Cameron's Request for Insurance Information

On or about April 24, 2006, Frank Lobb contacted Employee Benefit Specialist, Inc. for a contact at Aetna Health Care Insurance who could provide specific answers on Cameron's Health Care Insurance Policy. He was given the name of J. P. Kearney along with his e-mail address as the proper contact for all such matters. Mr. Lobb then asked Cameron's manager Rich Mangini to follow up with Mr. Kearney. The following is a consolidated record of their related communications. Please note that all discussions were in reference to the effect of Pennsylvania law on a subscriber's ability to pay for a covered service if Aetna elected to deny coverage based on their determination of medical necessity.

Wed. Apr. 26, 2006 (#1)
Rich Mangini e-mail to J.P. Kearney

> We are a medium size business that provides your health care insurance as part of our benefit package. Recently, one of our employees asked whether Pennsylvania law requires an employee to look only to his or her healthcare policy/plan for payment of care included in the plan. In short, they asked if the policy we are providing can in any way limit their individual ability to pay for care contained in the plan, but denied on your company's determination the care isn't medically necessary.
>
> While we tried to research the question, a review of our policy and a call to our broker failed to provide an answer. In fact, the broker said he had never heard of any such thing and was reluctant to take a position. He suggested we contact you.
>
> Please provide us with an answer so we can get back to our employee. Also, please identify any applicable Pennsylvania statute or regulation. We are committed to complete openness with our employees and need your help.
>
> Thank you for your time and consideration.

Wed. Apr. 26, 2006 (#2)
J.P. Kearney e-mail to Rich Mangini

> Hi Richard. Just so I understand the question - are they asking if Aetna denies a claim for some reason can they pay for the claim out of their pocket ? Thanks for your business. JP

Tue. May 2, 2006 (#3)
Rich Mangini e-mail to J.P. Kearney

> Sorry for the delay in getting back to you. I've been out with the flue.

The employee’s question appears to be simply one of, is an insured employee to look only to you (Aetna) for payment of medical procedures included in our plan. Apparently, the employ heard a state legislator say that the state protects policyholders by requiring something called the harmless clause in all hospital contracts that requires the hospitals to look only to insurance companies for payment. In essence, the state prevents hospitals from billing anyone but the insurance company for services offered by an individual’s plan. The question then is, can this attempt by the state to protect the individual in any way interfere with the employee’s ability to self- pay for a service Aetna might believe is unnecessary.

I don’t think there is any desire on the employee’s part to be critical here. He just seems to be following up on something he heard. ---- Hope you can help.

Many thanks for your time and assistance, ----- Rich

Wed. May 3, 2006 (#4)
J.P. Kearney e-mail to Rich Mangini

Hello Rich. If the hospital or doctor is participating in Aetna's network then they cannot bill the customer for additional charges above the Aetna payment. This is standard in all of our provider contracts. However, if Aetna concludes that a service is unnecessary then the employee can self pay with no interference from Aetna. This may be relevant if a customer has some type of cosmetic surgery. Let me know if you have any more questions. JP

Thur. May 4, 2006 (#5)
Rich Mangini e-mail to J.P. Kearney

JP,
Forgive me if I make sure I have this right!.

I’m to tell the employee that network hospitals and doctors can only bill Aetna for services that are considered a covered service under his plan. However the employee is free to self pay for any care Aetna concludes is unnecessary --- cosmetic surgery being a good example.

I sure hope this is right so I can get back to managing the business. ---- What ever happened to the simple world I grew up in?

Again, many thanks for your help, ----- Rich

Fri. May 5, 2006 (#6)
J.P. Kearney e-mail to Rich Mancini

Hi Rich. Yes, that is correct. Have a great weekend. JP

Tue. May 2006 (#6)
Rich Mangini e-mail to J.P. Kearney

The good news is I've been able to get back to our employee. The bad news is he is upset and saying we've confirmed his worst fears. Namely, our Aetna policy unreasonably limits his access to health care.

His point is that "unnecessary care like cosmetic surgery" is not relevant here as this form of elective care is clearly outside our plan, i.e., not a covered service. As such, Aetna, by definition, can't interfere with his ability to access and pay for this form of care. However, essentially all other forms of medical care are defined as "covered services" under the plan. Here, Aetna reserves the right to pre-certify the care and determine whether it is "medically necessary" in a particular situation. Consequently, if Aetna determines a covered service isn't "medically necessary" the hospitals and doctors in Aetna's network are still barred from billing the subscriber. --- If the hospital or doctor can't bill the employee, then the employee can't self pay and his access to health care is restricted. Aetna could honestly believe a covered service isn't medically necessary in a particular situation while the employee and his doctor believe just the opposite.

As I see it, there are 2 issues here. One is the restriction on billing that, as I understand it, is in all Aetna's contracts with hospitals and doctors. The other is a failure to disclose the restriction to our employees. On the first point, I'm not about to ask you to change your contracts. Furthermore, if I'm not mistaken, the restriction is a state requirement. Therefore, I think we can focus on properly disclosing the issue to our employees.

Fortunately, you must have run into this problem before. Consequently, you should have some form of prepared bulletin, pamphlet or policy statement explaining the restriction that we can give our employees. In addition, I'm sure that somewhere in all the paper we got from Aetna there is an acknowledgement of the restriction. If you would provide me with both, I feel confident I can deal with this employee's concerns as well as those of any other employee he might speak to.

I really appreciate your help with this. The employee appears far more upset with us than Aetna as he sees us as agreeing to restrict his access to health care without telling him.

Tue. May 9, 2006 (#8)
J.P. Kearney e-mail to Rich Mangini

Hi Rich. Give me a buzz this afternoon. 610-283-7036. I will be back in the office after 2pm.
thanks

Rich Mangini memo documenting the call.

Memo: I called Joe Kearny at the number he gave me. I explained that, of course surgery would not be considered necessary in most cases. I offered an example from my own experience to help clarify my question. I told him a few years ago I went to the hospital for a heart ablation. I explained that they had discovered an extra "line" in my heart that was firing causing my heart rate to remain high after physical exertion.

I had the option of taking a little pill once a day for the rest of my life or having the cardiologist go in an cordorize the line so it could no longer receive an electrical impulse. I chose to have it fixed. My insurance company, at the time, paid for everything but could have, just as easily, not authorized the surgery, deeming it unnecessary since it could be controlled merely by taking a pill. Since they paid for it I can conclude that they considered it a covered service.

My question to Atena, then is, "had my insurance company considered this unnecessary, even though it was a "covered service", and I wanted to go ahead and pay for it myself, would I be able to?"

Joe responded "yes." He said there was nothing in Aetna's policy he is aware of that would prohibit me from paying myself.

Tue. May 16, 2006 (#9)
Rich Mangini e-mail to J.P. Kearney

JP,
I've had some time to reflect on our phone conversation as well the opportunity to reconnect with our employee. To be honest, I'm confused and a bit frustrated.

In your e-mail of May 3rd. and again on May 5th., you agreed the State requires Aetna to include language in all your contracts with hospitals and doctors that says ***"they cannot bill the customer (our employee) for additional charges above the Aetna payment."*** for ***"any services that are considered part of his plan***". I'm attaching a copy of the state regulations that, at least to my understanding, says exactly that. However, when I asked you to give me something in writing explaining Aetna's position on the restriction, you came back saying there isn't a problem and you have never heard of any such restriction.

I have to admit that when our employee first came to me, I believed he was simply misinterpreting something he heard. However, my communications with you and reading of the copy of the state regulations the employee has pulled off the internet casts the issue in a whole new light. Putting it as simply as I can:

1. “Covered Services” are defined by the policy/plan.
2. The “Hold Harmless” clause in the state regulations makes it very clear hospitals and doctors cannot bill the employee for a “Covered Service”.
3. If hospitals and doctors are not free to bill the employee, the employee cannot be free to self-pay.
4. Lastly, our company is simply asking for Aetna’s published position on what is, at a minimum, a potential restriction to our employees’ access to health care and a matter of public policy.

JP, I need your help. I have an employee who has apparently taken the time to research the issue and asking what appears to be a very reasonable question.

Rich

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28 Pa. Code § 9.722. Plan and health care provider contracts.
(a) A plan shall submit the standard form of each type of health care provider contract, including any document incorporated by reference into that contract, to the Department for review and approval. The plan shall be responsible for assuring that the provider contract meets the requirements of all applicable laws. The Department will review a provider contract within 45 days of receipt of the contract. If the Department does not approve or disapprove the contract within 45 days of receipt, the plan may use the contract and it shall be presumed to meet the requirements of all applicable laws. If, at any time, the Department finds that a contract is in violation of law, the plan shall correct the violation.
(b) The plan shall submit any material change or amendment to a standard health care provider contract, including a material change or amendment to any document incorporated by reference into the contract, to the Department 10 days before implementation of the change or amendment except for changes required by law or regulation.
(c) To be approved by the Department, a standard health care provider contract may not contain provisions permitting the plan to sanction, terminate or fail to renew a health care provider’s participation for any of the following reasons:
(1) Advocating for medically necessary and appropriate health care services for an enrollee.
(2) Filing a grievance on behalf of and with the written consent of an enrollee, or helping an enrollee to file a grievance.
(3) Protesting a plan decision, policy or practice the health care provider believes interferes with its ability to provide medically necessary and appropriate health care.
(4) Taking another action specifically permitted by sections 2113, 2121 and 2171 of the act (40 P. S. § § 991.2113, 991.2121 and 991.2171).

(d) To be approved by the Department, a standard health care provider contract may not contain any provision permitting the plan to penalize or restrict a health care provider from discussing any of the information health care providers are permitted to discuss under section 2113 of the act or other information the health care provider reasonably believes is necessary to provide to an enrollee full information concerning the health care of the enrollee.

(e) To be approved by the Department, a standard health care provider contract shall include the following consumer protection provisions:

(1) Enrollee hold harmless language which survives the termination of the health care provider contract regardless of the reason for termination, and includes the following:

(i) A statement that the hold harmless language is construed for the benefit of the enrollee.

(ii) A statement that the hold harmless language supersedes any written or oral agreement currently in existence, or entered into at a later date, between the health care provider and enrollee, or persons acting in their behalf.

(iii) If the provider contract is a contract that affects plan enrollees, language to the following effect:

''In no event including, but not limited to, non-payment by the plan, plan insolvency, or a breach of this contract, shall the provider bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against the enrollee or persons other than the plan acting on the behalf of the enrollee for services listed in this agreement. This provision does not prohibit collecting supplemental charges or co-payments in accordance with the terms of the applicable agreement between the plan and the enrollee. ''

(2) Language stating that enrollee records shall be kept confidential by the plan and the health care provider in accordance with section 2131 of the act (40 P.S § 991.2131) and all applicable State and Federal laws and regulations, which include:

(i) Language permitting the Department, the Insurance Department, and, when necessary, the Department of Public Welfare, access to records for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Article XXI, this chapter and other laws of the Commonwealth.

(ii) Language which states that records are only accessible to Department employees or agents with direct responsibilities under subparagraph (i).

(3) Language requiring the health care provider to participate in and abide by the decisions of the plan's quality assurance, UR and enrollee complaint and grievance systems.

(4) Language addressing any alternative dispute resolution systems.

(5) Language requiring the health provider to adhere to State and Federal laws and regulations.

(6) Language concerning prompt payment of claims consistent with the requirements of section 2166 of the act (40 P. S. § 991.2166) and 31 Pa. Code § 154.18 (relating to prompt payment of claims).

(7) Language requiring that if the plan and the health care provider agree to include a termination without cause provision in the contract, neither party shall be permitted to terminate the contract without cause upon less than 60 days prior written notice.

(8) Language requiring the plan to give at least 30 days prior written notice of any changes to contracts, policies or procedures affecting health care providers or the provision or payment of health care services to enrollees, unless the change is required by law or regulation.

(f) To be approved by the Department, a health care provider contract shall satisfy the following:

(1) Include the reimbursement method being used to reimburse a participating provider under the contract. If a provider reimbursement is subject to variability due to economic incentives, including bonus incentive systems, withhold pools or similar systems, the plan shall describe the systems and the factors being employed by the plan to determine reimbursement when the contract is submitted to the Department for review.

(2) Include no incentive reimbursement system for licensed professional health care providers which shall weigh utilization performance as a single component more highly than quality of care, enrollee services and other factors collectively.

(3) Include no financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee.

Cross References

This section cited in 28 Pa. Code § 9.652 (relating to HMO provision of other than basic health services to enrollees); 28 Pa. Code § 9.723 (relating to IDS); and 28 Pa. Code § 9.724 (relating to plan-IDS contracts).

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31 Pa. Code § 301.122. Hold harmless.

A contract between an HMO and a participating provider of health care services shall include a provision to the following effect:

‘‘(Provider) hereby agrees that in no event, including, but not limited

to non-payment by the HMO, HMO insolvency or breach of this agreement, shall (Provider) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than HMO acting on their behalf for services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on the HMO's or provider's behalf made in accordance with the terms of the applicable agreement between the HMO and subscriber/enrollee.

''(Provider) further agrees that (1) the hold harmless provisions herein shall survive the termination of the (applicable Provider contract) regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

''Any modification, addition, or deletion to the provisions of this section shall become effective on a date no earlier than fifteen (15) days after the Secretary of Health has received written notice of such proposed changes.'' Cross References

This section is cited in 31 Pa. Code § 301.314 (relating to Department review).

Fri. May 19, 2006 (#10)
Rich Mangini e-mail to J.P. Kearney

Hi Joe. I just wanted to make sure you received my e-mail of 5/16/06. I'm looking forward to your response. Thanks.

Fri. May 19, 2006 (#11)
J.P. Kearney e-mail to Rich Mangini

Hello Rich. I sent this to my contracts department so they can respond. Typically, they will take several days to respond. JP

Thur. May 25, 2006 (#12)
Rich Mangini e-mail to J.P. Kearney

Hi Joe. I haven't heard anything from your contracts dept. yet. Maybe you could follow up for me. Thanks.
Rich

Thur, May 25, 2006 (#13)
J.P. Kearney e-mail to Rich Mangini

Hello Rich. They advised me that the contract language simply means that the contracted provider cannot balance bill the client beyond the Aetna reimbursement. If the employee has additional question please have him write a letter to the Aetna Grievance department. The Address is

P.O. Box 14462
Lexington, KY 40512

Fri. Jun 2, 2006 (#14)
Rich Mangini e-mail to J.P. Kearney

Joe. I'm kind of surprised at your response.

When this subject was first raised, I honestly thought the employee had to be mistaken or have taken something out of context. It's now quite obvious the issue is real and you are doing everything you can to avoid giving us an honest answer.

Let's start with your most recent suggestion that I have our employee contact the **Aetna Grievance department**. --- That's ridiculous. The employee is only a beneficiary of "our company's policy." In short, Cameron's owns the policy and it's Cameron's asking for information. Furthermore, we are only asking for Aetna's policy on what you have acknowledged is: 1.) A bar against our employees self paying for care the policy and your contracts define a "Covered Service", 2.) Language that is contained in all your provider contracts and 3.) A requirement of Pennsylvania law. ---- **Are you really expecting us to believe Aetna doesn't have a published policy on something this central to your operations?**

At a minimum, there have to be established guidelines for when and how a subscriber can pay for a covered service that Aetna believes isn't medically necessary, i.e., there have to be guidelines for when a provider is free to bill a subscriber. However, if the Legislature has created an insurance program that prohibits all such direct billing to a subscriber in order to protect the subscriber from any form of double billing, then it's the law and we have to accept it as fact. --- You just have to level with us.

Look, on one hand I simply want to get this issue resolved and move on. On the other hand, we are not going to short change our employees. If necessary, we will be more than willing to bring the Legislature and the Pennsylvania Insurance Department into this discussion.

Please, just level with us!

Date Uncertain (#15)
J.P. Kearney requests Rich Mangini's phone number for a phone discussion.

Wed June 7, 2006 (#16)
Rich Mangini e-mail to J.P. Kearney

> Sorry Joe. My computer took a hit in the bad storm we had Saturday and I just got it fixed. Thankfully I didn't lose anything.
> My phone # is 610-932-2416.

Thur Jun 8, 2006 (#17)
Rich Mangini Memo documenting phone conversation J.P. Kearney

Joseph Kearney of Aetna Insurance called me on 6/8/06 in connection with a lengthy discussion on the terms of our health insurance policy. The following points summarize our discussion on the phone;

- Received the phone call at about 1:40 pm. On 6/8/2006.
- He apologized if his last e-mail sounded harsh.
- I said we didn't have a grievance, we just wanted information.
- He said it's a matter of interpretation. They have nothing in writing that he could send me.
- He offered to fax me a copy of our contract.
- I told him I'm sure we already have a copy of our contract.
- He said if the employee still had questions he could contact the contracts dept. but he had nothing else to offer me.
- He said he was sorry but had done his best.
- I said, "o.k., thanks, good bye."

Fri June 9, 2006 (#18)
Rich Mangini letter and e-mail to J.P Kearney

Cameron's Hardware & Supply, Inc.
2195 Baltimore Pike
Oxford, PA 10363

J. P. Kearney
Aetna Health Care Insurance
2201 Renaissance Blvd.
King of Prussia, PA 19406

6/9/06

This is to both confirm and finalize our lengthy exchange on the ability of Cameron's employees' to pay for health care under the terms of our Aetna policy.

1. The Hold Harmless Clause in Aetna's' provider contracts forbids direct payment by a subscriber for a "Covered Service" purportedly to protect subscribers from any form of double billing.
2. "Covered Services" are defined by Aetna to be the services included in the policy benefit package and subject to Aetna's determination of medical necessity.
3. The definition of a "Covered Service" is independent of whether Aetna pays for the care or denies coverage based on medical necessity.
4. Subscribers are, however, completely free to pay for all "Non-Covered Services" which are defined by Aetna to include cosmetic care, experimental treatments and all other services not included in the policy benefit package.
5. Aetna is unable to provide a written policy, bulletin or pamphlet clarifying the impact of these contractual provisions and restrictions as requested by Cameron's.
6. Our employees are to write Aetna's Grievance Department if they have any additional questions.

Thank you for your time, patience and candor. It was extremely clear this has not been an easy subject for you to discuss.

Yours truly,
Rich Mangini, Store Manager

Mon Jun 12, 2006 (#19)
J.P. Kearney e-mail to Rich Mangini

Subject:	RE:
Date:	Mon, 12 Jun 2006 14:06:33 -0400
From:	"Kearney, Joseph P" <KearneyJP@aetna.com> View Contact Details Add Mobile Alert
To:	"Rich Mangini" <bigmax222@yahoo.com>

Hello Rich. Once again, thanks for your business. Please feel free to reach out to me in the future if you have questions on other insurance topics. The answer is yes to all the questions below. JP

-----Original Message-----
From: Rich Mangini [mailto:bigmax222@yahoo.com]
Sent: Friday, June 09, 2006 12:20 PM
To: Kearney, Joseph P
Subject:

Cameron's Hardware & Supply, Inc.
2195 Baltimore Pike
Oxford, PA 10363

J. P. Kearney
Aetna Health Care Insurance
2201 Renaissance Blvd.
King of Prussia, PA 19406

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Rich Mangini, Store Manager