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JIM PALOMBARO, MD

Out of network, Out of luck

If you think dropping a health plan means the hassles are over, think again. Insurers are coming up with ways to make life difficult for you so you'll come back to them.

STORY BY ROBERT KAZEL ■ PHOTO BY BRIAN GOMSAK

MANY PHYSICIANS undoubtedly would love to leave managed care networks and not look back.

But these days, it might be a good idea to survey the road ahead before deciding against renewing a contract. Increasingly, insurers are using payment policies to make out-of-network doctors' lives more difficult, and those medical groups that opt to take the "nonpar" path may well find that freedom carries a high price tag, extra time and work, and added exasperation.

Some plans have used these pressure tactics for years, but others are just starting to get more aggressive. Insurers say using sticks as well as carrots to make networks look attractive is fair business strategy. Doctors, on the other hand, argue that putting the squeeze on nonparticipating medical groups winds up using patients as a wedge in contract disputes — an approach they say is coercive and shortsighted.

Jim Palombaro, MD, an emergency physician in Raleigh, N.C., experienced *déjà vu* in March when he read a letter from UnitedHealthcare to his medical group. United said it would stop paying reimbursements directly to physicians who weren't in its network. Checks would be mailed directly to those doctors' patients, with the patients as payees.

Because the 46 doctors who constitute Wake Emergency Physicians didn't have a contract with United, Dr. Palombaro knew United's new procedures would spell trouble for the group, of which he is the president. In the past year, the group had grappled with those same problems with BlueCross BlueShield of North Carolina. The doctors, unhappy with what the Blues plan wanted to pay, dropped out of that network in April 2004. Immediately, the plan began sending checks to patients.

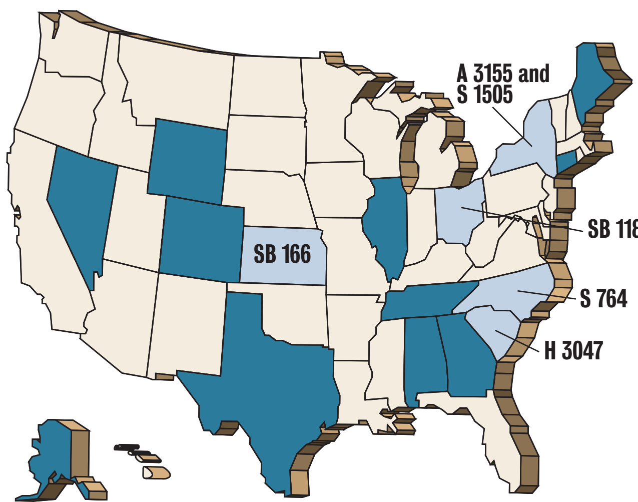
For the physicians, the average wait for payment has increased dramatically. Cash flow has been disrupted. Half the time, patients aren't forwarding their insurance checks to the medical group at all, Dr. Palombaro says. "You don't need to have the patient in the middle of this."

Actions and reactions

OUT-OF-NETWORK PHYSICIANS or practice administrators in North Carolina, Virginia and Georgia told *AMNews* that their groups had received letters from United in the past few weeks, announcing that they no longer would be paid directly if they did not join up. Some physicians in Florida received similar notices last summer. It's not clear to what extent United is changing its procedures across the country. A spokesman for the company did not return telephone calls.

Blue Cross Blue Shield plans, which cover one

ASSIGNMENT OF BENEFITS: STATE ACTION



■ States with assignment-of-benefits laws
■ States considering assignment-of-benefits legislation at press time

SOURCE: AMERICAN MEDICAL ASSOCIATION ADVOCACY RESOURCE CENTER, STATE LEGISLATURE WEB SITES

in four Americans, routinely send payments to subscribers if they're treated out of network, except in the minority of states where laws require insurers to honor assignment of benefits.

"It's a very frustrating situation for physicians," says Barry Rose, DO, an anesthesiologist in Richmond, Va. Large health plans "use it as a sledgehammer to keep you in the network."

Last year, Dr. Rose and several other doctors in Virginia organized a physician lobbying group called Virginians for Fairness in Healthcare. Now with 180 members, one of its primary goals is passage of a state law that would require plans such as Anthem Blue Cross and Blue Shield of Virginia, a unit of Indianapolis-based WellPoint, to pay out-of-network doctors directly when a patient has authorized assignment.

Though only a handful of states passed assignment-of-benefits laws in the 1980s, 1990s and early in this decade, the pace of legislative activity seems to have picked up lately.

In several states this year, lawmakers have introduced measures aiming to curb insurers' refusal to honor patients' assignment of payment to out-of-network doctors. These bills often have had the support of state and specialty medical societies. At press time, bills were under consideration in Kansas, New York, North Carolina and South Carolina, and health policy experts say more states are expected to consider the issue next year.

There will be battles. An assignment-of-benefits law that would have helped doctors failed to pass the Virginia General Assembly this year because of powerful opposition by business interests and insurers, particularly WellPoint.

State legislators instead approved a measure that mandates only that physicians' names and addresses appear on the explanation of benefits statements that accompany checks sent to patients. Many Virginia physicians still are skeptical that patients who find checks in their mailbox will do what they're supposed to do.

"If you get a check, you might assume you overpaid or that it's a refund," says Ann Hughes, director of legislative affairs for the Medical Society of Virginia. "If your roof leaks, you're going to get your roof fixed. It's an unexpected mini-windfall."

Brian Clare, MD, says his eight-physician emergency medicine group in Williamsburg, Va., is still faced with collecting $300,000 in receivables stemming from a three-month period when the practice didn't have an Anthem contract. The doctors rejoined the network, he says, because they had little choice. Not only were some patients confounded by getting insurance checks, but a few were trying to turn frivolous visits to the emergency department into an extra income, he says. "One family had seven visits in the two months before Christmas [with payments totaling] $6,000 and kept every bit of it," he says. "There are a certain number of people working the system."

In North Carolina, many medical groups appear to be intimidated by insurers and view leaving major networks as a foray into dangerous territory, according to Carol Scheele, associate general counsel of the North Carolina Medical Society.

"Gradually, what we're seeing is that physicians are becoming extremely reluctant to terminate their agreements even if they have a reasonable reason for doing so," she says.

Insurers: Business is business

DOCTORS MIGHT DREAM OF ESCAPING THE shackles of insurance network contracts and the obligation to accept deep discounts on fee schedules. But the grass, or rather the cash, may not be much greener as a nonparticipating doctor if plans strategically try to enhance the appeal of inclusion by paying out-of-network rates that appear to be exceptionally low.

Although the law might require plans to pay fees that are usual, customary and reasonable, the definition of those terms could be a mystery, and the actual mechanisms for setting rates might be hidden from doctors' view.

Some out-of-network doctors have recently fought for better rates. Wayne Surgical Center, an ambulatory surgery center in Wayne, N.J., in April filed a civil suit against Horizon Blue Cross Blue Shield accusing the plan of using "incomplete and inaccurate" market data to determine reimbursement rates for out-of-network doctors. The suit alleges that Horizon purchases information from New Jersey-based Ingenix, a subsidiary of UnitedHealth Group, knowing that the data do not appropriately reflect the rates prevailing in the region. Ingenix is also named as a defendant.

A Horizon spokesman said the company would defend itself vigorously but wouldn't comment further; United executives could not be reached for comment.

In Pompano Beach, Fla., an orthopedic surgeon, Peter F. Merkle, MD, sued four HMOs in January, alleging that the plans had conspired to reduce payment to out-of-network doctors in violation of Florida law. Dr. Merkle accuses the insurers of dramatically revising downward their fee schedules for nonparticipating doctors last year. The plans say their rates are reasonable.

And organized medicine in California scored a victory when California-based Health Net in January was instructed by state regulators to pay out-of-network emergency doctors and other hospital-based physicians between $6 million and $7 million. The California Dept. of Managed Health Care also fined the company $250,000, saying that state rules requiring prompt and fair payment of physicians plainly apply to out-of-network doctors but that Health Net had mishandled some 65,000 claims in 2004.

As for the doctors' ongoing discontent over the benefits assignment issue, health plan executives respond that they cannot understand why physicians who choose to be outside the network imagine that they should be paid directly — something they say is, by definition, a benefit reserved for doctors who accept network discounts and who agree to refrain from balance-billing their patients.

"We think this [is] a very important issue that goes to the heart of our business," says Leonard Hopkins, a WellPoint lobbyist who fought against the assignment legislation in Virginia.

Blues plans also say they view their payment policies as a way to keep premiums for patients more affordable. "It's good for our subscribers, because individually we're saving them thousands of dollars a year and collectively millions of dollars a year," says Sue Laudicina, director of research for the Chicago-based BlueCross BlueShield Assn.

Nevertheless, a single-minded focus on business strategy, without regard to harmful side effects, actually will hurt patients in the long term if physicians are forced to accept contracts that don't provide enough income to pay their expenses, says Jeremy A. Lazarus, MD, a Denver psychiatrist and the vice speaker of the AMA House of Delegates. Hospital-based doctors such as emergency physicians and anesthesiologists who want to leave networks are at a particular disadvantage, he says, because they usually don't have established patient relationships and could find collections to be impossible.

The AMA's Advocacy Resource Center will continue to provide medical societies with model legislation that would require out-of-network physicians to get direct payment when benefits are assigned, Dr. Lazarus says.

"Frankly, this is just another way insurers are trying to muscle doctors," he says. "Insurers need to find ways of treating physicians fairly, whether they're in network or out of network. If they treat them unfairly when they're out of network, it certainly doesn't build trust and make them want to come into the network." ◆

Dear Doctor,

"You should be aware that the UnitedHealthcare Certificates of Coverage give us the option not to honor the assignment of benefits obtained by non-participating physicians and hospitals and make claim payment directly to the enrollee. Beginning shortly, UnitedHealthcare will change its administrative process and make claim payments for services provided by non-participating physicians directly to our enrollees. UnitedHealthcare will continue to provide direct claim payments only to those physicians participating in our network.

"You can avoid the cost of collecting patient receivables and be eligible for timely, direct claim payment from UnitedHealthcare by becoming a participating physician now. Please contact us within the next 30 days to begin the contracting process...

"UnitedHealthcare is committed to maintaining a relationship with physicians that is professional and respectful."

Sincerely,
UnitedHealthcare

UNITED FRONT

UnitedHealthcare earlier this year sent letters, like the one excerpted here, to many out-of-network physicians in various states, warning that it would it pay patients directly, and that doctors would have to collect from them.

SOURCE: LETTERS FROM UNITEDHEALTHCARE TO MEDICAL GROUPS, MARCH 2005