

Testimony by

Mr. James E. Woys

President and Chief Operating Officer
Health Net Federal Services

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Mr. Chairman and Members of the Subcommittee - I am pleased to be here today to address the committee on commercial practices employed in the health care industry with regard to coordination of benefits practices between insurance companies when a patient is insured by more than one company.

I am Jim Woys, President and Chief Operating Officer of Health Net Federal Services, a division of Health Net, Inc. (HNI). HNI is one of the top 5 managed care companies in the nation, with over 10,000 employees servicing 5.7 million covered lives in a full line of medical, dental and behavioral health insurance and HMO products. The Government and Specialty Services Division includes my company, Health Net Federal Services (HNFS), and currently holds three TRICARE contracts as well as 11 VA contracts across the country. We are responsible for the administration and servicing of over 2 million beneficiaries who depend on the federal government for their health care benefits. More than 2,900 dedicated employees of my company and our subcontractor companies bring their collective commercial expertise to the government under these contracts.

My purpose today is to share the approaches used by my company within TRICARE administration and our industry in the private sector when coordinating health benefits payment responsibility among multiple health plan payers.

There are significant dollars involved in the management of health plan benefits for all plan sponsors, including government-sponsored programs. Based upon a nationally respected actuarial consulting firm's findings, savings in health care costs associated with Coordination of Benefits (COB) among carriers can range from 3 percent to over 6 percent of total paid claims. Additionally, since 85 percent of our nation has health insurance under at least one health plan, and many people are covered by more than one plan, the opportunity for avoiding overpayment of claims through coordination of benefits is immense. The chart below indicates the makeup of our nation's health insurance coverage for 1998 and 1999. Because many people are covered by more than one insurance plan the sum of the following is more than 100%.

<u>Type of insurance</u>	<u>1999</u>	<u>1998</u>
Non Government plans	71 %	70 %
Government plans	24 %	24%
Medicare	13 %	13 %
Medicaid	10 %	10 %
Military Health Care *	3 %	3 %
No insurance	15 %	16%

*Military Health care includes CHAMPUS/TRICARE CHAMPVA, Veterans and Military Health Care.

The opportunity for financial recovery is too great to ignore for health insurance companies and the sponsors of health programs who must be fiscally responsible for limited resources and the high demands placed on our health care system.

Effective health program administrators include a disciplined approach to ensuring overpayments are avoided when an individual has more than one form of coverage, and when overpayments occur, they are quickly and effectively recovered. I will outline the principles used in our approach to coordinating with other companies to avoid overpayments, but before I do, I would like to define a couple of terms that will help us start with a common understanding of some key references.

Other Health Insurance (OHI) is the term used when a plan beneficiary has other health care coverage available through an employer, an association, a private insurer, a student's health care plan obtained through his or her school, or any other entitlement program. Also referred to as "double coverage", other health insurance is typically the primary payer in government sponsored health plans. As an example, federal law requires that TRICARE benefits are always secondary with the exception of Medicaid and certain policies specifically designated as TRICARE supplements.

An Explanation of Benefits (EOB) is a document provided by insurance companies to the service provider and beneficiary detailing what services were covered, which were excluded from coverage and what was paid for each covered service. This form also lists any deductibles and co payments that were taken into account when determining payments. This form has sufficient detail to allow other insurance companies to calculate their COB payments

Diagnostic Related Groups (DRG) are a method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principle diagnosis, secondary diagnosis, procedures performed and the patient's age, sex, and discharge status. A specific reimbursement rate is established for each group and providers are paid according to this rate.

Third Party Liability (TPL) recoveries, often called Third Party Recoveries (TPR) are reimbursement for services rendered that have been paid by a health plan but are the responsibility of another third party, such as an automobile insurance policy, business or personal liability policy, worker's compensation insurance, etc.

INDUSTRY PRACTICES

The three principle activities involved in optimizing coordination of benefits with other health insurance coverage are:

- 1) Identification: Identify the existence of other health insurance information for the covered beneficiary;
- 2) Enforcement: Enforce the COB rules written in the policies of the various health insurance companies;
- 3) Recovery of Overpayments: Recover any overpayments made due to failure of the above two steps.

IDENTIFICATION

The first and most fundamental principle in managing coordination of benefits is the accurate identification and recording of information concerning the individuals' insurance or entitlement coverage. To be successful this has to be an aggressive and continuous information gathering effort by the health insurer. This information can be obtained in several ways. Among them, there are four principle approaches:

- The covered person is asked to provide information on any other health insurance coverage they have on the enrollment application that must be completed when applying for coverage. This information is then entered into an "Other Insurance" screen in our claims processing system that is

accessible to anyone using the system, and for claims processors to refer to when processing a claim.

- Each provider is required to ask the covered person if they have other insurance coverage and to indicate this on the claim form before submitting it for payment. In those instances where the “other insurer” information on the claim is different from what is currently in our system, a COB questionnaire is mailed to the covered person to verify the information received from the provider. If the information the covered person provides agrees with the information shown by the provider, the COB screen is updated to reflect the new information.
- In order to ensure that our COB records are current, a COB questionnaire is sent out annually to those individuals who have not submitted one within the last 12 months.
- Other than scenarios mentioned above, any contact with a provider, the covered person or claims recovery company, which indicates that our COB records might not be current, is followed up to obtain the most current data available.

In summary, the key to timely and accurate identification of other health insurance is gathering information at every opportunity and collecting it in a centralized data base environment that everyone can utilize as a single source for enforcing the collections effort in claims administration.

ENFORCEMENT

Once other insurance information has been collected and validated, action must be taken to enforce each insurer’s coordination of benefits or Third Party Liability (TPL) rules.

The claims processor staff must compare the covered person’s information and dates of service on the claim to the information in our COB records to determine if the person had other insurance coverage when they were treated.

If there is other coverage the processor must determine which insurance policy is primary to the others. There are industry-wide rules that offer two principle approaches that insurers or plan sponsors use to determine the order of payment responsibility among multiple payers. The predominant COB rule is the “birthday rule” which states that the policy covering the person with the earliest birthday is primary. In the event that the COB provisions of two plans cannot be reconciled The McGurl Case (US court of appeals for the Third Circuit – March 1997) held that the National Association for

Insurance Commissioner (NAIC) rules would be federal common law and would take precedence over the other provisions. The NAIC rule is the birthday rule.

If it is determined that another carrier is primary, the claims processor looks for an Explanation of Benefits (EOB) from the other insurer showing what benefits were paid under its policy. The secondary coverage would then pay its share to the claimant, whether it is the provider of care or the covered person who submitted the claim.

In the event that an EOB is not supplied, the claim is suspended and a copy of the EOB is requested before the secondary benefit coverage can be determined and the claim can be processed.

RECOVERY OF PAYMENT

In the best of systems, some claims will be overpaid and will need to be recovered. We recover claims using both our internal staff and outside claims recovery contractors. In instances where the overpayment is easily identified and providers continue to file claims, overpayments are recovered by offsetting the overpayment against a current claim for the same provider.

When we contract outside claims recovery firms to work as a COB clearinghouse, they identify unreported COB issues and pursue more difficult recovery cases. We provide the clearinghouse vendor with selected fields from our claims records that are compliant with HIPAA regulations. The clearinghouse vendor then matches what we provide against claims records of many other insurers seeking potential matches that would indicate that a claimant has multiple insurance policies. This information is then validated by the claims processing staff and any overpayments due to the coordination of benefits are identified and recovered.

TRICARE PROGRAM

My company manages three regional TRICARE contracts for the Department of Defense. Our COB activities, called Other Health Insurance (OHI) or double coverage by statute, are similar in many ways to commercial practices, but are also different in some very important areas.

IDENTIFICATION

In support of the TRICARE program, my company uses the following tools to identify OHI coverage:

- Enrollment applications - Beneficiaries enrolling in the TRICARE HMO option, called TRICARE Prime, must complete an enrollment application, which, among other questions, asks for OHI information much like the commercial plans do. This information is entered into an OHI screen in our claims system which is accessed during claims adjudication.
- Provider supplied information on submitted claims - OHI information for sponsors or beneficiaries who choose to utilize the TRICARE fee for service option, called TRICARE Standard, is captured from claims submitted by providers.
- OHI questionnaires - Periodic questionnaires are sent to providers and beneficiaries as needed.
- Service contacts with sponsors and beneficiaries – Any time a TRICARE beneficiary seeks services from the program, there is opportunity to update or obtain any new OHI information from the beneficiary.

To increase the effectiveness we also utilize several additional tools to find unreported OHI coverage.

- Claims Audits: Paid claims audits are performed to identify and recover overpayments due to double coverage and we use the results of these audits to update the OHI screens in our claims systems.
- Newsletters/Publications: There are quarterly newsletters and publications we prepare and distribute to beneficiaries and providers that include educational articles on their responsibility to report OHI coverage.

ENFORCEMENT

The largest difference between the TRICARE program and commercial COB rules is that TRICARE is statutorily determined to be secondary coverage with a few notable exceptions such as Medicaid, TRICARE supplemental plans, Indian Health, and other programs identified by the Director of the TRICARE Management Activity (TMA).

As with commercial plans the overriding principle of TRICARE double coverage rule is to ensure that beneficiaries receive maximum benefits from their health coverage, but no more than they are entitled to receive, and that the combined payments do not exceed the total charge for the service or supply.

The OHI screens in our claims systems are integrally linked with the enrollment system to ensure up-to-date OHI coverage information is used when processing claims. When OHI does exist, an EOB is required from the other payer(s) before the TRICARE claim can be adjudicated. If an EOB has not been provided, the claim is suspended and a questionnaire is sent to the beneficiary or provider who submitted the claim. This questionnaire must be completed and returned to us in a timely manner or the claim will be denied.

The key to effective OHI or double coverage management is the accuracy and currency of our OHI data. The data collection starts upon receipt of an enrollment application from a PRIME beneficiary then continues through claims adjudication and during each customer contact. Our OHI screens are updated whenever we obtain OHI information different than what we currently have.

RECOVERY

Due to a variety of reasons, TRICARE, as with commercial plans, can overpay claims which then need to be recovered. Recovery efforts are generally concentrated on providers because the majority of claims are paid directly to them. Recovery methods used, which are similar to commercial plans, include:

- Credit balance recovery - Credit balances can result from misposting accounts in a hospital's books, erroneous payments by insurance companies or two or more insurance companies paying as primary rather than one as primary and one as secondary.
- Paid claims retrospective review - Paid claims files are provided to a claims recovery contractor who has access to the claims files for over 1,500 health insurers in the country. The contractor compares claims files to those of the other insurers to determine if the covered person is insured by more than one company. If such a match is found we work with the provider to recover any overpayments.
- Overpayment recovery - Claims overpayments are recovered by working with the overpaid provider to obtain voluntary reimbursement, offsetting amount to be recovered against current

claims payment to the provider, or utilization of a collection agency if the first two approaches are unsuccessful.

Recovery tools that are unique to TRICARE include:

- Investigation by Program Integrity:

Cases are at times referred to our Program Integrity unit for review for potential fraud. Whenever such a referral is received, the OHI information reported by the provider and beneficiary is validated. If new information is obtained our OHI records are updated.

- DRG validation review:

The DRG validation review is a contractual requirement to review paid claims data for overpayment to DRG facilities. The purpose of the process is to ensure that the facilities billed correctly and were paid appropriately and part of the review includes an assessment for overpayment as a result of OHI or TPL.

The result of these efforts amount to millions of dollars in recovered health care costs. It amounts to as much as two percent in the TRICARE environment. Approximately 40 percent of recoveries are from paid claims and approximately 60 percent are from overpayment recovery and program integrity review.

In many cases both commercial insurance plans and TRICARE plans pay claims submitted for their beneficiaries even though the responsibility for the ultimate payment rests elsewhere. These payments are made to ensure that our customers receive medical care at the time it is needed for injuries resulting from auto accidents, work related injuries or accidents. These payments, identified as third party liability claims are the responsibility of companies providing Auto Insurance, Worker's Compensation or Liability policies and efforts to recover TPL payments are instigated after our patient has been treated.

State and Federal laws and regulations, as well as the terms in the various insurance policies determine the collectability of these claims. Commercial insurers and the TRICARE program devote significant efforts to understanding the rules and regulations guiding TPL recoveries, identifying those claims which are truly TPL claims, and recovering the TPL payments made from the responsible insurance company.

SUMMARY

In summary there are several issues that need to be addressed by a health plan sponsoring company or government agency if they wish to maximize their COB savings and TPL recoveries.

- 1) **Knowledge of COB/TPL Rules:** Determine who owns the COB and TPL recoveries. Program administrators should understand the COB and TPL rules in their policies and be able to interpret the rules of other plans to determine the order of payment responsibility.
- 2) **Knowledge of COB/TPL Regulations:** Rules vary within federal government programs and from state to state when determining when you can apply your COB rules. Some federal and state regulations allow insurers to “chase & pay”, obtaining COB information before paying the claim, while others require insurers to “pay & chase”, paying the claim then seeking COB recovery.
- 3) **Institute business processes that are adequate to identify potential COB and TFL savings:** Obtain and record other insurer information on a regular basis using all available contacts with beneficiaries and providers and store the information in a centrally placed database that can be used when adjudicating claims.
- 4) **Ensure centralized database integration among claims payments systems and other administrative applications:** Automatic matching of claims being adjudicated to your COB files is faster, more accurate and effective.
- 5) **Decide on in-house administration or external contracts:** If you do not have the ability to build an effective and cost efficient COB/TPL operation internally, there are many reputable companies who can perform this role to meet your specific needs and circumstances.
- 6) **Link other health plan operations to the COB/TPL effort:** There are other sources of OHI and TPL information in the operations of today’s comprehensive managed care programs. In particular, medical departments or utilization and medical management personnel receive current information concerning OHI existence or possible TPL recoveries that can be valuable in pursuing other coverage.
- 7) **Educate:** There must be an extensive and consistent effort to educate health plan providers (hospitals, physicians, ancillary services) as well as the beneficiaries themselves. Often, the providers’ information collection at time of services being rendered is the timeliest information available. It is important to facilitate the capturing of the information easily by program staff and educate providers on the importance supplying accurate OHI/TPL data.

CLOSING REMARKS

In this testimony, I have addressed many elements that contribute to a successful program for third party or other health insurance collections. In review of these points, *information collection* is the fundamental element for building and maintaining effective recovery programs.

There has to be a disciplined approach to collecting information wherever administrative interactions occur with a covered beneficiary or their provider of care. It is essential that the health program's administrative processes and data storage systems support this effort in a systematic way.

If these underlying practices are in place, then the VA can expect to realize the maximum potential benefit of a third party collections effort and ensure the health care resources of VA health programs will serve our veterans' best interests.

Thank you for the opportunity to present my comments to you today. I look forward to your questions and comments.