State and Public School Life and Health Insurance Board Benefits Sub-Committee Minutes October 8, 2010

The Benefits Sub-Committee of the State and Public School Life and Health Insurance Board (hereinafter called the Committee) met on Friday, October 8, 2010 at 9:00 a.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

Members Present	**Members Absent**
Janis Harrison	Jeff Altemus
Shelby McCook	Lloyd Black
Becky Walker	
Gwen Wiggins	
Bob Alexander	

Jason Lee, Executive Director, Employee Benefits Division (EBD).

Others Present:
Dr. Joe Thompson, ACHI; George Platt, Leigh Ann Chrouch, Michelle Hazelette, Amy Tustison, Doug Shackelford, Stella Greene, Tracy Collins, Lori Eden, Sherri Saxby, Kathy Johnson, Paige Harrington, Sherry Bryant, Amy Redd, Shannon Roberts, Cathy Harris, EBD; Rhonda Hill, ACHI-EBD; Barbara Melugin, Kathy Ryan, AR BC/BS Health Advantage; Shonda Rocke, InformedRx; Kim Henderson, AR Development Finance Authority; ADFA; Bryan Meldrum, NovaSys; Peggy Nabors, AR Education Association; Diann Shoptaw, Educational Benefits Inc; Marc Watts, AR State Employee Association; Wayne Whitley, Rhonda Walthall, Sarah Sanders, AR Highway & Transportation Dept;

Call to Order
The meeting was called to order by Janis Harrison, Acting Chairman.

Approval of Minutes
A request was made by Harrison to approve the September 10, 2010 minutes. Walker made the motion to approve. McCook seconded. All were in favor. Minutes approved.

FORMULARY MANAGEMENT RULES *by Jason Lee*
Lee explained they are required under federal law to provide the member with a written description regarding the appeals policy as to why a service or drug has been denied. The rules have been presented to the DUEC and their edits are incorporated in the document. Lee said the plan has been operating under the formulary management rules for quite some time; but it is the first it has been put in written form. Lee said there will be additional rules added over the course of the next few months.

Lee provided an overview of the rules.

McCook said he is concern about how much time will have lapsed before the DUEC reviews a new product not currently covered plan. McCook said members do not need to wait a long time before a new drug is reviewed because that is not providing service to the member.

Lee said they can do a mid-quarter emergency review. Lee said he will also review the original motion set forth by the Board regarding special circumstances for new drug review.

McCook made the motion to adopt the formulary management rules with the exception they include the option for a mid-quarterly emergency review of new products no currently covered by plan. Walker seconded. Motion carried.

APPEALS PROCESS & DISCUSSION *by Jason Lee*
Lee presented the appeal process document from the Summary Plan Description (SPD) that employees are required to follow to have any claim appealed. Lee informed the committee the document has been changed to incorporate the Independent Review Organization (IRO) required by the plan due to healthcare reform. Lee also provided the committee with the checklist used for research and investigation.

Lee provided the committee an appeal activity summary report that included the number of appeals, types of appeals and the approval & denial rates. Activity within the appeals department was examined from June 2009 through September 2010. The report indicated there were 179 events submitted to EBD for review. During this time, there were more than 7 million individual medical claims paid by both Health Advantage and NovaSys Health.

Lee explained only a member or his / her designated representative can submit an appeal so not all “events” are considered appeals. During this timeframe, fewer than 20% of the letters submitted to EBD were not classified as an appeal because EBD appeals department or appeals committee did not make a final decision regarding the coverage or exclusion of the specific item with the request.

McCook commented that the complaint and appeals process is very complicated and the appeal activity summary report did not provide the information he wanted. McCook said he would like more information regarding the outcome of the 179 events; why were they denied, how many where approve after the appeals process, and should they have ever been denied from the beginning?

McCook said a member will risk being turned over to collections before the outcome of an appeal. McCook said it is possible a mistake has been made by the carrier or the provider and so someone should find out the cause beforehand and then the claim can be taken care of immediately.

McCook then told the committee about a personal experience he encountered while inquiring into a claims issue for a family member. McCook said an appeal was filed and then approve but they have yet to find out why the claim was originally denied.

McCook referenced the complaint and appeals document. McCook suggested they utilize EBD's customer service to research and investigate claim issues reported by members.

Alexander commented the new internal and external appeal process is very laid out and it is complicated, but it is federal law. Alexander referenced the complaint and appeal document and then commented the federal government has an internal appeals process and that the process was not in the document presented to them. Alexander requested that they stay in sync with the federal government and include information for an internal appeal as well. Alexander said there is also a new rule that allows them to charge a minimum fee to file an appeal and he would like to see them incorporate that as well.

Lee said he is not comfortable with the idea of customer service researching paid claims and medical records initiated by a telephone call. Lee said a telephone request is not sufficient enough for them to gather all the facts. Lee said they discourage the use of emails because the information is not secured but they do have an internal web-based task system that is secure, but it is currently not available to the members

Alexander explained the process used by the Department of Insurance for gathering information in order to research claim issues. Alexander said you don't want to waste time on misinformation and so until you see the Explanation of Benefits (EOB) there is nothing to do.

Walker talked about creating a web-base form "Complaint form" for members who want to report a claim issue. Walker said the form can go to someone in customer service for research and then at some point become an appeal.

A conversation ensued about an “EBD Member Advocate” to assist members with claim issues.

McCook said he is against calling a claim issue an appeal on the front end until they find out the problem. McCook said it’s not the way they should operate.

Alexander said they have to be careful to comply with the federal law because members have the right to an internal appeal from the start. The form should be an inquiry and not a complaint about a claim. Alexander said this will give members their legal rights under federal law regarding internal and external appeals.

Lee said in no way are they trying to discourage members from appealing, but rather the goal is to pay as many claims as they can in a timely manner.

DIRECTOR’S REPORT *by Jason Lee*

Lee informed the committee Cheiron will be present a year end review of the 2010 public school group in the January 2011 meeting.

The committee decided by consensus to continue to meet on the 2nd Friday of the month for the 2011 plan year.

Meeting adjourned.

AGENDA

State and Public School Life and Health Insurance Board

Benefits Sub-Committee

EBD Board Room
501 Building, 5th Floor
October 8, 2010 9:00 a.m.

1. **Call to Order** ..... Janis Harrison – Acting Chairman
2. **Approval of Minutes** .....Janis Harrison – Acting Chairman
3. **Formulary Management Rules** .....Jason Lee, Executive Director
4. **Appeals Process & Discussion** .....Jason Lee, Executive Director
5. **Director's Report**.....Jason Lee, Executive Director

Next Meeting: 2011 Schedule to be released

Formulary Management Rules – For Consideration – October 8, 2010

As amended during DUEC October 4, 2010

1. Formulary changes for existing covered medications that are not due to significant clinical, access or financial reasons will only be made at the beginning of a plan year.

2. New products not currently covered by the plan in some other form will not be added to the formulary until a clinical review is completed by the DUEC. The college of pharmacy will bring new products to the DUEC for review in regards to any of the following conditions:
    a. When newly available on the market
    b. When requested by EBD, a member, a provider or the Board
    c. As part of a class review
    d. When medical literature shows a significant change in outcome or new clinical data

3. Brand products on tier 2 will automatically move to tier 3 when a generic equivalent is released with the generic version added to tier 1; if a generic is removed from the market or has significant shortages in supply, the equivalent brand product on tier 3 will automatically move to tier 2.

4. Excluded drugs will be reviewed in regards to any of the following conditions:
    a. When requested by EBD or the Board
    b. As part of a class review
    c. When medical literature shows a significant change in outcome or new clinical data

5. Financial appeals of formulary rules are not allowed; evidence of a medical reason to change a formulary rule will be considered by DUEC as part of a class review. This rule encompasses traditional tiered drugs, reference price drugs, and certain excluded drugs.

6. Applicable state and federal laws will be followed for the utilization of covered medications.

Complaints and Appeals

Definitions

Complaint - An expression of dissatisfaction either oral or written.

Appeal - A request to change a previous Adverse Benefit Determination (ABD) made by the Benefit Coordinator or EBD based on coverage or eligibility as defined by Plan Documents.

Types of appeals include claims payment or denial, benefit coverage, eligibility, or termination of coverage.

Excluded services are not subject to appeal but a letter of complaint requesting a review of the allowable benefit can be sent to the Board via EBD.

Members will not suffer any sanctions or penalties resulting from submitting a complaint or appeal.

Who do I call regarding questions about a claim?

If a claim for benefits is denied either in whole or in part, your medical plan's Benefit Coordinator can perform a re-review of the claim and will provide you with a notice explaining the reason(s) for the denial. For medical claims, this notice will be in the form of the Explanation of Benefits (EOB). If you have questions about how a claim was paid or why it was denied, you should contact your Benefit Coordinator (Health Advantage or NovaSys Health for medical issues or EBD for pharmacy issues) at the phone numbers provided in this SPD. The member services department will explain, in detail, how and why the claim was paid or denied. If you are unsatisfied with the results of this inquiry, the next step is to file a written appeal with EBD.

How do I file an appeal?

First Level Review:

You must file your written request for appeal within 180 days of receiving your notice.

Your appeal, and all supporting documentation, should be mailed to
EBD
P.O. Box 15610
Little Rock, AR 72231
Attn: Appeals Department

EBD Appeals Department will notify you within 3 business days of receipt of your appeal. Notification will be delivered via first-class mail. In preparing your appeal, you or your duly authorized representative will have the right to present documents and other information pertinent to your claim. A complete review of your claim will be performed by the Appeals Department and a determination will be made. Within 30 days of EBD's receipt of your appeal, you will be notified of the appeal determination. Please note that your social security number is required on appeal.

Second Level Review:

If you are not satisfied with the determination received on the first level review, you may request a second level review. The appeal must be received within 60 days of the notification of denial by the first level appeal. This request must also be made in writing to the EBD Appeals Department and should contain any additional information not presented during the First Level Review.

All Second Level Reviews are presented to the EBD Appeals Committee; a three-person panel comprised of EBD's Chief Fiscal Officer, Chief Health Services Officer, and the Deputy Executive Director. Designees may be named for any member on a case by case basis due to absence or recusals.

A member of the Appeals Department will present the information to the Appeals Committee along with any and all information presented by you and gathered from any outside resource such as medical professionals or other insurance carriers.

The appeal committee will review and make a determination of your appeal within thirty (30) days after the receipt of your second level appeal.

What is an expedited appeal? An expedited appeal may be requested related to a claim involving urgent or ongoing care. The request may be made in writing or by telephone followed by written confirmation. Expedited appeals will be progressed to Second Level Review with the Committee hearing the app within 72 hours of the request. You or your duly authorized representative will be notified of the appeal decision within 1 business day of the determination.

What is an external review? If you are still unsatisfied with the determination of the Appeals Committee, you have the right to request an external appeal by an Independent Review Organization (IRO). The IRO will consider issues such as medical necessity or experimental / investigational status of a procedure or medication. Your request for an external review must be in writing, submitted to EBD at the address above, and within 4 months of the initial notice of the Adverse Benefit Determination.

The determination of the IRO is binding upon the plan.

Who is an authorized representative? Any person to whom you have given express written consent to represent you during the appeal, a person authorized by law to provide substituted consent for you, a family member if you are unable to provide consent, or your treating health care professional if you are unable to provide consent and a family member is unavailable. The authority of an authorized representative shall continue for the period specified in your written consent or until you are legally competent to represent yourself and notify EBD in writing that the authorized representative is no longer required.

How is "Experimental and Investigational" determined for medical services? Not every medical procedure is covered by the Plan. Many procedures are performed by providers throughout the country that are not generally accepted as traditional treatment for the individual's specific medical condition. As such, a procedure may be considered "experimental and investigational" for one type of patient and medical condition but not "experimental and investigational" for another with different medical conditions. Also, prescription medications can be considered experimental and investigational in the treatment of one disease but considered standard treatment for another.

The initial determination as to whether or not a service or drug is experimental or investigational is made by the Benefit Coordinator based on their medical coverage policies. During the first level appeal to EBD on the grounds of Experimental and Investigational, a review will be performed and other plans and carriers, including Medicare and Arkansas Medicaid, will be researched. An E & I Worksheet will be completed and a determination will be made regarding the final decision.

Checklist for researching Investigational/Experimental

Appeal Number:		**Date**	
Member Number:			

Task #	Description	Answer	Weighted Score	Researched Score
1	**Medicare**		**5**	**0**
a	Is it a covered service for Medicare?			
b	Does member meet Medicare criteria?			
2	**Other Benefit Coordinator**		**2**	**0**
a	Is it a covered service for Other Benefit Coordinator?			
b	Does member meet Other Benefit Coordinator criteria?			
3	**Food & Drug Administration (if applicable)**		**1**	**0**
a	Is device, drug or service approved for use in the US?			
b	Does member meet the FDA criteria?			
4	**Arkansas Medicaid**		**3**	**0**
a	Is it a covered service for Medicaid?			
b	Does member meet Medicaid criteria?			
4	**Federal Employees Health Benefits Plan**		**2**	**0**
a	Is it a covered service for FEHBP			
b	Does member meet FEHBP criteria?			
5	**AETNA**		**1**	**0**
a	Is it a covered service for AETNA?			
b	Does member meet AETNA criteria?			
5	**CIGNA**		**1**	**0**
a	Is it a covered service for CIGNA?			
b	Does member meet CIGNA criteria?			
5	**United Health**		**1**	**0**
a	Is it a covered service for United?			
b	Does member meet Untied criteria?			
		Total Points:	**16**	**0**
			Approve:	**No**
			Deny:	**Yes**

Steps:

1. Enter Appeal Number
2. Enter Member Number
3. Enter Date
4. Research in order
5. If both a and b can be answered yes, place a "Y" in the answer field highlighted in White; otherwise enter "N"
6. If the Research Score Total points equals 50%, then the Approve field will be marked "Yes"; if the score does not reach 50% or greater, the Deny field will be marked with an "Yes".
7. Log the reponse in Chart Management and load this form to the Member's Medical Image.

Appeal Activity – Summary Report

Presented to Benefits Committee – October 8, 2010

Activity within the Appeals department was examined from June 2009 through September 2010 and identified 179 events submitted to EBD for review. During this time, there were more than 7 million individual medical claims paid by both Health Advantage and NovaSys Health.

Only a member or his / her designated representative can submit an appeal so not all "events" are considered appeals. During this timeframe, fewer than 20% of the letters submitted to EBD were not classified as an appeal because EBD appeals department or appeals committee did not make a final decision regarding the coverage or exclusion of the specific item within the request.

Appeals resulting in Approvals:

- 81 member requests resulted in appeals being approved
- Average completion time 21 days for all approved appeals
- Of the appeals completed within the 30 days, average is 12.7 days for completion
- 45% approval rating for any event submitted for review
- 56% approval rating for appeals

Appeals resulting in Denials:

- 64 member requests resulted in appeals being denied
- Average completion time of 16 days for all denied appeals
- Of the appeals completed within 30 days, average is 8.3 days for completion
- 36% denial rating for any event submitted for review
- 44% denial rating for appeals

Events resulting in neither denials nor approval:

- 34 items resulted in neither an appeal denial nor approval
- Many of the items in this category were immediately redirected back to medical benefit coordinator to re-process claim. Examples include an
    - Out-of-Network lab ordered to be reprocessed as in-network
    - Provider appeal / coverage question redirected to benefit coordinator
    - Request for pre-authorization redirected to Utilization Management department
    - Wellness exam processed as office visit ordered to be reprocessed at 100% covered benefit