On Your Behalf …
Legislative and Practice Affairs Division

Out of Network, Not Out of Mind

By Kenneth Y. Pauker, M.D.
Chair, Division of Legislative and Practice Affairs; Associate Editor

The clash between physicians and health insurers continues to escalate, nationally and state by state, and it is being played out on multiple complex and interrelated levels. In California, health care service plans and their trade groups, such as the California Association of Health Plans (CAHP) and California Association of Physician Groups (CAPG), have been particularly aggressive in trying to force themselves into what they claim to be a high ground between patients and physicians, professing to have a responsibility to uphold quality care and to restrain costs for patients. Independent Practice Associations (IPA)—risk-bearing entities interposed between health plans and physicians—manage care and disperse dollars, rewarding "risk" and paying "extra" for "performance," mostly by primary care practitioners, and limiting rewards to specialists, all the while capturing substantial dollars for corporate managers and physician shareholders. The IPAs have incomplete networks of specialists, despite requirements of the Knox-Keene Act, and therefore their patients present for both elective and emergency services to noncontracted practitioners. The rules concerning the balance billing of patients, particularly for out of network HMO patients who present for emergency care, have been completely rewritten by the California Supreme Court with the *Prospect* decision. This, without further legislation to define exactly how to determine what is fair and reasonable and prompt payment for out of network services, further and sharply tilts the already uneven playing field toward insurers and plans. Moreover, it draws to the horizon the ominous specter of potential fee setting by others for physician professional services, bringing physicians one step closer to being treated by healthcare planners and consumers as a commodity, one step closer to our feeling like tools of the medical-industrial complex.

In a striking example of what seems to be legislating from the bench, the California Supreme Court recently overturned the Appeals Court judgment in *Prospect* (see Goldberg piece). Essentially, this abolished the ability of

non-contracted practitioners to bill Knox-Keene patients for any discrepancy between the usual and customary charge and that sum paid by the health plan for the emergency services covered by that plan (so called "balance billing"). With this usurping of legislative intent, the court emphatically "took the patient out of the middle" once and for all. This is notwithstanding the fact that the health plans created the problem and put the patients there. How to determine what is fair and reasonable payment for these noncontracted emergency services was a question asked repeatedly by Cindy Ehnes, Director of DMHC, at the public hearings on the regulation to label "balance billing" as an unfair billing pattern. The plans have their own individual internal-dispute resolution mechanism, DMHC has its own (as yet unused), and the courts are available, if physicians want to take the time and resources required to sue plans, as permitted by *Bell v. Blue Cross*. In fact, two years ago CMA leadership developed and vetted within a Technical Advisory Committee a plan of redress, but the general CMA membership, through its delegates to the CMA HOD, then was unwilling, during that political epoch, to embrace its details. Draft legislation, the HMO Fair Payment Act (see Barnaby piece on p. 20)—conceived by the Barnabys (CSA lobbyists), written by Mr. Goldberg (CSA counsel) and vetted within CSA's Legislative and Practice Affairs Division and its Board of Directors—has been transmitted to the CMA for the CMA to develop further and to assume the primary leadership role in advancing it on behalf of all concerned. It soon may be introduced in the state legislature, and therefore looms more important than ever.

So, concerning patients who have health insurance or a health care service plan, the following scenarios may play out in California. All patients who have health plans governed by the Knox-Keene Act (all HMOs and some Blue Cross and Blue Shield PPOs), have been "taken out of the middle" for emergency services, and cannot be balance billed, except for co-pays, deductibles, and noncovered services. The physician may accept what the plan pays or contest it through either the plan's or the DMHC's dispute mechanism, or sue the plan. Patients who have true medical insurance may still be balance-billed for emergency services, but it is predictable that sometime soon the insurers will try to make this illegal as well. For nonemergency services for patients with both insurance and health plans, the practitioner may still bill the patient for non-contracted services, above and beyond whatever the insurer or plan pays. Hence, payments to out-of-network physicians will still be an issue for patients.

Just how insurers pay for out-of-network care for their insureds has increasingly come under intense scrutiny. After a yearlong investigation, New York Attorney General (AG) Andrew Cuomo labeled the construction of the Ingenix (a wholly owned subsidiary of UnitedHealthcare Group, UNH) database as "a scheme to defraud consumers," systematically underpaying patients for more than ten

years. The database was to track payments, and was constructed by having the insurers themselves submit data on what they were paying, often using low-ball figures and including data from government payers. Cuomo gave an illustration of a bill for $200 submitted for a 15-minute visit for a common illness visit to an office, for which Ingenix might determine that the UCR was $77. UNH then pays 80 percent, or $62, when it should have paid $160, and the patient is left with a balance to pay of $138. Cuomo said that the method used to construct the Ingenix database "created a well of conflicts … For years this database was treated as credible and authoritative, and consumers were left to accept its rates without question. This is like pulling back the curtain on the Wizard of Oz. We now have shown that for years consumers were consistently low-balled to the tune of hundreds of millions of dollars."[*New York Times,* 1/13/09, http://www.nytimes.com/2009/01/13/health/policy/13care.html] The patients paid more (were "balance billed"), and the physicians got less because of their failure to collect and, indeed, were writing off substantial amounts of the balances due.

In testimony on October 7, 2008, by Andrew Kleinman, M.D.—a plastic surgeon speaking on behalf of the Medical Society of the State of New York—at a New York State Department of Insurance Hearing on Out of Network Insurance Coverage, he stated that the Ingenix database, known as the Prevailing Healthcare Charges System, was alleged to have deficiencies, such as:

- *Systematically under-reports the actual number of procedures performed in a geographic area and often eliminates the highest charges for each type of medical procedure maintained in the PHCS database*
- *Includes the charges for medical procedures from other, and non-comparable, geographic areas in which the provider charges are lower*
- *Fails to segregate procedures performed by providers of the same or similar skill and experience level, but indiscriminately lumps together all provider charges by procedure code without regard to skill or experience level*
- *Fails to reflect the use of modifiers by providers in reporting charges, thereby aggregating charges that already may be discounted based upon bilateral or multiple procedure discounts*
- *Includes charges for various procedures that are determined by a fee schedule with participating, "in-network" providers, and that reflect a discount from the "usual" or "customary" charge, thereby skewing the data below an accurate "usual and customary" rate*

UNH agreed in a settlement to contribute $50 million to finance a new independent database, which is to determine prevailing rates in various regions. Aetna has agreed to contribute $20 million to support this new database. No criminal charges were filed and there is no directive to reimburse patients, although many class-action suits addressing this issue are working their way through courts across America (not yet in California).

In classic illustration of turning a lemon into lemonade, the CEO of America's Health Insurance Plans (a trade organization), Karen Ignagni, praised United Health for this settlement with Attorney General Cuomo, calling it a "major leadership effort," and pointing out that such data would allow patients, for the first time, to have a way to know what doctors charge for their services before they use them. She argued that such transparency could shed light on "one of the root causes" of rising costs to individuals, namely, what physicians charge for out-of-network procedures in various locales across the country. Hooray, UnitedHealth! Great job! Masterful, Ms. Ignagni—you have been promoted to a five-star spin doctor!

Furthermore, several cases have wended their way through the federal courts in New York and New Jersey since 2000. The plaintiffs—the AMA, the State Medical Society of New York, and the Missouri State Medical Association, as well as some private parties—alleged that UnitedHealthcare and other insurers conspired to underpay patients and physicians for out-of-network care by using the Ingenix grossly flawed database of charges and payments. Just this January, UnitedHealthcare (annual revenue $80 billion, and $4.65 billion in profits in 2007) agreed to settle these suits for $350 million in damages (to be paid in an as-yet-to-be-determined manner to physicians and patients), while not admitting wrongdoing. One attorney has objected that the settlement is far too low.

In July 2008, in a class action suit in federal court in New Jersey, HealthNet settled a case involving two million patients, agreeing to pay $255 million to the patients and to make changes costing an additional $40 million to improve business practices. The allegations were of violations of the federal Employee Retirement Income Security Act, New Jersey's employer health plan law, and the U.S. Racketeer Influenced and Corrupt Organizations Act.

The court in *McCoy v. HealthNet* (one of the federal suits) criticized the Ingenix database as follows:

- *Was a haphazard collection of voluntarily submitted data that was not tested "to see if the data represents an accurate sample of charges for a particular procedure in a particular geographic area";*

- *Excluded several key factors that are core concepts of UCR, including the provider's licensure or qualifications, the patient's age or health status, and the type of facility where the procedure was performed.*

  For example, the court here noted "One might expect that it would cost significantly more to have a highly skilled, Board Certified heart specialist interpret an echocardiogram that it would to have a general practitioner do the same task. The database improperly assumes that these factors are all irrelevant for determining the usual and customary rate charged for particular procedures. Any accurate database would control for these additional factors. Ingenix's failure to control for these factors means that the database is not actually comparing similarly situated procedures when it purportedly yields a 'usual' and 'customary' rate for that procedure."

- *Inappropriately was "scrubbed" of higher charges which should have been maintained in the database. As noted by the court, "The net result of this erroneous assumption is that high charges which are valid, usual, and customary are rejected as unreliable outliers, and are eliminated from the common data, thereby skewing downward the upper percentile values in the final reported data."*

- *Failed to account for the fact that some CPT codes have a wider distribution of charges than others. As noted by the Court, "Ingenix's failure to account for standard deviation when it derives data means that almost any charge above the mean in the less common CPT codes with a higher relative standard deviation can appear to be unusually high when in fact it is a usual and customary fee."*

And the beat goes on. Aetna recently settled with Attorney General Cuomo for $5 million, plus interest and penalties, to repay more than 73,000 college students nationwide who had overpaid for out-of-network services between 1998 and 2008, on account of the Ingenix database. Cigna and WellPoint have settled with Attorney General Cuomo for $10 million each over use of this Ingenix database, and Cuomo has stated that he intends to sue Excellus Blue Cross Blue Shield for manipulating payments for out-of-network services. Moreover, additional lawsuits are accumulating against additional insurers that use this pervasive Ingenix database. On February 9, the AMA, several state medical associations (Connecticut State Medical Society, Medical Society of New Jersey, Medical Society of the State of New York, North Carolina Medical Society and Texas Medical Association), and some individual physicians filed two class-action lawsuits in New Jersey federal court against Aetna and CIGNA, analogous to the aforementioned cases against HealthNet and

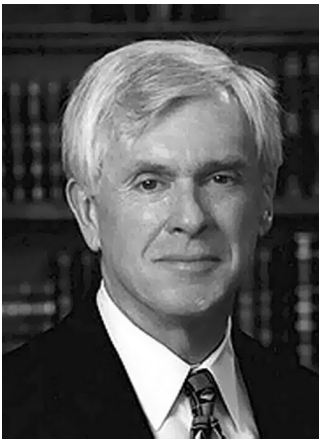
UnitedHealth. In a public relations announcement, a spokeswoman for Aetna expressed disappointment that "the medical community has chosen to litigate on top of already pending consumer litigation on the topic." Despite this kind of contrite disappointment, "right here in River City," the CMA is discussing how it might proceed in comparable fashion.

As we predicted when DMHC promulgated its own regulation defining balance billing HMO patients for covered emergency services as an "unfair billing pattern," private lawsuits have begun. Based upon the *Prospect* decision, which even goes many steps further than the DMHC definition, a class action suit has been filed against Scripps for overcharging emergency HMO patients for many years. It may be a stretch to make this retroactive, but the *Prospect* case did not say specifically that it was not, so here we go, an expected legal feeding frenzy to come, just something that will "help" all of the citizens of California.

The future is unclear and unpredictable, the present uncertain and confused, history subject to being rewritten, and logic as we thought we knew it set aside and overridden. It feels like a vortex swirling all around. What to do? My suggestion is that we all take a deep breath, then stand tall and simply continue to take the high road, focusing on taking care of our patients as best we can, despite economic pressures to give them short shrift. We are not tools, not health widgets, not dispensers of some product. Rather, we are practitioners of a noble profession, inheritors of a long and storied tradition. Understand we should. Participate we ought. Evolve we must.

Stayed tuned. Your CSA is in the hunt and at the table.

Fight for Fair HMO Payment Continues



By William E. Barnaby, Esq.,
CSA Legislative Counsel

While physicians took it literally on the chin in the recent *Prospect* decision, the fight to gain fair payment for out-of-network emergency care continues.

The January ruling authored by State Supreme Court Justice Ming Chin divined intent in the "Knox-Keene" health plan licensing law that had not been perceived by lower courts, the

Legislature, or the Department of Managed Health Care (DMHC). More specifically, the Court held:

> Interpreting the applicable statutory scheme as a whole—primarily the Knox-Keene Health Care Service Plan Act—we conclude that the doctors may not bill a patient for emergency services that the HMO is obligated to pay. Balance billing is not permitted.

Never mind that "balance billing" had long been upheld by appellate courts, or that for the past decade "balance billing" had been the subject of numerous legislative proposals, vetoes, and controversies. And also never mind that the main HMO regulator, the DMHC, earlier found it necessary to propose administrative rules to ban what the Court now deemed unlawful.

In fairness, the Court noted the existence of other remedies and was probably under the impression they are workable. HMOs are required to have "dispute resolution mechanisms" and physicians in 2005 "won" the right to sue HMOs directly "over billing disputes." In reality, neither has proved useful. Litigation is expensive and time-consuming. HMO dispute processes have been found so deficient by physician offices and billing agencies that they have been widely ignored. Which is unfortunate, since factual documentation of their futility is lacking.

Moving Beyond Prospect

"This area of the law might benefit from comprehensive legislation," observed the Court prospectively. Indeed! Now more than ever, it seems.

Resolving the balance billing controversy has long been a challenge facing medicine. As the most severely affected specialty, emergency physicians advanced several plans in recent years mostly focused on giving up balance billing in return for arbitration and interim payments of a percentage of Medicare reimbursement levels. Their vetoed 2008 bill, SB 981, was limited to emergency physicians. It was opposed by CSA, CMA, and other medical groups.

To protect the interests of the CSA membership, rather than just defensively responding to the regulatory and legislative initiatives of others, the CSA leadership decided to take a proactive role. Draft legislation, the HMO Fair Payment Act, is the result. The CSA Board of Directors, in vetting the draft, adopted the principle that the purpose was achieving consensus within the house of medicine rather than moving as a single specialty.

The draft would apply to noncontracted emergency services and would establish a system of "baseball" arbitration to settle payment disputes. The arbiter would

decide between the last, best offers of the physician and the payer, rather than the initial claim of the physician and the initial payment of the payer, as SB 981 specified. A more detailed explanation is better left to a more appropriate time by its chief architect, CSA Legal Counsel Phillip Goldberg.

A Steeper Road Ahead

Many medical leaders have felt balance billing could not be sustained forever. Pressures to end or curtail it from insurers, consumers, and government were constantly mounting. Finding a satisfactory alternative or trade-off has proved elusive.

A key feature of the draft HMO Fair Payment Act involved physicians giving up balance billing once the HMO made an initial payment of the physician's last best offer and agreed to arbitrate the amount in dispute. After *Prospect*, giving up balance billing is no longer a concession. It's gone.

Forcing better physician payment by HMOs and their IPA fiscal agents through legislation has always been an almost impossible sell, notwithstanding the usual understanding of what "reasonable" and "fair" mean. The multimillions spent by the health insurance industry on lobbying and public relations have had awesome influence. The Schwarzenegger Administration has been steadfast in its support of health insurers and managed care on payment issues. Ditto for the business community, as evidenced by the California Chamber of Commerce and other employer organizations. Consumer groups, including labor unions, are not sympathetic, especially if higher resulting premiums are hinted by insurers.

Organized medicine in California has been forced by *Prospect* to regroup. Some have urged a "go slow" approach in light of the Administration's interminable resistance. Others have suggested first developing a stronger factual record showing HMO dispute resolution deficiencies by more vigorously pursuing disputed claims. Billing services have been reluctant in the past because of little or no return on the time and resources invested. The paucity of documented disputed claims has allowed the insurance industry and DMHC to diminish, if not deny, the extent of underpayment. And it has hindered showing the courts and the Legislature the unfairness, if not the serious imbalance, of the present situation.

Discussions of a legislative response continue within medicine. On behalf of CSA, we have insisted that the issue remain a top priority. Physicians may have taken it on the chin, but *Prospect* need not be a knock-out blow. Healthcare cannot be allowed to be controlled by the gatekeepers whose primary concern is how much they can profit from a basic human need. Medicine must champion the lifeline over the bottom line.

The Gould Criteria and Your Billed Charges

By Phillip Goldberg, Esq., CSA Legal Counsel

The California Supreme Court, in the Prospect case, made clear that a non-contracting anesthesiologist providing emergency services to a health care-service plan patient is entitled to a reasonable payment for his or her services. Under applicable regulations, specific criteria—referred to as the Gould Criteria—are used in determining what is reasonable. Although the Gould Criteria may be more effective in preventing a responsible payer from paying too little than ensuring that an anesthesiologist receives full billed charges, it is important that anesthesiologists know how to employ the criteria to their best advantage. The six criteria are as follows:

1. The anesthesiologist's training, qualifications, and length of time in practice
2. The nature of the services provided
3. The fees usually charged by the anesthesiologist
4. Prevailing rates charged in the general geographic area by other anesthesiologists
5. Other relevant aspects of the economics of the anesthesiologist's practice
6. Any unusual circumstances in the case

The following is a narrative example incorporating the Gould Criteria, with references to the specific criteria per the number designations above. Although such a detailed statement could accompany an initial bill to the responsible payer, it is more likely to be included in an appeal after receipt of an inadequate payment from the responsible payer. The example below might help anesthesiologists to understand how the Gould Criteria may be used to support and defend a claim with a responsible payer or an independent dispute resolution arbitrator. This hypothetical case involves anesthesia for an emergency open-heart procedure.

> I wanted to provide comments in support of my bill accompanying this letter to explain why the payment requested for my services is reasonable.
>
> I am a board-certified anesthesiologist and fellow trained in cardiac anesthesia. I have been practicing for more than 20 years with extensive

experience in cardiac surgery procedures that present special problems for anesthesiologists (1).

As with other anesthesia procedures, billing is based upon a basic value, modifying units (if any), and time units. The American Society of Anesthesiologists Relative Value Guide code for this procedure is 00562, which has a base unit value of 20, and 17 time units were involved in this particular case (2). Since this was an emergency procedure, an additional 2 base units are added under the American Society of Anesthesiologists Relative Value Guide Code 099140. A physical status modifier of P5 was used because the patient was moribund and not expected to survive without the operation (6). My usual dollar value per ASA unit is consistent with that charged by other anesthesiologists in the same geographic area, even those with far less experience and training than I have (4). Multiplying the sum of the base units, time units, and modifier units by my dollar value per ASA unit translates to the total fee reflected on my bill (3).

My services were rendered on an emergency basis to address a life-threatening condition. Without the procedure, the patient certainly would have sustained permanent injury, or even died. Because the emergency occurred during the middle of night, I was awakened at home and rushed to the hospital to get the procedure going as quickly as possible. Emergency procedures may involve an additional degree of difficulty simply because there may be less time (if any) for a complete medical history and physical, as well as less opportunity to gather comprehensive information about the patient. Nighttime emergency procedures may be further complicated because the surgeon, operating room staff, and others may not be as alert and well-rested as in the case of an emergency procedure during regular operating room hours (6).

It is important to note that the standard billing methodology—where base units, any modifier units, and time units are multiplied by an ASA dollar unit value—does not take into account the special nature of emergency services where the patient has the greatest need and the physician has the greatest difficulty. As such, standard payment rates for nonemergency services or rates that do not distinguish between emergencies and non-emergencies are not appropriate indicators of the reasonable payment for my services.

> Given the relative scarcity of cardiac trained anesthesiologists, generally, and the particularly acute scarcity at the hospitals where I practice, I have a much more significant call burden than other anesthesiologists who do not provide cardiac anesthesia services. That is, I am required to spend more time on-call for emergencies than are other anesthesiologists who are not trained or otherwise qualified to perform these procedures (5).

The foregoing example involved a cardiac anesthesia procedure by an anesthesiologist with fellowship training and many years of experience. Obviously, the narrative needs to conform to the individual anesthesiologist's own credentials and the particulars of the case involved. An anesthesiologist new to practice cannot mention years of experience but may mention recent training in the latest techniques. In all instances, discussion of the emergent nature of the services should be included because both *Prospect* and the DMHC regulations apply only to emergency care. Accordingly, the additional 2 base units available under ASARVG Code 099140 would be appropriate for any claim to which *Prospect* and the DMHC regulations apply. Although payers may not be sensitive to the claim that emergency services should be compensated differently from nonemergency services, arbitrators should be receptive to this argument if they are considering the Gould Criteria.

Anyone familiar with anesthesia billing would be surprised to find this level of detail accompanying a request for payment. Indeed, other than the ASA code and modifier discussion in the second paragraph, none of the other information provided would typically appear in a bill. This highlights the fact that the Gould Criteria have little, if any, relevance in determining the payment an anesthesiologist receives for his or her services in most cases. It is important to put the Gould Criteria in perspective and realize what they can and cannot do.

Most important, the Gould Criteria prevent responsible payers from arbitrarily designating their own low payment as reasonable. In this sense the Gould Criteria may serve as a "shield" against excessively low rates. They do not serve well as a "sword" to ensure that a noncontracting anesthesiologist receives payment of full billed charges. Billed charges are one of the six Gould Criteria, but this criterion is offset by the prevailing rates charged by others in the area so that outliers are not entitled to whatever they have billed for their services under the Gould Criteria.

For better or worse, reasonableness will always be an issue in the compensation paid to noncontracting anesthesiologists, whether rendering emergency services or not. Consider the extreme hypothetical situation where a noncontracting anesthesiologist provides anesthesia for a 6-unit (ASA)

operative procedure for one hour (four time units) in a nonemergency so that he or she is free to balance-bill. Furthermore, suppose that the value assigned by this anesthesiologist is (just for the sake of exaggeration) $1,000 per unit for a total bill of $10,000. Few if any anesthesiologists would agree that the patient should have to pay $10,000 because the anesthesiologist's billed charges are not reasonable. This rather outrageous example helps to make the point that **reasonableness is always an issue**. It is not likely that lawmakers, regulators, payers, or even organized medicine for that matter can come up with a definition of "reasonable" that has meaningful application in all cases.

For practical reasons, I think a process is better than a definition to arrive at a reasonable payment for noncontracted services. I favor baseball arbitration of last, best offers because it provides the best way I know to arrive at a reasonable fee by encouraging the parties to be reasonable in the first place. I am open to considering another process (or even a definition) to determine reasonableness if **it makes sense for noncontracting anesthesiologists and has reasonable chance of gaining acceptance**. CSA will continue to work with other stakeholders to arrive at the best response possible.

Prospect Decision Significantly Limits Balance Billing

By Phillip Goldberg, Esq., CSA Legal Counsel

On January 8, the California Supreme Court issued its decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*. The decision significantly limits the ability of non-contracted anesthesiologists to balance-bill patients when the responsible payer fails to pay adequately for emergency services. The Supreme Court provided the following succinct statement of its decision on balanced billing:

> [W]e conclude that billing disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment. A patient who is a member of an HMO may not be injected into the dispute. Emergency room doctors may not bill the patient for the disputed amount.

Although the court used the term "emergency room doctors," the balance billing prohibition applies to any anesthesiologist who is not contracted with the responsible health care service plan or its risk bearing organization. The court also used the shorthand term "HMO," but the balance billing prohibition

will also apply to preferred provider organizations and point-of-service plans licensed under the Knox-Keene Act and regulated by the Department of Managed Health Care. In brief, the *Prospect* decision declares illegal any attempt by a non-contracting anesthesiologist rendering emergency medical care to a health care service plan patient from "balance billing" that patient for any part of a disputed reasonable payment amount. In this regard, the decision goes beyond the DMHC's recently promulgated balanced billing regulation, which declared balanced billing an unfair billing pattern. The court's decision effectively eliminates any obligation on the part of the patient to pay the disputed amount and therefore any pressure that might be placed on the responsible payer to resolve the dispute. The court's recognition that the non-contracting anesthesiologist is entitled to a reasonable payment for its emergency services from the responsible payer provides little consolation. The DMHC will almost certainly assert that it may fine providers who balance bill in light of the *Prospect* decision. Whether or not the DMHC has the authority to fine physicians, all noncontracting anesthesiologists are advised to refrain from balance billing patients in any situation where the decision applies.

Various responses to the *Prospect* decision have been considered, including requesting a rehearing, appeal to the United States Supreme Court, and filing a separate federal action challenging the balance billing prohibition. None of these alternatives has much chance of success, and these actions could even be counterproductive. Because the *Prospect* decision will be viewed as protecting consumers, attempts to overturn the decision may be seen as anticonsumer and make relief through a new statute that much more difficult to obtain.

Despite its significant impact, the *Prospect* decision does not apply to all non-contracted services provided by anesthesiologists. Most significant, the decision has **no application to nonemergency services**. Where an anesthesiologist is not contracted with the responsible payer, he or she may continue to balance bill patients when the responsible payer has not paid an appropriate amount for nonemergency services. Even in the case of emergency services, the *Prospect* decision does not apply to patients whose health care coverage is provided by an entity or program not regulated by the DMHC. Accordingly, patients who have coverage provided by their employer's self-funded plan—or through health insurance regulated by the Department of Insurance—are not subject to the *Prospect* prohibition on balance billing for emergency services. It is important to keep in mind that perceived abuses in balance billing for non-emergency services may make it more difficult to ameliorate some of the effect of the *Prospect* decision by subsequent legislation. Accordingly, anesthesiologists are urged to pursue balance billing where it is still available in a reasonable and prudent manner.

The Supreme Court did not precisely define the emergency medical care to which its decision applies. However, given the authority cited for its decision, the definitions in Health and Safety Code section 1317.1 are relevant. In that statute, "emergency services and care" is defined to include "the care, treatment, and surgery by a physician necessary to relieve or eliminate … [an] emergency medical condition" which is defined as:

> … a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in … placing the patient's health in serious jeopardy, serious impairment to bodily functions, [or] serious dysfunction to any bodily organ or part.

Although the court's decision does not elaborate on the "reasonable payment" due to the noncontracting anesthesiologist rendering emergency medical care, the criteria the responsible payer must apply to determine what is a reasonable payment is set out in applicable regulations. Under the Department of Managed Health Care's rule on "Claims Settlement Practices," the payment must be "based on statistically credible information that is updated as least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider: (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case." These criteria, often referred to as the Gould Criteria because of the case in which they were first established, are supposed to prevent responsible payers from setting their payments to non-contracting providers at artificially low levels. Unfortunately, the rule does not always have the intended effect. Even where the criteria are strictly adhered to, they do not result in a precise and objectively verifiable reasonable payment.

In those cases where the Prospect decision applies and anesthesiologists may not balance bill, there are avenues available for redress when a responsible payer fails to pay an appropriate amount. DMHC regulations require "plans and their capitated providers that pay claims … [to] establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve … non-contracted provider disputes." Additionally, the DMHC has established its own independent dispute resolution mechanism to supplement those required of the responsible payers. The existing dispute resolution mechanisms of responsible payers and the DMHC are voluntary procedures, so noncontracted anesthesiologists still have the right to bring a legal action through the courts, small

claims or otherwise. Strict limits apply to the number of claims that can be brought in small claims court and to the amount that can be recovered. The superior court does not impose limits on the number of claims that can be filed or the amount recoverable in a single lawsuit, but representation by legal counsel (with attendant costs) is a practical necessity in most cases and legal necessity in some.

Details on balance billing generally—and the *Prospect* decision in particular—are included in the California Medical Association's Balance Billing Advocacy Toolkit, which is available through the CSA Web Site in the Members Area (http://www.csahq.org/pdf/alerts/Bal_Bill_Toolkit_011409.pdf). The CMA also provides guidance on small claims court actions as well.

2008-2009 GASPAC Honor Roll

By Kenneth Y. Pauker, Chair, Division of Legislative & Practice Affairs

The Greater Anesthesia Service and Political Action Committee (GASPAC) is CSA's venerable political arm. GASPAC's charge is to raise funds and then to disburse them in the service of promoting improvement in the practice of anesthesiology, quality patient care, and public health. As a collateral benefit, GASPAC encourages anesthesiologists and others to be more active and effective in government affairs.

To represent CSA's interests adeptly before the legislature, we must elect lawmakers attuned to healthcare issues. Simply stated, money permits access and GASPAC is the CSA's tool to get it done. GASPAC can accept donations from virtually any individual or entity in California, personal or business, and the funds are in turn disbursed as contributions to candidates for state or local public office, regardless of party affiliation, if they are sympathetic and supportive of GASPAC's objectives.

The new state legislative session is underway, and the cast includes 34 freshman state legislators. On the docket are some very important issues—HMO payments and regulations, expanded scopes of practice for ancillary health professionals, medical peer review, and clinic licensing. Each of these could affect our practices, adversely and seriously. CSA needs to be visible and at the table when these matters appear on the menu. GASPAC enhances our visibility and offsets interests pushing a contrary agenda.

GASPAC has seen an increase in Gold Contributors ($500 annual donation designated by an asterisk). The CSA is pleased with each contribution but is

especially appreciative of those who have stepped up to lead in our efforts to strengthen GASPAC.

The 2008-2009 GASPAC Honor Roll is:

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