



2004 MANAGED CARE COMPLIANCE BRIEF

PART ONE:

**PROVIDER DISCOUNT ABUSE IN THE U.S.
HEALTHCARE MARKET**

HYGEIA

HEALTHCARE LEADERSHIP, ACCOUNTABILITY AND PROFIT



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I. EXECUTIVE SUMMARY

During the past decade, Provider discounts via PPOs have become a fundamental component of most health insurance plans. In fact, PPO discounts are now factored into the design, administration, and pricing of insurance plans. Prevalent discount abuse practices, however, have been threatening this component as well as the integrity of business relationships between medical Providers, Payers, and buyers of healthcare services. Two of the most common forms of these abuses are Silent PPO use and PPO stacking.

A silent or secondary PPO arrangement occurs when a PPO sells their Provider discount rates to a Payer **after** the Payer's plan member or client use the medical services of the PPO's contracted Provider. This action constitutes managed care fraud because the Payer has been left out of the preferred agreement and no incentives have been provided for their plan members or clients to choose the Provider. A silent PPO also refers to the practice of contracting with a PPO to access discounts, but failing to alert the provider at the time of service that the PPO contract exists and should be applied. Often, the failure to alert the provider stems from the fact that the PPO logo identification has been "left off" the insured's ID card.

PPO stacking or "cherry-picking" is a related practice in which a Payer "shops" a claim from a particular Provider to multiple PPOs looking for the contractual arrangement that offers the lowest reimbursement rate.

Explicit contracts between PPOs, Providers and Payers require each party to fulfill specific obligations in their business relationship. On one side of health service transactions, PPOs contract with medical Providers to provide healthcare services at discounted rates in exchange for patient volume, prompt payment of claims and other terms. On the other side of transactions, PPOs contract with healthcare Payers (as described above) whose customers or insured members are actively encouraged, and often required by contract, to use the PPO network. Forms of encouragement include directing patients to providers in the network, offering financial incentives, and applying penalties for use of out-of-network providers.

Provider discount abuse occurs when a Payer intentionally or unintentionally breaches the contracts they pay a PPO to access. Whether intentionally or unintentionally, many Payers invalidate both their contracts with a PPO, and their right to access valuable Provider discounts by their failure to fulfill their obligations under the contract.

Healthcare Providers and U.S. courts have become aware and less tolerant of these unauthorized and undisclosed practices, as well as other cases of managed care contract abuse. Many providers are taking

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steps to void discounts that are being taken inappropriately. Insurance refusal, dramatic discount reduction or denial, PPO contract terminations and litigation are growing industry trends.

U.S. courts and state legislatures are hearing cases brought against insurance companies, TPAs, HMOs, and other Payers who are improperly taking discounts from Providers. The most notable legal decision in favor of a medical Provider is HCA Health Services of Georgia, Inc. v. Employers Health Insurance Company, where a federal court disallowed a silent or secondary PPO arrangement of a Humana subsidiary. After cracking down on the "silent PPO" industry in the state in 1999, the California legislature's Business & Professional Senate Bills (SB) 559 and 1732 effective July 1, 2000, placed disclosure and other requirements on entities engaging in the "silent PPO" practice, essentially stopping "silent PPOs" from marketing and selling lists of provider panels that offer discounted rates.

Furthermore, The American Medical Association (AMA) has also been successful in banning silent PPOs from Federal Employee Benefit health Plan contracts, and continues to look for other possible legal challenges.

As a result of the aggressive pursuit of discount abuse offenders in the healthcare market, growing numbers of healthcare law, recovery management and managed care auditing firms are now specializing in helping Providers identify and recover monies lost to managed care contract abuse.

Permanently losing access to discounts, dramatic discount reduction and litigation are risks Payers should evaluate carefully before engaging in these practices.

At Hygeia, we have a long-standing reputation for encouraging Payer-clients to comply with managed care contracts, and support efforts to prevent PPO stacking and silent PPO use. We educate clients about the impact of non-compliance on their access to strong discounts and long-term financial success. This has strengthened our relationships with Providers who recognize and reward our commitment with their most competitive rates. Our compliance protocol clearly demonstrates the financial benefits of avoiding silent PPO and PPO stacking arrangements.



II. PROVIDER DISCOUNT ABUSE IN THE U.S. HEALTHCARE MARKET

ISSUE OVERVIEW

The financing and delivery of health services in the United States is managed through a variety of organizations. A major participant is the Preferred Provider Organization (PPO). A PPO is a health service intermediary that facilitates transactions between healthcare Providers and healthcare Payers through a series of contractual arrangements.

Healthcare Providers include hospitals, physicians and ancillary providers. Healthcare Payers include insurers, assistance companies, third party administrators, self-insured corporations, associations, employer groups, government and non-governmental organizations.

The PPO establishes contracts with Providers for the provision of health services at discounted reimbursement rates in exchange for patient volume, prompt claim payment and other benefits. The PPO also contracts with Payers whose customers or plan beneficiaries require access to medical services. Depending on the stipulations of the specific health insurance plan, a Payer's customers are required or actively encouraged to use the PPO's contracted medical network through financial incentives/penalties such as lower co-payments or higher deductibles. Both the PPO and its Payer-clients are required to establish steerage mechanisms to facilitate use of the PPO's Preferred Providers.

The business relationships between the PPO, Provider and Payer are conducted under the terms of explicit contracts that require each party to fulfill specific obligations. As the intermediary, the PPO's intrinsic value is the strength of the contracts it establishes. From the Provider perspective, it is the contractually binding relationships with, and related patient volume from Payers that are the specific value sought from a PPO. Conversely, from the Payer perspective, it is the right to access binding contracts for Provider discounts that is the specific value a PPO delivers.

In essence, the PPO's product is a critical mass of valuable business relationships and contractual arrangements. Provider discount abuse occurs when a Payer intentionally or unintentionally breaches the contracts they pay a PPO to access.

Are Your Health Plans Depending On Provider Discounts?

Since the 1980s, PPOs have had a dramatic impact on U.S. healthcare costs. The discounts PPOs provide to insurers and their plans are an integral part of plan design, administration, loss ratio assumptions and plan pricing. Today, an effective PPO can reduce U.S. health costs by as much as 40%.



Sample Provider Contract Language

DUTIES AND RESPONSIBILITIES OF PPO AND PAYERS

3.1 Payer Directory. Upon execution of this Agreement, Hygeia shall deliver to Hospital a Payer Directory. Hygeia shall notify Hospital in writing of any additions, changes or deletions to such Payer list no less often than quarterly.

3.2 Payer Notification and Directories. Hygeia agrees to notify Payers of this Agreement and to distribute material to Payers about the services of Hospital. If directories are provided, Hygeia shall list Hospital.

3.3 Eligible Person Identification. To facilitate and ensure accurate identification of an Eligible Person at the time of registration, pre-registration or admission of such Eligible Person as a patient of Hospital, Hygeia or Payer shall provide; 1) each Eligible Person with an identification card, or similar form of identification that contains the Hygeia PPO logo, 2) confirmation by telephone or by telefax, as appropriate, of a covered person's eligibility and Hygeia's involvement. Verbal notification must be confirmed in writing by telefax within 24hours.

3.4 Plan Design. Hygeia shall use its best efforts to ensure that each Payer includes incentives for Eligible Persons to utilize the services of those providers with whom or which Hygeia has contracted including, without limitation, Hospital.

3.5 Eligibility, Benefits and Authorization. Hygeia warrants that each Payer provides twenty-four (24) hour telephone access to verify eligibility and benefits, and to issue authorization for the provision of Covered Services to an Eligible Person.

3.6 Payer Agreements. Hygeia shall use its best efforts to negotiate Payer Agreements with terms consistent with the provisions of this Agreement.

3.7 Payer Authorization. Hygeia represents and warrants its Payer Agreements obligate Payers to abide by this Agreement in paying Hospital for Hospital Services to Eligible Persons in the manner set forth herein.

Whether intentionally or unintentionally, many Payers invalidate their contracts, and their right to access valuable Provider discounts, by their failure to fulfill their obligations under the contract. When the letter and spirit of a managed care contract is not fulfilled by one of the parties, the other parties are released from fulfilling their obligations. While most payments to Providers are made via discounted PPO contracts, few are contractually legitimate. Whether as a result of the outsourcing of U.S. claim cost containment and administration, or limited exposure to U.S. health claims, few health insurers understand the large risk exposure to their plans from non-compliance with managed care contracts. Risk-managing entities with U.S. claim exposure must objectively evaluate their cost containment programs to determine the security and legitimacy of the Provider discounts underlying the insurance plans' design, pricing and economic feasibility.

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The most common PPO contract breaches by Payers affect the two primary values that Providers seek from PPO contracts: patient direction to Preferred Providers (i.e. increased revenue) and prompt reimbursement (increased cash flow). This White Paper addresses the issue of patient direction. A separate brief discusses reimbursement.

The Importance of Patient Direction In Cost Containment

The structure of a PPO contract specifically aligns the interests of Payers and Providers by providing unit cost savings to Payers and volume driven revenue to Providers. This is achieved by the Payer receiving discounted prices in exchange for directing its patients to the Provider. In keeping with the letter of PPO contracts, Providers expect active patient direction (or “steerage”) by Payers.

It should be a Payer’s primary cost containment practice to save money by directing to lower cost in-network hospitals instead of higher cost non-network hospitals. This requires systematic steps on the part of Payers in the form of incentives/penalties and steerage mechanisms, which are clearly communicated to plan members and beneficiaries. However, plan administrators often fail to consistently direct patients to lower cost facilities. Ironically, plans often compensate for lost discounts due to the lack of patient direction by engaging in silent PPO use, PPO stacking or both. Yet without tangible demonstration of steerage, as defined in the contracts, Providers can deny discounts according to the language of the contract.

Silent PPO Use

The term “silent PPO” emerged in the mid-1990s to describe a network that allows its contracted Provider list – and reimbursement discounts – to be used by third parties that do not identify themselves or their patients as members of the PPO network prior to the provision of medical services. The third party’s patient is often unaware that they have access to the contracted practitioner or have not been actively steered to the medical Provider.

The Florida Hospital Association outlines the following as evidence of a silent PPO arrangement:

1. An entity does not use financial or educational mechanisms to steer patient volume to Preferred Providers.
2. An entity that allows a healthcare Payer access to PPO discounts AFTER services are provided, where a contract between the Payer and the Provider does not exist.
3. An arrangement similar to #2 above, but where a contract may exist; however, the patient is not identified as having access to the particular contractual arrangement (e.g. no PPO logo on ID card.)



The following example demonstrates the mechanics of a silent PPO:

A patient seeks medical treatment from a Provider and presents an insurance card identifying a specific PPO or without PPO identification. The Provider renders service and submits a claim to the patient's insurer, or its third party claim administrator for payment. The insurer or its TPA contacts a PPO or PPO broker with a database of Providers, particularly the Provider in question, and receives authorization to apply the discount that the PPO has secured from the Provider. The Payer submits the repriced claim in accordance with the discount, and pays an access fee to the PPO or PPO Broker (usually a percentage of savings). The Provider receives the Explanation of Benefit (EOB) form, which explains that the claim was discounted in accordance with the relevant PPO contract. Traditionally, the Provider applies the discount and closes the claim. Increasingly however, Providers are voiding discounts that fail to comply with the terms of the relevant PPO contract (e.g. no upfront PPO identification or logo on ID card.) The illegitimate practice is in violation of the contract between the PPO and the Provider, as well as between the PPO and the Payer.

Silent PPOs are alternatively known as blind PPOs, nondirected PPOs and wraparound PPOs.

PPO Stacking

With this practice, a Payer contracts with several PPOs in the same geographic area in order to have the ability to select or "cherry pick" from multiple PPO contracts for the lowest discounted rate(s) to apply to a claim for reimbursement. In another example of this practice, a Payer submits or "shops" a claim from a particular provider to multiple PPOs in order to identify the contractual arrangement which will yield the lowest reimbursement rate.

PPO stacking is generally in violation of the contractual agreement between the provider and the PPO, and between the PPO and the Payer. Additionally it may be in violation of U.S. state or local statutes and carry civil penalties.

These practices result in unpredictability in reimbursements to Providers, as well as difficulty in accurately tracking accounts receivable and lost revenue.



PROVIDER COMMUNITY RESPONSE

During the 1990's, HMO plans dominated the managed care industry. PPOs represented a newer arrangement, and with its minority status failed to be a primary focus of medical Providers. Instances of PPO stacking and silent PPO use that occurred were either overlooked or proved hard to detect.

During the past two years, many variables have changed.

Beginning five years ago, market share for HMOs declined from covering almost one-third of all U.S. employees in group health plans to less than one-quarter. The share for PPOs and Point of Service (POS) plans increased from 40 percent to 70 percent. As the impact of PPOs grew in significance, so did the scrutiny of their practices.

As U.S. medical inflation continues its upward trend, the hospital industry is witness to rapidly rising input costs and decreasing margins. As pressures on costs and revenues increase for medical facilities, they are reorganizing themselves internally and as an industry. Consolidation of hospitals in local markets has dramatically increased the bargaining power and clout of the industry in its relationships with PPOs and similar entities. The growing use of information technology is enabling Providers to gather and track information that affects their bottom line. Detecting managed care fraud and abuse are hot topics at Provider conferences.

Finally, as the cost of healthcare services in the U.S. continues to rise, and healthcare Payers struggle to contain medical claim costs, the number of participants and incidences of managed care abuse are on the rise.

The end result: healthcare Providers are becoming increasingly aware and less tolerant of silent PPO use and PPO stacking. A growing number of Providers are taking aggressive steps to eliminate the impact of these unauthorized and undisclosed practices on their operations through:

- Insurance Refusal at Admission
- Discount Denial and Reduction
- PPO Contract Renegotiations
- Litigation



Insurance Refusal

A healthcare Payer who appears as a listed client of or submits EOBs from multiple PPOs signals to a healthcare Provider that PPO stacking or silent PPO use may be occurring. Payers effectively become listed as being parties to managed care abuse or bad credit risks. Medical Providers have the ability to deny acceptance of a patient's insurance coverage at the point of admission, placing the insured in an extremely vulnerable position, and liable for 100% upfront payment. This can have a significantly negative impact on a patient's health and well being if he or she receives delayed service at the point of admission due to the actions of their insurer. This obviously impacts a Payer's reputation and customer service with its plan members and clients.

Discount Denial and Reduction

Providers are now beginning to monitor and enforce the PPO contracts that they have entered into. Hospital and physician associations are not only educating their members about Silent PPOs and PPO Stacking, but are also arming them with the skills to detect these practices and position themselves to recover illegitimate discounts.

Several Providers have also employed the services of managed care auditing firms to perform retrospective reviews of patient accounts to identify and recover improper managed care network and payer discounts. Through the use of information technology specifically created for managed care contract compliance auditing, these companies have the ability to review patient data on closed accounts as far back as four years, and assist Providers in retroactive discount denial and recovery services.

When challenged by third party auditors or directly by Providers, Payers that must defend themselves against discount denials have little to substantiate their cases. In fact, the very contracts that provided the discounts are the contracts that have been breached.

PPO Contract Renegotiation

To minimize revenue loss by closing "silent PPO" loopholes, Providers are adding new specific payer clauses to clarify vague PPO contracts during contract renegotiation. In other instances, key hospitals and medical groups have eliminated under-performing PPO contracts, or those guilty of silent PPO practices. In Florida, a major hospital group that owns fourteen (14) hospitals dramatically reduced their PPO portfolio from as high as 150 contracts down to only 20.



In 2002, large hospital groups began to take dramatic steps to reduce PPO discounts in response to widespread international and domestic noncompliance with managed care guidelines by healthcare Payers. In the state of Florida, several hospital groups reduced discount levels from as high as 55% to nominal 10% rates. These dramatic reductions impacted more than 65 hospitals. **Only a small number of Payers and PPOs that were in material compliance with their managed care contracts were permitted to maintain their original contracts.** As consolidation in the hospital industry continues, and similar groups in other states follow suit, this has significant cost implications for healthcare Payers.

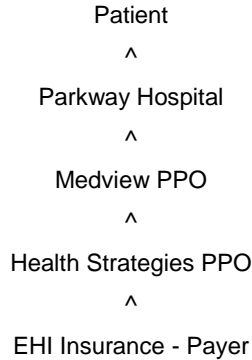
Litigation

In several instances, managed care contract disputes have been litigated. Many law firms have learned to litigate on either side of these cases, however in an ominous trend some firms have begun to work for Providers on contingency fee bases. It is difficult for Payers to defend themselves in these actions when the discounts that they are defending are based upon contracts, which they have materially breached.

Possibly the most notable case is HCA Health Services of Georgia, Inc. v. Employers Health Insurance Company, a federal court disallowed a silent or secondary PPO arrangement of a Humana subsidiary.

The case started as a collection case in state court by a HCA Hospital and was turned into a federal court as an Employee Retirement Income Security Act (ERISA) case by Employers Health Insurance Company, a Humana subsidiary. While there are a number of players involved in the case, the summary facts are simple. A patient, Steven J. Denton (“Denton”), selected an employer-sponsored PPO, Employers Health Inc. (“EHI”). EHI offered Denton a provider network managed by PHCS. The PHCS network was considered as an in-network benefit. Denton needed surgery and selected an out-of-network hospital, Parkway Medical Center (“Parkway”). The inference of the facts is that Denton understood and agreed that by going out-of-network he would pay an additional or higher co-insurance amount than if he chose a hospital within the PHCS network.

Unknown to Denton and initially by Parkway, EHI utilized a silent PPO arrangement or secondary PPO to receive a 25% discount of the Parkway bill. Parkway had a PPO contract with Medview Services, Inc. (“Medview”), which contracted its network to Health Strategies, Inc. (“HSI”), which then contracted its network to EHI.



Parkway uncovered the unauthorized discount and brought suit.

The District Court found in favor of Parkway and entered a judgment of 80% of the full amount of the medical center's bill for services. The Eleventh Circuit affirmed the appeal and went to great lengths to attack the concept of silent PPOs.

The court noted that Parkway contracted with Medview in exchange for the steerage of patients to an in-network hospital. Denton specifically went out-of-network under his PPO option. By definition, EHI could not steer patients to Parkway since it was an out-of-network provider under its PPO contract with Denton and other employers. **It is this basic contradiction that led the Court to find that there was no contractually binding agreement between Parkway and EHI for the discount. Under the basic tenet of contract law, Parkway bargained a discount in its contract with Medview in exchange for steerage. Since EHI downstream could not steer patients, there was no meeting of the minds, hence no contract.**

While the Court found that the benefits from Parkway to EHI did not travel over the three contracts based on the facts that Parkway failed to receive the benefits of a bargain and that the PPO plan participants were unaware of the discounts, the court noted that there were no prohibitions for a PPO arrangement to travel over a series of contracts, if the benefits of the bargain also traveled between the parties and there was proper notice to the appropriate parties as to the agreements. The Court stated that had Parkway been aware of EHI as a Payer and had promised EHI a plan participant discounted fee that would be "an entirely different matter."

A multitude of lawsuits and complaints to state insurance commissioners by medical Providers followed the original case filing in 1998.



Mostly recently in Florida, a multi-district litigation is underway involving physicians in seven states and the medical societies in Texas, Georgia, and California against seven health plans. Hospital, physicians and ancillary providers continue to file lawsuits on a local and regional basis to recover money inappropriately withheld by payers and to prevent payers from using inappropriate reimbursement tactics in the future.

PAYER STRATEGIES

Permanently losing access to discounts, dramatic discount reduction and litigation are risks that Payers and their outsourced partners should evaluate strategically.

As Providers become increasingly sophisticated at detecting silent PPO use and PPO stacking, and developing cohesive and aggressive responses, Payers that comply with managed care contracts will be at a distinct financial advantage than their non-compliant competitors. While it is expected that Providers want fair reimbursement for their services, the rising cost of healthcare delivery in the U.S. still leaves Payers with a significant cost containment challenge.

There are tangible advantages to dealing with this challenge without resorting to indefensible contract violation and managed care abuse.

Leveraging Contract Compliance as a Competitive Advantage

Compliant Payers are secure in their assumptions that strong discounts are legitimately earned and defensible in the short and long term. This provides a strong position from which to aggressively market your company's product and service performance guarantees in a crowded and competitive health service marketplace. Contract compliance also eliminates balance-billing issues for your company or end-customers, and the resulting impact on customer service commitments and brand value. Litigation risk is also reduced. Finally, for insurers, actuarial assumptions are solidified and protected from undefined contract compliance risk.

Maximizing Provider Discount Frequency

Choosing the most effective PPO partner is more critical to plan success than ever. The claim exposure and customer demographic of every health plan is unique. The right network should be able to deliver contractually compliant, comprehensive coverage across your important markets and with almost every provider. Network coverage should be supported with effective claim arbitration services for out-of-network claims. Working with a single, effective PPO with demonstrated results in key markets will provide maximum claim coverage with lower administrative costs. Additionally, a PPO that is a true strategic partner will focus



its network contracting efforts based upon a detailed analysis of your claim portfolio to tactically expand network coverage over time to further increase claim coverage. By working with a single, effective PPO nationwide or within defined geographies, Payers can return to Provider contract compliance while maintaining and often increasing overall plan savings. Regular coverage analyses can help to choose the right partner, and ensure that continuous network development supports coverage objectives.

Maximizing Provider Discount Levels

More than ever, Providers allocate their most favorable discount rates to those PPOs and Payers that can deliver on the spirit and letter of the contracts that are agreed upon. At Hygeia, our reputation for managed care compliance has earned us, and our Payer-clients, the industry's leading Provider discounts.

By using our compliant, single-source cost containment solutions our clients have the ability to track patient utilization and leverage this information for aggressive patient direction to maximize savings. Additionally, through affiliation with Hygeia, and the demonstrated patient volume of our total client base, our clients have access to our existing strong discounts, and increased savings secured at contract renegotiations with our Preferred Providers.

Conclusion

PPOs, cost containment vendors or consultants that advocate working with multiple PPOs within a geographical area, and recommend or facilitate other instances of managed care abuse are promoting business strategies that will place the Payer, and the Payer's customers, at risk.

Payers can achieve industry-leading cost containment results while operating in a compliant manner in the short term and the long run.



HYGEIA PPO COMPLIANCE

Since 1998, Hygeia has been anticipating and advocating managed care compliance in a variety of ways. We have structured our network and services to ensure discount security for clients that adhere to our compliance protocol. Our long-standing reputation for compliance as well as our education programs for our Payer-clients has strengthened our relationships with Providers who have rewarded our commitment with their most competitive discounts.

When contracting with providers, whether directly or with partners, Hygeia aligns its contracts in several ways.

First, we advise Providers of all contracts and relationships with third party payers.

Second, Hygeia's Payer contracts contain requirements for clients to:

- (1) take reasonable steps acceptable to Hygeia to create and implement systems and programs for the purpose of directing members to participating providers, including discounts and incentives;
- (2) provide evidence to Hygeia of the foregoing:
 - i. an identification card be given to the member with a 24 hour hot line telephone number and a member identification with the Hygeia logo;
 - ii. a 24 hour telephone hot line for client's members;
 - iii. copies of all plans offered by the client which are subject to the agreement;
 - iv. all payments be made within 30 or 45 days; and
 - v. end-customers have access to directories of Hygeia PPO network providers.

Hygeia supports the efforts to codify legitimate PPO arrangements and to ensure that payers do not stack or use silent PPOs to receive discounts that they are not entitled to. Hygeia stands by full disclosure to providers of all contracting relationships.

The decisions you make today will determine your company's long-term financial success. We strongly urge our clients to institute compliant managed care practices.





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A. General Definitions

Co-payment

The portion of a claim or medical expense that a patient must pay out of pocket as a fixed amount.

Deductible

The portion of a patient's healthcare expenses that must be paid out of pocket before any insurance coverage applies. Common in insurance plans and PPOs.

Explanation of Benefit (EOB)

Also known as Explanation of Reimbursement. A statement sent to a Provider and/or covered insured explaining how and why a claim was or was not paid.

Health Management Organization (HMO)

Also known as a Health Maintenance Organization. HMOs are organized healthcare systems that are responsible for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. Designated physicians act as medical gatekeepers to manage the delivery of care to plan members.

Healthcare Payer

The payer is the purchaser of medical services on behalf of client, insured and plan beneficiary through an agreement with a PPO or medical Provider.

Managed Care

A spectrum of healthcare delivery systems that try to manage the delivery, access, cost and quality of medical services. Plans include managed indemnity, PPO, Point of Service (POS), open-panel HMO and closed-panel HMO.

Network Lease

A network lease is an agreement between a PPO and another entity, whereby that entity and its Payers are entitled to apply the negotiated rates to claims of clients, insureds and plan beneficiaries.



Point of Service (POS)

A plan in which members do not have to choose how to receive services until they need them. The most common use of the term applies to a plan that enrolls each member in both an HMO (or HMO-like) system and an indemnity plan.

Preferred Provider Organization (PPO)

PPOs are entities through which employer health benefit plans, health insurance carriers and self-insured entities contract to purchase healthcare services for covered beneficiaries from a selected network of participating Providers. Typically, PPOs limit the size of their contracted network and provide incentives for covered individuals to utilize their Providers instead of other Providers. Participating Providers agree to accept the PPO's reimbursement structure and payment levels in exchange for patient volume and prompt reimbursement.

PPO Stacking

An unauthorized pricing practice whereby a healthcare Payer works with multiple PPO vendors in a given geographical area to identify and utilize the lowest contracted reimbursement rate for a particular claim or Provider.

Provider

The generic term used to refer to a physician or medical facility providing healthcare services.

Silent PPO

A term that applies to a practice where a insurance plan or plan administrator (a) does not use financial or education mechanisms to steer patient volume to Preferred Providers, (b) identifies PPO networks to Providers and accesses PPO discounts only after services are required or provided, or (c) uses a contract between insurer/self-insurer and Provider that they are not party to or the patient is not identified as covered by the contract.

Third Party Administrator (TPA)

A firm that performs administrative functions (e.g. claims processing, assistance services, membership services) for a self-funded plan, insurance company or managed care plan.



B. Healthcare Provider Industry Activism

Since October 1994, the American Medical Association has led an aggressive and visible campaign against silent PPOs, and was successful in getting silent PPOs banned from all Federal Employee Health Benefits Plan contracts.

The AMA and the American Hospital Association (AHA) have issued a joint statement, entitled “Providers Beware: Guarding Against Silent PPOs,” describing how most silent PPO arrangements attempt to apply legitimate PPO discounts to indemnity patients who are not covered by a PPO.

Since the AMA/AHA joint statement was issued, the AMA has published and distributed a “Silent PPO Alert Action Kit” containing a variety of information and resources that provides practical advice on contractual language that will help minimize Provider exposure to silent PPO; how to identify improper discounts; and how to recover monies owed to Providers by insurance companies imposing improper discounts. In particular, the action kit includes managed care contract applications, a sample recovery letter, a sample Provider letter to the patient, and potential legal strategies for responding to silent PPOs.

In addition, the AMA/State Medical Society Litigation Center has encouraged Providers and Provider groups to bring forth any egregious examples of silent PPO arrangements.

Section 1.11 of AMA Model Management Care Agreement specifically restricts Managed Care Organizations (MCO) from selling or renting their networks to others not entitled to the negotiated discounts and does not include an all payers clause

Several industry associations including American Academy of Physical Medicine and Rehabilitation, American Society of Cataract and Refractive Surgery, American Chiropractic Association, Healthcare Financial Management Association have prepared position papers and made public statements of their opposition to silent PPO activity.



C. Case Law

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 99-11241

D.C. Docket No. 96-03333-1-CV-CAM

HCA HEALTH SERVICES OF GEORGIA, INC.,

Plaintiff-Appellant,

versus

EMPLOYERS HEALTH INSURANCE COMPANY,

Defendant-Appellee.

Appeal from the United States District Court

for the Northern District of Georgia

(February 2, 2001)

Before TJOFLAT, MARCUS and KRAVITCH, Circuit Judges.

TJOFLAT, Circuit Judge:

This is an ERISA case involving the denial of benefits allegedly due a patient under the terms of a group health insurance policy issued and administered by an insurance company. The patient underwent covered outpatient surgery at a medical center. At the time of surgery, the patient assigned to the medical center his right to recover 80% of the costs of the surgery from the insurance company. Accordingly, the medical center billed the insurance company for the costs of the surgery. Although the amount of the bill was consonant with the usual and customary fee charged for such services, the insurance company reduced the bill by 25% and paid the medical center 80% of the reduced bill. The insurance company claims it was entitled to reduce the medical center's bill by virtue of the following series of contracts: the medical center promised a third party that it would charge a discounted fee upon rendering specified medical services; the third party, in turn, "leased" the right to the discounted fee to a fourth party; then, unbeknownst to the patient and the medical center, the fourth party "leased" the right to the discounted fee to the insurance company.

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The medical center demanded full payment of its bill and the insurance company refused. The medical center then brought this lawsuit on behalf of its assignee, the patient, seeking recovery of benefits due the patient under the terms of his health insurance policy. On cross motions for summary judgment, the district court granted the medical center the relief it sought, entering judgment for 80% of the full amount of the medical center's bill for services. The insurance company now appeals that judgment. We affirm.

I.

A.

The complex relationships among the multiple actors in this case necessitates a brief "who's who." Software Builders, Inc. ("Software Builders") is the employer of the patient, Steven J. Denton ("Denton") and sponsor of the welfare benefit plan it purchased for its employees from the insurance company, Employers Health, Inc. ("EHI"). EHI is the insurance company whose interpretation of the welfare benefit plan purchased by Software Builders is at issue in this case. Denton, a plan participant in the welfare benefit plan sponsored by Software Builders and administered by EHI, is the patient who underwent outpatient surgery performed by the medical center, HCA Health Services of Atlanta, d/b/a Parkway Medical Center ("Parkway"). Parkway is the medical center that performed the surgery at issue in this case, the assignee of Denton's claim against EHI, and party to a preferred provider network contract with MedView Services, Inc. ("MedView"). MedView is an entity that contracts with providers such as Parkway to form a preferred provider network which MedView then markets to third party payers, usually insurance companies. In its contract with MedView, Parkway agreed to accept seventy-five percent of its usual and customary fee when providing specified medical services to MedView Subscribers. MedView leased its preferred provider network to Health Strategies, Inc. ("HSI"). HSI is both a manager of provider networks (like MedView) and a vendor of provider discounts. As a vendor, it leases its networks (both the networks it forms on its own and the networks it leases from entities such as MedView) to insurance companies so that they may access the discounts that providers promised to accept as payment in full when they joined the network. HSI leased to EHI the right to access the discounts in HSI's provider networks, including the network leased from MedView (which included Parkway as a provider), in return for a percentage of the savings EHI gained from availing itself of the discounted fees promised by providers who were members of the networks.

B.

On March 31, 1995, Software Builders applied to EHI for a group health insurance policy providing medical, surgical, and hospital care for Software Builders' employees. Coverage under the policy became effective April 1, 1995, and a welfare benefit plan within the meaning of 29 U.S.C. § 1002(1) was established. In its contract with EHI, Software Builders elected to provide its employees with the Preferred Provider Organization ("PPO") form of managed care. Typically, the PPO form of managed care operates as follows: health care providers, such as doctors and hospitals, form a network of providers either on their own or by contracting with a third-party entity created for the purpose of forming provider networks. This third-party entity acts as a middleman between the providers in the network and third party payers such as insurance companies. In this case, Parkway, a provider, contracted with MedView, a middleman to become part of MedView's preferred provider network.

In essence, a PPO is a network of health care providers organized to offer medical services at discounted rates. The PPO providers furnish their services at discounted rates because they expect to receive a higher volume of patients, i.e., participants in the welfare benefit plan offered by the insurance company. The increase in the volume of patients is a result of third party payers, who pay the bills for medical services plan participants receive, directing plan participants to providers in the PPO network through marketing materials and financial incentives. Because third party payers, such as insurance companies, are financially responsible for the costs of a plan participant's covered medical care, it is in the third party payer's best interest for the plan participant to receive medical care from a provider who has promised to accept a discounted fee. The use of financial incentives and other measures to direct plan participants to providers in the PPO is known in the health care industry as "steerage."



Another component of the PPO form of managed care rests on the difference between "in-network" and "out-of-network" providers. Under the PPO form of managed care, providers in the network of health care providers who offer a payer discounted rates are often referred to as "in-network" providers. Conversely, providers who do not agree to offer the payer discounted rates are referred to as "out-of-network" providers.

In this case, EHI agreed to treat the providers in Private Health Care Systems ("PHCS") as its in-network providers (also known as "preferred providers") in return for PHCS members' promises to discount their fees when providing medical services to EHI's plan participants. Thus, when EHI contracted with Software Builders to offer a PPO form of managed care to Software Builders' employees, the providers in PHCS became the in-network providers for Software Builders' employees.

What makes PPOs attractive relative to some other forms of managed care is that a percentage of the bill for the plan participant's health care is still covered by the insurance company if the plan participant chooses to receive covered medical services from an out-of-network provider. Given in-network providers' promise to discount their fees, however, it is in the best interest of the third party payer to steer plan participants to in-network providers. Because Software Builders opted for the PPO form of managed care, EHI's financial obligations differ depending on whether Software Builders' employees such as Denton use the services of PHCS providers. Therefore, EHI steers plan participants to its in-network providers, i.e., members of PHCS, through financial incentives.

For instance, EHI states that if a plan participant receives medical care from an in-network provider (a member of PHCS), then EHI will pay 90% of the cost of service and the participant will pay 10%. If the plan participant receives medical care from an out-of-network provider, then EHI will pay 80% of the cost of medical service and the participant will pay 20%. In addition to the incentives created by the 10/20% co-payment differential, EHI fulfills its obligation to steer participants to PHCS by marketing the services of PHCS providers by supplying plan participants with a directory of the providers in the PHCS network. Similarly, EHI identifies PHCS as the network of preferred providers on the plan participants' insurance cards and provides a phone number for participants to confirm the identity of PHCS providers. Finally, in the participant's Certificate of Insurance ("COI"), EHI explains the

Reasons to Use a PPO Provider. 1. We [EHI] negotiate fees for medical services. The negotiated fees lower costs to You [Participants] when You use . . . providers in the PPO. 2. In addition, You may receive a better benefit and Your Out-Of-Pocket expenses will be minimized. 3. You will have a wide variety of selected . . . providers in the PPO to help YOU with Your medical care needs. In order to avoid reduced benefit payments, obtain Your medical care from Preferred Providers whenever possible. However, the choice is Yours.

As explained above, providers may either form their own network and then sell their services to insurance companies, or they can work through middlemen, such as MedView or HSI. In this case, Parkway agreed to become part of MedView's network of providers so that MedView could act as middleman between Parkway and third party payers like insurance companies to establish the insurance company/in-network provider type of relationship described above. HSI formed its networks of providers either on its own or by leasing existing provider networks. Instead of marketing its networks to insurance companies to be treated as in-network providers, HSI acts as a vendor, leasing provider discounts to insurance companies. As part of providing third party payers with access to provider discounts, HSI performs the administrative task of repricing provider invoices to reflect the discounted rate. In this case, MedView leased its network of providers (including Parkway) to HSI. HSI leased to EHI the use of the provider discounts in its networks, including that network leased from MedView.



II.

A.

Given this brief explanation of the pertinent participants and the PPO form of managed care, we turn to the events giving rise to this lawsuit. On December 6, 1995, Denton elected to undergo outpatient surgery at Parkway. Since Parkway was not a member of EHI's preferred provider network, PHCS, Parkway was considered an out-of-network provider under the terms of plan issued by EHI to Software Builders. As such, EHI covered 80% of the cost of medical service and Denton was responsible for the remaining 20%. Denton executed an Assignment of Insurance Benefits in favor of Parkway authorizing EHI to pay his insurance benefits directly to Parkway. Seeking payment for Denton's surgery, Parkway invoiced EHI in the amount of \$3,108.00 for services rendered. On December 22, 1995, EHI's claims department received the Parkway invoice. EHI referred the invoice to HSI for repricing. HSI recalculated the invoice to reflect the discounted fee Parkway had promised to MedView. On January 25, 1996, EHI processed the claim and sent Parkway an Explanation of Remittance along with payment in the amount of \$1,864.80.

The Explanation of Remittance reflected an "amount charged," an "amount allowed," and an "amount paid." The Explanation of Remittance indicated that EHI applied a 25% discount (\$777.00) to the amount charged (\$3,108.00) to arrive at the amount allowed (\$2,331.00). EHI paid 80% (the out-of-network percentage) of the amount allowed to arrive at the amount paid (\$1,864.80). In a footnote on the back of the Explanation of Remittance, EHI stated that "[p]ayment is based on a PPO contract with the HSI network, MedView Services, Inc. or their affiliates." According to EHI, Denton's co-payment obligation was 20% of the adjusted bill (\$466.20).

B.

EHI interprets its plan to mean that due to a series of contracts, it only has to pay Denton's assignee 80% of a discounted fee rather than 80% of the amount charged. EHI's plan interpretation involves two distinct but related components. First, EHI claims it is entitled to a 25% discount of Parkway's bill of \$3,108.00 based on a series of contracts that indirectly create contractual obligations between EHI and Parkway. The contracts in this series, the Parkway/MedView contract, the MedView/HSI contract, and the HSI/EHI contract, are discussed below. The second component of EHI's plan interpretation relates to the contract between EHI and Denton in which EHI promised to pay 80% of an out-of-network provider's fee for covered medical services. EHI claims that because it's participants have the right to be charged the discounted fee by Parkway, it only owes Parkway 80% of the discounted fee rather than 80% of the amount charged. In short, EHI uses its interpretation of its rights and obligations under the series of contracts to interpret its rights and obligations under the terms of its contract with Denton. According to EHI, the result of its interpretation is that EHI and Denton pay 80% and 20% respectively of Parkway's discounted fee. The following is a brief explanation of each contract in the series of contracts.

1.

The Parkway/MedView contract was formed on March 18, 1994, when Parkway entered into a Preferred Hospital Agreement with MedView. By virtue of this agreement, Parkway became a preferred provider in the MedView PPO network. In return for this preferred status, Parkway agreed to accept 75% of its usual and customary fee for specified outpatient services as payment in full.



2.

The MedView/HSI contract was formed on April 14, 1994, when MedView entered into a Letter of Agreement with HSI. The MedView/HSI contract stated that MedView "may enter into contractual arrangements with health care providers for the purpose of arranging for the delivery of health care services at a reduced fee, and will provide other services for [HSI]." The contract makes clear that HSI "desires to obtain the advantage of the reduced fees available through the preferred provider network by 'leasing' MedView's network of providers." 'Leasing' means "the Company [HSI] will perform all repricing functions to adjust fees from charges to contracted rates." Among other duties, HSI agreed to "expeditiously reprice fees for provider services to amounts contracted by MedView." According to EHI, the MedView/HSI contract allowed HSI to pass on to HSI's clients the provider discounts that MedView obtained from its own network of providers.

3.

The HSI/EHI contract is the final link in the series of contracts that allegedly entitles EHI to base the percentage it owes Parkway on the discounted fee referenced in the Parkway/MedView contract rather than on the fee charged by Parkway in its invoice. The HSI/EHI contract was formed on July 18, 1995, when EHI and HSI entered into the PPO Network Customary Participation Agreement. According to EHI, HSI is "a company which develops networks of participating health care providers, such as hospitals which agree to accept discounted payments from insurance companies and other payers. HSI [then] enters into contracts with network providers and with payers, including [EHI]." Under the terms of the HSI/EHI contract, HSI agreed to reprice bills that EHI received from HSI's network of providers (including MedView providers) for services rendered to participants in EHI's health insurance plan. EHI refers to the discounts it received by virtue of its contract with HSI as its "shared savings" agreement. Under the shared savings agreement, providers receive expedited payment for their services in return for the discounted fees.

EHI explains that when it received Parkway's invoice for the services performed on Denton, it sent the invoice to HSI. HSI, by virtue of its contract with MedView, repriced the bill to reflect the discount Parkway promised to MedView. Meanwhile, Parkway hired Network Analysis, Inc. ("Network Analysis") to detect and eliminate the practice of unauthorized discounts. EHI contends that months after the January 25, 1996 Explanation of Remittance, Network Analysis noticed that Parkway received \$777.00 less from EHI than the amount charged. Parkway sent letters to EHI dated August 6, 22, and 27, 1996 contesting the discount. In each of the three letters, Parkway stated that it found EHI's use of the discount inappropriate and requested that EHI remit \$777.00. Each letter identified Denton as the insured and referenced the claim number, the patient number, the date of service, the amount of the allegedly improper discount, and the treating facility. In its response of August 30, 1996, EHI asserted it was entitled to the discount and explained that it had "forwarded the cases in question and your letters to HSI for eligibility confirmation." Parkway received no further correspondence from EHI. On November 8, 1996, Parkway, as assignee of Denton, brought this suit for recovery of benefits allegedly due under the group health insurance policy between Software Builders and EHI.

III.

The district court's grant of summary judgment is subject to plenary review. *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1449 (11th Cir. 1997). Summary judgment shall be granted where the moving party has shown that "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). We construe the facts and draw all reasonable inferences in the light most favorable to the non-moving party. *Wideman v. Wal-Mart Stores, Inc.*, 141 F.3d 1453, 1454 (11th Cir. 1998).



IV.

According to EHI, Parkway lacks standing to bring this suit. EHI contends that Denton was not harmed by its plan interpretation because Parkway never balance billed Denton for the remaining \$777.00, i.e., 25% of the amount charged - \$3,108.00. Instead, EHI's plan interpretation benefited Denton because it lowered his co-payment. Because he was not harmed, Denton lacks standing to bring this action himself; thus, his assignee, Parkway, also lacks standing.

Under 29 U.S.C. § 1132 (a)(1)(B), a participant or beneficiary of an employee benefit plan may initiate civil proceedings to recover benefits under the terms of the plan. Parkway is Denton's assignee and in *Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997), we explained that "neither 1132(a) nor any other ERISA provision prevents derivative standing based upon an assignment of rights from an entity listed in that subsection." In *Cagle*, we rejected the same argument EHI is making in this case in favor of allowing provider-assignee standing in suits for the recovery of benefits under ERISA. We explained:

[i]f provider-assignees cannot sue the ERISA plan for payment, they will bill the participant or beneficiary directly for the insured's medical bills, and the participant or beneficiary will be required to bring suit against the benefit plan when claims go unpaid. On the other hand, if provider-assignees can sue for payment of benefits, an assignment will transfer the burden of bringing suit from plan participants and beneficiaries to "providers [, who] are better situated and financed to pursue an action for benefits owed for their services."

Id. at 1515 (alteration in original) (internal citation omitted). Given our reasoning in *Cagle*, we conclude that Parkway, as a provider-assignee, has standing to sue for the recovery of benefits under the group insurance plan at issue in this case.

V.

EHI also claims that it was entitled to summary judgment because Parkway failed to exhaust its administrative remedies prior to bringing this suit. "It is well-established law in this circuit that plaintiffs in ERISA cases must normally exhaust available administrative remedies under their ERISA-governed plans before they may bring suit in federal court." *Springer v. Wal-Mart Associates' Group Health Plan*, 908 F.2d 897, 899 (11th Cir. 1990). EHI cites the following provision of the COI to demonstrate that Parkway's claim is not timely:

If We partially or fully deny a claim for benefits submitted by YOU, and YOU disagree or do not understand the reasons for this denial, You may appeal this decision. Your appeal must be submitted in writing within 60 days of receiving written notice of denial. We will review all information and send written notification within 60 days of Your request.

According to EHI, Parkway did not appeal the alleged denial of benefits within 60 days of receiving the Explanation of Remittance from EHI. Parkway contends that the Explanation of Remittance did not constitute a written notice of denial. We agree. The above quoted language makes clear that the participant must appeal "within 60 days of receiving written notice of denial" (emphasis added). Although EHI's Explanation of Remittance indicated that the claim was discounted, it failed to explain the manner by which EHI adjusted the claim. The footnote on the back of the Explanation of Remittance stating "[p]ayment is based on a PPO contract with the HSI network, MedView Services, Inc. or their affiliates" does not contain sufficient information to constitute a "written notice of denial."

Further, we accept the finding of the district court that Parkway's letters dated August 6, 22, and 27, 1996, initiated the administrative review process. See *Springer*, 908 F.2d at 899 (stating that "the decision whether to apply the exhaustion requirement is committed to the district court's sound discretion") (quoting *Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.3d 842, 846 (11th Cir. 1990)). Parkway argues that EHI's



August 30, 1996 letter stating that it believed the discount was correct but that it had forwarded the letters "to HSI for eligibility confirmation" demonstrates that EHI understood it was taking part in the appeals process. Again, we agree that EHI's failure to respond further within the required sixty-day time frame was an implicit denial of the appeal. As such, the entry of summary judgment against Parkway on its ERISA claim would have been inappropriate on the ground that Parkway failed to exhaust its administrative remedies before filing suit.

VI.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), the Supreme Court stated that, generally, courts should review claims challenging an ERISA claims administrator's denial of benefits under a *de novo* standard. The Court adopted the *de novo* standard because the arbitrary and capricious, or abuse of discretion, standard, is too lenient. The Court explained that the arbitrary and capricious standard of review is appropriate, however, when the plan documents at issue explicitly grant the claims administrator discretion to determine eligibility or construe terms of the plan. See *id.* at 115, 109 S. Ct. at 954-56; see also *Florence Nightingale Nursing Serv., Inc. v. Blue Cross/Blue Shield*, 41 F.3d 1476, 1481 (11th Cir. 1995). The arbitrary and capricious deference is diminished though, if the claims administrator was acting under a conflict of interest. *Florence Nightingale*, 41 F.3d at 1481. If the claims administrator was acting under a conflict of interest, "the burden shifts to the [administrator] to prove that its interpretation of the plan provisions committed to its discretion was not tainted by self interest." *Brown v. Blue Cross & Blue Shield*, 898 F.2d 1556, 1566 (11th Cir. 1990). "Accordingly, this court has adopted the following standards for reviewing administrators' plan interpretations: (1) *de novo* where the plan does not grant the administrator discretion[;] (2) arbitrary and capricious [where] the plan grants the administrator discretion; and (3) heightened arbitrary and capricious where there is a conflict of interest." *Buckley v. Metropolitan Life*, 115 F.3d 936, 939 (11th Cir. 1997). We hold that heightened arbitrary and capricious review is the appropriate standard because EHI suffers from a conflict of interest.

In reviewing a claims administrator's benefits determination, the court follows a series of steps. The applicability of heightened arbitrary and capricious review is a result of the court making a specific determination at each step in the analysis. At each step, the court makes a determination that results in either the progression to the next step or the end of the inquiry. For ease of application, we lay out these steps below and then apply them in Part VII to the instant case.

First, a court looks to the plan documents to determine whether the plan documents grant the claims administrator discretion to interpret disputed terms. If the court finds that the documents grant the claims administrator discretion, then at a minimum, the court applies arbitrary and capricious review and possibly heightened arbitrary and capricious review.

Regardless of whether arbitrary and capricious or heightened arbitrary and capricious review applies, the court evaluates the claims administrator's interpretation of the plan to determine whether it is "wrong." See *Godfrey v. Bellsouth Telecommunications, Inc.*, 89 F.3d 755, 758 (11th Cir. 1996) ("we first conduct a *de novo* review to decide if the [claims administrator's] determination was wrong."); *Brown*, 898 F.2d at 1566 n.12 ("[i]t is fundamental that the fiduciary's interpretation first must be 'wrong' from the perspective of *de novo* review before a reviewing court is concerned with the self-interest of the fiduciary."); see also *Maracek v. Bellsouth Services, Inc.*, 49 F.3d 702, 705 (11th Cir. 1995) (explaining that when the district court agrees with the ultimate decision of the administrator, it will not decide whether a conflict exists. Only when the court disagrees with the decision does it look for a conflict and, when it finds such a conflict, it reconsiders the decision in light of this conflict).

If the court determines that the claims administrator's interpretation is "wrong," the court then proceeds to decide whether "the claimant has proposed a 'reasonable' interpretation of the plan." *Lee v. Blue Cross/Blue Shield*, 10 F.3d 1547, 1550 (11th Cir. 1994). Even if the court determines that the claimant's interpretation is



reasonable, the claimant does not necessarily prevail. At first glance it seems odd that a reasonable interpretation would not automatically defeat a wrong interpretation. The reason the claimant's reasonable interpretation does not trump the claims administrator's wrong interpretation is because the plan documents explicitly grant the claims administrator discretion to interpret the plan. See *Brown*, 898 F.2d at 1563 (stressing the importance of allowing an insurance company the benefit of the bargain it made in the insurance contract). We cannot over emphasize the importance of the discretion afforded a claims administrator; the underlying premise of arbitrary and capricious, rather than *de novo*, review is that a court defers to the discretion afforded the claims administrator under the terms of the plan. See *Firestone*, 489 U.S. at 111, 109 S. Ct. at 954 quoting Restatement (Second) of Trusts § 187 (1959) ("[w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion").

To find a claims administrator's interpretation arbitrary and capricious, the court must overcome the principle of trust law, which states that a trustee's interpretation will not be disturbed if it is reasonable. See *Firestone*, 489 U.S. at 110-11, 109 S. Ct. at 954 (explaining that when a trustee is granted discretion his interpretation will not be disturbed if it is reasonable). Thus, the next step requires the court to determine whether the claims administrator's wrong interpretation is nonetheless reasonable. If the court determines that the claims administrator's wrong interpretation is reasonable, then this wrong but reasonable interpretation is entitled to deference even though the claimant's interpretation is also reasonable.

The claims administrator's interpretation is not necessarily entitled to deference, however, if the claims administrator suffers from a conflict of interest. Therefore, the next step in the analysis requires the court to gauge the self-interest of the claims administrator. If no conflict of interest exists, then only arbitrary and capricious review applies and the claims administrator's wrong but reasonable decision will not be found arbitrary and capricious. *Lee*, 10 F.3d at 1550. The steps discussed thus far constitute arbitrary and capricious review and if there is no conflict of interest, the inquiry stops. If a conflict of interest does exist, however, then heightened arbitrary and capricious review applies. In applying heightened arbitrary and capricious review, the court follows the same steps that constitute arbitrary and capricious review, but given the claims administrator's self interest, it continues the inquiry.

Under the heightened arbitrary and capricious standard of review, the burden shifts to the claims administrator to prove that its interpretation of the plan is not tainted by self interest. *Id.* The claims administrator satisfies this burden by showing that its wrong but reasonable interpretation of the plan benefits the class of participants and beneficiaries. See *Brown*, 898 F.2d at 1568. Even when the administrator satisfies this burden, the claimant may still be successful if he can show by other measures that the administrator's decision was arbitrary and capricious. See *id.* at 1568. If the court finds that the claims administrator fails to show that its plan interpretation benefits the class of participants and beneficiaries, the claims administrator's plan interpretation is not entitled to deference.

VII.

The crux of EHI's appeal is two-fold. First, EHI contends that the district court improperly used the heightened arbitrary and capricious standard of review. Second, EHI asserts that even if heightened arbitrary and capricious review was appropriate, the district court erred in holding that EHI failed to purge the taint of self interest. We address these concerns in turn.

A.

To determine the standard by which to review a claims administrator's plan interpretation, a court follows the steps outlined in Part VI. Our application of these steps reveals that heightened arbitrary and capricious review is the correct standard.



1.

First, the plan documents grant EHI discretion to interpret disputed terms. The COI states:

With respect to paying claims for benefits under this Policy, WE [EHI] as administrator for claims determinations and as ERISA claims review fiduciary . . . shall have discretionary authority to 1) interpret policy provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage benefits.

Given this contractual grant of discretion, do novo review is inapplicable and at a minimum, arbitrary and capricious review applies.

2.

Next, we determine whether EHI's plan interpretation is wrong. EHI points out that under the Schedule of Benefits in the COI, it is required to pay a specified percentage of the expense of covered medical services and the participant is required to pay the balance of the expense. Crucial to determining whether EHI's interpretation is wrong is the meaning of the term "expense." EHI emphasizes the common meaning of the term found in Webster's Dictionary, and argues that "expense" is "the amount necessary to obtain covered medical services." According to EHI's interpretation of the plan, the term "expense," as it is used in the COI, includes the discounted fees in the Parkway/MedView contract.

EHI supports its plan interpretation by relying on 29 U.S.C § 1104(a)(1)(D), which states that a plan is to be administered by the fiduciary in accordance with the documents and instruments governing the plan. EHI asserts that the contract between HSI and itself (which is based on the MedView/HSI and the Parkway/MedView contracts) is a document and instrument governing the plan. EHI calls the provider discounts this contract allow EHI to access its "shared savings" program. As such, the scope of 29 U.S.C. § 1104(a)(1)(D) and this series of contracts entitle EHI to interpret "expense" to include the discounted fee Parkway promised in the Parkway/MedView contract.

We find that EHI's interpretation of the plan documents is wrong for two reasons. First, EHI wrongly interprets its contract with Denton. Second, EHI wrongly interprets its rights under the series of contracts linking it to Parkway. We discuss each of these reasons in turn.

a.

First, EHI's plan interpretation is not consonant with the terms of the COI - specifically, EHI's stance on the meaning of the term "expense." In the Schedule of Benefits of the COI, EHI specifically states:

[b]enefits are payable only if services are considered to be covered expenses and are medically necessary. All covered services [are] [sic] payable on a maximum allowable fee basis and are subject to specific conditions, durational limitations and all applicable maximums of this policy.

To understand EHI's duties under the COI, one must ascertain the meaning of "covered expense." The COI defines Covered Expense as:

(1) A Medically Necessary expense; (2) For the benefits stated in this Certificate; and (3) An Expense Incurred when You are insured for that benefit under this Policy on the date that the Service is rendered.

The definition of Covered Expense leads us to inquire into the meaning of the term "Expense Incurred."



Expense Incurred means the Maximum Allowable Fee charged for Services, which are Medically Necessary to treat the condition. The date Service is rendered is the Expense Incurred date.

This definition in turn necessitates a definition of "Maximum Allowable Fee."

Maximum Allowable Fee is the lesser of: (1) The fee most often charged in the geographical area where the Service was performed; (2) the fee most often charged by the provider; (3) the fee which is recognized by a prudent person; (4) the fee determined by comparing charges for similar Services to a national data base adjusted to the geographical area where the Services or procedures were performed; or (5) The fee determined by using a national Relative Value Scale (Relative Value Scale means the methodology that values medical procedures and Services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the Service, as adjusted to the geographic area where the Service or procedures were performed).

The district court found that, given these definitions in EHI's contract with Denton's employer and plan sponsor (Software Builders), the phrase "expense incurred" could not validly be interpreted to mean a charge reduced or discounted through EHI's contract with HSI. HCA Health Services, Inc. v. Employers Health Ins. Co., 22 F. Supp. 2d 1390, 1396 (N.D. Ga. 1998). The district court reasoned that,

such a discounted charge does not meet any of the definitions of "Maximum Allowable Fee" included in the contract. Second, the only terms of the contract, which speak to negotiated fees, are contained within the PPO provisions, and the shared savings discount is in conflict with those provisions. . . . Additionally, whereas EHI provides the insured with a list of PPO providers so that the insured can make a reasoned choice to use a shared savings provider rather than a provider with whom there are no negotiated savings.

Id. at 1396.

We agree with this reasoning regarding the plain language of the plan. To support its position that the district court erred in finding that "expense" cannot include the discounted fee at issue in this case, EHI points to the third definition of Maximum Allowable Fee, namely "(3) the fee which is recognized by a prudent person." EHI's Amicus Curiae explain that if EHI paid Parkway an amount 25% higher than Parkway was contractually obligated to accept, then this payment would not be a "fee . . . recognized by a prudent person." Not only does this argument erroneously assume that Parkway is obligated to charge Denton the discounted fee, but we disagree that the discounted fee is the fee recognized by a prudent person. Common sense dictates that the fee recognized by a prudent person is the usual and customary fee in the industry. Instead of supporting EHI's interpretation, the language in the COI stating that the Maximum Allowable Fee is the fee recognized by a prudent person further bolsters Parkway's interpretation of "expense." A prudent person would assume that the fee for a service is the reasonable, usual and customary fee. He would not even consider the discounted fee because it only arises out of a specified contractual relationship. The usual and customary fee is the reasonable fee and, as such, is the fee recognized by a prudent person.

b.

Second, we find that EHI's plan interpretation is wrong because it erroneously construes the series of contracts linking it to Parkway. Recall that EHI's plan interpretation is two-fold: first, the series of contracts entitles EHI's plan participants to be charged Parkway's discounted fee and, second, the discounted fee explains the meaning of the term "expense" in EHI's contract with Denton. For the reasons explained above, the term "expense" in the COI cannot be construed to include the discounted fee at issue in this case. Because EHI cannot retroactively modify the meaning of the term "expense" in its contract with Denton, its plan interpretation is wrong. Even if, as a general matter, EHI could use undisclosed, outside agreements not in existence at the time EHI issued its policy to Denton, to explain the meaning of the term "expense,"



the outside agreements in this case (i.e., the series of contracts linking EHI to Parkway) do not entitle EHI to the discounted fee because Parkway does not receive the benefit of its bargain. Because EHI is not entitled to the discounted fee, it follows that it cannot base the percentage it owes Parkway on the discounted fee. In short, consideration of either component of EHI's plan interpretation reveals that it is wrong.

The terms of the Parkway/MedView contract do not support the proposition that EHI is entitled to base the percentage it owes Parkway on the discounted fee. EHI argues that each contract in the series of contracts at issue in this case evidences its entitlement to the discounted fee. EHI interprets the first contract in this series, the Parkway/MedView contract, as follows: According to EHI, Parkway's "contract with MedView defined 'third party payer' to include 'any business entity' having a contract with MedView. As a 'business entity' having a contract with MedView, HSI qualified as a payer." Because Parkway knew that MedView could contract with 'any business entity' at the time of contract formation, Parkway cannot renege on its promise to discount its fees.

The terms of the Parkway/MedView contract are not the primary issue in the case before us; therefore, we decline to decide whether MedView's leasing contract with HSI is valid. Nonetheless, for the limited purpose of explaining why EHI's plan interpretation is wrong, we note that one of the express purposes of the March 18, 1994 agreement between Parkway and MedView was to coordinate and arrange for the delivery of hospital and physician services to MedView Subscribers. Integral to the contract (and to EHI's argument) are the definitions of the terms Third Party Payer and Subscriber.

The Parkway/Medview contract defines Third Party Payer as "an insurance company, employer, or other business entity which has contracted with MedView to pay for medical services and/or surgical services rendered by participating physicians to MedView Subscribers and Hospital Services rendered by Preferred Hospitals to MedView Subscribers." Instead of citing this complete definition, EHI's definition of Third Party Payor, quoted above, refers only to the phrase "business entity which has contracted with MedView." EHI claims that this excerpt from the definition of Third Party Payer evidences MedView's right to lease its provider list to HSI, which in turn validates HSI's right to lease the list to EHI, which then entitles EHI to be charged the discounted fee. The omissions in EHI's definition of Third Party Payer are not insignificant. Rather, they reveal the true nature of the Parkway/MedView contract, to wit: to pay for medical services rendered to MedView Subscribers. As such, the definition of Third Party Payer, and whether EHI qualifies as a Third Party Payer under the Parkway/MedView contract, necessarily depends on the definition of Subscriber.

Consider that Subscriber means "a person who, by virtue of a binding contract between MedView and any business entity, may obtain medical and/or surgical services of Preferred Hospitals." Denton is not a MedView Subscriber; he did not obtain medical care from Parkway by virtue of a binding contract between MedView and HSI. Similarly, neither HSI nor EHI is a business entity contracting with MedView to pay for medical services rendered by participating physicians to MedView Subscribers. EHI and HSI may be business entities that contracted with MedView, but the purpose of this contract was not "to pay for medical services rendered by . . . physicians to MedView Subscribers." Importantly, EHI and MedView never entered into a relationship that would result in EHI's plan participants becoming MedView Subscribers, and this relationship does not arise by virtue of a leasing contract like that peddled by HSI. Thus, insofar as EHI's plan interpretation rests on the contract between MedView and Parkway, it is wrong.

We note in passing that while EHI may interpret the plan in accordance with governing instruments and documents (29 U.S.C. § 1104(a)(1)(D)), we take issue with the notion that the Parkway/MedView contract and the MedView/HSI contract (contracts to which EHI is not even a party) govern the contract between EHI and Software Builders. EHI fails to provide Parkway with the benefit of its bargain. We also dismiss EHI's contention that it is entitled to the benefits of a promise in a contract to which it is not a party and from which it is three times removed. Basically EHI is saying that Parkway's promise to discount its fee travels from the Parkway/MedView contract through the MedView/HSI contract through the HSI/EHI contract to the EHI/Software Builders contract to modify the term "expense." We cannot accept such logic.



3.

Next, we consider whether Parkway's interpretation is reasonable. Parkway argues that no provision in EHI's ERISA plan allows EHI to base the percentage it owes Parkway on a discounted fee. The PPO provisions of the COI mention discounted fees in the context of explaining that if a participant uses an in-network provider, then his co-payment percentage will be less than if he uses an out-of-network provider. Since the COI discusses discounted fees only in the context of in-network providers and Parkway is not an in-network provider, Parkway's contention that the plan documents do not permit EHI to discount its charges is sound. Because the only terms in the COI even suggesting discounted fees are in the PPO provisions and because Parkway is not in EHI's network of preferred providers, EHI may not apply a discount to Parkway's charges.

We concur with the district court that Parkway's interpretation of the plan is reasonable. In the COI, EHI informs participants (1) that it has negotiated discounted fees with in-network providers and (2) that the participant's co-payment will be less if he uses the services of an in-network provider. Discounted fees are not mentioned anywhere else in the COI. As such, it can reasonably be inferred from the contractual language that at the time of contract formation EHI was not contemplating discounts with out-of-network providers.

4.

Having decided that EHI's plan interpretation is wrong and Parkway's interpretation is reasonable, we next determine whether EHI's interpretation is reasonable. Given the complex interrelation of the series of contracts at issue in this case, we assume for the sake of argument that EHI's interpretation is reasonable. Even if EHI's wrong interpretation is reasonable, we cannot afford it the deference attributable to arbitrary and capricious review because EHI suffers from a conflict of interest.

5.

We find that EHI acted under a conflict of interest because EHI pays claims out of its own assets. In *Brown v. Blue Cross & Blue Shield*, 898 F.2d at 1556, 1561-62, we explained that "because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business . . . [a] strong conflict of interest [exists] when the fiduciary making a discretionary decision is also the insurance company responsible for paying the claims. . . . The inherent conflict between the fiduciary role and the profit-making objective of an insurance company make a highly deferential standard of review inappropriate." Therefore, we cannot stop our inquiry at mere arbitrary and capricious review. Contrary to EHI's assertion, the district court did not err in applying the heightened arbitrary and capricious standards of review. Because we hold that heightened arbitrary and capricious review is the appropriate standard, we turn to EHI's other contention, namely: when applying heightened arbitrary and capricious review, the district court erred in finding that EHI failed to purge the taint of self interest. In addressing EHI's argument, we continue our application of the steps that constitute heightened arbitrary and capricious review.

B.

Under the heightened arbitrary and capricious standard, the burden shifts to EHI to demonstrate that its interpretation of the plan was not tainted by self interest. A conflicted fiduciary can purge the taint of self interest by proving that its wrong but reasonable interpretation of the plan was "calculated to maximize benefits to participants in a cost-efficient manner." *Lee v. Blue Cross/Blue Shield*, 10 F.3d 1547, 1552 (11th Cir. 1994). Although EHI's plan interpretation is wrong for either of the reasons discussed Part VII.A.2.a-b, we could still hold EHI's interpretation is not arbitrary and capricious if it results in a benefit to Denton and



other beneficiaries. According to EHI, its interpretation benefits Denton because his co-payment was limited to 20% of the discounted fee rather than 20% of the usual and customary fee. In order to determine whether this benefit to Denton and other participants purges the taint of self interest, we consider the consequences that follow from Parkway's and EHI's plan interpretations when applied to the following hypothetical scenario. The facts in this hypothetical scenario are based on a simplified version of the facts of this case.

1.

Assume there are only three health insurance carriers in a metropolitan area: Insurance Company A, Insurance Company B, and Insurance Company C. Each of these insurance companies has contracted with a different PPO to serve as the in-network providers under each company's respective health plan. For instance, Insurance Company A entered a contract with PPO A by which Insurance Company A promises to steer its plan participants to PPO A providers and PPO A providers agree to discount the fees they will charge Insurance Company A's participants. Insurance Companies B and C have identical agreements with PPOs B and C, respectively, exchanging steerage of plan participants for discounted medical services.

The insurance companies steer plan participants to in-network providers in their respective PPOs through economic incentives. A typical arrangement might operate as follows. If a participant (Participant A) in Insurance Company A's plan utilizes the services of a provider in PPO A, i.e., an in-network provider, then Insurance Company A will pay 90% of the provider's fee for medical service and Participant A will pay 10% of the fee. If Participant A utilizes the services of a provider not in PPO A, i.e., an out-of-network provider, then Insurance Company A will pay 80% of the provider's fee for medical services and Participant A will pay 20% of the fee. By requiring Participant A to pay a larger percentage (20%) of the fee for medical services obtained from an out-of-network provider than Participant A would have to pay if he utilized the services of an in-network provider (10%), Insurance Company A "steers" participants to providers in PPO A by making those providers more financially attractive. In return for this steerage, the providers in PPO A discount their usual and customary fees for medical services. Providers in PPO A are willing to charge Insurance Company A a discounted rate because the money they "lose" in discounting their fees is offset by the increased volume of patients they will serve as a result of Insurance Company A's steering efforts. For purposes of this hypothetical, assume that the Insurance Company B/Participant B contract and the Insurance Company C/Participant C contract use similar economic incentives to steer participants to providers in PPOs B and C, respectively. Thus, in return for this steerage, the providers in PPO B promise Insurance Company B they will discount their usual and customary fee for medical services. PPO C and Insurance Company C have the same arrangement. There are no other insurance companies or PPOs in this hypothetical metropolitan area.

Given this background, suppose Participant A breaks his arm. It is undisputed that in this metropolitan area, the usual and customary fee for setting a broken arm is \$1000.00. Providers in PPO A agree that because Insurance Company A steers participants to them, they will only charge \$800.00 for setting a broken arm rather than the customary \$1000.00. As such, if Participant A's arm is set by a provider in PPO A, then Insurance Company A will pay 90% of the \$800.00 fee (\$720.00) and Participant A will pay 10% of the \$800.00 fee (\$80.00).

However, if Participant A chooses to have his broken arm set by an out-of-network provider, i.e., a provider in PPO B or PPO C, Participant A expects that he will pay 20% of the fee for medical service and that Insurance Company A will pay 80% of the fee. Although the percentages are not disputed, at issue in this hypothetical and in this case is: what is the correct fee for medical service?

2.

Under Parkway's interpretation of the plan as applied to this hypothetical scenario, the fee for setting the broken arm is \$1000.00. As previously noted, it is undisputed that \$1000.00 is the usual and customary fee for setting a broken arm. While the provider in PPO B promised Insurance Company B that it would charge Insurance Company B \$800.00 for setting a broken arm, it did so only because (1) its loss from receiving



this discounted amount would be offset by the increased volume of patients PPO B providers would service given Insurance Company B's steerage efforts and (2) it can subsidize these discounted fees by continuing to charge its usual and customary fee (\$1000.00) when treating patients who are not participants in Insurance Company B's plan.

Parkway points out that the PPO B provider never contracted with Insurance Company A. Further, the PPO B provider made the promise to discount its fees in reliance on Insurance Company B's promise to steer plan participants to PPO B providers. According to Parkway, by claiming that it is entitled to the discounted fee of \$800.00, Insurance Company A is availing itself of the PPO B provider's promise to Insurance Company B without giving the PPO B provider the benefit it expected in return for its promise -- steerage. By claiming it is entitled to PPO B's discounted fee, Insurance Company A ignores the basic tenet of contract law that contracts are premised on a bargained for exchange. This basic tenet of contract law is violated when, by virtue of a brokering agreement, Insurance Company A uses the PPO B provider's discounted fee but does not give the PPO B provider the benefit it expected in return, namely, steerage.

Assuming Parkway's interpretation of the plan is correct, the fee remains \$1000.00, the usual and customary fee for setting a broken arm. Participant A pays 20% of the fee, or \$200.00 and Insurance Company A pays 80% of the fee, or \$800.00. Furthermore, Participant A receives the level of service he expects from a provider to whom he is paying full price. In essence, this interpretation maintains both of Participant A's contractual expectations: (1) he expected to pay 20% of an out-of-network provider's usual and customary fee and (2) he expected to receive the level of service consonant with this fee.

3.

Under EHI's plan interpretation, Participant A's fee for medical service obtained from the provider in PPO B should not be \$1000.00 but \$800.00 (the discounted fee PPO B providers agreed to charge Insurance Company B in exchange for Insurance Company B steering its participants to PPO B providers). If the fee is \$800.00, and Insurance Company A only has to pay 80% of an out-of-network provider's fee for medical service, then Insurance Company A pays \$640.00. By choosing to obtain medical service from an out-of-network provider, Participant A is responsible for 20% of the fee for medical service, \$160.00. If, despite that EHI's interpretation is wrong, it nonetheless benefits Denton and other participants, then EHI has purged the taint of self interest. We previously determined that EHI's plan interpretation is wrong for two reasons, see supra Part VII.A.2.a-b. We thus reevaluate each of the proffered reasons for its wrong interpretation and gauge whether, despite either reason, the plan interpretation results in a benefit to Denton and other like plan participants.

We first analyze EHI's interpretation from the view that it's interpretation is wrong because the series of contracts does not entitle EHI to the discounted fee. We then analyze the interpretation from the view that it is wrong because EHI cannot modify the meaning of the term "expense" in its contract with Denton. If we find a benefit to Denton and other participants, then EHI's wrong but reasonable plan interpretation is entitled to deference. If we find EHI's interpretation does not inure a benefit to Denton and other plan participants, we may conclude that the interpretation is arbitrary and capricious.

a.

Assuming EHI's interpretation is wrong because Insurance Company A is not entitled to the discounted fee PPO B providers promised to Insurance Company B, we consider whether EHI's wrong but reasonable interpretation is entitled to deference because it benefits Denton and other participants. If Insurance Company A is not entitled to the discounted fee PPO B providers promised to Insurance Company B, then the cost of medical services is just the usual and customary fee for setting a broken arm, i.e., \$1000.00. By only paying \$640.00 of the PPO B provider's bill, Insurance Company A leaves Participant A on the hook for the remainder of the bill, \$360.00. While Participant A expects to pay more for out-of-network medical



service, he only expected to pay 20% of an out-of-network provider's fee. Given that the usual and customary fee is \$1000.00, Participant A expects he will pay \$200.00 and that Insurance Company A will pay \$800.00. However, if Insurance Company A only pays 80% of the \$800.00 discounted fee, i.e., \$640.00, Participant A is responsible for a co-payment of 20% of the discounted fee (\$160.00) plus the remainder of the bill (\$200.00) when he is balance billed by the PPO B provider. Thus, Insurance Company A's interpretation of the plan results in Participant A paying \$360.00 rather than \$200.00 for out-of-network medical care.

This unexpected increase in cost will deter Participant A from seeking out-of-network medical care. The primary reason managed care plan participants choose PPOs over less expensive forms of managed care is that PPOs allow a participant the flexibility to seek out-of-network treatment for a small increase in the percentage of his co-payment. HMOs, in contrast, typically provide no coverage for out-of-network care. Because Insurance Company A's interpretation of the plan deters Participant A from utilizing the out-of-network care option, Participant A loses some of the benefit he expected to receive when he paid his premium. If out-of-network care was not going to be a financially viable option, Participant A might have chosen health care coverage from an HMO rather than a PPO.

Indeed, the ability to receive out-of-network care is the sine qua non of a PPO. Although the option of having out-of-network medical care covered by insurance will cost the participant more money, participants who choose PPOs over HMOs deem this burden outweighed by the benefit of the flexibility to choose one's health care provider. By making this option more financially onerous than the participant originally (and rightfully) expected when he entered the PPO arrangement, EHI deters the participant - in fact, all plan participants - from seeking out-of-network care. In so doing, EHI effectively limits participants to in-network providers. Therefore, at best, EHI is depriving participants of their bona fide contractual expectations. At worst, EHI is siphoning money from participants and splitting the proceeds of this ill-gotten gain between itself and HSI.

It is plain that EHI's wrong interpretation (i.e., wrong because EHI is not entitled to Parkway's discounted fee) is not entitled to deference because it deprives participants of their contractual expectation. As such, EHI has not purged the taint of self interest. We find, therefore, that its plan interpretation is arbitrary and capricious. EHI's success on appeal, however, depends on whether, in light of the other reason its plan interpretation is wrong, we find that the interpretation benefits Denton and other participants. Consequently, we now consider whether EHI's interpretation continues to be arbitrary and capricious even if EHI is correct that Insurance Company A is entitled to the discounted fee, but incorrect about how this discount impacts Insurance Company A's contract with Participant A.

b.

According to EHI, when Participant A received medical service from Provider B, Provider B should have charged Participant A \$800.00 based on a contract that Insurance Company A made through a series of middlemen. EHI deems it irrelevant (1) that Provider B never knew its promise to discount its usual and customary fee was leased to Insurance Company A and (2) that Provider B does not get steerable in return for this promise. Because both Participant A and Provider B are unaware that Provider B is obligated to charge a discounted fee, they agree that Participant A will pay \$1000.00 and Provider B will set Participant A's broken arm with a level of service consonant with this fee. Provider B bills Insurance Company A on Participant A's behalf demanding 80% of \$1000.00 (\$800.00) from Insurance Company A and 20% (\$200.00) from Participant A. Assuming EHI's plan interpretation as correct - that the series of contracts entitles Insurance Company A to the discounted fee - the correct total fee for setting Participant A's broken arm is \$800.00 and not \$1000.00. Therefore, Insurance Company A owes Provider B 80% of \$800.00 (\$640.00) and Participant A owes Provider B 20% of \$800.00 (\$160.00). At first glance it seems that Participant A benefits from this arrangement because he received the level of service he expected from an out-of-network provider yet only had to pay 20% of a reduced fee rather than 20% of the usual and customary fee.



However, our analysis reveals that Participant A does not benefit in the long run. Consider that after struggling with the hassle of determining and collecting its fee, Provider B is now aware that he is only going to receive \$800.00 when setting the broken arms of participants in Insurance Company A's plan. Financially, Provider B is in no different a position than Provider A, Insurance Company A's in-network provider. Like Provider A, Provider B is now obligated to charge Insurance Company A's plan participants a discounted fee. Unlike Provider A, however, Provider B does not get the benefit of steerage from Insurance Company A. Also unlike Provider A, Provider B collects \$640 (80% of \$800) from Insurance Company A while Provider A collects \$720.00 (90% of \$800.00). In comparison to Provider A, then, Provider B is burdened with collecting a higher percentage of his fee from an individual participant, who is invariably a payer less financially secure and able than an insurance company.

Consideration of these effects of EHI's interpretation on Provider B reveals that the interpretation deleteriously impacts Participant A and others like him. When Participant A breaks his other arm and returns to Provider B because he was pleased with the level of service he previously received, Provider B is unable to provide Participant A with the same level of service because he receives less compensation. The entire purpose of a PPO rather than an HMO is to afford participants the choice to receive out-of-network medical care. PPO Participants know their medical care will be less expensive if they receive such care from an in-network provider. They choose, nonetheless, to pay a higher premium for the freedom to have their medical expenses covered when they receive medical care elsewhere. A participant presumably believes the level of service he receives outside the network will be different from the level of service he receives inside the network; this is why he pays for the option of going outside the network. Implicit in the belief that the level of medical service differs outside the network is the participant's understanding that this level of service will cost more than in-network medical care. The participant's act of paying for this choice is evidence that participants value the ability to receive medical care outside the network. Presumably, this value is a different, if not better, level of medical service. We have no doubt this is a participant's contractual expectation when he opts for a PPO health insurance policy.

The results of EHI's plan interpretation crash head on into a participant's rightful and understandable expectation. When Provider B knows that he will be paid less for setting Participant A's arm, he will be unable to provide the same level of service. Participant A chose to receive medical care from Provider B because he thought he would receive a level of service consonant with the higher fee he expects the out-of-network provider to be paid. If Participant A wanted a level of service consonant with a discounted fee, he would get his broken arm set by an in-network provider. The ultimate result of EHI's plan interpretation is that participants receive a level of service consonant with a discounted fee regardless of whether they receive their medical care from an in-network or out-of-network provider. But for the co-payment differential, there is little difference between in and out-of-network providers. Because such an interpretation works to deprive participants of their contractual expectation upon entering a PPO, EHI has not purged the taint of self interest. Accordingly, we hold that EHI's plan interpretation is arbitrary and capricious.

4.

Not only does EHI's plan interpretation deleteriously impact current Participant A's contractual expectations, if followed through to its natural conclusion, EHI's plan interpretation could alter the rights and obligations of future participants and providers. Whether the Parkway/MedView, MedView/HSI, HSI/EHI series of contracts entitles EHI to the discount or not, Participant A has, in effect, lost the benefit of seeking and receiving out-of-network care. Under either of the reasons we determined that EHI's plan interpretation is wrong, Participant A is likely to demand lower premiums to compensate for the loss of this justified and bargained for contractual expectation. If Participant A and other similarly situated participants succeed in securing lower premiums, then Insurance Company A will have less income. Because Insurance Company A has less income, it will demand larger discounts from providers in PPO A, thereby driving down the fees of in-network providers. Because the level of service participants receive remains consonant with the amount of money providers receive, this reduction in fees will impact the level of service enjoyed by Participant A and others



like him. If Insurance Companies B and C interpret their plans to allow undisclosed discounts with out-of-network providers, they too may suffer a participant backlash which in turn may provoke Insurance Companies B and C to demand lower fees from providers in PPOs B and C, respectively. The downward spiraling of the level of service would repeat itself as the providers in PPOs B and C adjust the level of service they provide to reflect their reduced compensation.

Ironically, when a participant in a traditional PPO arrangement is not satisfied with his in-network care, he may seek medical care from an out-of-network provider. For instance, in our hypothetical scenario, Insurance Company A continues to cover the costs of Participant A's medical care when he obtains services from an out-of-network provider. Given the closed universe of our hypothetical scenario, the out-of-network providers available to Participant A would be those providers in PPO B or PPO C. By virtue of undisclosed contracts with a series of middlemen, Insurance Company A can base the percentage it owes the PPO B or C provider on the discounted fee the PPO B or C provider promised Insurance Company B or C rather than on the usual and customary fee. The fee the PPO B or C provider promised to Insurance Company B or C reflects the downward spiraling of provider fees spurred by participants' demand for lower premiums. Not only are the PPO B and C providers having to further discount their fees to remain in-network providers for Insurance Companies B and C, but due to the effect of agreements like the EHI/HSI contract and the HSI/MedView contract, PPO B and C providers no longer offset this loss by the usual and customary fees they receive when they treat patients who are not participants in Insurance Companies B and C's plans.

Importantly, it follows that this effect on providers will negatively impact participants. Consider that the level of service Participant A receives from an in-network provider reflects the further discounting of fees demanded by Insurance Company A to offset its lower premiums. Worse still, the level of service Participant A receives out-of-network is also diminished as providers in PPOs B and C adjust for the failure to receive their usual and customary fee when treating Insurance Company A's participants. When followed to its natural conclusion, EHI's plan interpretation in effect turns a discounted fee negotiated between a specific provider and specific insurance company into the usual and customary fee for the entire medical services industry. Because the level of service participants receive is directly related to this reduction in fees, participants' expectations continue to be unfulfilled.

As the above hypothetical scenario demonstrates, participants' contractual expectations are not satisfied as a result of EHI's plan interpretation. Because EHI's interpretation deprives plan participants of their contractual expectations, we find that EHI's plan interpretation is arbitrary and capricious. The judgment of the district court is, therefore, AFFIRMED



D. Legislation

The practice of silent PPO use has drawn the attention of U.S. Legislatures and state insurance commissioners. For example, to combat silent or stacked PPOs, California enacted legislation effective July 1, 2000, to prevent the improper selling, leasing or transferring of a health care provider's contract.

The law provides that every contracting agent that sells, assigns, transfers or leases its list of contracted health care Providers (network) to a payer must disclose to the provider:

(1) if the list can be sold, assigned, transferred or leased,

(2) what specific practices, if any, Payers utilize to actively encourage use the contracted providers when obtaining medical care that entitles a Payer to claim a contracted rate (e.g. steerage, call centers, logo on member cards)

(3) whether Payers that purchase, lease, transfer, or convey a network from another entity may be permitted to pay a Provider's contracted rate without actively encouraging the payers' beneficiaries to use the list of contracted Providers when obtaining medical care;

(4) upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a Provider or Provider panel, a Payer summary of all payers currently eligible to claim a Provider's contracted rate due to the Provider's and Payer's respective written agreements with any contracting agent; and

(5) upon the initial signing, renewal, or amendment of a provider contract, the right of a Provider to decline to be included in any list of contracted Providers that is sold, leased, transferred, or conveyed to payers that do not actively encourage the Payers' beneficiaries to use the list of contracted Providers when obtaining medical care.

In addition California requires that a Payer:

(1) provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the Provider whereby the payer is entitled, directly or indirectly, to pay a preferred rate for the services rendered; and

(2) demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a Provider who has received a claim payment from the payer. The failure of a Payer to make



the demonstration within 30 business days shall render the Payer responsible for the amount that the Payer would have been required to pay pursuant to the beneficiary's policy with the Payer, which amount shall be due and payable within 10 business days of receipt of written notice from the Provider, and shall bar the payer from taking any future discounts from that Provider without the provider's express written consent until the payer can demonstrate to the Provider that it is entitled to pay a contracted rate.

North Carolina implemented a law (N.C. Gen. Stat. 58-63-700) to specifically address silent PPOs, which makes it “an unfair trade practice” for insurers to make a material misrepresentation to a physician to the effect that the insurer or service company is entitled to a certain preferred physician or other discount off the fees charges for medical services, procedures, or supplies provided by the physician, when the insurer or service corporation is not entitled to any discount or id entitled to a lesser discount from the physician on those fees.”



California Business and Professions Code Sections 511

511. (a) No subcontract between a physician and surgeon, physician and surgeon group, or other licensed health care practitioner who contracts with a health care service plan or health insurance carrier, and another physician and surgeon, physician and surgeon group, or licensed health care practitioner, shall contain any incentive plan that includes a specific payment made, in any type or form, to a physician and surgeon, physician and surgeon group, or other licensed health care practitioner as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered under the contract with the health care service plan or health insurance carrier and provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

(b) Nothing in this section shall be construed to prohibit subcontracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are not tied to specific medical decisions involving specific enrollees or groups of enrollees with similar medical conditions.

511.1. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payer paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payer shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payer, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payers or other contracting agents, and specify whether those payers or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payers utilize to actively encourage a payer's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payer to claim a contracted rate. For purposes of this paragraph, a payer is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payer's contract with subscribers or insured offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced co-payments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payer provides information directly to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or internet web site addresses supplied directly to every beneficiary. However, Internet web site addresses



alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payers from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payers to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payers' beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payer to actively encourage the payer's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payer summary of all payers currently eligible to claim a provider's contracted rate due to the provider's and payer's respective written agreements with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payers that do not actively encourage the payers' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and on any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payers that actively encourage the payers' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payers that do not actively encourage the payers' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payers, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payer, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the plan or network that has a written agreement signed by the provider whereby the payer is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payer. The failure of a payer to make the demonstration within 30 business days shall render the payer responsible for the amount that the payer would have been required to pay pursuant to the contract between the payer and the beneficiary, which amount shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payer from taking any future discounts from that provider without the provider's express written consent until the payer can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this paragraph. A payer shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payer utilizes to comply with paragraph (2) of subdivision (b).

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or



conveyed to payers that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means:

(A) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(B) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(C) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(2) "Contracting agent" means a third-party administrator or trust not licensed under the Health and Safety Code, the Insurance Code, or the Labor Code, a self-insured employer, a preferred provider organization, or an independent practice association, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to provide health care services to beneficiaries. For purposes of this section, a contracting agent shall not include a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer.

(3)

(A) For purposes of subdivision (b), "payer" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For purposes of subdivision (c), "payer" means only those entities that provide coverage for hospital, medical, or surgical benefits that are not regulated under the Health and Safety Code, the Insurance Code, or the Labor Code.

(4) "Payer summary" means a written summary that includes the payer's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to this division.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(e) This section shall become operative on July 1, 2000.



E. Legal, Managed Care Auditing and Revenue Recovery Services

A growing number of healthcare law firms as well managed care auditing and recovery management companies are specializing in reimbursement recovery, legal contract interpretation and specialized silent PPO recovery strategies for medical Providers.

Law firms currently represent individuals and class action plaintiffs who were victims of silent PPOs in Florida and Massachusetts. Skilled in insurance law, ERISA and applicable commercial law, these healthcare law specialists provide contract review and contract renegotiation counsel to close silent PPO loopholes in hospitals managed care contracts. The intent is to:

- review proposed contracts from the Provider's perspective to ensure that payer clauses are clear and legally enforceable;
- anticipate potential problems prior to renegotiation; and
- provide civil litigation services to recover discounts obtained through silent and stacked PPO use.

Many are becoming increasingly familiar with the complex workings of silent PPO arrangements, and as well as with lobbying efforts in state and federal government

PPO contract auditing and recovery management firms work to facilitate prevention and detection of silent PPO use. Through the use of advanced data collection techniques, these companies provide regular and periodic financial audits of medical records, claims reports and PPO contracts, as well as recommend information systems to facilitate monitoring, maximize automatic auditing and generation of red-flag reports. System engineering is also provided to help medical providers improve internal documentation and controls to minimize future cash loss. Seminars and in-house training of business office staff to identify and minimize silent PPO occurrence at the front end is also offered.

Partial listing of relevant firms

*Latham & Watkins Health Care Practice Group
Gardner, Carter & Douglas
Morris, Manning & Martin, LLP
Phillips & Garcia LLP
MD-X Solutions Inc.
PpoRX Inc.
Triage Consulting Group
NJHA Corporate Services*



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