Health Plan Payments to Non-Contracted Providers

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Introduction

Payment disputes between health plans and their contracted health care providers continue to be the frequent subjects of contractual disputes, litigation and state legislative activity. However, one legal factor that may often bring at least some level of legal context or clarity to these disputes is the existence of a contract between the parties. A provider’s participation agreement with a health plan typically spells out in detail the services to be provided, the reimbursement payable and a variety of other administrative considerations, including a process for notice of breach and cure and dispute resolution. When a participating provider challenges a health plan’s reimbursement, the challenge is usually based on some aspect of the health plan’s reimbursement practices in the context of the contractual agreement – alleging that the plan did not pay fully or partially in accordance with the terms of the contract (wrong amount or wrong fee schedule, etc.), that the plan changed contractually governed elements of the payment relationship with inadequate notice or agreement (change in fee schedule, change in usual, customary or reasonable (“UCR”) calculation methodology, “bundling” of multiple coded services into a single code for reimbursement purposes, etc.).

However, another recent legal trend involves disputes between health plans and non-participating providers, physicians and other healthcare providers who have elected not to enter into a formal participation or services agreement with the health plan, but
who may still be eligible for and legally entitled to some level of reimbursement for
services rendered to plan participants. Resolution of these disputes can hinge on a
number of factors, including benefit design, state law, patient compliance with applicable
administrative requirements, etc.

**Traditional Closed Panel Plans**

In some more traditional health plans, patients are restricted to receiving
services from the contracted or employed provider network, except in situations where
the plan specifically authorizes the care (out of plan referral authorization for an
infrequently utilized specialty service, promising clinical trial, etc.) or where specific
prior authorization for going out of plan (e.g., receipt of emergency or some urgent care
services, plan provider was unavailable, etc.) is not required. In these plans, non-
emergent care received from a non-participating provider would be typically be deemed a
non-covered service, and the patient would be personally financially responsible for
making payment to the provider, either under the terms of a specific agreement with the
provider (execution of a “patient treatment agreement” or “financial responsibility” form)
or under common law *quantum meruit* or other available causes of action under state law
that allow the physician to recover the value of the services rendered from the individual
who benefited from the service.

**Plans Providing Out of Network Access**
An increasing number of health plans now provide for some level of routine patient access to non-participating providers. This can be through a traditional preferred provider organization (PPO) or other plan with a point of service (POS) or “open access” option. Typically, patients are subject to some level of financial incentive to utilize in-plan providers (lower co-payment or coinsurance levels applied to use of in-plan providers), but they may have the option of going to non-preferred or non-plan providers to receive their care if they are willing to pay an increased cost share. Depending on the terms of the policy, this option may be exercised through self-referral with no plan authorization, or the plan may have some level of pre-authorization or notice requirement that governs the patient’s ability to receive coverage for the services of non-plan providers.

Reimbursement of Non-Participating Providers

There are a variety of issues related to a health plan’s legal obligation to reimburse non-contracted providers.

Direct Payment to the Provider

Some plans refuse to make payment directly to a non-contracted provider and will only make payment directly to their insured who, in turn, is then obligated to reimburse the provider for services rendered. This practice may even be supported by a policy provision prohibiting the assignment of the patient’s right to receive reimbursement to
any non-plan provider. In at least one case, a state legislature has attempted to require carriers to recognize assignment and to make payment directly to certain classes of provider (e.g., ambulance services). See, Georgia General Assembly House Bill 747.

Rates Payable to Non-Contracting Providers

Once a non-contracted provider has rendered covered services to a plan member and it has been determined that all or some portion of the cost is the health plan’s financial obligation (and not the member’s), the key question then becomes: what rate is payable to the provider? By definition, the non-contracted provider has not entered into a legally binding agreement with the plan that would dictate the rate or rate formula applicable to the particular service rendered. In addition, as a non-participant in the health plan’s contracted provider network, the provider will generally not be seeing a significant volume of the plan’s patients (and even if so, this will typically not result from the plan purposely steering patients to that provider), so the plan may have little of the negotiating leverage that they have with their contracted providers, who may be seeing a substantial volume of that plan’s members.

There are a variety of methods that can be utilized to establish an appropriate payment rate with a non-contracted provider, some of which result from negotiations between the parties and some that may be imposed by law or regulation:
1. **Billed Charges.** The health plan can simply agree to pay the provider’s billed charges in full. Most health plans are reluctant to do this, since a provider’s full undiscounted charges are generally more (sometimes significantly) than what the health plan would otherwise pay a contracted provider for the same service, and may even be more than the non-contracted provider charges to individual patients or health plans that it does contract with. There may be situations where paying billed charges is relatively unavoidable -- to non-contracted health care facilities that rendered covered emergency care to the patient, or to out-of-state providers who may not be bound by any applicable patient “hold harmless” provision imposed by state law or contract that might otherwise prohibit the provider from seeking payment directly from the patient.

2. **Health Plan Fee Schedule.** The provider may be willing to accept the health plan fee schedule if they do not do any significant volume with that payor and the administrative effort of pursuing full charges or some other higher amount would outweigh any incremental increase in the amount recovered.

3. **Negotiated Rate.** The parties are always free to negotiate a rate for a specific patient. Some health plans may enter into “patient treatment agreements” in advance with a non-contracted provider who renders an
infrequently utilized or difficult to procure specialty service that spells out the scope of service and the rate payable. Application of these agreements will usually be limited by their terms to a specific patient and episode of care. The parties can also negotiate a mutually acceptable rate after the treatment has already been rendered, through the provider may be less willing to negotiate at that point.

4. **State Mandated Formula.** For a state regulated carrier, there may be statutory requirements governing what the non-contracted provider must be paid. For example, the Maryland Health maintenance Organization (HMO) Act mandates that a non-contracted provider who renders covered services to an HMO member must be paid the greater of 125% of what the HMO paid to a similarly licensed provider under contract, or the rate the HMO would have paid to a similarly licensed non-contracted provider in the same geographic area for the same service as of January 1, 2000. Maryland Health-Gen. Code § 19-710.1. The same statute requires trauma physicians to be paid at least 140% of the current Medicare rate for the same service. Indiana law requires HMOs to allow members to go out of plan for covered services not available from plan providers and mandates that the plan pay the provider the lesser of the UCR fee for the same service in the HMO’s service area, or some other amount mutually agreed upon by the parties. I.C. §27-13-36-5. Government sponsored health plans (e.g.,
Medicaid Managed Care Organizations) may also be subject to regulatory requirements on payment levels to non-contracted providers for certain self-referred, emergency or other out of plan physician services. The Code of Maryland Regulations (COMAR §10.09.65.20) provides that state-contracted Medicaid MCOs can pay non-contracted providers Medicaid fee schedule rates for certain specified services provided to beneficiaries outside the plan’s contracted network.

Time Frame for Recoupment of Overpayments

The agreement between a health plan and one of its contracted providers may govern the provider’s obligation to refund to the plan amounts incorrectly paid. This may include a time limitation that is different from the applicable state statute of limitations for contracts (e.g., state statute of limitations is three years, health plan would ordinarily be able to go back three years in requesting refund of overpayments, contract contains a provision limiting the health plan from going back more than one year from the date of original payment). Thus, under some circumstances, a health plan may actually have greater flexibility in pursuing non-contracted providers for recoupment of overpayments.

Patient Issues

Health Plan payments to non-contracted providers can also have significant legal and financial consequences for the patients involved.
Patient Coinsurance

If the provider does not receive reimbursement from the health plan, they may be able to bill the patient directly for the costs of the services rendered, unless a patient “hold harmless” provision applies under state or federal law. See, Maryland Health Gen. Code § 19-710(i). The hold harmless might prohibit a physician from billing the patient for the cost of covered services, or from “balance billing” – billing the patient for the difference between the plan’s payment and the physician’s billed charges. In some jurisdictions, the hold harmless may not apply to non-contracted physicians, though in others it applies to any physician providing services to health plan enrollees. See, Opinion of the Maryland Attorney General No. 98-018, 1998 Md. AG LEXIS 19.

If the health plan calculates the patient cost share based on a percentage of an “allowable” or “eligible” charge keyed to their own fee schedule, the patient may experience a dramatic increase in their cost share if the provider charges substantially more than the “allowable” charge. The patient may be liable for the difference between the amount the plan pays to the provider and the plan’s “allowable” charge, plus any difference between the allowable charge and the provider’s actual charge, although some plans include an annual cap on the patient’s out of pocket cost for these differentials. (For example – plan allowable charge for service is $100; patient coinsurance is 20% of allowable amount. Patient is billed $20 by participating provider. Non-contracted provider charges $200 for the same service, plan pays 80% of allowable charge, or $80,
non-contracted provider bills patient for $120). This practice has been the subject of attempts to certify a class action on behalf of affected patients and administrative actions within State Insurance Commissions. See, Hanoian v. Blue Cross and Blue Shield of Rhode Island, Rhode Island Superior Court, C.A. No. 96-2579 and File No. 51216, Michigan Commissioner of Financial and Insurance Services, January 21, 2003. The American Medical Association (AMA) Litigation Center, a cooperative effort between the AMA and state medical societies that pursues litigation in matters of importance to patients and providers, has participated in a suit alleging that certain payors used allegedly faulty data that understated the payor’s UCR, which resulted in a corresponding increase in the patient cost share amount. American Medical Ass’n v. Metropolitan Life Ins. Co., No. 00105266 (N.Y. Sup. Ct. Stret). South Dakota law requires disclosure in a health insurance policy that a UCR methodology is being utilized by the health plan and specific notice to the consumer that this may result in higher out of pocket costs. SDCL § 58-33A-8.1. See also, Illinois Public Act 92-0579. Some states are also attempting to address the issue of consumer confusion when receiving services from a non-contracted provider that may be practicing within a facility or institution that is itself a member of the plan’s contracted provider network. See, State of Colorado, House Bill 04-1177.

There have been numerous other suits by providers challenging a payor’s under calculation of UCR, which also have an indirect impact on calculation of patient cost share amounts. See, for example, Medical Association of Georgia v. Blue Cross & Blue Shield of Georgia, Inc., 244 Ga.App. 801 (June 19, 2000).
Patient Deductible

A number of health plans impose an out of pocket deductible, an amount that the patient must personally expend for health care services before they become eligible for other coverage under the policy. Some plans calculate the deductible in terms of what the plan would have paid for the service to contracted providers under its fee schedule, and not what the patient actually expended. Thus, if a patient receives services from a non-contracted provider that charges more than the plan fee schedule, they may only receive credit towards the deductible for what the plan would have paid, not the actual amount that they reimbursed the non-contracted provider. This can extend the period of time that it takes the patient to reach the deductible and become eligible to receive other coverage under the plan. Even though state or federal law may require the plan to disclose this practice to the consumer, patients may still be surprised that they have not met the deductible by actually spending that amount for health care services.

Conclusion

Payments by health plans to non-contracted providers can result in challenges from patients, providers and state and federal regulators. These payments may constitute virtually unregulated negotiations between providers and health plans, or they can be subject to specific regulations that may vary by state, plan and provider type. Health Plans should be aware of any applicable regulations in their service area, particularly if they operate in multiple jurisdictions. They should also develop consistent internal...
policies and procedures applicable to their payment of these claims, as well as clearly worded disclosures in policy documents, in order to avoid consumer confusion and challenges. In cases where a decision has been made to allow a patient to utilize a non-contracted provider in advance of the actual date of service, an agreement between the plan and the provider regarding the scope of services to be rendered and the applicable plan reimbursement and patient cost share should be set forth in writing.