COVERAGE DENIED:

Anthem Blue Cross Blue Shield's Emergency Room Initiative

Office of U.S. Senator Claire McCaskill

Coverage Denied

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EXECUTIVE SUMMARY

In May 2017, the insurer Anthem Blue Cross Blue Shield notified policyholders in Missouri that it would deny emergency room (ER) claims for services related to conditions it later deemed non-emergent.[1] Anthem previously instituted a similar policy in Kentucky in August 2015, later implemented the policy in Georgia in July 2017, and has since expanded the policy to Indiana, Ohio, and New Hampshire. This initiative raised serious concerns that Anthem policyholders would avoid necessary medical care in emergency situations due to fears that Anthem would not cover the cost of the care. In response to these concerns, Senator Claire McCaskill wrote to Anthem in December 2017 to request information on the company's ER initiative. Based on information Anthem and other parties provided, key findings of this report include:

- Anthem denied 12,200 ER claims in Missouri, Kentucky, and Georgia from July 2017 through December 2017. These denials represent approximately 5.8% of total ER claims submitted from these states during this period. Information Senator McCaskill received from the American College of Emergency Physicians on ER claims starting in January 2017 shows that denials of Missouri claims spiked sharply in July 2017—the beginning of the ER initiative.

- Anthem overturned the majority of ER claims denials appealed by Missouri beneficiaries each month between July 2017 and November 2017, and the rate of overturned denials increased every month to a high of 73% at the end of this period. The data show similar results for ER claims determinations appealed by Kentucky and Georgia beneficiaries.

- ER claims denial information for January 2018 through March 2018 shows that denials dropped sharply after Anthem implemented several "enhancements" to its claims review process.

[1] *See* St. Louis Public Radio, *Anthem Ask Missourians to Think Twice Before Going to the Emergency Room* (July 10, 2017) (news.stlpublicradio.org/post/anthem-asks-missourians-think-twice-going-emergency-room#stream/0).

These findings indicate Anthem may have pursued an overly restrictive initial approach to reviewing ER claims and may have failed to equip employees with the proper training to apply company policies correctly. Because Anthem failed to provide more detailed and extensive information regarding denial and appeal rates, as well as assessments of reviewers and claims cases, it is difficult to assess whether changes made by the company have fully addressed these issues.

BACKGROUND

In recent years, Anthem has implemented a policy to deny reimbursement for claims for emergency room (ER) services related to conditions it later deems non-emergent. In August 2015, Anthem implemented a policy within its commercial market in Kentucky "to not cover non-emergency care provided in the E.R."[2] In May 2017, Anthem notified policyholders in Missouri that as of June 1, 2017, the company's "avoidable" ER policy would apply to Missouri claims.[3] Specifically, Anthem informed Missouri beneficiaries they would be "responsible for ER costs when it's NOT an emergency."[4] (In correspondence with Senator McCaskill, Anthem indicated that the initiative ultimately went into effect in Missouri in July 2017.[5]) In May 2017, the company sent similar notices to policyholders in Georgia informing them of the same policy change beginning July 1, 2017.[6]

Anthem has justified its ER initiative as an effort "to reduce the number of non-emergency conditions treated in the ER and, thereby, to avoid the increased expense of treating those conditions in the ER."[7] Anthem noted, for example, that a 2017 study found that the "cost of care for patients with the same diagnoses is nearly 10 times higher in a hospital ER compared to an urgent care clinic."[8] These additional expenses are then "spread among other [Anthem] members in the form of higher monthly premiums and/or increased cost-sharing responsibilities."[9] Despite efforts by Anthem to educate the public

[2] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[3] Notice from Anthem to Enrollees in Missouri (May 11, 2017) (mediad.publicbroadcasting.net/p/kwmu/files/mo_er_member_letter_2017.pdf).

[4] Notice from Anthem to Enrollees in Missouri (May 11, 2017) (mediad.publicbroadcasting.net/p/kwmu/files/mo_er_member_letter_2017.pdf).

[5] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[6] Atlanta Journal-Constitution, *Blue Cross in Georgia to Limit Emergency Room Coverage* (May 2017) (politics.myajc.com/news/state--regional-govt--politics/blue-cross-georgia-limit-emergency-room-coverage/NSEXCZihiFwNzw1GdNnc1M/).

[7] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[8] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

[9] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

regarding this economic impact, according to the company, ER visits in Missouri "are up 20 percent since 2014 and a large percentage of those visits were for non-emergency ailments like itchy eyes from seasonal allergies, treatment for ingrown toenails, and suture removal."[10]

Estimates by experts of the percentage of "avoidable" ER visits vary greatly. A study published in the *International Journal for Quality in Health Care* in October 2017, for example, found that just 3.3% of ER visits were avoidable.[11] By comparison, a 2013 Truven Health Study analyzed ER visits of individuals with private insurance and found that 66% of these visits were for care that did not require treatment in the ER.[12] Another study in *JAMA* found that only 6.3% of ER visits "were determined to have a primary care-treatable diagnosis."[13] At the same time, however, "the chief complaints reported for these ED [emergency department] visits with 'primary care-treatable' ED discharge diagnoses were the same chief complaints reported for 88.7%...of all ED visits."[14] Moreover, if providers "were to redirect patients away from the ED based on 'nonemergency complaints,' 93% of the redirected visits would *not* have 'primary care treatable diagnoses.'"[15]

The authors of the *JAMA* study concluded that these results indicated the need for provider review and evaluation that extends beyond a review of symptoms and complaints.[16] They further noted "the flaws of a conceptual framework that fails to distinguish between information available at arrival in the ED and information available at discharge from the ED."[17] Similarly, the authors of the *International Journal for Quality in Health Care* study highlighted the difficulty of "defining what is 'non-urgent,' 'unnecessary,' or inappropriate'" due to "the lack of consensus for a standard definition of a non-urgent visit."[18]

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[10] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

[11] Renee Hsia and Matthew Niedzwiecki, *Avoidable Emergency Department Visits: a Starting Point*, International Journal of Quality in Health Care (Oct. 1, 2017).

[12] Truven Health Analytics, *Avoidable Emergency Department Usage Analysis* (2013).

[13] Maria C. Raven, et. al., *Comparison of Presenting Complaints vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits,* JAMA (Mar. 20, 2013).

[14] Maria C. Raven, et. al., *Comparison of Presenting Complaints vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits,* JAMA (Mar. 20, 2013).

[15] Maria C. Raven, et. al., *Comparison of Presenting Complaints vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits,* JAMA (Mar. 20, 2013) (emphasis in original).

[16] Maria C. Raven, et. al., *Comparison of Presenting Complaints vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits,* JAMA (Mar. 20, 2013).

[17] Maria C. Raven, et. al., *Comparison of Presenting Complaints vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits,* JAMA (Mar. 20, 2013).

[18] *See* HealthIT Analytics, *How Many Emergency Department Visits are Really Avoidable* (Sept. 2017) (healthitanalytics.com/news/how-many-emergency-department-visits-are-really-avoidable).

Providers have expressed similar concerns about the expansion of Anthem's ER policy. In June 2017, the American Medical Association (AMA) asked Anthem to "rescind this policy in states where it has taken effect, and halt implementation in all other states."[19] The AMA expressed concern that "with this policy, Anthem is asking that patients act as highly trained diagnosticians.... The impact of this policy is that very ill and vulnerable patients will not seek needed emergency medical care while, bluntly, their conditions worsen or they die." Dr. Paul Kivela, President of the American College of Emergency Physicians, also noted that "Anthem is risking patients' live by forcing them to second guess their medical symptoms before they go to the ER."[20] In addition, several hospital groups, including the American Hospital Association, America's Essential Hospitals, the Federation of American Hospitals, and the Association of American Medical Colleges, expressed the similar sentiment in March 2018 that "Anthem's policy puts the patient in the position of knowing their diagnosis before seeking care."[21]

These hospital associations also worried that "Anthem's retroactive determination of coverage for emergency services is both dangerous and out of compliance with the 'prudent layperson' standard."[22] This standard defines an emergency medical condition as one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[23] In 1997, Congress established this standard in Medicare and Medicaid managed care plans, and the Affordable Care Act later extended the same standard to group and individual plans that cover emergency services.[24] As outlined in their March 2018 letter, the hospital groups expressed the concern that the retroactive

[19] Letter from the American Medical Association to Joseph R. Swedish, Chairman, President, and Chief Executive Officer, Anthem, Inc. (June 29, 2017) (www.mag.org/georgia/UploadedFiles/AMA-Letter-BCBS-ER-Policy.PDF).

[20] American College of Emergency Physicians, *Emergency Physicians Expose Anthem's Harmful Emergency Care Policy with New Video* (Jan. 17, 2018) (newsroom.acep.org/2018-01-17-Emergency-Physicians-Expose-Anthems-Harmful-Emergency-Care-Policy-With-New-Video).

[21] Letter from America's Hospitals and Health Systems to Craig Samitt, M.D., Executive Vice President and Chief Clinical Officer, Anthem, Inc. (Mar. 5, 2018) (www.aha.org/system/files/2018-03/180305-let-anthem-retract-ed-coverage-changes.pdf).

[22] Letter from America's Hospitals and Health Systems to Craig Samitt, M.D., Executive Vice President and Chief Clinical Officer, Anthem, Inc. (Mar. 5, 2018) (www.aha.org/system/files/2018-03/180305-let-anthem-retract-ed-coverage-changes.pdf).

[23] 42 C.F.R. § 438.114.

[24] P.L. 105-33; P.L. 11-148.

nature of Anthem's ER claims review process does not properly consider the assessment a prudent layperson would make prior to seeking care.[25]

In response to the concerns described above, Senator McCaskill wrote to Anthem CEO Joseph R. Swedish on December 20, 2017, requesting information on ER reimbursement policies and how the company complies with the prudent layperson standard in Missouri, Kentucky, and Georgia.[26] Among other items, the letter requested Anthem presentations, internal communications, and other documents related to emergency room care utilization and potential cost savings resulting from new company policies.[27] Senator McCaskill also requested a description of the process by which Anthem has denied reimbursements for emergency room claims, "including identification of questionable costs and dispute resolution."[28] Between January 2018 and June 2018, Anthem produced a limited set of documents and information in response to these requests.[29]

Anthem declined, however, to provide information that could have enabled a more detailed analysis of its ER initiative. The company, for example, did not produce the list of diagnosis codes it uses to filter ER claims for further review, which might have allowed for a deeper understanding of potential impacts on Anthem beneficiaries. The company also failed to provide information from assessments of Anthem medical directors and their ER claims cases, making it difficult to determine the extent to which inadequate reviewer understanding of ER policies and guidelines led to overturned claims decisions. (Overall data on claims denied in error and associated diagnosis codes, which Anthem also failed to provide, could have aided in this analysis as well.) And Anthem did not provide the number of decisions it has reversed since undertaking the re-review of past claims it announced in February 2018; information on reversals to date might have indicated how many Anthem beneficiaries with previously denied claims could benefit from a second review under "enhanced" procedures.

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[25] Letter from America's Hospitals and Health Systems to Craig Samitt, M.D., Executive Vice President and Chief Clinical Officer, Anthem, Inc. (Mar. 5, 2018) (www.aha.org/system/files/2018-03/180305-let-anthem-retract-ed-coverage-changes.pdf).

[26] Letter from Sen. Claire McCaskill to Joseph R. Swedish, Chairman, President, and Chief Executive Officer, Anthem, Inc. (Dec. 20, 2017).

[27] Letter from Sen. Claire McCaskill to Joseph R. Swedish, Chairman, President, and Chief Executive Officer, Anthem, Inc. (Dec. 20, 2017).

[28] Letter from Sen. Claire McCaskill to Joseph R. Swedish, Chairman, President, and Chief Executive Officer, Anthem, Inc. (Dec. 20, 2017).

[29] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018); Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018); Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Apr. 23, 2018); Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

FINDINGS

When Anthem implemented its new ER policy, it developed new procedures for reviewing ER reimbursement claims. As a way to filter certain ER claims for further review, Anthem "developed a list of diagnosis codes that often are not associated with emergency care."[30] (In correspondence with Senator McCaskill, the company stated that it "views the primary diagnosis code ER filter list to be sensitive and proprietary information," and the company declined to provide this list.[31]) If an ER claim contains one of these primary diagnosis codes, then Anthem will select the claim for review.[32]

Absent the presence of certain "must-pay events" described below, "an Anthem medical director will review all available claims information, and request medical records, to better understand the member's presenting symptom(s)."[33] The medical director will then determine whether the symptoms at issue "would have led a prudent layperson to conclude that he or she was experiencing an emergency medical condition, even if the final diagnosis turned out be a non-emergency ailment."[34] If so, Anthem will honor the claim for reimbursement; if not, Anthem will deny the claim.[35] Anthem outlined the procedures for this medical director review in a training presentation the company produced to Senator McCaskill on January 25, 2018. *See* Exhibit A.

Following the process outlined above, Anthem denied approximately 12,200 ER claims in Missouri, Kentucky, and Georgia from July 2017 through December 2017.[36] These denials represent roughly 5.8% of total ER claims submitted from these states during this period and include "roughly $1 million in claims not paid" from Missouri.[37] Notably, information Senator McCaskill received from the American College of Emergency Physicians on ER claims starting in January 2017 shows that denials of Missouri claims spiked sharply in July 2017—the beginning of the ER initiative. Data Anthem produced also shows

[30] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

[31] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Apr. 23, 2018).

[32] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[33] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018). According to Anthem, the company has assigned four physicians to perform reviews for Missouri claims; these directors report to a Senior Clinical Director, who reviews their cases for accuracy, and also complete an annual assessment of reviewers to ensure the consistent application of policies and guidelines. Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Apr. 23, 2018).

[34] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

[35] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

[36] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[37] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018); Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

that the company overturned the majority of ER claims determinations appealed by Missouri beneficiaries each month between July 2017 and November 2017, and the rate of overturned determinations increased every month to a high of 73% at the end of this period. (Data shows similar results for ER claims determinations appealed by Kentucky and Georgia beneficiaries.) Finally, ER claims denial information for January 2018 through March 2018 shows that denials dropped sharply after Anthem implemented several "enhancements" to its claims review process.

A. Anthem Denied 12,200 ER Claims in Missouri, Kentucky, and Georgia from July 2017 through December 2017

Anthem has explained in correspondence with Senator McCaskill that between July 1, 2017, and December 31, 2017, the company processed roughly 73,000 ER claims in Missouri and filtered approximately 7,500 claims for further review.[38] (As noted previously, Anthem filtered these claims based on a list of diagnosis codes the company determined were not associated with emergency care.[39] These filtered claims also failed to meet one of the "must-pay events" described below.[40]) Anthem then denied around 3,700 claims—5% of all ER claims in Missouri during the time period in question—"as not for the treatment of an emergency condition under the prudent layperson standard."[41] *See* Figure 1.

Out of approximately 51,000 Georgia claims during this same time period, Anthem filtered around 10,000 claims that did not meet a "must-pay event" for further review and ultimately denied reimbursement for around 3,500 claims—7% of all claims during the period in question.[42] In Kentucky, Anthem reviewed roughly 117,000 ER claims between July 2017 and December 2017, filtered around 13,000 claims for further review, and denied around 5,000 claims—4% of all the claims during the period in question.[43] *See* Figure 1.

[38] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018); Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[39] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

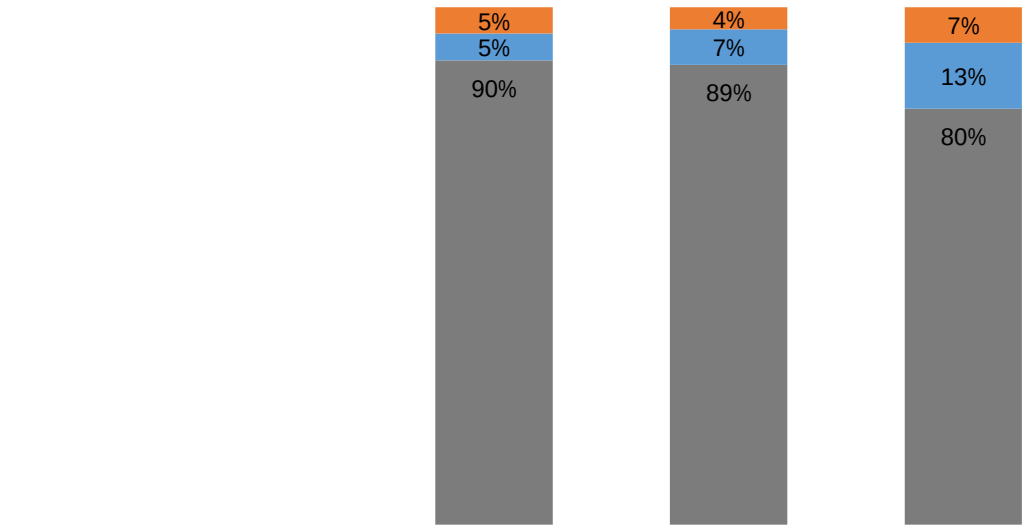
[40] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[41] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[42] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[43] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

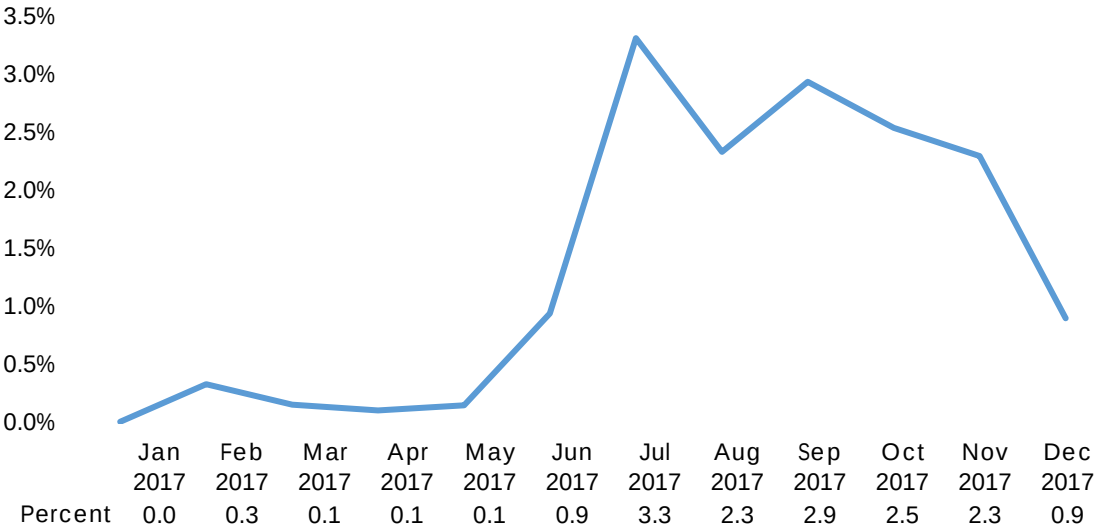
Figure 1: Anthem ER Claims Reviews for Missouri, Kentucky, and Georgia
July 2017-December 2017



	Missouri	Kentucky	Georgia
Claims Reviewed and Denied	3,700	5,000	3,500
Claims Reviewed and Approved	3,800	8,000	6,500
Claims Not Filtered for Further Review	65,500	104,000	41,000

In addition, information the American College of Emergency Physicians provided to Senator McCaskill illustrates monthly changes in Anthem denial rates for Missouri ER claims between January 2017 and December 2017. This information shows a sharp spike in denials starting in July 2017—the beginning of the ER initiative. *See* Figure 2.

Figure 2: Percentage of Denied ER Claims per Month for Missouri
January 2017-December 2017



	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Percent	0.0	0.3	0.1	0.1	0.1	0.9	3.3	2.3	2.9	2.5	2.3	0.9

Anthem previously projected that its ER initiative would identify $2.9 million per year in Missouri claims that did not meet the prudent layperson standard.[44] While Anthem has not provided the information staff would need to gauge whether the initiative met this projection, the company reported that ER claims denied in Missouri between July 2017 and December 2017 "represent roughly $1 million in claims not paid," not accounting for denials overturned on appeal (as discussed further below).[45]

B. Majority of Determinations on Appealed Missouri ER Claims Have Been Reversed

Information Anthem produced to Senator McCaskill details the number of appeals on ER claims beneficiaries submitted between July 2017 and November 2017 and the outcome of these appeals—including the percentage of claim determinations overturned on appeal.[46] According to the data, Anthem overturned more than half of appealed Missouri ER claims determinations for every month during this period, with the rate increasing almost every month from 58% in July 2017 to 73% in November 2017.[47] *See* Figure 3. In total, Anthem overturned 62% of initial claims determinations beneficiaries appealed during the five-month period.[48]

[44] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Apr. 23, 2018).

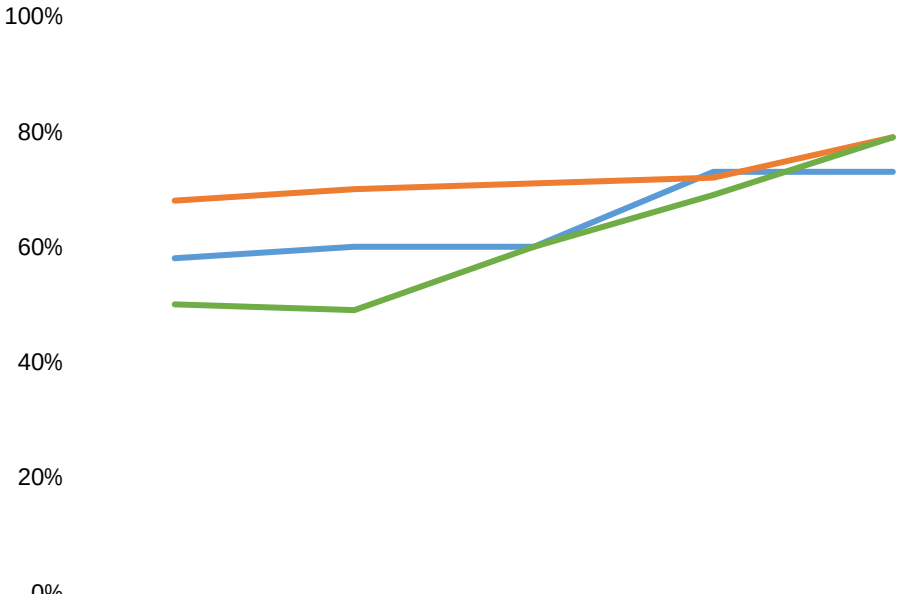
[45] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[46] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[47] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[48] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018). Anthem has noted that "[g]enerally, the time for claim submission, processing and resolution of an appeal is

Figure 3: Percentage of Appealed Claims Determinations Overturned per Month for Missouri, Kentucky, and Georgia
July 2017-November 2017



	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017
Missouri	58%	60%	60%	73%	73%
Kentucky	68%	70%	71%	72%	79%
Georgia	50%	49%	60%	69%	79%

Appeals information for Georgia and Kentucky shows that the percentage of claims determinations overturned on appeal between July 2017 and November 2017 were similar—60% and 70%, respectively.[49] In the case of Kentucky, the rate of overturned determinations increased every month during this period—from 68% in July 2017 to 79% in November 2017.[50] The rate for Georgia dipped slightly from 50% in July 2017 to 49% in August 2017 before steadily increasing to 79% in November 2017.[51]

approximately six months from the date of service." Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Apr. 23, 2018). Anthem has also stressed that the appeals data "are subject to change for various reasons, including the timing mandated by law for members to request appeals, additional timeline requirements for reviews, and in some cases, [are] contingent on health care providers…provid[ing] the Company with additional information." Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[49] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[50] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

[51] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

These statistics indicate a significant percentage of initial denials were improper—a troubling result given that Anthem places the burden of appeal on beneficiaries, and individuals without the time and resources to file an appeal may face a significant (and potentially improper) financial responsibility.

C. Changes Made by Anthem to Address Concerns

In January 2018, Anthem made a series of "enhancements" to its process for evaluating ER claims.[52] Specifically, Anthem added several conditions that would automatically trigger payment of ER claims, including situations in which the beneficiary is under the age of 15 or receives IV fluids or IV medications.[53] The current list of "must pay" conditions is as follows:

1) The member was directed to the ER by a provider;
2) The member was under the age of 15;
3) The member's home address was more than 15 miles from an urgent care center;
4) The ER visit occurred during certain weekend hours or on major holidays;
5) The member was traveling out of state;
6) The member received any kind of surgery;
7) The member received IV fluids of IV medications;
8) The member received a MRI or CT scan;
9) The ER visit was billed as urgent care; or
10) The ER visit was associated with an outpatient or inpatient admission.[54]

In addition to these changes, the company also "added several steps to [its] review, including requesting medical records prior to every review."[55] In February 2018, the company also announced that it would "review all denied ER claims dating back to the ER Initiative's inception and apply [these] enhanced procedures."[56] These new reviews may also involve requests for additional medical records from relevant ER departments.[57] *See* Exhibit B. Anthem estimates the new reviews will take several months for the company to complete.[58]

[52] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[53] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

[54] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Jan. 25, 2018).

[55] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Feb. 8, 2018).

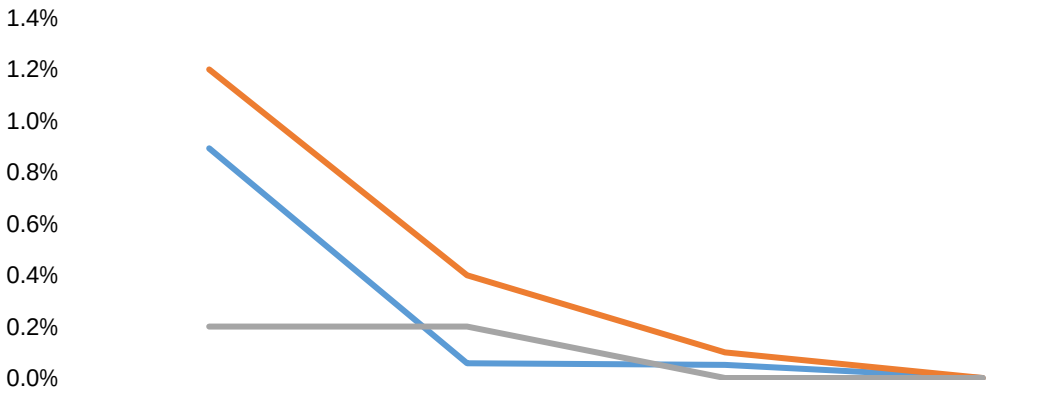
[56] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Apr. 23, 2018).

[57] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (Apr. 23, 2018).

[58] Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

The changes described above resulted in a substantial decline in claim denials beginning in January 2018. According to information Senator McCaskill has received from the American College of Emergency Physicians, the percentage of Missouri ER claims Anthem denied declined from 0.9% in December 2017 to 0.1% in January 2018 and February 2018 and 0% in March 2018. A similar decline applied to Kentucky denials, which dropped from 1.2% of ER claims in December 2017 to 0.4% in January 2018, 0.1% in February 2018, and 0% in March 2018. Georgia saw a less dramatic decline, but denied ER claims still dropped from 0.2% in December 2017 and January 2018 to 0% in February and March 2018. *See* Figure 4.

Figure 4: Percentage of Denied ER Claims per Month for Missouri, Kentucky, and Georgia
December 2017-March 2018



	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Missouri Percent	0.9	0.1	0.1	0.0
Kentucky Percent	1.2	0.4	0.1	0
Georgia Percent	0.2	0.2	0	0

Because Anthem only provided information on appeals for July 2017 through November 2017, staff cannot determine whether or how changes to ER claims review policies in January 2018 affected the volume of subsequent appeals or their outcome.[59]

[59] *See* Letter from Elizabeth P. Hall, Vice President, Federal Affairs, Anthem, Inc., to Sen. Claire McCaskill (June 8, 2018).

CONCLUSION

By implementing a policy to no longer cover emergency room services for care the company later deems non-emergent, Anthem has essentially required patients to act as medical professionals when they experience urgent medical events. Given the stakes involved—thousands of dollars in medical costs, in some cases—Anthem, at the very least, owes its beneficiaries careful consideration during the claims determination process. As discussed above, however, the company overturned 62% of appealed decisions on Missouri ER claims between July 2017 and November 2017—and the rate of decisions overturned on appeal increased almost every month in this period. Similar results applied in Georgia and Kentucky. These statistics raise the concern that Anthem employees may lack the necessary experience or training to apply ER claims policies correctly in the first instance. The fact that Anthem added "enhancements" to its policies in January 2018—resulting in a sharp decline in denials—also suggests the company pursued an overly restrictive initial approach to its review of ER claims.

In May 2018, Missouri lawmakers passed legislation requiring insurers to review medical histories of patients—using physician reviewers—before denying coverage for ER claims.[60] (An Anthem spokesperson stated in response that the company complies with these measures.[61]) As legislators in Missouri and other states consider further responses to insurer ER policies, the challenges outlined above should inform their efforts to prevent patients from unfairly bearing the costs of emergency medical services.

[60] *Consumers Would Get Protection From Surprise ER Bills Under Measure OK'd By Missouri Lawmakers*, St. Louis Post-Dispatch (May 23, 2018) (www.stltoday.com/news/local/govt-and-politics/consumers-would-get-protection-from-surprise-er-bills-under-measure/article_fd0de953-a2f8-5ce4-8b32-a6fcf46896be.html); *see also* S. 982, 99th Mo. Gen. Assembly (2018). Former Gov. Eric Greitens signed the bill on June 1, 2018. *Missouri OKs Law to Combat Anthem's Controversial ER Policy. Will it Help?*, Springfield News-Leader (June 6, 2018) (www.news-leader.com/story/news/local/ozarks/2018/06/06/missouri-approves-law-combat-anthem-controversial-er-policy/674772002/).

[61] *Consumers Would Get Protection From Surprise ER Bills Under Measure OK'd By Missouri Lawmakers*, St. Louis Post-Dispatch (May 23, 2018) (www.stltoday.com/news/local/govt-and-politics/consumers-would-get-protection-from-surprise-er-bills-under-measure/article_fd0de953-a2f8-5ce4-8b32-a6fcf46896be.html).

EXHIBIT A

Prudent Layperson ER Reviews

Understanding and appropriately implementing the Prudent Layperson ER Review process

Physician mandatory training (KY, MO, OH, IN, GA, CT, NH)

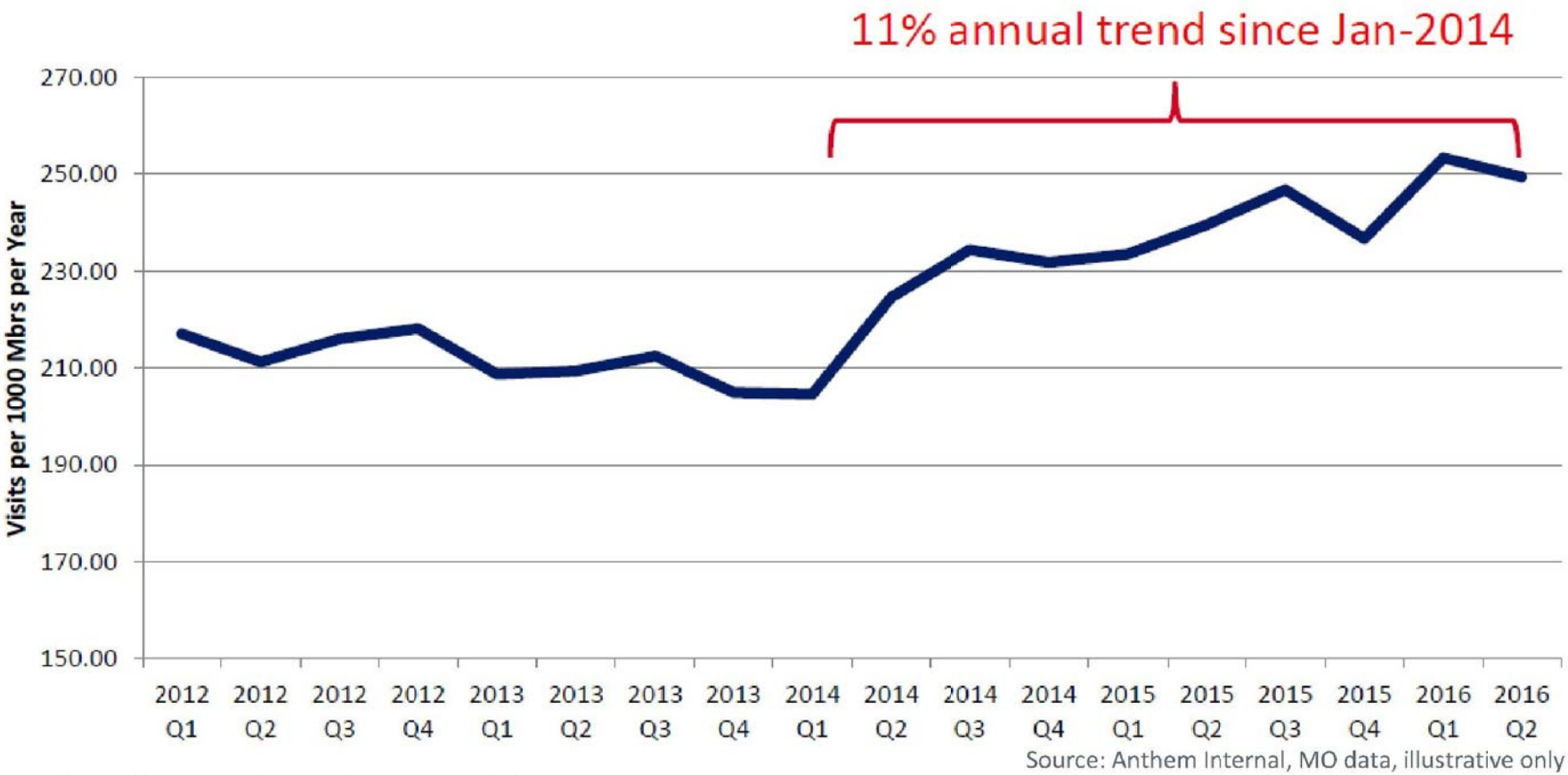
January 15, 2018

Anthem

ANTHEM COMPANY CONFIDENTIAL

Highly Confidential and Proprietary

The need for ER Reviews



Source: Anthem Internal, MO data, illustrative only

ER visit trend has increased in recent years

ER visits are costly and inefficient for non-emergency situations

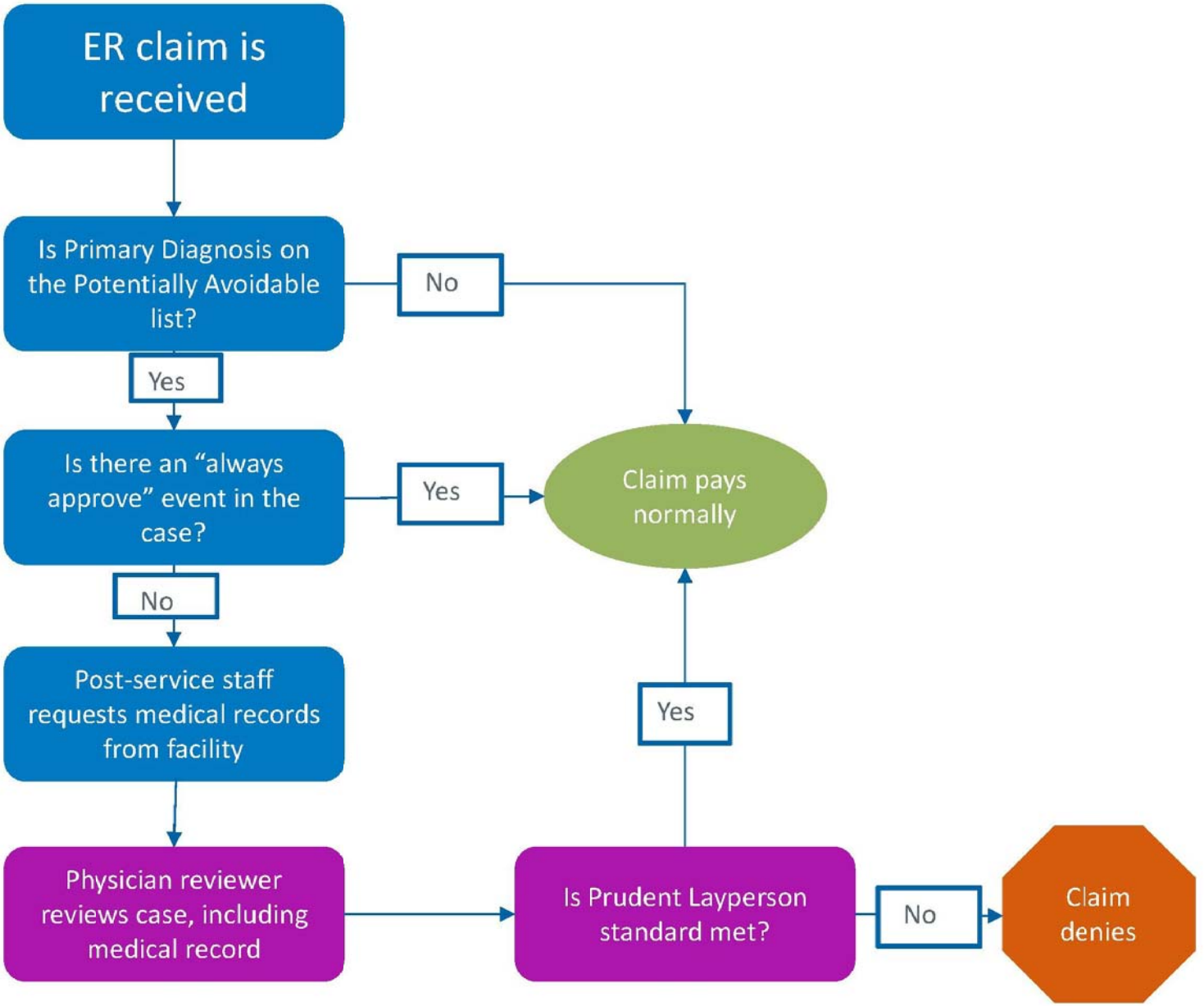
There are other settings that are more appropriate for non-emergency care

Primary care physicians should always be the first medical professional members see with any non-emergency medical concerns, with urgent care, telemedicine, retail clinics and Anthem's free 24-7 nurse lines available to assist members in after-hours situations.

Process

= non-physician reviewer step

= physician reviewer step



What are the Always Approve events?

- The post-service staff reviews for the presence of any of these factors, and if one (or more) is present, the claim will be processed normally.
- Physician reviewers should be aware of these and if a mistake has been made, alert post-service staff.
- The ten "always approve" events are:

- The member is under age 15
- The member is directed to the ER by a provider (including an ambulance)
- The member is traveling out of state
- The ER visit happened Saturday from 8 PM to Monday 8 AM, or a major holiday*
- The member's home address is >15 miles from an urgent care center
- Surgery is billed on the claim with the ER visit
- ER visit is associated with an outpatient or inpatient admission
- The member received IV fluids or medications
- Urgent care is billed on the claim with the ER visit
- MRI or CT is billed on the claim

*Holidays are New Years Day, Martin Luther King Day, Presidents day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas.)

Physicians should review based on the "Prudent Layperson" standard

- The Medical Director should review the information presented to determine if any of the following factors are present that would require approval of the case as appropriate emergency room visit that meets the prudent layperson standard:

  (a) A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

  1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
  2. Serious impairment to bodily functions, or
  3. Serious dysfunction of any bodily organ or part; or

  (b) With respect to a pregnant woman who is having contractions:

  1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery, or
  2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

- In performing the review the Medical Director should consider the following:
  - all billed diagnosis including the patient reason diagnosis;
  - presenting symptoms; and
  - the medical records submitted with the claim or submitted in response to a request for records.
- The next slide contains a quick reference guide that includes the standard above and a list of the ten "always approve" conditions

Prudent Layperson Quick Reference Guide
(Print this slide and keep it handy when doing reviews)

The ten "always-approve" conditions for the Prudent Layperson reviews are:

- Members under age 15
- Directed to ER by provider (including ambulance, nurse line, etc.)
- Member traveling out of state
- ER event happened Saturday 8pm-Monday 8am (or major holiday (New Years Day, Martin Luther King Day, Presidents day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas.)
- Closest Urgent Care from member's home is >15 miles away
- Surgery billed on the claim (revenue code ranges 0360-0369 and 0480-0481)
- ER visit associated with OP or IP admission (OBS revenue codes '0760', '0761', '0762', '0763', '0764', '0765', '0766', '0767', '0768', '0769')
- Member received IV fluids or IV medications
- Urgent care billed on claim (revenue 0456)
- MRI/CT billed on claim ('0340','0341','0342','0343','0344','0349','0350','0351','0352','0359','0610','0611','0612', '0613','0614','0615','0616','0617', '0618','0619')

An ER visit which is approvable by the "prudent layperson" standard is:
(a) a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part; or

(b) With respect to a pregnant woman who is having contractions:

1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery, or
2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Case Scenario #1

A fifty-three year old man presents to the emergency room with a four-day history of cough. The cough has not been worsening. The patient has not seen any other health care provider for this problem. The cough is slightly productive. The patient says that the cough is "driving him crazy" and he cannot get to sleep at night. He has not been running a fever. He has a history of high blood pressure and occasional heartburn. His wife has been sick with a cough for two weeks.

Would this meet prudent layperson standards?

Case Scenario #1

A fifty-three year old man presents to the emergency room with a four-day history of cough. The cough has not been worsening. The patient has not seen any other health care provider for this problem. The cough is slightly productive. The patient says that the cough is "driving him crazy" and he cannot get to sleep at night. He has not been running a fever. He has a history of high blood pressure and occasional heartburn. His wife has been sick with a cough for two weeks.

Would this meet prudent layperson standards?

No. A prudent layperson would not expect that absence of immediate medical attention would put one's health in serious jeopardy, cause serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.

Case Scenario #2

A thirty-three year old woman comes to the emergency room with back pain. The pain has been present for some time, but in the last day has become "excruciating." The patient says that standing up and walking is almost impossible. She has been some pills for back pain and would like more. She isn't sure what they are called but says they are "oxy-something." Her vital signs are normal, but she hobbles around the ER and is not able to sit down. A pregnancy test is negative.

Would this meet prudent layperson standards?

Case Scenario #2

A thirty-three year old woman comes to the emergency room with back pain. The pain has been present for some time, but in the last day has become "excruciating." The patient says that standing up and walking is almost impossible. She has been some pills for back pain and would like more. She isn't sure what they are called but says they are "oxy-something." Her vital signs are normal, but she hobbles around the ER and is not able to sit down. A pregnancy test is negative.

Would this meet prudent layperson standards?

Yes. This patient has severe pain, which meets for prudent layperson standards.

Case scenario #3

A nineteen-year old woman comes to the ER for mild to moderate pain on urination and urinary frequency. She says she has been diagnosed three times in the last six months with a UTI. She is otherwise healthy and is not pregnant. A UA is performed and shows moderate leukocytes, moderate nitrites, and trace protein, but is otherwise normal. She has no signs of pyelonephritis.

Would this meet prudent layperson standards?

Case scenario #3

A nineteen-year old woman comes to the ER for mild to moderate pain on urination and urinary frequency. She says she has been diagnosed three times in the last six months with a UTI. She is otherwise healthy and is not pregnant. A UA is performed and shows moderate leukocytes, moderate nitrites, and trace protein, but is otherwise normal. She has no signs of pyelonephritis.

Would this meet prudent layperson standards?

No. This patient does not have severe pain, nor a symptom that is severe enough that a prudent layperson would consider the patient's health to be at risk.

Case Scenario #4

A thirteen-year-old boy is brought to the ER by his mother. He has a skin rash that has developed in the last two days. It is itchy and red. Eczema is diagnosed.

Would this meet prudent layperson standards?

Case Scenario #4

A thirteen-year-old boy is brought to the ER by his mother. He has a skin rash that has developed in the last two days. It is itchy and red. Eczema is diagnosed.

Would this meet prudent layperson standards?

No, but this is a trick question. Being under the age of fifteen is an "always approve" event and the case should not be referred to a physician for review. Please keep a list of the always-approve conditions handy when performing these reviews, and if one applies, be sure and let a post-service staff person know.

If you have questions or concerns…

- Please contact your plan's Senior Clinical Officer for more details
- If you are a Senior Clinical Officer and you have questions, please contact [redacted] with questions or concerns

EXHIBIT B

Enhancements made to avoidable ER program

Anthem strives to make health care simpler, more affordable and more accessible, and one of the ways to help achieve that goal is to encourage consumers to receive care in the most appropriate setting for their health care needs. Anthem's avoidable ER program aims to reduce the trend in recent years of inappropriate use of ERs for non-emergencies. We recognize, however, that there are ways to further improve and enhance the program.

Anthem has made the decision to implement a number of enhancements to ensure that this program is implemented effectively across our participating markets. We are applying our new and enhanced procedures to previously denied claims and will overturn decisions where the new procedures would have resulted in an approval.

Specifically, we have expanded our list of "always-approve" exceptions. We will take that new list of exceptions and look back at claims that were previously denied. If one of those conditions was present, we will change the decision and pay the claim according to the terms of the benefit plan. If you have not already provided medical records, we will request them as part of our re-review of the claim denial. We will reach out to our hospital partners with details on how we will be requesting those medical records.

We are looking back at emergency room visits in Kentucky (since August 2015), Georgia (since July 2017), Missouri (since June 2017) to make certain we are using the best information to make the decision. While the program was live in Ohio and Indiana since January 1, 2018, reviews in these states have already occurred with our latest improvements and enhancements. For self-funded employers, we are offering to do the review for them.

Anthem stands by our belief that emergency rooms are an expensive place to receive routine care. The costs of treating non-emergency ailments in the ER has an impact on the cost of health care for consumers, employers and the health care system as a whole.