

Balance Billing Taken to the Press

Reported by Stephen Jackson, M.D., Editor

The *San Jose Mercury News (SJMN)* has a column known as “Action Line,” written by a Mr. Rochstroh, in which readers request advice on various matters. One such column was devoted to the failure of insurance companies to provide panels of physicians for various specialties.

A patient gave birth at a local San Jose hospital and later received a bill from an anesthesia group for her labor epidural. The patient’s husband wrote that the bill “had an unusually high balance after the insurance payment.” He had discovered, after the fact, that the anesthesiologists in the group providing obstetrical coverage at the hospital were not preferred providers. His complaint revolved about the fact that because the insurance payment was so small that, in addition to his co-pay he also was responsible for the balance, a sum which proved to be a significant percent of the total bill. He offered that he was using a preferred provider hospital and obstetrician—so why not the anesthesiologist?

The *SJMN* column’s reporter stated to the patient that “you are caught in the middle of a health care tug of war.” He related that the hospital’s chief administrator claimed that “... since Blue Cross basically has no panel of physicians at their contracted hospitals, they let the patient deal with the issue.” The patient also lost an appeal to Blue Cross for the low payment that allowed for the non-contracted anesthesiologist.

Craig Berlinberg, M.D., the president of the group of anesthesiologists, had “harsh words” for Blue Cross: “Unfortunately, some health plans, such as Blue Cross, punish patients financially when they receive services from a non-contracted provider, even when an adequate network of providers has not been established.” ... [His] group “now has to deal with patients’ financial burdens brought upon them by their health plan’s abandonment.” Blue Cross’s only comment was that they “understand the situation.”

Perhaps our readers would like to see Dr. Berlinberg’s full letter of response to Mr. Rochstroh:

Thank you for forwarding [the patient’s husband’s] letter regarding his experience with charges for anesthesia services provided by our group and for allowing me to comment on this matter.

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First of all, my group is not the only provider of anesthesia services in Santa Clara County. We also are not the sole provider of anesthesia services at the hospital. Finally, we are also stung by this unfortunate situation.

My group, like any other service provider, bills charges based upon a usual, customary and reasonable rate (UCR). Insurance plans typically contract services for health care at a discounted rate, often at rates far below the UCR. My group has several dozen contracts with health care insurance plans; however, Blue Cross PPO is not among them because the discounted reimbursement rate offered has been unacceptably low. Apparently many other anesthesia groups in the County have come to a similar conclusion. We live and work in one of the most expensive places in the nation, yet reimbursement for physician services is below average. Many physicians have left the area because of this issue, and recruiting quality providers has suffered. Mainly for these reasons, my group has decided not to be a Blue Cross Prudent Buyer Preferred Provider, and it has not been for over three years, a fact well known to the obstetrician and facility involved in this situation. This also is evidenced by our absence on the Blue Cross PPO preferred provider list.

Unfortunately, some health care plans, such as Blue Cross, punish patients financially when they receive services from a non-contracted provider, even when an adequate network of providers has not been established, as is required by law. The result is that my group, in addition to providing quality care, now has to deal with patients' financial burdens brought upon them by their health plan's abandonment, such as has occurred with the patient in question.

My group has, and will continue, to negotiate with health plans to obtain reasonable reimbursement for our services, and to maintain quality anesthesia care for our patients. In the meantime, we also are committed to continue to help our patients to cope with the cost of our services when their health plan fails them.

It is ironic that just a few days after the above correspondences—but before SJMN publication of the above-mentioned column—and pursuant to several months of negotiations, Dr. Berlinberg's group actually reached an agreement with Blue Cross Prudent Buyer PPO and now are contracted providers.

And, a few days after the SJMN publication, another patient, who had an enlarging neck mass that required surgery, wrote of being a victim of a health insurance company. Her ENT surgeon had scheduled her surgery at a non-contracted ambulatory surgery center, which informed the patient that nothing would be covered by her insurance plan. Her surgeon, who was a participant in

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her health care plan, had no privileges at facilities that were approved (covered) by her plan. She decided to pay for all non-covered services, which apparently included everything except her surgeon. She ended her letter to “Action Line” with *“Now I feel like a victim. The [health insurance] company didn't have to pay for my medical care. How convenient.”*

Epilogue by Craig Berlinberg, M.D.

In Santa Clara County there is another major health care insurance plan whose subscribers have a grossly inadequate panel of contracted anesthesiologist providers. This plan, in essence, punishes its subscribers for this situation. Here are some questions to consider:

1. Should this health care plan be forced to disclose that in order to utilize contracted anesthesiologists, their subscribers are, for most intents and purposes, limited to having surgery at Santa Clara County Valley Medical Center or Stanford University Hospital?
2. How does a health care plan go unpunished by the Department of Managed Health Care while having forced thousands of its subscribers in Santa Clara County to go “out of network” because an adequate specialist network (and not just anesthesiology) does not exist. How is it permitted to contend that those subscribers that do go “out of network” (for specialty care) do so as a “matter of choice?”
3. Why should these subscribers be punished financially for their health care plan's failure to provide adequately covered physicians' services?
4. If the Department of Managed Health Care exists to protect consumers, then why have they done **little or nothing** to correct this situation?

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