Balance Billing When You Don't Have a Contract With the Health Plan

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Anesthesiologists, like other hospital-based physicians, do not always have a contract with the health plan in which their patients are enrolled. Obtaining payment for their services can be a challenge. Should they bill the health plan or the patient? How much can they collect?

The answers to these questions depend principally on state law, which governs commercial health insurance. Many states ban balance-billing for amounts beyond plan copays and deductibles by contracted physicians. (On the federal level, physicians may not charge Medicare patients for more than the allowable amount, and they may not balance-bill Medicare Advantage plan enrollees at all.)

Few of the state statutes address the rights of non-contracted providers, however. A Los Angeles County appellate court recently looked at whether the California statute prohibiting balance-billing extended to non-contracted emergency physicians and decided, on February 17, 2006, that it did not. The decision in *Prospect Medical Group, Inc. v. Northridge Medical Group, Inc.* will almost certainly be appealed to the California Supreme Court, where its fate is uncertain. Until and unless it is overturned, however, it has precedential value in California, and judges in other states may follow its sound reasoning.

As Mark F. Weiss, Esq., a Los Angeles lawyer who spoke at the January 2006 ASA Conference on Practice Management, wrote in a personal communication, "The implications for all non-contracted providers, especially hospital-based doctors, are tremendous. Many of my clients have suffered this take it or leave it, 'we're reporting you to the Department of Managed Care,' or worse treatment at the hands [managed care plans]."

The California statute at issue in *Prospect Medical Group* provides that patients shall not be liable to a health care provider for sums due under contracts between the provider and a health plan, and that the provider shall not attempt to collect from or sue the patient. This statute (Business & Professions Code Section 1379) is part of the Knox-Keene Health Care Service Plan Act of 1975, which was enacted as a comprehensive system to regulate health plans and ensure that they maintain an adequate network of physicians and other providers. The plaintiff in *Prospect Medical Group* claimed that there was an "implied" contract between itself and the defendant emergency physicians that both prohibited balance-billing the patients and limited the physicians to collecting a "reasonable" payment equal to the Medicare allowance.

The *Prospect* court disagreed. It held:

First, that there was no explicit or implicit contract barring balance-billing. The prohibition only applies where there are "voluntarily negotiated contracts" between physicians and health plans. The federal Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals providing emergency room services to do so without regard to a patient's insurance or ability to pay, did not give rise to an implied contract between the physicians and the third-party payer. Note that EMTALA covers labor epidurals placed by anesthesiologists; under the *Prospect* logic, though, it could not be interpreted to prevent non-contracted anesthesiologists from balance-billing obstetrics patient.

Second, that the defendant emergency physicians were not required to accept the Medicare rate as full payment from the plaintiff. The court ruled that it did not have the authority to impose any payment rate and that in any event the California Department of Managed Health Care (DMHC) had stated that the Medicare rate was not appropriate as a benchmark for a "reasonable" rate. (See inset/box).

Third, that the plaintiff health plan, like the defendant physicians, would be able to contest the reasonableness of the fee charged in court, although the court could not itself set the amount.

Medicare as a Benchmark for "Reasonable Value" — *Not*

"The Department *[California Department of Managed Health Care]* recognizes that these government programs *[Medicare, Medicaid]* **are not designed to reimburse the provider for the fair and reasonable value of the services and are therefore an inappropriate criteria.**" (DMHC Statement in the rulemaking record supporting the Knox-Keene regulations.)

How much may non-contracted physicians charge?

In 2003, the California DMHC adopted a six-part test to

determine the "reasonable and customary" rate for paying non-contracted physicians, basing it upon "statistically credible information that is updated at least annually and that takes into consideration:

- The provider's training, qualifications and length of time in practice;
- The nature of the services provided;
- The fees usually charged by the provider;
- Prevailing provider rates charged in the general geographic area in which the services were rendered;
- Other aspects of the economics of the medical provider's practice that are relevant; and
- Any unusual circumstances in the case.

This six-part test is not likely to lend itself to easy application. There is no guidance on valuing the physician's qualifications or "other aspects of the economics of the medical provider's practice that are relevant," and "unusual circumstances" are as nebulous as a regulation can get. One commentator has noted that "prevailing provider rates charged in the general geographic area" may include rates charged to contracted health plans and thus full charges would not be as important a benchmark as it might seem. In the end, the DMHC analysis is not unlike the traditional *"in quantum meruit"* standard by which courts evaluate the amount that a party receiving services should pay to the party furnishing those services in the absence of a contract. The theory behind the *in quantum meruit* principle is that if the receiving party would be unjustly enriched if he or she paid nothing, that party should pay for the reasonable value of the services, or, as one court put it, "for what health care providers actually receive for their services."

Some states have simplified matters by legislating the rates that physicians and other providers may charge to a non-contracted health plan. Maryland, for example, does prohibit balance billing for "covered services" and, in the case of health maintenance organizations (HMOs), sets the maximum amount that a provider may collect at 125 percent of the HMO's contract rate, or 140 percent for trauma care. In Colorado, if an HMO patient knowingly goes out of network rather than travel a "reasonable' distance to receive services from a participating provider, the plan is still liable to the provider for the lesser of (a) billed charges, (b) a negotiated rate or (c) the usual and customary rates, and the patient may be billed for the balance. Another way to simplify matters is to ban balance-billing patients outright, for both participating and nonparticipating physicians, as Connecticut has done.

Laws and regulations on balance-billing vary widely from state to state and also from one year to the next. Any anesthesiology practice contemplating its options for collecting for services provided to out-of-network patients needs to familiarize itself with the applicable local statutes and regulations. Both the American Medical Association and the American Health Lawyers Association offer their members state-by-state information on this subject.

Source Materials:

- Prospect Medical Group, Inc. et al. v. Northridge Medical Group, Inc., et al., B172737 (Cal. Ct. App., 2d App. Dist. 2006) (Court's decision and opinion)
- Lucas C. Non-Contracted Provider Billing: The "Who?" and the "How Much?" *Health Lawyers News;* October 2005, 7-12.