Tips on How to Protect the Plan from Egregious Billed Charges

1. It all starts with the Plan Document(s). We recommend that our payor clients have their plan documents reviewed by The Phia Group, LLC. As a leader in health benefit plan cost containment, The Phia Group is uniquely positioned to appreciate how important strong plan language is to such cost containment efforts. Their understanding of benefit plan needs, innovative cost containment methodologies, applicable law, and interaction between industry players, led them to develop the industry's best plan document language. The Phia Group offers a wide range of plan document services, including document review, revision, template drafting, and online plan drafting software. They can be reached at 888-986-0080, or visit their website: www.phiagroup.com.

2. Plan sponsors of programs administered in accordance with The Employee Retirement Income Security Act of 1974 ("ERISA") have a fiduciary responsibility to make *reasonable* plan expenditures and are obligated to prudently manage plan assets. It therefore stands to reason that identifying and defining what is (and what is not) *reasonable* in your plan documents should be a priority. To that end, plan documents should limit reimbursement for air ambulance services to a reasonable and appropriate amount based upon (and taking into consideration) numerous parameters, such as (but not limited to) the actual provider's expenses, current rates charged by other providers, and what other payers pay (including Medicare). Sentinel Air Medical Alliance maintains a comprehensive database of air ambulance provider costs. For a given geographic area and aircraft type, we can determine with great accuracy the provider's cost to perform the service. For example, in many areas of the country the provider's cost to perform a helicopter-based patient transport is less than $8,000. This information can be used by a plan to develop cost-plus reimbursement to the provider. By crunching the numbers, you'll find that – more often than not – payment in excess of 170% of the prevailing Medicare reimbursement rate is simply excessive. Medicare rates, set by The Centers for Medicare & Medicaid Services ("CMS") are generally favorable to providers. The proof? Since the early part of the last decade, when Medicare instituted changes in its reimbursement policy, the number of helicopters performing air ambulance transport services has doubled.

3. Plan Documents should either contain a clause prohibiting assignment of benefits by patients to providers, or alternatively, the plan should have language indicating that a provider's acceptance of assignment of benefits - along with deductibles, co-payments and coinsurance - is payment in full for services, supplies, and/or treatment rendered. In other words, the assignment is the payment itself, rather than the plan funds it entitles the provider to receive. This is because assignment of benefits is more than "just" money; it is direct access to the plan sponsor's "deep pockets", assurances that payment will occur, and avoidance of patient billing (often resulting in little to no payment to providers). Assignment of benefits is more than a method to receive payment; it is "peace of mind." That has value and plan sponsors should take advantage of that value. By using

assignment – and the peace of mind it brings – as a bargaining chip, the plan has more leverage with providers, and an incentive to providers to accept the plan's maximum allowable rate.

4. Providers often use the plan participant or beneficiary as a weapon against the plan through the specter of balance billing. Often, Plan administrators will reimburse the provider at a reasonable (i.e., reduced) rate and send payment to the provider in the hope that they will accept the reduced payment as payment in full. **They will not**. In fact, you have armed the provider with the ability to balance bill your plan participant. A better way to approach reimbursement would be to offer to pay the provider directly if they are willing to accept reasonable payment as payment in full. If the provider refuses to accept reasonable payment as payment in full, payment should be made directly to the Plan participant. After all, the Plan's responsibility is to the Plan participant, not to the provider. Pursuing patients for payment is costly, time consuming, and often fruitless. The fear of losing access to the plan's funds often turns the tide in negotiations.

5. The key to success lies in your willingness to remain firm with providers. We do not use the term "negotiation" when looking to settle claims. Rather, we are merely informing the provider of the terms of the plan documents and letting them know that they will not receive reimbursement in excess of that provided for in the plan documents. The only issue is whether the provider will receive reimbursement from the plan directly or from the plan participant.

6. **All** air ambulance claims should be reviewed ***prior to payment*** for medical necessity and reasonableness of rates. A large percentage of claims we review indicate the following:

- The patient was not transported to the nearest appropriate facility
- The patient could have arrived at receiving facility faster via ground ambulance
- Air transport was not medically necessary
- Competing providers could have performed the transport for lower cost.
- Provider charges were not reasonable
- The claim contains billing errors (inaccurate loaded miles, billing for supplies, etc.)
- Self-referral issues

7. Finally, many air ambulance providers offer "memberships" to the public. For an annual fee (usually about $50 per family), the air ambulance provider agrees to transport the owner of the "membership" and accept as payment in full whatever the insurance company/health plan pays. What they don't tell the purchaser of the "membership" is

that they will bill the payor at egregious rates- sometimes more than 700% of Medicare.

It is important that the plan request that plan participants inform the plan administrator when a "membership" has been purchased by the plan participant.

Under the terms of the "membership" agreement the provider waives their right to balance bill the plan participant. That being the case, a payor can reimburse the provider at reasonable rates without concern over balance billing, ***if*** they know the plan participant has purchased a "membership".