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## The Law of Unintended Consequences

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Unintended consequences—probably the best reason for every physician to join one's peers as a member in organized medicine—are the unanticipated results created when someone without a deep understanding of an issue, any issue, begins to micromanage the business where the issue arose. When a physician administers a medication, a narcotic, for example, to a patient and the patient suffers a side effect, nausea possibly, often the side effect has been anticipated and the physician is prepared to manage the nonbeneficial effect of the medication effectively. In my example, the physician had an in-depth understanding of pharmacology and judged that the benefits to the patient outweighed the risks of administering the medication. In our current political environment, organized medicine spends innumerable hours explaining the potential unintended consequences to legislators and bureaucrats who propose to solve a medical issue for their constituents without an in-depth understanding of the medical landscape. Happily, the legislators and bureaucrats usually listen carefully, incorporate the insights of physicians into their understanding of the issue, and make the best informed decisions they can.

Let me encourage you, at this point, to help educate our legislators and bureaucrats by getting to know your elected representatives personally and by contributing generously to the anesthesiology PACs. GASPAC and ASAPAC are effective PACs to support with your contributions.

This is our Governor's self-proclaimed "Year of Health Care." Legislatively, the project has come down to the closing days of the session. Who can predict what will happen or what portions, if any, of the 185-page legalese in the governor's proposal will be signed into law. The most onerous provision contained in the Governor's original plan, the 2 percent tax on a physician's gross receipts, is **not** in the current proposal because it was universally opposed. Organized medicine spoke pointedly against it, but, importantly, so did the public in numerous opinion polls.

As I write this article, the Department of Managed Health Care (DMHC) public hearings on their proposed "balance billing" regulations are ongoing and the written comments deadline has been extended until November 30th. A number of CSA members and leaders, along with other physicians and other

interested parties, have shared their verbal and written comments on these draft regulations with the DMHC. A partial list of CSA members and leaders includes Drs. David Black, Christine Doyle, Wayne Kaufman, Earl Strum, Larry Sullivan, Paul Yost, Mark Zakowski, and me. Individually, we have presented our strong opposition to the DMHC proposals.

Those of us who took a day off work to attend the public hearings had a chance to see and hear the interaction between the DHMC officials and representatives of the public, the health insurance industry, and individual physicians who gave their testimony before the DMHC panel. At times, the testimony was sedate and reasoned, but some individuals became impassioned. What was clear to me from watching the DMHC officials was that the bureaucrats were defensive when the testimony impugned their objectivity or motives in bringing these proposals forward.

The proposed regulations include modifications to the Gould criteria that have historically provided the legal foundation for determining what passes for a "reasonable" usual-and-customary physician's fee. The Gould criteria (*Gould v. WCAB*, 4 Cal.App.4th 1059, decided in 1992), which legally define the determinants of a reasonable billed fee for medical services rendered by a physician are: (1) the provider's training, qualifications, and length of time in practice, (2) the nature of the services provided, (3) the fees usually charged by the provider, (4) prevailing provider rates charged in the general geographic area in which the services were rendered, (5) other aspect of the economics of the medical provider's practice that are relevant, and (6) any unusual circumstances in the case. The DMHC proposal would add Medicare reimbursement rates and discounted contracted (insurance) rates to the Gould criteria.

For emergency services the DMHC proposal mandates an expedited, interim payment equal to 150 percent of 2007 Medicare rates if the billed charges are disputed by the health plan or, if undisputed, payment in full. Accepting the expedited payment "would not constitute an agreement by the provider that the claim has been satisfied," but "acceptance of an expedited payment by the emergency service provider shall constitute the provider's agreement to not balance bill the enrollee for any disputed amount owed to the provider by the payer."

After the payment of an expedited fee to the provider, either the plan or the provider may dispute the amount of payment and seek an adjustment to the payment through an Independent Dispute Resolution Process (IDRP) after payment of a filing fee and "a reasonable cost structure for participation in the IDRP." The IDRP would be conducted using the expanded Gould criteria by

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“an Independent Dispute Resolution Organization (IDRO) contracted or appointed by the Department (DMHC) to administer and fulfill the dispute resolution” process.

Billing “an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services” would be defined as an “unfair billing practice” under the proposed regulations.

Clearly, the Medicare physician fee schedule is a poor benchmark for determining any physician payment for non-Medicare medical services if only because of the flawed Sustained Growth Rate formula used to determine current physician fees under Medicare. Medicare payments are problematic as benchmarks of anesthesiologist fees when the Medicare fee schedule pays only 25 percent to 30 percent of commercial insurance fee schedules to anesthesiologists whereas other physician specialties receive about 83 percent of commercial rates. More to the point, however, Medicare's budget is limited by employer and employee payroll tax revenues which are subject to the political will of Congress—a capricious situation at best.

Ultimately, one must anticipate that the businesspeople of medicine, the health plans and risk bearing organizations, would begin to limit their contract fee schedule to the 150 percent of the Medicare fee schedule unless their current fee schedule already pays physicians less. Consequently, the proposed regulations become a default fee schedule for emergency medical services and possibly for elective medical services as well.

The unintended consequences of DMHC's proposed regulations would flow from the reaction by physicians and hospitals to the expected response of the health plans and RBOs to reduce their fee schedules and the lack of a workable IDR process outside of the courts. Emergency physicians in every specialty would be discouraged from continuing to deliver emergency care unless they could find a source of adequate funding from an alternative source. The hospitals with their EMTALA mandate would of necessity need to increase their subsidies to physicians for coverage of their emergency services. But when the hospital could not afford to cover the added costs, the emergency programs would have to be reduced. Trauma centers might close or limit access because of reduced capacity and reduced physician availability.

The final consequence of these proposals would be a reduction in access to medical care for patients. Access to care is already a significant problem in rural parts of California, particularly in areas where more than 15 percent of the residents have annual incomes below the federal poverty line. In these areas of

California, the number of physicians per capita is well below that of California as a whole or the United States in general—in the range of 1.3 physicians compared to 2.3 physicians per 1,000 population. One can easily envision difficulties in retaining and recruiting physicians to practices significantly impacted by the DMHC proposed regulations further reducing access to physician-based medical care for local residents.

Many physicians, however, question the legal authority of DMHC to propose these draft regulations. If DMHC persists and finalizes these proposals as written, one might anticipate a legal challenge by organized medicine along the lines of *Bell v Blue Cross* where the 2nd Appellate Court of Appeals in California found that the Knox-Keene Act allowed Dr. Bell to pursue reasonable payment for his noncontracted emergency care of a Blue Cross enrollee.

In *Prospect Medical Group v. Northridge Medical Group et al.*, the 2nd Appellate Court of Appeals held that the Prospect Medical Group was also entitled to balance billing for monies unpaid by the IPA after non-contracted medical services were performed for a patient whose health insurance plan had passed the responsibilities for payment to the IPA.

In some respects, the current DMHC proposals appear to be an answer to the court's ruling in *Prospect*. The similarities are best shown in the CMA legal department's February 17, 2006 analysis of *Prospect*:

Briefly stated, the *Prospect* Court held that Section 1379 of the Health & Safety Code did not prohibit emergency physicians from balance billing. That section provides that contracts between a plan and provider shall be in writing and shall provide that where the plan fails to pay for health care services, the enrollee shall not be liable to the provider for sums owed by the plan. The provision goes on to provide that where the contract has not been reduced to writing or fails to prohibit balance billing, no provider may collect or attempt to collect sums owed by the plan.

The Court concluded that Section 1379 refers to and includes within its scope only freely and “voluntarily negotiated contracts” between physicians and plans “based on traditional contractual principles such as a meeting of the minds.” In reaching this conclusion, the court rejected the IPA's argument that “implied” contracts based on the parties' conduct or the physicians' obligation to provide EMTALA services could suffice to trigger the balance billing prohibition. The Court reasoned, among other things, that because the prohibition only applies to “sums owed by the plan,” there would need to be a

voluntarily negotiated agreement “as to how much the plan will pay for a particular procedure in advance of the medical procedure.”

Interestingly, in reaching its holding, the court bolstered its argument upon the fact that the DMHC did not adopt a regulation to ban balance billing. The court gave no weight to the DMHC's attorney letter opining that balance billing was prohibited because it was not adopted pursuant to agency rulemaking powers and because it was not a result of “responsibility statutorily imparted.”

Significantly, the Court also concluded that the IPA was not entitled to a declaration imposing the Medicare rate as the reasonable rate. The Court explained that it had no authority to set rates and noted that in any event, the DMHC had already opined in the record supporting the AB 1455 regulations that the Medicare rate was not appropriate, stating in the rulemaking that, “The Department recognizes that these government programs are not designed to reimburse the provider for the fair and reasonable value of the services and are therefore an inappropriate criteria.”

The Court concluded by reiterating that non-contracted physicians providing emergency services were entitled to reasonable compensation, and that IPA and plans, like providers in the *Bell* case, should be able to contest the reasonableness of the rates charged. Thus, the Court dismissed the IPA's claims for declaratory relief and unfair business practices against the emergency physicians.”

Subsequently, the California Supreme Court agreed to review the appellate court's *Prospect* decision. That decision is still awaited.

In conclusion, the issues today that will determine the environment in which we practice medicine are complex and subject to the law of unintended consequences. Organized medicine continuously advocates for physicians and attempts to maintain a suitable practice environment for physicians. CSA's ability to advocate forcefully for its members ultimately rests with the members. If you know someone who's not a member, let them know what we're busy doing and ask them to do you a huge favor and join CSA! We must speak with the biggest voice possible—every anesthesiologist should be a member!