TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

VISION: To improve the health of all Texans.

MISSION: TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

TMA Division of Medical Economics

Physician Prices, Fee Schedules, and Managed Care Contract Offer and Acceptance

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What is my price? OR What is the price of medical services?

A physician's price is his billed charge. Like any other small business, the physician should ensure that his price is adequate to cover the cost to provide services, including overhead costs, non-physician labor costs, and adequate compensation to the physician for his services and expertise. Furthermore, the price must be sufficient to cover all the costs of charity care and bad debt and allow a reasonable return on the investment of the practice owners. Due to antitrust concerns, any price a physician may decide upon must not be the result of agreements with other physicians who are external to the practice, but instead must be his independent determination.

The billed charge is the amount the practice will collect from a patient for services absent an agreement (such as a managed care contract) or discount policy (if applicable).

How do I evaluate contract rates?

A physician's contract rate is generally considered to be the cash payment due for services provided pursuant to a managed care contract. The cash amount accepted from an insurance carrier and patient in a managed care arrangement is not the practice's price (usually referred to as the billed charge). In the context of managed care, the total economic transaction is more complex and less transparent than in a simple cash-payment arrangement.

A typical managed care contract contains various obligations that a physician must meet, such as abiding by the insurer's physician manual, providing medical

services, and meeting claims filing deadlines, in exchange for payment. The contracted physician may receive other benefits, including a listing in the insurer's provider directory and other patient steerage, the ability to submit claims electronically (versus having to mail invoices to cash pay patients), the application of Texas' prompt payment laws, and the increased ability of an insurer to pay versus individuals (as physicians grant patients and insurers credit unless payment is made prior to the provision of services). Contract rates may vary from carrier to carrier and from physician to physician based on many factors, such as the company's business conduct in interacting with physicians, the number of enrollees in the physician's practice area, and the price that physicians accept.

Physicians should evaluate contract rates in relation to their total practice costs, including all of the practice cost components listed above. Although most businesses will sometimes sell goods or services at below their cost, that strategy is generally a limited or temporary one designed to build customer base or to reduce excess inventory or capacity. Any business that consistently sells goods or services at less than their full cost will eventually become insolvent. A practice will want to carefully review its insurance carrier contract rates to ensure they do not create a circumstance where the practice cannot meet its obligations as they become due.

I want to join other physicians and negotiate fees with an insurance company. That's legal; right? OR I dislike the current offer made by a health insurance carrier and I want to convince my physician colleagues that they should reject the current offer. Is that allowed?

Generally, no, those actions (i.e., joint price negotiation and refusals to deal, respectively) are not permitted by or among physicians external to a practice nor is it generally permitted to combine or collude with colleagues to determine the price of services.

This prohibition is contained in federal and state antitrust laws, which prohibit any contract, combination or conspiracy that unreasonably restrains trade[1] In making the reasonableness determination, some conduct has been deemed "per se" illegal for being plainly anti-competitive.[2] Among the activities that have been treated as per se violations of the law are price fixing[3] and boycotts.[4]

[1] See the Sherman Act, 15 U.S.C. §1 stating: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $100,000,000 if a corporation, or, if any other person, $1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court"; see also, Standard Oil Co v. United States, 221 U.S. 1 (1911)(regarding the reasonableness requirement and "rule of reason"); see also, Tex. Bus. & Comm. Code §15.05(a).

[2] See.,e.g, National Collegiate Athletic Association v. Board of Regents, 468 U.S. 85 (1984).

[3] See, e.g., Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984).

[4] See, e.g., FTC v. Superior Court Trial Lawyers Association, 492 U.S. 411 (1990).

If a physician is determined to meet with other physicians to discuss prices or whether particular insurer offers should be accepted, the physician should first seek the services of legal counsel with expertise in antitrust law. There are business combinations, such as financial risk-taking independent practice associations (IPAs), that can facilitate joint negotiation, but they must be carefully structured and undertaken only with appropriate legal advice.

Furthermore, a physician group that can undertake joint negotiations is a group that is truly clinically or financially integrated in accordance with the highly-technical standards for integration established by the Federal Trade Commission and Department of Justice.[5] Physicians who merely share office space or staff or who maintain medical records in a comingled fashion do not necessarily meet the requirements for clinical integration. Physicians must be careful to comply with antitrust laws. Violations of antitrust laws are criminal in nature and punishable by fines of $100,000,000 if a corporation, or, if any other person, $1,000,000, or by imprisonment not exceeding 10 years.[6]

It is important to note that antitrust laws apply with equal force to trade associations. In fact, these laws apply to the Texas Medical Association and its advocacy activities on behalf of its physician members (which under the law will be viewed as competitors). Thus, the TMA bylaws prohibit the Association from setting or negotiating fees. TMA's bylaw on this issue states as follows:

> 16.50 Prohibition on fee setting. No action shall be taken by the association or any of its component county societies establishing a fixed schedule of fees for the services of members.
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> The association shall not enter into a contract with any person, firm, or agency with respect to the practice of medicine or fee for such practice.

It is illegal for an insurer to offer a contract rate that is less than Medicare; right? OR It is illegal for me to accept a contract rate that is less than Medicare; right?

No, the offer or acceptance of a contract rate below the Medicare fee schedule can be perfectly legal and the contract enforceable.

Here is the provision of federal law that is generally referred to in regard to this question:

[5] For more information on medical practice integration and antitrust law, see the American Medical Association publication entitled "Competing in the marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration," available at: http://www.ama-assn.org/resources/doc/psa/competing-in-market.pdf

[6] 15 USC §1.

> (6) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services
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> Any individual or entity that the Secretary determines--
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> (A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under subchapter XVIII of this chapter or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs.[7]

The federal government previously attempted to further define what "substantially in excess" and "usual charges" mean in the context of this provision. In 2003, a rather convoluted and complex method of calculation was proposed to discern "usual charge."[8] However, that method proved to be so unworkable the federal government withdrew the proposal and never adopted a final regulation.[9]

Nonetheless, in correspondence to TMA, the then Chief of the OIG Industry Guidance Branch stated that the provision referenced above does not prohibit contract discounts to private carriers (citing a letter sent to the American Ambulance Association as authority)[10] and referred to OIG Advisory Opinion 98-8 upon the meaning of "substantially in excess."

According to the American Ambulance Association letter, the government asserted that the law "addresses a much narrower issue, tiered pricing structures that set one price for Medicare or Medicaid and a substantially lower price for most other customers."[11]

Substantially in Excess

The circumstances that the OIG was analyzing in Advisory Opinion 98-8 can be characterized as follows:

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[7] 42 USC 1320a-7(b)(6)(A)
[8] See, generally, 68 Fed. Reg. 53939 (September 15, 2003).
[9] Medicare and State Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, Notice of withdrawal of proposed rulemaking, 72 Fed. Reg. 33430 (June 18, 2007); available at: http://oig.hhs.gov/authorities/docs/FR%20Notice%20Withdrawal%20of%20Substantially%20in%20Excess%20Rule.pdf
[10] See OIG Letter at http://oig.hhs.gov/fraud/docs/safeharborregulations/amldiscount.htm
[11] Id.

"Company AB" sold durable medical equipment of which approximately 300 of the 3,000 products offered for sale were reimbursable under the Medicare program. In order to participate in the Medicare program, the company asserted it would have to meet certain regulatory standards that added cost and hassle to its usual billing processes (among other things). "Company AB" proposed to charge Medicare an amount equal to the maximum reimbursement amount allowable under Medicare's payment regulations. Company AB asserted that that would mean its proposed charges to Medicare will generally be higher than its charges to its "cash and carry" customers.[12]

The OIG replied, in its advisory letter, that:

> Because the amount Company AB proposes to charge Medicare is generally 21-32% higher than its 'cash and carry' price for any given item, we believe that Company AB's charges to Medicare for some products would be substantially in excess of its usual charges and potentially subject Company AB to exclusion absent 'good cause'.[13]

It is this OIG letter that has led many to conclude that a price differential of more than 20% in the price for private persons and companies risks exclusion from Medicare (or worse). However, the federal government rejected this seeming "bright-line" approach to "substantially in excess." When withdrawing the proposed regulations discussed previously the government stated that "we believe that a single benchmark for ''substantially in excess'' is unadvisable at this time. We believe it is more appropriate to continue to evaluate billing patterns of individuals and entities on a case-by-case basis.[14]"

An insurer offered me a contract rate I found unacceptable, I then made a counter-offer for a different contract rate. The insurer didn't accept, but now I am being told I can't accept their first offer. That isn't legal; is it?

Yes, it is generally legal. In fact, it is traditionally how contract negotiations are conducted. First we must outline some contracting basics.

All contracts must contain several basic elements before it can be said to be legally binding. Of those elements, the most basic are mutual assent, offer, and acceptance.

In Texas, network contracts between an insurer and physician are generally in writing and there are many required contract provisions.[15] As with any contract,

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[12] See OIG Advisory Opinion No. 98-8, dated July 6, 1998; available at: http://oig.hhs.gov/fraud/docs/advisoryopinions/1998/ao98_8.pdf

[13] Id.

[14] See, 72 Fed. Reg. 33430 (June 18, 2007).

[15] For example, Texas Ins. Code §843.361 states, "ENROLLEES HELD HARMLESS. A contract or other agreement between a health maintenance organization and a physician or provider must specify that the physician or provider will

both parties must demonstrate the intent to be mutually bound by the contract. This is demonstrated by the acts of "offer" and "acceptance." An offer is a promise to do or refrain from doing some act in the future. In order for a promise to become an offer in terms of contract law, the promise must be made in such a manner that a reasonable person would conclude that his assent is invited. In regard to most insurance contracts, because they are generally in writing, assent to contract will be invited and evidenced by the physician's signature and reciprocal promises. Thus, for an offer from an insurer to become a legally binding contract, the physician must sign the contract offer.

An offer is terminated by the offeree (physician) if the offerree (physician) rejects the offer or if the offeree (physician) manifests a contrary intention, such as through a counter-offer. At common law, a counter-offer is a response to the offer that adds qualifications or conditions to the offer. A counter-offer acts as a rejection even if the qualification or condition relates to a trivial matter.

Thus, by making a counter-offer for a different contract rate, it is very possible the physician has terminated the insurance company's offer. This means there is no longer a "first offer" to which the physician can agree.

Readers should note that these negotiations do not terminate any contracts that may still be in effect at the time of negotiations. The issue discussed above merely deals with offers and counter-offers for new contracts. There is no effect on old executed contracts.

If I terminate my contract with an insurer, I must also notify patients that I am terminating the patient-physician relationship, right? OR I have decided I will not agree to the health insurer's latest offer to contract. Now I must notify patients that I will no longer be available to provide medical services, right?

No, your patients can continue to receive services from you even if you do not accept the contract offer from their insurance carrier. Termination of an insurance contract is entirely separate from the termination of the patient-physician relationship. A physician may want to inform patients that they can continue to see him on an out-of-network basis.

I have heard Texas law prohibits charging different fees. Does that mean I must offer the same contract rate for each health insurer?

No, you are not required to have the same contract rate for each health insurer because of Texas law (although you may voluntarily do so). Texas law prohibits charging a different price based upon the fact that an insurer will pay for all or

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hold an enrollee harmless for payment of the cost of covered health care services if the health maintenance organization does not pay the physician or provider for those services."

part of the services.[16] Readers will also be interested in knowing that the offense occurs only in those circumstances where the insurer is charged the higher amount.[17] However, the physician's price is always his or her billed charge. The fact that different contract rates may be accepted for payment in specific circumstances does not alter the fact that a physician's billed charge is his or her price.

Also, the provision of Texas law discussed above applies to all lines of insurance - including property and casualty insurers. Thus, an auto repair shop can't have a different price for auto repairs when an insurer pays, but a lower price when a customer pays. That is an instance where two different prices are actually being charged and an offense may have taken place.

Does the Texas law upon "different fees" mean that I can't offer charity care or waivers to the indigent?

The law does not prohibit such aid for the indigent. You can provide charity care without violating the law. In fact, the Texas legislature specifically clarified the law to expressly permit these charitable policies.[18]

The federal government has also stated, in regard to excess charges, "that, when calculating their 'usual charges' for purposes of [the relevant provisions of the Social Security] Act, individuals and entities do not need to consider free or substantially reduced charges to (i)uninsured patients or (ii) underinsured patients who are self-pay patients for the items or services furnished.[19]"

Although waivers for the sole purpose of aiding those in true hardship are not per se illegal, you will want to ensure your managed care contracts permit the practice.

[16] Tex. Ins. Code §552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A person commits an offense if:
(1) the person knowingly or intentionally charges two different prices for providing the same product or service; and
(2) the higher price charged is based on the fact that an insurer will pay all or part of the price of the product or service.
(b) An offense under this section is a Class B misdemeanor

[17] Id.

[18] Tex. Ins. Code Sec. 552.001. APPLICABILITY OF CHAPTER. (a) This chapter does not apply to the provision of a health care service to a: (1) Medicaid or Medicare patient or a patient who is covered by a federal, state, or local government-sponsored indigent health care program; (2) financially or medically indigent person who qualifies for indigent health care services based on: (A) a sliding fee scale; or (B) a written charity care policy established by a health care provider; or (3) person who is not covered by a health insurance policy or other health benefit plan that provides benefits for the services and qualifies for services for the uninsured based on a written policy established by a health care provider.

[19] See, generally, 68 Fed. Reg. 53939 (September 15, 2003).

to anyone for any negligence, inaccuracy, error or omission, regardless of cause, or for any damages resulting therefrom. Any legal forms are only provided for the use of physicians in consultation with their attorneys. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought.