employees' Health Benefits Plan (SEHBP) provide health coverage for 841,943 participants and beneficiaries (1) or roughly 10% of the State's population. The SHBP and SEHBP are self-insured, and utilize Horizon and Aetna as TPA's. In 2016, these programs paid a total of $3.27 Billion in "medical claims" expenditures (2).

It is commonly perceived that these medical expenditures represent a "pass-through" from the SHBP/SEHBP trust account, through the TPA variance account, to providers of medical services. Unfortunately, ample legal evidence demonstrates that this is not always the case (3).

Based on recent court cases, it seems apparent TPAs can and do hide "undisclosed" Administrative Compensation fees within Medical Claims payments (4). These undisclosed fees, which can account for 30%-60% of a plan sponsor's health claims expenditures (5), are usually siphoned into the TPA variance account through "retention reallocations" and "cross plan overpayment" offsets, among other techniques.

Using industry estimates and national claims processing standards, we believe the New Jersey State Health Benefits Plan and the School Employees' Health Benefits Plan can realize a $1 billion/year reduction in expenditures by rigorous monitoring of TPA practices. We offer straightforward disclosure and transparency measures for health insurance claims in order to achieve these savings.

The following court cases illustrate how self-funded health plans, such as SHBP/SEHBP, have been victimized by duplicitous TPA practices.

RETENTION REALLOCATION – THE SELF-FUNDED PLAN PAYS MORE THAN THE PROVIDER RECEIVES

Sponsors of self-funded health plans depend on their TPAs to properly adjudicate a provider's raw charge prior to submission for payment. For example, reductions should be made for in-network discounts (for network providers), or modifiers correctly applied that can reduce a claim amount by 50-80%. Providers rarely expect full payment of a raw charge.

In a landmark suit (3) brought by Hi-Lex Corporation against its TPA Blue Cross Blue Shield of Michigan (BCBSM), the TPA was found guilty of submitting most or all of a provider's raw charge to the Hi-Lex trust account. Only <u>after</u> Hi-Lex paid this inflated amount did BCBSM adjudicate the claim according to policy. A fraction of Hi-Lex's money was subsequently paid to the provider.

The difference was kept by BCBSM as Administrative Compensation. In finding against BCBSM for fiduciary fraud, the Sixth Circuit stated:

> **"The difference between the amount billed to [HiLex] and the amount paid to the [provider]**

was retained by BCBSM. This system was termed "Retention Reallocation."

"BCBSM …misled Hi-Lex into believing that the disclosed administrative fees and charges were the only form of compensation that BCBSM retained for itself"

Following the HiLex decision, 34 Michigan businesses filed suit over "**hidden fees**" (6), accusing BCBS of "**charging hidden and unauthorized fees to the employers' health plan assets."** (7)

In a similar suit bought by United Teamsters against its TPA MagnaCare (5), and the subsequent case brought on by the US Department of Labor (8), the court documents stated:

"[MagnaCare]…simply misappropriated the difference between what Plaintiffs paid MagnaCare and what MagnaCare negotiated to pay the providers…Both the Plaintiffs and the providers were thus unaware that the Plaintiffs were paying MagnaCare substantially more than the healthcare providers were receiving."

"[MagnaCare]…retained over 65% of the diagnostic fee schedule payments without the Trustees' knowledge.

"The amounts retained by MagnaCare were <u>so grossly excessive as to shock the conscience</u> and constituted a violation of MagnaCare's fiduciary duty to Plaintiffs… ", according to the court.

Recently, in New Jersey, Horizon was penalized for similar self-dealing as an administrator for the Medicaid program (9). Additionally, Horizon was sued by a "whistleblower" alleging the insurance giant intentionally and systematically denied, underpaid or delayed member claims (10)

<u>CROSS-PLAN OFFSETTING –USING NJ STATE PLAN FUNDS TO PAY FOR FALSELY ALLEGED DEBTS OF NON-NJ STATE PLAN MEMBERS AND BENEFICIARIES</u>

This occurs when the TPA's for SHBP/SEHBP abstract, withhold/convert SHBP/SEHBP Plan Assets that were approved and allegedly paid for SHBP/SEHBP member claims, to purportedly, but impermissibly, satisfy a falsely alleged overpayment for another stranger claim.

In an extraordinary class action lawsuit, Peterson v. UHC (11) a federal judge criticized the largest insurer in the nation, UnitedHealthcare, for its "**cross-plan offsetting**" practice as a "**troubling use of plan assets**", ruling the industry standard practice of "**Cross-plan offsetting creates a substantial and ongoing conflict of interest**" for all claims administrators who "**simultaneously administer both self-insured and fully insured plans.**" The court also called into question United's practice of reaching "**into the pockets of the sponsors of self-insured plans**" and putting that money "**in United's pocket**".

According to court records:

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> **“Cross-plan offsetting creates a substantial and ongoing conflict of interest for claims administrators who, like United, simultaneously administer both self-insured plans and fully insured plans…”**

Not surprisingly, Aetna, the second largest TPA in the state of New Jersey, has also been sued for the same violations (12) in a case now being heard in a New Jersey Federal Court (13). The case is awaiting the judge’s final decision on class certification.

ANATOMY OF AN IN-NETWORK “UNDISCLOSED” FEE (RETENTION REALLOCATION), NJ SHBP/SEHBP

The claim below represents a HIPAA-mandated, ANSI X12 ERA 835 for a complex, 12-hour surgery performed on a beneficiary of the Sparta Board of Education. The surgery, performed by an in-network provider, entailed 32 individual CPT codes, each of which is billed separately as a line item. This claim was paid by SHBP/SEHBP. It should be noted that **administrators and auditors for SHBP/SEHBP are not privileged to access to this information**.

Claim List | Claim Detail | Remit Summary | Data View | Search | Glossary

CHECK/EFT #:

REND-PROV RARC	SERV-DATE	POS	PD-PROC/MODS	PD-NOS SUB-NOS	BILLED SUB-PROC	ALLOWED GRP/CARC	DEDUCT CARC-AMT	COINS ADJ-QTY	PROV-PD BS
NAME:									
	0911	091117	63101	1.000	79000.00	10412.52	0.00	0.00	10412.52
	0911	091117	22612	1.000	57000.00	13447.65	0.00	0.00	6723.83
						CO-45	43552.35		
	0911	091117	63047	1.000	55250.00	0.00	0.00	0.00	0.00
						CO-197	55250.00		03
	0911	091117	6304659	1.000	54000.00	10230.00	0.00	0.00	5115.00
	0911	091117	22327	1.000	48100.00	6696.84	0.00	0.00	3348.42
						CO-45	41403.16		
	0911	091117	2251259	5.000	47500.00	0.00	0.00	0.00	0.00
						CO-197	47500.00		03
	0911	091117	225127659	5.000	47500.00	0.00	0.00	0.00	0.00
						CO-197	47500.00		03
	0911	091117	2261059	1.000	46500.00	0.00	0.00	0.00	0.00
						CO-197	46500.00		03
	0911	091117	22842	1.000	31600.00	0.00	0.00	0.00	0.00
	0911	091117	2285459	1.000	22900.00	1524.00	0.00	0.00	1524.00
	0911	091117	2251159	1.000	18500.00	0.00	0.00	0.00	0.00
	0911	091117	63048	1.000	17920.00	1787.40	0.00	0.00	1787.40
	0911	091117	2261459	4.000	62160.00	0.00	0.00	0.00	0.00
				9.000					
	0911	091117	21600	1.000	10500.00	2552.04	0.00	0.00	1276.02
						CO-45	7947.96		

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Line items marked in green show "properly" adjudicated CPT codes. For example, inspection of the top green line item shows that the "BILLED" amount of $79,000 was correctly adjudicated to the in-network "ALLOWED" amount of $10,412.52 (13.2% of the original charge). This reduced amount was subsequently paid to the provider (last column).

Line items marked in red show CPT codes that are subjected to network discounts, plus an additional 50% "multiple-procedure" markdown that the provider has agreed to. Inspection of the bottom red line item shows the "BILLED" amount of $10,500 was correctly adjudicated to the in-network "ALLOWED" amount of $2,552.04 (24.3% of the original charge). However, the additional 50% markdown was not applied until the provider got paid (last column, $1,276.02). For this CPT code, SHBP/SEHBP paid $2,552.04, but the provider received only 50%, or $1,276.02. The difference was retained by the TPA.

For this entire in-network claim, SHBP/SEHBP paid $53,211.90. The provider received $36,748.64. The difference of $16,463.26 was retained.

The amount retained by the TPA represents 30.9% of what the State paid.

HOW CAN SHBP/SEHBP END "UNDISCLOSED" OVERCHARGES?

Simple transparency mandates will suffice. Currently, SHBP/SEHBP administrators cannot audit a claim payment after it has been sent to the TPA variance account. Therefore, auditors cannot assess whether a full claim remittance was actually paid to a provider, or partly retained by the TPA. Greater auditing authority can be mandated by either statute or regulation.

In addition, all ANSI X12 EDI 810 invoices sent to SHBP/SEHBP, along with EDI 820 remittances generated, should to be transparent and publically available to requesting providers. This measure will allow providers to become "external" auditors, by directly comparing their charges to SHBP/SEHBP payments.

Finally, the legislature can pass a law requiring the following:

All SHBP/SEHBP medical payments shall be made directly from the SHBP/SEHBP bank (Wells Fargo, Minnesota) to the medical provider.

Payments shall no longer be made through a TPA variance account. **These variance accounts function as a barrier to transparency**, and facilitate self-dealing, hidden fees, and other fiduciary violations for which the insurance industry has been successfully sued.

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Direct payments to providers will help the State more accurately file DOL 5500 forms. There will no longer be a mixing of Claims and Administrative payments.

Direct payments will eliminate additional bank fees associated with variance accounts.

All these substantial savings to the SHBP/SEHBP can be achieved by disclosure and transparency measures alone.

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Notes:

1. http://www.state.nj.us/treasury/pensions/annrpts/cafr-fy2016.pdf.
2. http://www.state.nj.us/treasury/pensions/health-benefits.shtml
3. http://www.ca6.uscourts.gov/opinions.pdf/14a0100p-06.pdf
4. "… some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to You as additional claim liability." City of Belleville ASO file:///E:/Twshp%20of%20Belleville%20Med%20ASC%20eff%202-03_Redacted.pdf
5. https://dockets.justia.com/docket/new-york/nysdce/1:2013cv06062/416865
6. http://wlns.com/2017/08/16/34-michigan-businesses-file-lawsuits-against-blue-cross-over-hidden-fees/
7. https://www.bna.com/blue-cross-michigan-n73014463119/
8. "Self-Insured Health Plan TPA MagnaCare to return $14.5 Million for Violations" http://avym.com/self-insured-health-plan-tpa-magnacare-return-14-5-million-erisa-violations/
9. http://www.politico.com/states/new-jersey/story/2017/06/28/155m-horizon-sanction-is-the-largest-issued-by-state-over-last-decade-113126
10. http://www.nj.com/healthfit/index.ssf/2016/05/former_horizon_employee_claims_wage_discrimination.html?lipi=urn%3Ali%3Apage%3Ad_flagship3_profile_view_base_recent_activity_details_all%3BnmGYyl%2BPShKGMBBf%2BC78kQ%3D%3D
11. UHC "Overpayment" Offset Practice Dealt Deathblow-ERISA Court Rules Cross-Plan Offset Constitutes "Grave Conflict Of Interest" http://avym.com/uhc-overpayment-offset-practice-dealt-deathblow-erisa-court-rules-cross-plan-offset-constitutes-grave-conflict-of-interest/
12. Aetna Sued for Alleged Illegal Overpayment Offset, http://www.prweb.com/releases/2014/11/prweb12294286.htm
13. Notice of Motion for Class Certification: http://d.classactionreporternewsletter.com/f/16/njd15-02595-0115.pdf

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