

DISCOUNT PLANS

**Hardships
Prompt Payments
Cash Discounts
Prepayment Plans**

ARE THEY LEGAL?

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DISCOUNT PLANS ARE THEY LEGAL?

Every doctor in private practice is faced with the decision of how much to charge for services rendered. At one time this was a simple issue. The doctor decided on a fee and charged that fee to virtually all patients. But today that's no longer true. Ten different patients may come to the doctor's office on one day, and each one is charged a different fee for virtually the same service. Many of the differences are mandated by law. For instance, Medicare patients pay one fee; Medicaid another; and workers comp patients are subject to yet a different mandatory fee schedule.

With the onset of managed care, the situation became even more complex. HMO's, PPO's, and IPA's all realize that they have the ability to negotiate with doctors for reduced fees. While some attempt to dictate the fee schedule, others simply attempt to negotiate a percentage discount from the doctor's "usual" fees. The latest trend, "capitation", takes fee setting to a different level, where the doctor is asked to agree to a fixed monthly fee for all services which are provided to a patient.

Yet with the plethora of fee structures available to (or in some cases imposed upon) the doctor, some areas of fee setting have important legal ramifications. Doctors are not lawyers and some of the fine legal points and distinctions are not always clear. Even with best of intentions, it's easy for a doctor to run afoul of the law.

Many of the legal issues relating to fee structures are not clearly defined by statute or regulation. This difficulty arises because the states have been reluctant to regulate in the area of fee setting or fee structures, realizing that those issues should be left to be determined in a competitive market place. For this reason, the legal opinions expressed herein are not solely based upon "black letter law", but instead upon a combination of factors, including case law, rules, regulations, and twenty years of experience in dealing with the forces in the chiropractic profession.

THE DOCTOR'S RIGHT TO SET FEES

In general, the doctor has the legal ability to negotiate a different fee for each individual patient, with the exception of those who are covered by a mandatory or previously negotiated fee schedule. The thought, however, of negotiating with each patient is scary and such a system would prove to be cumbersome in the office. Therefore, virtually all doctors have adopted a schedule of fees for their services.

As a general rule, the schedule of fees will apply to all patients (again with the exception of those subject to a mandated or negotiated fee schedule). The doctor is generally free to choose the amount to be charged for any particular

service. There are, however, some practical restraints. Some states have laws which prohibit the charging of "unconscionable" fees. As a practical matter, if the doctor's fees are too high, the doctor will encounter substantial difficulties with third party reimbursement. These difficulties include not only fee reductions, but also systematic claim denials, and allegations of fraudulent billing practices.

While the doctor may have some knowledge of the fees charged by other doctors in the area, setting fees by collusion with other doctors, or through any association or organization, is prohibited by the anti-trust laws, and should be avoided.

HARDSHIP PATIENTS

Almost all doctors treat patients who have a financial hardship and are simply unable to pay for the care they need. This type of charity care is encouraged, and doctors can provide care to these individuals free or at substantially reduced rates. We suggest that the person's hardship and the agreement for any payments to be made be in writing, signed by the patient, and placed in the patient's file. A sample hardship agreement and financial verification is attached to this memo.

PROMPT PAYMENT DISCOUNTS

California law specifically permits the offering of a discount for prompt payment by third party payors. Business and Professions Code § 657 provides:

"To encourage the prompt payment of health or medical care claims, health care providers are hereby expressly authorized to grant discounts in health or medical care claims when payment is made promptly within time limits prescribed by the health care providers or institutions rendering the service or treatment."

Thus we believe that the doctor may offer a reasonable discount for prompt payment. We recommend the offer be extended to all patients (both insured and uninsured). If the offer allows a certain time period after the date of service within which to pay, it should be communicated to the third party payors allowing them a reasonable period of time to pay the claim and avail themselves of the discount. Note that the amount of the discount and the specific period of time are not defined by the statute and therefore leave these issues to the doctor's discretion, within the bounds of reasonableness.

CASH DISCOUNTS

A "cash discount" occurs when the doctor offers a discount in return for payment directly from the patient. Although this may seem logical, there are hidden problems with "cash discounts".

The Mercy Center Guidelines oppose dual fee schedules. In addition, some states have laws which specifically prohibit the establishment of a "dual fee schedule". As a practical matter, most insurance policies provide that they will not pay for any charges which would not have been made in the absence of insurance. Thus carriers want to pay only the fee which would have been charged to each patient in the absence of insurance.

Cash discount programs which charge a lower fee to uninsured versus insured patients, thereby creating dual fee schedules, are now being treated in some states as fraud and over billing. From the carrier's standpoint, it's much like the waiver of co-payment situation, where the carrier claims that the bill is fraudulent because it does not represent the doctor's true fee for the service.

Some states also have laws which specifically prohibit dual fee schedules. For instance, Michigan law provides that a physician cannot charge a fee to any insured patient under the State's no-fault law which would exceed the amount the person customarily charges for like services in cases not involving insurance.

Other states mandate that worker's compensation cannot be charged more than the doctor customarily charges. In Oregon, a number of chiropractors were recently faced with criminal indictments and civil lawsuits spearheaded by the State Accident Insurance Fund, which claimed that the doctors committed fraud by submitting billings for workers compensation cases which exceeded the amount they charged cash patients for the same treatment. The civil claims were brought under Oregon's racketeering law and sought actual damages, punitive damages, forfeiture of the doctor's property, and revocation of professional licenses.

Personal injury defense attorneys have also now gotten into the act. It's not unusual at all to have a defense attorney ask the doctor about his charges to cash patients and whether he charges insurance and PI patients the same.

A specific California Law was added in the late 90's, recognizing the problem which exists with a high population of uninsured residents who cannot afford basic health care. This law, codified as Business and Professions Code §657 specifically permits health care providers to grant discounts for health care provided to any patient who is not insured. The law then specifically provides that the discounted fee shall not be deemed to be the provider's usual, customary, or reasonable fee for any other purpose, blocking insurance companies from objecting to this particular discount. Note, however, that this provision applies solely to patients who are uninsured, and that it is up to the doctor to verify this fact. The verification should,

of course, be in writing, and contained in the patient's chart. A sample form is appended.

PREPAID PLANS

Prepaid plans come in a variety of forms. They generally, however, offer to the patient health care service at a fixed fee for a period of time. For example, the patient would pay \$100 per month for whatever chiropractic care he or she needs. Longer term plans would have the patient paying \$1000 for the entire year's worth of care.

Under California law, prepaid plans, such as these, are illegal unless they have been registered with the California Department of Managed Health Care. The Knox-Keene Health Care Service Plan Act applies to both full service health care plans (Health Maintenance Organizations) and to plans which offer just one type of service, which are called specialized health care service plans.

Under the Knox-Keene Act, a specialized health care service plan contract is broadly defined as:

“...A contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.”

Somewhat like the State's need to regulate insurance companies, the State has a compelling interest in regulating pre-paid plans in order to adequately protect the public. State requirements include minimum capitalization and reserve requirements to insure financial viability; financial projections and auditing to assure long term viability; approval of the plan documents; proper credentialing, quality assurance, and utilization review standards to assure that appropriate services are rendered in a timely manner; and grievance procedures to assure fairness.

In addition, if the plan accepts risk for an uncertain quantity of care, then the plan may constitute the business of insurance. Operation of an insurance plan also requires state registration, and the penalties for violation can be severe. A bulletin issued by the National Association of Insurance Commissioners states: “If a health care provider enters into an arrangement with an individual, employer or other group that results in the provider assuming all or part of the risk for health care expenses or service delivery, the provider is engaged in the “business of insurance.”

For example, the case of Manasen v. California Dental Services⁵ the Court held that a plan under which employers paid a fixed per capita premium to a provider in exchange for dental services to their employees, the plan constituted the

business of insurance" and was operating unlawfully. The same analysis holds true if the plan is offered to an individual, or if the plan involves a partial capitation (fixed payment) combined with a partial fee for service or co-payment requirement.

Many of the prepaid chiropractic plans we have reviewed to date, whether established by some loosely run organization or by an individual doctor's office, are operating in direct violation of the Knox-Keene Act. The statutory penalties for violation are serious including fines of up to \$10,000, imprisonment of up to one year, and forfeiture of the assets of the plan".

Typically, unlicensed plans may encounter other difficulties as well. The services are often vaguely described, creating great opportunities for argument over covered versus non-covered services. This includes determination of what services are necessary, as well as the range of services available, such as therapy modalities, x-ray, laboratory work, and specialized diagnostic tests. Another common problem, particularly with the longer term plan is what happens upon early termination (i.e. the patient moves from the area - is he entitled to a refund, and if so, how much?).

Here are our suggestions for pre-paid chiropractic plans:

1. The plan should be set forth in writing, and clearly describe what services are to be included.
2. The plan should be for a fixed number of visits or specific services, recommended by the doctor following and consistent with the patient's diagnosis.
3. The plan document should have a specific provision for refunds if the plan is terminated by either the patient or the doctor. The refund should be calculated on a pro-rata basis, with credit given for any unused visits or services.
4. Any refund should be made within 30 days following the patient's request.

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^[1]Guidelines for Chiropractic Quality Assurance and Practice Parameters, '5.5.4 (1993).

^[2] M.C.L.A. 500.3157

^[3]Health and Safety Code Section 1340, et. seq.

^[4]National Association of Insurance Commissioners; August 10, 1995; Bulletin re: Suggested Bulletin Regarding Certain Types of Compensation and Reimbursement Arrangements between Health Care Providers and Individuals, Employers, and Other Groups.

^[5]Manasen v. California Dental Services, 424 F. Supp. 657 (N.D. Cal. 1976), rev'd on other grounds at 638 F.2d 1152 (9th Cir. 1979).

THIS MEMORANDUM CONTAINS A GENERAL DISCUSSION OF LEGAL PRINCIPLES APPLICABLE IN CALIFORNIA AS OF JANUARY 1, 2010. IT SHOULD NOT BE TAKEN AS SPECIFIC LEGAL ADVICE. PRACTICE STRUCTURE AND OPERATIONAL ISSUES HAVE BECOME LEGALLY COMPLEX DUE TO SIGNIFICANT AMOUNTS OF GOVERNMENTAL REGULATION. WE URGE EACH DOCTOR TO CONSULT WITH A COMPETENT HEALTH CARE ATTORNEY ON THESE AND OTHER ISSUES AFFECTING THE PRACTICE OF THE HEALTH PROFESSIONS.

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FINANCIAL HARDSHIP VERIFICATION

The undersigned requests special consideration as a Financial Hardship. The following information is submitted in support of this statement. The undersigned states that the following financial information and circumstances are true and correct, and therefore does make application for financial hardship status, alleging that payment for health care services would create a severe financial hardship:

1. Name: _____
2. Gross Family Income: _____
3. Number of Persons in Household: _____
4. Address: _____
5. Amount of Rent or Mortgage: _____
6. Employer (Patient): _____
7. Employer (Spouse): _____
8. We owe the following creditors: (include amount)
 - A. _____
 - B. _____
 - C. _____
 - D. _____
9. Other extenuating circumstances are: _____

Patient or Legal Guardian Date: _____

Witness

APPROVED: _____ Date: _____

FINANCIAL HARDSHIP PAYMENT AGREEMENT

Patient Name _____

I hereby certify that I have been informed of the usual fees of this office for the examination, testing and treatment which has been recommended. I am unable to pay those fees at this time without substantial financial hardship.

To enable me to obtain services, I have agreed to the following payment arrangement:

It is my responsibility to make these payments without any need for periodic bills or other reminders of payments due.

The health care provider's office reserves the right to discontinue this special payment arrangement upon reasonable notice to the patient.

Date

Patient Signature

Print Name

Witness Signature

Print Name

**PATIENT'S PAYMENT ARRANGEMENT
FOR UNINSURED PATIENTS**

PATIENT'S NAME: _____

I hereby verify the following:

1. I have been informed of the nature of the services recommended for my condition(s) and of the usual fees charged by this office.
2. To the best of my knowledge, I am not eligible for or entitled to reimbursement for such serviced by any insurance plan, health care service plan, any governmental program (including Medicare and Medi-Cal), or any third party.
3. I am not financial able, at the present time, to pay the full amount of the fees which would be charged by this office.
4. To enable me to receive services, I have been offered and have agreed to a special payment arrangement. My payment will be in the following amount:

I agree to make these payments without any need for periodic bills or other reminders of payments due.

5. I agree to notify the office of any change in my health care coverage or financial situation.

This payment agreement does not apply to any services, which are covered by insurance, any health care service plan, any governmental program, or any third party claim.

The doctor's office reserves the right to discontinue this special payment arrangement upon reasonable notice to the patient.

Patient's Signature

Date