CalAAEM LEGISLATIVE UPDATE

Emergency Services in Governor's Cross-Hairs

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Fair resolution to payment disputes involving EMTALA-mandated emergency care to patients who are "out-of-network" continues to elude our leaders in Sacramento. Traditionally, if a patient's health plan did not have a contract with the emergency physician, insurers were required to pay for all of the emergency care. However, in recent years, health plans have enacted a strategy of underpayment, claiming that physician charges are "unreasonable" and instead paying an arbitrarily discounted amount. Because the underpayments in dispute are typically eclipsed by the expense of litigation, the courts are not a viable venue for physicians' claims. Therefore, physicians have begun to seek fair compensation by sending a balance bill directly to their patients, much in the same way dentists bill patients for the services not covered by an insurance provider. This practice has resulted in consumer pressure on health plans to provide full indemnity for emergency care. Instead of heeding consumer demand, health plans have instead turned to Sacramento for relief.

Governor Schwarzenegger, in an Executive Order issued in July 2006, weighed in on this matter.[1] He released a press statement announcing that he would "protect" insured consumers from "balance billing, a practice that makes patients responsible for paying" their bills. The governor's policy asserts: "The state will try to provide extra tools to help ensure fair and fast payment – but leave the unwitting consumer out of it." On February 21, 2007, Senator Yee echoed the governor's position by introducing SB 389, a bill that essentially seeks to codify the governor's Executive Order.

It is perplexing that the governor seeks to keep the consumer "unwitting" of health plan underpayment. In fact, removing the consumer from the debate creates two unintended outcomes that drastically abrogate consumer power in the insurance market while simultaneously diminishing coverage. First, by shielding health plans from claims disputes, health plans incur little risk of losing enrollees due to dissatisfaction from sparse coverage. This allows health plans to continue profiting from their "unwitting" insured's premiums while not actually providing the indemnity promised. Second, insurance companies' power to unilaterally set rates for out-of-network emergency care destroys the health plans' incentive to create contracts with an adequate physician network. As a result, access to care erodes as Emergency Departments continue to shut down under growing financial strain and increasing difficulty finding specialists who are willing to participate in on-call panels. By keeping consumers ignorant of these issues, the governor is preventing Californians from making informed, market-driven decisions about which health plan to choose.

The governor's policy also creates an irresistible incentive for health plans to engage in unfair or even fraudulent business practices with little risk of punishment. Eradicating balance billing has shifted the financial burden for hundreds of millions of dollars of under-compensated care from health plans to individual physicians. A closer examination reveals a frightening business model. The average emergency physician's bill ranges between $300-$400 per patient. Unpaid portions of an individual bill are relatively small – found to be only $37 per patient, in one recent action against Health Net.[2] However, when a health plan underpays thousands of claims by a small amount, the total profit to the company is measured in the millions. This highlights a powerful business incentive to "discount" emergency services.

Unfortunately, the specter of action by the Department of Managed Health Care (DMHC) fails to deter these practices. As in the case with Health Net, fines are small compared with ill-gotten profits, and most physicians ultimately abandon their claims because the process is time-intensive and the reimbursement is nominal. Therefore, health plans have every incentive to create "disputed claims." Ultimately, more than $250 million per year in disputed claims sit in health plan coffers, inflating profits and further incentivizing unfair practices.

In fact, the pilot dispute resolution process instituted by DMHC in response to the governor's Executive Order was flawlessly constructed to benefit health plans. To illustrate, let's follow a typical $50 dispute from start to finish through the pilot "Independent Dispute Resolution Process (IDRP)." [3]

Step 1: The health plan denies, adjusts or contests a physician claim. **30-45 day delay**[4]

Step 2: The underpaid physician must overcome an aversion to the legal process, make a cost-benefit analysis of whether to seek the $50 underpayment, and attempt to guard against the risk of an after-the-fact "contract" for the rates agreed upon during the claims-resolution process.

Step 3: The disputed claim must be submitted to the health- plan's internal dispute process. **45 working-day delay**[5]

Step 4: If the resolution from the health plan's internal review process is unsatisfactory, then the underpaid physician

can turn to the DMHC's pilot IDRP. Participation requires the physician to agree "not to balance bill or otherwise seek to collect from the patient."

Step 5: The physician must submit a two-page Filing Coversheet, Provider Participation Agreement, a nine-page Claims Description Form, and a myriad of supporting documents. The physician must also pay **$25** to submit the claim. [6]

Step 6: Once the claim is submitted, the IDRP arbitrator, Maximus (the choice of Maximus raises further concerns given its troubled track record in Florida with making timely decisions, delays in payment, etc.) will review the dispute and issue a decision. **60 day delay**

The Cost-Benefit Analysis

Total Cost to Physician: 150+ days, $25, substantial time and effort completing forms

Total Benefit to Physician: potential net gain $25

Total Cost to Health Plan: potential net loss $50

Total Benefit to Health Plan: most physicians' cost-benefit analysis will result in abandoned claims, enhancing profits and inflating stock values by skimming physician payments

Total Cost to Patient: diminished access to care, inability fully participate in health-plan market

Various solutions to the fair-payment issue have been proposed. One solution enacted in Colorado compels health plans to pay the physician in full for out-of-network emergency care. This option removes the patient from the dispute and places the burden of challenging the reasonableness of claims on the health plans. Although seemingly an excellent option, this solution also fails to allow consumers to drive the market. Potential enrollees should be afforded the opportunity to know how their health plan is spending their premium dollars. Consumers should know which insurance plan spends more on medical care and less on administration and marketing. Health plans should be compelled to publish their networks and inform enrollees of contracted emergency facilities as well as disclose to potential enrollees the percentage of non-contracted emergency services that will not be underwritten. Required disclosure will empower consumers to compare plans and make informed insurance decisions. Transparency will also serve to restore healthy market incentives for insurers to improve their products as well as eliminate the expectation that doctors accept the burden of uncompensated work for the benefit of insurance company stockholders.

REFERENCES

1. Executive Order S-13-06 July 2006
2. DMHC Copnsent Decree, File No. 04-300 Jan. 12, 2005
3. See IRDP Complaint Form, available at http://www.dmhc.ca.gov/providers/clm/clm_idrp.asp
4. Health plans covered under the Know-Keene Health Care Service Plan Act of 1975 are required to provide explanation for fee adjustment/denial within 30 days for PPO or 45 days for HMO.
5. Knox-Keene Health Care Service Plan Act of 1975
6. Claims form and fee schedule are available at the DMHC website: http://www.dmhc.ca.gov/providers/clm/clm_idrp.asp