The State-Mandated Enrollee Hold Harmless Clause: a Modern-Day Trojan Horse

Frank Lobb

Heralded by the insurance industry as being "for the benefit of the subscriber or enrollee," the Enrollee Hold Harmless Clause is probably the single most frequently repeated piece of legal language in healthcare.

In a world where no two attorneys use the same language to draft a contractual provision, and essentially no two states ever promulgate the same legislation, the Enrollee Hold Harmless Clause stands out as a clear and bold exception. It's also language that both the states and the insurance industry have gone well out of their way to keep hidden. Quietly imbedded, without discussion, in the laws and regulations of every state, and mandated for incorporation in every provider contract that doctors and hospitals are required to have with managed-care plans, the Enrollee Hold Harmless Clause has been written into about a million healthcare documents across the nation, with nothing more than the assurance that it is for the benefit of enrollees in managed-care plans. And while each and every one of these documents qualifies as a public document, no more than a hundred of them are available to the public for review.

Much as the Greeks decorated their wooden horse to ensure that the people of Troy wouldn't look inside, the states and the insurance industry have adorned the Enrollee Hold Harmless Clause with the assurance that it is for the benefit of the people. In essence, people believe that there is no reason to look inside the clause, and no need to examine its language or question its role in our third-party payment system. Just as the people of Troy stood idly by as that ancient wooden horse was pulled within their city walls, we have stood equally silent while the Enrollee Hold Harmless Clause has been incorporated in every provider contract in the country. Over my many years of researching the clause, I have never found a single instance of any person or organization seriously questioning it. Nobody has questioned the purpose and reach of its ever-so-clear language—language that, on its face, clearly appears to leave no room for an enrollee to pay for necessary healthcare and severs the patient-physician relationship as we have known and honored it.

Originally drafted by NAIC (National Association of Insurance Commissioners)[1] for the purpose of preserving the authority of states to regulate insurance in cases of HMO insolvency, the Enrollee Hold Harmless Clause has become a fixture in the laws and regulations of every state in the country. While its place in those laws and regulations varies from state to state, its structure and language are essentially identical.

HMOs are required to have a state-approved provider contract with every doctor, hospital, and provider of skilled care in their networks of approved providers, and these contracts must contain the Enrollee Hold Harmless Clause. However, by failing to limit the contracts to HMOs, the states have allowed insurers to extend the reach of these contracts and the Enrollee Hold Harmless Clause to every form of managed care in the country. In fact, given the length and complexity of the contracts, it is impossible to say that their reach stops at managed care. By allowing insurers to draft these contracts largely as they choose and extend them to all of their many subsidiaries, affiliates, contractors, and who knows how many others, the insurance industry has established contractual control over a network of products, organizations, and providers so large and broad that it defies definition.

Let's take a look inside this modern Trojan Horse:

> Hospital/Doctor agrees that in no event, including but not limited to non-payment by Insurance Company, Insurance Company's insolvency or breach of this agreement, shall Hospital/Doctor, one of its subcontractors, or any of its employees or independent contractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Subscriber or persons other than the insurance company acting on behalf of Subscriber for Covered Services provided pursuant to this Agreement. This provision shall not prohibit the collection of coinsurance, co-payments or charges for Non-Covered Services. Hospital/Doctor further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Subscribers, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital/Doctor and Subscribers or persons acting on their behalf. Hospital/Doctor may not change, amend or waive this provision without prior written consent of the Insurance Company. Any attempt to change, amend or waive this provision are [*sic*] void.

To appreciate the significance of the language, we will look at three questions: 1) Can an enrollee of a managed-care plan pay for necessary care that his doctor has prescribed and that the insurer is refusing to approve? 2) How does the clause affect the patient-physician relationship? 3) Is the Enrollee Hold Harmless Clause legally defensible?

Enrollee Payment for Denied Necessary Care

The plain language in the clause leaves no room for any form of direct payment by a subscriber/enrollee for a "covered" service. All can agree about this—except for the representatives of the state departments of health and insurance along with the entire insurance industry, who are, in my experience, ready and willing to assure us that the language does no such thing. Their most

common explanation is that the clause is solely a provision to protect enrollees from balance billing. In fact, I am confident that the working representatives of these organizations have heard this refrain so often that they believe it's true. I heard it constantly over my 10 years of litigating the issue. However, not one time in all those years did I ever hear exactly how an enrollee could pay for a covered service if he wished to pay. The most I have ever heard, and the reader is likely to ever hear, is "we would let them pay," or "the enrollee is completely free to pay for an uncovered service." Anyone at the top of state government and the insurance industry must know that these two statements are deliberately misleading and therefore false.[2]

Once the Enrollee Hold Harmless Clause is incorporated in a private provider contract, contract law is responsible for interpreting its meaning. And since the language is so clear in barring providers from billing enrollees, and there is no defined limitation on the language, or set-aside or work-around provision, the meaning can only be exactly what the language states. To say "we would let them pay" is a travesty. The issue isn't even whether the insurer will allow an enrollee to pay a provider. It's that the provider has been stripped of the authority to issue a legally enforceable bill. Yes, as a signer of a provider contract, an insurer can assert a willingness to allow an enrollee to be billed for a covered service. However, the provider has irrevocably surrendered the right to issue and enforce such a billing. Furthermore, the Enrollee Hold Harmless Clause is a state-mandated provision that insurers cannot simply and arbitrarily waive.

As to the claim that "an enrollee is completely free to pay for an uncovered service," one really can't find a better example of the industry's willingness to deliberately mislead enrollees and the nation. State law, provider contracts, and the long-established precedent of the insurance industry make it absolutely clear that "Covered Services" are the services available under a managed-care plan, not what an insurer agrees to pay for in a particular instance. As much as insurers would like us to assume differently, a service remains "covered" even though the insurer declines to approve it in a particular patient and denies payment. The Enrollee Hold Harmless Clause only allows providers to bill enrollees for "Non-covered Services" that are typically defined in a managed-care plan as limited to elective cosmetic surgery and experimental treatments. As explained to me in a telephone conversation by David Murdock, the former vice-president of Caron Foundation's legal department, *"We have tried everything and there is just no way under the Enrollee Hold Harmless Clause for an enrollee to pay for necessary care*."

The Effect on the Patient-Physician Relationship

Though a full discussion of this issue is beyond the scope of this article, a few basic observations should be made.

First, the definition of the patient-physician relationship has undergone significant change in recent years as legislators and the courts have wrestled with the changes brought on by the explosion in information technology and, of course, the growth of managed care. Where we were once secure in the view that the relationship is uniquely intimate and personal, legislators and the courts have had to broaden the definition to include physicians who simply come in contact with a patient's confidential data. On the other hand, because of the entrance of managed care into the decision-making process for necessary and appropriate care, these same legislators and courts have had to re-think the basis for assigning liability in cases of medical malpractice. Those countercurrents, not surprisingly, have created tension and uncertainty in defining the modern patient-physician relationship.

Second, even with this change and uncertainty, there remains broad agreement on the underlying basis for the relationship. Doctors are still expected to treat the patient with the same measure of duty, skill, and care as has always existed. Furthermore, the duty owed to the patient remains that of a fiduciary wherein the patient's interests must be paramount to those of the doctor. Fiduciary duty comes from the Latin *fiduciarius*, meaning to hold "in trust." *Fides* means "faith," and *fiducia*, "trust." Or, as one court has stated it, "The patient must necessarily place great reliance, faith and confidence in the professional word, advice and acts of the physician."[3]

Given the language in the Enrollee Hold Harmless Clause, how can such faith and trust exist without disclosure? After all, the only way a doctor can get paid for his time and effort is to agree with the decisions of a third party on appropriate care for an enrollee. That conflict of interest not only dictates whether the doctor will be paid, but also essentially assures that the standard of care will be something less than the highest level of available care, as well as one in which the cost of the patient's care will be balanced against the interests of other patients and the third party's goals for profitability. Or, to summarize the fear in an old aphorism, "When money speaks, truth is silent."

Most states already require physicians to disclose all material information to enable a patient to make an informed decision on care. The California Supreme Court has held that the patient-physician relationship must include a physician's disclosure of economic facts material to a patient's consent or that might affect the physician's medical judgment. The AMA has long advocated that physicians disclose all relevant financial interests to a patient. While these positions limit disclosure to information that is "material" or "relevant" to a physician's medical judgment, can there be any doubt that the conflict of interest created by the Enrollee Hold Harmless Clause qualifies as material and relevant?

While there has been a great deal of debate on whether doctors need to disclose managed care's use of financial incentives to encourage less costly testing, care, and treatment, the issue imbedded in the Enrollee Hold Harmless Clause rises to a much higher level. The use of financial incentives is at the margin of the total cost of care and is computed across the range of a doctor's many patients. The Enrollee Hold Harmless Clause, on the other hand, is focused on the individual patient and is absolute in terms of compensation. Simply put, the only way for the physician and other in-network providers to get paid is to agree with the decisions of a third party that admittedly employs some form of rationing to reduce the total cost of care.

What makes this situation even worse for the physician is that by signing a provider contract with its Enrollee Hold Harmless Clause, which almost certainly also has a provision on confidentiality, the doctor can be accused of participating in a

deliberate attempt to hide this conflict of interest from his patients. How can a doctor argue that he remains an unbiased advocate for a patient's care when the only way he can get paid is to agree with a third party's decision on appropriate care? Furthermore, how can a physician successfully argue that he doesn't understand the severity of the restriction the Enrollee Hold Harmless Clause places on compensation when physicians can be readily shown to struggle with this reality each day of their practice? It is a liability that can only be addressed by refusing to sign such provider contracts, or by disclosing the Enrollee Hold Harmless Clause to the patient as a state-mandated requirement.

Is the Enrollee Hold Harmless Clause Legally Defensible?

Not being an attorney, I will not undertake a legal analysis of the Enrollee Hold Harmless Clause. Fortunately, however, I don't believe such an analysis is needed to get to the truth. After all, there has to be a reason why the states and the insurance industry have kept the clause so hidden and so free from discussion. Where are the articles, the seminars, and the position papers on how to interpret and implement the clause in a provider's everyday practice and billing procedures? Providers are just expected to accept the control that insurers have been given over whether providers get paid.

The Achilles Heel in all this is that, by mandating the Enrollee Hold Harmless Clause, the states have infringed the right of an enrollee to contract and pay for necessary care without any informed consent or process on the part of the enrollee, something most of us understand even without legal training. Remember, no one has explained the Enrollee Hold Harmless Clause to the enrollee, and the enrollee isn't a party to any applicable provider contract or even the managed-care plan. By requiring the clause to be incorporated in every provider contract in a market dominated by managed care, the states have made these companies state actors in a scheme that can only be viewed as depriving enrollees of one of their most fundamental freedoms: the right to seek out and independently contract for the physician and care of their choice outside the interference of an insurance company or the state.

The U.S. Department of Justice acknowledged, in a letter to the White House, that "a more difficult issue is raised if an individual willing to forgo reimbursement of the fee is unable to choose his or her own private physician."[4] And, "States may want to require that these 'Enrollee Hold Harmless Clause' be part of plan-enrollee contracts in order to better defend them as insurance regulation."[5]

Both of these comments are related to the constitutionality of the clause. If the clause were constitutionally defensible, I believe we would have seen what was inside this Trojan Horse long ago. We would have literally had it explained to us chapter and verse!

The Promise versus the Obligation

While managed-care companies sell their plans under the promise of providing insurance for all the care an enrollee will "need," they only obligate themselves to deliver the care they alone decide to supply. In other words, the third-party payer reserves the right to overrule the enrollee's doctor on all decisions on necessary and appropriate care. To achieve this, despite the fact that the law reserves these decisions for properly licensed physicians, the clause is essential. By making it impossible for its contracted network of approved doctors and hospitals to get paid unless they agree with the payer's decisions on necessary and appropriate care, the third party effectively forces these providers to follow its lead in all such decisions.

Exposing the Trojan Horse

The Enrollee Hold Harmless Clause is the beating heart of the managed-care business model and its ever-expanding power to marginalize doctors. Remove the state-mandated language of the clause from the system and the body of managed care would wither and die. However, that is not about to happen.

The clause is buried so deep in the laws and regulations of every state in the country that no amount of lobbying or political pressure can be expected to bring about that kind of tectonic change.

Similarly, no amount of persuasion is likely to unite doctors in refusing to sign provider contracts. The associated costs are too great. On the other hand, the simple disclosure of the clause and its far-reaching consequences can be expected to create all kinds of tension and controversy around its denial of process and contract in the healthcare market.

While a direct assault on the fortress of the Enrollee Hold Harmless Clause may be difficult or impossible, we can still bring about reform and a return to a sound patient-physician relationship. One can simply expose the clause to the bright light of day and allow the ensuing heat to consume it. Physicians should simply follow conscience, the Oath of Hippocrates, and the law, and fully disclose the clause to patients.

It's not just an ethical obligation and moral imperative; it is absolutely required if physicians want to avoid the liability that comes from concealing the clause and the ever-encroaching power of managed care. Furthermore, disclosure carries little or no risk because: 1) It is not physicians' responsibility to change the law or the system in which they are forced to practice, and 2) The physician is only disclosing what is in the law and required by law.

Frank Lobb is a retired businessman, who lives in Pennsylvania. Contact: frank.lobb@kennett.net.

REFERENCES

1 Maryland Health Care Commission and the Maryland Health Services Cost Review Commission. *Study of the Balance Billing Prohibition in Maryland*; 2003.
2 Foley & Lardner LLP. *HMO Insolvency: Implications of the Maxicare Decisions*; January 1990. Available at: http://www.foley.com/intelligence/detail.aspx?int=11590. Accessed Aug 7, 2012.
3 *Witherell v. Weimer,* 421 NE2d 869 (1981).
4 Lobb F. *The Great Health Care Fraud*. Nottingham, Pa.: Kimkris Publishing; 2012:39.
5 Butler P. *ERISA Preemption Manual for State Health Policy Matters*. Alpha Center, National Academy for State Health Policy; January 2000. Available at: http://www.nashp.org/sites/default/files/ERISA_Manual.pdf. Accessed Aug 3, 2012.