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The *Cigna* Decision: A Road Map to Dealing with Out-of-Network Providers

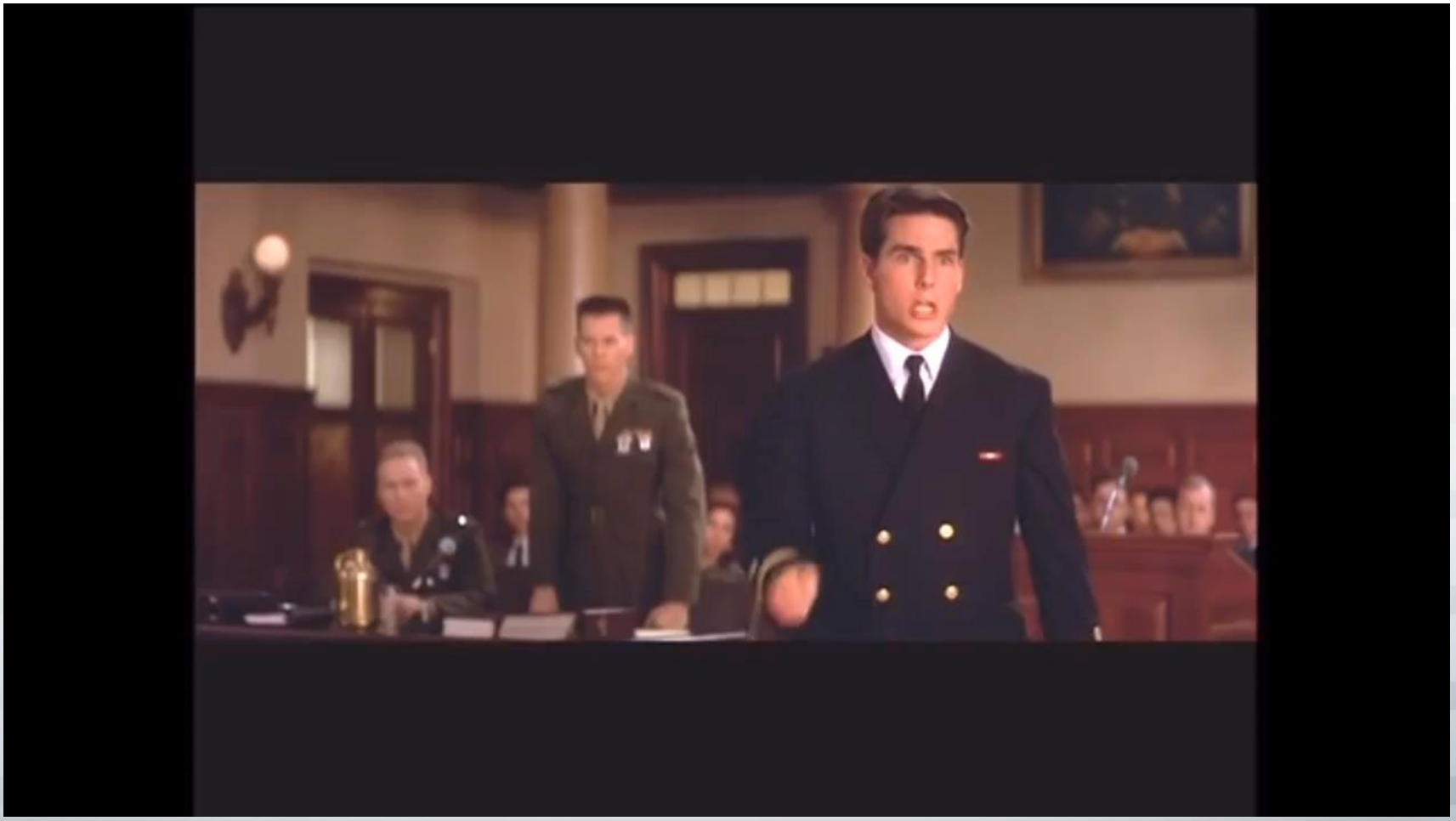
TAHFA & HFMA South Texas Fall Symposium – September 13, 2016

INTRODUCTION

The Roadmap

- Today we are going to talk about a lawsuit:
  - Decide June 15, 2016
  - Between a Hospital and an Insurer
- That Addresses Many of the Issues faced by a Hospital as an Out-of-Network Provider
  - What Rate of Reimbursement Does an OON Hospital Have to Accept?
  - How do you know if an OON Hospital was Paid Properly?
  - What is the impact on Reimbursement for not being able to collect all Patient Responsibility at the Time of Service?
  - What do you do when a Plan refuses to provide Plan Documents?
- *Cigna* is a case that, at least according to one Judge, answers these questions

Answers



THE *CIGNA* FACTS

Parties to the Suit

- Connecticut General Life Insurance Company and Cigna Health Life Insurance Company (“Cigna”) Filed Suit
- Against Humble Surgical Hospital, LLC (“Humble”)
- In Federal Court
  - The Southern District of Texas
  - Fifth Circuit Court of Appeals

Background Facts

- Humble was an Out-of-Network Hospital in Texas
- Humble Routinely Obtained Assignment of Benefits and Personal Guarantees from Patients
- Humble billed Cigna on all OON patient claims
- Cigna processed Humble's claims using third party pricing entities and negotiated pricing agreements (including Multiplan)
  - Ranged from usual and customary to 500% of the Medicare allowable
- Starting in 2010, Cigna directed all incoming claims to its Special Investigations Unit (SIU) because it felt Humble was submitting "exceedingly large-dollar claim amounts"
- Cigna also accused Humble of "Fee Forgiving"
  - Waiving patient cost-share for deductibles, co-pays and co-insurance
  - Humble's Evidence was that it Sought these payments but were not always successful

Cigna Claim Processing

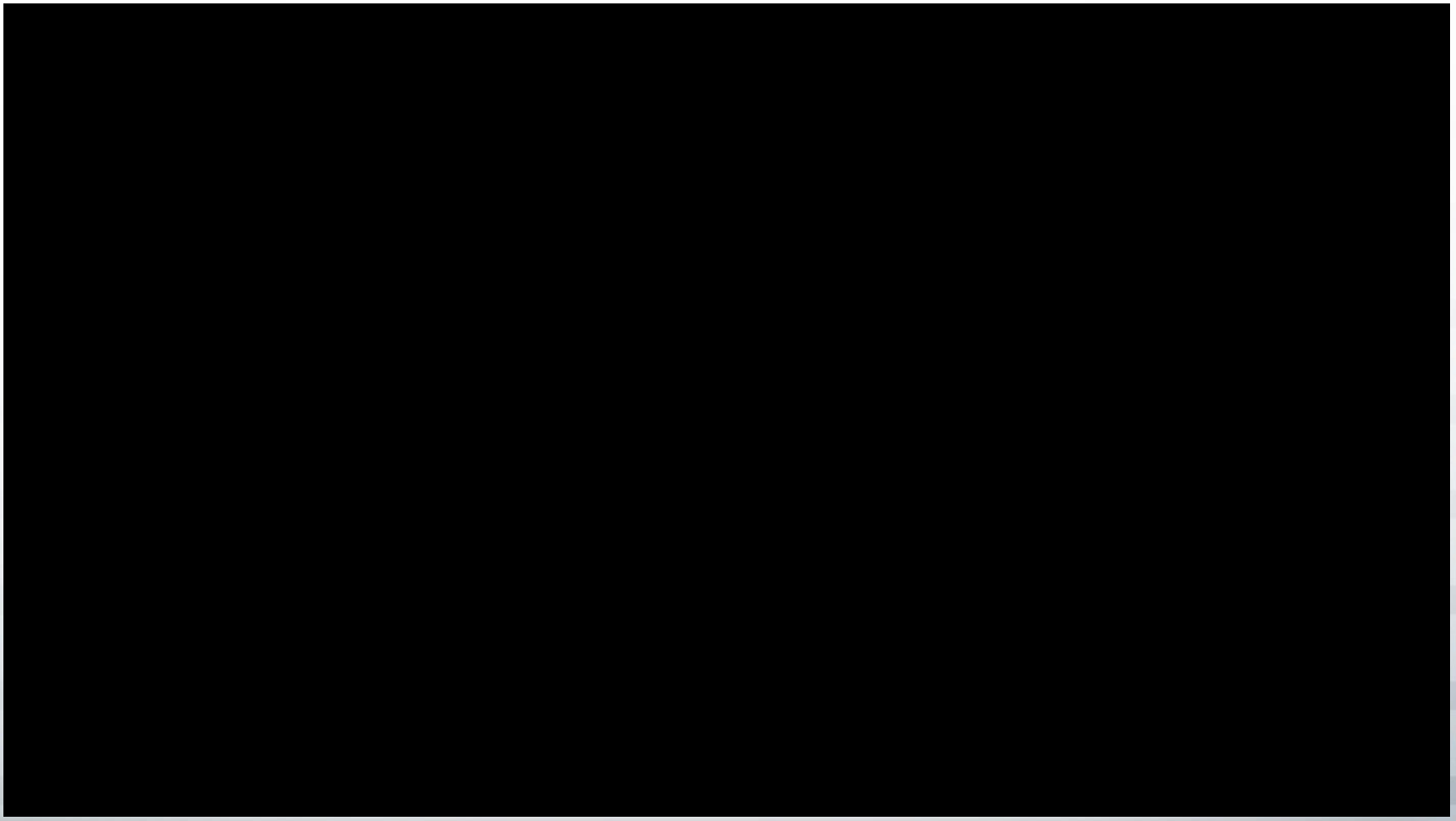
- Cigna stopped paying claims in full where the Patient did not fully pay deductible, co-payment and\or co-insurance at time of treatment
- Other claims sat in the SIU Department and were not paid at all
- Cigna began using a “Proportionate Share Analysis” on some claims
  - Cigna started paying the same percentage of Humble’s claim as the Patient had paid on deductible, co-pay or co-insurance
- Cigna even told Humble patients that if Humble did not collect deductible, co-pay or co-insurance, the patient had no obligation to pay any balance

Basis for Proportionate Share Analysis

- Cigna used an Exclusionary Provision in its Plan that it interpreted to mean that:
  - If patient did not have a legal obligation to pay or was excused from having to pay any portion of the bill, Cigna was excused from making full payment under the Plan
  - Cigna's argument was because Humble did not collect all patient responsibility owed at the time of treatment, Cigna did not have to pay or could pay a proportionate amount

THE *CIGNA* LAWSUIT

The *Cigna* Lawsuit



Cigna's ERISA Claims

- Overpayment Claims based on section 502(a)(3) of ERISA:
- Cigna wanted to recoup claims made to patients that had not fully paid their patient responsibility
- Specific Claims seeking Recoupment:
  - Lien by Agreement
    - Cigna Argued that the Plan Language created a Lien by Agreement
  - Tracing Method
    - Cigna asserted that Overpayments were still in possession and readily ascertainable
  - Injunction and Declaration
    - Cigna sought an order from the Court Declaring Overpayments and Enjoining Humble from Historical Billing Practices
  - Money Had and Received\Unjust Enrichment

Cigna's Non-ERISA Claims

- Cigna's Additional Non-ERISA Claims based on Humble's conduct, including:
  - Fraud -- Cigna claimed that:
    - Humble's failed to disclose Physician Use Agreements
    - Increased Cigna bills by 30% as a "kickback" to Physicians
  - Negligent Misrepresentation – Cigna claimed that:
    - Humble failed to supply accurate billing information on the UB form
    - Humble failed to properly document the UB billing information
  - Texas State Statutory Violations – Cigna claimed that:
    - The Humble Physician Use Agreements allowed referral fees
    - Which were kickbacks banned by Texas statutes

Humble's Counterclaims

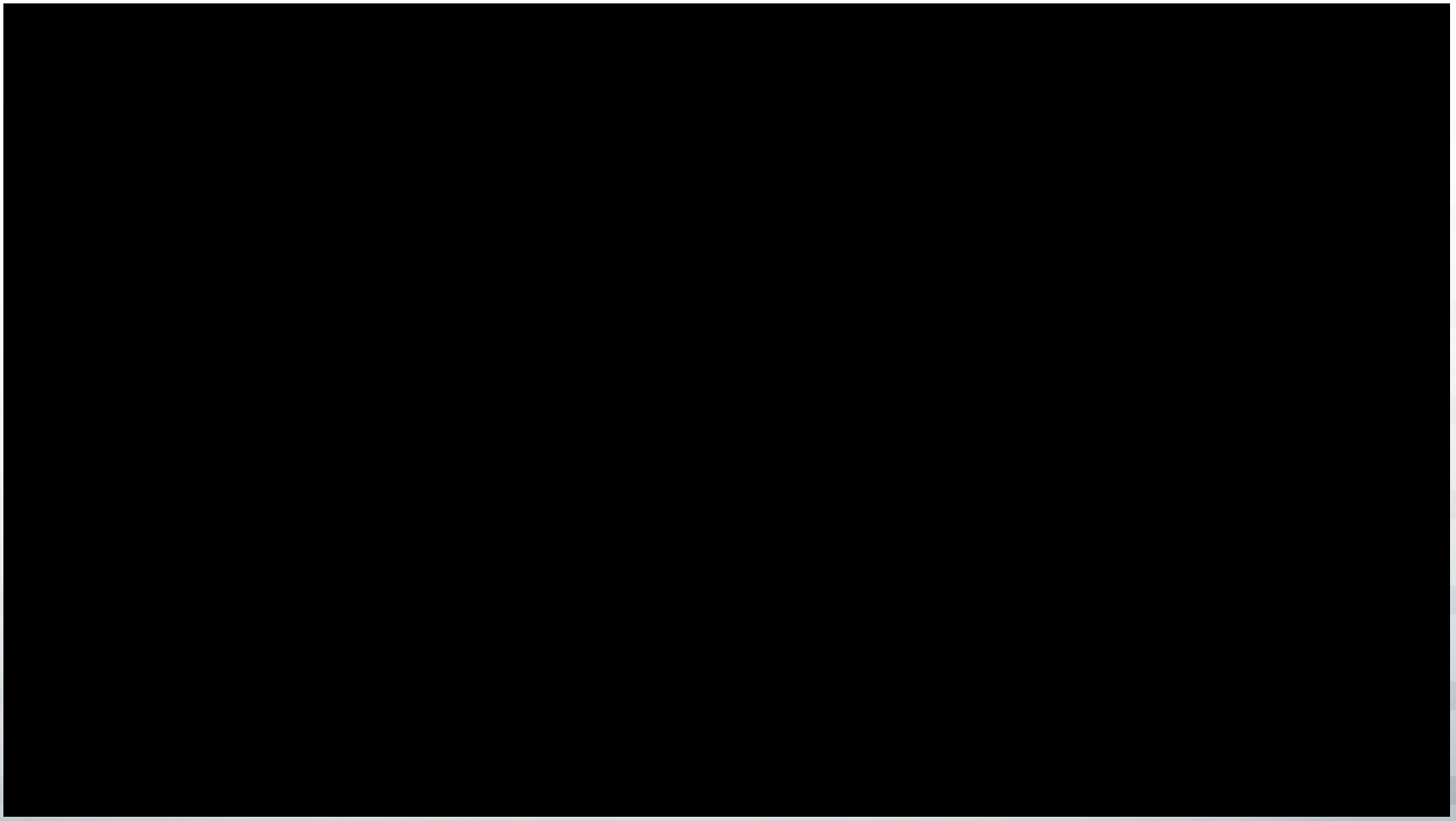
- ERISA Claim for the full benefits owed on 595 Claims billed to Cigna
  - Claims included Plans:
    - Insured by Cigna
    - Administered by Cigna
  - Humble, pursuant to the Assignment of Benefits, stands in the shoes of the Patient
- Declaratory Judgment
- Claim for Penalties under ERISA
  - Section 502(c) requires a Plan Administrator to respond to document requests or face a monetary penalty

Scope of the Dispute

- Issues between Cigna and Humble went unresolved for three and half years
- Cigna sued Humble for $5,121,137 in overpayments
  - Cigna also asked for the right to offset any additional overpayments from future payments to Humble
- Humble counter-sued Cigna for $11,392,273
  - Humble also asked the Court to declare that it:
    - Properly submitted claims to Cigna
    - Did not engage in fraud or misrepresentation
    - Disclosed to Patient that OON Facility before procedure
    - Stepped into the shoes of the Patient (Participant) and was entitled to a full and fair review of the claim
  - Humble also asked for Penalties under ERISA

THE *CIGNA* RULINGS

Ruling on Cigna's Claims



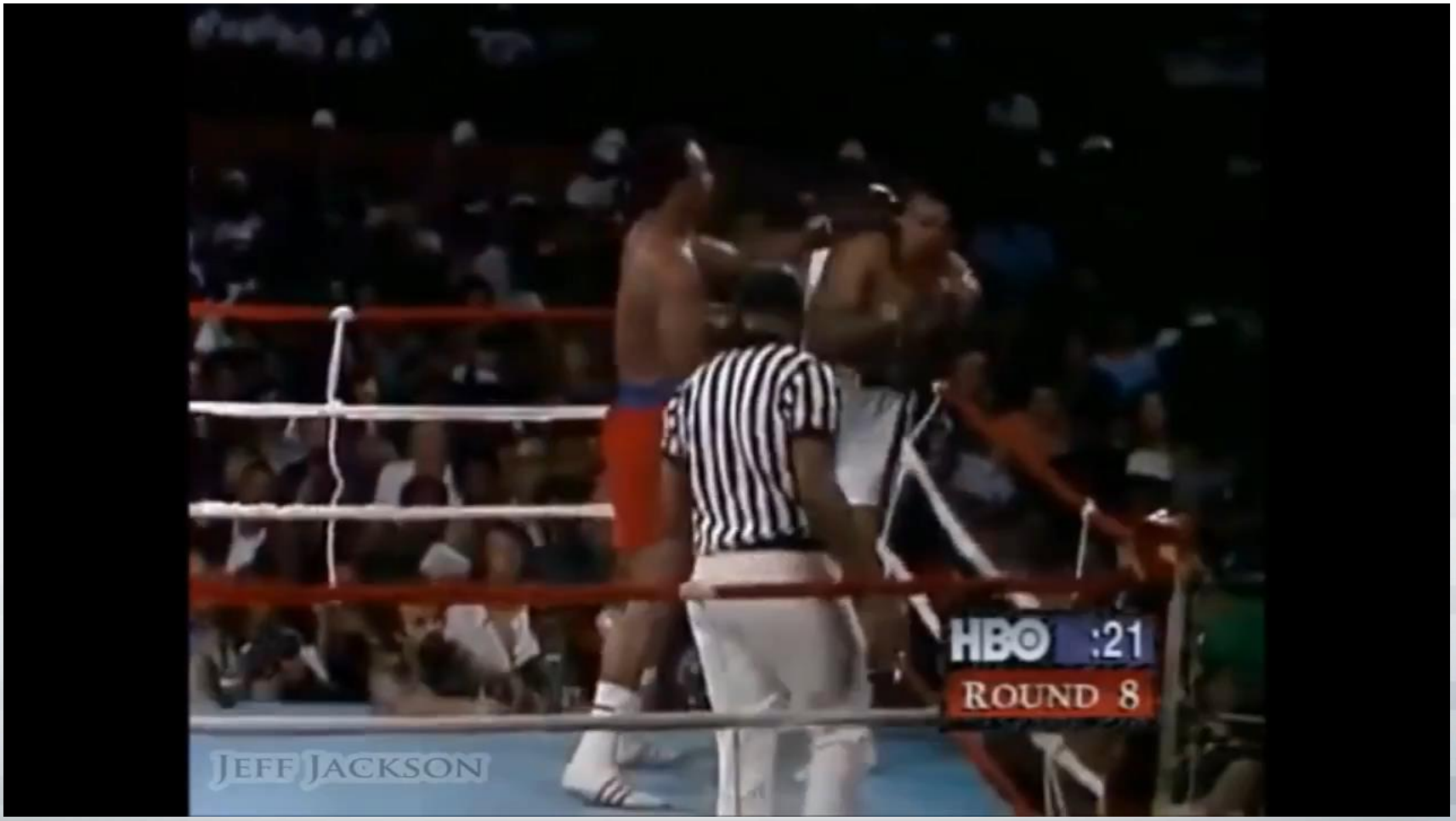
Ruling on Cigna's Claims

- The Court ruled that Cigna was not entitled to any refunds because of Humble's actions:
  - When third party contractors (such as Multiplan) negotiated the rates, the negotiated rate because the "usual and customary rate" for the specific claim
  - The Court essentially held that there was a negotiated agreement for the specific claim and no overpayments
- The Court denied all of Cigna's claims for refunds and for relief, including:
  - ERISA Claims
  - Fraud
  - Negligent Misrepresentation
  - Texas Statutory Claims

Ruling on Cigna's Proportionate Share Analysis

- The Court ruled that Cigna could not use a Proportionate Share Analysis because:
  - The "average plan member" would not understand that his insurance coverage was conditioned on whether Humble collected his entire deductible, co-pay and co-insurance before Cigna paid; and
  - The "average plan member" would not understand that his insurance would pay in proportion to the payments made by the patient\plan member at the time of service.

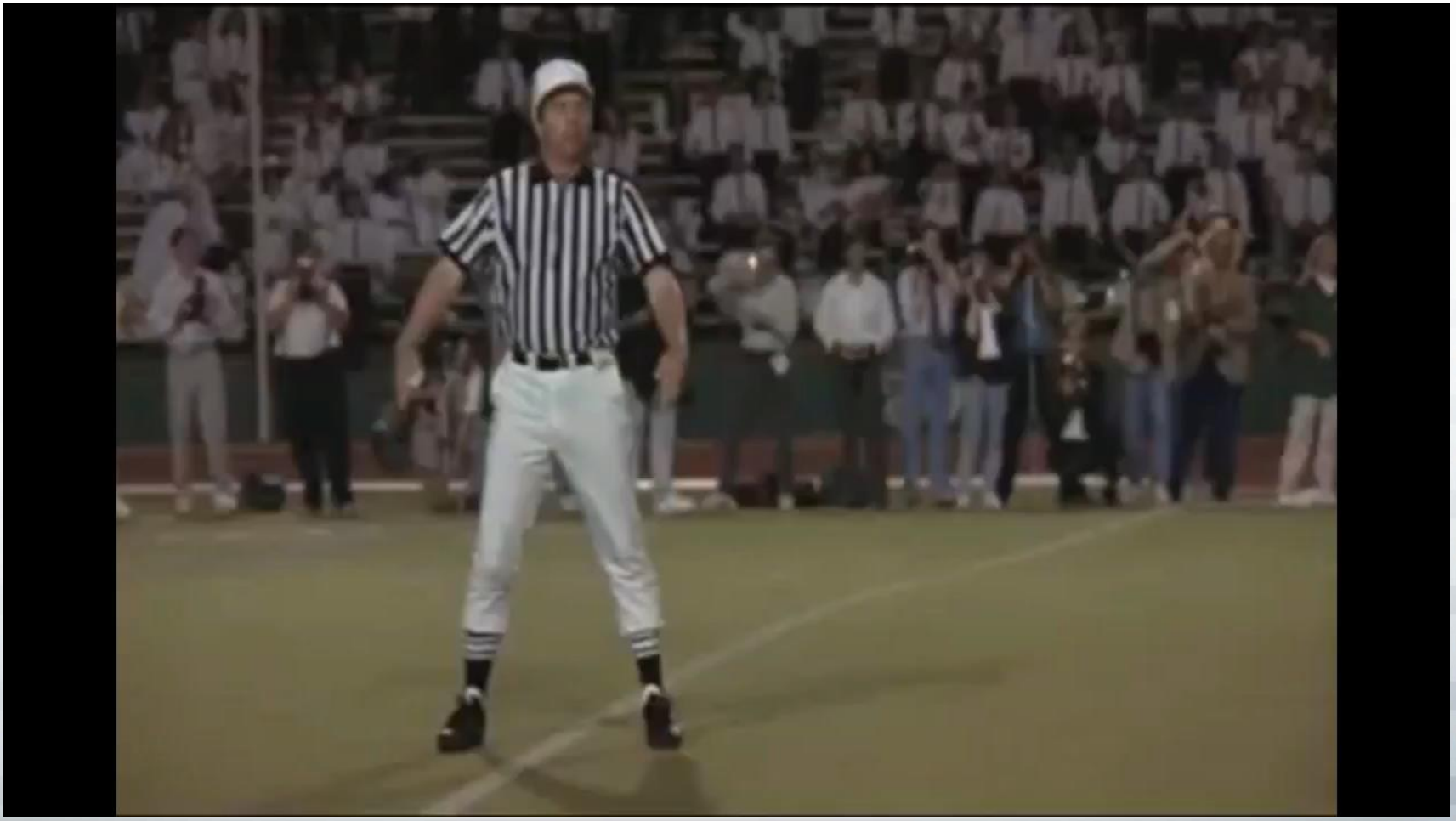
Ruling on Humble's Counterclaim



Ruling on Humble's Counterclaims

- The Court ruled that Humble was entitled to be reimbursed for underpayments over the three and half year period
  - $11,392,273 in Underpayments
  - Basis of Recovery was not Contractual with Cigna, but as Plan Beneficiary under ERISA

Ruling on Humble's Claim for Penalties



Ruling on Humble's Claim for Penalties

- The Court found that Humble was entitled to Penalties
  - $2,299,000 in Penalties
  - Findings that:
    - Cigna was the appropriate entity from which to Request Plan Documents
      - Cigna was more than a Third Party Claims Administrator
      - Ruled that Cigna was the Plan Administrator and subject to the ERISA Document Request requirements
    - Cigna acted in Bad Faith by not Producing the Requested Documents
    - The Failure to Produce the Plan Documents was Detrimental to Humble's Ability to Appeal denied and underpaid Claims

WHAT DOES IT ALL MEAN?

Out-of-Network Hospital Protection

- The Court clearly protected the Out-of-Network Humble by Ruling that:
  - Cigna could not Deny Claims or Reduce Payment based on Failure of the Facility to Collect Patient Responsibility (Deductibles, Co-pays, Co-insurance)
    - Facility has to make the attempt to Collect
    - Could be specific to the Plan language at issue
  - Cigna could not Deny all Claims because there is a pending Balance Billing Audit
  - Cigna had to process Claims and issue EOBs before the Facility and the Patient could know the true patient responsibility
  - Use of Third Party Contractors with negotiated rates precluded later claiming overpayment when those rates were utilized

Strong Enforcement of ERISA

- The Court very strongly enforced the Provisions of ERISA by:
  - Utilizing the Third Party Contractor rates as the negotiated rate on Specific Claims
  - Assessing high dollar penalties for failure to respond to statutorily authorized document requests (specifically the Plan documents)

Appeal in Progress

- Understandably, Cigna did not like the outcome of this Case
- The *Cigna* Ruling is currently being appealed to the Fifth Circuit Court of Appeals
  - Interventions have been filed by MultiPlan, Viant and Humble Surgical Hospital
  - The Fifth Circuit will review and issue an opinion regarding the Trial Court's
  - Could take between 12 and 24 months for a Fifth Circuit Ruling
- Stay tuned…

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- Douglas Turek
  - Senior Vice President of Operations
  - Telephone: 832-489-4939
  - Email: dturek@alegisrevenue.com

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  Douglas Turek

  The Turek Law Firm, PC

  Telephone: (281) 296-6920

  Email: dturek@tureklawfirm.com