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January 26, 2010

To Whom It May Concern:

I am writing in response to the January 25, 2010, invitation to interested parties to submit comments on the draft NCOIL model entitled "Healthcare Balance Billing Disclosure".

Section 3. Definitions. A. "Balance Billing". Recommend to strike the word "fully" from the third line. This phrase establishes an inference that the health care provider is entitled to be fully reimbursed for the amount billed. This definition should be neutral in describing the practice by health care providers.

Section 4. Applicability. Recommend that this section have an initial subsection as follows: <u>A. In General. This Act applies to any health benefit plan, any healthcare facility, and any facility-based physician as described below.</u> B. Health Benefit Plans. [Text]. C. Healthcare Facility. [Text]. D. Facility-Based Physicians. [Text]. Clearly this Act is intended to apply to all of these entities and not just health benefit plans.

Section 6. Facility-Based Physician Disclosure. Subsection A.2.(b). Recommend to strike the text of draft (b) and replace it with the following: <u>(b) the facility-based physician has billed an amount that is in excess of amounts that the health benefit plan pays to network participating healthcare providers</u>;

The current draft language establishes an inference that the health benefit plan has no basis for paying an amount that is below the facility-based physician billed amount. This disclosure should plainly state that the physician wants more money.

In addition, recommend a new item for disclosure that would be helpful to consumers as follows: <u>7. contains an explanation and reasons for the difference between the higher billed amount by the physician in comparison to the amount paid by the health benefit plan.</u>

Thank you for the opportunity to offer comments on this important draft model legislation.

Sincerely,

William G. Schiffbauer, Esq.

BNA, INC.

HEALTH PLAN & PROVIDER

REPORT

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Health Care Reform and Provider Balance Billing: A Blank Check Bending Costs, Bankruptcies Upward

BY WILLIAM G. SCHIFFBAUER, ESQ.

Among the first acts in the delivery of health care is a patient's required signature in a health care provider's waiting room on a ''financial consent'' agreement. This ''consent'' guarantees that the patient will make payment upon demand for any balance due but not paid for by an insurance carrier. The patient must agree to be responsible for the balance due of the full, billed charges demanded by the provider—so called ''balance billing.''

What other business in America can require its customer to sign an agreement to pay all unknown and undisclosed costs for items and services that might be provided? No one other than health care providers—doctors and hospitals. Pending health care reform legislation does not directly address the problem of ''balance billing'' and the nature of ''financial consent'' that is more a contract of ''adhesion'' offered on a take-it-or leave it basis. It is part of the ''cost'' issue that has been largely ignored by health care reformers.

Health care providers are not obligated to provide ''informed'' financial consent. It is a standardized form provided on a non-negotiated basis. Despite the coverage of insurance that makes payments for ''reasonable and customary'' expenses, many patients face unexpected out-of-pocket costs. There are few constraints in the private market—-outside of a ''network'' agreement—-on what providers can bill as patient. Providers, however, often resist ''network'' agreements.

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News stories document the fact that insurers cannot easily keep pace with the rise in charges levied by health care providers and simultaneously keep premiums from rising. Politicians and attorneys general demand that insurers pay more to providers but without increasing premiums. Health care reformers should be asking why did that procedure cost $58,000, or $25,000, more than what insurance paid as ''customary and reasonable''?

Medicare's Balance Billing Model

Pending health care reform legislation would, in part, address the issue of provider balance billing for individuals that enroll in the ''public health insurance option'' proposed in the House version of the bill. Medicare's ''balance billing'' limiting charge would be incorporated by reference for physicians who do not accept the plan's payment as payment in full. Other private insurers are not afforded this ''reform'' feature in the legislation. See, H.R. 3200, section 225 (c)(1)(B).

After several years of Congressional attempts to settle the unpredictable nature of physician billing for amounts above Medicare's payments in 1989 the Congress enacted several significant reforms of physician charges that included a national price ceiling for physician fees that limited balance billing charges initially to 125% of the Medicare approved rate; that percentage has phased down to 115%. See, H.R. 3299, section 6102, 101st Cong., 1st Sess. (Omnibus Budget Reconciliation Act of 1989).

States followed the federal enactment with more restrictive limits on ''balance billing'' for Medicare benefi-

ciaries. Recent studies of the effects of these limitations appear to conclude that beneficiary access to physician services was not harmed, and that they resulted in out-of-pocket spending by Medicare beneficiaries declining by up to 8%. See McKnight, Robin. ''Medicare Balance Billing Restrictions: Impact on Physicians and Beneficiaries'' (September 2004).

Wide and Unexpected Variations in Provider Charges

Various studies have documented the potential extent of liability for ''balance billing'' by out-of-network providers in the private market through comparison of billed charges and Medicare ''allowed'' charges.

For example, the New York Health Plan Association found that billed charges for some general surgery amounted to $20,000, and $25,000, compared to Medicare's allowed charges of $175.96, and $641.00. These represent percentage increases over Medicare of 11,366.22% and 3,900.16%. See Crain's *Health Pulse Extra* (January 21, 2009). More recently, a national survey and comparison of provider charges based on CPT codes reveals that similar exorbitant variations are commonplace in every state of the union. See, Dyckman & Associates, *A Survey of Charges Billed By Out-of-Network Physicians* (August 2009).

For payments to doctors, Medicare considers the amount of work required to provide the service, expenses for maintaining a practice, and liability insurance costs. These amounts are then adjusted by variations in ''input'' prices in different markets and then multiplied by a standard dollar amount to arrive at a ''fee schedule'' payment amount. This may be further adjusted based on provider characteristics, geographic and other factors, and incentive bonus payments. See, MedPAC, *Payment Basics: Physician Services Payment System* (October 2008).

Many private insurers pay providers amounts greater than Medicare payments but may use Medicare as a starting base because of the comprehensive nature of its data and process for determining payment rates. Providers assert that Medicare's payment rate is too low. However, one measure of payment adequacy is the access of Medicare beneficiaries to primary care physicians. MedPAC has found that beneficiary access is better than that reported by privately insured patients and that physicians continue to accept and treat Medicare patients. See MedPAC, *Report to the Congress: Medicare Payment Policy* (March 2009).

Outside of the Medicare Market

Where a person is not a Medicare beneficiary ''balance billing'' is a cause of great concern because charges by providers are not predictable, are often unexpected, and are generally not ''discretionary'' on the part of the patient. Especially now, these unknown and unpredictable expenses add to the financial anxieties faced by Americans who have little ''cushion'' in household budgets for unexpected medical costs. See, Center for Studying Health System Change. ''Living on the Edge: Health Care Expenses Strain Family Budgets'' (December 2008).

A Harvard University study examined 1,771 personal bankruptcy filers in five federal courts and found that about 50% of the filers cited ''medical causes'' for bankruptcy. The study observed that many insured families are bankrupted by medical expenses. See, Himmelstein, D. et al, ''Illness and Injury As Contributors to Bankruptcy,'' 24 *Health Aff*. at W5-63 (Web Exclusive Supplement I, February 2005). While the study did not specifically identify ''balance billing'' as a cause, because some of the filers were insured it is likely that ''balance billing'' was a factor in the medical debt burden. Other reports estimate that at least one in four bankruptcy filers has significant medical debt. See *USA Today*, ''Bankruptcy Filings Up 22% in August vs. Last Year'' (September 9, 2009).

The practice of ''balance billing'' in the private health care market is widely known, and seems to occur especially in the context of medical emergency circumstance. Several recent news reports have documented the practice and effect of ''balance billing'' in the private health care market. See, Mathews, Andrea Wilde. ''Surprise Health Bills Make People See Red.'' December 4, 2008, *The Wall Street Journal*. See also, Terhune, Chad. ''Medical Bills You Shouldn't Pay'' August 28, 2008, *Business Week*; and CBS News, ''Huge Medical Bills You Shouldn't Pay'' (August 29, 2008).

For example, a patient is ''balance billed'' $8,200, by an out-of-network surgeon after an emergency at an ''in network'' hospital, and another was balance billed $5,600, by an out-of-network ambulance service in an emergency. Even outside of emergency rooms physicians routinely bill an additional $1,000 more for a standard colonoscopy that is determined to cost $250 under ''usual, customary, and reasonable'' standards of an insurer. State Attorneys General have investigated complaints against hospitals for ''balance billing'' patients.

The provider can bill the patient relying on the ''financial consent'' signed in the waiting room to pay all costs. This is because providers treat the ''financial consent'' form as a contract between the provider and the patient, although it is hardly a bargained for exchange. The provider insists that this ''consent'' form is enforceable against a patient for the amount that ''billed'' charges exceed the amount paid to the health care provider under the insurance policy.

The ''financial consent'' clause becomes the basis for providers to unleash debt collectors, make adverse credit reports, and bring lawsuits against a patient to force payment of all billed charges. Generally, providers maintain that they are entitled to ''billed'' charges and reject payments based on ''usual, customary, and reasonable'' data as being unfair or too low.

Network Protections for Policyholders

The practice of balance billing can occur under two circumstances: directly by a provider for any amount not covered by an insurance payment; and indirectly, where a facility, such as a hospital, might be in a ''network'' but that employs other ''ancillary'' providers such as anesthesiologists, emergency room physicians, or pathologists, who—unbeknown to the patient—are not ''network'' participating. These ''ancillary'' providers ''balance bill'' a patient because they have not agreed to accept the insurance network's payment as payment in full.

If a patient consults a health care provider under an insurance contract that is ''in network'' that provider is obligated by contract with the insurance company to ac-

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cept the plan's payment as ''payment in full'' similar to Medicare's ''participating provider'' requirement. However, unlike Medicare, if a person sees a health care provider who is not ''in network,'' the provider may be free to ''balance bill'' for amounts that are in excess of the ''usual, customary, and reasonable'' amount paid by the insurer.

State Laws Limit Some Balance Billing

In the absence of federal laws several states have enacted laws limiting charges by hospitals and doctors in the private market in ''emergency'' situations, but there is currently no federal law limiting provider balance billing of ''billed'' charges under any circumstance outside of Medicare. Some states ban balance billing for out-of-network emergency services, while others have adopted managed care plan ''hold harmless'' laws, or dispute resolution procedures, and still others have not adopted any of these protections. See, Lucas, C., et al, ''Fifty State Survey of Balance Billing Laws'' (American Health Lawyers Association, 2006). See also, California HealthCare Foundation, ''Unexpected Charges: What States Are Doing About Balance Billing'' (April 2009).

Recently, hospitals and doctors in California challenged a state ''balance billing'' limits law for out-of-network emergency services. In the case of *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, payments made by Prospect to Northridge based on ''reasonable amounts'' were challenged by Northridge because they were less than billed charges. In addition, a state law prohibition on ''balance billing'' in an emergency service was relied upon by Prospect in making the payments to Northridge.

On January 8, 2009, in a unanimous decision, the Supreme Court of California declared that state law prohibits emergency room doctors from ''balance billing'' a patient for the disputed amount under statutory provisions of the Knox-Keene Act. This decision is read by the California Department of Managed Health Care to also uphold regulations that became effective October 15, 2008, outlawing the practice of ''balance billing'' for emergency care, although the rules were not raised in the *Prospect* litigation.

Federal lawmakers have chosen to largely ignore the health care provider ''balance billing'' issue and instead focus their attentions solely on whether the insurer's ''usual, customary, and reasonable'' payment is enough for health care providers. Most recently, an investigation and hearings by one Senate committee only reviewed the use of ''usual and customary'' rates by insurers and ignored provider ''balance billing''. See, U.S. Senate Committee on Commerce, Science, and Transportation, ''Underpayments to Consumers by the Health Insurance Industry'' (June 24, 2009).

However, state policymakers have been more attentive. The National Conference of Insurance Legislators (''NCOIL'') has initiated an investigation into ''balance billing'' practices to review concerns about patients held liable for unpaid medical bills by out-of-network health care providers. In addition, the National Association of Insurance Commissioners (''NAIC'') scheduled a meeting at its Fall National Meeting on September 24, 2009, to consider the issue and how consumers have been affected.

Health Care Provider Response

The American Medical Association has encouraged the introduction of federal legislation to repeal Medicare's limiting charge rule that prohibits ''balance billing'' of over 115% of the Medicare approved amount. The bill, H.R. 1384, was introduced on March 9, 2009, and would not only repeal the Medicare protection for beneficiaries but would also preempt all state laws that prohibit ''balance billing'' to allow a physician to impose any amount of charges for services without any limitation.

One commentator has suggested that if Medicare's limitations on balance billing were repealed it would ''have a dramatic effect'' on the health care marketplace because the uniformity of Medicare entitlement would ''fall by the wayside''. Beneficiaries would face ''higher copayments'' and some physicians, it was noted, would ''price themselves out of the traditional Medicare market and work only with cash-rich patients.'' See, Forman, Howard P. ''National Health Care Expenditure Update: A New Threat or an Opportunity?'' *American Journal of Radiology* (March 2008).

Fair Payments to Out-of-Network Providers

Politicians and Attorneys General have not focused on the ''balance billing'' practices of providers, but rather, have chosen to reform the insurance industry to require increased payment amounts to providers and yet also demand that premiums for health insurance be ''affordable''. An analysis of the components of each dollar of premium has demonstrated that up to 87-cents of each dollar of premium for group health plan coverage represents payments to hospitals and doctors. See, Congressional Research Service, ''Costs and Effects of Extending Health Insurance Coverage'' at 46 (October 1988).

Most recently, the New York Attorney General reached a settlement agreement with the key insurance industry payments database—-Ingenix—-to reform payment data in determining ''reasonable and customary'' payments to reflect ''fair reimbursement''. While this action is projected to result in payment increases to providers, it does not address the problem of ''balance billing'' by providers that are not part of a ''network'' agreement to accept the insurance plan's payment as payment in full.

Neither does this settlement agreement address the issue of maintaining ''affordable'' premiums for health insurance coverage despite the fact that it will, without a doubt, increase the amount of payments to health care providers.

Under the settlement the Ingenix database is no longer used to calculate out-of-network payments, and $50 million is contributed by the insurance industry for the creation of a new, independent and not-for-profit run database that will become the industry standard. The new database has been described as bringing ''accuracy, transparency, and independence'' to the system. See, Testimony of Linda A. Lacewell, Office of the Attorney General, State of New York, Before the U.S. Senate Committee on Commerce, Science, and Transportation (March 26, 2009).

Conclusion

Pending federal health care reform legislation would only provide protection to individuals that enroll in the ''public health insurance option'' proposed in the House version of the bill. Other policyholders of private insurance are not afforded this ''reform'' protection feature in the legislation for out-of-network ''balance billing.'' This legislation also proposes to require nearly ''$1 trillion'' that will be paid over to the health care providers.

To afford genuine cost control and protections for all patients the pending health reform legislation should extend this out-of-network protection to everyone that is not protected by a ''network agreement.''

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THE BATTLE RAGES ON: RECENT DEVELOPMENTS IN REIMBURSEMENT OF NON-PARTICIPATING EMERGENCY SERVICE PROVIDERS

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Introduction

The reimbursement battle between payors and non-contracted providers of emergency services continues to be waged in various forums and venues across the country. The key issue is the proper amount of reimbursement non-contracted providers should receive from payors for providing emergency services. A satisfactory solution to this nationwide problem has thus far proved elusive. Recent legislative initiatives, state enforcement actions, and court decisions, while helpful, have failed to resolve the dispute on a consistent and practical basis. In the absence of clear legislation or uniform state action, these battles will continue, and it will be incumbent on the judiciary to provide definitive guidance. This article discusses several recent legislative initiatives, state enforcement actions, and judicial decisions in this controversial and closely watched area.[1]

Competing Payor and Provider Policy Arguments

The countervailing policy arguments regarding the proper reimbursement levels to be paid by payors to non-participating providers of emergency services are well-known and have been well-articulated.[2] On the one hand, payors argue generally that non-contracted providers should not be paid their "full, billed" charges because such "rack rate" or "retail" charges typically are not paid by any payor and would lead to "windfall" reimbursement. Further, providers have discretion to set their charges, which may or may not bear any relationship to their cost to provide the services. Moreover, payors argue, payment of "full, billed" charges would disincentivize providers to contract with payors and result in higher healthcare costs.[3]

In contrast, providers argue that state and federal laws mandate they provide emergency services without regard to or even the ability to inquire about payment.[4] While providers are obligated to provide emergency services to health plan subscribers, they are also subject to payors' threshold and often arbitrary decisions regarding the amount of reimbursement to pay for those services. Providers who lack the size, wherewithal and resources to contest what are often small dollar claims are left with little meaningful recourse to challenge the payors' unilateral payment decisions. Providers argue that this reimbursement framework provides incentives to health plans to terminate existing contracts or not contract at all with providers as a means of generating additional profits for the health plans. Fueling the fire is the decision of some payors to reimburse non-contracted emergency services providers at extraordinarily low levels.[5]

Caught in the middle of the battle are the health plan subscribers. In an emergent situation, a subscriber usually has little or no choice in determining where he or she is brought for treatment and care. Moreover, even if a subscriber is treated at or otherwise able to choose an in-network hospital, the treating emergency room physicians and other hospital-based physicians may not have a contract with the subscriber's health plan. While some states have enacted legislation to prevent the provider from balance billing the subscriber in these circumstances, the subscriber may otherwise be faced with payment of the entire bill or that portion of the bill that remains unpaid by the subscriber's health plan.[6] Subscriber dissatisfaction ultimately is not beneficial for either the provider or payor.

In the emergency services arena, therefore, the reimbursement payable to non-contracted providers presents a "perfect storm" microcosm of the competing policy arguments on all sides of the current national debate regarding healthcare cost containment.

Legislative Initiatives

Legislative efforts to resolve the dilemma, although admirable, largely have raised more questions than answers, as demonstrated by the statutory schemes in Florida, California and Maryland. In Florida, a statutory framework provides that a non-contracted provider of emergency services is entitled to reimbursement for services provided to a health maintenance organization ("HMO") member at the lesser of the "provider's charges" or the "usual and customary provider charges for similar services in the community where the services were provided."[7] The statute provides no definitions of key terms and phrases such as "provider's charges," "usual and customary provider charges" or "similar services." Legislative history sheds little light on what those terms were intended to mean. No Florida appellate court has provided definitive guidance as to how the lower courts – much less the payors and non-participating providers – are to interpret and apply the statute's framework and key words and phrases, and the statute has spawned pending litigation throughout Florida's state courts, as noted below.

Similarly, California's regulations require an HMO to pay "the reasonable and customary value" for the healthcare services rendered. The calculation must take into consideration: (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. California courts have not determined how the amount of reimbursement is to be calculated pursuant to the regulations, however, noting that it will be a fact-based inquiry based on the specific circumstances at issue.[8] Like the Florida statutes, the California regulations fail to provide objective measures of certainty to the reimbursement analysis.[9]

Maryland has enacted a more definitive, objective statutory scheme. The Maryland framework requires an HMO to pay a provider of emergency services the greater of 125 percent of the rate the HMO pays contracted providers or the rate the HMO paid non-contracted providers as of January 1, 2000. The statute requires payment to hospitals at an approved rate by the Health Services Cost Review Commission[10] and payment to trauma physicians at the greater of 140 percent of the Medicare allowable rate or the rate the HMO paid to similarly licensed providers.[11] Although far from perfect, Maryland's statutory scheme nonetheless eliminates many of the subjective analytical factors contemplated by the Florida and California statutory frameworks.

Administrative Agency Actions

Recently, state administrative agencies have intervened in these disputes. For instance, the New Jersey Department of Banking and Insurance issued an Administrative Order regarding Aetna Health, Inc.'s ("Aetna") payment practices for non-participating providers.[12] Aetna had been paying non-participating providers at 125 percent of the Medicare allowable amount, contending that this was "fair payment for the services provided" and notifying providers that it would not consider any additional reimbursement.[13] Under New Jersey law, for emergency services rendered by non-participating providers, the health plan member is not liable for the difference between the provider's billed charges and the reimbursement paid by the HMO.[14] The Department of Banking and Insurance thus concluded that Aetna was required to pay the non-participating provider a benefit large enough to insure that the non-participating provider would not balance bill the patient for the difference between the provider's billed charges and Aetna's payment. The Department ordered Aetna to cease using 125 percent of the Medicare allowable amount as the maximum allowable reimbursement amount and required Aetna to reprocess claims for emergency care so that the total benefit paid equaled the provider's billed charges, less the member's responsibility. Aetna challenged the Order, and in March 2009, entered into a Settlement Agreement and Consent Order. While Aetna agreed to reimburse the affected providers, including the payment of interest, the Consent Order provided that the payments of the providers' full billed charges "do not establish and are not intended to establish generally the level of payment to be paid to out-of-network providers in these circumstances."[15]

In July 2008, the California Department of Managed Health Care filed a lawsuit in California state court against Prime Healthcare Services to prevent Prime from balance billing HMO patients for emergency services received at its hospitals. The suit was triggered when the Prime Healthcare system began sending collection notices to large numbers of Kaiser Permanente members who were treated at emergency rooms at one of its nine hospitals in Southern California. In announcing the filing of the lawsuit, the California Department of Managed Health Care issued a press release articulating the parameters and difficulties of the dilemma:

> Balance billing is a controversial practice. It pits health care providers, who are seeking reimbursement for emergency services they rendered, against health plans, who have a duty under the law to pay only the reasonable and customary value of those services, often less than the provider's billed charge, leaving a balance then passed on to the consumer. Health plan members are caught in the middle of this dispute, not knowing if they legitimately owe the amount.[16]

Although state agency efforts have attempted to address the issue, they have been unable to provide clear guidance regarding the appropriate reimbursement payable to non-contracted providers for emergency services.

State attorneys general have also weighed in. In January 2009, the New York Attorney General reached a much-publicized agreement with United Healthcare and Ingenix.[17] Ingenix, a wholly-owned subsidiary of United Healthcare, compiled information from some of the largest health insurers in the country, which in turn used the compiled data to create schedules to calculate the reimbursement payable to non-network providers. The New York Attorney General found that Ingenix had a conflict of interest in creating reimbursement schedules used by its parent company to reimburse providers, and that health insurers had a financial incentive to manipulate the data they submitted to Ingenix so as to reduce the reimbursement rates determined through use of the Ingenix schedules. The New York Attorney General has since reached settlements with 12 insurers who previously used the Ingenix database,[18] collecting approximately $100 million toward the creation of an independent and transparent database.[19] However, the Attorney General did not make any findings[20] as to the establishment of the proper levels of reimbursement payable to non-contracted providers.[21]

Private Litigation: The Long and Winding Road

Private litigation has also brought some, albeit limited, resolution of the issues. In a class action filed in Florida federal court, non-contracted emergency

continued on page 32

continued from page 31

room physicians sued Aetna alleging it had violated Florida law by improperly paying for emergency services at 125 percent of the Medicare allowable amount.[22] In April 2009, the federal district court approved a settlement of the class action whereby Aetna agreed to establish a new Florida ER Fee Schedule, set reimbursement for future emergency services at 239 percent of the applicable Medicare allowable amount through December 14, 2012, and reprocess claims paid under the prior methodology.[23]

In another Florida case, an intermediate state appellate court held that Florida's non-contracted emergency services provider statute, section 641.513(5), Florida Statutes, "clearly imposes a duty on HMOs to reimburse non-participating providers according to the statute's dictates, not based on Medicare reimbursement rates."[24] The court further held that the "intent of the section is to ensure that the non-participating providers are adequately paid for a service they are required by law to perform." The Florida court did not provide further guidance, however, as to what constituted "adequate payment," the definition of the statute's key terms and phrases, or how the parties or the lower court should establish the "usual and customary provider charges for similar services in the community."[25]

Litigation between payors and non-contracted providers regarding emergency services reimbursement has also spawned numerous tangential issues arising out of various factual and legal defenses asserted by payors. For example, payors are asserting ERISA preemption as a defense to providers' state common law or statutory claims for reimbursement,[26] seeking to substantially limit or deny reimbursement altogether by arguing either that the services are not emergent at all[27] or narrowly defining the patient's initial assessment and stabilization for purposes of limiting those services deemed to be emergent,[28] and arguing that a determination regarding key terms such as "usual," "customary" and "reasonable" requires analysis of the amounts providers receive from all payor sources rather than the amounts providers charge.[29] Payors have also taken a hard line in the discovery process.[30] The end result is that the litigation of these disputes is protracted, expensive and time-consuming, usually pitting large non-contracted providers, such as hospitals or health systems, against major health plans. Absent participating in claims asserted on a class-action basis, individual physicians and other small provider groups typically do not have the necessary resources to fully litigate these disputes.

Quasi-Administrative Alternative Dispute Resolution Procedures

In an effort to provide a more efficient, cost-effective dispute resolution mechanism to private litigants outside the courtroom, and, in particular, to aid smaller providers with relatively small claims, several states have established quasi-administrative procedures.[31] The theory is that state agencies, presumably staffed by professionals with industry knowledge and expertise, or in an oversight capacity with regard to retained independent review organizations, are better equipped to address and resolve these payment disputes than the courts. The results have been mixed.

In California, the Department of Managed Health Care established an Independent Dispute Resolution Process ("IDRP") in 2007 to afford non-contracted providers of emergency services an alternative way to resolve claims payment disputes with health plans.[32] The IDRP, a voluntary process for both non-contracted providers and payors, is overseen by a governing committee consisting of provider and payor representatives, a consumer representative and two government or Department staff members. The Department retained the Maximus Center for Health Dispute Resolution ("Maximus") as the IDRP's independent review organization.

The process requires the provider to submit a uniform complaint form and both parties to submit supporting documentation. The IDRP utilizes a "baseball style" arbitration model, whereby the provider's original billed amount and the payor's original paid amount are used to determine which amount better reflects the reasonable and customary value of the services performed. Participating providers must agree not to balance bill members, and participating payors must agree to pay any amounts determined to be due within fifteen (15) days of receipt of notice of such a determination. The decision of the independent review organization carries no precedential weight, prompting one commentator to note that the process "is a nonstarter for hospitals because it cannot establish the legal precedent that will settle how such services should be valued."[33]

Florida has a similar voluntary procedure for resolving disputes between health care providers and payors, although, unlike California's IDRP, its availability is not limited to non-contracted providers of emergency services. As with California's IDRP, the Florida process, which is overseen by Florida's Agency for Healthcare Administration, consists of an evaluation by Maximus of the supporting documentation submitted by the parties, with no hearing, no sworn testimony or cross examination of witnesses, no judge, and no identification of the fact-finder.[34] There is limited review of Maximus' determinations which, unlike in the California IDRP, are binding.

The Florida process has been harshly criticized, however, and has not been a panacea for addressing or resolving the non-contracted provider problem. One Florida intermediate state appellate court declared that the "legal conclusions made by these undisclosed professionals" are

"informal rulings" that have "no precedential value."[35] The court further noted that the process allows for few procedural safeguards and is ill-equipped to address legal issues, and labeled its dispute resolution process "inefficient."[36] The court noted that the process was "not an adequate method to resolve legal issues of first impression that involve the payment of millions of dollars."[37]

Thus, while state-sponsored alternative dispute resolution mechanisms may be beneficial to resolve the small claims of small non-contracted providers, they are generally inadequate to address and resolve large, complex claims involving large providers and payors with substantial sums at stake. The most critical defect in these processes with respect to resolution of the non-contracted provider problem is their inability to issue precedential decisions that afford guidance and certainty in future provider-payor disputes. The battles necessary to lead to the development of such precedential guidance can be waged only by the goliaths in the courtroom.

Conclusion

Absent clear legislative direction or state agency enforcement, the establishment of "usual," "customary" or "reasonable" reimbursement rates to be paid by payors to non-contracted providers of emergency services will continue to be best left to the discretion of the judiciary. In deciding these cases, courts will have to balance a myriad of subjective and objective factors and countervailing policy arguments and considerations. In the end, whether the solution is legislative, administrative or judicial, all parties concerned will benefit from greater certainty regarding this important reimbursement issue.

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Endnotes

1 This article focuses on issues arising out of the reimbursement of emergency services provided by non-contracted providers. While the reimbursement of out-of-network providers in general has gained national attention, the issue is more acute in the emergency services context. This area is unique for several reasons, including the lack of patient choice in selecting the provider, the prevalence of hospital-based physicians who, in contrast to the hospitals for whom they provide services, may be non-contracted with particular payors, and federal and state laws that compel providers to provide emergency services without regard to a patient's ability to pay. Nevertheless, many of the issues discussed here have general applicability to the reimbursement of non-emergent services provided by out-of-network providers.

2 A good discussion and overview of the countervailing policy arguments is contained in the majority and dissenting opinions in *Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc.*, 832 A.2d 501 (Pa. Super. Ct. 2003). In *Temple University*, the court found that in the absence of an express agreement, the amount an insurer should pay for emergency services is what the services are ordinarily worth in the community, meaning what people ordinarily pay for them. The court held that the proper reimbursement, or "reasonable fee," would be the average reimbursement rate in the provider's contracts with governmental agencies and insurance companies. *Id.* at 510. In a sharply worded opinion, the dissent argued that the reasonable fee should be the hospital's billed charges, based on the evidence showing that the hospital's charges were the same or less than those of other similar hospitals. *Id.* at 511-17. The dissent found that in the absence of a contract, the hospital has no recourse but to rely on its published charges, in part because of its weakened bargaining position resulting from its obligation to treat the patients. *Id.*

3 On this point, United Health's CEO testified that "physician reimbursement based on nothing but the doctor's bill is simply not economically tenable for consumers nor our healthcare system." *See* Staff of Committee on Commerce, Science and Transportation, Office of Oversight and Investigations, Underpayments to Consumers by the Health Insurance Industry (June 24, 2009) at p. 3. In defending its now-prohibited uniform practice of reimbursing non-contracted emergency services providers at 125 percent of Medicare in New Jersey, Aetna's spokeswoman stated: "[O]ur policy protects our members and customers in the state of New Jersey from excessive billed charges by a small group of physicians who do not participate in insurer networks. . . . We are concerned that this . . . small subset of physicians [will] drive up medical costs and insurance premiums." See Caroline Procter, *New Jersey Fines Aetna for Fee Schedule, Orders More Pay for Doctors*, *Amednews.com*, August 13, 2007 at p. 2.

4 *See, e.g.*, Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. §1395dd.

5 *See, e.g.*, *Neighborhood Health Partnership, Inc. v. Merkle*, 8 So. 3d 1180 (Fla. Dist. Ct. App. 2009) (HMO adopted a policy of reimbursing non-contracted providers of emergency services at a rate of 120 percent of the Medicare rate). In response to Aetna's practice of paying 125 percent of Medicare to non-contracted New Jersey providers of emergency services, the American Medical Association ("AMA") wrote, "The AMA cannot overemphasize its opposition to Aetna's policy of failing to adequately reimburse nonparticipating physicians, and strongly encourages Aetna to withdraw its policy of creating a ceiling tied to the Medicare fee schedule . . . Physicians must be immediately and correctly reimbursed for their billed charges." *See* Pamela Lewis Dolan, *Physicians Fight Aetna Over Caps of Out-of Network Pay*, *Amednews.com*, January 14, 2008, at p. 1. The general counsel for the Medical Society of New Jersey stated: "When patients come into the office under emergency situations, and they've purchased a contract of insurance, the physician expects to work on the patient and not have to chase down bills. We're not talking about elective procedures; we're talking about necessary and immediate health care. Physicians should be compensated appropriately for that." *See* Procter, *supra* note 5 at p. 2.

6 For those state agencies that have addressed the subject, consumer protection, rather than adequate provider reimbursement, has been the primary objective and focus. In trumpeting the

continued on page 34

continued from page 33

California Supreme Court's decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 198 P.3d 86 (Cal. 2009) prohibiting out-of-network providers from balance billing health plan subscribers for emergency services, the Director of California's Department of Managed Health Care said in a statement: "With today's ruling, we've started out the New Year right by removing a crushing economic burden off the backs of California health care consumers. . . 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 fairly paid." *See* Press Release, California Dept. of Managed Health Care, January 8, 2009.

7 *See* Fla. Stat. Ann. § 641.513(5) (2009).

8 *See, e.g., Prospect Medical Group*, 198 P.3d at 90-91 (recognizing that the methodology for determining the reimbursement to non-contracted providers can create obvious difficulties, and that in a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between).

9 In 2008, a bill was passed in California that would have set reimbursement rates at 250 percent of the Medicare allowable amount; however, the legislation was vetoed.

10 The Health Services Cost Review Commission is a commission created by the Maryland legislature that sets the rates that Maryland's hospitals may charge.

11 *See* Md. Code. Ann., Health-Gen, § 19-710.1 ("Payment of noncontractually provided services"). This statute has been amended, effective January 1, 2010, further defining "similarly licensed providers," distinguishing reimbursement for evaluation and management services from other services, defining the calculation of average rates paid, and empowering the Insurance Administration to enforce the statute's provisions. *See* 2009 Md. Laws Ch. 664 (H.B. 255).

12 *See* N.J. Dep't of Banking & Ins. Order No. A07-59, available at: http://www.state.nj.us/dobi/pressreleases/pr070725_ordera07_59.pdf.

13 However, if the provider balance billed the member, who in turn complained to Aetna about the balance billing, Aetna would pay the member the difference between the provider's billed charges and 125 percent of the Medicare allowable amount.

14 New Jersey law requires: that an HMO limit a member's liability for all services rendered during an admission to a network hospital when admitted by a network physician to the network copayment, deductible or coinsurance (*see* N.J. Stat. Ann. 11:22-5.6(b)); that an HMO limit a member's liability for emergency care rendered by out-of-network providers to the network copayment, deductible or coinsurance (*see* N.J. Stat. Ann. 11:24-5.3(b)); and, in the event an HMO refers a member to an out-of-network provider, that the HMO be fully responsible for payment to the provider and limit the member's liability to the network copayment, coinsurance or deductible (*see* N.J. Stat. Ann. 11:24-5.1(a)(1)).

15 The Department of Banking and Insurance also fined Aetna $9,457,500. As a result of the Settlement Agreement and Consent Order, the amount of the fine was reduced to $2.5 million. The details of the Consent Order can be found at: http://www.state.nj.us/dobi/division_insurance/insfines.htm.

16 Press Release, California Dept. of Managed Health Care, July 1, 2008.

17 United and Ingenix reached the agreement without any admission of liability or wrongdoing.

18 The insurers included: Group Health Incorporated and HIP Health Plan of New York; United Healthgroup, Inc.; Aetna, Inc.; MVP Health Care, Inc.; Healthnow New York, Inc., d/b/a BlueCross BlueShield of Western New York and BlueShield of Northeastern New York; Independent Health Association, Inc.; Cigna Corporation; Wellpoint, Inc.; Excellus Health Plan, Inc.; Capital District's Physician's Health Plan, Inc.; and the Guardian Life Insurance Company of America.

19 In the settlements, Aetna, Cigna and WellPoint agreed to stop using the Ingenix database anywhere.

20 Following these settlements, the New York Department of Insurance has proposed regulations requiring insurers that provide out of network benefits to use an independent source for establishing "usual and customary" rates and to respond to consumer requests for the disclosure of the specific amount of reimbursement for a particular procedure within three business days of a request. The proposed regulations can be found at: http://www.ins.state.ny.us/r_misc/draft_reg_ucr_062009.pdf

21 The settlements with the New York Attorney General are not the end of litigation arising out of the use of the Ingenix database. The AMA has filed separate class action lawsuits against Aetna, Cigna, Wellpoint and United Healthcare, alleging that these payors have been systematically understating the calculation of "usual, customary and reasonable" ("UCR") payments for out-of-network medical services. In a statement, the AMA's president stated: "We can no longer ignore the improper business practices of health insurers who decide to play by their own rules without regard to patients, or the legitimate costs required to care for them." See *American Medical Association, Others File Lawsuits Against Aetna, Cigna Alleging Physician Payment Deficiencies*, Medical News Today, February 11, 2009. The AMA reached a settlement with United Healthcare for $350 million.

22 *Weinberger v. Aetna Health, Inc.*, Case No. 1:06-cv-20249-Moreno/Torres, U.S. District Court, Southern District of Florida.

23 *See id., Final Approval Order and Judgment*, Docket No. 76, entered April 17, 2009.

24 *Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1196 (Fla. Dist. Ct. App. 2006).

25 Although Florida's intermediate state appellate courts have elucidated the statutory framework's goals and objectives, these appellate courts have stopped short of providing specific and definitive guidance as to how to practically apply the statute's reimbursement formula and methodology. Such real-world interpretations to date have been left to the sound discretion of Florida's state trial courts, with resulting inconsistencies and variations in the construction of key terms. Unless and until these Florida state trial court cases work their way up to the state's appellate courts, non-contracted providers and payors in Florida will have little clear direction as to the remaining open questions regarding the state's statutory framework.

26 *Coast Plaza Doctors Hospital v. Blue Cross of California, et al.*, 93 Cal. Rptr. 3d 479 (Cal. Dist. Ct. App. 2009). The California appellate court reversed the trial court's holding that the non-contracted hospital's claims for reimbursement of emergency services rendered to a health plan beneficiary were subject to ordinary preemption under ERISA, section 514(a), as set forth in 29 U.S.C. § 1144(a). The court held that the hospital's claims under section 1371.4 of California's Knox-Keene Health Care Service Plan Act of 1975, which requires a health plan to reimburse a provider for the cost of emergency care rendered to a health plan enrollee, were not subject to ordinary preemption under ERISA because the statute fell under the purview of ERISA's savings clause. *Id.* at 485-87.

27 *See* Keith Darc, *Hospitals' owner sues Kaiser over ER bills, The San Diego Union Tribune*, February 14, 2008. The article details a lawsuit filed in San Diego Superior Court by Prime Healthcare, the owner of several hospitals in Southern California, against Kaiser Permanente for Kaiser's alleged failure to reimburse the non-contracted hospitals for emergency services. One basis upon which Prime alleged Kaiser had denied payment was Kaiser's contention that the condition of some patients did not constitute "true emergencies."

28 *Coast Plaza Doctors Hospital*, 93 Cal. Rptr. 3d at 482, n. 4. In denying payment to a non-contracted hospital for emergency services, the health plan asserted that the patient's "condition was not an 'emergency medical condition.'" *Id.* The appellate court's decision dealt only with the ERISA preemption argument raised by the health plan, and did not address whether the services rendered to the patient were emergent in nature.

29 *Temple University Hospital*, 832 A.2d at 508-10.

30 *Neighborhood Health Partnership*, 8 So. 3d at 1184-85 (Fla. Dist. Ct. App. 2009) (Florida intermediate appellate court upheld trial court's rejection of HMOs' work product privilege objection to require production of HMOs' communications with private consulting company specializing in provider reimbursement and with State of Florida's Agency for Health Care Administration in

connection with non-contracted providers' dispute with HMOs regarding reimbursement of emergency services.).

[31] By "quasi-administrative," the authors mean a quasi-judicial or administrative procedure conducted either by a state agency or a private review organization under the auspices of a state agency and enacted or implemented by state statute, rule or regulation. *See, e.g.*, Fla. Stat. Ann. § 408.7057; Cal. Code Regs. Health & Safety Code § 1371.38.

[32] The full text of the process can be found at the California Department of Managed Health Care website, http://www.hmohelp.ca.gov/providers/clm/clm_idrp.aspx.

[33] Frank P. Fedor, "*Independent Dispute Resolution Process: No Cure for the Rate Issue*," Journal of the Healthcare Financial Management Association, May 2007, at pp. 44-47.

[34] Fla. Stat. Ann. § 408.7057 (2) (e-f); Fla. Admin. Code Ann. Rule 59A-12.030; *Health Options, Inc. v. Agency for Health Care Administration*, 889 So.2d 849, 850 (Fla. Dist. Ct. App. 2004).

[35] *Baycare Health Sys. Inc. v. Agency for Healthcare Admin.*, 940 So. 2d 563, 568 (Fla. Dist. Ct. App. 2006).

[36] *Id.* at n. 5 ("Even if the Maximus CHDR process was altered and equipped to adequately address legal issues, it would be an inefficient process because the resolution of each claim carries no precedential value. A lawsuit resolves not only the claim before the court, it also provides potentially binding precedent for future claims.").

[37] *Id.* at 568.

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