

## **MANAGING MANAGED CARE: PROVIDERS FIGHT BACK AGAINST HMOS**

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The managed care market has become a battleground which pits hospitals and physicians against payors such as health maintenance organizations (“HMOs”) and other entities which pay for healthcare services. What is at stake in this struggle between healthcare providers and payors? The answer is money (and lots of it) and the ultimate control of the healthcare delivery system. Many physicians and hospitals believe that HMOs are turning the procedure for the payment of claims for the provision of healthcare services into a financial nightmare. Armed with the help of attorneys, regulators, and legislators, providers are voicing their concerns about HMOs’ payment for the delivery of healthcare services. Providers are most concerned about two things: the late payment of claims and wrongful denial of claims.

Typically, an HMO contracts with a hospital or physician to provide healthcare services to the members of the HMO plan subject to the rules of the HMO. The HMO uses such rules to “manage the care” of the enrollee in the plan. Once a patient is treated, the physician files a claim with the HMO, which either denies or accepts the claim. Too often, however, healthcare providers allege that their claims are unfairly denied by a payor or payment of the claim is delayed for an extended period of time. These two issues are the root of most disputes between providers and HMOs.

In the past, hospitals and physicians were content to simply be participants in an HMO’s network. Times have changed, however, and, today, providers are looking for a sound economic benefit for participating in a managed care network. If an HMO does not pay claims in a timely manner, or wrongfully denies claims, then this economic benefit can not be achieved.

Consequently, hospitals and physicians are challenging the timing of payments as well as the denial of payments by HMOs. In a study based on a survey of thirty-three out of Maryland's forty-seven hospitals, the Maryland Hospital Association discovered that HMOs denied \$74 million in hospital claims in 1998. According to the survey, HMOs denied at least part of a claim in fifteen percent of hospitalizations. Studies by other state hospital and medical associations have indicated that the percent of denied claims is even higher in some areas of the country. HMOs counter by saying the denied care was not medically needed, or that the hospitals failed to follow proper procedures when documenting the care. Providers argue that the "proper procedures" for documenting care are often a moving target which is arbitrarily changed by HMOs as a means of denying claims. Many hospitals and physicians complain that they are forced to submit the same claim numerous times in order to get the payor to begin to process the claim - only to have the payor deny the claim for no reason or some arbitrary reason.

Most HMOs have extensive utilization review procedures which the HMOs use to decide the appropriateness of the provider's claims. While many providers allege that this process is akin to practicing medicine, the use of utilization review by HMOs is one of the foundations of managed care. The question in these disputes is whether payors are wrongfully using the utilization review guidelines to escape the obligation to pay for claims, rather than to manage the care of the patient.

Providers argue that when claims are eventually paid, they are often paid late. Most provider agreements require payment of claims within 30 to 60 days of the receipt of the claim by the payor. Some providers feel that payors intentionally institute a pattern of delaying claims and using the money owed to the providers for the HMOs' own purposes. This process is then described as

“managing care”. This theme is echoed across the country, as health providers claim that they are losing millions of dollars due to egregious delays.

For example, of the \$561 million that Massachusetts’s HMOs owed to Massachusetts’s 20 hospitals in 1999, \$163 million was more than 60 days overdue, and \$122 million was more than 90 days overdue. In New York, claims are delayed an average of 64 days despite a 45-day prompt-payment law, and in Maryland, delays rose 28% in two years to 78.2 days in 1998. The Oregon Medical Association conducted a recent study that shows that Oregon physicians wait an average of 40.5 days before recovering payment on claims and some wait even longer. The American Medical Association conducted a survey of over 18,000 physicians, and over one-third of those surveyed indicated that, on average, it takes more than 45 days to get paid on clean claims.

One of the biggest hurdles faced by providers is accumulating the necessary data to determine if claims are delayed, and if so, for how long and for what reason. Many providers are still struggling to obtain this type of information so that they will be able to address and resolve time issues of prompt pay. In South Carolina, many hospitals and physicians are in the process of conducting the necessary analysis to determine the timeliness of payments by HMOs doing business in South Carolina.

### ***An Attempt at Reform: Legislation***

Hospitals and physicians have sought political assistance in this battle with payors. Consequently, forty-four state legislatures have passed prompt pay statutes. These prompt pay provisions require that HMOs pay providers' claims within a certain amount of days. Under these statutes, the required amount of time to reimburse a claim generally runs from 30 to 60 days. Georgia currently has one of the toughest prompt pay laws, requiring that HMOs pay, deny, or request further information within 15 days of receiving a claim.<sup>1</sup> North Carolina recently passed its own prompt pay law which goes into effect on July 1, 2001.<sup>2</sup> South Carolina is one of the few states in the country that does not have a prompt pay statute.

Most of these prompt pay statutes impose financial penalties, such as the imposition of interest charges or other fines if the prompt pay statute is violated. Some of these prompt pay statutes rely on the payors to calculate the penalties themselves. This creates a real question of whether this penalty process will act as a true deterrent to payors.

Many providers argue that prompt payment statutes are often ineffective because they offer little incentive for an HMO to comply with the prompt pay requirement. If a fine or penalty is small, these costs are often absorbed by the HMO as a cost of doing business. Since many of these prompt pay statutes are new, it remains to be seen whether they will improve the timeliness of payments. In many cases these laws may not create prompt pay as much as they create prompt response by payors because the payors can comply with many of these statutes by denying or requesting additional information within the statutory time frame. In any case, these laws should prevent the scenario in which a provider submits the same claim numerous times and the payor does not respond to these

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<sup>1</sup> See GA. CODE ANN. § 33-24-59.5 and § 33-30-6(b)(5) (2001).

<sup>2</sup> See N.C. GEN. STAT. § 58-3-225 (2001).

claims for weeks or months. It remains to be seen whether these laws will have a significant impact on improving the time lines of payments.

In addition to passing prompt pay statutes, many states have passed or revised utilization review laws to give patients and providers additional rights in appealing denied claims. These statutes include creating the process for an independent review of denied claims by a neutral third party who can determine the legitimacy and necessity of the claim in question. Some of these statutes also create new time periods in which payors must provide notice of denials or appeals to denials.

The South Carolina Hospital Association, South Carolina Medical Association and several South Carolina HMOs are currently working together to determine if a prompt pay statute is needed in South Carolina.

### ***The Implementation of Policy: Administrative Regulation***

During the past several years, many state insurance commissioners have leveled stiff fines against HMOs who fail to comply with prompt pay statutes or other related statutes. In Florida, the State Department of Insurance recently focused a 13-month examination into HMO business practices. After the result of the investigation, two HMOs faced tens of thousands of dollars for not promptly paying claims. Other states, including Georgia, Maryland, and North Carolina, have conducted similar formal and informal studies with similar results. Hospitals and physicians hope that this kind of scrutiny will improve the payment practices by payors.

Many insurance commissioners indicate that large damages are necessary to put HMOs on notice that compliance with prompt-pay laws is crucial. To this end, the Maryland Insurance Commission leveled fines against United HealthCare (\$250,000), Magellan Health Services

(\$150,000), and Aetna U.S. Healthcare (\$225,000) for failing to pay claims within the state's 30-day limit. In Georgia, the State Insurance Commissioner recently fined Prudential Healthcare (\$200,000) and Coventry Healthcare (\$262,700). The Ohio Department of Insurance recently fined seven health insurers a total of \$545,000 for violation of the state's prompt pay laws. In New Jersey, Oxford Health Plans was forced to pay \$275,000. The North Carolina Department of Insurance has also recently fined HMOs, including Aetna U.S. Healthcare, for failure to pay claims in a timely manner. This trend is continuing to develop across the country as patterns of delayed payments become evident.

But fines are not the extent of the regulation. Some Departments of Insurance have forced HMOs like United, Magellan, and Aetna U.S. Healthcare to sign consent agreements requiring them to report on their compliance efforts. Additionally, some insurance commissioners suggest that the insurance commissions should bar an HMO from enrolling new patients for a period of time if they found a pattern of noncompliance. If the noncompliance was particularly egregious, then an HMO licence could be revoked. Revocation of an HMO license is the ultimate penalty in regulatory enforcement and, in some states, hospitals and physicians have begun building administrative cases against HMOs to attempt to have the licenses of HMOs revoked, thereby restricting those HMOs from doing business in that state.

### ***The Final Straw: Litigation***

While state legislatures and regulatory bodies can assist providers on the issues of prompt payment and wrongful denials through new legislation and administrative enforcement, healthcare providers have been forced to turn to the judicial system for additional help in this area. As a result,

there has been a significant increase in individual physician and hospital lawsuits against HMOs over the last few years. In these individual lawsuits, providers usually allege the following claims:

- Breach of contract
- Unjust enrichment
- Unfair trade practices
- Fraud, misrepresentation
- Breach of covenant of good faith
- Conversion

The theme of these cases is simple: HMOs are breaching their contractual obligation to providers by engaging in an intentional pattern of wrongfully denying claims or delaying payments which increases the profitability of the HMOs.

Unfair trade practice claims are very popular in the states which have such laws because they often allow for treble damages and attorneys fees. When one considers the fact that some providers are often seeking millions of dollars in unpaid claims, it is easy to see why unfair trade practices could be a powerful claim. Accordingly, the unfair trade practices claims are seen by many as being the biggest potential weapon used by providers in a lawsuit with an HMO over a concerted pattern of late payments or wrongfully denied claims.

Although breach of contract and violation of unfair trade practices are by far the most common causes of action in these lawsuits, several of the lawsuits also allege violation of the Federal Racketeering Influence and Corruption Organizations Act (RICO). When alleging a RICO claim, providers claim that HMOs are improperly interfering with the physician-patient relationship by offering financial incentives, which reward claim reviewers for denying diagnostic tests, referrals, hospitalizations, or other expensive treatments. Providers allege that HMOs have engaged in an enterprise with other parties to intentionally deny claims and withhold payment. The providers argue that the HMOs have used their “overwhelming and dominant economic and market power” to

force providers to accept managed care industry practices that are detrimental to patients and providers. Generally, the courts have not been receptive to these RICO claims, and many RICO claims alleged by providers have been dismissed.

There has also been a recent wave of class-action lawsuits against HMOs filed by hospitals and physicians over the past two years. In California, Florida, Georgia, New York, New Jersey, Pennsylvania, Connecticut, and a few other states, more than a dozen class-action lawsuits have been filed by groups of hospitals and physicians against several HMOs including Aetna U.S. Healthcare, Humana, Inc., and United Healthcare.

Recently, some of these class actions were consolidated in a federal district court of Florida.<sup>3</sup> This Florida case is part of a group of consolidated class actions, brought by consumers and physicians on behalf of thousands of potential class members against eight HMOs. These lawsuits allegedly “involve common questions of fact concerning whether defendants - either singly or as part of a conspiracy - implemented certain policies including..utilization review processes, physician financial incentives and/or failure to pay clean claims in a timely manner, which unlawfully deprived health care plan subscribers of the health care for which they contracted and/or unlawfully interfered with health care providers’ deliver of that care.”

On March 2 of this year, the Florida federal district court handling this consolidated class action dismissed some of the claims for alleged violations of RICO and state and federal prompt payment laws. The Florida court found that the plaintiffs failed to plead the RICO and state prompt payment claims properly, but allowed plaintiffs to amend their complaint. However, the court held

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<sup>3</sup> *In re: Managed Care Litigation*, No. MDL-1334, (S.D. Fla. Miami Div transferred April 17, 2000).

that no federal cause of action existed under Medicare for prompt payment for services. The court also found that ERISA did not pre-empt claims for breach of contract and unjust enrichment.

The plaintiffs responded by amending their complaint to add more specific allegations of violations of prompt pay statutes and that the defendant HMOs engaged in an enterprise to violate the applicable laws. This allegation regarding the enterprise to violate the law was needed to support the plaintiff's RICO claim. Three medical associations from California, Georgia and Texas were also added as additional plaintiffs. Together these medical associations represent over 80,000 physicians.

A hearing in the Florida case on the issue of class certification for the provider track of plaintiffs was held in early May, but a ruling has yet to be entered. Meanwhile, the HMOs have filed a joint motion to dismiss the plaintiffs' amended complaint, claiming the proposed class action is still too vague and unduly broad in its new RICO enterprise pleading. A hearing date has not been set for this motion to dismiss.

Some feel, however, that a class action is a risky approach. A key to success is whether the plaintiffs can uncover a "smoking gun" document demonstrating that HMO executives knew they were wrongfully denying or delaying payment. In many respects, these disputes may not be as dramatic as alleged but, rather, involve a plain-vanilla breach of contract. However, because the damages in these types of case can rise to tens of millions of dollars and the fact that some states allow for trebled damages under unfair trade practices claims, these are very significant legal actions.

### ***An Alternative Remedy: Termination of Provider Agreement***

Physicians and healthcare providers who do not want to wait on legislative, administrative, or judicial help have one more option: terminate their provider contract with HMOs. Citing poor financial results, and noncompliance by HMOs with their agreement, many hospitals and physicians are considering terminating HMO contracts and not accepting patients who are managed by certain HMOs. If providers terminate their provider contracts and are no longer participating providers in that payor's network, then the patients who see these providers may have to pay a higher cost to continue to receive treatment from these providers.

According to a recent survey of hospital CEOs by Deloitte & Touche LLP, nearly one-third of America's hospitals have terminated contracts with HMOs, citing poor financial results. That number increases to 60 percent for large hospitals. A number of South Carolina hospitals have terminated managed care agreements with HMOs and this number is likely to increase in the near future. Sometimes, termination of the agreement is the last resort because it could place the provider in a strategic disadvantage if it is not able to see the HMO members. Ultimately, the consumers of healthcare could be negatively impacted by these terminations because it could affect the patients' access to certain providers.

### ***Outlook for the Future***

Recently, some HMOs have taken steps to remedy these problems. These steps include the establishment of voluntary independent review mechanisms which allows independent third party reviewers to review the legitimacy of claims denied by the HMOs. Other HMOs have acknowledged the problems in their payment of claims and have vowed to improve their performance. Some HMOs have also established public relation campaigns to demonstrate a more

“provider-friendly” nature. Time will tell if these efforts will make a difference. In the meantime, the battle between payors and providers will continue to be fought.

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