

What surgeons should know about...

Health plan settlements

by Carol Scheele, JD, Raleigh, NC

After a decade of frustrating negotiations and failed legislative reform efforts, physician groups took their complaints about inequitable health plan policies to court, filing federal and state lawsuits against most major U.S. insurers. At press time, settlements had been reached with six health plans. As a result of these actions, physicians have received monetary compensation, and insurers have promised to reform their policies. This article attempts to answer questions surgeons may have about how these settlements affect them.

What is the nature of these lawsuits?

Physicians and their representative medical societies filed the lawsuits against health plans because of unfair payment policies, interference with medical practice, one-sided contracts, and so on. Most of the lawsuits have been consolidated in the U.S. District Court of the Southern District of Florida (Miami).

How have the medical societies been involved?

Approximately 19 state and county medical societies have filed lawsuits. Five state medical societies (California, Texas, Georgia, Florida, and Louisiana) filed lawsuits claiming that health plans were engaging in racketeering by using fraud and extortion to wrongfully deny payment to physicians. These five state medical associations were the “signatory” societies for the lawsuit settlements; other groups subsequently became “additional signatory societies,” enabling them to file complaints on behalf of their members.

Which health plans have been sued?

Defendants include Aetna, Inc.; CIGNA Corporation; Pacificare Health Systems, Inc.; United Healthcare; Anthem/Wellpoint, Inc.; Health

Net/Foundation; Coventry Health Care, Inc.; Prudential Insurance Company; Blue Cross and Blue Shield Association; numerous Blue Cross/Blue Shield plans; and Humana, Inc.

Which plans have signed settlement agreements?

At press time, the following had signed settlement agreements: Aetna/US HealthCare; CIGNA Healthcare; Health Net; Prudential; Wellpoint/Anthem; and Humana, Inc. The Prudential settlement provides funding for compliance and other advocacy initiatives on behalf of physicians but does not include monetary or prospective damage awards because the company sold its health insurance business in 1999. Plans that have not signed settlement agreements are scheduled for trial in April 2006.

How are the settlements structured?

Settlements are negotiated on behalf of all physicians nationwide. The agreements include a general release of prior claims and allow physicians to opt out of the agreement. Physician contracts must incorporate certain provisions of the settlement agreements, and certain business practices must be changed by specified dates. The settlements typically retain more favorable clauses in physician contracts and pending and existing state laws and regulations.

The health plans that have settled pay all litigation costs, and the provisions apply to all patients unless otherwise stated.

What types of relief do the agreements provide to physicians?

The settlements reached with Aetna, CIGNA, Health Net, Anthem/WellPoint, and Humana contain the following components of interest to surgeons:

- *Prospective relief:* Reform health business

practices to simplify physician office administration

- *Disclosure requirements:* Transparency in claims processing, medical necessity requirements, and other policies and processes
- *Monetary damages:* Some cash payments for monetary damages to physicians and physician foundations
- *Compliance and dispute process:* Several mechanisms to enforce agreements related to compliance and dispute processes

What are some examples of settlement agreement business requirements?

The settlement agreements are not identical, but some similarities exist, including:

- *Payment rules.* Certain Current Procedural Terminology (CPT)* code combinations and modifiers (-25, -57, and -59) must be paid when adequately documented; evaluation and management codes may not be downcoded; and modifier -51 exempt, add-on, and indented codes must be handled as specified in CPT guidelines.
- *Consistency and disclosure of payment rules.* Payment rules become more consistent across health plan products, and plans must disclose reimbursement edits and claims adjudication rationales.
- *All-products clauses.* Health plans are generally prohibited from requiring participation in all product line.
- *Assignment of benefits.* Four agreements have specific requirements regarding the plan's obligation to honor valid assignments of benefits for nonparticipating physicians.
- *Gag clauses prohibited.* Health plan administrators are restrained from inhibiting free communication between physicians and their patients.
- *Refund restrictions.* Refunds must be paid within specific time limits.
- *Medical necessity determination.* Clinical guidelines must be based on scientific evidence; a clinical definition of "medical necessity" has been established.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.

Will physician-member committees monitor and advise the health plans?

Yes. The agreements call for the health plans to establish physician advisory committees (PAC) to review national policies as well as redundant claims, payment, and medical necessity disputes. Details about the Aetna and CIGNA PACs are posted at www.aetna.com/provider/physician_advisory.htm and www.cigna.com/health/provider/medical/procedural/advisory.html, respectively.

What if a plan fails to comply with the settlement agreement?

A compliance dispute process has been established to enforce payment issues, payment policies, and other substantive provisions of the agreement. A compliance dispute facilitator will be assigned to each settlement agreement. If this individual cannot negotiate an agreement, the complaint may be referred to a compliance dispute officer, who will mediate or arbitrate the case. If no resolution is possible at this point, the case may be referred back to the court.

The agreements also provide for an independent review of billing disputes separate from the compliance dispute process. After exhaustion of appeals, billing disputes are heard by an independent organization with coding expertise. Its decision is binding and is passed on to the PAC. A similar mechanism has been established for resolving medical necessity disputes.

What are some examples of disputes?

- Contracts with key provisions that do not comply with the settlement agreement
- Failure to pay the -25 modifier
- Refund demands outside the time limits
- Failure to pay add-on codes
- Enforcement of "all products" clauses or practices in violation of the settlement agreement

continued on page 31

Ms. Scheele is associate general counsel for the North Carolina Medical Society in Raleigh.

WHAT SURGEONS SHOULD KNOW ABOUT, from page 9

How can I get help filing a dispute?

Any signatory medical society or compliance dispute facilitator assigned to a particular health plan may evaluate a dispute and complete the requisite paperwork. A list of signatory medical societies, contact information for compliance dispute facilitators, and the form are available at *www.hmosettlements.com*.

Where can I find out more?

For more information, surgeons may want to visit *www.milbergweiss.com* and *www.physiciansfoundation.org*, or call the College at 312/202-5000 and ask to speak with the State Affairs staff. Ω