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Legislative and Practice Affairs Division

Balance Billing Issues Threaten Anesthesiology

CSA House of Delegates Declares CSA Policy

By David E. Willett, Esq., CSA Legal Counsel

California anesthesiologists have enjoyed relative peace and prosperity for the last few years. Hospital administrators modified their attitudes as anesthesiologists became scarce. Even health plans began to temper their ways, as anesthesiologists learned to fight back. Hospitals have not been so eager to furnish muscle for health plans. Ambulatory surgery centers provide anesthesiologists with new opportunities.

Partly because anesthesiologists have been successful in combating health plan abuses, the profession faces a new threat. CSA's legislative advocates continue to contest inequities in government program and workers' comp funding, and other issues such as CRNA claims to independent status. However, the most urgent issue facing anesthesiologists in the 2005 legislative session involves bills targeting balance billing of patients whose insurers and health plans have avoided contracting with anesthesiologists. Many carriers are beginning to offer reasonable fees to anesthesiologists, and more and more contracts have been signed. However, balance billings as a number of health plans continue stonewalling anesthesiologists, refusing to agree to reasonable reimbursement, has prompted new legislative proposals.

The most threatening of these proposals is contained in AB 1321, authored by Assemblyman Yee of San Francisco. The bill is sponsored by the California Association of Health Plans (CAHP). A legislative analysis says that it is "supported by labor, consumer and medical groups." The "medical groups" supporting the bill are those that subcontract with health plans.

AB 1321 would provide:

> Commencing March 1, 2006, a hospital-based physician who provides services at a general acute care hospital that contracts with a health care service plan shall seek reimbursement for medically necessary covered services provided to an enrollee of that plan solely from the plan or its contracting risk-bearing organization that is financially responsible for

> the covered services rendered under the contract between the plan and the risk-bearing organization. The hospital-based physician shall not seek payment from individual enrollees for those covered services, except for allowable copayments and deductibles.

In plain words, no more balance billing. Moreover, if enacted as the bill is written, there will be a return to "take it or leave it" health plan fee schedules. Anesthesiologists and other hospital-based physicians will have to look solely to health plans and their subcontractors for payment of services rendered to health plan patients, even if they have no contract with the responsible health plan, IPA, or medical group. While the Department of Managed Health Care (DMHC) is mandated to develop "an independent provider dispute resolution system," there is nothing in the bill requiring health plans to pay reasonable fees. In short, there is no incentive for health plans to offer reasonable contracts to hospital- based physicians, and no leverage for physicians who would be required to seek payment directly from payers, and not from patients. Lawsuits may be the only solution.

AB 1321 is the worst of pending proposals, but there are other bills. SB 417, authored by Senate Health Committee Chair Ortiz of Sacramento attacks balance billing but allows contacting patients if a claim has first been submitted to the identified health plan and the plan "has denied all or part of the claim." At least one potential bill on this topic is under active negotiation.

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Anesthesiology must anticipate that balance billing, patient responsibility, and health plan obligations are going to be the subject of increasing debate. The author of AB 1321 repeats a conclusion expressed by a *San Jose Mercury News* Action Line columnist reacting to a patient complaint ("Balance Billing Taken to the Press," *CSA Bulletin*, Oct-Dec 2003, p. 46) "... You are caught in the middle of a health care tug of war." Even though at least one court ruling (*Prospect Health Service Medical Group vs. St. John's Emergency Medical Group*: see *CSA Bulletin*, Jan-Mar 2004, p. 14) upheld the right of noncontracted physicians to balance bill, public sympathy for patients cannot be ignored. Most anesthesiologists have recognized this and have made every effort to be sensitive to patient concerns. They have tried to enlist patients as allies instead of enforcing patient responsibility, even after billing them. In a few instances, anesthesiologists have

overreached or failed to take the patient's plight into account, and those instances have generated adverse publicity which figures into the current discussion.

Anesthesiologists could forego balance billing if health plans would pay reasonable fees. There is general agreement, in the courts and even by DMHC, as to the definition of "reasonable fees." That frequently cited definition appears in *Gould vs. Workers Compensation Appeals Board* (1992) 4 Cal. App. 4th 1059:

> In deciding whether fees in excess of the schedule are reasonable, the WCAB may consider evidence regarding the medical provider's training, qualifications and length of time in practice; the nature of the services provided; *the fees usually charged by the medical provider; the fees usually charged in the general geographic area in which the services were rendered; other aspects of the economics of the medical provider's practice that are relevant; and any circumstances of the case* (emphasis added).

The definition of "fees usually charged" will be at the center of further discussions. Health plans and other payers have already signaled efforts to include all payments received by anesthesiologists in the calculation, including Medicare, Medi-Cal, and workers' compensation. This approach, of course, ignores that fees "charged" are quite different than fees paid under these programs to the physician, who has no opportunity to bargain. When rebutted, payers offer a second argument. They assert that physicians who accept a stipulated fee under a contract have established their reasonable charge to all payers, whether contracted or not.

Giving noncontracting payers the status of plans that have entered into bilateral, voluntary agreements is clearly inappropriate. At the same time, anesthesiologists argue that their usual charge, the per unit fee or "rack rate" which is charged patients, is equally applicable to noncontracted health plans. That position has yet to be tested. The CSA House of Delegates Statement on Anesthesia Billing Practices (p. 5) is not an "all or nothing" assertion which precludes any middle ground between rack rates and contracted rates.

When it comes to getting paid, it is true that even a noncontracted health plan is distinguishable from individual patients. The responsibility of health plans to pay may be less uncertain. Billing a plan may be easier and cheaper, arguably without the need to bill repeatedly. Courts may recognize these distinctions between health plans and individual patients. However, courts as well as DMHC should recognize that the difference between arrangements with contracted plans and the obligations of noncontracted plans and their subcontractors are "aspects of the economics of the medical provider's practice," and thus are factual circumstances

which must be considered. Dr. Patricia Dailey's article, "Hospitals to Anesthesiologists: Our Way or the Highway," *CSA Bulletin* Oct-Dec 2004, p. 19, offers a "how to" guide for evaluating payments by various payers and will be very valuable in any discussion of reasonable fees under third-party arrangements. The House of Delegates' resolution anticipates such discussions whenever anesthesiologists and health plans are forced to address health plan responsibility as a substitute for patient responsibility. A more extensive discussion of applicable law can be found in "Billing Patients–What Are the Limits?" *CSA Bulletin* Apr-June 2003, p. 14. Anesthesiologists must be alert to new pressures in this aspect of their practice.

Presentation of Resolution to Linda J. Mason, M.D., CSA President

By William E. Barnaby III, CSA Legislative Advocate

Thank you, Madame Speaker. It has been my pleasure to represent CSA for almost 14 years, and my father's pleasure to represent CSA for over 27 years.

In that time, we have worked with many CSA presidents and experienced their own special mark that they leave on the Society. It has been my observation that past presidents are often forgotten–unless they establish a role for themselves post presidentially.

For example, Dr. Sullivan is the ASA Director for California, and Dr. Jackson is the *Bulletin* Editor, but not all past presidents find a niche for themselves.

I just mention this as food for thought so that this treasured body of knowledge and experience can be more effectively utilized as anesthesiology faces increasing challenges from health insurers, ancillary practitioners, and worst of all–other physicians acting as business people under the guise of their medical degrees!

Having said that, it is an honor to present this resolution from the California Legislature to our outgoing President, Linda J. Mason, M.D.

Dr. Mason has left a legacy of keeping the faith, or the status quo–something that has not been easy, given the constant attack by the evil forces previously mentioned. She has worked tirelessly with us, legal counsel David Willett and Phillip Goldberg, and the CSA staff.

During her tenure, CSA beat back last year's "balance billing" bill, only to see the issue return this year. It is one issue that will not be resolved during Dr. Mason's presidency.

However, under Dr. Mason's presidency, CSA completed a reorganization that was difficult, but the Society kept moving smoothly, which is a credit to the leadership of Dr. Mason.

In sum, Dr. Mason's firm hand on the helm of one of the Society's most tumultuous years speaks leagues of her ability to navigate CSA through the storm of turbulent seas towards the goal of a calmer working environment for every CSA member–even those anesthesiologists who are not members of CSA. We are not there yet, but under her leadership we have made strides to achieve that goal.

Dr. Mason, on behalf of your representative, Assemblyman Bill Emmerson, D.D.S., (R-Rancho Cucamonga), it is a pleasure to present this resolution to you.

On behalf of CSA, thank you for a job well done!