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CMS Announces Region Designations for the New Medicare Prescription Drug Benefit and for the Revamped Medicare Advantage Program

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On December 6, 2004, the United States Department of Health and Human Services (DHHS), in a significant step toward implementing the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA or Act), announced that its Centers for Medicare and Medicaid Services (CMS) had established 26 separate regions in which the new Medicare Advantage Regional Preferred Provider Organization plans (MA Regional Plans) will be offered and 34 separate regions in which the new Medicare Prescription Drug Plans (PDPs, together Plans) will be offered.¹ The designations are the result of a lengthy process that included varied sophisticated statistical analyses; input from health plans, beneficiary, and other consumer groups; public meetings; and written comments. CMS acknowledges that these configurations will be a significant factor in the success or failure of these new programs and hence the MMA.² Did CMS get it "just right," or, will the designations work to discourage private, risk-bearing entities from offering Plans?

I. Background

Congress enacted the MMA on December 8, 2003.³ The Act made a number of significant changes to the Medicare Program. Among them, Title I of the MMA expands the Medicare Program with the creation of a new prescription drug benefit to be offered through the regional PDPs beginning January 1, 2006.⁴ This has been the most popularly publicized aspect of the MMA. Equally important to the managed care industry, however, Title II of the MMA makes changes to the Medicare+Choice (M+C) program under Medicare Part C, which the MMA renames as the Medicare Advantage program. Existing M+C plans are now known as Medicare Advantage Local Plans (MA Local Plans). In addition, Title II provides for the establishment of the new MA Regional Plans, also beginning January 1, 2006.⁵

Many consider the local plan structure under M+C to be a failure. The plan offerings were confusing, due to multiple and often subtle variations in benefits and cost sharing that made it difficult for an elderly and often impaired population to make educated plan choices.⁶ Low reimbursement rates caused many plans to decrease benefits while raising beneficiary cost-sharing amounts.⁷ There was high provider turnover, making it difficult for beneficiaries to maintain continuity of care.⁸ The program was

plagued with plan withdrawals that left a weird patchwork of largely county-based coverage in profitable areas.⁹

Recent increases in fees paid to managed care plans that were implemented as part of the MMA have allowed the MA Local Plans to reduce premiums and co-payments and to reinstate or expand benefits, and some plans are even expanding their coverage.¹⁰ Congress nevertheless remained concerned with the low number of beneficiaries selecting private managed care and the continuing gaps in the availability of managed care to beneficiaries, particularly in rural areas that, historically, have had a very low level of managed care penetration.¹¹ In order to expand the role of private health plans in the Medicare program, and thereby to increase the number of beneficiaries enrolled in private plans, and, in particular, to insure that all 42 million Medicare beneficiaries have access to PDPs, Congress decided to establish a regional managed care system.

To implement the new Plans, Congress required that CMS define appropriate regions for both PDPs and MA Regional Plans. In so doing, it identified certain criteria that CMS should consider in creating the regions. These criteria ostensibly further the underlying goals of a regional system, that is, to increase

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—from a declaration of the American Bar Association

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both private plan and beneficiary participation. In further support of its regional paradigm, Congress imposed a moratorium on the approval of new MA Local Plans during 2006 and 2007, i.e., the first two years in which MA Regional Plans may be offered.¹²

The legislation requires that there be no fewer than 10 regions and no more than 50 regions for both types of Plan.¹³ The service area for a Plan must be an entire region and Plan premiums must be uniform throughout the region. The MA Regional Plan designations must “maximize the availability of MA Regional Plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.”¹⁴ The PDP regions must be the same as the MA regions, but may differ if the Secretary of DHHS determines that the establishment of different regions would improve beneficiary access to PDPs.¹⁵

In addition to the legislation itself, the Senate-House Conference Agreement that reconciled the House and Senate versions of the legislation imposes additional requirements for MA Regional Plans. To the extent possible, each region should include at least one state and should not divide states into separate regions. Multi-state Metropolitan Statistical Areas (MSAs) should be included within a single region.¹⁶ Finally, both the legislation and the Conference Report require that the Secretary “conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.”¹⁷

To encourage private entities to offer PDPs and MA Regional Plans, the MMA offers a number of incentives to Plan sponsors. These include: premium “rebates” that must be used to add benefits or reduce premiums; creation of a \$10 billion stabilization fund, payments from which may be made to managed care entities to encourage market entry; the ability to offer a limited risk PDP in a region that does not have at least two full-risk PDPs; and, wide latitude in structuring prescription drug formularies.¹⁸ It is anticipated that these and other incentives will work together with the region designations and the requirements for region-wide coverage to address the main failings that plagued the old M+C structure.¹⁹

II. Establishing the Regions

CMS and the consultant it retained to assist with the required market analysis, RTI International, admitted early on in the process that they could not meet all of the legislative and Conference Agreement criteria simultaneously. For example, keeping all multi-state MSAs within a single region would have required formation of fewer than the legislated minimum of 10 regions.²⁰ CMS also was acutely aware of the many market factors that could impact individual managed care supplier response.²¹ CMS therefore developed a number of analytical criteria for assessing the possible region configurations that it believed would serve the primary goal of maximizing access to Plans while optimizing compliance with the legislative and Conference Agreement criteria.

For the MA Regional Plans, CMS developed four analytical criteria:

- *Eligible Population Size.* CMS sought regions with eligible beneficiary populations large enough to ensure plan viability, but not so large that the Plans would have difficulty enrolling beneficiaries or administering the Plan and providing services. Based on a number of factors, CMS determined the theoretical minimum viable population to be 200,000 and the maximum viable population to be 3,000,000.
- *Multiple Potential Plan Entrants.* CMS sought to define regions with a sufficient number of existing plans so that an adequate number of entrants into the MA Regional Plan Market reasonably could be assumed.
- *Limited Variation in Health Plan Costs.* CMS recognized that establishing payments for providing quality service to all areas within a region might be more difficult if there is a high variation in healthcare costs within a region. CMS therefore sought to minimize the differences in average state payments within a region and did not join states with large differences in average payments.
- *Preserving Medicare Patient Flow.* An important goal was to limit disruption to the natural Medicare “patient flows,” i.e., where patients live in one state, but routinely seek treatment in another state.

For the PDPs, CMS developed three analytical criteria:

- *Eligible Population and Capacity.* As with the MA Regional

Plans, CMS sought to define PDP regions with a sufficient number of potential enrollees to assure PDP viability, but not so many that the a Plan would have difficulty enrolling beneficiaries and providing services. CMS determined the appropriate population range to be between 400,000 and 3,000,000 potential enrollees.

- *Beneficiary Considerations.* CMS’s goal was to make the PDP regions fit within the MA regions as closely as possible so that the regions would be as transparent to beneficiaries as possible. Presumably, this goal was designed to decrease the potential for confusion among beneficiaries.
- *Limited Variation in Prescription Drug Spending.* CMS looked at state-by-state variations in prescription drug spending and sought to minimize the variation in average state prescription drug spending within a region.

From the beginning, stakeholders were split on the question of the number of regions, with CMS and some commercial PPO providers favoring a fewer number of multi-state regions and others, notably the Blue Cross Blue Shield Association, favoring 50 state-based regions.²² Support for 50 state-based regions focused on:

- States as a common current boundary for commercial PPOs.
- Many existing provider networks are state-based.
- Differences among states in terms of licensure, capital, trademark, and other requirements would make multi-state

regions difficult and more costly to implement.

- Drawing smaller regions might encourage local plans to participate as regional plans.
- Network development in rural and other traditionally underserved areas would be difficult, if not impossible, in some areas.
- If these “difficult” areas were combined (under larger multi-state regions) with currently served areas, the result might be to reduce access to managed care.
- State based regions would cause the least disruption to current PPO market activity, thus lowering the costs of entry into the MA regional market.
- CMS would most likely see more MA regional plan participants.²³

Support for fewer multi-state regions focused on:

- A perception that the goal of the MA regional plans was to create something “different” from local MA plans.
- Providing improved choice of plans to traditionally underserved areas.
- Because multi-state regions could potentially offer large number of potential enrollees, this might be sufficient incentive to attract managed care to traditionally underserved areas.
- MA regions based on states would result in continued managed care participation in certain states—states with larger supply of providers, higher historic payment rates, lower risk scores. MA regions based on 50 states therefore would

do little to encourage managed care to participate in some states, such as heavily rural states, and hence continue the status quo.²⁴

CMS’s market analysis showed that both a 50-state structure and a structure with the minimum allowable number of regions failed to optimize both the Conference Agreement criteria and the CMS analytical criteria. The 50-state model created a large variation in region populations with 11 states and the District of Columbia having fewer than the estimated minimum number of beneficiaries necessary to make plans viable. At the opposite extreme, several states had close to, or more than, the maximum number of beneficiaries thought to be desirable for quick plan start-up and optimal plan administration (e.g., Florida, California, Texas, and New York).²⁵

Analysis also showed that there is little or no commercial PPO presence in eight states and Puerto Rico, while other states had unusually large numbers of commercial PPOs.²⁶ Six states had relatively little PPO market penetration, including two states (California and New York) having some of the highest beneficiary populations.²⁷ Another group of states had very small median PPO provider network sizes, which would impact the ability of existing PPOs to offer region-wide networks.²⁸ The 50-state model created a wide variation among regions in beneficiary health status and estimated payment rates, thus making some regions much more desirable than others based on the fact that PDPs and MA Regional Plans must be open to all

beneficiaries in a region, regardless of health status, and must charge the same premium to all beneficiaries within a region.²⁹ Finally, the 50-state option did not consider traditional “patient flows” across state borders.

A number of models utilizing the minimum or close to the minimum number of regions exhibited a host of different complications. All regions in these models had a sufficient minimum number of beneficiaries, but some necessarily would contain far in excess of the maximum number of beneficiaries. The variation in health status and payment rates across the regions was minimal, but the model did not address stakeholder concerns regarding multi-state regions, e.g., licensure and other regulatory matters, existing PPO services areas, and the administrative difficulties associated with providing equal benefits and quality of care to millions of potential enrollees across large geographical expanses.³⁰

A third analytical model looked at “building up” regions around “core” areas of demonstrated PPO penetration and viability. In defining these areas, CMS considered the number of commercial PPOs serving the state, the number of commercial PPOs based in the state, current PPO penetration, and existing PPO network size. It then looked at current Medicare PPO demonstration sites as a guide to determining the minimum and median values for these factors that would demonstrate adequate penetration and viability to support entrance of MA Regional Plans into the market.³¹ Using the median values, CMS selected

23 “core” states and then combined them with the non-selected states based on observed patient flows and other factors. This resulted in the creation of 24 regions, thirteen of which consisted of a single state.³²

This model produced a number of desirable results. The eligible population in every region met the minimum requirement of 200,000 and there was only one “mega region” with a population significantly in excess of the upper limit of 3,000,000.³³ In this model, states with low numbers of PPOs or low PPO penetration were combined with states that had higher scores on these criteria so that all the regions met the median criteria for viability. Finally, the variation across regions in health status and estimated monthly payments was minimal.³⁴

CMS ran a number of similar models in selecting the PDP regions. The 50-state model displayed significant variations among regions in key metrics such as eligible populations, the number of retail pharmacies per 100,000 population, the average number of prescriptions per capita (utilization rate), and the average prescription drug price per capita. This suggested that certain markets would not be viable either because they lacked sufficient numbers of eligible beneficiaries or because the risk in those states would be too high to attract market participation by private, risk-bearing PDPs.³⁵

The models using the minimum number of regions showed large populations and wide variations in the aforementioned metrics *within* the regions. This suggest-

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ed that it would be difficult for managed care companies to provide uniform coverage throughout the region for a single premium. As was the case in the MA regional analysis, the large populations also presented significant start-up and administrative hurdles that could have prevented or slowed market entry.³⁶

CMS also used a “build up” model to determine possible PDP region configurations. This model used minimum population and drug utilization rates (as a measure of risk) as the criteria for “building up” possible regions. States were combined into multi-state regions based on minimizing the variation of drug utilization, and hence risk, within the resulting region. Using a minimum population of 400,000 resulted in the “build up” of 34 PDP regions.³⁷

While it is tempting to assume that, in the end, CMS chose to follow these “build up” models in defining the regions, close comparison of the study results with the actual region designations shows this not to be the case. While the final number of regions is consistent with the “build up” model results, the regions themselves are not. With the exception of a few single state regions that are the same as those in the study results, the final regions are entirely different from those suggested by the “build up” model.

CMS did not indicate in its announcement how it settled on the final configurations. Some changes, however, suggest obvious considerations, while the reasoning behind other changes appears opaque. For instance,

in the “build up” model, California (a “core” state) was matched with Nevada, Hawaii, and Arizona to create a single MA region. In the final designations, each of these states is its own region.

Splitting off Hawaii seems to make sense, as the administrative difficulties posed by its geographic isolation likely outweigh the fact that, standing alone, Hawaii did not meet the median criteria for viability that were assumed as part of the modeling process. Similarly, combining California with Nevada and Arizona creates a vast region of fairly isolated population centers separated by large empty spaces. Ensuring uniform benefits, quality of care and premiums across such a large and disperse area legitimately might have been viewed by CMS as a greater barrier to market entry than the fact that Arizona or Nevada, standing alone, did not meet one or more of the study criteria and therefore was not identified as a “core” state.

In the end, it appears as if CMS largely gave into industry desires for state-based regions except where either traditional “patient flows” or extremely small beneficiary populations dictated combinations. The latter concern seems to underlie the combination of the Upper Midwest and Northern Plains states into a single, concurrent PDP/MA Regional Plan region containing seven states. The concern over splitting multi-state MSAs among regions seems to have fallen completely by the wayside as a criteria for developing the regions. Although CMS did not provide a final count, from the previous studies

it performed, it appears that the final designations split in excess of 30 multi-state MSAs. This is not surprising either, given that it would be impossible to preserve all multi-state MSAs and have more than ten regions.

The need to meet multiple objectives and constraints served to assure from the beginning that the end result would be borne of multiple compromises among competing and often incompatible interests and that no party would get exactly what it was hoping for in the region designations. Nevertheless, reaction to the designations has been surprisingly divergent. One commentator described the final configuration as a “shocker, . . . satisfying pretty much nobody completely,”³⁸ that “will make it difficult for . . . insurance companies to become involved.”³⁹ The same commentator predicts that, for the time being, there will be “little interest in 2006” in establishing Plans.⁴⁰ Both the Blue Cross Blue Shield Association (Blues) and America’s Health Insurance Plans (AHIP) expressed disappointment that there were not more single state regions.⁴¹

The Blues are correct that it will prove difficult for plans to build up multi-state capabilities without entering into joint ventures with companies across state lines. This type of business arrangement, whatever its ultimate structure, presents a number of complex business, regulatory, organizational, and fraud and abuse issues. No one previously had put together a joint venture or other business arrangement for this specific purpose and it is unclear what such a venture would look like

or whether it can be made viable both organizationally and financially. It is difficult, however, to understand some of the more biting criticism.

Of the 34 PDP regions, 25 are single states. Six more regions consist of only two adjacent states that have historic, strong “patient flow” connectivity. Only three regions encompass more than two states. Of the 26 MA Regional Plan regions, 11 consist of a single state and another 11 consist of only two adjacent states. It would appear that the “50-state” supporters got a fair amount with which to start working; so, it would seem that their “interest” in establishing plans, at least in the single-state regions and some of the closely connected two-state regions, should be no less than if all 50 states were their own region.⁴² Moreover, it would be unreasonable to expect Plans to pop up in all regions over night. There would seem to be ample time to work out the details of joint ventures or other business arrangements necessary to accommodate multi-state regions, assuming the financial fundamentals make sense.

Not surprisingly, DHHS characterized the region designations quite differently, describing them as “another step in bringing more choices, better benefits and more savings to millions of Medicare beneficiaries.”⁴³ CMS Administrator Mark B. McClellan stated that “these regions provide us with the strongest foundation possible to get affordable and comprehensive new coverage in place quickly so seniors and people with disabilities can get the most from Medicare’s new, up-to-date ben-

efits.⁴⁴ Some private health plans seem to agree.

A senior Humana official commented that “the number and design of the regions . . . appears to maximize private plans’ ability to offer seniors the same kinds of core oriented products now offered to the under-65 market.”⁴⁵ Aetna CEO Jack Rowe said that CMS’s decision on the MA Plan Regions would “increase the number of health plans” that participate in Medicare Advantage.⁴⁶ Rowe predicted that Aetna likely would participate in multiple regions.⁴⁷

Whether these rosy predictions pan out is left to be seen. It is entirely unclear whether these region designations will correct for the challenges that led to the failure of the M+C program. Plan choices will remain extremely complicated, making it difficult for beneficiaries to give up the security and simplicity of fee-for-service Medicare.⁴⁸ It is also left to be seen whether payments to Plans will keep pace with costs and whether beneficiaries will be able to bear the built-in increases in out-of-pocket expenses, which are tied to the overall rate of increase in Medicare costs for prescription drugs. These are predicted to rise at a rate of 10% per year for the next seven years.⁴⁹ Finally, no one yet knows whether the incentives built into the MMA will be sufficient to entice managed care companies to undertake the regulatory, administrative, and business burdens of entry into the regional PPO and PDP markets.

As stated earlier, CMS recognizes that configuration of the regions will be a significant fac-

tor in the success or failure of new regional paradigm. At this point, it is for the managed care industry to determine whether CMS got it “just right.” If not, the industry and Congress might find itself with an M+C redux and with the need to go back to the drawing board to try and determine whether *any* regional configuration will make managed care work for Medicare.

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Endnotes

¹ DHHS News Release, *HHS Announces Regions to Administer New Medicare Prescription Drug Benefit and Medicare Advantage Program*, www.hhs.gov/news/press/2004pres/20041206.html (Dec. 6, 2004) (HHS Press Release).

² Pear, Robert, *U.S. Settles on Regions for Dispensing Medicare Drug Benefits*, *New York Times*, A20, column 3 (Dec. 7, 2004).

³ Pub. L. No. 108-173 (Dec. 8, 2003).

⁴ Social Security Act (SSA) § 1860D-11.

⁵ *Id.* at § 1858.

⁶ Biles, Dallek, and Nichols, *Medicare Advantage: Déjà vu All Over Again?*, *Health Affairs*, the Policy Journal of the Health Sphere, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.586/DC1>, p.2 (Dec. 15, 2004).

⁷ *See id.* at p. 4.

⁸ *See id.* at pp. 4-5.

⁹ *See id.*

¹⁰ For instance, Humana, Inc. announced that it recently received approval to market local PPO products in 14 markets, has submitted applications for approval in eight additional markets and is preparing applications for seven more markets. BNA Health Plan and Pro-vider Report, vol. 10, no. 47, p. 2 (Dec. 8, 2004).

¹¹ SSA § 1858(a)(2)(C); July 21, 2004 CMS Public Meeting materials, www.cms.hhs.gov/medicarerereform/mmaregions/All_Info_Materials.pdf (Public Meeting Materials).

¹² MMA § 221(a)(2).

¹³ SSA §§ 1858(a)(2)(C)(i), 1860D-11(a)(2)(B) (requiring that PDP regions be the same as MA regions unless different regions would improve accessibility).

¹⁴ *Id.* at § 1858(a)(2)(C).

¹⁵ *Id.* at § 1860D-11(a)(2)(B).

¹⁶ Medicare Prescription Drug, Improvement and Modernization Act of 2003, Conference Agreement, Title II.

¹⁷ *Id.*; SSA § 1858(a)(2)(D).

¹⁸ *See* SSA §§ 1854 (competition program, as amended, to include rebates and their permitted uses), 1858(e) (MA Stabilization fund), 1860D-16 (Medicare Prescription Drug Account), 1860D-11(f) (limited risk plans). The MMA requires that beneficiaries in each PDP region have access to at least two, full risk bearing PDPs. SSA § 1860D-3(a). If two such plans are not available, the Secretary may approve limited risk plans under § 1860D-11(f). SSA § 1860D-3(b).

¹⁹ 69 Fed. Reg. 30,659 (May 28, 2004).

²⁰ *See* Public Meeting Materials, Root, Mobley and West materials, p. 7.

²¹ July 21, 2004 CMS Public Meeting Notice, 69 Fed. Reg. 30,659, 30,660 (May 28, 2004).

²² *E.g.*, Medical News Today at www.medicalnewstoday.com/medical-news.php?newsid+17454 (Dec. 7, 2004) (cache).

²³ *See* Public Meeting Materials, Root, Mobley and West materials, pp. 23-25.

²⁴ *Id.* at pp. 26-27.

²⁵ *Id.*, Greenwald materials, pp. 5-6.

²⁶ *Id.* at pp. 7-8.

²⁷ *Id.* at pp. 9-10. Market penetration is defined as the number of PPO enrollees divided by the total population.

²⁸ *Id.* at pp. 11-12.

²⁹ *Id.* at pp. 15-20.

³⁰ *Id.* at pp. 22-33.

³¹ *Id.* at pp. 34-42. Specific values were (min/median): Number of PPOs serving state (17/29); Number of PPOs based in state (3/17); commercial PPO penetration rate (0.226/0.383); PPO provider network size (242/N/A).

³² *Id.* at 38.

³³ *Id.* at 40. The regions formed by California, Nevada, Arizona, and Hawaii contained 5.5 million eligible beneficiaries.

³⁴ *Id.* at 42.

³⁵ *Id.* Hoerger materials at 7-13.

³⁶ *Id.* at 14-17.

³⁷ *Id.* at 18-27.

³⁸ Medical Newswire, *New Medicare Regions Will Create Winners and Losers*, www.medicalnewswire.com/artman/publish/article_4729.shtml (Dec. 21, 2004), quoting, John Gorman, president, Gorman Health Group.

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³⁹ BNA Health Plan and Provider Report, vol. 10, no. 47, p. 2 (Dec. 8, 2004), *quoting*, John Gorman, president, Gorman Health Group.

⁴⁰ *Id.*

⁴¹ *E.g.*, BNA Health Plan and Provider Report, vol. 10, no. 47 at p. 2; Medical News Today, *Bush Administration Announces Regions for Medicare Drug Coverage*, www.medicalnewstoday.com/medicalnews.php?newsid+17454 (Dec. 7, 2004) (cache).

⁴² As for the PDP MA overlap, 14 single state PDP regions have been nested into seven two-state MA Regional Plan Regions. Two of the two-state PDP regions have been nested into the single four-state MA region. The remaining PDP two-state regions and the other multi-state PDP regions are identical to their MA Regional Plan counterpart regions.

⁴³ DHHS Press Release.

⁴⁴ *Id.*

⁴⁵ BNA Health Plan and Provider Report, vol. 10, no. 47 at p. 2.

⁴⁶ Medical News Today at www.medicalnewstoday.com/medicalnews.php?newsid+17454 (Dec. 7, 2004) (cache).

⁴⁷ *Id.*

⁴⁸ Biles, et al. at pp. 2-3.

⁴⁹ *Id.* at 3.

Upcoming Teleconference

IMPLEMENTATION OF THE PART D DRUG BENEFIT

Friday, February 18, 2005
1:00-2:30 pm Eastern

AHLA will present a teleconference discussing the newly released final regulations governing the Medicare prescription drug benefit featuring speakers who have monitored the drug benefit's development during the past year. This teleconference will describe the features of the benefit (including premium costs and subsidies, beneficiary protections and access options, eligibility and enrollment requirements, and the Medicare prescription drug discount card provisions) and will analyze some of the effects the drug benefit will have on providers, physicians, payers, manufacturers, suppliers, employers, and beneficiaries.

Presenters:

Alan S. Goldberg, JD, LLM - *Presenter and Moderator*
Goulston & Storrs PC, Washington, DC

Mark Joffe, Esquire
Law Offices of Mark S Joffe, Washington, DC

Greg Johnson
Pharmaceutical Care Management Association, Washington, DC

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UCR Reimbursement Methodology: Under Siege*

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I. Introduction

The tug-of-war between non-contracted physicians and health plans over reimbursement has reached a heightened level. As healthcare costs continue to escalate, managed healthcare plans are under pressure to “manage them.” At the same time, physicians who have not contracted with health plans complain that they are not being fairly reimbursed and are being “shaken down” by powerful managed care companies.

As of December 2002, approximately 63% of the population in California was enrolled in an insured health maintenance organization (HMO). As of the end of 2002, the four largest HMOs in California, Kaiser Permanente, Blue Cross of California, Blue Shield of California, and Health Net, held 72.9% of the HMO market.¹ Although the vast majority of providers have a written contract with these health plans for the majority of a member’s covered services, some emergency services are rendered by a physician who does not have a written contract. Submission of the billed charges to health plans by these non-contracted physicians oftentimes result in a denial of payment or reimbursement in an amount less than the billed charges. In states that permit balance billing, the unpaid balance becomes the member’s

responsibility. On the other hand, in states like California that prohibit providers from balance billing the member, the non-contracted physician is left holding the bag.² These physicians complain that they are not getting paid adequately or appropriately for the services rendered.

In an effort to address provider payment problems, the California legislature passed Assembly Bill 1455 on July 23, 2003 (AB 1455) which became effective on August 25, 2003. The regulations required by AB 1455, referred to as the California Claims Settlement Practice and Dispute Resolution Mechanism Regulations, 28 Cal.Code Regs. §1300.71, were to be fully implemented by healthcare service plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) by January 1, 2004.³ The AB 1455 regulations establish a timetable for processing claims, claims payment, and provider dispute resolution mechanisms. Additionally, the AB 1455 regulations require California health plans and their capitated providers to file quarterly and annual reports of compliance.

The most challenging aspect of AB 1455 requires health plans to incorporate the *Gould* criteria in their claims payment standards for non-contracted providers (excepting non-contracting providers who provide non-emergency services to preferred provider organizations (PPO) and point of service (POS) members). These standards require:

the payment of the reasonable and customary value for the health care

services rendered based upon statistically credible information that is updated at least annually and takes into consideration the following six (6) factors (commonly referred to as the “*Gould*” criteria):⁴

- (1) the provider’s training, qualifications, and length of time in practice;
- (2) the nature of the services provided;
- (3) the fees usually charged by the provider;
- (4) the fees usually 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.⁵

On September 1, 2004 the California Department of Managed Health Care (DMHC), the agency that is charged with regulating California health plans pursuant to Knox-Keene, challenged the integrity of the California health plans compliance with this regulation. The DMHC stated in a memorandum that the health plans had failed to disclose an appropriate methodology used to adjudicate the reasonable and customary value of healthcare services rendered by non-contracted providers.⁶ Specifically, the DMHC commented that “[w]hile a [p]lan’s methodology must take into consideration all six factors, almost every plan failed to adequately demonstrate that their methodology included all of the required factors.”⁷ Consequent-

ly, the DMHC directed all Knox-Keene licensed health plans to file a “Supplemental Verification of Compliance Statement for the Implementation of the Claims Settlement Practice and Dispute Resolution Mechanism Regulations.”⁸ The DMHC specifically instructed the health plans to provide the following supplemental information:

A clear and complete description of the methodology the plan is using to determine the reasonable and customary value of health care services rendered by non-contracted providers; including the source(s) of the data used for prevailing provider charges; document and explain the statistical credibility of that data; and explain how the plan is utilizing the source data to determine the reasonable and customary value of the non-contracted provider’s services.⁹

Additionally, the DMHC mandated that health plans that contract with any capitated providers or claims processing organization, must describe the plan’s protocol for verifying that these organizations: (1) have implemented a statistically credible methodology, consistent with the AB 1455 regulations, for calculating the reasonable and customary value of non-contracted provider claims, and (2) are, in fact, utilizing that methodology in the payment of non-contracted provider claims.¹⁰

The DMHC met with a task force comprised of the major stakeholders, the California

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Association of Physician Groups (CAPG), the California Medical Association (CMA), the California Association of Health Plans (CAHP), and the California Healthcare Association (CHA) in an effort to reach a consensus on an appropriate methodology for calculating the reasonable and customary value for non-contracted providers claims. This article explores what is at stake in defining “reasonable and customary” values for non-contracted providers and the proliferation of litigation and legislation that has ensued on behalf of physicians, in particular, against health plans over claims reimbursement and payment methodologies.¹¹

II. Payment Methodology

A. Medicare Fee Schedule

Some California health plans reimburse non-contracted providers based on the Medicare Fee Schedule. Historically, Medicare Part B was used for physician reimbursement on a fee-for-service basis based on the prevailing and reasonable charge system for specific services within a specific geographic area. A “prevailing fee” was defined as an amount not to exceed the 75th percentile of charges for a particular service by all physicians within a specific geographic community, in addition to a cost-of-living factor.¹² Generally, under this method, payments for services were made at the lower of the physician’s usual, actual billed charge, or the Medicare Fee Schedule amount based on an average of similar physician charges in a geographic area. Payment increases were capped

by an inflationary factor, the Medicare Economic Index, on an annual basis.¹³ This prevailing and reasonable charge system was criticized because it resulted in wide variations in payment levels for the same service in different geographic areas or for different specialties.

In 1966, the CMA devised its own non-monetary unit values reflecting relativity or resource costs among procedures and assigned procedure numbers, the California Relative Value Studies (CRVS), using charge data provided by Blue Shield of California.¹⁴ This system became the basis for fee determinations by private and governmental payors in California until the Federal Trade Commission forced the CMA to cease publishing the CRVS in 1979.

In 1992, the Omnibus Reconciliation Act of 1989 (OBRA) replaced the fee-for-service reimbursement system based on prevailing fees and established the Medicare Fee Schedule calculated on the basis of a resource-based relative value scale (RBRVS). The RBRVS system was an attempt to contain costs by instituting the same payments for the same services, whether performed by a generalist or specialist physician.¹⁵

The RBRVS system established payments for services based on the resource costs of the services. The cost of providing each service is based on a relative value scale (RVS). The RVS incorporates the sum of three components: the physician’s work (time and intensity of effort, skill training, and medical judgment), an allowance for medical practice expenses, and

an allowance for the malpractice insurance costs. The system assigned each service a specified number of relative value units, which are multiplied by a national conversion factor (a dollar per unit value determined by the Centers for Medicare and Medicaid Services), which would equal the amount of reimbursement. In addition, the relative value units are adjusted for geographic area variations in costs. Even though the RBRVS system was able to limit cost increases, it has many shortcomings as noted by two commentators:¹⁶

The fundamental criticism of the RBRVS system is that, while it controls total Medicare spending for physician services in the aggregate, it does so by arbitrarily lowering the prices for all physician services provided under the program and for all physicians. It does not however, provide much of an incentive for the individual physician to question the provision of a given service. On the contrary, by lowering the prices each physician receives per service, the system may be encouraging physicians to offer more services to compensate for lost revenues.¹⁷

Indeed, the DMHC commented during the review period of the AB 1455 legislation that the Medicare Fee Schedule was not an appropriate factor in assessing reasonableness “as those government programs are not designed to reimburse the provider for the fair and reasonable value of the services rendered and are, therefore an

inappropriate criteria.”¹⁸ The DMHC concluded that “[b]oth Medicare and Medi-Cal fee schedules are designed to pay less than the prevailing value for health care services.”¹⁹

Most recently, the DMHC fined Health Net of California \$250,000 for failing to correctly and accurately pay claims to non-contracted physician providers in accordance with the payment requirements of AB 1455. The DMHC concluded that Health Net’s methodology of reimbursing non-contracted physician providers claims based on 80% of RBRVS did not comply with the AB 1455 regulations.²⁰

Research by the Medicare Payment Advisory Commission revealed in 2001 that Medicare physician payment rates averaged 81%-83% of private rates. In 2002 and 2003 Medicare physician fees were projected at approximately 77%-78% of the average private rates.²¹

B. Reasonable and Customary Value

Historically, a reasonable fee was described as “UCR” meaning “usual, customary, or reasonable.” A “usual” fee means the fee most commonly charged by the practitioner. The “customary” fee is the fee charged by similar practitioners in the same geographic area. Yet, a fee which is neither usual or customary, may still be reasonable, if one takes into consideration circumstances such as the difficulty of the case and the special qualifications of the provider.²²

Some health plans developed their own UCR fee schedules by conducting a survey of fees

charged by a physician for each service. From the health plans' perspective, such fee schedules helped to manage costs and helped keep physicians' charges uniform for specific services. On the other hand, some physicians felt that UCR fee schedules were unfair because there was no adjustment for inflation or additional physician expenses such as overhead expenses.²³

The AB 1455 regulations state that health plans are required to pay non-contracted providers the "reasonable and customary value" for the healthcare services rendered. Shortly after the passage of AB 1455, the CHA, a nonprofit trade association representing hospital providers filed a Petition for Writ of Mandate against the DMHC. The CAHP intervened in the action as a party-in-interest and challenged the validity of the administrative regulations by labeling it "an impermissible rate-setting, which is beyond the authority of the DMHC, and is inconsistent with the governing statutes and with contract law."²⁴ In denying CHA's petition in its entirety, the court reiterated that the DMHC has broad authority to regulate under Knox-Keene and the AB 1455 regulations, and stated that "the Department is not 'dictating a rate' to be paid for any particular service. By setting criteria enabling objective review of claims submitted where there is no written contract, the Department is making the claims billing, processing, and payment process more efficient, and has established an initial payment for purposes of applying the claims processing timelines and in determining unfair

payment practices."²⁵ The court's ruling held that the DMHC regulations "appeared consistent with the controlling law and was not arbitrary, capricious or without reasonable or rational basis."²⁶

The criteria required by the DMHC to be utilized in determining a "reasonable value" is drawn upon the factors discussed in the California workers' compensation case, *Gould v. Workers' Compensation Appeals Board*, and is commonly referred to as the "*Gould* criteria."²⁷ In that case, the Court of Appeals stated:

In deciding whether fees in excess of the schedule are reasonable, the WCAB may consider evidence regarding the medical provider's training, qualifications, and length of time in practice; the nature of the services provided; the fees usually charged by the medical provider; the fees usually charged in the general geographic area in which the services were rendered; other aspects of the economics of the medical provider's practice that are relevant; and any unusual circumstances in the case.²⁸

From the health plans' perspective, most of the *Gould* factors are very subjective and would be difficult to quantify, such as the provider's training, qualifications, and length of time in practice. Moreover, such criteria present operational challenges for automated claims payment systems. Nonetheless, many health plans use non-contracted providers' billed charges as a

basis for payment, which presumably takes into consideration the *Gould* factors.

C. Proprietary Source Data

Several of the major health plans demonstrated in their Compliance Statements a reliance on proprietary databases such as Ingenix, or internally developed databases, for establishing non-contracted provider rates. Essentially these proprietary databases establish benchmarking for provider payments. When the Health Insurance Association of America (HIAA) merged with the American Association of Health Plans (AAHP) to form America's Health Insurance Plans (AHIP) in 1998, HIAA's claims database program, known as the Prevailing Healthcare Charge System (PHCS) database, was purchased by Ingenix. In addition to the PHCS database, Ingenix also has a MDR (Medical Data Research) relative value database. Ingenix only collects billed charges data for both databases, not payment made data. Percentiles are then created by using the charge data of similar ranges of procedure codes for a particular geographic area. The CMA contends that the health plans fail to indicate how they are incorporating the *Gould* factors in individual cases.²⁹

Additionally, the American Medical Association (AMA) has criticized the statistical credibility of Ingenix's data. In the class action, *American Medical Association v. United Healthcare Corporation*, the AMA cited Ingenix's PHCS database with having the following systematic deficiencies in establishing UCR to include, *inter alia*:³⁰

- a. Systematically under-reports the actual number of procedures performed in a geographic area, and often eliminates the highest charges for each type of medical procedure maintained in the PHCS database;
- b. Includes the charges for medical procedures from other, and non-comparable, geographic areas, in which the provider charges were lower;
- c. Fails to segregate procedures by providers of the same or similar skill experience level, but rather indiscriminately lumps together all provider charges by procedure code without regard to skill or experience level;
- d. Includes charges for various procedures which are determined by a fee schedule with participating "in network" providers, and which reflect a discount from the "usual" or "customary" charge, thereby skewing the data below an accurate "usual" or "customary" rate;
- e. Considers ten charges to be statistically significant, which is arbitrary and not statistically significant; and
- f. Lacks quality control, such as basic auditing, to ensure the validity

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and authenticity of data submitted to it for inclusion in the database.³¹

The DMHC's position with respect to these proprietary databases is that reliance upon such databases was only appropriate if the health plans could demonstrate that the source data was statistically credible and properly used. Moreover, the DMHC expects that health plans should explain the basis upon which a specific percentile, mean, or median point was selected to calculate the UCR reimbursement level.

From the health plans' perspective however, the use of Ingenix or similar vendor software meets the requirements of the AB 1455 regulations; other subjective factors set forth in the regulations, such as the provider's training and unusual circumstances, are only appropriate for consideration in the provider dispute process on appeal. Additionally, the provider's billed charges and regional databases include the factors that the provider considers relevant to his practice such as his/her training, qualifications, and the treatment rendered in the case.

III. Other Legislation

Other states have tried to ease the tension between health plans and physicians by passing legislation concerning physician reimbursement. By way of example, the State of Maryland does not permit out-of-network providers or non-contracting providers to balance bill HMO patients.³² In an effort to achieve equity, the Maryland legislature passed Senate Bill 405 in 2000 which requires

HMOs to reimburse non-contracting providers the greater of: 125% of the rate the HMO pays providers in the same geographic area for the same covered services to a similarly licensed provider under a written contract; or a rate that the HMO paid as of January 1, 2000 in the same geographic area for the same covered service, to a similarly licensed provider not under a written contract with the HMO.³³

Additionally, the Maryland legislature mandated the Health Services Cost Review Commission, in consultation with the other health services and HMOs, to develop a methodology to ensure reasonable payment to healthcare providers not under a contract with an HMO.³⁴ As part of the study, the Commission's task force analyzed 1.8 million claims processed by HMOs of which 12% were out-of-network. The Commission compared payments for each CPT code and for each payor to the Medicare Fee Schedule. The data generally revealed that network services varied greatly from one HMO to another as do the out-of-network payments. Ultimately, the Commission recommended payment of 125% of the in-network payment to be paid to the out-of-network providers. However, the Commission also suggested several alternative payment options: (1) continue the requirement that HMOs pay the greater of 125% of the in-network payment to out-of-network providers or, the rate at which the service was reimbursed on January 1, 2000; (2) require that the out-of-network payment shall

be at least the Medicare payment (or some percentage above that); or, (3) require the 125% out-of-network payment with the Medicare Fee Schedule amount as the floor. While all of these options have their advantages, they also have disadvantages. For instance, the Medicare payment rate does not include all CPT codes and the Medicare Fee Schedule varies by region and fluctuates annually. Additionally, the Commission was concerned that the 125% payment to out-of-network providers would be a financial incentive for contracted providers not to contract with HMOs if they know that they will be paid 25% more than the HMO in-network contract rate.³⁵ Clearly, the Maryland system highlights the difficulty in developing a payment methodology that will be "reasonable" and fair to both health plans and providers.

The State of Utah health insurance regulations require health insurers to reimburse healthcare providers not under contract at least 75% of the average amount paid by the insurer for comparable services of preferred healthcare providers who are members of the same class of healthcare providers.³⁶

Oklahoma law requires health insurers who authorize payment in an amount that is less than the healthcare providers billed charges to furnish, for a reasonable charge upon request of the healthcare provider, information, the rationale, and documentation of sources in the determination of the average area charges or customary and reasonable charges for the healthcare services.³⁷

In Colorado, nonparticipating providers, health carriers, and HMOs are required to pay the provider the lesser of: the nonparticipating providers billed charges; a negotiated rate; or the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area.³⁸ Under Colorado law, "usual, customary, and reasonable rate" is defined as a rate established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.³⁹

New York's health insurance laws require insurers to disclose the usual and customary, or reasonable form of reimbursement and updating of schedules periodically to accurately reflect geographic differences in costs, the method upon which the usual and customary or reasonable charge is determined, and the percentile of charges.⁴⁰

IV. Class Actions

In addition to legislative efforts, the physician providers have decided to take their battles with managed care plans to the courts. The most widely publicized class action was brought by over 600,000 physicians, joined by a number of state and county medical societies, against the largest for-profit managed care plans: Humana, Aetna, CIGNA, Coventry Health, PacificCare, United Healthcare, Inc., WellPoint, Prudential, and Anthem. These actions were consolidated in the U.S. District Court for the Southern District of Florida before Judge Frederico Moreno and were certified as a national class action on September 26, 2002 (*In re Man-*

aged Care Litigation, MDL-1334).⁴¹ The *Managed Care Litigation* was divided into two tracks—the Provider Track and the Subscriber Track. In addition to breaking new ground by suing so many managed care plans, the plaintiffs also asserted many novel and creative theories against the managed care plans, such as violations of the federal Racketeer Influenced and Corrupt Organizations Act (RICO). Essentially, the providers alleged in the *Managed Care Litigation* that the managed care plans engaged in a pattern of failing to pay claims in full and in a timely manner.⁴²

One of the initial suits concerning usual, customary, and reasonable fees was brought by several individual physicians and the Medical Association of Georgia against Blue Cross and Blue Shield of Georgia.⁴³

Although the physicians had a contract with Blue Cross & Blue Shield, the contract permitted Blue Cross to determine usual, customary, and reasonable fees and allowed Blue Cross to change the reimbursement methodology at its discretion upon changing conditions. An action for declaratory judgment was instituted because Blue Cross changed the meaning of UCR from the fee doctors usually charge for a particular service to the fee that doctors usually receive for a particular service. The physicians and the Medical Association claimed that changing the definition of UCR constituted a breach of the implied duty of good faith. The court disagreed and held that no duty had been breached because the contract permitted Blue Cross to change the definition. However, the court held

that Blue Cross was obligated to provide the physicians with a fee schedule and “the precise methodology used to determine the usual, customary and reasonable payments.”⁴⁴

Another class action suit was brought by the AMA against United Healthcare and Metropolitan Life Insurance Company.⁴⁵ In this lawsuit the plaintiffs allege that the managed care plans breached their fiduciary duty by not disclosing the data to determine usual, customary, and reasonable payments in violation of the Employee Retirement Income Security Act (ERISA) of 1974.⁴⁶ Moreover, the plaintiffs contend that the managed care plans (plan administrators) relied upon faulty or no UCR data in justifying reduced benefit determination. The case is still ongoing.

V. Conclusion

Disclosure of payment methodologies for non-contracted providers will increasingly become a requirement imposed upon health plans as a result of legislation and court actions. But the battle is not won there. Reaching a consensus among competing parties—physicians at one end of the spectrum and health plans at the other—as to what constitutes “reasonable and customary value” is a difficult, if not impossible task.

Without a doubt, due to burgeoning healthcare costs, both providers and health plans are feeling the squeeze. In those states which prohibit balance billing, the provider is left disgruntled with less than his or her expected reimbursement. On the other hand, in those states which permit balance

billing, the member is hit with an unexpected bill from the non-contracted provider. All in all, there appears to be no happy ending to this dilemma.

** Disclaimer: The views and opinions expressed in this article are solely those of Ms. Walton and do not express in any way the views, opinions, and position of Great-West Life.*

Endnotes

¹ Allan Baumgarten, *California Health Care Market Report*, 10 (2004).

² Cal. Health & Safety Code § 1379.

³ The definition of health care service plan in the Knox-Keene Act includes HMOs. In this article, the word “health plans” is used to collectively refer to HMOs, PPOs and all managed health care plans. See Cal. Health & Safety Code § 1345(f).

⁴ See 28 Cal.Code Regs. § 1300.71(a)(3)(B); see also, *Gould v. Workers’ Compensation Appeals Board*, 4 Cal.App.4th 1059, 1071 (1992).

⁵ *Id.*

⁶ Memorandum to All Licensed Service Health Plans from Kevin F. Donohue, Sr. Counsel, DMHC (September 1, 2004) p. 2.

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ This article will only address physician provider reimbursement issues, not hospital (institutional) issues.

¹² H.A. Sultz, *Health Care USA: Understanding Its Organization and Delivery*, 232 (2d ed. 1999).

¹³ *Id.*

¹⁴ David Willen, *Billing Patients – What Are the Limits?* CSA Bulletin, 15 (April-June 2003).

¹⁵ H.A. Sultz, *Health Care USA: Understanding Its Organization and Delivery*, 232 (2d ed. 1999).

¹⁶ *Id.* at 233.

¹⁷ *Id.*

¹⁸ DMHC Responses to Comments, 2nd Comment Period, No. 62;

¹⁹ DMHC Responses to Comments, 3rd Comment Period, No. 10.

²⁰ Consent Agreement, *In the Matter of Health Net of California, Inc.* (January 12, 2005).

²¹ Medicare Payment Advisory Commission and Direct Research Final Report, *Medicare Physician Payment Rates Compared to Rates Paid by the Average Private Insurer*, 1999–2001 (August 27, 2003), pp. 9-15.

²² David Willen, *Billing Patients – What Are the Limits?*, CSA Bulletin, 15 (April-June 2003).

²³ David Mirkin, *Getting Paid in the Managed Care Workplace: The Basics of Physician Compensation*, Hospital Physician, 17 (2000).

²⁴ Order and Judgment Denying Writ of Mandate, *California Healthcare Association v. Department of Managed Care*, No. 03CS01643 (Sacramento County Super. Ct. Aug. 10, 2004).

²⁵ *Id.* at 11.

²⁶ *Id.*

²⁷ *Gould v. Workers Compensation Appeals Board*, 4 Cal.App.4th 1059, 1071(1992).

²⁸ *Id.*

²⁹ CMA Memorandum, *AB 1455 Requirements and the Obligation To Pay Non-Contracted Physicians “Reasonable and Customary Value”* (May 7, 2004).

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30 *Id.*, See also, *American Medical Association v. United Healthcare Corporation*, No. 00Civ2800(LMM) (S.D.N.Y. 2003).

31 *Id.*

32 Md. Code Ann. Health-Gen. § 19-701(p)(1)(West 2004).

33 Md. Code Ann. Health-Gen. § 19-710.1(b)(3)(West 2004).

34 Health Services Cost Review Commission, *Comparison of HMO In-Network and Out-of-Network Payment*, (December 2001).

35 *Id.*

36 Utah Code Ann. § 31-A-22-617(2)(b) (West 2004).

37 Okla. Stat. Ann. tit. 36, § 6571 C (West 2004).

38 Colo. Rev. Stat. § 10-16-704(2)(i)(I) (West 2004).

39 Colo. Rev. Stat. § 10-16-704(2)(f)(III); Colo. Rev. Stat. § 10-16-704(2)(i)(I)(C) (West 2004).

40 McKinney's Insurance Law § 3217 (West 2004).

41 The HMOs and Health Plans Newsletter has previously addressed this litigation in the Winter 2002 and Spring 2003 issues of the Newsletter. See *In re Managed Care Litigation*, MDL No. 1334 (S.D. Fla. 2003).

42 *Id.*

43 *Medical Association of Georgia v. Blue Cross & Blue Shield of Georgia*, 244 Ga.App. 801 (Fulton County Super. Ct. 2001).

44 *Id.* at 803.

45 *American Medical Association v. United Healthcare Corporation*, 2001 WL 863561 (S.D.N.Y. 2001).

46 *Id.*, See *Employee Retirement Income Security Act of 1974*, § 502(a)(10)(B), 29 U.S.C. § 1132(a)(1)(B) (West 2004).

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Legal Implications of Concierge Medical Practice for Health Plan Providers and Enrollees

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I. Introduction

During the past several years, an increasing number of healthcare providers have been redesigning the financial and contractual relationships between themselves and third party payors and their patients to engage in one form or another of what is variously known as “concierge,” “boutique,” “retainer,” or “VIP” medicine, a development that may have significant implications for the legal relationship between health plans and their enrollees, and contracted and non-contracted providers. This trend has been driven partly in response to downward pressure on health plan provider reimbursement and physician frustration with real or perceived increases in health plan contractual and administrative burdens that may be seen as detracting or interfering with the physician patient relationship, and partly in response to demands from patients, particularly the chronically ill, for a more responsive and personalized treatment relationship with their physicians.

The economic and lifestyle issues for physicians can be compelling—a physician may be able to maintain the same income by covering several hundred patients than what they

formerly made while covering thousands, with significantly fewer administrative obligations and virtually no bad debt. Concierge practices can currently be found operating in some form in about half of the states. There is an association for such practices that recently changed its name from the “American Society of Concierge Physicians” to the “Society for Innovative Medical Practice Design” (www.conciergephysicians.com).

Some critics of these arrangements contend that the physicians are taking advantage of vulnerable patients who fear abandonment or feel compelled to pay the retainers in order to continue receiving necessary medical care. Others argue that they are catering to the “healthy wealthy,” pulling local physician capacity offline and increasing the burden on the remaining providers in the area, and providing a level of dedicated care management to a relatively few well-off patients that should be available to everyone who needs it.

There are a variety of models of concierge medicine currently in operation, and they offer a wide range of value added benefits to their patients. In exchange for an annual or monthly membership fee, the physician generally agrees to limit the number of patients they accept in their practice, and to offer more personalized services to their members, including annual physicals or wellness exams; same or next day appointments; telephone physician advice, including review of labs and tests, preventive services, and counseling; house calls; guaranteed response time on patient call backs; referral and prescription requests;

access by e-mail; completion of medical history and referral forms; scheduling with referral providers; publication of a patient newsletter; availability during non-business hours; etc.

The most prevalent model involves the payment of an annual fee (ranging from \$1,500 to \$4,000 per year for an individual) and an agreement by the patient to make immediate payment for services based on a fee schedule developed and maintained by the practice. The physician agrees not to bill the patient’s insurance, although the patient may be expected to maintain any coverage that they have in order to cover hospitalization and specialty and catastrophic care. In the second model, the patient may pay a lower fee and the physician continues to bill insurance at contracted or out-of-plan rates, and the fee charged is only for the value added services not otherwise covered by the third party payor. The third model is similar to a traditional fee-for-service practice, where the physician bills the patient for all services rendered and the patient submits claims to their health plan with the knowledge that some services rendered may not be covered by their plan.

The American Medical Association (AMA) has issued guidance supporting the development of concierge medical practice as consistent with the AMA’s traditional support of pluralism in the delivery and financing of healthcare and establishment of trust-based physician patient relationships. *See American Medical Association, Policy H-140.893*. The AMA does caution its members, however, to: be care-

ful not to apply undue pressure on patients to enter into such an arrangement, particularly vulnerable patients who may fear abandonment; be mindful of any implications the arrangement has for the patient’s insurance coverage; exercise care in transitioning patients to other providers; and to clearly articulate the difference between special services and amenities and reimbursable medical services. *See AMA Code of Ethics E-8.055*. The AMA has also reinforced its traditional positions that physicians should refrain from providing unnecessary care just because there is a patient demand for the service and they should strive to provide some level of care to patients regardless of the individual’s ability to pay.

II. Legal Issues for the Provider

A. Contracts

A physician making the transition to concierge practice will typically terminate his or her contracts with all commercial third party payors in an effort to avoid the restrictions of contracted reimbursement, submission to utilization review, and application of the patient “hold harmless” clause. The physician will also typically enter into some form of patient agreement, whereby the patient agrees to pay the annual fee in advance and all fee schedule charges at the time of service in exchange for access to a specific menu of enhanced services. The patient may also acknowledge that the physician does not participate in any third party payment plan and either agrees not to submit any claims to their

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plan or to accept whatever level of reimbursement their plan may provide. The agreement may state whether the physician is refusing to process or submit any claims to third party payors, which may be necessary to maintain private contracting status with Medicare or for commercial populations in some jurisdictions, or whether they are specifically offering to perform that service for patients as part of the annual fee. A physician may also be legally obligated to reimburse the health plan for any amounts that are inadvertently being billed to the plan by either the patient or the physician's office. *See Opinions of the Maryland Attorney General 00-030, 03-005.*

B. Insurance Licensure

Some state laws, such as the California Knox-Keene Health Care Service Plan Act, may prohibit arrangements whereby physicians undertake to arrange for the provision of healthcare services on a prepaid or periodic charge unless the provider has a health maintenance organization (HMO) license or other form of state licensure or certification allowing the provider to assume risk. The Office of the Insurance Commissioner of Washington issued Draft Advisories challenging the receipt of a retainer as the acceptance of risk without appropriate licensure and as constituting illegal "access fees" for the receipt of covered insurance benefits.

As a result, some concierge arrangements are structured so that the retainer is characterized as a flat fee for specific services, or the arrangement is billed in

arrears to avoid the application of state laws prohibiting prepayment in the absence of appropriate licensure. Legal practitioners representing concierge practices will need to help structure the arrangement in a manner that avoids characterization as an unlicensed insurance arrangement. This may not be a problem in jurisdictions that make the regulatory distinction between "insurance risk" (assumption of risk for both services rendered by the provider and for certain specified referral services) and "service risk" (assumption of risk only for services directly rendered by the practitioner). This same distinction prevents physicians accepting capitated arrangements for personally performed primary care and other professional services from being characterized as impermissible insurance arrangements in some jurisdictions.

C. Hold Harmless/Balance Billing Enforcement

An additional insurance regulatory issue at the state level is the application of the patient "hold harmless" clause, which generally prohibits balance billing patients for the costs of non-covered services. *See generally, Maryland Opinion of the Attorney General 98-018.* Providers with third party payor participation agreements may be prohibited from billing the patient for any amounts not reimbursed by the plan, unless the services are contractually excluded (e.g., cosmetic and experimental procedures, etc.). The Maryland statutory hold harmless clause even applies to non-contracted providers, Md. Code Ann., Health-Gen. § 19-710(i), so the hold harmless clause is still an issue even

where a physician has terminated all payor participation arrangements.¹ However, the Maryland Attorney General has opined on several occasions that physicians and patients may enter into "private contracts" outside an HMO coverage arrangement, provided that the HMO does not authorize the service, refer the patient to the practitioner, or receive any claim for payment. *Opinions of the Maryland Attorney General 00-030, 03-005.* The Attorneys General of Texas and Arkansas have also issued opinions on balance billing issues.

In light of the facts that violation of the ban on balance billing is a fairly frequent complaint among MCO members, and that enforcement of the hold harmless clause is one of the relatively few areas where state insurance regulators may have direct statutory jurisdiction over licensed healthcare professionals, physicians should make significant efforts to understand the application of the hold harmless rules in their jurisdiction and to work with their patients to avoid violations and enforcement actions.

D. Accessing Patient Third Party Coverage

Even if a physician terminates all formal contractual relationships with third party payors, they may continue to have unavoidable interaction with the health plans providing other benefits to their patients. Physicians may agree to perform the billing function and assist their patients in submitting claims to the carrier. They may be billing the plan themselves as an out-of-network provider or under the applicable terms of a non-Pre-

ferred Provider or Point of Service arrangement. Patients may still need physician orders for covered ancillary services (lab, imaging, pharmacy, durable medical equipment, home care, etc.), referrals to specialists, hospital admissions, and physician orders to other covered services requiring physician authorization. Providers need to understand the terms of their individual patient's coverage and be willing to work with them to maximize their access to covered benefits and avoid unnecessary coverage denials and balance billing issues.

E. Medicare

Section 1802 of the Social Security Act already gives physicians and fee-for-service Medicare beneficiaries the option of "private contracting" outside of the Medicare program for the receipt of services at privately negotiated rates not subject to the Medicare limiting charges. Once the physician "opts-out" of Medicare participation by submitting an appropriate affidavit to the Medicare carrier, the patient agrees to accept full financial responsibility for the cost of the services rendered and not to submit a claim to Medicare for the privately contracted services. The physician agrees not to bill Medicare or accept capitation payments from a Medicare Advantage organization for any service (except for certain emergency or urgent care services) for any Medicare patient for two years from the date the affidavit is signed. *See generally 42 C.F.R. §405.400 et seq.*

However, there are a number of federal issues for physicians who desire to bill Medicare for some

of their patients or for some portion of the services provided pursuant to a retainer arrangement. Like some state insurance regulators, the federal Centers for Medicare and Medicaid Services (CMS) has expressed a concern that the annual retainer may be considered an insurance policy, since it may cover services that Medicare does not—such as an annual physical—and thus violate the Medicare supplemental insurance provisions of the Medicare statute, which establishes minimum standards for Medigap policies and requires them to comply with all applicable state laws regulating such policies.

A second area of concern for CMS is that the additional fee paid by the patient may violate the Medicare limiting charge and assignment rules if the retainer agreement includes covered services billed to the Medicare program. The limiting charge rules prohibit a physician from charging a Medicare beneficiary more than a fixed percentage over the Medicare physician fee schedule for covered services. Under the assignment rules, Medicare participating physicians agree to accept the Medicare fee schedule rate as payment in full for covered services. Thus, if the retainer agreement includes features that enhance or waive applicable copayments for covered services, the agreement may violate either the limiting charge or assignment rules. There may also be a False Claims Act (31 U.S.C. §§ 3729-3733) issue if physicians fail to include the cost of the annual fee when billing Medicare—the physician may be seen as illegally misstating the true amount charged to Medicare beneficiaries.

Based on the legal concerns and anecdotal complaints that Medicare beneficiaries who did not pay the retainer fees were being dropped by their physicians, a variety of measures have been introduced at the federal level containing provisions that would essentially criminalize any practice design that charges a monthly fee to Medicare beneficiaries.² These statutes would provide for sanctions and exclusions for physicians charging an “extraneous or incidental” fee to a Medicare beneficiary or requiring a patient to purchase an item or services as a pre-requisite to receiving other covered services. Thus far, there has not been significant legislative traction for these measures, due in part to a small number of Congressional sponsors and the existence of larger Medicare-related issues on the legislative agenda.

III. Legal Issues for the Patient

The legal issues facing the patient will primarily center around the execution of a Patient Agreement with their physician and the interface with any third party payor coverage that they would otherwise have access to. There may also be issues of common law abandonment if a physician terminates a treatment relationship with a patient who declines to enter into the Patient Agreement if they are undergoing a course of treatment and the physician has not made clinically appropriate arrangements for transfer of the patient’s care to another qualified provider.

A. Patient Agreements

Is any portion of the retainer refundable if the patient termi-

nates after a partial year or otherwise leaves the practice prior to receiving some of the specified services (e.g., annual physical)? Is the patient being improperly induced to accept the agreement through promises of higher quality care and/or perceived threats of abandonment? Has the impact on the patient’s otherwise available insurance coverage been fully disclosed and documented? If a patient has contractually agreed to refrain from billing their health plan to avoid triggering a hold harmless provision, how does the agreement cover situations where claims may have been intentionally or negligently submitted to the carrier? Are there unreasonable penalties for opting out of the arrangement at some point during the contract year?

IV. Legal Issues for Health Plans

Health plans may have to recognize that a certain percentage of their enrollees will inevitably opt to participate in concierge medicine practices and that some of their contracted physicians may terminate their existing arrangements with the health plan to participate in such practices. Depending on the number, locations, and specialties of the physicians involved, the health plan may have to adjust its network configuration to compensate. Although there is a general bias on the part of health plans for enrollees to receive services from within the contracted provider network, there may also be cost savings if a significant number of relatively high utilizing patients opt to receive services under arrangements where they pay out-of-pocket

and agree to refrain from billing the health plan for the services.

In addition, health plans should consider developing internal policies and procedures for handling claims from physicians or patients in concierge practices and hold harmless/balance billing enforcement. Adequate arrangements should also be made for an orderly and appropriate transition of patients whose physicians terminate their agreements with the health plan to the care of another contracted provider in situations where a patient declines to join the physician’s concierge practice and elects to continue receiving physician services through the health plan’s contracted network.

V. Conclusion

Concierge medicine is a growing phenomenon and it remains to be seen whether it is a short term reaction to market and other forces, or whether it will play a significant part in the future delivery of professional medical services. There are a variety of significant legal issues that will need to be worked out at the state and federal levels, and additional regulation may be in the offing as regulators continue to examine these arrangements more closely. Legal practitioners will need to assist physician and health plan clients in working their way through the fairly detailed administrative issues that need to be addressed.

Endnotes

¹ A hold harmless clause generally becomes effective in one of two ways: (1) it can be included as a specific term of the services agree-

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ment between a health plan and a participating provider, or (2) it can be mandated by statute or regulation, regardless of the existence of any agreement between the plan and the provider. Under the Maryland scheme, the hold harmless is a statutory consumer protection that applies to the patient's interaction with any provider, regardless of whether the provider has a contract with the payor.

² See The Equal Access to Care Act of 2001 (S. 1592), the Medicare Equal Access to Care Act of 2002 (H.R. 4752), the Medicare Equal Access to Care Act of 2003 (H.R. 2423), the Medicare Payment Restoration and Benefits Improvement Act of 2003 (H.R. 26).

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Connecticut v. Health Net, Inc.: A Setback for States Seeking to Pursue Citizens' ERISA Claims as Assignees, But Not a Complete Defeat

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In early September 2004, the Eleventh Circuit ruled in *Connecticut v. Health Net, Inc.*,¹ (*Health Net*) that the State of Connecticut did not have standing to pursue claims under the Employee Retirement Income Security Act (ERISA)² against eight managed care companies. First, the court held that Connecticut did not have standing as an assignee of its citizens' ERISA claims against the managed care companies because the State itself did not suffer an injury in fact.³ The court also held that Connecticut did not have standing in its capacity as *parens patriae* because ERISA does not provide for such actions.⁴ In doing so, the court relied on the Second Circuit's reasoning in *Connecticut v. Physicians Health Services of Connecticut, Inc. (PHS)*.⁵ Hence, it is necessary to look at the Second Circuit's opinion in *PHS* to analyze the Eleventh Circuit's decision in *Health Net*.

Prior to filing the Health Net lawsuit, which ultimately was decided by the Eleventh Circuit, Connecticut filed a separate, but nearly identical lawsuit, the appeal of which ended up before the Second Circuit (*PHS*).⁶ In *PHS*, Connecticut filed suit against only one defendant, managed care entity PHS, and claimed that PHS used "a drug

'formulary'—a list of drugs preapproved by PHS for reimbursement—that . . . prevent[ed] plan enrollees from receiving drugs prescribed for them by their physicians that are medically necessary or preferable to a comparable listed drug."⁷ In contrast, in *Health Net*, Connecticut filed suit against eight different managed care companies,⁸ and contended that the eight companies: "violated ERISA by using inappropriate and arbitrary guidelines as the basis of coverage denials; by employing prescription drug formularies in a manner that obstructs enrollee access to medically necessary prescription drugs; by failing to make timely payments to providers; by failing to respond to enrollee letters and phone calls; and by failing to disclose to enrollees essential information about the health insurance plans upon which the enrollees rely."⁹ Connecticut asserted the same bases for standing in both lawsuits—as an assignee of its citizens' ERISA rights and as *parens patriae*. Hence, the Second Circuit's analysis in *PHS* is directly on point with the issues raised in *Health Net* in the Eleventh Circuit.

This article will discuss first the issue of Connecticut's standing, or lack thereof, in its capacity as *parens patriae*, as it is the more straightforward of the two issues. This article then will analyze the issue of "whether a state, after obtaining assignments from some of its citizens for claims those citizens have under [ERISA], has standing to assert those claims on behalf of its citizens in federal court."¹⁰ In contrast to the *parens patriae* issue, the opinions of the Second Circuit and the Eleventh Circuit (*Connecticut*

opinions) do not completely close the door on a state's ability to pursue ERISA claims against third-party payers as assignees of citizens' claims, although a state is unlikely to fulfill the necessary steps so as to take advantage of the narrow opening that remains. While the *Connecticut* opinions are clear and well-reasoned, they ultimately depend on the particular assignment of claims at issue. If a state is interested in pursuing the ERISA claims of some of its citizens against third-party payers, based on the *Connecticut* opinions, it must provide the benefits denied but allegedly owed by the managed care companies (payment for healthcare services) as consideration for the assignment, in order to satisfy Article III standing requirements.

I. Connecticut Lacks Standing to Bring Claims for Violations of ERISA in its Capacity as *Parens Patriae*

Parens patriae is a common law doctrine that allows a state to sue on behalf of its citizens in certain limited circumstances to enforce a "quasi-sovereign interest."¹¹ Although it is unclear exactly what qualifies as a "quasi-sovereign interest,"¹² the Eleventh Circuit has stated, relying on Supreme Court precedent, that "[w]hen a state sues in *parens patriae* to enforce a federal statute, it must demonstrate that, in enacting the statute, Congress clearly intended that the states be able to bring actions in that capacity."¹³ Accordingly, the Second Circuit (and the Eleventh Circuit by reference to the Second Circuit's opinion) looked to the text of ERISA to see if there was evidence of a Congressional intent to allow *parens patriae*

suits to enforce the provisions of ERISA. The court focused on 29 U.S.C. § 1132(a)(3), the section upon which Connecticut relied, which merely allows "a participant, beneficiary, or fiduciary" of an ERISA plan to file suit for injunctive and equitable relief.¹⁴ The court also noted that although other parts of ERISA, specifically §§ 1132(a)(7) and 1169(b),¹⁵ authorize states to bring certain types of actions, ERISA does not explicitly permit *parens patriae* actions for injunctive and equitable relief. Because courts have consistently read § 1132(a)(3) as strictly limiting who could file suit to enforce ERISA, and states are not mentioned in § 1132(a)(3),¹⁶ the Second Circuit concluded that Congress did not intend for states to have the ability to bring suit pursuant to that section.¹⁷

II. Connecticut May Have Standing to Bring Claims for Violation of ERISA as an Assignee of Citizens' Claims

The *Connecticut* opinions make very clear that the assignment of a claim does not in and of itself create standing for the assignee. Rather, the assignee must still "suffer an injury of a nature that would confer standing upon it under Article III of the Constitution."¹⁸ As both courts explain, "[a]t an 'irreducible constitutional minimum,' Article III standing requires that the plaintiff 'have suffered an injury in fact—an invasion of a legally protected interest which is (a) concrete and particularized; and (b) actual or imminent, not conjectural or hypothetical.'"¹⁹ Accordingly, a plaintiff generally "must assert

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his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties.”²⁰ Of course, the Supreme Court has held that in certain situations an “assignee of a claim [does have] standing to assert the injury in fact suffered by the assignor.”²¹ The question, then, is whether the assignment of certain citizens’ claims under ERISA to the State of Connecticut is one of those special situations where the assignee has standing. For the reasons explained below, the Second Circuit and Eleventh Circuit answered this question in the negative. The opinions appear to preserve a situation, however, where a state as assignee of citizens’ ERISA claims would have standing, although a state is highly unlikely to take advantage of this possibility.

The Eleventh Circuit summarized its reasoning succinctly: “[N]o evidence exists in the record to suggest that this assignment was supported by any consideration or that the State of Connecticut has suffered, or will suffer, any type of injury as a result of the practices it claims violate ERISA.”²² The Second Circuit provided more detail. It explained that the assignee usually obtains the assignment in exchange for some consideration, which then effectively places the assignee in the stead of the assignor.²³ In other words, the exchange of consideration from the assignee to the assignor gives the assignee “a sufficient stake”²⁴ in the controversy to confer standing. When courts have allowed the assignment of ERISA claims,

there has been an exchange of consideration.²⁵ Despite the temptation to take from the *Connecticut* opinions a bright line rule that states *per se* do not have standing as assignees of ERISA claims, it is important to note that the identity of the assignee is not the decisive factor. As the Second Circuit explained, “We do not base our holding on the State’s status as a state.”²⁶ Rather, it is the nature of the assignment of the claim that determines whether the State has standing. This becomes abundantly apparent when one considers the instances in which courts have found other entities to have standing as assignees to assert the ERISA claims of others.

Courts have consistently found that healthcare providers in some situations have standing as assignees of ERISA claims because there is an exchange between the provider and the ERISA beneficiary sufficient to give the provider a sufficient stake in the controversy. For example, in another Second Circuit case, the provider assumed the cost of medication prescribed to the assignor-beneficiary in exchange for the right to seek reimbursement from the ERISA plan.²⁷ In this situation, the provider gave the beneficiary that which the provider and beneficiary believed was owed the beneficiary by the ERISA plan: payment for the prescribed medication. It is important to keep in mind that it is the payment for services and not the services themselves that served as consideration for the assignment. Most managed care companies do not provide services, but rather provide pay-

ment for services. The question of whether an ERISA plan will pay for services is different than the question of which services a provider considers to be medically necessary for a patient-beneficiary. Allowing providers to obtain assignment of a beneficiary’s ERISA claim in certain situations, however, alleviates the situation which may place a provider and patient in an adversarial context regarding payment for certain services. As the Fifth Circuit has explained:

Many providers seek assignments of benefits to avoid billing the beneficiary directly and upsetting his finances and to reduce the risk of non-payment. If their status as assignees does not entitle them to federal standing against the plan, providers would either have to rely on the beneficiary to maintain an ERISA suit, or they would have to sue the beneficiary. Either alternative, indirect and uncertain as they are, would discourage providers from becoming assignees and possibly from helping beneficiaries who were unable to pay them “up-front.” The providers are better situated and financed to pursue an action for benefits owed for their services. Allowing assignees of beneficiaries to sue under § 1132(a) comports with the principle of subrogation generally applied in the law.²⁸

Providers stand to receive the alleged benefit owed from the third-party payer (payment) when they assert the claim of a

beneficiary as an assignee. In contrast, Connecticut was not in a position to receive any benefit itself, even if it prevailed in the lawsuit.

In addition to noting the lack of a shift of loss from the individuals to the State, the Second Circuit also emphasized that the assignments did not “confer ‘actual’ rights or benefits under ERISA on the State. The right to recover benefits or to seek monetary damages remains with the assignors. Moreover, the assignments . . . do not create a fiduciary duty running from PHS to the State.”²⁹ This effectively distinguished the assignments at issue from those where the Supreme Court previously found standing despite the absence of an injury, loss, or expense by the assignee.³⁰ First, the court noted that an assignment must be of “a *claim* (or a portion thereof)—not only the right or ability to bring suit.”³¹ Because the assignors in *PHS* and *Health Net* retained the right to bring a claim identical to that brought by the State (albeit for different relief), it was clear from this distinction alone that the Connecticut assignments did not confer standing on the assignee-State.

The court went on to distinguish the Connecticut assignments from those involved in *qui tam* suits. Most importantly, the court noted that in *qui tam* actions the *qui tam* relator (who is the equivalent of an assignee) “[stands], personally and individually, to recover a monetary award,”³² even though the damages claim he pursues is really that of the government. In contrast, Connecticut “acquired only the right to control the

equitable portion of a lawsuit seeking redress of the assignor-participants' rights under ERISA. None of the remedies sought would flow to the State as assignee.³³ Therefore, if successful, Connecticut would not directly receive benefits under the ERISA plan (payment for services the State itself received) or monetary damages resulting from an alleged breach of fiduciary duty. The State also would not be in a position to receive payment for services it paid for or provided to a beneficiary. In fact, the State conceded in its appellate brief that the case was "brought solely for the benefit of the assignors and those similarly situated."³⁴ Accordingly, the courts held that "Connecticut, in its capacity as assignee, . . . failed to allege an actual or imminent invasion of a legally protected interest that is 'concrete and particularized,' [and therefore] . . . lacked Article III standing."³⁵

In summary, the Second Circuit and the Eleventh Circuit, either expressly or through adoption of the Second Circuit's reasoning, found that Connecticut did not have standing as an assignee to bring ERISA claims against managed care companies because: (1) there was no consideration for the assignment of the claim; and (2) the State would not otherwise get a direct benefit from a successful suit. The courts did not close the door completely, however, to a state having standing as an assignee to bring ERISA claims against a third-party payer in all situations. The holdings of these courts are particular to the assignments at issue. Accordingly, under a different set of facts, a state may have standing as an assignee to assert the ERISA

claims of its citizens, although it is highly unlikely a state would ever take the necessary actions to take advantage of this possibility.

To meet the criteria set forth in *PHS* and *Health Net*, a state would have to provide beneficiaries-assignors some consideration for their claims. Because the courts generally have found healthcare providers to have standing as assignees if they forgive payment for services, a state could theoretically place itself in a position identical to that of some healthcare providers. In other words, a state interested in enforcing the ERISA claims of its citizens could provide the benefits denied but allegedly owed by a third-party payer, *i.e.* payment for healthcare services. The beneficiaries would obtain the benefits (services) they allegedly need and would not need to retain the right to recover benefits or to seek money damages, as they did in the *Connecticut* cases. The state would bear the burden then of enforcing the rights of the assignors and those similarly situated. The state would even arguably be able to assert claims for equitable relief for a breach of fiduciary duty because the assignments would "shift the loss suffered by individual enrollees from the alleged breach of [fiduciary] duty from the individuals to the State."³⁶ Then, according to the reasoning of the Second Circuit and Eleventh Circuit in the *Connecticut* opinions, the state would have standing as an assignee to bring citizens' ERISA claims because it would have suffered an individual and particularized injury in fact. This scenario would fit under the test articulated in *PHS* and *Health Net*, but a state most like-

ly would not be interested in taking these steps.

III. Conclusion

Although the Eleventh Circuit ruled in *Health Net* that the State of Connecticut did not have standing to pursue ERISA claims against eight managed care companies, the court did not rule that states could never have standing to pursue ERISA claims against third-party payers. Based on the reasoning of the Second Circuit in *PHS*, which the Eleventh Circuit adopted, a state could have standing as an assignee of its citizens' ERISA claims if the assignment actually gives the state a "concrete private interest in the outcome of the suit."³⁷ The clearest way for a state to ensure it has such an interest is to pay for the benefits denied and allegedly owed by the managed care company. This solution, however, is highly unlikely.

First, paying for the healthcare of citizens who claim to be wronged by their managed care companies no doubt would be of significant financial and political consequence. To reduce this exposure, the state could try to limit payment to only those citizens it thought had legitimate complaints against their respective third-party payers. This could prove to be a difficult differentiation to make on an individual basis, however, and most likely would be politically untenable. Moreover, only paying for the healthcare services of those who have complaints against third-party payers would be difficult to justify in light of the millions of Americans who do not receive healthcare coverage through third-party payers—namely, those who do not

receive any healthcare coverage at all.³⁸ Considering that states generally have difficulty in adequately maintaining their own Medicaid programs at the current enrollment rates,³⁹ it is unlikely that any state would be willing to intercede and pay for medical services relating to disputed claims between private parties (*i.e.*, managed care companies and insureds).

In short, although the decisions of the Eleventh Circuit and Second Circuit in *Health Net* and *PHS*, respectively, leave the door open for states that want to pursue actions against ERISA plans as assignees of citizens' claims, it is not likely that a state would take the necessary steps to walk through this slight opening. Based on these decisions, it appears that if states are interested in regulating managed care, they will take the traditional approach of doing so through legislation.⁴⁰

Endnotes

¹ *Connecticut v. Health Net, Inc.*, 383 F.3d 1258 (11th Cir. 2004).

² 29 U.S.C. §§ 1001-1461.

³ *Id.* at 1261.

⁴ *Id.* at 1262.

⁵ *Id.* at 1260 (citing *PHS*, 287 F.3d 110 (2d Cir. 2002)).

⁶ Connecticut filed the lawsuit against PHS in the United States District Court for the District of Connecticut, the decision of which was appealed to the Second Circuit Court of Appeals. While the appeal was pending in the Second Circuit, Connecticut filed in the Connecticut

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district court the lawsuit against Health Net et al., but the Connecticut district court appropriately stayed the proceedings pending the Second Circuit's decision in the PHS action. Before the Second Circuit reached a decision, the Judicial Panel on Multi-district Litigation transferred the Health Net case to the United States District Court for the Southern District of Florida. Subsequent to the transfer of the Health Net case, the Second Circuit affirmed the Connecticut district court's determination in the PHS case. Thereafter, the Southern District of Florida dismissed the Health Net case, which generated the appeal before the Eleventh Circuit. *Id.*

⁷ *PHS*, 287 F.3d at 112.

⁸ The title defendant, Health Net, Inc., was formerly known as "Physicians Health Services of Connecticut, Inc.," the lone defendant in the first case. *Health Net*, 383 F.3d at 1258.

⁹ *Id.* at 1259-60.

¹⁰ *Id.* at 1259.

¹¹ *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 601 (1982).

¹² *See id.* (explaining that "quasi sovereign interest" is "a judicial construct that does not lend itself to a simple or exact definition.")

¹³ *Health Net*, 383 F.3d at 1267 (citing *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 260-66 (1972)); *see also PHS*, 287 F.3d at 120 ("When determining whether a state has *parens patriae* standing under a federal statute, we ask if Congress intended to allow for such standing.")

¹⁴ *PHS*, 287 F.3d at 120-121.

¹⁵ It is worth noting that 29 U.S.C. § 1169(b) "authorizes states to acquire the rights of third parties through assignment for the limited purpose of recouping payments

made under state plans for medical assistance." *PHS*, 287 F.3d at 121 (citing 29 U.S.C. § 1169(b)). In other words, a state has standing as an assignee of third-party claims against an ERISA plan when the state's interest, maintenance of the medical assistance program (Medicaid) it funds, is directly affected. This is entirely consistent with the courts' decisions in *PHS* and *Health Net*.

¹⁶ The court explained that it did not "intend to imply that states may only sue in their *parens patriae* capacity when a statute specifically provides for suits by states," noting that those "federal statutes under which states have been granted *parens patriae* standing all contain broad civil enforcement provisions that permit suit by any person that is injured or aggrieved," which ERISA does not contain. *Id.* (internal quotations and citations omitted).

¹⁷ *Id.*

¹⁸ *Id.* at 115.

¹⁹ *Id.* at 116 (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992)); *Health Net*, 383 F.3d at 1261.

²⁰ *Warth v. Seldin*, 422 U.S. 490, 499 (1975) (cited by *Health Net*, 383 F.3d at 1261).

²¹ *Vt. Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765, 773 (2000) (cited by *PHS*, 287 F.3d at 117).

²² *Health Net*, 383 F.3d at 1261.

²³ *PHS*, 287 F.3d at 117.

²⁴ *Sierra Club v. Morton*, 405 U.S. 727, 731-32 (1972) (cited by *Health Net*, 383 F.3d at 1261).

²⁵ *See e.g., Dallas Cty. Hosp. Dist. v. Associates' Health & Welfare Plan*, 293 F.3d 282 (5th Cir. 2002); *Hobbs v. Blue Cross Blue Shield of Ala.*, 276 F.3d 1236 (11th Cir. 2001); *I.V. Servs. of Am. v. Trs. of Am. Consulting Eng'rs Council Ins. Trust Fund*,

136 F.3d 114 (2d Cir. 1998); *Hermann Hosp. v. MEBA Medical & Benefits Plan*, 959 F.2d 569 (5th Cir. 1992); *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988); *Misic v. Building Serv. Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986).

²⁶ *PHS*, 287 F.3d at 119 n. 13.

²⁷ *I.V. Servs. of Am. v. Trs. of Am. Consulting Eng'rs Council Ins. Trust Fund*, 136 F.3d 114, 117 (2d Cir. 1998) (cited by *PHS*, 287 F.3d at 117).

²⁸ *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1988).

²⁹ *PHS*, 287 F.3d at 115-16.

³⁰ *Vt. Agency*, 529 U.S. at 773.

³¹ *Id.* at 117 (emphasis in original).

³² *Id.* at 118.

³³ *Id.*

³⁴ *Id.* (quoting the State's Appellate Brief at 11 and adding emphasis).

³⁵ *Health Net*, 383 F.3d at 1261.

³⁶ *PHS*, 287 F.3d at 116.

³⁷ *Vt. Agency*, 529 U.S. at 772 (cited by *PHS*, 287 F.3d at 118).

³⁸ Of course, everyone in this country has a minimum amount of healthcare; EMTALA, 42 U.S.C. § 1395dd, requires all hospitals that operate an emergency department and accept payment from Medicare to treat a patient with an emergency medical condition presenting at the hospital's emergency department. This minimum amount could not get much lower, but this is the base healthcare that every individual in this country has.

³⁹ *See e.g., Centers for Medicaid & Medicare Services, Michigan Form 416, available at www.cms.hhs.gov/medicaid/epsdt/ep2000.pdf* (showing that in 2000, the most recent year for which statistics are available

online, only 43% of Medicaid-eligible children in Michigan who were supposed to be provided one or more comprehensive screening examinations actually received at least one such examination).

⁴⁰ *See e.g., N.J. Stat. Ann. § 26:2J* (regulating HMOs).

Non-Contracting Physicians or HMOs: Who Gets Stuck Holding the Bag When the Provider Network Goes Bankrupt?

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A medical provider network goes bankrupt. It has happened many times before, and will likely happen again. Numerous physicians have claims that will not be paid. Many of those physicians will have directly contracted with the provider network, and can simply be viewed as having made a bad contracting decision. But, there will invariably be many other non-contracted physicians, such as emergency room doctors, who have not contracted with the network, never agreed to be paid by the network, and will argue that their fortunes should not be tied to those of the network. The question arises: do these non-contracted physicians have any recourse against the health service plan? Two recent California decisions provide some guidance on the issue.

I. *California Emergency Physicians Medical Group v. PacifiCare of California*¹

In *Emergency Physicians*, PacifiCare contracted with Family Health Network (FHN) to provide medical services, including emergency services, to PacifiCare members who had chosen FHN as their medical provider. FHN went bankrupt, owing California Emergency Physician Medical Group over \$100,000 for services provided to PacifiCare

members who had chosen FHN. Emergency Physicians then sought payment from PacifiCare. PacifiCare, however, refused to pay the claims and Emergency Physicians sued PacifiCare.

In its lawsuit, Emergency Physicians alleged causes of action for: (1) violations of §§ 1371, 1371.35 and 1371.4 of the Knox-Keene Act²; (2) common counts for services rendered and quantum meruit; (3) negligence; (4) breach of contract as third party beneficiary; and (5) unfair business practices. In essence, Emergency Physicians claimed that § 1371.4 of the Knox-Keene Act required PacifiCare to pay its claims. The lower court sustained PacifiCare's demurrer³ to the complaint "holding that healthcare service plans that enter into risk-sharing agreements with medical providers are not obligated to pay emergency service providers." Emergency Physicians then appealed the lower court's decision to the Fourth Appellate District of the California Court of Appeals.

A. *Emergency Physicians' claim for Violation of § 1371.4 of the Knox-Keene Act*

Section 1371.4 of the Knox-Keene Act, the act governing health maintenance organizations (HMOs) licensed in California, provides *inter alia*, that:

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care

be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases where the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist.

(d) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

Based on § 1371.4(b), Emergency Physicians argued that healthcare service plans have a mandatory duty to pay for emergency services, and thus PacifiCare had a duty to pay for services Emergency Physicians had provided to PacifiCare

members who had chosen FHN doctors. Emergency Physicians further argued that although the healthcare service plan was allowed to "delegate" their § 1371.4 responsibilities to contracting medical providers, the plan remained liable in the event the contracting provider failed to pay for the emergency services. PacifiCare, on the other hand, contended that once the duty was delegated, it no longer had any responsibility to pay, even if the contracted provider failed to pay.

The court held that the term "delegate" had a specific meaning when applied to licensees such as healthcare service plans, a meaning that could be determined when contrasted with the well established rule regarding "nondelegable" duties of licensees.⁴ As the court stated, "under that rule, a licensee remains liable for the acts of its agents and employees,"⁵ and "the rule of nondelegable duties for licensees is of common law derivation. The essential justification for this rule is one of ensuring accountability of licensees so as to safeguard the public welfare."⁶

Based on the definition of the term "delegate," the court held that "because a licensee like PacifiCare remains liable for a *nondelegable* duty, when the Legislature used the term 'delegate' in subdivision (e), it must have intended that the obligations of section 1371.4 are *delegable* duties; that is, duties for which the healthcare services plan does not retain liability."⁷ And, the court further held that "by using the term 'delegate,' the Legislature clearly and unequivocally

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ocally disclosed an intention to depart from the common law rule that licensees are liable for the acts of their agents.”⁸

In addition to basing its decision on the definition of the term “delegate,” the court also held that its decision was consistent with the Legislature’s intent when passing § 1371.4. First, the court held that subdivision (e) of § 1371.4 was added to reduce the opposition of several large HMOs to the bill. Second, and more importantly, initially the Legislature had passed an amendment which would have required healthcare service plans to pay emergency service providers if a contracting medical provider failed to pay. The governor, however, vetoed the amendment stating that the amendment “would adversely affect HMO patient care . . . by prohibiting delegated risk arrangements between HMOs and physician groups based upon the type of service.”⁹ The court therefore held that the 2001 legislation reflected the Legislature’s understanding that under § 1371.4(e), healthcare service plans that delegate their responsibilities under § 1371.4 to contracting medical providers are not responsible to pay emergency services providers when the contracting medical providers fail to pay.¹⁰

B. Emergency Physicians’ Remaining Claims

After determining that PacifiCare had no liability to Emergency Physicians based on the statute, the court next considered Emergency Physicians’ claim for violations of California’s expansive unfair business

practices act, Cal. Bus. & Prof. Code § 17200. Section 17200 broadly prohibits any business practices that can be considered “unlawful, unfair or fraudulent.”¹¹ And, as numerous California cases have held, “by proscribing ‘any unlawful’ business practice, §§ 17200 borrows violations of other laws and treats them as unlawful practices that the unfair competition law makes independently actionable.”¹²

Here, the court held that although the unfair competition law was broadly written, the court may not impose its own notions as to what is “fair” or “unfair.” More specifically, legislation may limit the court’s ability to declare conduct unfair, and thus violative of § 17200. And, that is precisely what the Legislature did when it enacted § 1371.4(e), which specifically allows healthcare service plans to delegate to contracting medical providers the responsibility to pay for emergency services. Thus, Emergency Physicians could not state a claim under § 17200.¹³

Next, the court considered Emergency Physicians’ implied contract claim. While the court held that § 1371.25 of the Knox-Keene Act itself contemplated that a healthcare service plan may be held liable under theories based on other laws, such as breach of contract, negligence, etc., as a matter of common sense § 1371.25 cannot be read to allow a common law cause of action that is contrary to another specific provision of the act.¹⁴ Furthermore, the court held that an implied contract is one which arises from a mutual agreement and intent to promise where the agreement and promise have not been

expressed in words. Here, the alleged course of conduct does not show that PacifiCare ever paid Emergency Physicians directly for the provision of emergency medical care.¹⁵ Thus, there was no factual basis to conclude an implied contract existed between Emergency Physicians and PacifiCare.

Next, in perhaps its most interesting and creative cause of action, and one which presaged the claim in *Ochs v. PacifiCare of California*,¹⁶ to be discussed below, Emergency Physicians asserted a claim for negligence, arguing that PacifiCare breached its duty “to use due care so as not to cause harm to [Emergency Physicians’] financial interest.”¹⁷ The court first held that the threshold question is whether there exists a duty to use due care toward the interest of another that enjoys legal protection from unintentional invasion. If there is not, no cause of action for negligence can be stated.

The court then said that recognition of a duty to manage one’s business affairs to prevent purely economic loss to third parties in their financial transactions is the exception, not the rule, in negligence law. The court described a six part test to be used to determine whether a duty exists. “The determination [of] whether in a specific case the defendant will be held liable to a third person not in privity is a matter of policy and involves the balancing of various factors, among which are [1] the extent to which the transaction was intended to affect the plaintiff, [2] the foreseeability of harm to him, [3] the degree of certainty that the plaintiff suffered injury, [4] the closeness of

the connection between the defendant’s conduct and the injury suffered, [5] the moral blame attached to the defendant’s conduct, and [6] the policy preventing future harm.”¹⁸

While it would appear as though there was some room for a claim against the healthcare service plan, the court held that Emergency Physicians could not satisfy the first factor, because it could not show that PacifiCare’s conduct was intended to affect Emergency Physicians, but instead was only going to affect the general class of persons to which Emergency Physicians belonged.¹⁹ Additionally, the court said that Emergency Physicians’ failure to show a particularized effect precludes a finding of a special relationship giving rise to a duty of care.²⁰ Finally, shutting the door completely on Emergency Physicians’ negligence claim, the court held that even if Emergency Physicians could satisfy certain of the six factors, it still would not find liability as a matter of policy. The court believed that because the Legislature had allowed risk sharing plans (such as capitation) and the delegation of payment responsibility to contracting medical providers, allowing a negligence claim against the healthcare service plan would be contrary to the intent of § 1371.4(e) of the Knox-Keene Act.²¹

Next the court considered Emergency Physicians’ claim for *quantum meruit*, which under California law is an obligation created by law without regard to the intentions of the parties in situations where one person would be unjustly enriched or the other would unjustly suffer

loss.²² The court concluded that no such claim could be stated because *quantum meruit* only applies where the restitution to be made involves no frustration or violation of law or public policy, either indirectly or directly.²³ Here, the court refused to grant Emergency Physicians restitution because it believed that the Legislature had specified the payment obligations in this situation.²⁴ When it enacted § 1371.4 of the Knox-Keene Act the Legislature weighed the competing interests of emergency providers and healthcare service plans and concluded that the healthcare service plans could delegate payment obligations. To grant restitution would contravene the Legislature's intent, and would undermine the Legislature's determination that "the benefits to the public of allowing healthcare service plans to delegate risk to contracting medical providers outweigh the cost to emergency service providers."²⁵

Finally, the court also held that Emergency Physicians could not state a breach of contract claim as a third party beneficiary of the contracts PacifiCare entered into with its enrollees. Emergency Physicians argued that when PacifiCare agreed to pay the medical claims of its enrollees, those claims would include emergency medical services.²⁶ The court, however, held that to assert a claim as a third party beneficiary one must be an *intended* beneficiary under the contract, and here Emergency Physicians was not an intended beneficiary. As the court stated, the enrollee's policies "do not show an intention to benefit non-contracting providers, who are not mentioned in the contract."²⁷

II. *Ochs v. PacifiCare of California*

The case, *Ochs v. PacifiCare of California*²⁸ was almost identical to *Emergency Physicians*. It also involved the nonpayment of emergency services by FHN. Just as in *Emergency Physicians*, the contract between FHN and PacifiCare in *Ochs* delegated PacifiCare's obligation to pay for medical services to FHN. In this case, the plaintiff, Melvin Ochs, M.D. Medical Corporation provided emergency medical room services at a hospital in San Diego, California.²⁹ Ochs provided emergency services to PacifiCare enrollees who had chosen FHN as their medical provider. Ochs, however, did not have a contract with either PacifiCare or FHN. Because FHN has declared bankruptcy, Ochs sought payment from PacifiCare directly, which declined to pay the bills on the grounds it was not financially responsible for the services it delegated to FHN.³⁰

Ochs filed suit against PacifiCare, alleging causes of action for: (1) statutory violations of the Knox-Keene Act; (2) unfair business practices; (3) negligence; (4) declaratory relief regarding PacifiCare's obligation to pay; (5) common law counts for services rendered; (6) *quantum meruit*; and (7) breach of contract as a third party beneficiary. The lower court sustained PacifiCare's demurrer on the grounds that PacifiCare had delegated its responsibilities to FHN and was not obligated to pay for non-contract emergency services simply because FHN had not paid the claims.

A. *Ochs' claim under § 1371.4 of the Knox-Keene Act*

The Second District Appellate Court first considered Ochs' claim under § 1371 of the Knox-Keene Act. Ochs argued, just as had *Emergency Physicians*, that under § 1371.4(b) PacifiCare was required to pay for emergency services when the medical provider could not pay.³¹ The court, however, declined to hold PacifiCare responsible for paying the unpaid claims, and addressed the issue at even greater length than the court in *Emergency Physicians*. The court first stated that it found the reasoning of the *Emergency Physicians* court persuasive, and that while not all delegations connote the complete relinquishment of all rights and responsibilities, when it is a *legal duty* that is delegated (as under § 1371.4), no residual liability remains.³²

Ochs next argued that a delegation under § 1371.4 does not relieve a healthcare service plan of its ultimate obligation unless the emergency care provider has agreed to only look elsewhere for payment. Ochs relied upon Cal. Civ. Code § 1457, which provides that "the burden of an obligation may be transferred with the consent of the party entitled to its benefit, but not otherwise . . .,"³³ and argued that he had not agreed to transfer the burden. The court, however, disagreed with Ochs, holding that PacifiCare's obligation to pay Ochs in the first place arises exclusively from § 1371.4.³⁴ The same statute, in § 1371.4(e), provides that the payment obligation may be delegated to another. Thus, assuming that Cal. Civ. Code § 1457 even applies to statutory as well

as contractual obligations, a healthcare service plan only has an obligation to pay because one is created by § 1371.4, and that very same statute (including subsection 1371.4(e) thereof) takes precedence over the general rule set forth in Cal. Civ. Code § 1457.³⁵

The *Ochs* court then analyzed the legislative history of § 1371.4, just as the *Emergency Physicians* court had done. The court believed that when the progenitor of § 1371.4 was being considered, healthcare service plans were opposed to the statute out of concern that it would shift the decision making authority from the healthcare service plans to the emergency physicians, thus impeding the healthcare service plans' ability to manage care and costs.³⁶ The Legislature therefore enacted § 1371.4(e) which allowed the healthcare service plans to delegate the payment obligations to contracting medical providers, and silenced the healthcare service plans' opposition to the statute. Because § 1371.4(e) was enacted as a concession to the healthcare service plans to allow them to better manage care and costs, it must be interpreted in accord with that purpose, which dictates that once payment obligations are delegated the emergency physicians can no longer look to the healthcare service plan for payment.³⁷

In addition, the court believed that a proposed 2001 amendment to the statute, which was not adopted, provided further evidence in support of the court's holding. The authors of the proposed 2001 amendment were concerned that emergency

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room physicians were frequently not paid for services because many provider groups were on the verge of bankruptcy, and that as a result fewer and fewer physicians were willing to provide emergency care.³⁸ The court believed that the rationale for amending the law illustrated the Legislature's understanding that, absent the amendment, emergency room doctors would not be paid for care they had provided if the provider group went bankrupt.³⁹

Ochs then argued that PacifiCare had a duty to pay pursuant to §§ 1371 and 1371.35 of the Knox-Keene Act, both of which establish timelines for the payment of claims by healthcare service plans.⁴⁰ Section 1371 provides "the obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice association, or other contracting entities to pay claims for covered services," and § 1371.35 contains identical language. Ochs argued that under those sections PacifiCare could not avoid its responsibility to timely pay claims merely by delegating the payment duty to an intermediary.⁴¹ The court, however, rejected Ochs' argument holding that the statute did not require the delegating entity to pay the claims, but instead merely provided that if the obligation was delegated, the entity to which it was delegated was also required to comply with the claims handling procedures set forth in § 1371.⁴²

Finally, the court considered Ochs' argument that it was

unjust to allow PacifiCare to delegate its statutory duty to pay for non-contract emergency services when physicians are required by law to provide such services regardless of a patient's ability to pay.⁴³ The court appeared sympathetic to the emergency physicians' situation, and stated that "we have no quarrel with the proposition that emergency care providers should be paid for the important services they provide, and, were we writing on a clean slate, we might well conclude that it is preferable for the healthcare service plan to bear the ultimate cost when an intermediary that it has selected becomes insolvent."⁴⁴ In the end, however, the court held that it was not at liberty to rewrite the relevant statute or revise the legislative history to do what was "fair." Indeed, the court concluded that while the Legislature addressed some of the concerns of the emergency physicians when it enacted § 1371.4, the new right under § 1371.4 was "tempered by a provision that specifically allowed plans to delegate their payment responsibilities thus allowing them to better manage their costs and pass the savings along to their insureds. Whatever the flaws of the current system, the solution must come from the legislature and not the courts."⁴⁵

B. Ochs' remaining claims

With respect to Ochs' remaining claims, the court first considered the claims for unfair business practices, negligence, and third party beneficiary claims.⁴⁶ The court, however, quickly disposed of each claim for the same reason the claims had been denied by the *Emergency Physicians* court.

The court, however, reached a different conclusion than the *Emergency Physicians* court with respect to a claim for negligence. The court first considered the trial court's refusal to grant Ochs leave to amend, stating that a denial of leave to amend is reviewed under an abuse of discretion standard, which is demonstrated if there is a reasonable possibility that the pleading could be cured by amendment.⁴⁷ The court concluded that Ochs could possibly amend his complaint to state a cause of action for negligence on the basis that "PacifiCare knew or should have known that FHN was insolvent based on its audits of that entity, resulting in foreseeable financial harm to Ochs."⁴⁸

In his opening brief, Ochs had argued that the complaint could be amended to allege that Ochs suffered an economic loss because PacifiCare contracted with FHN when it knew or should have known that FHN was insolvent. The court stated that in certain circumstances the law recognizes a duty to manage one's business affairs to protect against the economic loss of a third party, and cited the same six factors as were cited in *Emergency Physicians* for the existence of the duty when there is no contractual privity.⁴⁹ The court also stated that though the recognition of a duty to protect a third party from harm is the exception rather than the rule, the six factors could weigh in favor of imposing a duty in this case, depending on the specific facts alleged by Ochs in an amended complaint.

In addition, the court disagreed with the *Emergency Physicians*

court and rejected PacifiCare's argument that a claim of negligent delegation is precluded because it would require a showing that the allegedly negligent conduct was intended to affect Ochs specifically, rather than the class of emergency physicians generally. The court said that although the argument is based on the language in *Emergency Physicians*, it is "well established that liability for negligent conduct may be imposed when a duty is owed to the plaintiff or to a class of which the plaintiff is a member."⁵⁰ Thus, the court believed that Ochs should be allowed to amend his complaint to attempt to state a cause of action for negligence.

Finally, the court implicitly rejected the holding in *Emergency Physicians* that even if Emergency Physicians could satisfy certain of the six factors, it still would not find liability as a matter of policy because allowing a negligence claim against the health services plan would be contrary to the intention of § 1371.4(e). The *Ochs* court was obviously aware of that dicta in *Emergency Physicians*, but never addressed the argument.

III. Conclusion

Thus, coming full circle, does a non-contracting physician have any recourse against a healthcare service plan? That appears to depend on whether one follows the holding in *Emergency Physicians* or *Ochs*. *Emergency Physicians* appeared to completely shut the door on any type of claim by the non-contracted provider, including claims for negligence. *Ochs*, however, seems to have reopened the door, albeit only slightly, for a non-contracted provider to at

least attempt to show that the healthcare service plan negligently delegated payment obligations to a medical service provider that the healthcare service plan should reasonably have known would be unable to pay its claims. While certainly not a simple claim to prove, *Ochs* should give non-contracted providers some hope, and should cause healthcare service plans to take a harder look at the medical service providers to whom they delegate payment obligations if they want to take advantage of the protections afforded by § 1371.4(e) of the Knox-Keene Act.

Endnotes

- ¹ *California Emergency Physicians Medical Group v. PacifiCare of California*, 111 Cal.App.4th 1127 (2003).
- ² Knox-Keene Health Care Services Plan Act, Cal. Health & Safety Code, § 1340 et seq.
- ³ A demurrer under California law is the equivalent to a motion to dismiss for failure to state a claim under Fed. R. Civ. P. 12(b)(6).
- ⁴ See *California Association of Health Facilities v. Department of Health Services*, 16 Cal.4th 284, 295 (1997).
- ⁵ *Emergency Physicians* at 1132.
- ⁶ Citing *California Association of Health Facilities* at 295.
- ⁷ *Emergency Physicians* at 1132.
- ⁸ *Id.*
- ⁹ *Id.*, citing Governor's veto message to Senate on Senate Bill No. 117 (October 10, 2001) #3 Sen. J. (2001-2002) Teg. Sess. pp. 3082-3083.
- ¹⁰ *Id.* at 1133.
- ¹¹ Cal. Bus. & Prof. Code § 17200.

- ¹² *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.*, 20 Cal.4th 163, 180 (1999).
- ¹³ *Emergency Physicians* at 1133.
- ¹⁴ *Id.* at 1134.
- ¹⁵ *Id.*
- ¹⁶ *Ochs v. PacifiCare of California*, 115 Cal.App.4th 782 (2004).
- ¹⁷ *Emergency Physicians* at 1135.
- ¹⁸ *Id.*, citing *Quelimane Co. v. Stewart Title Guaranty Co.*, 19 Cal.4th 26, 57-58 (1998).
- ¹⁹ *Id.* at 1135-1136.
- ²⁰ *Id.* at 1136.
- ²¹ *Id.*
- ²² *Id.*, citing the Restatement of Restitution, general scope note, p. 1.
- ²³ *Id.*, citing *Dinosaur Development, Inc. v. White*, 216 Cal.App.3d 1310, 1315 (1989).
- ²⁴ *Id.* at 1137.
- ²⁵ *Id.*
- ²⁶ *Id.*
- ²⁶ *Id.* at 1138.
- ²⁸ *Ochs v. PacifiCare of California*, 115 Cal.App.4th 782 (2004).
- ²⁹ *Id.* at 787.
- ³⁰ *Id.*
- ³¹ *Id.* at 789.
- ³² *Id.* at 789-790.
- ³³ *Id.* at 790.
- ³⁴ *Id.*
- ³⁵ *Id.* at 791.
- ³⁶ *Id.*, citing *Emergency Physicians*.
- ³⁷ *Id.* at 791.
- ³⁸ *Id.* at 791-792.
- ³⁹ *Id.* at 792.

- ⁴⁰ *Id.*
- ⁴¹ *Id.*
- ⁴² *Id.*, citing *Desert Healthcare Dist. v. PacifiCare, FHP, Inc.*, 94 Cal.App.4th 781, 791 (2001) and *California Medical Association v. Aetna U.S. Healthcare of California, Inc.*, 94 Cal.App.4th 151, 160-162 (2001).
- ⁴³ *Ochs* at 792.
- ⁴⁴ *Id.* at 793.
- ⁴⁵ *Id.* at 793.
- ⁴⁶ The court also denied *Ochs*' claim seeking a declaration that PacifiCare was required to pay the claims because it was completely derivative of *Ochs*' claims for statutory violations, and because the statutory claims failed, there was no basis for declaratory relief. In addition, the court denied *Ochs*' claim seeking a declaration that he had a right to bill patients if PacifiCare and FHN failed to pay the claims because the party that would be affected by such a declaration was not PacifiCare, but instead was the patients themselves, which were not joined as parties.
- ⁴⁷ *Ochs* at 796.
- ⁴⁸ *Id.*
- ⁴⁹ *Id.* at 797.
- ⁵⁰ *Id.* (emphasis in original).

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