

HEALTH CARE LAW UPDATE

January 2008

Hospital Law Issues

Attorney Advertising

Federal Appeals Court Ruling in Favor of Hospitals Regarding “Silent PPOs” - - Don’t Leave Money on the Table!

The Federal Court of Appeals for the Third Circuit (governing New Jersey) recently entered a ruling in favor of a hospital to recover its full standard charges in connection with a patient’s 3-week stay (in the amount of approximately \$250,000).

The patient was covered by a self-insured employer health plan governed by ERISA (the “Plan”), whose third party claims administrator attempted to access discounts pursuant to a PPO’s contract with the hospital, even though the Plan itself did not directly contract with the PPO. This arrangement is often referred to as a “passive” or “silent PPO.”

This case is significant because:

- (i) It is the first Third Circuit Court of Appeals case which has reviewed legal issues relating to a “silent PPO” arrangement involving a hospital;
- (ii) It highlights the importance of hospitals carefully reviewing payments they receive from self-insured plans and other payors to ensure that they are entitled to the PPO discounts which they claim; and
- (iii) It emphasizes the need for hospitals to carefully review and consider the provisions of their managed care contracts.

(1) Background

The patient was covered under the Plan, which contained a PPO option. The only PPO that the Plan had contracted with was Consumer Health Network (“CHN”), and the hospital was not a provider in CHN’s network.

The Plan’s administrator searched for other PPOs in which the hospital participated to see if it could access their discounts, even though the Plan did not have a contract with such PPOs. Such an arrangement has been coined a “silent PPO” or a “passive PPO” because the hospital’s discount agreement with a PPO is accessed by another health plan which does not have a direct contract with the hospital or the PPO.

The administrator determined that it could access a 10% discount through MultiPlan, or a 40% discount through National Preferred Provider Network (“NPPN”). The administrator, desiring the greatest discount, sent a check to the hospital reflecting a 40% discount.

The hospital questioned the applicability of the 40% discount, and after many months of exchanging letters, filed a lawsuit against the Plan 3 ½ years later in federal court.

(2) Court Decision

The federal district court ruled in the hospital’s favor (in the amount of the

40% discount improperly taken, approximately \$100,000), and also awarded attorneys' fees to the hospital under the provisions of ERISA in the amount of \$136,000. The Plan appealed.

The Third Circuit Court of Appeals affirmed the key rulings made by the district court. As a threshold matter, it rejected the Plan's defenses regarding statute of limitations and failure to follow an administrative review process.

The Court ruled that the 40% discount under NPPN's PPO was not applicable to the hospital. NPPN, itself, had concluded this to be the case because it did not have a contract with the hospital, and had notified the Plan of its determination in this regard.

Thus, the crux of the appeal was whether MutliPlan's 10% discount applied. The court concluded that MultiPlan's contract with the Plan only applied to practitioners (e.g., physician services), and therefore, did not apply to the hospital's bill for services.

Further, although the Plan cited to an alleged "facility agreement" between the hospital and MultiPlan, the Appeals Court noted that such agreement required payment to be made in 30 days in order for the discount to apply, and that because payment was not made within such time period, the discount would not have applied anyway.

(3) Practical Recommendations

This case highlights the importance of hospitals - - either internally or through the use of outside consultants - - carefully reviewing payments received from self-insured employers and other payors which apply discounts relying on PPO arrangements.

Notably, be on the look out for:

(a) In the first place, PPOs and other plans with which the hospital does not have a contract; and

(b) Even if the hospital has a contract with a PPO, review and assess the following factors:

(i) Does the contract cover the services that were provided?

(ii) Did the health plan properly access the PPO's discounted rates? For example, the plan may not have a contract with the PPO (or may not have had one at the time of the service), and also, the hospital's contract with the PPO may prohibit assignment to other plans.

(iii) Was the payment made within the required timeframe necessary to be eligible for the discount? (This is very important, as PPOs and other payors often delay payment beyond required timeframes).

(c) Whether the patient's insurance card identifies the PPO which the plan is attempting to access.

On a final note you should also carefully review whether the hospital's registration process captures all relevant information needed in order to assess the propriety of payments based on PPO discounts.

We send these Updates to our clients and friends to provide information on recent developments in the law. The Updates, however, should not be relied on for legal advice in any particular matter. If you would like additional information, please contact: Gary W. Herschman at 973-643-5783 or Anjana D. Patel at 973-643-5097.

A multi-disciplinary team of attorneys who represent hospitals and other health care facilities.

Gary W. Herschman
Michael B. Tischman
Anjana D. Patel
Diane M. Lavenda
Richard M. Slotkin
Alexandra Khorover

Mark S. Olinsky
James M. Hirschhorn
Jack Wenik
A. Ross Pearlson
Mark E. Duckstein
Thomas A. Della Croce
Thomas S. Novak
Jeffrey J. Greenbaum
Peter G. Verniero
Andrew W. Schwartz
Jason L. Jurkevich
Robin Countee Pistorius

David W. Garland
Lynne Anne Anderson
Jerrold J. Wohlgenuth
William R. Horwitz
Jill Turner Lever
Laura S. Grosshans