# HEALTH PLANS VERSUS NON-PARTICIPATING PROVIDERS

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## I. INTRODUCTION.

The courts have been busy for many years hearing disputes between health plans and non-network providers. The disputes can be categorized, generally speaking, into three areas.

A. **Recognition of Assignment of Benefits.** Plans that seek to draw bright line distinctions and incentives between non-network and network providers frequently use the refusal of assignment as a means to discourage the use of non-network providers and encourage the use of network providers. If non-network providers can mandate the acceptance of assignment, however, one of the key distinctions between non-network and network providers is eliminated.

B. **How much is a Non-Network Provider Entitled to be Paid?** Without the benefit of a rate negotiated before the service is rendered the plan and non-network provider are forced to confront what may be a striking difference in perception as to the dollar value of a service that has already been rendered.

C. **May a Non-Network Provider Balance Bill the Patient?** Often, Plans pay less than a non-network provider's billed charges. May the provider bill the patient for the difference?

These issues frequently overlap with each other. They also intersect with a number of other issues that arise in a managed care context. At the end of this outline, some of the

intersections among non-network provider disputes and other issues in managed care will be briefly addressed.

## II. HONORING AN ASSIGNMENT OF BENEFITS.

A. Most reported decisions have supported a payer's refusal to honor an assignment of benefits to a non-network provider even in the face of traditional public policy supporting the assignability of contracts. *See, e.g.,* Somerset Orthopedic Assocs. v. Horizon Blue Cross and Blue Shield, 345 N.J. Super 410, 785 A.2d 457 (N.J. Super. Ct. 2001); Parrish v Rocky Mountain Hosp. & Med. Servs. Co.. 754 P.2d 1180, (D. Colo. Ct. App. 1988); Obstetricians-Gynecologists, P.C. v. Blue Cross & Blue Shield of Neb., 219 Neb. 199, 361 N.W.2d 550 (1985); Kent General Hosp. Inc. v. Blue Cross & Blue Shield of Del., 442 A.2d 1368 (Del. 1982); Augusta Med. Complex v. Blue Cross of Kansas, 230 Kan. 361, 364 P.2d 1123 (1981); Riddle Mem'l Hosp. v. Blue Cross of Greater Philadelphia, 63 Del Co. 361 (Pa. Common Pleas 1976); Kassab v Medical Serv. Ass'n. of Pa., 39 Pa. D & C. 2d 723 (1966), aff'd 425 Pa. 630, 230 A.2d 205 (1967).

B. There is only one reported state court decision, the Arkansas Supreme Court decision of *American Med. Int'l. v Arkansas Blue Cross & Blue Shield*, 299 Ark. 514, 773 S.W. 2d 831 (1989), that prohibits a payer, as a matter of public policy, from refusing to honor an assignment of benefits.

C. For ERISA plans federal courts have, as a general rule, enforced anti-assignment clauses in ERISA health benefit plans if they are clear and unambiguous. *See* Physicians Multispecialty Group v. The Health Care Plan of Horton Homes, Inc., 371 F. 3d. 1291 (11th Cir. 2004); LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc., 298 F.3d 348 (5th Cir. July 10, 2002); City of Hope Nat'l. Med. Ctr. v. Healthplus, Inc., 156 F.3d 223 (1st Cir. 1998); Davidowitz v. Delta Dental Plan of Cal. Inc., 946 F.2d 1476 (9th Cir. 1991); St. Francis Reg'l. Med. Ctr. v. Blue Cross Blue Shield of Kansas, 49 F.3d 1460 (10th Cir. 1995); Lutheran Med. Cntr. Of Omaha v. Contractors, Laborers, Teamsters & Eng'rs Health & Welfare Plan, 25 F.3d 616 (8th. Cir. 1994); De Bartolo v Blue Cross and Blue Shield of Illinois, 2001 WL 1403012, 2001 U.S. Dist. LEXIS 18363 (N.D. Ill. 2001); Neurological Resources v. Anthem Ins. Cos., 61 F.Supp.2d 840 (S.D.Ind.1999); Parkside Lutheran Hosp. v. R.J. Zeltner & Assocs., 788 F.Supp. 1002 (N.D. Ill. 1992); Washington Hosp. Ctr. Corp v. Group Hosp. and Med. Servs. Inc., 758 F. Supp. 750, (D.D.C. 1991). *Contra*, Hermann Hospital v. MEBA Medical & Benefits Plan, 959 F.2d 569 at 575 (5th Cir. 1992).

D. On the other hand, a few jurisdictions have adopted statutes with the effect of overruling this judicial authority and requiring payers to accept assignment from non-network providers. There are two types of mandated

assignment statutes.

1. The first type is of general applicability to all covered services. This is present in only a few jurisdictions. *See, e.g.*, Tenn. Code Ann. §56-7-120 & Alaska Statutes 21.51.120. *See also* Ohio Revised Code § 3901.38 enforced in Fairview Provider v. Fortune, 141 Ohio App. 3d 314, 750 N.E.2d 1203 (Ohio Ct. App. Feb. 12, 2001) *appeal denied* 91 Ohio St. 3d 1529, 747 N.E.2d 253 (Ohio May 23, 2001); Louisiana Revised Statute 40.2010 *enforced in* Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana v. Rapides Healthcare System, 461 F.3d 529 (5th Cir. 2006), & Texas Insurance Code Article 21-24-1 *enforced in* Toranto v. Blue Cross and Blue Shield of Texas, 993 S.W.2d 648, (Tex. 1999).

    a. Some of the HMO class action settlements mandated that the payer accept assignment. *See* Sections 7.15 of the Aetna settlement of May 21, 2003, the CIGNA settlement of September 4, 2003, and the Humana settlement of October 17, 2005. Interestingly, this section is not part of the WellPoint settlement of July 11. 2005. www.hmosettlements.com.

    b. The UCC may offer some fertile ground for litigation in the future. Section 9-406 seeks to preserve and protect the general rule in favor of the assignability of debts, but Section 9-406(i) makes Section 9-406 inapplicable to "health care insurance receivables." In some states, however, health care service plans are not deemed to constitute insurance. *See, e.g.*, Cal. Health & Safety Code § 1343(e)(1). In such states, could providers assert the primacy of Section 9-406 to mandate plans to honor assignment of benefits? See also Section 9-408, which protects assignment for the purposes of creating secured debt in financing transactions.

E. The second type is more common. It concerns emergency medicine services where health plans are required to pay providers directly for emergency services irrespective of whether the provider is a network provider. *See e.g.*, 42 C.F.R. § 422.113. *See also* 8 Fla. Stat. 641.513; Cal. Health & Safety Code § 1371.4 & 40 Pa. Cons. Stat. Ann. § 991.2116. The California Department of Managed Health Care has taken the position that the state's HMO law mandates that payers reimburse providers directly for emergency services. This is consistent with a Court of Appeals decision Bell v. Blue Cross of California, 131 Cal. App. 4th 211 (2005). In a Consent Agreement filed on August 4, 2006 between the DMHC and Blue Shield of California, the DMHC noted that the statutory

duty on the part of plans to pay for emergency services, whether or not the providers are contracted, required that plans pay the providers directly. Under the Consent Agreement Blue Shield agreed to pay providers for emergency services rendered to enrollees without seeking to recover amounts previously paid to enrollees directly and agreed to pay an administrative penalty in the amount of $50,000. http://www.dmhc.ca.gov/library/enforcements/actions.

F. When a state law prohibiting anti-assignment clauses intersects with an anti-assignment clause in an ERISA plan, only one court has declared a resolution. In *Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana v. Rapides Healthcare System*, 461 F.3d 529 (5th Cir. 2006), the Fifth Circuit Court of Appeals ruled that ERISA does not preempt the application of the Louisiana anti-assignment statute to ERISA plans.

## III. AMOUNT OF PAYMENT.

A. Courts have frequently imposed a reasonableness concept on payment amounts. *See, e.g.,* Bell v. Blue Cross of California, 131 Cal. App. 4th 211 (2005); Anticaglia v. Lynch, 1992 W.L. 138983 (Del. Sup. 1992); Yellowitz v. J. H. Marshall & Associates, Inc.; 284 A. 2d 665, 666 (D.C. App. 1971); Nursing Care Services, Inc. v. Dobos, 380 So. 2d 516, 518 (Fla. Dist. Ct. App. 1980); Moncrief v. Hall, 63 So.2d 640, 642 (Fla. 1953); Payne v. Humana Hospital of Orange Park, 661 So.2d 1239, 1241 (Fla. Dist. Ct. App. 1995); Culverhouse v. Jackson, 194 W.E.2d 585 (Ga. App. 1972; Majid v. Stubblefield; 589 N.E.2d 1045, 1048 (Ill. App 1992); Poulson v. Foster, 93 N.W. 361 (S.D. 1940); and Miracle v. Barker, 136 P.2d 678, 683-4 (Wyo. 1943).

1. For example, it has been held that a plan cannot unilaterally pay a non-network provider the same amount as the non-network provider used to accept when it was a network provider. *See* River Park Hosp. Inc. v. BlueCross BlueShield of Tenn., 173 S.W. 3d 43 (Tenn. Ct. App. 2002) & Temple University Hosp. v. Healthcare Management Alternatives, Inc., 832 A.2d 501 (Pa. Super. Ct. 2003).

2. Courts have also criticized plans that base reimbursement on Medicare or Medicaid rates. *See* Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, 135 Cal. App. 4th 1155 (2006).

B. Conversely, the provider is not entitled to recover whatever charge the provider chooses to bill. *See* Victory Memorial Hospital v. Rice, 483 N.E.2d 117, 119 (Ill. App. 1986) & Greenfield v. Manor Care, Inc., 705 So.2d 926, 930-31 (Fla. Dist. Ct. App. 1997).

1. This is true even in the face of admission agreements signed by patients to pay the hospitals full billed charges. *See* Doe v. HCA Health Services of Tennessee, 46 S.W.3d 191 (Tenn. 2001) & Payne v. Humana Hospital Orange Park, 661 So. 2d 1239 (Fla. App. 1995).

2. The legal theory of *quantum meruit*, generally speaking, measures the claim for damages by the value to the defendant rather than the prevailing market rates or overhead costs of the plaintiff. *See* Temple University Hosp. v. Healthcare Management Alternatives, Inc., 832 A.2d 501 (Pa. Super. Ct. 2003).

C. While establishing reasonableness as a benchmark, the cases offer little guidance on how to measure reasonableness. In this vacuum, legislators and regulators have occasionally attempted to define "reasonableness."

1. One reported case concluded that reasonableness was to be determined by what the provider was customarily paid, not what the provider customarily billed, for the service. *See* Temple University Hosp. v. Healthcare Management Alternatives, Inc., 832 A.2d 501 (Pa. Super. Ct. 2003).

2. Oklahoma Heath plans that pay less than the out-of-network provider's billed charges are required to provide, upon request of the provider and the payment of a reasonable fee, a written statement describing the plan's rationale and documentation of sources used to calculate the fee paid. *See* Oklahoma Stat. Ann. tit. 36 §6571C.

3. In Colorado, plans must pay non-network providers the lesser of billed charges, the average participating provider rate, or the UCR rate; further, the UCR rate must be established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices. *See* Colorado Rev. Stat. §10-16-704.

4. New York Medicaid program requires plans to pay a triage fee of $40 to non-network providers even if the triage determines that the condition was not an emergency. *See* N.Y. Medicaid Managed Care and Family Health Plus Model Contract, Schedule G.

5. Medicare Advantage plans are entitled to require non-network providers who are Medicare providers to accept payment at traditional Medicare rates. *See* 42 U.S.C. §1395w-22(k) & 42 C.F.R § 422.214.

6. The Deficit Reduction Act of 2005 mandated that effective January 1, 2007, non-participating providers that provide emergency

services to Medicaid beneficiaries are entitled to receive the state Medicaid rate less direct and indirect graduate medical education costs. *See* 42 U.S.C. §1396u-2(b)(2).

7. Florida provides that emergency services shall be paid at the lesser of the provider's actual charges, the UCR rate for the community, or as the provider and plan may agree. *See* Fla. Stat 641.513(5). In Adventis Health System/Sunbelt, Inc. v. Blue Cross and Blue Shield , No. 5D05-1735 (July 21. 2006), the court gave emergency room physicians a private right of action to enforce this statute.

8. Utah requires health plans to pay non-network providers at least 75% of the participating provider rate. *See* Utah Code Ann. §31-A-22-617(2)(b).

9. Maryland requires HMOs to pay non-network providers the greater of 125% of the HMO's participating provider rate (140% for trauma physicians) or the amount paid by the HMO to non-network providers on January 1, 2000 (200% for trauma physicians). *See* Md. Code Ann. Health-Gen. §19-710.1(b).

10. Under California regulations, out-of-network providers providing emergency care must be paid the "reasonable and customary value" of their services based upon statistically credible information that is updated at least annually and takes into consideration: (1) the providers' training, qualifications, and length of time in practice; (2) the nature of the services provided; (3) the fees usually charged by the provider; (4) prevailing provider rates charged in the general geographic area in which the services were rendered; (5) other aspects of the economics of the medical provider's practice that are relevant; and (6) any unusual circumstances in the case. *See* California Regulations §1300.71(a)(3)(B). *See also* Compliance Statement of the Payment of Non-Contracted Provider Claims Under Rule 1300.71 (September 2, 2005). The court in Bell v. Blue Cross of California, 131 Cal. App. 4th 211 (2005), noted that these factors were to be considered in a *quantum meruit* analysis, but were not dispositive. *Id.* at 216.

## IV. Balance Billing.

A. Sometimes non-network providers are explicitly permitted to balance bill.

1. The WellPoint, Humana, and 2003 CIGNA settlements in the HMO class action litigation allow non-participating providers who accept assignment to balance bill. *See* Sections 7.29(q) of the WellPoint settlement of July 11, 2005 and the Humana settlement

of October 17, 2005. *See also* Section 7.21(b) of the CIGNA settlement of September 4, 2003. www.hmosettlements.com. Section 7.29(q) of the 2003 CIGNA HMO class action settlement proclaims that an assignment of benefits "does not create an implied contract between the Non-Participating Physician and CIGNA HealthCare…." Yet oddly, the settlement then proceeds to define in great detail what the legal relationship between provider and payer will be, including the principle that non-participating providers who accept assignment bind themselves to the provider obligations set forth in the "Business Practice Initiatives" of the settlements. To reconcile what the settlement says versus what it does, it could be concluded that the exhortation of Section 7.29(q) to the effect there is no implied contract is primarily intended to preserve the non-participating provider's ability to balance bill even when they accept assignment. Iterations of 7.29(p) and (q) in other HMO settlement agreements omit the language denying the existence of an implied contract while preserving the principle that non-participating providers who accept assignment bind themselves to the provider obligations set forth in the "Business Practice Initiatives" of the settlements. *See* Section 7.29(o) of the WellPoint settlement of July 11, 2005 and the Humana settlement of October 17, 2005 and Section 7.29(p) of the Aetna settlement of May 21, 2003. www.hmosettlements.com

2. A California appellate court, ignoring the Governor's and the Department of Managed Health Care's policies to the contrary, ruled that while plans were obligated to pay emergency room physicians a reasonable fee, the physicians could still balance bill the patient. *See* Prospect Medical Group v Northridge Emergency Medical Group, 136 Cal. App. 4th 1155 (2006). This case is currently being reviewed by the California Supreme Court.

B. As a general rule, however, non-network providers do not need a statute authorizing them to balance bill. In the absence of legislation, payers can rarely preclude an out-of-network provider from balance billing a beneficiary. *See, e.g.*, Texas Attorney General Opinion GA-0040 March 17, 2003.

C. This has led some jurisdictions to outlaw balance billing by out-of-network providers.

1. Particularly when the government asserts a paternalistic interest in protecting patients who are victims of accidents or sudden injuries that require emergency care. *See, e.g.*, New York Ins. Law §3221(i)(15) ("Ambulance Mandate"). On July 25, 2006, California Governor Arnold Schwartzenegger issued an Executive Order (Executive Order S-13-06) directing the DMHC to take all

steps necessary to protect Californians from balance billing. http://gov.ca.gov/index.php?/press-release/2613. Again, the Prospect case took the opposing view and the matter is currently before the California Supreme Court.

2. Other jurisdictions have extended their paternalism beyond the emergency context to include all beneficiaries. For example, Florida law states that no HMO enrollee is liable to any provider for services covered by the HMO policy. *See* Fla. Stat. 641.315. This is also true in Maryland. *See* Md. Code Health-Gen. §19-701(p)(i).

3. The traditional Medicare program imposes a 15% cap on balance billing by "non-participating" physicians, a cap that Medicare imposes by virtue of the fact that even "non-participating" physicians must seek and be awarded Medicare certifications (also known as "provider numbers"). Only by agreeing to leave the Medicare program entirely for a two year period through so-called "private contracts," in which the patients themselves must agree not to seek reimbursement from Medicare, could a physician be free to balance bill without restriction. *See* 42. U.S.C. §1395(a)(b). Even then, at least one state requires physicians, as a condition of the states' grant of a medical license, to accept Medicare assignment for low income persons. *See, e.g.*, Conn. Gen. Stat. Chapter 319jj, Section 17b-552.

4. Under Medicare managed care, any Medicare participating provider, as a condition of their participating provider status, must accept payment from a Medicare Advantage plan as payment in full even though they are non-participating providers with respect to that Medicare Advantage plan. *See* 42 U.S.C. §1395cc(a)(1)(O); 42 C.F.R. §422.214

D. These conflicting ideas suggest two methods to shape the *ad hoc* contractual relationship arising by operation of law between a payer and non-network provider when a health insurance benefit is assigned.

1. The first is by forging the benefit plan document to condition the acceptance of assignment on certain terms set forth in the plan. If a payer may refuse to honor an assignment of benefits to a non-network provider, payers ought to be able to condition the honor of an assignment of benefits to a non-network provider upon the non-network provider accepting a certain fee schedule and promising not to balance bill the patient. This would be reflected in the language of the benefit plan or coverage agreement and is similar to the principle stated in some of the HMO class action settlements in which non-participating providers who accept assignment bind

themselves to the provider obligations set forth in the "Business Practice Initiatives" of the settlements. *See* Sections 7.29(o) of the WellPoint settlement of July 11. 2005 and the Humana settlement of October 17, 2005 and Section 7.29(p) of the Aetna settlement of May 21, 2003. www.hmosettlements.com Nonetheless, the WellPoint and Humana settlements allow balance billing by non-participating providers that accept assignment. *See* Section 7.29(q) of the WellPoint and Humana settlements. Whether the fee schedule is imposed by the payer or by a governmental agency is unimportant. The issue is not who imposes the fees, but that some fee schedule is imposed on the temporary contractual relationship between payer and non-network provider.

2. The second method to shape the *ad hoc* contractual relationship arising by operation of law between payer and non-network provider is to do so by statute. Texas, for example, mandates an assignment of benefits, but the same statute also imposes upon providers accepting assignment to not waive cost-sharing amounts and to forego balance billing. *See* Texas Insurance Code §1204.051 *et.seq*.

3. It would not be a great step in principle to also impose a fee schedule on both provider and payer as several states have chosen to do. Such a statute or regulation would have two mandates. The first would be that payers must accept assignment from non-network providers. The second would be that while non-network providers could refuse assignment of benefits, if the provider accepts assignment, the provider must accept a fee schedule, bill all applicable cost-sharing amounts, and forego balance billing. Under this method, the temporary relationship is established by law.

## V. INTERSECTIONS WITH OTHER MANAGED CARE TOPICS

A. **Concierge Medicine**. Patient and providers may, by contract, "opt-out" of the patient's health insurance plan altogether where assignment of benefits, the amount of payment, and balance billing prohibitions are superseded by a private contractual agreement between provider and patient.

B. **Charity Care and Discount Policies**. Even in a state where the government has not intervened to establish prices for non-network providers, for certain low income patients, another form of governmental intervention may establish prices.

C. **Silent PPOs**. In a world of national and regional network brokers and multi-state health plans, it is not always clear when a provider is a network

or non-network provider.

D. **Transparency**. As non-network providers seek to understand and challenge the reasonableness of plan payments, the demand for plans to publicly release adjudication and payment methodologies increases.

E. **Repatriation**. Does state law protect a plan's ability to manage the care of enrollees who receive emergency care at an out-of-network facility?

F. **Pay Twice.** If an intermediary accepts payment from a plan and becomes insolvent, can the non-network provider force the plan to pay twice?

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