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# the balancing role of balance billing

### AT A GLANCE

A recent court case, *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group et al.*, has ruled that emergency physicians are allowed to balance bill health plan subscribers when the plan itself underpays the providers. Partly at issue was whether the providers' contract with the health plan was only implied. The court's advice: Put all contracts in writing.

**One of the most controversial issues in managed care today is the payment rate for noncontracted providers of emergency services.** In a market-based managed care scheme, health plans and providers agree on the rate of payment for healthcare services in negotiated contracts. If a plan does not have a contract with a provider, it will not direct its subscribers to that provider. Nevertheless, some of the plan's subscribers will inevitably present at the emergency department of a noncontracted hospital where they will be treated by noncontracted emergency physicians. In a market-based system, the plan will pay these noncontracted providers their standard rates because this is the economic choice the plan made in deciding not to contract with them. This system is in fact the customary practice in health care.

### How Health Plans See It: "Unreasonable Charges"

In recent years, some plans have begun to argue that despite the fact that they paid a provider's full charges for years, those charges are now "unreasonable," and the plan need pay only a lesser "reasonable" amount that the plan unilaterally decides. This strategy forces the provider to sue the plan for the balance of its unpaid fees.

There are obvious benefits to the health plan of making the provider initiate a recovery action: It forces the provider to make the cost benefit analysis of whether to seek the underpayment, and small amounts are likely not to be pursued. Also, many providers are not used to using the legal process and will not pursue even larger amounts. Those providers that do initiate a recovery action may compromise the dispute, resulting in an after-the-fact "contract" for discounted rates for the claims in dispute.

The health plan obtains many of these benefits without making any initial investment in a dispute resolution process and can control its dispute resolution costs by fighting only the cases where it calculates it has a high probability of success. The leverage that a plan has in supporting this underpayment strategy is somewhat lessened by the provider's right to balance bill the plan's subscriber for the amount the plan underpays. Individual subscribers' complaints to the plan then may result

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in the plan fully paying such claims. Too many subscriber complaints to the state regulator may bring unwanted scrutiny or an enforcement action. Also, subscriber dissatisfaction is not useful at open enrollment and undercuts marketing campaigns.

#### **How Regulators See It: Subscribers in the Middle**

Regulators abhor balance billing because it puts the subscriber in the middle of the financial dispute between the plan and the provider. The consumer or employer has purchased plan benefits to obtain not only coverage, but also peace of mind. He or she does not want to be the subject of debt collection actions simply because the purchased health plan and the hospital or physician—often two large corporate entities—cannot work things out. Statutes thus commonly prohibit balance billing by providers that have a contract with a payer.

For example, section 1379 of the California Health and Safety Code states:

(a) Every contract between a plan and a provider of healthcare services shall be in writing, and shall set forth that in the event the plan fails to pay for healthcare services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

Under this statute, the provider's sole remedy is to pursue only the plan. Although such a contract term gives a plan great leverage in taking short-term loans from its contracted providers by underpaying them,

the term still makes good sense for the provider because the provider has knowingly agreed to the rate it is willing to accept, the balance-billing prohibition, and any other terms it can negotiate to protect itself in the event of a dispute.

#### **How a Recent Court Sees It: Rejecting the Implied Contract Argument**

California's Department of Managed Health Care, as well as California plans, also wanted to prevent non-contracted providers of emergency services from balance billing subscribers. They interpret subdivision (b) of the same section 1379 to also prohibit providers who they claim have an "implied contract" from balance billing. Subdivision (b) states:

In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan.

In the recent case of *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group et al.* (136 Cal.App.4th 1155, 2006), a California court of appeals limited the application of subdivision (b) to only voluntarily negotiated contracts.

Plaintiff Prospect Medical Group was an independent physician association that contracted with health plans. As part of these contracts, it accepted responsibility to pay for emergency services furnished by noncontracted providers to the plan subscribers for which Prospect was responsible.<sup>a</sup> Defendant Northridge Emergency Medical Group had exclusive licenses at two California hospitals to provide emergency department physician care.

Prospect argued that although it had negotiated no written or oral contract with Northridge, it did have one of two types of "implied" contracts, or both of them. These "implied" contracts arose solely from the facts that the Northridge emergency physicians were legally obligated to provide emergency services under federal and state law without regard to a

a. Under California's Knox-Keene Health Care Service Plan Act, Prospect was a "delegate" of its contracting health plans under Health and Safety Code §1371.4(e).

patient's insurance or ability to pay (42 U.S.C. §1395dd and California Health and Safety Code §1317[d]), and that Prospect, as the health plans' delegate, was legally obligated to pay Northridge.

Under common law principles applicable in most states, there are two types of implied contract. An implied-in-fact contract is just like a written or oral one, but the agreement is shown by conduct rather than by written or spoken words. An implied-in-law contract, also known by the Latin term *quantum meruit*, is not actually a contract because no agree-

provider, the member may be liable to the noncontracted provider for the cost of the services" (Title 22, California Code of Regulations §1300.63.1(c)[15]). The department would not have required that such a notice be given if section 1379 prohibited balance billing of the subscriber. The court also took judicial notice of a regulation proposed by the department that would have prohibited balance billing on the facts of the *Prospect* case, but that the department withdrew. The department would not have withdrawn this proposed regulation if it understood section 1379 to prohibit balance billing and thus provide the statutory

authority for the department to promulgate this regulation.

These implied contract arguments have also been used by plans to force confiscatory rates upon noncontracted providers of emergency

services. This effort was rejected in July 2005 by another California court of appeal in *Bell v. Blue Cross of California* (131 Cal.App.4th 211, 2005). *Bell* ruled that a noncontracted provider of emergency services has a right to recover the reasonable value of its services on the basis of an implied-in-law *quantum meruit* claim. The *Prospect* court similarly rejected Prospect's claim that what the Medicare program paid for emergency services should supply the default rate that plans owe to noncontracted providers who furnish emergency services to commercial subscribers.

The common theme of both the balance billing limitation and rate reduction strategies of the health plans is to impose by economic power a rate of payment for emergency services that is lower than what the plan can obtain by negotiations in the market place. This rejects the free-market approach that is the foundation of managed care.<sup>b</sup> Perversely, the plans' strategy seeks to replace a free market, not with state-mandated rates

## The health plan can control its dispute resolution costs by fighting only the cases where it calculates it has a high probability of success.

ment ever occurred. Rather, it is a legal remedy of reasonable value that is imposed on the recipient of a benefit to avoid unjust enrichment.

Applying a textual analysis of section 1379, the *Prospect* court concluded that the statute's references to "contracts" were limited to freely negotiated contracts "based upon traditional contractual principles such as a meeting of the minds." The court pointed to the requirement in subdivision (a) that every contract between a provider and health plan be in writing "to strongly suggest that the parties must have entered into a freely negotiated contract with a traditional meeting of the minds." The court stated that where the opening clause of subdivision (b) states, "in the event that the contract has not been reduced to writing as required by this chapter," it "must be referring to the contract referenced in subdivision (a), which is a freely negotiated contract, not an implied contract."

The court also addressed two actions of the Department of Managed Health Care that supported its analysis. First, the department had promulgated a regulation requiring plans to advise their subscribers in an evidence-of-coverage document that "in the event the healthcare plan fails to pay a noncontracted

b. See the analysis of the economic consequences of a Medicaid health plan's effort to use a Tennessee balance-billing statute to give the plan the right to impose rates on noncontracted providers in *River Park Hospital, Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W.3d 43 (2003).

(something that already exists with the Medicare, Medicaid, and other federal and state healthcare programs) but with rates mandated by one of the purported participants in the healthcare market.

**Is There a Solution?**

*Prospect* does not put the balance-billing issue to rest as it now moves to the California legislature. Based on the recent rulings by the *Bell* and *Prospect* courts that both providers and plans have a legal right to litigate the reasonable value of noncontracted emergency services, a strong policy argument exists that the best solution to the problem is to require the plans to pay the full charges of noncontracted providers of emergency services, subject to the right of the plan to challenge the reasonableness of the price of these charges in court.

First, payment of the full charges to a noncontracted provider was the customary practice that was applied for years and continues to be applied by many payers.

Second, this practice removes the subscriber from pricing disputes as there is no unpaid "balance" for the provider to bill the plan, and leaves the dispute to the interested parties to resolve. Finally, it forces the plan to make a rational business decision as to which provider rates it wants to challenge. A plan will likely not wish to invest in attacking the charges of all non-contracted providers of emergency services, but only those charges that it calculates it may be able to prove unreasonable.

However, if the legislatures continue to allow plans to exercise their market power by unilaterally paying less than full charges and thereby forcing providers to initiate legal proceedings, then this market power must continue to be balanced by allowing providers to balance bill subscribers. ●

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