

AVOIDING ANOTHER HEALTHCARE CROSSFIRE:

**The Fight between Corporate Employers
and the Administrators of their Employee Health Plans
over Provider Discounts**

THE ADVERSARIES

Many substantial corporations self-insure their employee health plans. In such cases, the corporation typically hires a third-party administrator ("TPA") such as a Blue Cross Blue Shield entity, CIGNA or Aetna U.S. Health-care to administer the medical, dental and prescription drug plans that it sponsors. The TPA uses the plan sponsor's funds to pay healthcare providers for covered services or products delivered to employees and their families.

The contract between the plan sponsor and its TPA (known in the industry as an "administrative services only," or "ASO," contract) usually restricts the TPA's compensation to payment of an administration fee. The fee typically is computed on the number of employees or beneficiaries in the plan or the amount of money paid out to the providers of health care services under the plan.

THE ISSUE

But plan sponsors have learned that in addition to this fee, some TPAs are retaining all or a portion of the discounts, year-end rebates and other adjustments that they obtain from hospitals, doctors, labs, pharmacists and other health care providers. (In some cases, TPAs have credited the initial discount to the employer but have failed to disclose or credit year-end rebates or other adjustments.)

In some regions of the U.S., the larger TPAs have the economic leverage to negotiate discounts of from 20% to 50% off the hospital's or other provider's "list price" for the procedure, service or product. Therefore, a very sizable amount may be at issue in determining who

ultimately is entitled to the cost reductions that TPAs obtain from healthcare providers.

THE LAWSUITS

In actions by various parties claiming the right to provider discounts, the courts, the U.S. Department of Labor ("DOL") and various state insurance commissioners have all regularly ruled that a TPA is obligated to pass through the discounts it has obtained unless the ASO contract expressly provides to the contrary. The courts have also held that a TPA's records which are relevant to determining whether any discounts have been improperly withheld are subject to audit by the plan sponsor. (The records that a TPA is required to disclose include its pricing agreements with hospitals and other providers. TPAs do usually insist, if only out of competitive self-interest, on confidential treatment for their provider contracts.)

The usual plaintiff in these proceedings is the corporation that hired the TPA to administer its health plans and allegedly has been charged undiscounted amounts. The corporation may also have an obligation as a fiduciary of the plans to recover any amounts that its employees have been overcharged by paying a higher coinsurance percentage or reaching plan maximums sooner.

Other suits have involved the DOL, state attorneys general, labor unions and class actions on behalf of all the beneficiaries of a plan. The complaints commonly allege breach of contract (the ASO agreement) and breach of fiduciary duty (under ERISA). They sometimes allege state law claims (which may not survive a challenge of

federal pre-emption by ERISA) and racketeering (under the federal RICO statute).

THE FALLOUT

Very often these suits are settled by the TPA confidentially. Nevertheless, it is apparent that the aggregate recovery against the various state Blue Cross Blue Shields alone has already exceeded \$500 million. In addition, the number of provider discount audits (to which TPAs are being subjected as a precursor to litigation) continues to rise. Such audits generally look back over five to ten years of employee health claims administration by the TPA.

THE IMPLICATIONS FOR PROVIDERS

How serious is this legal crossfire from the provider's point of view? In what has become extremely high-stakes litigation for the TPAs with their corporate clients, hospitals and other providers have not yet featured as defendants. However, a provider would be well advised to review its relationships with insurance carriers acting as TPAs, and its transactions with patients who are employees or other beneficiaries of corporate plans administered by these TPAs, to determine whether the provider's practices or documents expose it to avoidable risks.

Such a review should include any forms containing billing information that the provider furnishes to patients or other plan beneficiaries.

For instance, the provider's form may indicate a "billed amount" higher than the amount the provider ultimately will receive in payment from the TPA. In such a case, if the patient is covered by a so-called "indemnity" plan pursuant to which the patient pays a percentage of the amount billed (commonly, this coinsurance factor is 20%), the provider's own documentation may establish an overcharge creating legal exposure in several possible ways:

- A state statute or regulation may require a provider who negotiates rates with TPAs to calculate copayments on the negotiated amounts.

- The employer (acting as fiduciary for its employees under ERISA) may claim that the provider has conspired or aided and abetted in the commission of a TPA's fraud.
- If the number of patients covered by similar transactions is large enough, plaintiffs' lawyers may attempt to pursue a class action on behalf of them to recover not only coinsurance overcharges but also attorneys' fees and any penalties the courts may award.

REDUCING A PROVIDER'S RISKS

In most cases, a simple review of the provider's contracts with insurance companies and related patient billing forms and practices should confirm whether the provider is running unnecessary risks.

This review should determine, for instance, whether any coinsurance percentage that the provider is charging directly to the patient does not reflect a discount for the service that has been agreed with the TPA (or, where coinsurance is a factor in an HMO plan, with the HMO).

The review should also determine whether the paperwork furnished by the provider to patients (or to corporate plan sponsors through the TPA) contains statements that arguably are misleading with respect to the amount that the provider will actually receive for the transaction.

Any provider collecting coinsurance amounts from patients covered by an ASO or HMO contract should:

- obtain from the TPA/HMO (i) a written acknowledgment that the provider's billing of coinsurance amounts is done at the TPA/HMO's direction, and (ii) a warranty that these amounts are lawful and violate no contractual obligation or duty of the TPA/HMO
- include in relevant UB92's or other forms that the provider issues to patients a notice that the billed amount is the charge that it renders pursuant to its contract with the TPA/HMO and that the underlying charge on which it is based may be subject to adjustment

- determine whether additional measures are required to insure compliance with the federal and state law applicable to it

SUMMARY

In view of the growing size of provider discounts—and therefore the amounts TPAs and providers may be charged with improperly retaining—hospitals and other healthcare providers should review their relevant procedures and documentation.

In many cases, a combination of accurate descriptions and careful disclaimers regarding amounts billed may offer an easy way to reduce exposure to this growing legal crossfire in the healthcare industry.

MORE INFORMATION

For advice on the review of a provider's procedures that may impact exposure in this area, please call **Pat Weitzman** of the Firm at 203-222-3116. For more information on the underlying dispute between TPAs and health plan sponsors and beneficiaries, please call **Rob Barberi** of the Firm at 203-222-3114.

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