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State Laws Related to Billing Third Parties for Health Care Services at Public Sexually Transmitted Disease Clinics in the United States

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Abstract

Background: Health departments (HDs) cite state laws as barriers to billing third parties for sexually transmitted disease (STD) services, but the association between legal/policy barriers and third-party HD billing has not been examined. This study investigates the relationship between laws that may limit HDs' ability to bill, clinic perceptions of billing barriers, and billing practices.

Methods: Two surveys, (1) clinic managers (n = 246), (2) STD program managers (n = 63), conducted via a multiregional needs assessment of federally funded HD clinics' capacity to bill for STD services, billing/reimbursement practices, and perceived barriers were combined with an analysis of state laws regarding third-party billing for STD services. Statistical analyses examined relationships between laws that may limit HDs' ability to bill, clinic perceptions, and billing practices.

Results: Clinic managers reported clinics were less likely to bill Medicaid and other third parties in jurisdictions with a state law limiting their ability to bill compared with respondents who billed neither or 1 payer (odds ratio [OR], 0.31; 95% confidence interval [CI], 0.10–0.97) and cited practical concerns as a primary barrier to billing (OR, 2.83; 95% CI, 1.50–5.37). The STD program managers report that the staff believed that STD services should be free (OR, 0.34; 95% CI, 0.13–0.90) was associated with not billing (not sure versus no resistance to billing); confidentiality concerns was not a reported barrier to billing among either sample.

Conclusions: Practical concerns and clinic staff beliefs that STD services should be free emerged as possible barriers to billing, as were laws to a lesser extent. Attempts to initiate HD billing for STD services may benefit from staff education as well as addressing perceived legal barriers and staff concerns.

Many sexually transmitted disease (STD) programs have experienced budget reductions in recent years, and some STD clinics have been closed in part due to financial considerations.^{1,2} Sexually transmitted disease clinics play an important safety-net role in STD prevention (primarily chlamydia, gonorrhea, and syphilis) by providing confidential, high-quality STD

services and expertise, particularly to underserved populations at increased risk of infection.³ Many STD clinics have also traditionally not billed for services, particularly third parties.^{4,5} Concurrently, health care system changes that are expected to improve access to health care,^{6–8} and reimbursement requirements for certain STD-related services by both private health insurance plans and Medicaid have been implemented.⁹ The combined effect of state budgetary cuts and changes in the health care delivery system¹⁰ have led clinics to explore options for revenue generation, including billing third parties for services. Opportunities for revenue generation may exist, as recent studies have shown that many STD clinic patients have health insurance, yet barriers may exist to patient use of health insurance, including a patient's unwillingness to provide their insurance information due to confidentiality concerns.^{11,12}

Barriers to billing third parties by public clinics have been identified, including credentialing, becoming "qualified providers" to enter into contractual arrangements with Medicaid and Medicare, and issues related to coding and billing systems.¹³ Although often not absolute impediments to billing, policies, such as state laws, local/county ordinances, and health department (HD) policies and regulations may pose barriers to billing of varying degrees. Previous research has identified laws in some states that require the state HD to operate clinics that provide free STD services.¹⁴ Other states require free STD treatment only under some circumstances, such as only certain STD-related services, provided by certain public clinics, and/or only to those with an inability to pay.¹⁴ Enactment of such laws may have been motivated by a concern that individuals in need of care would not have obtained services if they were not "free" to the patient. This may particularly be the case in older laws that originated when public and private insurance coverage was less available. Nevertheless, although these laws are not universal across states and typically apply to a limited set of circumstances, research has found that some programs perceive legal/policy barriers to limit the ability of clinics to bill third parties.¹

Another potential legal barrier is legal requirements that state agencies to transfer collected funds to the state's treasury.¹ These laws are a matter of state financial administration and apply broadly to state agencies (ie, not specifically public health). Nevertheless, research has identified a perception of some public health programs that, even if they implemented a billing system, the money would have to be transferred to the state's general fund and not come back to the program.¹

It is not clear the extent to which these laws may impact programmatic beliefs and actions in current practice, or how programmatic challenges, such as what constitutes an "inability to pay" or the potential of revenue being transferred to the state's treasury, affect uptake of billing. Although policy barriers remain a commonly expressed barrier to HDs billing third parties, the extent to which state laws that may limit billing are associated with HD billing practices, perceptions, and beliefs has not been examined. This study investigates the relationship between laws/policies regarding billing third parties, perceptions of barriers to billing expressed by clinic administrators and STD program managers and billing practices.

MATERIALS AND METHODS

Participants

Data were derived from combining 3 separate data sources into 2 distinct data sets: (1) a survey examining, in part, billing and reimbursement practices within HD agencies/clinics distributed as part of a needs assessment exploring the billing practices and technical assistance needs of clinics receiving funding or assistance from state/city HDs receiving federal funding to support STD program operations (clinic manager survey), and (2) a survey focused on the same topics distributed to funded project areas as part of the aforementioned needs assessment (project area program manager survey); both combined separately with, (3) a legal analysis of state laws relevant to the ability of HDs to bill clients for services through a third party or that impacted the feasibility of implementing a billing system. Although the larger clinic manager survey data set included HD STD clinics, HD Family planning clinics, and community health centers or look-alikes, or planned parenthood or free standing family planning clinics not receiving Title X funding (N = 870, overall response rate of 72%), this analysis included only HD entities and entities receiving funds from the HD to support service provision as the laws examined did not apply uniformly to clinics not administered by HDs. The HD-focused analysis represents 35 states and the District of Columbia (DC) (n = 246) (see Fig. 1 for participating states). Clinic/agency managers, who were in charge of clinic operations and/or billing, responded to the clinic manager survey. If an agency oversaw multiple clinics and all billing was done the same way across all clinics within the agency, an agency representative was allowed to answer on behalf of all the clinics it represented. This survey asked for information specific to the clinic/agency in which the respondent was employed. More information regarding the full needs assessment's findings and methods can be found elsewhere.¹² Project area manager survey data come from STD program managers in project areas funded by CDC (N = 59; 50 states, 7 cities, and 2 territories) and pertained to funded project areas as a whole as opposed to specific clinics or agencies. This survey was specific to the state or city HD, and its subsidiaries are represented by the program manager. Overall, after excluding US territories for purposes of this analysis, 48 states and 7 cities had at least 1 respondent (n = 63); in 10 states, respondents from both the HD STD program and HD Family Planning program managers responded separately. Clinic and project survey data were collected in the first half of 2013 via an online survey tool. The legal analysis of state laws was conducted as of December 2014. This project was deemed exempt from Institutional Review Board review as it did not focus on human subjects; respondents were given the option to participate.

Measures

Clinic Characteristics—In the clinic manager survey, clinic characteristics were collected, including size of the clinic, types of services provided, and billing practices.

Policy Variables—Policy variables were developed through an examination of previous research¹⁴ and an iterative review of state laws (statutes or regulations) identified via a Boolean key word search using Westlaw (Thompson Reuters, New York, NY), an online legal research service. Search terms included: site-type identifiers (eg, STD clinic, public

health clinic), billing requirements (eg, insurance, no fee), and types of payment allowed (eg, third-party payer, sliding scale). Once relevant laws were collected, a single coder with expertise in public health law assigned codes based on (a) preidentified variables related to billing/reimbursement policy issues prevalent in existing literature (based in part on Temple University's study¹⁴ although different in scope), and (b) inclusion of new variables related to billing/reimbursement identified systematically across multiple states during the coding process.

State law requiring free services: The presence of a state law affecting the ability of a HD to bill clients for services through a third-party under at least some circumstances (No/Yes). This included laws that required a public clinic (inclusive of but not limited to STD clinics) to provide "free" services or used similar language (ie, "without charge" or "at public expense") under some circumstance.

State law regarding ability of program to retain collected funds: The presence of a state law requiring state agencies to transfer collected revenue to the state's general fund or another state agency, rather than retain funds within program (no/yes).

State law indicating destination of funds where funds cannot be retained: If the state has a law requiring transfer of collected revenue, the destination of this revenue (general fund, state treasury, or municipal treasury).

Clinic-Level Manager Survey Variables

Awareness of state law or regulation: Respondents indicated whether they knew, did not know, or were unsure if they knew of any state/local laws or regulations that prevent their organization from billing for STD services (hereafter, state laws) (Knew/Did not know/Unsure if knew).

Billing status: Respondents indicated whether their clinic (s) were billing third parties (including Medicaid) for STD-related services (no/yes, billing Medicaid only/Yes, billing Medicaid and other third-party payers). This variable was dichotomized for analyses examining associations between billing status and reasons for not billing.

Reasons for not billing: Respondents were asked to identify the reasons why they were not billing Medicaid and/or other third parties, including Medicaid Managed Care. Reasons were categorized from 10 categories to 4 main categories: (1) funds would not return to the program or would go to the general fund of the government agency that provided annual funding for the clinic (the agency/clinic may not be able to retain collected funds), (2) staff felt that services should be free, (3) practical concerns (eg, do not know how to set up a contract with a third-party payer, not enough staff, etc.), and (4) confidentiality concerns (eg, do not want an Explanation of Benefits to go to the policyholder). Respondents could select multiple reasons. The ability to retain funds at the agency/clinic level, a belief that services should be free, and confidentiality concerns were addressed by a single measure, separately (selected/not selected). Selection of any of 6 items indicating practical concerns was used to

create a single measure (selected/not selected). In addition to those who reported not billing, respondents could select a barrier to billing if they billed some payers but not others.

Project Area Program Manager Survey Variables

Resistance to billing: respondents' perception of resistance to billing for STD services in their project area (no/yes/not sure).

Main barriers to billing: respondents were asked to identify the reasons why they were not billing in their funded clinics; options were identical to the "reasons for not billing" included in the clinic manager survey.

Data Analysis Plan

These analyses assess the association between: (1) awareness of a state law regarding an organization's ability to bill for STD services and presence of a state law requiring free services, (2) presence of a state law requiring free services and their billing status, (3) billing status and self-report of why the agency/clinic was not billing, (4) a state law regarding ability of program to retain collected funds and the perception that a program's inability to retain collected funds is a barrier to billing for STD services, (5) resistance to billing within a funded area and perceived main barriers to billing, and (6) belief that STD services should be provided without cost and a state law requiring free services. Associations 1, 2, 3, and 6 were addressed using the data from the clinic manager survey; associations 4, 5, and 6 used data from the project area program manager survey.

Descriptive statistics were calculated using SPSS v21. The analyses examining associations 1 and 3 were conducted in Mplus v7 via binomial logistic regression, and the analysis examining association 2 was conducted in Mplus v7 via multinomial logistic regression using the TYPE = COMPLEX command and specifying maximum likelihood parameter estimates, resulting in odds ratios (ORs) and 95% confidence intervals (CIs) which were adjusted to account for correlation introduced through the clustering of responding clinics within states. Associations 4 and 6 were examined in SPSS v21 via binary logistic regression for the project area program manager survey; association 6 was examined in Mplus v7 via binomial logistic regression for the clinic manager survey. Multinomial logistic regression was used to examine association 5. Although more than 1 entity per state responded to the funded project area program manager survey in a very few cases, there was an insufficient number of clusters to support an analysis correcting for any correlation this may have introduced. Findings with *P* values of 0.05 or less where confidence intervals did not include 1 were considered significant.

RESULTS

Clinic Manager Survey Findings

In all, 246 HD agency/clinics participated in the clinic manager survey. Legal analysis indicated that, of the states included in the billing needs assessment, 10 states and DC had a law that required public clinics to offer free services, at least in some circumstances, and 8 states had a law addressing retention of funds (Fig. 1). More of these states could be found

in the southern United States ($n = 6$); no states came from the western United States. See Table 1 for descriptive information regarding participating clinics.

Respondents in states without a law requiring free services were less likely to report awareness that the state had a law that prevented billing as compared with those whose state laws required free services (OR, 0.314; 95% CI, 0.156–0.634; $P > 0.05$) (Table 2). If their state had a law requiring free services, respondents were less likely to bill Medicaid and other third-party payers than to bill neither (OR, 0.31; 95% CI, 0.10–0.97; $P > 0.05$).

Respondents trended toward being less likely to bill third-party payers if they identified, as a reason for not billing, that funds would not return to their agency/clinic (OR, 0.43; 95% CI, 0.19–0.98; $P = 0.09$) or that the staff felt that STD services should be free (OR, 0.34; 95% CI, 0.13–0.90; $P = 0.07$). Conversely, they were more likely to bill third parties if they identified practical concerns as a barrier (OR, 2.83; 95% CI, 1.50–5.37; $P = 0.007$). There was no association between billing and identifying concerns about confidentiality (OR, 0.62; 95% CI, 0.37–1.06; $P = 0.14$). Likewise, there was no association between presence of a state law requiring free services and a belief that services should be offered for free (OR, 1.26; 95% CI, 0.39–2.30; $P = 0.53$).

Project Area Program Manager Survey Findings

Overall, 63 respondents from 55 funded project areas participated in the project area program manager survey. Fifteen (23.8%) respondents were located in states ($n = 10$) with a law addressing retention of funds. Within these 10 states, collected funds were directed to the state treasury/treasurer ($n = 8$), the general fund ($n = 1$), and the municipal treasury ($n = 1$), and thus would not necessarily return to the program. Although respondents from 13 (27.1%) project areas indicated funds may not be retained by the program as a barrier to billing, there was no association between having a law regarding retention of revenue and respondents' perception funds may not return to the program/go to a general fund (OR, 0.18; 95% CI, 0.02–1.52; ns) (Table 3).

The majority of respondents did not perceive resistance to billing in their project area ($n = 33$, 52.3%), though the remainder were evenly divided between perceiving no resistance and uncertainty if there was resistance ($n = 13$, 20.6%), respectively. Respondents who indicated there was not resistance to billing were less likely to indicate that staff believed services should be free than respondents who were unsure if there was resistance to billing (OR, 0.20; 95% CI, 0.05–0.85; $P = 0.03$) (Table 3). As no respondents indicated that confidentiality was a main barrier to billing, it was not included in the analysis. As with the clinic manager survey findings, there was no association between having a state law requiring free services and endorsement of a staff belief that services should be offered for free (CI = 1.16, OR = 0.31, 4.32, ns).

DISCUSSION

This analysis examined awareness of billing practices by providers of STD care and the alignment of these beliefs with state laws requiring the provision of free STD services. Respondents in states with laws requiring free services had more certainty that there was a

law preventing them from billing third parties than respondents in states without such laws. The attention that legal barriers to billing has received in the literature has perhaps increased uncertainty of legal barriers among those who lack knowledge of their laws by creating a general perception that these laws may exist. Furthermore, among clinics that were not billing third parties and were located in states without restrictive laws, few believed that legal barriers to doing so existed. This would seem to indicate that few would benefit from broad educational campaigns about legal barriers to billing. Alternatively, these data may be used to identify and target programs for outreach who believe there are barriers when in fact there are none.

Although agencies/clinics located in states with laws requiring free services were also significantly less likely to bill Medicaid and third-party payers than agencies/clinics in states without such laws, staff beliefs that STD services should be free emerged as a possible factor complicating the decision to bill. This may indicate that attitude about the role of public health in a community is an important factor in deciding to bill, notwithstanding beliefs about laws. The long-standing convention of free provision of STD services by public health agencies may be culturally ingrained in some areas,⁴ although despite this and the presence of practical barriers to billing, multiple agency/clinics respondents are billing regardless. Interestingly, those who indicated that practical concerns were a barrier were actually more likely to bill. It is possible that these respondents encountered practical barriers when exploring or developing billing capacity. Regardless, our findings might suggest that, should practical concerns be overcome, a possible factor undermining the development of a billing program might be attitudes about how it could affect the public health mission of providing needed services.

These findings were partially supported by findings from the project area program manager survey. As compared with STD program managers who were unsure of resistance to billing in their project areas, STD program managers who did not perceive resistance to billing in their project area were less likely to endorse a staff belief that services should be free as a main barrier. As with the clinic manager survey, there was no link between a state law limiting billing or confidentiality concerns and actual billing practice. The results of this analysis would suggest that state laws are merely one of several barriers to public STD clinics billing third parties for services in the states included in the survey.

This analysis has some limitations. This study was cross-sectional, and findings are not generalizable to the larger population of HD clinics, especially those with Title X funding as those agencies/clinics were not included in the needs assessment. Some key findings should be interpreted with caution. In the agency/clinic assessment, the associations between billing status and (a) retention of funds and (b) a staff belief that services should be free did not reach significance at *P* values of 0.05 or less though the confidence intervals for both estimates do not include 1; as such, those findings have been described as trending toward significance. It is possible that the findings would be more robust with an increased sample size. Likewise, the project area program manager survey findings should be interpreted with caution due to its relatively small sample size (*n* = 63). The framing of the legal issues underlying legal variables was based on the types of legal issues specific to billing previously discussed in the literature^{1,14}; it is not inclusive of all potential legal barriers to

billing third parties for services, including confidentiality and minor consent. State laws may have changed since the time of this analysis, and various health system changes have occurred since 2013. Accordingly, this should not be accepted as a current reflection of state laws or the US health care system. Additionally, this analysis did not consider non–state-level legal/policy barriers (ie, local or contractual); the few clinics that are not currently billing and who cite laws/policies as a barrier may be referencing laws that are outside the scope of this analysis.

These results suggest that billing is more likely to occur in jurisdictions without a law explicitly requiring free provision of STD services. Barriers to billing are both attitudinal (belief that services should be free) and practical (eg, budgeting, including up-front and ongoing billing infrastructure costs and training). Thus, future efforts to bill for STD services may need to address not only the “hows” of billing, both practical and financial, but also overcome objection to the “whys” by the staff who believe the provision of STD services should remain free. Policymakers and stakeholders considering third-party billing may wish to consider practical and financial barriers to billing, as well as how state laws could be perceived as influencing billing practices.

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Figure 1.

State laws potentially limiting the ability of public clinics to bill third parties for services and retain collected revenue. This figure includes only the 36 jurisdictions that represent respondents to the clinic manager survey. Laws requiring public clinics to provide free services do so in a variety of ways, sometimes under only some circumstances. A lack of a bar indicates that a state lacks a relevant law.

TABLE 1.

Attributes of Participating HD Clinics (N = 246)

	n (%)
Legal status *	
No state law requiring STD services provided for free	150 (61.0)
State law requiring STD services provided for free	96 (39.0)
Types of agency/clinic	
HD STD clinics	159 (64.6)
HD family planning clinics	66 (26.8)
Other	21 (8.5)
Payers billed	
Not billing Medicaid or other third-party payers	118 (48.0)
Billing Medicaid and other 3rd party payers	72 (29.3)
Billing Medicaid only	56 (22.8)

* Results from the legal analysis. All other results from the clinic manager survey.

TABLE 2.

Findings From the Clinic Manager Survey (N = 246)

	Association 1		Association 2		Association 3*		Association 6	
	State Law Requires Free Services	OR (CI)	State Law Requires Free Services	OR (CI)	Billing Status	OR (CI)	State Law Requires Free Services	OR (CI)
Agency awareness of law regarding billing								
Not sure if aware vs aware		0.26 (0.05–1.30)						
Not aware vs aware		0.31 (0.16–0.63) [†]						
Billing status								
Billing Medicaid only vs not billing			0.41 (0.12–1.44)					
Billing Medicaid and other third-party payers vs not billing			0.31 (0.10–0.97) [†]					
Barriers to billing								
Retention of funds					0.43 (0.19–0.98) [‡]			
Staff belief services should be free					0.34 (0.13–0.90) [‡]		1.26 (0.69–2.30)	
Practical concerns					2.83 (1.50–5.37) [‡]			
Confidentiality concerns					0.62 (0.37–1.06)			

* Findings are not adjusted to account for all barriers to billing in a single model.

[†] $P < 0.05$.[‡] Although 95% CIs do not cross 1, P value not less than 0.05.

TABLE 3.

Findings From the Project Area Program Manager Survey (N = 63)

	Association 4		Association 5		Association 6	
	State Law Regarding Retention of Funds	OR (95% CI)	Resistance to Billing	OR (95% CI)	State Law Requires Free Services	OR (95% CI)
Barriers to billing			Yes vs No	Not Sure vs No		
Retention of funds		0.18 (0.02–1.52)	4.32 (0.49–38.13)	0.58 (0.15–2.23)		
Staff belief services should be free			0.95 (0.16–5.63)	0.20 (0.05–0.85) *		1.16 (0.31–4.32)
Practical concerns			2.41 (0.60–9.71)	0.70 (0.13–3.92)		
Confidentiality concerns			—	—		

* $P > 0.05$.