Piercing the Corporate Healthcare Veil for Your Patients: Getting a Fair Price on Your Terms

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Participate in polling questions and submit your questions to https://aafp4.cnf.io/

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Learning Objectives

By the end of this educational activity, participants should be better able to:

- Understand how patients may use HITECH to demand cash pricing
- Understand when a hospital contract for payment with a patient is unenforceable
- Understand how to obtain reference based pricing to argue on your patient's behalf
- Understand the evolving landscape of medical malpractice liability

Why the Strange Title?

"Piercing the corporate veil" refers to a situation in which courts put aside limited liability and hold a corporation's shareholders or directors personally liable for the corporation’s actions or debts.

Florida (example) has two requirements in these types of cases:

1) That the relevant corporation is only the alter ego or mere instrumentality of the parent corporation or its shareholder(s)

2) That the alleged parent company or shareholder(s) also engaged in improper conduct

Outline

- HITECH
- Contract Concepts (Adhesion, Duress, Unconscionability)
- Rumors & Retaliation
- Evolving Medical Malpractice Liability

HITECH Intro Questions

- May a patient decline to sign the HIPAA forms?
- May a patient demand a cash price?
- May a clinic offer a cash price below Medicare?
- Who may initiate this privacy request?

HITECH – Cash Pay for Privacy

- Section 13405(a) of the HITECH Act sets forth certain circumstances in which a covered entity now MUST comply with an individual's request for restriction of disclosure of his or her protected health information.
- 45 C.F.R § 164.522(a)(1)(vi)

HITECH – Cash Pay for Privacy

Specifically, section 13405(a) of the HITECH Act requires that when an individual requests a restriction on disclosure pursuant to § 164.522, **the covered entity must agree to the requested restriction unless the disclosure is otherwise required by law**, if the request for restriction is on disclosures of protected health information to a health plan for the purpose of carrying out payment or health care operations **and** if the restriction applies to protected health information that pertains solely to a health care item or service **for which the health care provider has been paid out of pocket in full**.

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HITECH – HMO / Medicaid Implications

If a provider is required by **State or other law** to submit a claim to a health plan for a covered service provided to the individual, **and there is no exception or procedure for individuals wishing to pay out of pocket for the service**, then the disclosure is required by law and is an exception to an individual's right to request a restriction to the health plan pursuant to § 154.522(a)(1)(vi)(A) of the Rule.

HITECH – Medicare Implications

With respect to Medicare, it is our understanding that when a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of section 1848(g)(4) of the Social Security Act (the Act), which requires that if a physician or supplier charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the physician or supplier must submit a claim to Medicare. However, **there is an exception to this rule** where a beneficiary (or the beneficiary's legal representative) refuses, of his/her own free will, to authorize the submission of a bill to Medicare. In such cases, **a Medicare provider is not required to submit a claim to Medicare for the covered service and may accept an out of pocket payment for the service from the beneficiary**. The **limits on what the provider may collect from the beneficiary continue to apply** to charges for the covered service, notwithstanding the absence of a claim to Medicare.

HITECH Privacy Implementation

- Have the patient sign a request that information relative to self-paid services not be disclosed (usually called a Restrictions on Uses and Disclosures Form)
- Flag this information so that it is not shared with the “health plan”
- Inform the patient about the need to make the same request downstream (pharmacies, labs, specialists)

Model HITECH Request Statement

I _____ (patient's name) require pursuant to the HITECH Act codified in §45 C.F.R 164.522(a)(1) that my health information related to this set of medical services not be shared with my health plan in exchange for my cash payment in full for the set of medical services. I am making this request of my own volition. I understand that I will need to repeat this request as I approach other covered entities for care related to these same medical services.

University of Chicago Example: http://hipaa.bsd.uchicago.edu/Restriction%20Request%20Form%202018.pdf

#1 What if the patient's check bounces?

A) The HITECH privacy contract was already signed by the hospital and must be honored

B) The HITECH privacy contract is now voided and the hospital may bill the patient's insurance pursuant to those usual terms

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#2 What if you prescribe a medication?

A) It is the obligation of the patient to ensure that the pharmacy is aware of her HITECH preference and that it does not inadvertently bill the plan for this medication

B) It is your (the DPC physician's) obligation to ensure that those downstream in the system (pharmacies, labs, specialists) are aware that HITECH rights are being invoked.

#2 What if you prescribe a medication?

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B) It is your (the DPC physician's) obligation to ensure that those downstream in the system (pharmacies, labs, specialists) are aware that HITECH rights are being invoked.

#3 What if you have opted out of Medicare?

A) You no longer need to honor HITECH requests from Medicare patients

B) You MAY (but are not required) to honor HITECH requests from Medicare patients

C) You MUST honor HITECH requests from Medicare patients and the Medicare limiting charge rates apply

D) You MUST honor HITECH requests from Medicare patients and the Medicare limiting charge rates DO NOT apply

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#4 What if the patient returns for a second visit and does not make a HITECH request?

A) The previously private information in the first visit is still protected.

B) The previously private information may inadvertently be shared since much of it may be included in the follow up office note

C) Both A & B are true

D) Both A & B are false

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D) Both A & B are false

#5 Which of the following patients **may NOT** have transparent pricing rights under HITECH?

A) Medicare
B) HMO Patient
C) ERISA (Employer Based) PPO Patients
D) Individual Exchange PPO Patients
E) Health Share & Uninsured Patients

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#5 Which of the following patients **may NOT** have transparent pricing rights under HITECH?

A) Medicare (Yes, but limiting charges apply unless you opted out)

B) HMO Patient (Medicaid patients would have been a correct answer also)

C) ERISA (Employer Based) PPO Patients

D) Individual Exchange PPO Patients

E) Health Share & Uninsured Patients

#6 Which of the following statements is true?

A) The hospital must offer the patient a price that reflects fair market value for a planned service purchased privately under HITECH.

B) The hospital must offer the patient a price for the procedure, and it need not reflect fair market value.

C) HITECH requires that the hospital offer the patient a complete list of published prices for all possible procedural options

D) HITECH payments count toward the in-network deductible

E) HITECH payments count toward the out-of-network deductible

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#7 Which patient would theoretically never benefit from making a HITECH request?

A) Uninsured
B) Medicaid
C) Medicare
D) HMO
E) PPO

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#8 Once a HITECH restriction is in place, it would limit sharing PHI with which of the following:

A) The specified Health Plan
B) A non-specified Health Plan
C) The patient's employer
D) Law Enforcement

#8 Once a HITECH restriction is in place, it would limit sharing PHI with which of the following:

A) **The specified Health Plan** (**Yes** – this is THE point)
B) A non-specified Health Plan (optional)
C) The patient's employer (optional)
D) Law Enforcement (no, this is not an option)

#9 May an individual use an HSA or FSA to pay for services he wants restricted from the plan?

A) Yes

B) No

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A) Yes

B) No

"An individual may use an FSA or HSA to pay for the health care items or services that the individual wishes to have restricted from another plan; however, in doing so the individual may not restrict a disclosure to the FSA or HSA necessary to effectuate that payment."

HITECH Privacy Summary

- All covered entities MUST have a process
  - Request must be of patient's "own free will"
- Medicare
  - May accept cash payments, but limiting charges apply
- Medicaid
  - May or may not provide an exception (ex KY & CO)
- HMO laws (state based)
  - May or may not provide an exception
- Private Insurance Contracts
  - Federal law trumps terms of private agreements

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Contract Law

A contract consists of voluntary promises between competent parties to do, or not to do, something, which the law will enforce. These are binding promises, which may be oral or written. Consideration is required.

Contract “In-Writing” Requirements

- surety / guaranty (debt contracts)
- any promise that the parties cannot possibly fulfill within one year from when they made the promise;
- any promise involving the change of ownership of land or interests in land such as leases;
- any promise for the sale of goods worth more than $500 or lease of goods worth more than $1,000 (UCC);
- any promise to bequeath property (give it after death);
- any promise to sell stocks and bonds.
- Some states have additional requirements

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Adhesion Agreement

- An adhesion contract (also called a "standard form contract" or a "boilerplate contract") is a contract drafted by one party (usually a business with stronger bargaining power) and signed by another party (usually one with weaker bargaining power, usually a consumer in need of goods or services). The second party typically does not have the power to negotiate or modify the terms of the contract.

(Breaking) Hospital-Patient Contracts

- Capacity (lack of)
- **Duress**
- **Unconscionability**
- Ambiguity
- Undue influence
- Impossibility
- Mistake
- Public Policy

Is a written contract required to receive medical services from a hospital?

A) Yes, except in emergent situations

B) Yes, even in emergent situations a durable power of attorney should be located to sign documents for the patient

C) Yes, because the value of the services delivered is likely to be over $500

D) No because this is a contract for a service that will be completed in under one year

E) A and C are both correct

F) B and C are both correct

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Obscene contracts: the doctrine of unconscionability and hospital billing of the uninsured

The admission agreement between a hospital and a patient, in which the patient agrees to pay the hospital's “billed charges" for necessary medical services, is **unenforceable because it is unconscionable**, and as a result **the most that the patient is liable to pay the hospital is the reasonable value of the medical goods and services received**. Moreover, reasonable value should be defined as **the average reimbursement actually collected**, not billed, by the hospital for the diagnostic code that applies to the medical services received by the patient.

Procedural Unconscionability (1)

The concept of an adhesion contract is similar to procedural unconscionability. Most courts find that an adhesion contract is procedurally unconscionable. A procedurally unconscionable **contract results in the surprise, oppression, or both of the weaker party**. That is, **the weaker party is surprised to learn of the terms of the agreement because they were hidden in fine print or obtuse language**, or because the only way for the weaker party to acquire the goods or services was to agree to the terms dictated by the stronger party.

Procedural Unconscionability (2)

Hospital admission contracts are **drafted in a way that prevents the patient from knowing how much money they are agreeing to pay the hospital**. In addition, the admission contract does not make clear that uninsured patients are, by agreeing to pay the hospital's "full charges," agreeing to pay many times the amount insured patients pay for the same medical services.

Substantive Unconscionability

Substantive unconscionability is concerned with the **terms of the agreement between the parties and not with the process from which they resulted**. Specifically, a contract is substantively unconscionable if it is grossly unfair or contains terms that are so one-sided or unfair as to shock the conscience of the court.

Referenced Based Pricing
Used to calculate “reasonable value”

- Percentage off “billed charges” = fake price = DO NOT USE
- Medicare Price List
  - https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx
- Medicaid Price List
- Surgery Center of Oklahoma City & Others
- Needed for many reasons:
  - Proves degree of unconscionability in court
  - Used to argue for better pricing

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Fiduciary Duty (Strike 1)

Do hospitals (or physicians) have a fiduciary duty to guard their patient's finances?

While "New Jersey has recognized that doctors owe a fiduciary duty to patients in making medical decisions, ... and that nonprofit hospitals owe a fiduciary duty to the public with regard to staffing decisions," a New Jersey court followed Georgia's rule because **no precedent "extended a hospital's fiduciary duty to its billing practices."**

Which of the following is NOT a component of Informed Consent?

A) Risks of the Procedure
B) Benefits of the Procedure
C) Nature of the Procedure
D) Alternative Procedures
E) Price of the Procedure

Which of the following is NOT a component of Informed Consent (Strike 2)?

A) Risks of the Procedure
B) Benefits of the Procedure
C) Nature of the Procedure
D) Alternative Procedures
E) Price of the Procedure

What if the patient argues that a procedure was done without consent?

A new patient arrives at your office in atrial fibrillation and passed out from Afib with RVR. She is sent to the hospital and wakes up in the ICU, started on diltiazem and warfarin and sent home in two days. She later argues that she only wanted your opinion and says that she never wanted to go to the hospital. What will the court do?

A) Invalidate all hospital charges due to lack of consent

B) Hold your DPC practice liable for her hospital charges

C) Hold her liable for the charges under an implied consent doctrine

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What if the patient argues that a procedure was done without consent (strike 3)?

A new patient arrives at your office in atrial fibrillation and passed out from Afib with RVR. She is sent to the hospital and wakes up in the ICU, started on diltiazem and warfarin and sent home in two days. She later argues that she only wanted your opinion and says that she never wanted to go to the hospital. What will the court do?

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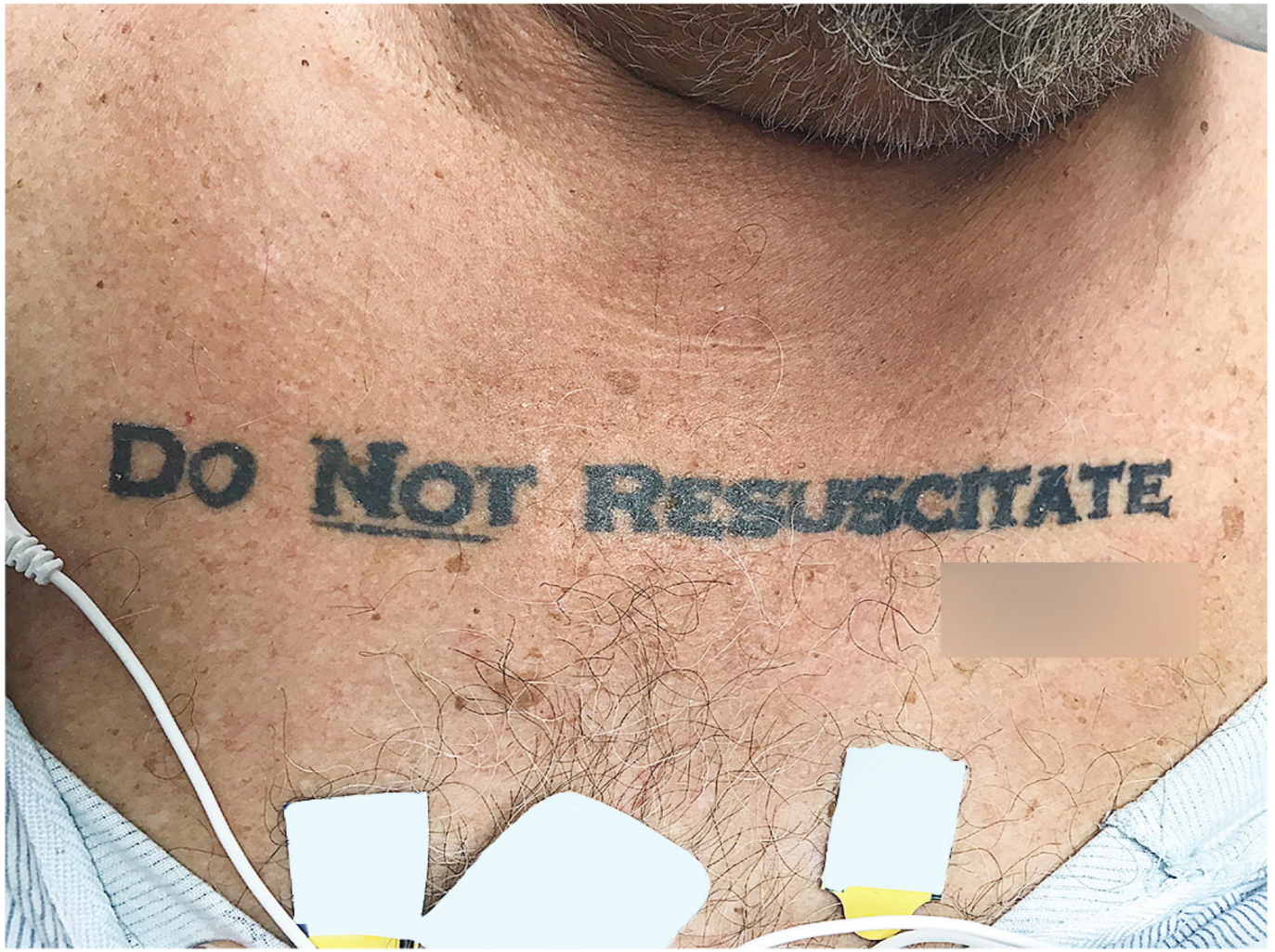
What does this do to implied consent?



What does this do to implied consent?

Summary of Failing Arguments

- Fiduciary Duty (Hospital to Patient)
- Lack of Informed Consent (Price is not a component)
- Lack of General Consent (Implied in emergencies)

Summary of Successful Arguments

- HITECH
- Adhesion & Duress
- Unconscionability

Patient ER Order of Operations

If you are uninsured (or if you have not met – and do not anticipate meeting) your deductible:

1) Demand HITECH privacy,

2) Request Medicare (or Medicaid or TBD FMV) rates on anything you sign at the hospital, and

3) Litigate if your rates are unfair

Hospital Obfuscation Directed at the Patient

- “We don’t accept health sharing ministry patients”
- “You Must sign all HIPAA forms”
- “You Must use your insurance”
- “We are forbidden by law from posting our prices”
- “We are not allowed to offer a cash price below the Medicare rate”

Hospital Retaliation – Against the Physician

- May revoke your privileges
- May require more unassigned ER call
- May end your part-time (moonlighting) options
- May initiate a sham peer review case

- Think ahead!
  - Whistleblower protections (most often using medical staff bylaws)
  - NPDB implications (next slide)

National Practitioner Databank

- Privileges resigned during an open investigation (must report)
- Investigation lasting longer than thirty days (must report)
- Medical Malpractice Payments (not always reported – details matter!)
  - Payment solely out of personal funds
  - Payment solely in name of multiple physician corporation
  - Waiver of patient debt

health care services)

SUBMIT A MEDICAL MALPRACTICE PAYMENT REPORT

Submit within 30 days of when the payment was made

The NPDB notifies the subject of the report when the report is submitted.

SUBMIT A REPORT:

- ✔ If the payment was made by an entity comprised of a sole practitioner for the benefit of a named practitioner
- ✔ If a practitioner fee was refunded as the result of a written request
- ✔ If a business entity comprised of a sole practitioner settles a claim
- ✔ If the dismissal of the practitioner was the result of a condition in the settlement or release
- ✔ If the payment was based on a high-low agreement that was in place prior to a verdict or arbitration decision

DO NOT SUBMIT A REPORT:

- ✖ If the payment made by the individual practitioner out of personal funds (not a solo practitioner corporation)
- ✖ If there was a waiver of debt where no money exchanged
- ✖ If the settlement is made on behalf of a named business or corporation with multiple practitioners
- ✖ The practitioner was dismissed from the claim or complaint prior to settlement or final adjudication without condition or promise of payment
- ✖ The fact finder ruled in favor of the defendant practitioner and assigned no liability

REPORT MODIFICATIONS (when needed):

Did your organization determine there is an error or omission in a previously submitted report?

Did your organization determine that an action should not have been reported because:

1. The report was erroneously submitted?
2. The action is not reportable?
3. The action was reversed or overturned?

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Medical Malpractice Liability

1) Duty
2) Breach
3) Causation
4) Damages

Medical Malpractice Liability

1) Duty – if one element is missing = summary judgment
2) Breach
3) Causation
4) Damages

Issues of fact = Jury

Issues of Law = Judge

Medical Malpractice Minnesota Sup Ct Case

- Warren v Dinter
- "A physician-patient relationship is not a necessary element of a claim for professional negligence. A **physician owes a duty of care to a third party when** the physician acts in a professional capacity and **it is reasonably foreseeable that the third party will rely on the physician's acts** and be harmed by a breach of the standard of care."
- "…it was reasonably foreseeable that a patient seeking admission to a hospital would rely on a hospitalists acts and be harmed by a breach of the standard of care, thus making summary judgment for the hospitalist and his employer on the element of duty improper."

Warren v Dinter

- NP calls hospitalist physician, presents case over ten minute call
- Hospitalist says – sounds like diabetes, no reason noted to admit
  - Told that DM explained elevated WBCs, never given any records
- NP calls supervising physician (Baldwin), then given the same answer
- Three days later Warren's son found her dead (staph-sepsis)
- Summary judgment granted at district court & court of appeals
- Later remanded by Supreme Court for jury to determine foreseeability

Warren v Dinter

Majority Opinion:

"When duty depends on foreseeability, and the material facts regarding foreseeability are disputed, or there are differing reasonable inferences from undisputed facts (a "close call"), **summary judgment on the element of duty should be denied** and the negligence claim, including the issue of foreseeability, should be tried."

Dissent Opinion:

"A harm which is not objectively reasonable to expect is too remote to create liability."

What would you do if a hospitalist blocked your attempt at a direct admission?

A) Call a different hospital and try again

B) Send the patient to the ER

C) Accept the hospitalist's advice, document the hospitalist's name in the chart, and then "forgettaboutit" for the weekend

D) A or B

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****How might this answer change if the hospitalist was now your brightest colleague from residency?**

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Additional Dissent Language

“”Why one medical professional – the professional with the first-hand, direct knowledge of the patient’s condition – would rely on the opinion of a “randomly assigned” physician to make a treatment decision is difficult to ascertain.”

“…that reliance is even less persuasive where the “randomly assigned” physician has neither talked to nor examined that professional’s patient, has not seen the patient’s medical records…”

Additional Dissent Language

"Dinter had no reason to know and certainly was not "bound to know" that Simon (the NP) would conclude an alternate path toward hospitalization such as the emergency room was not needed for her patient."

"If these kinds of conversations create a duty, and thus potential liability, **then no prudent professional will share insight, ideas, and recommendations with a colleague 'without a promise of indemnification'**"

Curbside Consult Implications

- When you contractually indemnify a third party you have:
  - Exposed yourself to a new liability cap
  - Incurred a new category of liability that may not be covered by your malpractice policy
- Extend your analysis to the “foreseeability of harm”
  - Especially in MN, AZ, IA, OR, SC
- If you are paying someone to be your friend, then they are not your friend.
- “A physicians breach of care is not excused by another’s later breach.”

Lessons on Malpractice Liability

- No license lending
  - Employment ≠ Collaborating/Overseeing
- True curbside consult is 1) not anonymous, and 2) not compensated
- Possible Hospitalist Reactions:
  - Record all phone interactions
  - Limit response to two answers: 1) direct admit, or 2) ER recommendation
  - Refuse to interact with any non-hospital-employed providers
- No good deed goes unpunished

Questions?

Submit your questions to:
aafp4.cnf.io

Don’t forget to evaluate this session!

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