

***2006 National TPL Conference
COB Portions of the Deficit Reduction Act***

September 11, 2006

Rob Dickerson, HMS

Requirement to Provide Coverage Information

- ➔ **April 2006: spoke to the Society of Professional Benefit Administrators (SPBA) about their responsibilities under the DRA**
 - TPAs were very positive about providing eligibility
 - Many actually provide data for other purposes such as Medicare Voluntary Data Sharing Agreement (VDSA) and were concerned about providing multiple feeds in different layouts
 - Suggestion to use the VDSA layout, or a government-approved standard layout

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- **May 2006: Campaign to SPBA plans requesting eligibility**
 - 30 TPA plans were contacted with letter requests
 - Plans do not want the administrative burden of building a matching process using Medicaid data; prefer to send their data to the State
 - Some plans reference DRA mandate that each State needs to pass regulation before they will comply
 - Some feedback regarding the “minimum necessary rule” and if providing a full file is really the minimum necessary
 - Some do not have business in HMS client states
 - 20% of plans agreed to provide eligibility
 - Many plans in legal/compliance review
 - Payors that initially refuse often will agree after a legal appeal

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➔ **Top 10 reasons plans don't want to give eligibility data**

1. "HIPAA forbids me to give out PHI"
2. "It's administratively burdensome to create the file"
3. "There's no State regulation requiring me to do so"
4. "What's your authority to ask for this data?"
5. "We don't have anyone in your States"
6. "We don't have the authority to give out the data" (PBM/TPA)
7. "The eligibility is not ours" (PBM/TPA)
8. "We don't want to participate in your effort"
9. "We are covered by ERISA and Federal law not State laws"
10. "We don't think any of our people are on Medicaid"

➔ **Over 25 "refusals" have been overturned through legal appeal**

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→ Results an eligibility file can deliver

- In 2004, a national payor provided eligibility resulting in a \$40M increase in payments from the previous year
- In 2006, another national payor is being billed with first-time eligibility and is on pace to pay \$75M
- BCNC recently agreed to supply self-insured data due to new State regulation which should double the lives
- Getting all major plans to share data will turn millions into billions!

No Denials on Claims Submitted Within Three Years of Date of Service

→ What we are hearing...

- Many payors are aware of the DRA and the three-year rule
 - BCBSVA has waived all timely filing for TPL claims
 - BCBSCT will not budge until the State passes regulations requiring them to. All HMO policies have 120 days for any submitter.
- Self Insured/ERISA-covered employer plans could still fight a State regulation (Sierra Pacific)
- TPAs at SPBA were concerned about clients that terminated
 - If they give eligibility, who is liable for terminated clients?
 - They have no “reserves” left for those clients: the run-out is over

No Denials on Claims Submitted Within Three Years of Date of Service

→ What we are seeing...

- After the DRA, HMS starting to bill more claims beyond two years from the date of service, up to three year limit
 - Over 100 plans paying claims with dates of service 2003 and prior this year!
 - \$16M recovered in 2006, with more being processed
 - Timely filing rejects still exist with plans that pay
 - Different timely filing based on payor's product (HMO vs. PPO) or payor's clients (self-insured vs. fully insured)
- Appeals of timely filing rejections with State or DRA regulations do work: over 10% of older DOS recoveries

Next Steps.....

- ➔ **Spread the word to all payors about the DRA**
- ➔ **Work with States to pass State-specific regulations**
- ➔ **Encourage States to use fines in their regulations (TX)**
- ➔ **Determine a national standard for eligibility files for plans that need guidance**
- ➔ **Address the HIPAA rules for “minimum necessary”**
- ➔ **Address self-insured ERISA-covered plans that “set their own rules”**
- ➔ **Appeal timely filing rejects with State-specific regulations to get payors to change their date of service edits**

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Do not
Reject
Anything

Contact Information:

Robert Dickerson

(212) 857-5270

RDICKERSON@HMSY.COM