

California High Court Bans “Balance Billing” and Spawns Uncertainty in Emergency Services Billing Disputes

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When a patient receives emergency room services, and the patient’s managed health care plan subsequently refuses to pay the entire bill, can the emergency service provider directly bill the patient for the unpaid balance? In *Prospect Medical Group v. Northridge Emergency Medical Group*,¹ the California Supreme Court ruled earlier this year that this practice—known as “balance billing”—is illegal, and physicians and health maintenance organizations (HMOs) must resolve billing conflicts without injecting patients into the dispute. Unfortunately, this decision raised more issues than it resolved.

Prospect Medical Group left much uncertainty in its wake with regard to billing for emergency services. While acknowledging that billing disputes are bound to arise between emergency physicians and health plans, the California high court ignored the practical issue of how to resolve these disputes. The Court also failed to anticipate the decision’s effect on pending and prospective lawsuits by patients against their health care providers. In essence, the Court proscribed balance billing, but punted on consideration of the practical effects and consequences. This raises the specter of significant litigation and other collateral effects, imposing further drag on California’s already overburdened health care system unless and until courts or appropriate legislative and regulatory bodies provide further clarity.

Inherent Dispute Between Emergency Providers and Health Plans

Typically, HMOs enter into contracts with physicians² and other health care providers that stipulate the amount the HMO will pay for services rendered to HMO members. Accordingly, when contracting physicians treat HMO members, physicians receive compensation at the rate specified in the contract, and the potential for dispute is relatively small.

In emergency situations, however, HMO members are frequently treated by physicians with whom no contract exists, creating situations that are ripe for billing disputes. When confronted with medical emergencies, HMO members typically will go to the nearest emergency room, irrespective of whether physicians in the department contract with the member’s health plan. California and federal law forbid emergency physicians from refusing to provide emergency care, irrespective of a patient’s payment source or ability to pay.³ Nor may HMOs refuse to pay emergency physicians, because state law requires HMOs to reimburse physicians for emergency services rendered to HMO members.⁴ Without a preexisting agreement, however, physicians and HMOs often disagree as to what constitutes “reasonable value” for services rendered. As a result, physicians submit bills that HMOs refuse to pay in full, requiring physicians either to accept reduced payment, or to charge the balance of the bill to the patient.

According to the California Association of Health Plans (CAHP), in the past two years 1.76 million privately-insured patients in California received balance bills from physicians and hospitals, for a total cost of \$528 million.⁵ Nationwide, emergency providers balance bill patients a total of \$1 billion or more each year.⁶ Emergency physicians say that they are routinely underpaid by HMOs, and as a result, they must seek reimbursement from patients. Physicians also argue that balance billing is necessary to put pressure on insurance companies to pay bills in full.⁷ CAHP, on the other hand, calls the practice of balance billing “abusive,” claiming that physicians in the United

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States earn two to three times the salary of physicians in other industrialized countries.⁸ CAHP also contends that in 2005, private payers paid an average of 40 percent more than the hospitals' costs of providing health care.⁹

In 2006, California Governor Arnold Schwarzenegger ordered the state Department of Managed Health Care (DMHC) to promulgate regulations to protect Californians from balance billing.¹⁰ Governor Schwarzenegger asserted that HMO members might pay balance bills unnecessarily, not realizing that they are not obligated to pay bills from non-contracting emergency care providers. In response, in 2008 DMHC issued regulations defining balance billing as an "unfair billing pattern" and authorizing sanctions against providers who engage in balance billing.¹¹ By the time DMHC's regulations took effect, however, the issue of the legality of balance billing had reached the California Supreme Court in *Prospect Medical Group*.

California Supreme Court Weighs In

In *Prospect Medical Group*, the Court limited the scope of its ruling to the "narrow" issue of whether emergency care providers may balance bill patients enrolled in health plans.¹² In ruling that emergency physicians may not balance bill such patients, the Court explicitly refused to address how HMOs and physicians will resolve such disputes. Viewing the 1975 Knox-Keene Act and related statutes as a whole, the Court concluded that the only reasonable interpretation of the statutory scheme is to conclude that emergency room physicians may not bill HMO members for contested amounts. In addition, the Court found a clear legislative policy to avoid involving patients in disputes over the reasonable cost of health care services.

The Knox-Keene Health Care Service Plan Act of 1975 requires HMOs to pay for medical services rendered to enrollees and prohibits *contracting* providers from balance billing enrollees.¹³ In the event of a billing dispute, the Knox-Keene Act contains provisions governing dispute resolution between health plans and providers, without involving patients.¹⁴ The Knox-Keene Act also requires HMOs to reimburse emergency physicians for emergency services, even if no contract exists, and a related law requires physicians to provide emergency services regardless of the patient's ability to pay.¹⁵ Together, the Court viewed these provisions to (i) compel HMOs to pay the full cost of emergency care services and (ii) prohibit emergency physicians from seeking reimbursement from any patient. Enrollees have no obligation to pay for emergency care, and providers may not bill them for amounts in dispute.

The Court also noted policy reasons for excluding patients from billing disputes. Compared to physicians and HMOs, the Court reasoned, patients are ill-equipped to understand whether the amount in a medical bill is reasonable in light of the services received. In addition, the Court held, that the HMO, not the patient, is statutorily obligated to pay for emergency treatment. The Court observed that patients receiving balance bills may feel pressure to pay the bill, or may complain to the HMO, "which complaints will in turn pressure the HMO to make payment even if it is unreasonable."¹⁶ Because the statutory scheme is designed to ensure that physicians receive no more than reasonable payment, the Court concluded, this roundabout reimbursement scheme serves no legitimate purpose.

After Prospect Medical Group, Few Remedies Remain for Health Care Providers

At the core of any billing dispute between health care providers and HMOs is the question of whose suggested payment is correct. In California, regulations require health plans to pay providers the "reasonable and customary" rate for services provided. The rate must be verified by statistically credible information that is updated at least annually, and must take into account (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.¹⁷

Prospect Medical Group failed to supply further guidance on how to measure “reasonable and customary.” Legislative efforts to set minimum reimbursement rates have been unsuccessful in California and in most other states that prohibit balance billing.¹⁸ In the absence of a predetermined minimum or interim reimbursement rate, clashes will likely continue as physicians submit bills that they consider reasonable, but the HMO considers unreasonably high. Now divested of the option of balance billing, California physicians may only seek recourse in litigation or in dispute resolution procedures promulgated under the Knox-Keene Act. Whether either option is effective to resolve billing disputes is open to debate.

In 2005, the California Supreme Court interpreted the Knox-Keene Act to permit emergency care providers in California to sue HMOs directly over billing disputes.¹⁹ Practically speaking, however, physicians have reason to balk at the concept of taking health plans to court. Litigation is an expensive option, especially given that the average balance bill amounts to only \$300,²⁰ given the superior legal resources of most HMO relative to emergency physicians or medical groups, and given the uncertainties of trials. In a recent dispute over emergency room bills between health care provider NorthBay Healthcare and Kaiser Permanente health plan, the jury both denied NorthBay \$4.9 million in unpaid ER charges and denied Kaiser \$4 million in what Kaiser argued were overcharges.²¹ A NorthBay spokesperson said that the jury may have had difficulty understanding complicated testimony from accountants and other expert witnesses. She was quoted as saying, however, that other hospitals and health plans were waiting throughout the trial “to hear how Kaiser came to its understanding of what are reasonable and customary charges.”²²

The Knox-Keene Act and DMHC, the agency responsible for enforcing the Act, offer dispute resolution services as an alternative to litigation. The Knox-Keene Act requires each health plan to adopt a dispute-resolution mechanism for resolving billing disagreements with both contracting and non-contracting providers.²³ HMOs must resolve all claims within 45 days of submission and pay any amounts owed to the provider within five days of the claim’s resolution.²⁴ All costs related to dispute resolution are borne by HMOs.²⁵ HMOs must also make annual reports to DMHC detailing the number and types of providers submitting disputes, how disputes are resolved, and any billing patterns indicated.²⁶

While the Knox-Keene Act does not require that physicians submit contested claims to the health plan’s dispute-resolution mechanism, DMHC strongly recommends that physicians attempt to resolve each dispute directly with the health plan as a first step. DMHC itself operates a provider complaint network, but DMHC refuses to consider physicians’ claims unless physicians first submit the claim to the health plan’s dispute-resolution mechanism. Health care providers do appear to use DMHC’s network in practice. In 2008, DMHC reports that it received more than seven thousand complaints, for a total of more than \$7 million in recovered funds. Hospitals or specialty physicians accounted for approximately two-thirds of the complaints, with non-specialist emergency physicians submitting a total of only 22 complaints.²⁷ One potential problem with the network is that DMHC’s review is almost always limited to detecting unfair payment *patterns* by the health plan, rather than investigating the specific facts of a complaint. Physicians generally can not initiate a substantive case review; rather, DMHC elects to undertake case reviews “based on staff resources available.”²⁸

DMHC also recently established a pilot Independent Dispute Resolution Program (IDRP) specifically for the use of non-contracted emergency providers (including hospitals that operate emergency departments).²⁹ The IDRP uses a so-called “baseball-style” approach, whereby an independent panel considers the provider’s original billed amount and the HMO’s original paid amount, and chooses the more reasonable rate. Providers may elect to submit an alternate rate, in which case the HMO may also submit an alternative amount for the disputed claim. These alternative amounts will then be used to determine which amount better reflects the reasonable and customary value of the services performed. DMHC hopes that the IDRP will encourage both providers and health plans to act reasonably in their initial dealings with one another. At present, however, participation in the IDRP is voluntary for both providers and health plans. Inasmuch as

both litigation and HMO dispute-resolution mechanisms appear to give HMOs the upper hand, it is unclear whether HMOs have any incentive to submit to the IDR.

Pressure from Patients

Soon after *Prospect Medical Group*, an HMO member filed a class-action lawsuit in San Diego, California on behalf of himself and similarly-situated plaintiffs, alleging that defendants Scripps Health and La Jolla Emergency Physicians had engaged in illegal balance billing. The named plaintiff, Ariel Sabban, contends that the defendants balance billed him \$57.83 after his HMO refused to pay the full balance of a bill for emergency services.³⁰ A member of Blue Cross of California, Mr. Sabban took his son to the emergency room at Scripps Memorial Hospital after his son fell and injured his head. Scripps submitted a bill for \$521.00 to Blue Cross, but Blue Cross only paid \$463.71.³¹ According to the lawsuit, Mr. Sabban then received a balance bill that instructed: "If payment was not in full contact [Blue Cross] for reason of non-payment or make payment yourself. Responsibility for payment is yours."³²

Notably, Mr. Sabban received the bill on December 15, 2007, more than a year before *Prospect Medical Group* ruled balance billing illegal, and ten months prior to the effective date of DMHC regulations declaring balance billing an unfair billing pattern. Mr. Sabban purported to sue on behalf of all patients whom defendants allegedly balance billed *over the past four years* and up to the point of trial.³³ The lawsuit asserts that *Prospect Medical Group* applies retroactively to the inception of the statutory scheme, which could be as long ago as 1994, the date of the last Knox-Keene Act amendment that was central to the Court's reasoning.³⁴

This class action, and at least one similar class action, remain pending in southern California; suits may follow. If courts determine that *Prospect Medical Group* applies retroactively, as the *Sabban* plaintiffs contend, then any emergency-services provider who has engaged in balance billing since 1994 could find itself vulnerable to suit. Hospitals may also face liability for enabling the practice, even if (like Scripps Health) they deny sending balance bills to patients.

Rocky Road Ahead for Hospitals and Emergency Physicians

Prospect Medical Group dealt the final blow to the practice of balance billing for emergency services in California, and the Court's decision explicitly leaves health care providers and HMOs to pick up the pieces. Providers (specifically emergency physicians and hospitals) will likely bear the brunt of this burden as billing disputes with HMOs continue. In the past, physicians depended on patients either to put pressure on HMOs to pay disputed amounts, or simply to pay the balance themselves. Now denied the option of balance billing, physicians must turn to the courtroom or statutory dispute resolution services for payment – and both alternatives seem to give HMOs the upper hand.

Accordingly, the likely practical significance of *Prospect Medical Group* is to place a thumb on the scales in favor of HMOs. The decision will likely encourage HMOs to limit their network of emergency physicians under contract. Moreover, now that emergency physicians cannot target HMO members for payment, HMOs have less incentive to pay emergency care bills in full. Emergency physicians will therefore have to wait longer to be reimbursed, accept reduced payment, or both. To the extent that emergency specialists are unwilling to accept reduced payment for their services, hospitals could eventually face shortages of such physicians. Adding insult to injury, physicians and hospitals are now vulnerable to class action lawsuits brought by patients to recover past balance bills. Until courts provide further guidance, uncertainty will prevail in California emergency services billing disputes.

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¹ 45 Cal.4th 497 (2009).

² *Prospect Medical Group* uses the term “physician” to refer more broadly to health care providers, as defined under the Knox-Keene Act, Cal. Health & Saf. Code § 13400 *et. seq.*, and “HMO” to refer more broadly to health plans as defined under the Act. For consistency’s sake, we use the same vocabulary in this article.

³ Cal. Health & Saf. Code § 1317; 42 U.S.C. § 1395dd.

⁴ Cal. Health & Saf. Code § 1374(b).

⁵ *Id.*

⁶ Angela M. Lai & M. Dylan McClelland, *California Ends Balance Billing*, ABA Health eSource, vol. 5 no. 6 (February 2009), available at <http://www.abanet.org/health/esource/Volume5/06/Lai.html>.

⁷ Evan George, *Doctors, State Spar Over Medical Billing Ban*, LOS ANGELES DAILY J., Oct. 13, 2008, at 1.; Keith Darce, *Proposal Would Ban Some Charges to ER Patients*, San Diego Union-Tribune, May 17, 2008, available at <http://www.signonsandiego.com/news/business/20080517-9999-1b17balance.html>.

⁸ California Association of Health Plans, 2009 Policy Documents, *The Rising Costs of Health Care – Causes*, available at <http://www.calhealthplans.org/documents/HCCostsAffordabilityCauses012009.pdf> (last visited June 14, 2009).

⁹ California Association of Health Plans, 2008 Fact Sheet – Hospital Costs in California, available at http://www.calhealthplans.org/documents/DH01_HospitalCostsinCA.pdf (last visited June 14, 2009).

¹⁰ Exec. Order No. S-13-06, GAAS:483:06 (July 25, 2006).

¹¹ Cal. Code Regs. tit. § 1300.71.39.

¹² 45 Cal.4th 497, 502 (2009).

¹³ Cal. Health & Saf. Code § 1379.

¹⁴ *Id.* at §§ 1371.37, 1371.39.

¹⁵ *Id.* at §§ 1371.4(b), 1317.

¹⁶ 45 Cal.4th at 508.

¹⁷ Cal. Code Regs., tit. 28, § 1300.71(a)(3)(B).

¹⁸ In 2008, Governor Schwarzenegger vetoed SB 981, a bill that would have set a default payment rate for non-contracted to emergency room physicians of 250% of Medicare rates. One exception in Maryland, which requires plans to pay non-contracting providers 125% of what it pays contracting providers. Md. Health-Gen. § 19-710(p).

¹⁹ *Bell v. Blue Cross of California*, 131 Cal.App.4th 211, 220 (2005).

²⁰ California Association of Health Plans, 2009 Policy Documents, *The Rising Costs of Health Care – Causes*, available at <http://www.calhealthplans.org/documents/HCCostsAffordabilityCauses012009.pdf> (last visited June 14, 2009).

²¹ *NorthBay Healthcare Corp. v. Kaiser Foundation*, Cal. Super. Ct., No. FCS032489 (jury verdict Feb. 19, 2009).

²² “Kaiser, NorthBay Healthcare lawsuits Over Emergency Room Fees End in Split Verdict,” 18 HLR 256 (26 February 2006), available at http://news.bna.com/hln/HLLNWB/split_display.adp?fedfid=11630354&vname=hlnotalissues&wsn=499303500&searchid=8197162&doctypeid=1&type=date&mode=doc&split=0&scm=HLLNWB&pg=0.

²³ Cal. Health & Saf. Code § 1367(h), see also § 1371.38 (requiring DMHC to enact regulations ensuring HMOs adopt “fast, fair and cost-effective” dispute-resolution mechanisms)

²⁴ Cal. Code Regs. tit. 28 §§ 1300.71.38(f), (g).

²⁵ *Id.* at § 1300.71.38(j).

²⁶ *Id.* at § 1300.71.38(k).

²⁷ Department of Managed Health Care, Health Care Providers – Claim Issues, <http://www.dmhc.ca.gov/providers/clm/08pcdistats.pdf> (last visited June 14, 2009).

²⁸ Department of Managed Health Care, Health Care Providers – General Information, http://www.dmhc.ca.gov/providers/gen/gen_faq.aspx#resolve (last visited June 14, 2009); see also Cal. Health & Saf. Code § 1371.39 (entitling providers to report “unfair billing patterns” to DMHC (emphasis added)).

²⁹ Department of Managed Health Care, Health Care Providers – Claim Issues, http://www.dmhc.ca.gov/providers/clm/clm_idrp.aspx (last visited June 14, 2009).

³⁰ Complaint at 22, *Sabban v. Scripps Health*, San Diego County Super. Ct., Case No. 37-2009-00081871-CU-BT-CTL (filed January 28, 2009).

³¹ *Id.* at 20-21.

³² *Id.* at 22.

³³ *Id.* at 27.

³⁴ *Id.* at 11.