# PLAN OVERPAYMENT RECOVERY

## REGULATORY AND LEGAL INSIGHTS

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# Is Your Plan Overpaying Claims?

- Estimates are 3% to 10% of U.S. annual health care spend - $84 billion to $280 billion
- CMS identified $8.6 billion in overpayments and $543 million as “uncollectible” in 2010
- Feds recovered $4.2 billion in 2012

# Is Your Plan Overpaying Claims?

- Beyond fraud, abuse and the obvious:
  - Not just double pay or lack of coverage
  - Incorrect rate or edits applications
  - Incorrect use of provider type or provider breach of contract scenario

# Can We Get the Money Back?

- Yes, but …
- Commercial Dollars = Federal, State and contractual land mines:
  - Federal = ERISA and PPACA
  - State = Texas Prompt Pay Laws and Insurance Regulations
  - Contractual = Provider agreement and Plan term restrictions

# Federal Restrictions

- ERISA & PPACA
  - Potential application of ERISA's "full and fair review" regulations for "adverse benefit determinations" defined as:
    - "any … denial, reduction, or … failure to provide or make payment (in whole or in part) for, a benefit … including … failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review … [or] a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate."
    - Extended to rescission decisions by PPACA

# Federal Restrictions (cont.)

- Does an overpayment recovery = "adverse benefit determination"? Does it matter what the basis for recovery is?
  - *Tri3 v Aetna* case: Tri3's preemptive suit against Aetna alleging ERISA violations for failing to provide notice and "full and fair review" rights for overpayments sought by Aetna.
    - DOL Amicus sided with provider; focused on potential recourse against the participant for ultimate payment.
    - 3rd Court of Appeals left issue open
  - *Pennsylvania Chiropractic Ass'n v BCBS* case: ruling that reasonable fact finder could conclude provider suffered "adverse benefit determination" when defendant demanded repayment.

# Federal Restrictions (cont.)

- Implications if ERISA claim regs do apply:
  - Required claims procedures = additional administrative costs and potential delays in recovery (*e.g.* 45 days to appeal under Texas PP laws vs. 180 days to appeal under ERISA regs)
  - Potential remand to administrator for further review (or possible risk of loss of deferential review if otherwise applicable) if "full and fair review" not provided

# State Restrictions

- As to contracted providers, Prompt Pay laws require:
  - Overpayment recovery:  Notice within 180 days of payment, 45 days to pay, and option to appeal
  - Auditing option:  100% initial payment, notice, complete within 180 days of claim receipt, and option to appeal
  - Exception for fraud and material misrepresentation—but still need to timely pay on front end.

# State Restrictions (cont.)

  - Contractual provisions to request information to determine payment, including description of the "procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment"
- Can the payor recoup by offsetting against another claim payment and under what circumstances?
- What constitutes fraud or material misrepresentation?

# State Restrictions (cont.)

- As to non-contracted providers and insureds:
  - Chapter 542 (general processing of first party claims) is silent on overpayment recovery, but…
  - ERISA application
  - PP laws apply to non-contracted providers rendering ER or services at insurer's direction
  - What if there is a non-ERISA plan and non-ER care?

# Contractual Restrictions

- Provider Agreements:
  - PP law requirements apply even if not expressly written in contract
  - Be aware of ambiguous or non-standard terms that may restrict overpayment recovery (e.g. older contracts that have not been updated, limited negotiated payment agreements with a non-contracted provider)
  - Absence of any right to overpayment recovery could be construed as no right

# Contractual Restrictions (cont.)

- Plan restrictions:
  - Mainly for participants and non-contracted providers
  - What do the plans specifically provide in terms of recovery of overpayments – fraud, overpayments, mistaken payments.
  - Some courts narrowly construing ERISA plans' rights to recovery based on express plan terms; see also Supreme Court *McCutchen* decision (equitable principles do not override express terms)

# How Do We Get the Money Back?

- Put right to recoup and recover in the provider agreement
- Put right to recover and type of funds to be recovered in plan document
- Identify overpayments in a timely manner
- Pursue recovery and recoupment through compliant measures

# How Do We Get the Money Back? (cont.)

- Judicial Relief:
  - Tension between federal and state law based on ERISA preemption
  - ERISA decisions requiring plans to "trace the funds" except where there is an "equitable lien by agreement" – what constitutes an "equitable lien by agreement"? See *Sereboff* (Supreme Court) and *ACS Recovery Srvs* (Fifth Circuit) decisions.
  - Recent Fifth Circuit *Truitt* decision (recognizing that ERISA does not outline how a plan administrator may recover fraudulently obtained benefits)

# Chasing Federal and State Dollars

- PPACA's stiffer regulations for provider's return of overpayments once identified
  - Increase in provider self-auditing as part PPACA compliance?
  - Impact on return of funds to MA and Medicaid Plans?

# Chasing Federal and State Dollars (cont.)

- Increased CMS oversight of and pursuit of overpayments to MA plans
- Medicare/Medicaid Contractor obligations to pursue overpayments:
  - Contractor requirement for FWA prevention and detection program
  - OIG's recommendations that CMS amend regulations to require MA plans to refer fraud & abuse
  - CMS FWA training requirements

# Chasing Federal and State Dollars (cont.)

- Medicaid-required plan to prevent and reduce FWA
- Notice to HHSC-OIG for suspected fraud and abuse
- HHSC-OIG may want first crack at recovery over $100k
- Other contractual requirements

# Impact to Health Plans

- Spike in litigation
  - Plans initiating suit - against insureds largely in subrogation/other payor scenarios and providers in various areas
  - Plans defending provider suits may assert counterclaim or equitable offset based on overpayments

# Impact to Health Plans (cont.)

- Ensure ongoing pursuit and recoupment practices are compliant with both federal and state regulations
- Ensure provider agreements permit recoupment
- Ensure plan documents permit all scenarios for overpayment recovery