

Editor's Notes

Costly Surprises for Patients

“Balance Billing” in an Unbalanced Playing Field—CSA Responds with Anesthesia Billing Practice Statement

By Stephen Jackson, M.D., Editor

The clamor concerning balance billing has risen to the point that now even the *Wall Street Journal*, in its June 23 edition, has published an article on the “Costly Out-of- Network Surprises” suffered by patients who have procedures performed in an “in-plan/in-network” hospital by non-contracted physicians. Indeed, for some time we have heard about several California patients with health insurance complaining to a smattering of our state legislators about balance billing. Judging from the content of many of these complaints, it appears that some patients may know relatively little about how health plans function as insurers beyond the basic fact that they have health insurance (most through their employer), and thus assume that they should be covered for all medical services, be they physicians, hospitals, laboratories, pharmacies, or diagnostic centers. Moreover, some insured patients are of the belief that they should not be held responsible for more than, at most, a minimal co-payment. Belatedly, they discover that one or more of their physicians—many, but not all, of whom are hospital-based—are not contracted participants in their health plan (you pick your term: non-contracted, out of network, non-participant). In fact, that hospital—or even community—may have no participating physicians, reflecting their health plan’s unwillingness to offer reasonable and fair contracts to physicians. This is, indeed, the plight of many of our patients.

The California Association of Health Plans is the prime mover behind legislation (AB 1321—Yee) introduced to ban balance billing for hospital-based physicians. Not surprisingly, there even has been support for such a ban by some physician groups (subcontracting IPAs and medical groups) who would, in the short term, benefit economically from such a legislative mandate.

The vast majority of patient complaints reflect the calculated intransigence of health plans in declining to offer anesthesiologists contracts with reasonable and fair reimbursement. In order to remain economically viable, anesthesiologists finally are terminating existing “abusive” contracts, and rejecting new offers that, upon due study and deliberation, are economically unsustainable. Meanwhile, health plan executives and the investors to whom they owe a fiduciary duty continue to profit handsomely from health care premium dollars which are not spent on delivering care to patients. For the record, we also know of patients who receive (and keep) reimbursements from their health plans intended for their physicians.

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To be even-handed, a few of the billing behaviors cited by patients have, indeed, been maladroit, exploitive and insensitively pursued. However, the truth is that the overwhelming majority of anesthesiologists have been following the reasonable and fair billing practices suggested in a series of articles in previous *Bulletins*. The gist of these recommendations for non-contracted physicians is to explain in advance (when possible) to patients their financial responsibility, and to urge and abet patients in demanding that their health plans meet their responsibilities.

In fact, the Department of Managed Health Care (DMHC) finally has begun to fulfill its mandated responsibility to enforce existing laws that protect patients and their physicians from the abuses heaped on them by health plans. Indeed, recent DMHC actions against Health Net included a \$250,000 fine, but also and more importantly, a restitution of balance billing amounts paid by patients. Organized medicine must assure that the DMHC doesn't waiver from this responsibility. With the pressures of DMHC regulation and the continuing successes of the CMA's RICO lawsuit weakening the previously impenetrable fortifications of the avaricious health insurance conglomerates, some of their recalcitrant moguls now are recognizing the need to contract fairly and reasonably with physicians on the same basis as competing plans.

Hopefully, advocacy by your CSA, the CMA and other specialty organizations will result in a reasoned and fact-based understanding by our legislators of the environment that led to AB 1321's proposal. Even if this bill is, hopefully, defeated, unless this matter is addressed in a satisfactory manner, similar legislation will most certainly be reintroduced in ensuing sessions. In fact, a slightly different bill to prohibit balance billing (AB 2389, Koretz) was introduced *last* year, necessitating expenditure of time and energy by CSA, CMA and other branches of organized medicine to derail that bill.

Some incorrigible for-profit plans already have been arguing that they should reimburse physicians, whether contracted or not, at rates no greater than those paid by under-funded government programs serving vulnerable segments of the population. When these arrogant attempts at coercion fail to succeed, then these same plans actually do propose to pay physicians the same rates available to competitors who have been willing to negotiate and achieve agreements based on mutual consent and particular circumstances.

CSA leadership, in anticipation of future contentiousness in Sacramento over balance billing, believed that it would be prudent for CSA to adopt a statement on billing practices. This document would be presented as part of a cogent argument against any mandate to ban balance billing for anesthesiologists. After all, the *ASA Guidelines to the Ethical Practice of Anesthesiology* (Section I., 1.9) remind

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anesthesiologists that their responsibilities to their patients includes avoiding exploitive billing practices. Accordingly, and after lengthy discussion at the Reference Committee and on the floor of the House of Delegates, the resolution set out below was adopted. An article by CSA legal counsel, Mr. Willett, providing additional background information, including citations to past *Bulletin* articles, is to be found in this issue's Legislative and Practice Affairs Division section.

Statement on Anesthesia Billing Practices (Adopted by the CSA House of Delegates, May 14, 2005)

1. Bills to patients should not exceed usual, customary or reasonable fees, as defined by the California Court of Appeal in *Gould v. W.C.A.B.* (1992) 4 Cal. App. 4th 1059, taking into account the physician's usual fees and other factors, which particularly include the fees usually charged in the geographic area in which the services were rendered.
2. Fees negotiated by anesthesiologists with health plans cannot be the sole measure by which fees paid by non-contracted plans are determined. Other measures that can be used to determine reasonable fees include the extent that the non-contracted plan provides similar ease of billing, certainty of collection, a comparable volume of referrals and ease of appeal, and also meets other reasonable criteria for comparison; and
3. Anesthesiologists, when billing non-contracted health plan patients directly, whether initially or for balances unpaid by the health plan, should provide an explanation to patients why this process is required, and assist patients in securing payment to the physician by their responsible health plan, seeking patient responsibility only as a last resort when the health plans refuse or fail to make timely payment of reasonable fees for services rendered.