

The Gloves Are Off: The Battle for Balance Billing Gets Bloody

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Let's face it; the legislature and Gov. Schwarzenegger are determined to end the practice of balance billing, and they are poised to act. A "solution" to this problem is imminent. Although claims underpayment by plans is clearly the source of the problem, plans have spent enormous resources creating a smokescreen for the legislature that has artfully spun the problem into one of physician and hospital greed. And with the Department of Managed Health Care (DMHC) a Schwarzenegger-controlled agency, squarely in the health plans' corner, it is evident that a legislative solution provides the best alternative for physicians, hospitals, and of course our patients.

DMHC Lands a Serious Blow

As of the time of this submission, balance billing is under attack from multiple fronts. First, the Department of Managed Health Care (DMHC) has approved a new regulation entitled "Unfair Billing Practices."¹ This regulation, effective October 15, 2008, adds §1300.71.39 to Title 28 of the California Code of Regulations and reads as follows:

§ 1300.71.39 Unfair Billing Patterns

(a) Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists, of 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.¹

The DMHC, an agency with a plan-friendly track record since its inception, erroneously justifies this new regulation as "part of the Department's ongoing comprehensive efforts to comply with the legislative directive to assist in the development of a new and more effective system of claims submission, processing and payment, to bring greater efficiency and stability to California's health care delivery

system and to bring an end to balance billing of health plan enrollees."¹

The DMHC maintains that "an enrollee should not be billed for services that are the financial responsibility of the health plan, and has attempted to eliminate the detriment to enrollees through measures other than rulemaking action."² Seemingly their intent is noble; however, why then should physicians and hospitals incur the financial responsibility that enrollees have already paid the plans to accept? Obviously, the DMHC could have simply required that plans comply with preexisting law requiring payment at "reasonable and customary" rates, as already established by *Gould*.

Keeping the Fists Up

CMA, together with CAL/ACEP, and others, has filed a lawsuit aimed at stopping this regulation. The suit will show that the DMHC has overreached its authority in promulgating this regulation. The Knox-Keene Act gives the DMHC the authority to regulate **plans**, not physicians. Further, the legislature directed the DMHC to investigate and "report back" to the legislature and the governor with recommendations regarding the definition of "unfair billing practices," not to promulgate regulations on billing practices without legislative oversight.³ The suit will therefore seek a writ of mandate compelling the DMHC to repeal the regulation as well as seek a declaration that the regulation is invalid and seek immediate injunctive relief from DMHC enforcement of this regulation.

What does this all mean? Since the lawsuit will likely not be heard until after the new regulation goes into effect, **as of October 15, balance billing patients enrolled in non-contracted plans must cease.**

Schwarzenegger Vetoes SB 981; the Compromise Solution to Balance Billing

SB 981 promised an end to balance billing by establishing an interim payment standard at 250% of 2007 Medicare rates (with a medical COLA). This not only would have put an end to direct patient billing, but also would have saved the cost of disputing thousands of underpaid claims.

Gov. Schwarzenegger, however, vetoed the bill stating in a press release that "this bill, in essence, asks for California to ...

reward noncontracting physicians by assuring their continued financial slice of the pie, and allow the status quo to continue.” The governor also cited concerns that SB 981 would not end all balance billing (non-ER specialists were not included under the proposal) and concluded his press release by directing the Department of Managed Health Care to “aggressively continue in its efforts to identify unfair payment practices.” Obviously the governor does not understand that the health plans have created this problem. It is also interesting to note in his directive to the DMHC that he correctly states that his agency’s authority is in regulating unfair *payment* practices – DMHC has no authority to regulate providers.

Cracks in the Coalition

Unfortunately, the greater House of Medicine is divided on this issue. CMA has always had an “oppose” position on this bill both because it sets a precedent for “price-fixing” and because of the possible slippery slope it poses for other specialties. Of course, as EMTALA-mandated providers, we simply cannot choose not to see certain patients or take ourselves off call lists. We don’t have hospitals offering us \$1,000 daily subsidies to provide emergency care. These commercial patients represent the majority of emergency physicians’ income. For emergency physicians, this is not a battle that can be lost.

The CMA House of Delegates is poised to convene in early October; and by reading a series of proposed resolutions, it is abundantly clear that this issue will prove divisive at the upcoming meeting. Many specialties express a right to bill and collect their usual charges without limitation. Although this policy may represent the best solution for physicians, this stance, even under current law (Gould, “reasonable and

customary”) in untenable. Further, the enormous political pressure to curb healthcare costs and end balance billing means that a solution is coming; and we, the House of Medicine, had better get our acts together to figure out a reasonable solution before one is imposed on us.

Further complicating this fight is the perception that our SB 981 coalition, which includes AARP, AFL-CIO, and CNA, may have as they see emergency physicians battle Regulation §1300.71.39 in court. Further, in the unlikely scenario that Regulation §1300.71.39 is upheld in court, the coalition partners may find this an adequate solution to their members’ concerns and relegate SB 981 to the bottom of their agendas.

Success with the Maddy Fund

On a brighter note, for the ninth consecutive year, the State Budget contains an allocation of \$24.8 million of cigarette-tax funds to county Maddy EMS Funds – to reimburse physicians for treating non-paying, uninsured patients in ERs. However, even the Maddy Fund is not completely safe. Rumors are swirling about Sacramento that there may be an attempt to allocate a portion of the Maddy fund for other state programs next year.

REFERENCES

1. State of California Department of Managed Health Care. Title 28, California code of regulations. § 1300.71.39 Unfair Billing Patterns. 2008; Sacramento, CA. Available at: <http://wps0.dmh.ca.gov/regulations/regs/?key=19>. Accessed September 29, 2008.
2. Department of Managed Health Care Title 28 Section 1300.71.39, “Initial Statement of Reasons: Unfair Billing Practices,” 2008-1536.
3. California Health & Safety Code §1371.39. July 31, 2008.

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