

From the CEO

The Brave New World of “Taking the Patient out of the Middle”

What Now, Since You Can’t Balance Bill?

By Barbara Baldwin, M.P.H.



In 2008, California physicians were dealt a triple blow in the quest to retain the right to balance bill patients for amounts not paid by the health care service plan for out-of-network emergency services. First came the Department of Managed Health Care regulation that defined balance billing under those circumstances as an “unfair billing pattern.” This regulation became effective October 15, 2008. The next setback was a state court ruling denying the CSA, CMA, and other stakeholders’ lawsuit to enjoin the DMHC from implementing the regulation in December 2008. Then, on January 2009, the final blow was the state Supreme Court *Prospect* ruling prohibiting balance billing of patients for out-of-network emergency services, overturning a lower court decision that previously held that physicians have the right to balance bill patients for noncontracted services.

It is important to keep in mind that the application of *Prospect* is limited to HMOs and PPOs regulated by the DMHC. DMHC regulates all HMOs but covers only two PPOs—Anthem Blue Cross’ Prudent Buyer and Blue Shield’s Commercial PPO. This means that all PPOs regulated by the Department of Insurance (DOI) are unaffected by *Prospect*. Because it is often difficult to tell whether a patient’s health coverage is regulated by DMHC or DOI, physicians should carefully review a patient’s Explanation of Benefits to determine the appropriate regulator.

What Options are Available for Obtaining Fair Payment?

The theme of all three actions described above was to “take the patient out of the middle” of payment disputes. The new reality is that physicians cannot bill patients directly for the amounts not paid by non-contracted health plans for emergency services. The question that remains, however, is what options are available for obtaining fair payment for physicians. In *Prospect*, the Supreme Court asserted that adequate mechanisms are in place for physicians to resolve disputes over payments:

Additionally, the Legislature contemplated there may be disputes over the amounts owed to noncontracting providers such as emergency room doctors, and therefore the Knox-Keene Act requires that each HMO “shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.” (§ 1367, subd. (h)(2); see also § 1371.38, subd. (a) [directing the DMHC to adopt regulations ensuring that each HMO adopt a dispute resolution mechanism that is “fair, fast, and cost-effective for contracting and noncontracting providers.”]) Finally, the Legislature has acted to protect the interests of noncontracting providers in reimbursement disputes by prohibiting HMOs from engaging in unfair payment patterns involving unjust payment reductions, claim denials, and other unfair practices as defined, and by authorizing monetary and other penalties against HMOs that engage in these patterns. (§ 1371.37; see also § 1371.39 [authorizing providers to report HMOs that engage in unfair payment patterns to the DMHC.]

Filing a Dispute with a Payer’s Internal Dispute Resolution Process

Under AB 1455 (2001), HMOs are required to establish an internal dispute resolution process, and this requirement extended to their affiliated risk bearing organizations. In theory, a physician’s initial approach to obtaining fair payment ought to be entering the payers’ internal appeals processes. With negotiating power stripped from physicians, however, securing additional amounts from payers relies on their benevolence in any particular case to revisit and to modify their own earlier payment decisions, which is unlikely.

Seeking Redress from the State

The DMHC has its own mechanism whereby a practitioner may submit complaints against payers: <http://www.hmohelp.ca.gov/providers/default.aspx>.

The complaint must first be submitted to the payer, and if the result is not satisfactory, or if the complaint is not acted upon within 60 days, it may be submitted to the DMHC. The DMHC collects quarterly data on several elements, including the number and type of complaints, as well as the payers who have received complaints. The 2008 report shows that Blue Cross had the highest number of complaints, 1,818, Aetna second, and Kaiser third. The number of complaints received each quarter from anesthesiologists ranged from only 20 to 27. The average number of calendar days to close a complaint increased from 38 in the first quarter to 74 in the fourth quarter. The number

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of complaints received in the fourth quarter, 2,886, is more than double the previous month's 1,134. The report also shows that over \$7.4 million was collected as "recovered funds." The report does not indicate how payments were distributed among the payee categories, and with hospitals/institutions having the highest number of complaints, it seems likely that a high percentage of the funds were distributed to facilities.

The Oft-Cited and Never Used IDR

The DMHC created a voluntary Independent Dispute Resolution Process for services rendered after January 1, 2006, for practitioners who are not satisfied with the payers' determinations, or when they wish to bypass the payers' appeals process. The DMHC Web Site has extensive information on the process and required documentation for filing. To date, the IDR has not been utilized even once, probably because as structured, the system is financially and administratively burdensome for filers. Another disincentive to initiate the process is that payers may simply refuse to participate, thus closing the door on an *independent* determination.

Take it to Court

"Anyone can sue anyone over anything" is an oft quoted maxim, but litigation costs time and money. Suing health plans to obtain reasonable payments is an option, but filing a lawsuit, even in small claims court, requires expenditure of considerable resources.

In *Bell v. Blue Cross*, the plaintiffs asserted that practitioners must be paid a reasonable amount for emergency care services, not any amount at the pleasure of the health plan. The DMHC submitted an *amicus curiae* ("friend of the court") brief supporting that assertion. The *Prospect* decision cites the *Bell* case and notes that physicians must be paid reasonable fees, and they may sue health care plans for reasonable payments:

When a dispute exists between doctors and an HMO, the bill the doctors submit may or may not be the reasonable payment to which they are entitled. The *Bell* court made clear that an HMO does not have "unfettered discretion to determine unilaterally the amount it will reimburse a noncontracting provider. ... (*Bell*, supra, 131 Cal.App.4th at p. 220)" But the converse is also true; emergency room doctors do not have unfettered discretion to charge whatever they choose for emergency services.

Because emergency room doctors prevailed in *Bell* ... and won the right to resolve their disputes directly with HMOs, no reason exists

to permit balance billing. Thus, the DMHC, which supported doctors' rights to sue the HMOs directly in *Bell*, has appeared in this case as *amicus curiae* supporting patients' rights to be free of balance billing.

Is All Lost?

Dire predictions have been made that the loss of the right to balance bill sounds a death knell for contracting with payers. After all, why should the payers contract when they can pay what they wish with little threat of adverse consequences? Similarly, payers could decrease contracted rates, knowing that many physicians will opt for the predictability of payment rates. It will take at least a year of experience under the prohibition to gauge the extent to which payers are utilizing the apparent *carte blanche* granted by the state's courts.

Last year's implementation of the DMHC rule and the reversal of the *Prospect* decision were touted as the solution to the balance billing problem. It certainly takes patients out of the middle, a goal of both providers and payers. However, the remedy created a playing field heavily tilted in favor of the payers. The legislature can correct the inequity if they can be convinced that a problem exists.

Lawmakers need data, not anecdotes, to be persuaded that the solution to the "patient in the middle" problem created many new problems. The way to develop data is by participating in the payers' appeals processes and the DMHC complaint mechanism, and to create a record of results. The more detailed the information, the better. Data needed include:

- Whether your payments for non-contracted emergency services have decreased, increased or remained the same since the balance billing regulation was implemented.
- Whether you appeal underpayments to payers.
- Outcomes of appeals to payers for underpayments, and in the event of successful appeals, the percentage increase of the conversion factor.
- Changes in contracting since October 15, 2008 (reduced rates, cancellation).
- Increased administrative costs.

Please see the link on the CSA home page—www.csahq.org—to submit information. If you have any questions, call me at 650-345-5226.