

**Payment Litigation Other Than UCR
Presented by Steven M. Ziegler**

I. SILENT PPOS

A. Introduction

Silent PPOs occur when a payor accesses a discount to a network with which it does not have a contract. An example of this type of arrangement can be found in the factual background of the Christie Clinic, P.C. v. MultiPlan, Inc., Case Number 08-CV-2065 (C.D. Ill). In that case, Plaintiff, a health care provider, entered into an agreement with MultiPlan, a PPO, whereby Plaintiff agreed to accept discounted rates for services in exchange for MultiPlan agreeing to market its provider network in such a way as to increase the volume of patients Plaintiff would see, a practice commonly referred to as “steerage.” Plaintiff alleged that MultiPlan in turn contracted with other payors, which contracts allowed these payors to access the discounts Plaintiff had given MultiPlan but did not require that the other payors steer patients toward Plaintiff. This type of arrangement, according to Plaintiff, constituted a silent PPO. See Order Denying Plaintiff’s Motion for Class Certification, 2009 WL 175030 (Jan. 26, 2009).

Another description of a silent PPO was provided in Roche v. Travelers Prop. Cas. Ins. Co., 2008 WL 2875250, *1 (S.D. Ill. Jul. 24, 2008):

A silent PPO is a term of art for a kind of PPO abuse. Essentially a silent PPO occurs when a payor receives a PPO discount to which he is not entitled. For example, suppose a patient with an indemnity insurance plan goes to a provider who is part of a PPO. By definition, the patient with an indemnity insurance plan is not steered toward a provider, but is free to choose any provider he wishes. The patient typically pays a percentage of

the total bill, and his insurance pays the rest. In a silent PPO, after the patient pays his share of the bill and the provider submits the outstanding balance to the payor for payment, the payor notices that the provider is a member of a PPO. The payor then proceeds to pay the provider at the PPO discounted rate, instead of the usual and customary rate. If the payor and provider are both members of the PPO, this discount payment may constitute a breach of the PPO contract. If the payor is not a member of the PPO, but pays only the PPO rate, this discount may constitute fraud.

B. Historical Silent PPO Cases

One of the first cases to discuss the silent PPO issue was Mitzan v. MedView Services, Inc., 1999 WL 33105613 (Mass. Super. Jun. 16, 1999). That case was a class action suit brought by plaintiff chiropractors against a PPO, managed care discount brokers and auto insurers for taking allegedly improper discounts on submitted claims. Plaintiffs had a preferred provider contract with MedView in which they agreed to accept a 20% discounted rate in exchange for MedView's promise that it would market Plaintiffs' services, thus increasing its patient volume. MedView then contracted with Concentra and IntraCorp, which allowed them to access a MedView database that showed the discounted fees of MedView preferred providers. Concentra and IntraCorp in turn entered into cost containment contracts with a number of automobile and PIP carriers in which they processed medical claims and accessed Plaintiffs' discounted rates. Plaintiffs filed suit against all parties and alleged that this was an illegal silent PPO arrangement that was an actionable deceptive practice.

In a ruling on the Defendants' Motion to Dismiss, the Court held: (1) Plaintiffs stated a claim for breach of contract against the PPO because the discount brokers and auto insurers were not proper payors to whom the PPO could disclose the chiropractors' negotiated discount rates, since they did not contract with the PPO to pay for services rendered to the PPO members; and (2) the claims against the discount brokers for

operating a silent PPO in violation of Massachusetts' Unfair Business Practices Act had to be dismissed because there was no contract between the brokers and the chiropractors, as was required to bring suit under the Act.

A few years later, the Seventh Circuit was confronted by the silent PPO issue in a case that pitted a directed PPO against a non-directed PPO. The Plaintiff in First Health Group Corp. v. BCE Emergis Corp., 269 F.3d 800 (7th Cir. 2001), was a directed PPO which brought an action under the Lanham Act for false advertising against a non-directed PPO (UP & UP). According to the Court, a non-directed PPO is different from a directed PPO in that steerage is not expected, but future business is encouraged because patient bills are lower. The PPO Plaintiff, First Health, argued that the Defendant was engaging in false advertising by calling itself a PPO because it did not provide steerage and so was really just a silent PPO.

The Court, in an opinion by Judge Easterbrook, expanded the legal definition of a PPO. Specifically, the Court held that the use of the term "PPO" by the non-directed network did not violate the Lanham Act and did not constitute a silent PPO, and that there was nothing false or misleading with Defendant UP & UP's business model:

[W]e conclude that First Health has not established that any of UP & UP's statements was false or even misleading. What First Health wants – a judicial decree that only businesses using a single model can employ the term "PPO" or the phrase "preferred provider network" – is nothing less than an order establishing property rights in the language. Words are not born with meanings. They acquire meaning with use, and as use changes so does meaning. It may well be that all of the initial PPOs were "directed." But for many years not only UP & UP but also other similar intermediaries have been offering what they call non-directed PPOs. Both have become standard usages.

Id. at 804.

Next, HCA Health Services of Ga., Inc. v. Employers Health Ins. Co., 240 F.3d 982 (11th Cir. 2001),¹ involved the widespread, multi-faceted leasing of a PPO contract. In that case, the plaintiff hospital had previously entered into a PPO contract with a third party whereby it agreed to a 25% discount on services rendered in return for steerage. Unbeknownst to the hospital, the third party then leased this agreement to a fourth party. Subsequently, a PPO member had surgery at the plaintiff hospital and assigned his rights to the hospital to recover 80% of the cost of treatment from his insurer, which amount was consistent with the member's contractual right to reimbursement under his policy. The insurer, which had a contract with the fourth party, discovered that the hospital had entered into the PPO arrangement with the third party and thus first reduced the bill by 25% before paying 80% of that amount. The hospital sued, arguing that the insurer did not have a right to access or pay the discounted rate.

The Court ultimately agreed with the hospital. Critical to its decision was its analysis of the word "expense," given that the insurer was contractually obligated to reimburse 80% of the "expense" of covered services. The insurer argued the definition was broad enough to include the discounted rate it had taken, but the Court disagreed, finding nothing in the member's policy to support such an interpretation. More importantly, the Court also found that the insurer was not entitled to the discounted rate because the "silent PPO" arrangement was not in place at the time the insurer issued the policy to the member and because the hospital had received no benefit from the bargain between the insurer and the fourth party. Id. at 997.

¹ Impliedly overruled on other grounds. See Doyle v. Liberty Life Assur. Co. v. Boston, 542 F.3d 1352 (11th Cir. 2008).

Finally, in New England Physical Therapy Network, P.C. v. HealthCare Value Mgt. Inc., 2002 WL 1923805 (Mass. Super. Aug. 21, 2002), a group of physical therapists filed suit against a PPO which allowed a third party, Concentra, to access a database containing rate discount information for the PPO's members, which database included plaintiffs' discounted rates. Concentra then entered into separate agreement with a number of auto insurers to allow Concentra to reprice medical bills based on the rate discount information. Plaintiff filed suit against the PPO and Concentra, arguing that Concentra's contract program with the auto insurers did nothing to steer patients toward them. The Defendants moved to dismiss the Complaint on the grounds that Plaintiff was not the real party in interest, but the Court found that a party such as plaintiffs, who had contracted for the benefit of another, were permitted to sue in their own name and allowed the suit to continue.

C. Present Situation

On February 15, 2005, the U.S. Legislature enacted the Class Action Fairness Act of 2005 ("CAFA"), which grants federal courts jurisdiction in diversity over class actions with 100 or more class members in which any member of the class is a citizen of a state different of that of any defendant. One of the main goals of CAFA was to eliminate "forum shopping" on the part of plaintiffs who would file suit in jurisdictions that were notoriously plaintiff-friendly. Two such jurisdictions are St. Clair and Madison Counties, Illinois.

Very shortly before CAFA was to go into effect, dozens of lawsuits were filed in state court in St. Clair and Madison Counties accusing health plans of engaging in silent PPO operations. The timing of these suits makes clear their intent to avoid application of

CAFA and litigation of claims in federal court. The first wave of litigation over these cases occurred when the plaintiffs amended their complaints to include additional causes of action, which led to removal attempts on the part of the defendants, who argued that such amendments were materially different from the causes of action previously alleged such that they did not “relate back” to the initial complaint and therefore were properly removable under CAFA. For the most part, such attempts were unsuccessful, and new allegations were deemed to indeed relate back to the initial complaint. See, e.g., Kaltenbronn v. Liberty Mut. Ins. Co., 2007 WL 2802328, *4 (S.D. Ill. Sept. 24, 2007) (“[t]he gravamen of Plaintiffs’ action remains the same, however, despite the addition of a claim that Liberty concealed its silent PPO operation. Plaintiffs have not, by the addition of this claim, propounded a claim “sufficiently distinct” such that the Court would treat it as a new piece of litigation”); Eavenson v. Selective Ins. Co. of America, 2007 WL 489206, *4 (S.D. Ill. Feb. 12, 2007) (“Eavenson’s second amended complaint relates back to the first amended complaint filed prior to the enactment of CAFA, in that the first amended complaint furnished to the defendant all the information necessary to prepare a defense subsequently asserted in the amended complaint”). But see Coy v. Country Mut. Ins. Co., 2006 WL 3487653 (S.D. Ill. Dec. 4, 2006) (finding that the plaintiffs’ addition of a breach of contract action in its amended complaint, which relied on different contracts than those pled in the initial complaint, stated a separate cause of action which did not relate back to the initial complaint, and thus removal was proper).

There are several class actions now pending in St. Clair and Madison Counties, including those quoted above. The suits generally assert fraud-based causes of action, such as violation of the Illinois Consumer Fraud Act, civil conspiracy, fraudulent

concealment and unjust enrichment. In opposition to class certification, the defendants made a number of arguments. First, they argued that individualized issues regarding actual damages, whether each class member was deceived and proximate cause would predominate over questions of fact and law common to class members. Next, they argued that plaintiffs' claims would require review of numerous individual contracts, making class treatment inappropriate as a matter of law. Finally, they argued that fraud-based allegations created additional individual issues that could not be resolved in a class action.

Most of the cases were certified, however, the Court finding that the four specific requirements for class certification had been met. First, given the number of class members, the geographical dispersment of class members and the likelihood that class members would bring individual suits, the numerosity element was satisfied. Second, the questions of fact and law – namely that improper PPO discounts were taken and processed the same way regardless of provider – predominated over individual claims sufficient to meet the commonality requirement. Third, the representative parties would fairly and adequately protect the interests of the class. Fourth, considering the relatively small amount of money at issue per class member, the extensive discovery that would be required, the vast number of class members, the limited judicial resources and the likelihood of inconsistent verdicts, class certification was the most appropriate vehicle for ensuring a fair and efficient adjudication of all claims.

Some of the more pertinent actions include Kaltenbronn v. Liberty Mutual Ins. Co., Case No. 04-L-1416 (Madison County, IL), cited above, in which Plaintiffs allege that Defendants wrongfully took PPO discounts of First Health preferred providers

without using financial incentives such as steering patients toward the Plaintiff providers. The Court, in a June 30, 2008 Order, found that Plaintiffs satisfied the requirements for class certification. Also of interest are the Fischer cases, Fischer v. Gen. Cas. Ins. Cos., Case No. 05-L-113 (St. Clair County, IL) and Fischer v. Universal Underwriters Ins. Co., Case No. 05-L-108 (St. Clair County, IL). In those cases, Plaintiffs argue that Defendants wrongfully reduced payment to them by taking PPO discounts without a valid payor agreement or without steering patients toward them. The Court again found that Plaintiffs satisfied the requirements for class certification, in Orders dated November 17, 2007 and November 26, 2007, respectively. Finally of note is Coy Chiropractic Health Center, P.C. v. Travelers Cas. & Sur. Co., Case No. 05-L-151 (Madison County, IL), in which the Plaintiffs allege that Defendants wrongfully took PPO discounts without “preferring” them and ensuring them a higher volume of patients. An October 14, 2008 Order by the Court found that Plaintiffs satisfied the requirements for class certification. Several of these decisions are now up on appeal, and while no opinion has yet been issued, we expect them to begin being handed down soon.

One of the few silent PPO cases to remain in federal court in the Southern District of Illinois was Roche v. Travelers Prop. & Cas. Ins. Co., Case No. 07-cv-302-JPG, 2009 WL 839310 (S.D. Ill. Mar. 31, 2009), a case with a long and tangled history. After allowing the Plaintiff five chances to amend her complaint to state a cause of action, the Court for a sixth time found that Plaintiff again failed to state a claim for unjust enrichment against a payor who had a contract with Plaintiff’s PPO network and dismissed the case with prejudice. However, Roche has a companion case in Illinois state

court that received class certification. Also of note is the previously mentioned Christie Clinic case, which failed to receive class certification in the Central District of Illinois.

D. Legislation Aimed at Stopping the Practice of Silent PPOs

The National Conference of Insurance Legislators adopted a model law governing network rentals at its annual meeting in November of 2008. The law is supported by the American Medical Association and requires that insurers disclose to providers accurate information when a contract is accessed by a third party while also barring unauthorized use of network discounts. Under the terms of the model law, a third party “renting” a network must abide by the terms of the original contract, and providers have a right to deny discounts to insurers who do not follow those rules. Third-party insurers who have access to a network discount must also direct patients to the provider as if they were in-network and must grant providers the benefits of network providers.

At least five states – Connecticut (Public Act No. 08-126), Colorado (Colo. Rev. Stat. § 25-37-101), Florida (Fla. Stat. § 627.64731), Indiana (Ind. Code § 27-1-37.3) and Ohio (Ohio Rev. Code § 3963.02) – have passed laws over the past two years that are similar to the model law. Many other states limit or prohibit silent PPOs. These include:

- **Arkansas**: Ark. Code § 23-63-113(b)(1) provides: “No contracting agent shall sell, lease, assign, convey, or otherwise grant access to the contracting agent's panel of contracted health care providers or the contracting agent's contracted reimbursement rates to another entity unless authorized in an agreement between the contracting agent and the provider.”
- **California**: Cal. Health and Safety Code § 1395.6(a) provides: “In order to prevent the improper selling, leasing, or transferring of a health care provider's

contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.”

- **Kentucky**: Ky. Rev. Stat. Ann. § 304.17A-728(2) provides: “An insurer or entity shall not reimburse on a discounted fee basis unless the disclosure is provided in the contract with: (a) A provider or organization of providers; or (b) An organization that has a network of preferred providers and the insurance entity has the written consent of the health care preferred providers.”
- **Louisiana**: La. Rev. Stat. Ann. § 40.2203.1(B)(5) provides that “written notice shall be required by any entity accessing an existing group purchaser’s contractual agreement or agreements at least thirty days prior to accessing services through a participating provider under such agreement or agreements.” The purpose of the statute is “to notify a provider in advance that if service is rendered to a patient of a particular payor, payment will be discounted per the PPO network agreement.” CCN Managed Care, Inc. v. Shamieh, 2007 WL 2088302, *5 (W.D. La. Jul. 20, 2007). It has been recognized that the statute applies to “silent PPOs,” where there is no direct contract between the provider and PPO. Id. at *7; see also Liberty Mutual Ins. Co. v. Gunderson, 2006 WL 367700, *4 (W.D. La. Feb. 15, 2006).

- **Maryland**: Maryland’s statute applies only to PIP insurers. Md. Code § 15-125(b)(1) provides: “(1) A carrier may not in any manner assign, transfer, or subcontract a health care provider's contract, wholly or partly, to an insurer that offers personal injury protection coverage under § 19-505 of this article without first informing the health care provider and obtaining the health care provider's express written consent.”
- **Minnesota**: Minn. Stat. § 62Q.74(2)(a) provides: “No health plan company shall require a health care provider to participate in a network under a category of coverage that differs from the category or categories of coverage to which the existing contract between the health plan company and the provider applies, without the affirmative consent of the provider obtained under subdivision 3.”
- **North Carolina**: N.C. Gen. Stat. § 58-63-70 provides: (a) It is an unfair trade practice for any insurer or service corporation subject to this Chapter to make an intentional misrepresentation to a health care provider to the effect that the insurer or service corporation is entitled to a certain preferred provider or other discount off the fees charged for medical services, procedures, or supplies provided by the health care provider, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the provider on those fees. (b) It is an unfair trade practice for any person with knowledge that an insurer or service corporation intends to make the type of misrepresentation prohibited in subsection (a) of this section to provide substantial assistance to that insurer or service corporation in accomplishing that misrepresentation.

- **Oklahoma**: Okla. Stat. § 36-1219.3 provides that insurers or TPAs may not reimburse a provider based on a discounted rate unless the insurer or TPA has contracted with the provider or a PPO, the provider has agreed to provide services under the contract, and the insurer or TPA has agreed to provide coverage for those services under their policies. Parties to PPO contracts may not sell or lease reimbursement terms of the contract without the express authority of all contracting parties.
- **South Carolina**: S.C. Code Ann. § 58-63-70(a) provides that “ it is an unfair trade practice for any insurer or service corporation subject to this Chapter to make an intentional misrepresentation to a health care provider to the effect that the insurer or service corporation is entitled to a certain preferred provider or other discount off the fees charged for medical services, procedures, or supplies provided by the health care provider, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the provider on those fees.”
- **Texas**: Like the Oklahoma statute, Tex. Ins. Code § 1301.056 provides that an insurer may not reimburse a provider based on a discounted rate unless the insurer has contracted with the provider or a PPO, the provider has agreed to provide services under the contract, and the insurer has agreed to provide coverage for those services under their policies. Similarly, parties to PPO contracts may not sell or lease reimbursement terms of the contract without the express authority of all contracting parties. Texas, however, takes it a step further and makes violation

of the statute an unfair claim settlement practice that subjects an insurer to administrative penalties.

- **Virginia**: Va. Code § 38.2-3407.10(O) provides: “If a provider contracts with a carrier or other entity that subsequently contracts with one or more unaffiliated carriers to include such provider in the provider panels of such unaffiliated carriers, and which permits an unaffiliated carrier to impose participation terms with respect to such provider that differ materially in reimbursement rates or in managed care procedures, such as conducting economic profiling or requiring a patient to obtain primary care physician referral to a specialist, from the terms agreed to by the provider in the original contract, the provider panel contract shall contain a provision permitting the provider to refuse participation with any such unaffiliated carrier.” Subsection P also provides: “A carrier that rents or leases its provider panel to unaffiliated carriers shall make available, upon request, to its providers a list of unaffiliated carriers that rent or lease its provider panel. Such list if available in electronic format shall be updated monthly. The provider shall be given the means to request and receive a printed copy of such list.”

E. The Future of Silent PPOs

While it is unlikely that silent PPO arrangements will disappear entirely, what is likely is that the recent spate of class action litigation will spark several changes in the PPO realm. First, we anticipate that there will be more pressure put on the PPOs to increase both financial and non-financial steerage and network penetration in order to increase the number of patients who see contracted providers. We also likely will see

changes in the language in PPO contracts, explanations of benefits and related documents in an effort to clarify the steerage obligations and the PPOs' relationship with the payors.

II. WAIVER OF PATIENT RESPONSIBILITY BY PROVIDERS

A. Background

This issue occurs when providers agree to waive collecting co-payments, coinsurance or deductibles from members and instead seek reimbursement solely from the payor. It normally arises in one of two contexts. Suppose a payor reimburses 80% of a provider's charge, leaving the member with a 20% co-payment. If a provider's usual charge is \$100, it normally would collect \$80 from the payor and \$20 from the member. In the first waiver situation, the provider inflates its charge to \$125 and collects the full \$100 from the payor. In the second, the provider would readily accept \$80 as payment in full, so stating that the normal billed charge is \$100 is making a false claim.

One of the earliest cases to discuss the issue is Feiler v. New Jersey Dental Assn., 467 A.2d 276 (N.J. Super. Ct. 1983), in which a state dental association brought suit against an individual dentist for engaging in allegedly fraudulent billing practices. The Court held that the dentist's routine waiver of co-payments was indeed a fraudulent practice. As in the second waiver practice discussed above, the Court found that the dentist in question "lied" to carriers when he submitted a charge of \$100 when he only intended to collect \$80 from the carrier and waive the co-payment cost to the member. See id. at 286-87 ("[t]he simple facts remain that Feiler does not tell the truth on his billing statements, that carriers largely rely on them and pay on the strength of them, that Feiler achieves a competitive advantage by offering what appears to be free or reduced

price dentistry, and that the only way for honest practitioners to equalize is to adopt his unsavory approach. That is a choice the law should not demand of honest practitioners”). The Court ordered the dentist to disclose to all payors sufficient information on his billing practices to enable the payors to make a true and correct payment determination.

Another landmark case on this issue is Kennedy v. Conn. Gen. Life Ins. Co., 924 F.2d 698 (7th Cir. 1991), which was a suit brought by a provider as an assignee of a participant against a health plan. The plan had refused to pay the provider after suspecting he was waiving co-payments and agreeing to accept as full compensation whatever the plan would pay, which was 80% of expenses. The plan pointed to a provision in the policy, section 12(5), which provided that no payment would be made for charges which the employee was not legally required to pay, and argued that because the provider had completely waived the member’s payment obligation, it was not legally obligated to pay anything. The provider, on the other hand, argued that his co-payment waiver agreement with the patient governed, which provided that the agreement was void to the extent that it was prohibited by the terms of the member’s policy or if the benefits payable under the agreement were less than they would be if not subject to the agreement.

The Court, in an opinion by Judge Easterbrook, agreed with the plan, stating:

Here we encounter delicious circularity. The agreement relieves Myers [the patient] of any obligation to pay. That triggers § 12(5) of the policy, which relieves CIGNA of any obligation to pay. That in turn triggers the clause of the Kennedy-Myers contract *reinstating* Myers’ obligation to pay. Once this occurs, § 12(5) of the policy is no longer applicable. Thus CIGNA must pay. Kennedy stops here. Let us press on: once CIGNA becomes liable, the Kennedy-Myers contract again relieves the patient of any legal obligation. Which in turn reactivates § 12(5). And so it goes.

Where one breaks the circle depends not on formal logic but on the function of the two contracts. The Kennedy-Myers contract is designed to eliminate co-payments. [The employer’s] plan and CIGNA’s policy

require co-payments in order to maintain incentives that hold down the cost of medical care. We could not break the circle in favor of reimbursement without abrogating the co-payment requirement – a requirement that [the employer] had every legal entitlement to create. So Kennedy must lose. If he wishes to receive payment under a plan that requires co-payments, then he must collect those co-payments – or at least leave the patient legally responsible for them ... Allowing the provider to “pay” the co-payment to himself is just another way to describe waiver of co-payment, with the baleful consequences we have mentioned. Some welfare benefit plans have lower (or no) co-payments, perhaps because they doubt that the incentive effects of co-payments justify saddling with higher costs those employees unlucky to encounter medical difficulties. Co-payments mean more risk borne by participants. Whether full indemnity is preferable to a co-payment system is a question for the marketplace. The answer in this health plan is co-payments, and its terms will be enforced.

Id. at 701-02.

B. Is there an ERISA issue?

In Davidowitz v. Delta Dental Plan of Cal., Inc., 946 F.2d 1476 (9th Cir. 1991), the Ninth Circuit was presented with the issue of whether ERISA affirmatively mandated assignability of plan benefits notwithstanding an express plan provision prohibiting assignment. The case involved an action by non-par dentists against a health plan, seeking an injunction ordering the plan to honor patient assignments of benefit payments. The dentists had been waiving patient co-pays in exchange for assignment of beneficiary rights to receive checks. The plan pointed to anti-assignment provisions in the members’ contracts and argued that co-pays introduce beneficiary cost-sensitivity into the market; beneficiaries who must pay some portion of their treatment are more inclined to shop competitively for services and not overuse them. The dentists, on the other hand, argued that ERISA mandated assignability.

The dentists made a number of arguments in support of their position, analogizing that they were akin to garnishors or creditors who could obtain plan benefits

notwithstanding an anti-assignment clause. After examining the case law, including Kennedy and state court decisions holding that non-assignment provisions help keep medical costs down, the Court rejected the dentists' arguments and agreed with the plan:

While the beneficiary's right to assign when the plan is silent furthers ERISA's policies, the absolute right to assign, notwithstanding a contract anti-assignment clause, does not necessarily further these policies. As discussed above, Delta cites ERISA policies that are benefited by its co-payment non-assignment structure, including promotion of consumer cost-sensitivity to hold down medical costs. The Court is unwilling to say that the underlying ERISA policies benefited by assignment outweigh the benefits promoted by Delta's non-assignment structure.

Id. at 1480.

C. Consequences of Patient Responsibility Waiver

The problems associated with co-payment waivers were first recognized in the Medicare arena. In May of 1991, the Office of Inspector General of the Department of Health and Human Services issued a Special Fraud Alert directed specifically to the routine waiver of copayments or deductibles by providers under Medicare Part B. The Alert identified several consequences resulting from such routine waiver:

A provider, practitioner or supplier who routinely waives Medicare copayments or deductibles is misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is \$100, but routinely waives the copayment, the actual charge is \$80. Medicare should be paying 80 percent of the \$80 (or \$64), rather than 80 percent of \$100 (or \$80). As a result of the supplier's misrepresentation, the Medicare program is paying \$16 more than it should for this item.

In certain cases, a provider, practitioner or supplier who routinely waives Medicare copayments or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them.

At first glance, it may appear that routine waiver of copayments and deductibles helps Medicare beneficiaries. By waiving Medicare copayments and deductibles, the provider of services may claim that the beneficiary incurs no costs. In fact, this is not true. Studies have shown that if patients are required to pay even a small portion of their care, they will be better health care consumers, and select items or services because they are medically needed, rather than simply because they are free. Ultimately, if Medicare pays more for an item or service than it should, or if it pays for unnecessary items or services, there are less Medicare funds available to pay for truly needed services.

Notices, Department of Health and Human Services, Publication of OIG Special Fraud Alerts, 59 FR 65372, 65374-75 (Dec. 19. 1994).

Courts have also recognized certain real world consequences of such waivers, the first being an across-the-board inflation of provider billed charges and a consequent stifling of competition. As the Feiler court explained, where a provider is relieving co-payments, pressure is placed on other providers to do the same, lest they lose out on patients:

Doubtless, Feiler's methods give him a competitive advantage. They permit him to relieve patients of the burden of cash outlays that copayment plans normally require. To the patient, Feiler's services are free or much reduced in cost. All other things being equal, patients will be attracted to a dental office that offers services that are, to them, free or cheaper than elsewhere. There is nothing wrong, of course, with offering dental services at reduced prices. It is the mechanism of price reduction that is in issue. If the method works by shifting cost away from the patient and, fraudulently, onto the shoulders of another payer, honest competitors for patients may be unfairly disadvantaged.

Feiler, 467 A.2d at 283. See also Parrish v. Lamm, 758 P.2d 1356, 1360 (Colo. 1988) (upholding a law passed to bar a provider from waiving co-payments and noting the argument that such practices raise the cost of health insurance to all subscribers).

A second consequence is an interference with health plans' relationships with network providers. By waiving a patient's out-of-pocket costs, a provider removes any

economic disincentive to accessing out-of-network services, which then harms in-network physicians. See, e.g., Horizon Blue Cross Blue Shield of New Jersey v. East Brunswick Surgery Ctr., 2009 WL 1097858, *1-2 (D. N.J. Apr. 23, 2009).

A third consequence is that members who do not have to pay out-of-pocket costs wind up over-utilizing services, which places a drain on the whole industry. As Davidowitz notes, one of the ways to combat the problem is through the use of anti-assignment clauses in members' plan documents:

Delta says its main purpose for including non-assignment clauses is to police co-payment waivers by non-participating dentists. Co-payments, Delta argues, introduce beneficiary cost-sensitivity into the dental services market, which is lacking if a third party pays the entire cost of dental treatment. Beneficiaries who must pay some portion of their own dental bills are more inclined, Delta asserts, to shop competitively for dental services, and not over-use them.

Davidowitz, 946 F.2d at 1477.

Feiler also recognizes a plan's right to use co-payments in order to combat over-utilization:

Dental insurers are entitled to write policies containing copayment provisions. Whether or not copayment encourages more conservative use of dental services or achieves some other lawful goal, the carriers are entitled to write a copayment provision and to enforce it. If it is a socially undesirable provision, it is up to the government to bar its use. It is not up to dentists to tiptoe around it by overbilling.

Feiler, 467 A.2d at 284.

D. State and Federal Legislation

Several states, as well as the federal government, have passed legislation aimed at stopping the practice of waiver of co-payments, and other state attorneys general have issued opinions regarding the practice. Moreover, the American Medical Association has also concluded that a routine practice of waiving co-payments is improper. In the federal

arena, Congress has passed legislation making the routine waiver of member cost sharing obligations improper with respect to Medicare members and imposing various monetary penalties for such violation. See 42 U.S.C. § 1320a-7a(a)(5).

The following list summarizes actions taken by individual states to combat co-payment waiver:

- In Connecticut, Conn. Gen. Stat. § 53-442 bars waiver by providers of out-of-pocket cost sharing obligations.
- In Maryland, Md. Code Ann. § 19-710(p)(3) requires that providers collect co-insurance and deductibles owed by patients.
- In Colorado, Colo. Rev. Stat. § 18-13-119 provides that a practitioner commits “abuse” if he or she knowingly waives a deductible or co-payment and accepts from a plan payment in full for services rendered or submits an inflated fee to the plan.
- In Florida, Fla. Stat. § 817.234(7) provides that a service provider, other than a hospital, commits insurance fraud when it engages in a general business practice of billing amounts as its usual and customary charge where the provider has agreed with the insured or intends to waive deductibles or copayments, or does not intend to collect the total amount of such charge.
- New York Insurance Department’s General Counsel has issued several opinions stating that regular practice of waiving co-pays is fraudulent under New York’s penal code. *See* N.Y. GC Op. Nos. 03-04-09; 05-04-07; 04-02-25.
- Louisiana Attorney General Opinion 84-6 finds that providers make statements that are “untrue” when they assert they charge \$100 for a procedure if they intend

to forgive co-payments upon receipt of \$80 and if they almost always receive such payment.

- Texas Attorney General Opinion DM-215, interpreting Tx. Ins. Code. 21.24-1(4)(c), finds that a “physician or other health care provider may not waive co-payments or deductibles by acceptance of an assignment.”
- California is the clear minority. Attorney General Opinion 81-304 states that a provider who advertises it will waive co-insurance is not participating in a deceptive practice.

E. Areas of Contention

Providers often take the position that they cannot determine patient responsibility until they receive the EOB from the payor, and if the payor denies or pends the claim for any reason, the provider cannot calculate the patient’s responsibility. Payors contend, however, that if the patient has not met his or her deductible, then the entire claim should be paid by the patient and the provider does not need to wait for an EOB. Also, providers usually call to verify benefits and often learn what the patient’s co-payments and coinsurance amounts are before even rendering a service.

Some states forgive waiver of patient responsibility if the provider can show evidence of attempts to collect or if the patient can establish financial hardship. To comply, providers sometimes create financial hardship forms and request that their patients sign these forms. Payors contend that certain providers do not verify that the information on the form is accurate nor do they require the forms be notarized, and thus use these forms as a sham to provide “evidence” of financial hardship.

III. “TAKE BACK” STATUTES AND LITIGATION

A. Overpayment Statutes and Regulations

Recoupment of overpayments, known as “take backs,” occur where, either by contract or statutory or common law, a payor is entitled to recover overpayments from a provider. Most times, a payor’s right to recover overpayments is specifically stated in its contract with the provider. Some states, however, have enacted laws or regulations allowing for such recovery. This section briefly summarizes those laws and regulations.

In Louisiana, La. Admin. Code. 37:XIII.6015 provides:

Health insurers that limit the period of time that a claim may be filed for payment of benefits shall have the same limited period of time following payment of such claims to perform any review or audit for purposes of reconsidering the validity of such claims. For example, where a health insurance issuer limits the period for filing a claim for benefits to 12 months, then the health insurance issuer shall be limited to 12 months from the date of payment to perform any review or audit of the claim.

This Regulation was held valid in St. Charles Parish Hosp. Serv. Dist. v. Ochsner Health Plan, Inc., 874 So.2d 885 (La. App. 5 Cir. 2004).

In Texas, V.T.C.A. § 843.350 provides that HMOs may recover overpayments to providers if, not later than the 180th day after the provider receives payment, the HMO makes a written request for recovery and the provider fails to repay within 45 days. Providers are afforded the opportunity to appeal. V.T.C.A. § 1301.132 is identical in all respects and applies to PPOs.

Florida has Fla. Stat. § 641.3155(5), which, until recently, provided that HMOs who have made overpayments to providers may seek recoupment within 30 months of payment of the claim. A provider must pay, deny, or contest the claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must

be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim. In the case of fraud convictions, claims for overpayment may extend past 30 months.

The statute was recently amended to shorten this time period. The amendment added a provision that notwithstanding the 30-month period in subsection (5), all claims for overpayment submitted to various types of providers must be submitted to the provider within 12 months after payment of the claim. A claim for overpayment may not be permitted beyond 12 months after payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.

B. Current Issues

There are several issues that have come up with regard to overpayments made by payors, though most of these issues occur at the trial court level and have not yet been tested on the appellate level.

First is the issue of how these overpayment statutes interact with other statutes of limitations. For instance, the recently amended Florida statute (Fla. Stat. § 641.3155) limits the time period for a payor to recoup an overpayment to 12 months after payment of the claim. The general statute of limitations on a contract action in Florida is five years. See Fla. Stat. § 95.011(2)(b). Thus, some payors have taken the position that overpayment statutes such as Fla. Stat. § 641.3155 only apply to “true” overpayments, such as where a charge is \$300 but the payor mistakenly pays \$400; a payor would only have 12 months to recoup the additional \$100. However, if a payor finds out after the fact that a claim was wrongly paid because, for instance, the service wasn’t a covered

benefit or the member was not eligible to receive the service at the time it was provided, the overpayment statute does not apply and rather the situation is governed by the more general statute of limitations. Providers, however, contend that both situations are covered by the more specific overpayment statute. The statutes do not define “overpayment” and therefore this issue remains in dispute.

A second issue that has arisen pertains to the mechanics of making a claim for overpayment. In some instances, payors have offset overpayments on new claims related to other patients. Providers generally argue that this is improper and that payors must rather request the specific overpayment from the provider and wait for the provider to pay it back or, alternatively, can offset the overpayment only in the case of a future claim for the same patient.

In a very recent class action filed in the Northern District of Illinois, a number of chiropractors filed suit against multiple Blue Cross/Blue Shield entities, alleging the payors of numerous ERISA and RICO violations. In Pennsylvania Chiropractic Assn. v. Blue Cross Blue Shield Assn., Case No. 1:09-cv-05619 (N.D. Ill.), the chiropractors accuse the payors of engaging in concerted extortion by falsely accusing them of fraud, demanding immediate recoupment of past payments without allowing them the opportunity to appeal, and withholding future payments on claims for other BCBS insureds as a means of seeking recoupment. The plaintiffs in the suit are three state chiropractic associations and fifteen individual chiropractors.

Typical of the individual plaintiffs are the allegations of Dr. Jeffrey Leri. Dr. Leri alleges that he obtains written assignments of benefits from his patients, which allows him to seek payment directly from Highmark, a corporation that provides health care

service to BCBS insureds. In 2005 and 2006, Highmark informed Dr. Leri that it was conducting an audit of claims and inspected numerous records during that time. Dr. Leri then received a letter from Highmark stating that it had determined he was overpaid approximately \$100,000 and demanding repayment. Highmark gave Dr. Leri three options: remittance of the entire sum, installment payments, or offset against future payments. Dr. Leri alleges Highmark did not inform him of his right to appeal the decision, and when he pressed Highmark for further information as to how this sum was calculated, he learned that Highmark had only looked at a total of \$7,000 worth of claims and extrapolated out additional damages from there. Dr. Leri retained his own consultant to go through the records and submitted to Highmark documentation showing that the extrapolation method was unreliable. The matter went before Highmark's review committee, of which Dr. Leri complained there was insufficient chiropractic presence, and the committee upheld the recoupment demand. Dr. Leri then agreed to a settlement.

The suit seeks benefits under the members' ERISA plans, injunctive relief from Defendants' failure to provide full review under ERISA, damages as a result of an alleged enterprise under RICO, declaratory and injunctive relief under RICO, and declaratory and injunctive relief barring Defendants from further recoupment efforts. The suit is still in its infancy but should be monitored closely for future developments.

The overpayment issue has also arisen at the state level. For the most part, it appears that such issues are governed by the language of the particular overpayment statute or by the language of the provider's contract with the payor. The Texas statutes, V.C.T.A. §§ 843.350 and 1301.132, both provide that a payor may "recover an overpayment to a physician or provider if: (1) not later than the 180th day after the date

the physician or provider receives the payment, [the payor] provides written notice to of the overpayment to the physician or provider that includes the basis and specific reasons for the request of recovery of funds; and (2) the physician or provider does not make arrangements for repayment of the requested funds on or before the 45th day after the date the physician or provider receives the notice.” The statutes also provide that the payor must afford the provider an opportunity to appeal and may not recover overpayments until all appeal rights are exhausted. The statutes do not, however, specifically delineate the mechanics by which a payor may “recover an overpayment.”

In Quality Infusion Care, Inc. v. Health Care Serv. Corp., 2009 WL 798552 (S.D. Tex. Feb. 24, 2009), the payor overpaid a provider for patient claims and withheld payments of later claims as a setoff. The provider sued to recover the setoff and argued that the setoffs were improper because the later claims involved different patients and different benefit plans. The Court ruled in favor of the payor and held that the payor had properly sought recoupment of the overpayment under the statutes through the use of set-offs:

Recovery of overpayment is lawful. Tex. Ins. Code §§ 843.350, 1301.132. It includes the 180-day limit. Blue Cross requested a refund for overpayment on [the claim] within the 180-day period. Offsetting [the claim] was proper.

Id. at *2.

In Texas, therefore, a payor may offset overpayments against future claims, and the statutes appear to provide a mechanism through which the payor may enforce this right. In the other state with a specific overpayment statute, Florida, the issue is not as clear, as no appellate court has weighed in on the precise situation. The Florida statute provides, in relevant part:

(5) If a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the health maintenance organization must make a claim for such overpayment to the provider's designated location. A health maintenance organization that makes a claim for overpayment to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The health maintenance organization must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, a health maintenance organization shall adhere to the following procedures:

...

3. The health maintenance organization may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health maintenance organization's overpayment claim as required by this paragraph.

While the precise mechanics of the statute have not been tested in any reported decision, especially in light of the recent amendment of the statute to alter subsection (5) and shorten the time period for seeking recovery of an overpayment, it appears that Florida may not be as liberal as Texas when it comes to offsetting overpayments.