Supreme Court of California Bans Balance Billing for Emergency Services

In the ongoing dispute between HMOs and emergency service providers in California over payments for emergency services, the Supreme Court of California has weighed in against the practice of balance billing. The case is *Prospect Medical Group v. Northridge Emergency Medical Group*, No. S142209 (January 8, 2009).

California requires emergency service providers to furnish services without regard to a patient's ability to pay. California also requires that HMOs pay the emergency provider the "reasonable and customary value for the health services rendered" when the provider is out of network and the rate of payment thus is not governed by contract. When the inevitable dispute arises over the adequacy of out-of-network payment, emergency service providers often resort to billing patients for the difference between the HMO payment and what the provider believes should have been paid under this nebulous "reasonable and customary" standard – a practice known as "balance billing."

In 2005, a California intermediate court ruled that emergency service providers are entitled to sue HMOs to settle disputes over amounts owed. While the intermediate court's decision in *Bell v. Blue Cross of California*, 131 Cal. App. 4th 211 (Cal. Ct. App. 2005), appeared to offer an avenue to resolve claims of inadequate payment, many providers continued to balance bill patients, arguing that lawsuits are too often an impractical means of effectuating redress. Patient advocacy groups protested that putting patients in the middle of a payment dispute to which they were not a party was unfair. In response, the California Department of Managed Health Care (DMHC) issued a regulation outlawing balance billing as an unfair billing practice; and, on September 30, 2008, the governor signed Assembly Bill No. 1203 banning balance billing for post-stabilization services in most circumstances.

In its January 8 decision in *Prospect Medical Group v. Northridge*, the Supreme Court of California has now stepped with one foot into this fray. Carefully avoiding any ruling on either the DMHC regulation or the 2008 legislation – and thus avoiding the thorny question of what constitutes reasonable payment – the court held that "doctors may not bill a patient for emergency services that the HMO is obligated to pay."

The court started its reasoning with the ban against balance billing imposed by the Knox-Keene Act when a plan's contract with a provider has not been reduced to writing. Analogizing such an unwritten contract to the statutorily imposed relationship between an HMO and non-contracting emergency service provider, the court concluded that balance billing patients when they receive out-of-network emergency services must likewise be impermissible. The court found a compelling basis for its analogy in Section 1371.4 of the Health and Safety Code, with its requirement that HMOs must pay for emergency services, and Section 1317, which requires that "emergency care providers must provide emergency services without first questioning the patient's ability to pay."

Prospect Medical Group leaves to another day the question of what constitutes a reasonable payment. By avoiding this issue, the court has shifted the balance of power over payments squarely in favor of HMOs, at least until further litigation is brought to resolve what is meant by the regulatory standard of "reasonable and customary value for the health services rendered."

No doubt cognizant of this shift, DMHC promptly issued a statement reaffirming its intent to remain vigilant in enforcing fair payment: "We've never retreated from protecting patients caught in the middle of billing disputes and, just as vigorously, we won't retreat from efforts to make sure that doctors are paid fairly."

The breadth of the *Prospect Medical Group* holding remains uncertain. On the one hand, its reasoning could be read to extend to any framework in which (1) a payor must pay for a service, (2) the provider of that service must furnish it, (3) no contract governs the parties' relationship and (4) adequate mechanisms exist for resolving disputed payments without recourse to the patient. On the other hand, because the court's initial premise rested on the Knox-Keene Act's prohibition against balance billing, the decision may be limited to banning balance bills when submitted to patients covered by a Knox-Keene plan. The court further limited its holding by disclaiming any "opinion regarding the situation when no such recourse is available; for example, if the HMO is unable to pay or disputes coverage." That said, and whatever the uncertain reach of the court's decision, the court was clear in its bottom-line holding: the "entitlement [of doctors to reasonable payments for emergency services] does not further entitle the doctors to bill patients for any amount in dispute."

If you have any questions about the court's ruling in *Prospect Medical Group*, please contact your usual Ropes & Gray attorney.