

REPORT OF THE BOARD OF TRUSTEES

B of T Report 27 - A-05

Subject: Liability Surcharges in Physician Offices
(Resolution 213, A-04; Board of Trustees Report 20, I-04)

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Referred to: Reference Committee B
(Richard M. Peer, MD, Chair)

BACKGROUND

Resolution 213, introduced by the District of Columbia Delegation at the 2004 Annual Meeting, asked that the AMA study, support and develop guidelines regarding physician “liability surcharges.” Resolution 213 was referred by the House of Delegates to the Board of Trustees. BOT Report 20, “Liability Surcharges in Physician Offices,” was presented at the 2004 Interim Meeting. At that meeting, the House of Delegates referred Report 20 back to the BOT so that the report’s scope could be broadened to develop guidelines regarding all “administrative surcharges,” and to offer physicians further guidance as to when and how both liability and administrative surcharges can appropriately be charged.

DISCUSSION OF ISSUE

AMA Policy

The AMA has no policy directed specifically at physician surcharges. However, AMA Policy H-385.989, “Payment for Physician Services,” (AMA Policy Database) states, “Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment.” (See also H-383.989). Two separate policies, each entitled “Payment for Physicians’ Services,” H-383.990 and H-380.992, support the right of physicians to establish fair and equitable fees.

Additionally, Policy H-285.943 announces the AMA’s opposition to managed care contract provisions that prohibit physician payment for the provision of administrative services, and encourages physicians entering into managed care contracts to seek specific reimbursement for provision of administrative services.

Administrative Surcharges

Physicians are increasingly levying administrative surcharges on their patients to obtain reimbursement for provision of non-medical, non-insurance covered services. While “administrative fees” are not defined in law, the term is commonly associated with fees charged for specific support services such as: providing copies of medical records; filling out forms/writing letters for school, work, travel and other patient activities; phone calls made on the patients’ behalf; emails sent to patients; no-show fees and other services. Administrative fees may also offset costs

1 associated with implementation of unfunded regulatory schemes, such as those imposed under the
2 Health Insurance Accountability and Portability Act, the Occupational Safety and Health
3 Administration and Clinical Laboratory Improvement Amendments regulations, and health
4 information technology initiatives like electronic medical records. In short, administrative fees are
5 charged to cover the cost of administrative functions surrounding the provision of medical care. In
6 contrast, “liability surcharges” are imposed specifically to defray the cost of medical professional
7 liability insurance (PLI) premiums.

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9 While historically physicians may have provided administrative services free of charge, continuing
10 declines in service reimbursement coupled with rising overhead costs fueled by PLI premiums and
11 regulatory mandates, make medical practice financially infeasible for many physicians unless some
12 costs are passed on to patients. Access to care could be compromised if more physicians find
13 practicing medicine financially unviable.

14 15 **Legal Aspects of and Barriers to Surcharges**

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17 Administrative and liability surcharges attempt to offset different costs borne by physicians.
18 Physicians will find they have greater leeway, though still subject to restrictions, in implementing
19 administrative surcharges as compared to liability surcharges. Reimbursement rates paid
20 physicians by private insurers usually are intended to account for liability premium costs, and
21 physicians are usually contractually prohibited from “double charging” patients for costs already
22 reimbursed. Administrative fees, however, typically cover non-reimbursed services. Because
23 physicians are not receiving double payments by charging patients for these services, physicians
24 are more likely to be able to implement these fees.

25 26 **a. Administrative Surcharges**

27 28 **i. Privately-Insured Patients**

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30 Private payer contracts and state law and regulations may prevent physicians from charging
31 patients for any services already reimbursed to the physician by an insurer. Physicians may be able
32 to charge patients for non-insurance-covered services, such as certain administrative services.

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34 Contracts between private health care insurers and physicians may consider that administrative
35 costs a physician incurs are “bundled,” or included, in health service payments made by the payer
36 to a physician. Contracts will commonly prohibit physicians from charging a patient redundantly
37 for costs already bundled. Because most contracts do not clearly define which services are covered
38 or bundled, physicians will have to determine with each insurer with whom they contract whether
39 administrative costs are already reimbursed.

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41 Contracts may also forbid physicians from charging patients any fees “above and beyond” what the
42 payer agrees to reimburse to the physician, even if costs associated with administrative tasks are
43 not specifically prohibited.

44
45 State balance billing laws commonly prohibit “in-network” physicians from charging patients for
46 covered services. To avoid violating these laws, physicians should survey their state’s laws with
47 the assistance of counsel, and, if a balance billing law exists, determine what services are covered
48 under contract. Violation of balance billing laws may lead a health plan carrier to de-select a
49 contracting physician from its network, among other penalties.

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2 State insurance regulations complicate the issue and should also be reviewed with the assistance of
3 counsel. Certain states protect enrollees in private insurance plans from being billed for any sums
4 beyond what the insurance company reimburses, aside from co-payments and deductibles. (See
5 e.g., Connecticut Code § 381.193(c) and § 20-7(f)(9)(b) (2004)).
6

7 Physicians are advised to retain counsel to review their contracts and determine if applicable
8 “balance billing” restrictions exist. Where a contractual barrier exists, physicians may consider
9 renegotiation to assure adequate payment for administrative costs either directly from the payer or
10 by surcharging in-network patients.
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12 **ii. Publicly-Insured Patients**

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14 The propriety of administrative surcharges is difficult to assess in respect of Medicare or Medicaid-
15 covered patients. Physicians can bill patients only for services not covered by and unrelated to
16 those billed to Medicare or Medicaid. Again, what constitutes a covered charge is not clear.
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18 The Health and Human Services’ Office of the Inspector General (OIG) alert (*OIG Alerts*
19 *Physicians About Added Charges For Covered Services*, Mar. 31, 2004) reminded physicians that
20 “when participating providers request any other payment for covered services from Medicare
21 patients they are liable for substantial penalties and exclusion from Medicare and other Federal
22 health care programs.” The OIG takes the position that non-participating physicians could also be
23 “subject to penalties and exclusion for overcharging beneficiaries for covered services.” The OIG
24 indicated that Medicare already reimburses for services like “coordination of care with other
25 providers,” “a comprehensive assessment and plan for optimum health” and “extra time” spent on
26 patient care. While certain services may not be reimbursed by Medicare, the OIG has not provided
27 any clarification or guidance.
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29 Physicians are urged to check with their regional Medicare and Medicaid carriers for guidance on
30 whether the administrative and overhead costs portions of the Medicare physician fee schedule
31 already reimburse for the provision of the particular administrative service of interest to the
32 physician.
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34 **b. Liability Surcharges**

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36 As detailed in “Liability Surcharges in Physician Offices,” (BOT Report 20 (I-04)), network
37 service contracts between physicians and private insurance payers often prohibit physicians from
38 levying redundant or supplementary charges upon insured patients. State law and regulations may
39 impose similar restrictions. Likewise, physicians who accept Medicare and Medicaid
40 reimbursement are prohibited from charging publicly insured patients for costs associated with PLI
41 because these costs are already accounted for in reimbursement rates. In short, substantial legal
42 barriers exist to implementing liability surcharges on patients except for those who are uninsured or
43 pay out of pocket.
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45 **Political and Ethical Considerations**

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47 In instances where physicians are neither prohibited by contract, nor by state or federal law or
48 regulation, from assessing a surcharge, political and ethical implications must next be considered.

1 A physician's thorough explanation to a patient of the reasons behind an administrative surcharge
2 may underscore the value of a physician's time and expertise, and bring attention to declining
3 reimbursement rates and rising overhead. Explanation of the reasons for a liability surcharge may
4 help patients better understand the current medical liability crisis and the connection between costs
5 associated with litigation and the rising cost of healthcare, along with access to care issues.
6 Patients, however, often resent additional charges when their out of pocket health care expenses are
7 rising and physicians remain relatively well-paid.

8
9 If not properly explained, surcharges have the potential to alienate patients and harm the physician-
10 patient relationship. Many physicians believe that administrative and PLI-associated costs must be
11 absorbed by physicians and not passed on if there is any risk of patients losing access to care.
12 Critics point to surcharges as evidence that physicians care predominantly about personal
13 pocketbook issues rather than patient concerns.

14
15 The AMA has no express ethical guidelines regarding surcharges. Physicians do have an
16 obligation to support access to medical care (Principle IX of the "Principles of Medical Ethics" and
17 E-9.065). More specifically, Opinion E-6.12, "Forgiveness or Waiver of Co-Insurance Payments,"
18 states, "When a co-payment is a barrier to needed care because of financial hardship, physicians
19 should forgive or waive the co-payment." By analogy, physicians should not impose a surcharge if
20 it would constitute a barrier to needed care. Surcharges should then be "reasonable" and voluntary.
21 However, in fulfilling their obligation to support access, it is not expected that physicians would
22 compromise the viability of their practice (E-10.05). Ethical considerations caution that
23 surcharges should not be applied without a careful balancing of patient and physician interests
24

25 Notice must be given in advance of implementation of a surcharge (particularly to those publicly-
26 insured). Most physicians offer an opt-out or hardship waiver option. Any fee should be
27 accompanied by an explanation of why it is being instated. Communications should make clear
28 that the patient's decision whether or not to pay will have no affect on the physician-patient
29 relationship or quality of care. A physician cannot treat patients differently based on whether a fee
30 is paid, particularly if the non-paying patient is publicly-insured.

31 32 **Implementing Surcharges**

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34 Implementation of surcharges must be handled with care. Physicians may find barriers to
35 surcharges so significant that they become impractical.

36
37 To start, Medicare and Medicaid patients must be exempted from liability surcharges outright.
38 Assessing an administrative fee is permissible, provided these patients are not charged for anything
39 already reimbursed by the government. Defining exactly what is and is not covered is difficult and
40 misguided efforts will face severe potential penalties. Physicians should consult their local
41 Medicare and Medicaid carriers to determine what services are covered. Implementation of an
42 administrative fee should be preceded by advance notice and explanation.

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44 Next state law restrictions on surcharging publicly and privately insured patients must be
45 identified, along with restrictions in existing network contracts with private payers. Even where no
46 contract restrictions appear, it may still be advisable to inform private payers in advance of
47 implementing a surcharge. Physicians have reported that even where a private insurer does not
48 prohibit surcharges, the insurer is not enthusiastic about this practice.

1 After taking account of these limitations, physicians may find a relatively small number of patients
2 remain eligible for a surcharge. Physicians should consider the fairness and practicality of
3 charging a small portion of their total patient base a surcharge.
4

5 Finally, there are logistical considerations. Administrative surcharges might be administered based
6 on the volume or type of administrative services provided or as a flat, periodic fee. Liability
7 surcharges are typically periodic, assessed annually, quarterly, per visit or otherwise. Physicians
8 may alternatively request a “donation” from patients to help offset administrative costs. Such an
9 approach may be more likely to survive OIG scrutiny, given that the physician is not charging for
10 any particular service rendered.
11

12 **Common Surcharges**

13 State law can affect the appropriateness of the following. Consultation with counsel is strongly
14 recommended.
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16 Widely accepted administrative fees include those charged for:

- 17 • filling out forms for school/camp/employment wellness/disability outside of an office visit;
- 18 • copies of medical records (state law may impose price limitations);
- 19 • no shows for appointments (if equally applicable to all patients); and
- 20 • returned checks.
21

22 Sometimes acceptable administrative fees (subject to verification there are no contractual or
23 regulatory prohibitions) include those for:

- 24 • email consultations;
- 25 • phone consultations; and
- 26 • prescription refill requests.
27

28 Fees that must not be charged publicly-insured patients, and are of questionable validity for
29 privately-insured, include those for:

- 30 • PLI premium offset;
- 31 • coordination of care with other providers;
- 32 • a comprehensive assessment and plan for optimum health; and
- 33 • extra time spent on patient care.
34

35 **Model Contract Language**

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37 Physicians may seek to negotiate with private insurance payers for contract language that permits
38 surcharging. An example of such language, which should be reviewed with the physician’s
39 counsel and tailored to the situation at hand, follows:
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41 *“Administrative surcharges”*: Nothing in this contract shall affect the right the physician-signatory
42 to charge insureds a reasonable and otherwise legal surcharge for individual or aggregated
43 administrative services conducted for the benefit of the insured with the insureds’ agreement after
44 being fully informed about the surcharge and the probability that such surcharge will not be
45 reimbursed by the insureds’ health plan, unless such services are otherwise specifically identified
46 and reimbursed under this contract.

1 “*Liability surcharges*”: Nothing in this contract shall affect the right the physician-signatory to
2 charge insureds a reasonable and otherwise legal surcharge to defray the physician’s liability
3 insurance premium costs, with the insureds’ agreement after being fully informed about the
4 surcharge and the probability that such surcharge will not be reimbursed by their health plan,
5 unless this cost is specifically identified and reimbursed under this contract.

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7 RECOMMENDATION

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9 The Board of Trustees recommends that the following be adopted in lieu of Resolution 213 (A-04)
10 and Board of Trustees Report 20 (I-04) and the remainder of this report be filed:

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12 1) That our AMA support the ability of physicians to institute an “administrative
13 surcharge” and/or a “liability surcharge” where not prohibited from doing so. (New
14 HOD Policy)

Fiscal Note: No Significant Fiscal Impact