Balance Billing of HMO by non-contracted providers

Outside of the state of Nevada, there is no more intimate professional relationship than exists than that between a physician and patient. That relationship has changed rather dramatically over the past years as insurance companies and government have taken an ever-increasing role in the healthcare system. Our healthcare environment is plagued by high costs due, in part, by providing a large amount of uncompensated services and by dramatic underpayment for services by Medicare and Medicaid. In such an environment, health insurance has become a critically important benefit to Americans. Insurance companies have thus become a necessary evil, and as dependence on insurance companies has increased, so has their power in the marketplace. The marketplace not only includes where they sell their products (to employers and consumers), but in the political marketplace as well. But the question is whether the insurance company can or should dictate the terms of healthcare between members and physicians. Over the years HMOs have tried to do exactly that. They have specified in their provider contracts that physicians could not discuss alternative care to patients, and have required physicians to follow recommendations for care as determined by the HMO. Such situations have been found to be contrary to the public good and deemed illegal by the courts. In addition, this has been addressed legislatively, Florida Statute 641.315(5) states:

“A contract between a health maintenance organization and a provider of health care services shall not contain any provision restricting the provider’s ability communicate information to the provider’s patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.”

Given that an HMO will always push the limits until denied by a court or legislature, it is understandable an HMO will create a perverse reading of any law for its benefit.

As we frame the issue on balance billing of an HMO member by a non-contracted physician, it is important it is framed in a way to address the underlying problem. Certainly HMO members don’t believe they should be balance billed, certainly HMOs don’t want their members billed, certainly the Department of Insurance doesn’t want to be bothered by HMO or HMO members who have been billed by physicians, and certainly physicians don’t want to have to bill HMO members.

Since balance billing HMO members is not to anyone’s benefit or liking, there must be rational reasons to do so. The Florida Legislature placed balance billing verbiage in the rewrite of the Provider Contracts section of the law (Title XXXVII, Chapter 641, sections 315-3156), but clearly did not prohibit balance billing in all circumstances. At issue is whether the newly drafted language provides the ability for an HMO to determine what it will pay for services when that HMO is not contracted with the physician. The battle here is not whether the HMO intends to pay a reasonable fee but whether the HMO has to right to unilaterally determine what that fee should be.

Do the HMOs truly believe that the Florida Legislature has given them the ability to determine what amount to pay for services which have been provided in good faith by physicians the HMO has been unable or unwilling to contract with? That is illogical and arguably unconstitutional.
Here is first pass of issues and analysis regarding the ability of a non-contracted physician to balance bill an HMO member in the state of Florida. Topics included are:

1. Issue
2. Related Questions
3. Interested parties
5. Other Payors Stance
6. Dept of Insurance
7. Game plan
8. Attachments

1. **Issue:**
   Can an HMO that is not contracted with a physician (or group), unilaterally determine what amount it should pay to the non-contracted physician (NCP) who provided services to an HMO member, and should the NCP be forced to accept the HMO payment as payment in full regardless of the amount?

2. **Related questions**
   - If an HMO member receives services from a NCP, should the member have to pay for those services?
   - Does it matter whether the NCP knew the patient was an HMO member?
   - Does it matter whether the member knew the physician was non-contracted?
   - Did the Florida legislature intend to give an HMO unilateral unbridled authority to determine what amount it should pay to a physician who provides medical services to one of its members if the HMO has not contracted with that physician?
   - What is the plain language of the statute?
   - What are the possible consequences of a perverse reading of the statute?
     - Payors would shortly terminate contacts with all hospital based providers (anesthesiology, radiology, pathology, emergency medicine) since these providers do not have the ability or authority to deny treatment to patient.
     - Payors would not need to negotiate in good faith with hospital based providers.
   - Should HMOs not have to contract with hospital based providers because Florida legislature has given HMOs authority to unilaterally set reimbursement rates?
   - Why do HMOs have a different benefits level if they go out of network if there is no obligation on the member for doing so?

3. **Interested Parties**
   - HMO members – having been told by their HMOs that they will not have to pay out of pocket for covered services, they focus their anger towards providers, even though the HMO contract typically spells out situations in which the member is obligated to pay for some covered services, such as when the member goes out of network for services;
• **HMOs** – having marketed their product as shielding patients from physician costs, HMOs want legislative protection on balance billing their members; expanding those protections to prohibit balance billing from non-contracted physicians significantly improves the HMOs negotiating position with all providers, since they are not required to actually contract with anyone, but can set their prices unilaterally; realistically HMOs must contract with non-hospital based physicians who can choose which patients to take, but do not need to contract with hospital based providers because these physicians are unable to deny services to anyone who presents at the hospital.

• **Physicians** – much effort and costs have been diverted from providing patient care to following HMO paperwork rules; should the primary requirement of physicians be to secure insurance data for HMO members or to provide medical services; should physician function be to provide care without regard to being reimbursed for services while maintaining professional liability for those services?

• **Government** – desires to have quality health care; desires to have viable insurance products available to citizens; desires to protect HMO members; seems to believe that supporting HMOs can best accomplish these desires. But could the Florida legislature possibly have desired to allow HMOs unilateral authority to dictate reimbursement terms for contracts so that physicians have no negotiating status.

### 4. Analysis

A non-contracted physician can choose to be treated as an in-network provider, i.e., contracted, in any number of specific instances, such as to treat a particular patient that the physician has had a longstanding relationship with, or to be able to treat patients at an ambulatory surgical center, etc. Under the wording of the new law, if the physician chooses to be treated as in network under these limited circumstances, the HMO becomes liable for services, and the physician cannot turn to the patient for an unpaid balance. Reference Fl Statute 641.3154(2):

> For purposes of this section, a health maintenance organization is liable for services rendered to an eligible subscriber by a provider if the provider follows the health maintenance organization's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

In the above situation the HMO has become liable within the statute. Arguably, the HMO becomes liable for fees only if the physician follows the HMO authorization’s procedures. A non-contracted provider does not default into becoming a contracted provider merely because the physician provides services to an HMO member, nor does the HMO become responsible for paying for non-covered services merely because the member goes to an out of network provider. This serves as a protection to both the HMO and the provider. A provider is no more required to take a HMO’s subjective payment than is the HMO required to pay for non-covered services.
HMOs are relying on a portion of the statute, specifically 641.3154 (4) which states that:

A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services …

If you stop reading the statute at this point, it does appear as though balance billing is prohibited. HMOs end their analysis at this point, however the statute continues as follows:

… for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;
(b) A court of competent jurisdiction determines that the organization is liable;
(c) The office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel pursuant to s. 408.7056; or
(d) The agency issues a final order that the organization is required to pay for such services…

The prohibition on balance billing only applies if the organization (HMO) is liable. The HMO is liable in specific circumstances only, such as if the provider follows the health maintenance organization's authorization procedures and receives authorization [641.3154(2)] or the instances listed in 641.3154 (4) (a) through (d), above.

Other portions of the statute gives additional support for balance billing. Here is a section of 641.3155 (8). This section states:

A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber for payment of covered services for which the health maintenance organization contested or denied the provider's claim. **This prohibition applies during the pendency of any claim for payment made by the provider to the health maintenance organization for payment of the services or internal dispute resolution process to determine whether the health maintenance organization is liable for the services.** For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health maintenance organization's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit
collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

This section limits prohibition on balance billing to no more than sixty days during which a claim is pended for payment, but only while the HMO determines if it is liable. The implication is that the prohibition on balance billing only applies while the physician is disputing how much is owed by the HMO on the bill. The sections states “the claim or a portion of the claim,” plainly indicating that if an HMO pays only a portion of the claim, this amounts to a denial. Once the dispute resolution procedures between the provider and HMO have concluded and there remains a “portion of the claim” denied, the prohibition against billing the patient has ended. The prohibition against balance billing only applies during the pendency in which the HMO determines if it liable. If the HMO is not liable, and there are only limited specific circumstances in which the HMO is liable, then there is no limitation to balance billing.

One could argue that this section actually allows a contracted provider to balance bill and HMO member. It states that the prohibition applies “regardless of whether the provider is under contract with the health maintenance organization” and last for no longer than sixty days. HMO’s will fervently argue that a contracted provided cannot balance bill an HMO member. From a provider’s perspective, there are only 2 types of HMOs/HMO members: 1) those with whom we are contracted; and 2) those with whom we are not contracted. This language in the statute has to apply to some HMO member, and if the HMO statement that balance billing an HMO member is prohibited, than this language has to apply to non contracted HMO members.

According to C. Ballentine, Florida courts have held that a physicians does not have the right to directly sue an HMO pursuant to the provision of Florida Statute Chapter 641 (See Villazon v. Prudential Healthcare Plan, Inc., 843 So. 2d 842 (Fla. 2003); Florida Physicians Union, Inc. v. United Healthcare of Florida, Inc., 837 So. 2d 1133 (Fla. 5th DCA 2003); Greene v. Well Care HMO, Inc., 778 So. 2d 1037 (Fla. 4th DCA 2001). His analysis states:

One of these decisions discussed in detail that the primary intent of the HMO act is to protect patients/subscribers from the acts of HMOs. The statute is not focused on protecting medical providers. Additionally, it is the Department of Insurance that enforces the act rather than parties through litigation. See Florida Physicians Union, Inc. v. United Healthcare Florida, Inc., 837 So. 2d 1133 (Fla. 5th DCA 2003). Based on this rationale and the language of the statute, Florida courts have simply not recognized the right of a medical provider to sue an HMO pursuant to the terms and provisions of the statute itself. Apparently, the Florida courts have determined that the only private party with the right to bring suit directly under Chapter 641 is the patient/subscriber and only for claims that there has been a failure to provide promised benefits. See Riera v. Finlay Medical Centers HMO Corp., 543 So. 2d 372 (Fla. 3d DCA 1989); Puig v. Pasteur Health Plan, Inc., 640 So. 2d 101 (Fla. 3d DCA 1994).

HMOs will likely claim immunity and that they cannot be sued due to provisions of Florida Statute § 641. This argument that there is no right to sue them may have serious constitutional implications. Our counter argument would be that if the statute is interpreted in this manner that it is
unconstitutional because it denies access to courts and denies due process. See Nationwide Mut. Fire Ins. Co. v. Pinnacle Medical, Inc., 753 So. 2d 55 (Fla. 2000).

Attached is a May 22, 2001 letter from the law firm of Piper, Marbury, Rudnick, and Wolfe to Karen Smock of MAPMC. Their letter does not analyze the statute but states the position of the DOI and AHCA. Under their interpretation, it is never acceptable to balance bill an HMO member. However, attached to their letter is a description of the amended Act. The description clearly states, “An act relating to managed care organization; amending ss 641.315 … prohibiting provider from billing a subscriber under specified circumstances…” The act was not intended to prohibit balance billing an HMO member, but to prohibit balance billing an HMO member under specified circumstances. The only such circumstance provided in the amended act was when a non-contracted provider petitioned the HMO through the authorization process to be treated as a contracted physician. Under that circumstance, the member may not be able to be balanced billed. Any attempt to expand a prohibition on a physician’s ability to balance bill an HMO member is merely a fabrication.

5. Other Payors

The “Important Disclosure Information” on the Aetna website discussing the need for precertification states: “It is your responsibility to contact Aetna to precertify those services which require precertification to avoid a reduction in benefits paid for that service.” The benefit is paid on behalf of the member and a reduction in benefit will cause a cost to the member. Thus Aetna acknowledges that member benefits can be reduced and members will have to pay additional costs to providers.

UnitedHealthcare recently issued a letter to its Choice Plus customers defining how they will handle out of network providers. They state “Out of network benefit levels expose you to higher financial obligations than in-network benefits and may result in direct billing by physician and facilities for non-reimbursed balances.” They then provide an example of using an in network versus an out of network facility, and show the patient is responsible for additional costs when going out of network.

6. Department of Insurance

The Department of Insurance (DOI) Mission Statement as taken from its website:

To ensure that insurance companies licensed to do business in Florida are financially viable; operating within the laws and regulations governing the insurance industry; and offering insurance policy products at fair and adequate rates which do not unfairly discriminate against the buying public. The Office of Insurance Regulation has primary responsibility for regulation, compliance and enforcement of statutes related to the business of insurance and the monitoring of industry markets. Bureaus within the Division are organized into centers of regulatory expertise related to life and health, property and casualty, specialty lines and other regulated insurance entities. It is within the Division of Insurer Services that the mission of public protection is implemented.
through regulatory oversight of company solvency, policy forms and rates, market conduct performance and new company entrants to the Florida market. The Bureaus of Life and Health Insurer Solvency and Property and Casualty Insurer Solvency underwent a comprehensive review of solvency monitoring activities and practices resulting in the re-accreditation of the Florida Department of Insurance by the National Association of Insurance Commissioners.

As you can see by the mission statement, the DOI is responsible for enforcement of statutes, while at the same time maintaining a close relationship with the insurance industry. I suspect that there is consistent and significant lobbying of the DOI by the insurance industry, but I suspect physician practices are rarely represented. It should come as no surprise that the DOI is highly influenced by insurance companies.

The Department of Insurance takes the easy way out, which up to this point has been in the direction against balance billing the HMO member. We have allowed this easy way out because providers have not been uniform in our challenge to the DOI, and have not forced the DOI to actually examine the law. The DOI even interpreted the prior law to not allow balance billing, which was purely a fabrication on its part and quite preposterous. In a section of the law titled “Provider Contracts” the DOI determined that this applied to providers not under contract, even though no such language was included in the law. On that prior law, a lower level court in Pratts v. E.S.R Diagnostics (11th Circuit Court, Miami-Dade County), ruled that the Dept. of Insurance’s stance was determined to be improper as the court stated a non-participating provider may balance bill HMO members.

At the FAAA meeting held June 27, 2003, Michelle Newell, Assistant Director of the Department of Insurance, was unequivocal in stating that the law does not prohibit balance billing of an HMO member by a non-contracted physician. She later refused to put that in writing, but the meeting was attended by dozens of administrators from around the state, and there is no questioning her comments.

7. Game Plan

Among the options for dealing with non-contracted HMOs who refuse to pay the entire charge include one or more of the following:

A) Sue the HMO: The problem with suing an HMO is resources. The only HMO currently taking the position that non-contracted physicians cannot balance bill HMO members is Aetna. Their resources are so large that it would be virtually impossible to beat them in court. They could drag on the proceedings for so long that it would bleed all the cash out of physician practices.

B) Petition Department of Insurance: Going to the DOI will not likely provide a benefit. Their stance is geared to the industry, with whom they have a close relationship, and the desire to keep members, a significant voting block, calm.
C) Petition Governor: Taking this issue directly to the Governor may be a reasonable option. There are hundreds of thousands of HMO members in Florida, thousands of providers, but just a small number of HMOs. If we can convince the executive branch, particularly in an election year, that the HMO members and providers are aligned and that the HMOs are outliers, we clearly will prevail.

D) Balance Bill Patients: In any event, it seems rational to continue to balance bill HMO members if the physician is not contracted. Failure to do so will give credence to the HMOs preposterous argument. Billing non-contracted HMO members could be done in many ways.

1. First you could choose to not bill the HMO, but to bill directly to the patient. This is more work for the practice and would likely delay payment, but eliminates the HMO and requires the patient to deal with his/her insuror directly.

2. Another option is to balance bill the HMO member after inadequate payment from the HMO, and send a letter to the patient with an analysis of the law and recommend that the patient to contact the DOI stating that the HMO has not paid the bill, and to send a letter to the HMO demanding prompt payment.

3. A conservative option would be to send a letter as soon as any HMO refuses to pay all of your bill citing the exact language of Florida Statute § 641.3155(8) and advise the HMO that due to the fact that they have denied a portion of the claim, that under this statute you have the right to bill the patient if they do not make payment of the bill in full within sixty days. Make sure that after sending this letter wait at least sixty days before balance billing the patient. When you do balance bill the patient, copy the HMO and again advise them of the fact that you are doing this due to their refusal to pay a portion of the claim and you are, therefore, protecting your rights pursuant to Florida Statute § 641.3155(8). You should again quote the statute.

E) Develop follow up letters to patients and to HMOs and DOI citing applicable Florida Statutes and the desire that physicians do not want to balance bill HMO member, but have no alternative since the HMO refuses to provide the coverage to member as promised. This letter could be sent with the balance bill to HMO members.

The Dept of Insurance wants to take the path of least resistance. Only HMOs are sending letters to the DOI stating their stance, and without opposition to that stance, it is easy for the DOI to call the physician and request the patient not be billed. However, we can remove this easy way out, by sending letters of legal substance. At that point, the DOI cannot merely dismiss the issue by defaulting to the HMO argument.

8. Attachments
- Florida Statutes Title XXXVIII, Chapter 641, Section 315-3156
- Letter dated may 22, 2001 from Piper Marbury Rudnick & Wolfe to Karen Smock of MAPMA
- Balance Billing of HMO Patients from Florida Medical Association