

## BALANCE BILLING: THE BAN ON UNFAIR BILLING PRACTICES INCREASES TENSION BETWEEN COST CONTROL AND QUALITY CARE

*If a physician perform[s] a major operation on a freeman with a bronze scalpel and . . . save[s] the freeman's life . . . he shall receive ten shekels of silver.<sup>1</sup>*

### INTRODUCTION

“Balance billing” is a term coined by the health care industry in which a physician bills a patient directly for costs of medical services that a health insurance company is unwilling to pay.<sup>2</sup> On January 8, 2009, the California Supreme Court determined that it is unlawful for emergency room physicians or hospitals to balance bill patients for the cost of emergency services.<sup>3</sup> This landmark decision, rendered in *Prospect Medical Group, Inc. v. Northridge Medical Group*, specifically affects physicians who do not have a contractual relationship with the patient’s insurance company, guaranteeing reimbursement for emergency care provided.<sup>4</sup>

The conflict concerning balance billing arises when a health maintenance organization (“HMO”) and a noncontracting physician disagree as to the cost of the services provided to a

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1. LYNN HUNT ET AL., *THE MAKING OF THE WEST: PEOPLE AND CULTURES* 15 (Bedford/St. Martin’s 2009) (citing JAMES B. PRICHARD, *ANCIENT NEAR EASTERN TEXTS RELATING TO THE OLD TESTAMENT* 175 (Princeton University Press 1969)) (on the Code of Hammurabi).

2. *See Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 87 Cal. Rptr. 3d 299, 301–02 (2009).

3. *Id.* at 299, 306. For convenience, this Note will refer to the role of providers loosely while recognizing the category is much broader than only emergency room physicians, such as hospitals. To the same end, this Note will refer to reimbursement entities as HMOs even though the category includes other groups as well, such as risk-bearing organizations or delegates.

4. *See id.* at 301, 306.

plan member.<sup>5</sup> When an emergency room physician contracts with a HMO, the HMO reimburses the physician at the contracted rate for services rendered to its plan members.<sup>6</sup> However, as required by law, noncontracting emergency room physicians provide necessary medical treatment to HMO plan members.<sup>7</sup> Because these doctors are not under contract with the HMO and have no predetermined contractual rate for the amount they may charge for services, they bill the insurance company the full cost of the services provided to the patient.<sup>8</sup>

More often than not, HMOs pay noncontracting health care providers less than the amount billed.<sup>9</sup> To make up for the shortfall in the insurance payment, emergency room physicians in California previously billed HMO members the difference between the amount reimbursed by the HMO and the cost of services provided to the patient.<sup>10</sup> As a result of the court's holding in *Prospect*, however, patients are not required to pay for the costs of services rendered by noncontracting emergency room physicians in excess of the amount covered by their HMO.<sup>11</sup>

Although the court acknowledged the existence of public policy considerations surrounding a ban on balance billing, it expressly declined to address the social and economic effects of its holding.<sup>12</sup> Thus, the California Supreme Court failed to

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5. *Id.* at 304.

6. *See* CAL. HEALTH & SAFETY CODE § 1379(a) (West 2008). Contracts between health care providers and insurance plans must be reduced to writing, providing that the sums owed by the plan are determined by the terms of the contract. *See id.*

7. *See* 42 U.S.C. § 1395dd (2000) (mandating that physicians at the federal level provide emergency services regardless of payment); *see, e.g.*, CAL. HEALTH & SAFETY CODE § 1317(d) (requiring all emergency room physicians in California to provide emergency services regardless of patients' ability to pay).

8. *See* discussion *infra* Part I.A.2.

9. *See Prospect*, 87 Cal. Rptr. 3d at 301 ("The conflict arises when there is no advance agreement between the emergency room doctors and the HMO regarding the *amount* of the required payment.").

10. *See, e.g., id.* at 302.

11. *Prospect*, 87 Cal. Rptr. 3d at 308 (holding that its decision mandates the HMO pay the doctor directly, "not [to] involve the patient in the payment process at all").

12. *Id.* at 309 (quoting *Bell v. Blue Cross of Cal.*, 31 Cal. Rptr. 3d 688, 697 (Cal. Ct. App. 2005)) ("[W]e reject the parties' suggestion that we can solve the societal and economic problems defined by their rhetoric, and emphasize

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recognize the pressure that the ban places on noncontracting emergency room physicians to deliver emergency medical care without just compensation. The ban substantially increases the financial burden on noncontracting emergency room physicians.<sup>13</sup> Essentially, these doctors must choose between accepting a substantially lower payment for the services rendered and litigating the matter to receive full payment.<sup>14</sup> The ban on balance billing may also discourage emergency room physicians from taking certain cases or may even cause them to leave emergency practice altogether.<sup>15</sup> Consequently, this ban could create access problems for emergency room patients and inadvertently compromise the quality of emergency care in general.<sup>16</sup>

Under current statutory law, it is unlawful for HMOs to engage in unfair payment reimbursement and claim denials.<sup>17</sup> As it stands now, however, unless physicians report HMOs to the Department of Managed Health Care (“DMHC”), HMOs can determine the minimum amount to reimburse emergency room physicians.<sup>18</sup> The power of insurance companies to select an arbitrary payment amount and the limitations physicians face in collecting full payment demonstrates a flaw in the California health care system, and necessitates a change in the law.

Rather than enact laws that place pressures on emergency room physicians to deliver care without just compensation, the legislature should enact laws that put pressure on insurance companies to fully compensate physicians for the cost of services rendered. Part I of this Note summarizes the development of managed care in the United States and the health care legislation that has shaped balance billing regulations in California. Part II considers the economic and legal pressures on emergency room physicians, the current condition of California’s emergency rooms and hospitals, and economic and fiscal effects on patient access to emergency room treatment. In particular, this section highlights the effect that the ban may have on an already

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that our decision is limited to the precise issue before us . . .”).

13. See discussion *infra* Part II.A.

14. See discussion *infra* Part II.A.

15. See discussion *infra* Part II.C.

16. See discussion *infra* Part II.C.

17. CAL. HEALTH & SAFETY CODE § 1371.37 (West 2008).

18. See CAL. HEALTH & SAFETY CODE § 1371.39.

burdened emergency room system. Part III proposes an amendment to the Knox-Keene Act,<sup>19</sup> providing an adequate compensatory scheme for all noncontracting emergency room physicians and resolving the disproportionate control managed care companies have over health care providers. This solution will maintain incentives for emergency room physicians to practice in California and, in turn, ensure that patients have access to emergency treatment in California's emergency rooms and hospitals.

### I. THE ORGANIZATION OF MANAGED CARE AND THE BAN ON BALANCE BILLING

State law primarily governs the regulation of health insurance.<sup>20</sup> State agencies, such as the DMHC,<sup>21</sup> regulate states' health care provisions by restricting health care costs and services.<sup>22</sup> In California, HMOs—as opposed to other types of managed care organizations (“MCOs”)—primarily manage medical care for a large majority of medical care recipients.<sup>23</sup> Because California currently has more than 6.7 million residents without health insurance,<sup>24</sup> the government has a strong incentive to insure its residents and regulate California's health care costs effectively. A brief overview of the health care industry and the law that has influenced the ban on balance billing illustrate the manner in which California's protective measures have taken shape.

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19. CAL. HEALTH & SAFETY CODE §§ 1340-1399 (originally enacted as the Knox-Keene Health Care Service Plan Act of 1975).

20. McCarran-Ferguson Act, 15 U.S.C.A. § 1012(a) (West 1997).

21. The DMHC is primarily responsible for regulating and licensing health care services in accordance with the Knox-Keene Act. *See* CAL. HEALTH & SAFETY CODE § 1341(a).

22. *See, e.g., id.*

23. *See* Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, 87 Cal. Rptr. 3d 299, 301 (2009).

24. Harry W.R. Chamberlain II, *Out of Balance: The California Supreme Court Will Decide Whether “Balance Billing” Unfairly Puts Patients in the Middle of Fee Disputes Between Providers and Health Plans*, 49 ORANGE COUNTY LAW. 26, 27 (2007).

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A. *The Development of Managed Care: An Alternative to the Fee-for-Service System*

The purpose of health insurance is to shift the risk of unexpected or costly medical expenses from the individual to the insurance company.<sup>25</sup> The earliest health care regulatory scheme in the United States shifted this risk so much that the federal government found it necessary to intervene, controlling the costs incurred by insurance companies through various limitations.<sup>26</sup> The following sections discuss the development of health care regulation in California, and the varying costs patients and physicians incur.

1. *The Shift to Managed Care Organizations*

Health insurance is a recent development in the United States.<sup>27</sup> Insurance coverage did not become widespread until the Great Depression of the 1930s.<sup>28</sup> In 1945, Congress enacted the McCarran-Ferguson Act, which affirmed that states have the right to regulate health insurance.<sup>29</sup> The first insurance regulatory system utilized by the health care industry operated under a fee-for-service (“FFS”) system, where insurance companies paid health care providers a particular fee for each type of service performed.<sup>30</sup>

The FFS system, in its operation, allowed physicians

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25. BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 564 (6th ed. 2008) (“Insurance involves by definition the transfer of risk from the insured (also called the beneficiary, recipient, member, or enrollee) to a financing entity (the insurer, managed care organization, or self-insured benefits plan).”).

26. See Barry Furrow, *Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos*, 43 *VILL. L. REV.* 361, 367 (1998); 42 *U.S.C.* § 300e (2000).

27. FURROW, *supra* note 25, at 559.

28. *Id.*

29. See 15 *U.S.C.A.* §§ 1011-1015 (West 1997).

30. Jacob S. Hacker & Theodore R. Marmor, *How Not to Think About “Managed Care”*, 32 *U. MICH. J.L. REFORM* 661, 668 n.28 (1999) (citing THEODORE R. MARMOR, *UNDERSTANDING HEALTH CARE REFORM* 260 (1994)) (“‘Fee-for-service’ is a system of reimbursement in which a medical provider charges a patient (or third party payer) a specific price for a specific service.”).

complete discretion as to the medical services they provided.<sup>31</sup> As insurance companies reimbursed physicians and hospitals for all services performed—even unnecessary services—this insurance structure proved to be quite costly.<sup>32</sup> By the 1970s, the escalating costs of FFS medicine created a national health care crisis.<sup>33</sup> As a result, Congress passed the Health Maintenance Organization Act of 1973 to promulgate the growth of HMOs, the leading form of managed care.<sup>34</sup>

Managed care is a delivery system that attempts to regulate health care finances and maintains the delivery of medical services.<sup>35</sup> In order to operate effectively, managed care plans contract with physicians and place cost restrictions on the amount charged for medical care by service providers.<sup>36</sup> This, in turn, limits the patients' choice of physicians they can seek for medical services.<sup>37</sup>

MCOs limit the cost of care through a variety of techniques. For example, MCOs commonly require utilization review to examine the medical necessity of a specific procedure before the organization will authorize and cover the requested service.<sup>38</sup> MCOs also place controls on inpatient admissions and the length of hospital stays—to the extent individual insurance guidelines permit—based on the patient's condition and necessity of treatment.<sup>39</sup> In addition, MCOs provide economic incentives for physicians and patients, who participate in less costly forms of medical care.<sup>40</sup>

The managed care system was meant to bring doctors and hospitals in-line with current economic conditions.<sup>41</sup> As such,

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31. *See id.* at 667.

32. *See id.*

33. Furrow, *supra* note 26, at 367.

34. *See* 42 U.S.C. § 300e (2000); Hacker & Marmor, *supra* note 30, at 669.

35. *See* Hacker & Marmor, *supra* note 30, at 667 n.26 (quoting STEDMAN'S MEDICAL DICTIONARY 283 (26th ed. 1995)) (“[Managed care is] an arrangement whereby a third-party payer . . . mediates between physicians and patients, negotiating fees for service and overseeing the types of treatment given.”).

36. *See* FURROW, *supra* note 25, at 592.

37. *See id.*

38. *See id.* at 592–94.

39. *See id.* at 594.

40. *Id.* at 596.

41. Hacker & Marmor, *supra* note 30, at 667.

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this new health care regulation promised cost-control, organization and cooperation, and improved management and care between physicians and MCOs superior to the system provided by FFS.<sup>42</sup> Until the 1990s, the distinction between insurance and managed care was quite apparent.<sup>43</sup> Today, however, they are practically indistinguishable, as a variety of private insurance plans currently use managed care techniques to control costs for plan members.<sup>44</sup>

## 2. *HMOs and Their Role in Balance Billing Practices*

HMOs are one form of MCOs, which typically limit their members to an exclusive network of providers.<sup>45</sup> HMOs permit their enrollees to go to noncontracting or out-of-network providers only in limited circumstances, such as medical emergencies.<sup>46</sup> Consequently, when plan members are in need of emergency services, ambulances or family members rush them to hospitals where physicians may or may not have preexisting contracts with the HMO.<sup>47</sup> As required by statutory law, physicians must provide emergency care to patients regardless of their ability to pay for the services rendered.<sup>48</sup> Accordingly, HMOs are statutorily required to pay some amount for the emergency care of their members, regardless of whether the physician performing the service is under contract.<sup>49</sup>

HMOs may deny immediate payment for emergency services when noncontracting emergency room physicians and

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42. *Id.*

43. *See* FURROW, *supra* note 25, at 559 (“[I]t was possible, and indeed sensible, to make a distinction between insurance (meaning indemnity or service benefit insurance) and managed care as different approaches to financing health care.”).

44. *Id.*

45. *See* FURROW, *supra* note 25, at 564–65.

46. *Id.* at 564.

47. *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 87 Cal. Rptr. 3d 299, 301 (2009).

48. *See* 42 U.S.C. § 1395dd (2000) (mandating that physicians at the federal level provide emergency services regardless of payment); CAL. HEALTH & SAFETY CODE § 1317 (West 2004) (requiring all emergency room physicians in California provide emergency services regardless of patients’ ability to pay).

49. CAL. HEALTH & SAFETY CODE § 1371.4(b) (“A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees . . . .”); *see also Prospect*, 87 Cal. Rptr. 3d at 301.

HMOs do not agree on the payment amount.<sup>50</sup> If no preexisting contract exists, HMOs typically pay emergency room physicians the “reasonable and customary” amount.<sup>51</sup> Most commonly, disputes arise when HMOs consider a request for payment unreasonably high and deny full payment for the services rendered.<sup>52</sup> In the past, physicians would remedy such disputes by engaging in balance billing to collect payment for the unpaid balance of the services performed.<sup>53</sup>

State legislation differs on how to address the balance billing issue.<sup>54</sup> Some state legislatures have enacted statutes to protect patients from billing disputes between medical providers and insurers.<sup>55</sup> Most of these states leave the dispute concerning

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50. See *Prospect*, 87 Cal. Rptr. 3d at 301–02; LOIS GREEN ET AL., CALIFORNIA HEALTHCARE FOUNDATION, ON-CALL PHYSICIANS AT CALIFORNIA EMERGENCY DEPARTMENTS: PROBLEMS AND POTENTIAL SOLUTIONS 3 (2005), <http://www.chcf.org/documents/hospitals/OnCallPhysiciansAtCAEmergencyDepts.pdf> [hereinafter CHF] (noting that over fifty percent of on call medical specialists in California reported that insurance companies have refused to pay for emergency services).

51. *Prospect*, 87 Cal. Rptr. 3d at 304 (“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.”).

52. *Id.* at 301–02.

53. See Chamberlain, *supra* note 24, at 27–28 (discussing the past practice of balance billing); *Prospect*, 87 Cal. Rptr. 3d at 302, 306 (prohibiting emergency room physicians from engaging in the practice of balance billing).

54. Compare COLO. REV. STAT. § 10-16-704(3)(a)(II) (2007) (indicating noncontracting physicians cannot hold patients responsible for emergency services when patients are unaware that they are receiving services from out-of-network physicians), R.I. GEN. LAWS § 27-41-26 (2008) (specifying that no HMO members are liable for charges covered by the HMO, except for the amount in copayments), MASS. GEN. LAWS ANN. ch. 176G, § 5(f) (West 2007) (providing that HMOs must indemnify a member or health care provider for the reasonable amount charged by a noncontracting physician for emergency medical services received), and W. VA. CODE ANN. § 33-25A-7a(6) (LexisNexis 2006) (stating that HMOs are responsible for payment to noncontracting providers for the normal charges for those health care services, minus any deductibles or copayments), with FLA. STAT. ANN. § 641.513(5) (West 2005) (indicating that noncontracting providers must be reimbursed the lesser of the provider’s charges, the usual and customary provider charges for similar services in the same geographic area, or the charge mutually agreed to by the HMO and the provider within 60 days of the submittal of the claim), and *Prospect*, 87 Cal. Rptr. 3d at 306 (citing CAL. CODE REGS., tit. 28, § 1300.71) (stating that noncontracting providers must be reimbursed at a reasonable rate determined by various factors, including provider training, the nature of the services, and prevailing provider rates).

55. See COLO. REV. STAT. § 10-16-704(3)(a)(II); R.I. GEN. LAWS § 27-41-26; MASS. GEN. LAWS ANN. ch. 176G, § 5(f); W. VA. CODE ANN. § 33-25A-7a(6).

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the amount of reimbursement to be handled solely by the insurance companies and noncontracting providers.<sup>56</sup> Other states protect patients from the financial burdens of unpaid emergency services by requiring health insurance plans to pay providers in full before disputing the reasonable amount.<sup>57</sup> The *Prospect* case offered California the opportunity to finally resolve the balance billing issue for noncontracting emergency room physicians.

*B. The Ban on Balancing Billing for Noncontracting Emergency Physicians in California*

On January 8, 2009, the California Supreme Court prohibited the ability of noncontracting physicians to engage in the practice of balance billing through its interpretation of the Knox-Keene Act.<sup>58</sup> Despite the lack of express language in the statute, the court made this determination by examining “the purpose of the statute, the evils to be remedied, and public policy.”<sup>59</sup> Although the *Prospect* decision prohibited noncontracting physicians from engaging in balance billing, other judicial and legislative proceedings foreshadowed *Prospect*’s holding.

*1. The Knox-Keene Health Care Service Plan Act*

The Knox-Keene Act is a comprehensive health care statute that governs the regulation and licensing of medical care in California.<sup>60</sup> The Act provides for basic health care services, including emergency services and payment to medical providers

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56. See COLO. REV. STAT. § 10-16-704(3)(a)(II) (stating that when a HMO patient unintentionally receives medical services from a noncontracting emergency room provider, the physician cannot hold the patient liable for the cost incurred); R.I. GEN. LAWS § 27-41-26 (providing that HMO patients are only liable to physicians for copayments for emergency services rendered). *But see* MASS. GEN. LAWS ANN. ch. 176G, § 5(f) (indicating that HMOs must indemnify members for charges incurred from emergency services rendered by noncontracting physicians).

57. DEL. CODE ANN. tit. 28, § 3565 (Supp. 2008) (requiring that HMOs fully reimburse physicians for emergency services provided to members of blanket or group policies).

58. See *Prospect*, 87 Cal. Rptr. 3d at 305–06.

59. *Id.* at 306.

60. *Bell v. Blue Cross of Cal.*, 31 Cal. Rptr. 3d 688, 691 (Cal. Ct. App. 2005) (citing *Cal. Med. Ass’n v. Aetna U.S. Healthcare of Cal., Inc.*, 114 Cal. Rptr. 2d 109, 121 (2001)); see CAL. HEALTH & SAFETY CODE §§ 1340-1399 (West 2008).

for these services.<sup>61</sup> Its purpose is to ensure that patients receive low-cost, quality health care from their health care plans.<sup>62</sup> The Knox-Keene Act expressly prohibits balance billing for physicians who contract with insurance companies, but fails to address billing restrictions for noncontracting emergency room physicians.<sup>63</sup>

If services rendered were, in fact, necessary, HMOs must reimburse emergency room physicians for services provided to all HMO enrollees.<sup>64</sup> HMOs may deny payment to providers for emergency services only if the health plan reasonably determines that the physician never performed the emergency service.<sup>65</sup> In other words, a health plan may interpret a provided service as a non-emergency service and deny a physician payment for the service performed.

If a procedure qualifies as an emergency service, the insurance company determines the reimbursement rate based on a standard of reasonableness—the reasonable and customary value.<sup>66</sup> In California, the DMHC issued regulations providing that HMOs must pay noncontracting providers:

[T]he reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes 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 . . . .<sup>67</sup>

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61. See CAL. HEALTH & SAFETY CODE § 1371.4 (Supp. 2009).

62. See CAL. HEALTH & SAFETY CODE § 1342.6 (“It is the intent of the legislature to ensure that the citizens of this state receive high-quality coverage in the most efficient and cost-effective manner possible.”).

63. See *id.* at § 1379; see also *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 39 Cal. Rptr. 3d 456, 460 (Cal. Ct. App. 2006) (interpreting CAL. HEALTH & SAFETY CODE § 1379 to only prohibit balance billing between a contracting provider and an insurance plan).

64. See *Prospect*, 87 Cal. Rptr. 3d at 304 (citing CAL. HEALTH & SAFETY CODE § 1371.4).

65. CAL. HEALTH & SAFETY CODE § 1371.4.

66. *Prospect*, 87 Cal. Rptr. 3d at 303–04.

67. *Bell v. Blue Cross of Cal.*, 31 Cal. Rptr. 3d 688, 691–92 (Cal. Ct. App. 2005) (quoting CAL. CODE REGS. tit. 28, § 1300.71(a)(3)(B) (2009)).

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The specific amount a physician will be paid is not dependent on the usual fee charged by a contracting physician.<sup>68</sup> In practice, HMOs might base their payment amount on: (1) the bill a physician submits; (2) the amount another HMO paid for the same service; or (3) some rate in between.<sup>69</sup>

Before July 2000, the Health Plan Division of the California Department of Corporations regulated managed care plans pursuant to the Knox-Keene Act.<sup>70</sup> In July 2000, the legislature transferred the duty of oversight to the DMHC.<sup>71</sup> The California legislature intended for the DMHC to control the costs and services of physicians, and ensure that managed care plans comply with the regulations of the Knox-Keene Act.<sup>72</sup> Any payment disputes fall under the jurisdiction of the DMHC because it is the state agency empowered to regulate and resolve disputes between insurance plans and providers.<sup>73</sup> Whether the DMHC is the only avenue in which emergency room physicians may seek reimbursement from health insurance companies was first addressed in *Bell v. Blue Cross of California*.

## 2. *Recognizing a Private Action for Noncontracting Emergency Physicians Against Insurance Companies: Bell v. Blue Cross of California*

In *Bell v. Blue Cross of California*, Dr. Mark R. Bell, a noncontracting emergency room physician, brought an action against Blue Cross, a health insurance plan, for unfair business

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68. See *id.*; *Geddes v. United Staffing Alliance Employee Med. Plan*, 469 F.3d 919, 930 (10th Cir. 2006).

69. *Prospect*, 87 Cal. Rptr. 3d at 304.

70. See *Cal. Med. Ass'n, Inc. v. Aetna U.S. Healthcare of Cal., Inc.*, 114 Cal. Rptr. 2d 109, 117 n.12 (Cal. Ct. App. 4th 2001); see also CAL. HEALTH & SAFETY CODE § 1341.11.

71. See *Cal. Med. Ass'n*, 114 Cal. Rptr. 2d at 117 n.12; see also CAL. HEALTH & SAFETY CODE § 1341.11.

72. See CAL. HEALTH & SAFETY CODE § 1341(a); see also *Cal. Consumer Health Care Council, Inc. v. Cal. Dep't of Managed Health Care*, 74 Cal. Rptr. 3d 215, 217 (Cal. Ct. App. 2008); *Medeiros v. Superior Court*, 53 Cal. Rptr. 3d 307, 315 (Cal. Ct. App. 2007); *Consumer Clause, Inc. v. Nat'l Vision, Inc.*, 4 Cal. Rptr. 3d 448, 450 (Cal. Ct. App. 2003).

73. See *Bell*, 31 Cal. Rptr. 3d at 692; *Coasta Plaza Doctors Hosp. v. UHP Healthcare*, 129 Cal. Rptr. 2d 650, 658 (Cal. Ct. App. 2002) (stating the DMHC does not have *exclusive* jurisdiction to enforce provisions of the Knox-Keene Act).

practices.<sup>74</sup> Bell asserted that Blue Cross habitually underpaid him for emergency services he provided to plan members.<sup>75</sup> Bell argued that since he had a statutory duty to render services to patients regardless of their ability to pay, Blue Cross also had a statutory duty to reimburse him for the cost of the services rendered.<sup>76</sup> The California Court of Appeals for the Second District accepted Bell's argument.<sup>77</sup> The court also held that the Knox-Keene Act did not preclude a noncontracting physician from maintaining a private action against a health insurance company to contest the amount of the plan's reimbursement.<sup>78</sup>

The court in *Bell* reinforced the notion promulgated by the DMHC that noncontracting providers should have the ability to sue in alternative forums outside the limited, exclusive jurisdiction of the DMHC.<sup>79</sup> The DMHC expressed the opinion that "health care providers must be allowed to maintain a cause of action in court to resolve individual claims—payment disputes over the reasonable values of their services."<sup>80</sup> Accordingly, the court found that noncontracting emergency room physicians retain the right to sue HMOs under unfair competition laws and in "quantum meruit" for payment disputes that are allegedly below the value of the providers' services.<sup>81</sup>

Further, the court noted that the Knox-Keene Act requires insurance plans to reimburse doctors at a reasonable amount, as opposed to any arbitrary rate that the insurance company

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74. *Bell*, 31 Cal. Rptr. 3d at 690.

75. *See id.*

76. *Id.* (citing CAL. HEALTH & SAFETY CODE § 1371.4(b)).

77. *See id.* at 695.

78. *See id.* at 691. The Court affirmed that the Knox-Keene Act "compels for-profit health care service plans to reimburse emergency health care providers for emergency services to the plans' enrollees." *Id.* (citing CAL. HEALTH & SAFETY CODE § 1371). A health insurance plan must "reimburse claims . . . unless the claim or portion thereof is contested by the plan." *Id.* (citing CAL. HEALTH & SAFETY CODE § 1371). Additionally, a for-profit health insurance plan "shall reimburse providers for emergency services and care provided to its enrollees, until care results in stabilization of the enrollee . . ." *Id.* (citing CAL. HEALTH & SAFETY CODE § 1371.4).

79. *See id.* at 694.

80. *Id.* (citing Brief of the Dep't of Managed Health Care, *Bell v. Blue Cross of Cal.*, 31 Cal. Rptr. 3d 688 (Cal. Ct. App. 2005) (No. B174131), 2005 WL 1124595, at \*4).

81. *Id.* at 691, 693–94. "Quantum meruit" is Latin for "as much as he has deserved." BLACK'S LAW DICTIONARY 1276 (8th ed. 2004).

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chooses.<sup>82</sup> In *Bell*, the court recognized that emergency room doctors retain the right to sue HMOs directly when payment disputes arise over the reasonable rate.<sup>83</sup> But, even after *Bell*, some noncontracting emergency room physicians continued to accept unreasonably low reimbursements from HMOs and billed patients directly for payment of the balance.<sup>84</sup>

### 3. *The California Legislature's Proposals to Amend the Knox-Keene Act*

On September 25, 2006, Governor Arnold Schwarzenegger issued an executive order directing the DMHC to take any measures necessary to prohibit balance billing.<sup>85</sup> In response to the Governor's direction, the DMHC promulgated rules to define balance billing as an "unfair billing practice."

[T]he practice, by a provider of emergency services, including but not limited to hospitals and hospital based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services.<sup>86</sup>

The California Medical Association and other providers disputed the rules as invalid and unenforceable, and brought a lawsuit for injunctive and declaratory relief in the California Superior Court.<sup>87</sup> The court ruled, however, that the DMHC's balance billing regulations were valid and enforceable against any violators.<sup>88</sup>

Also responding to the Governor's request to resolve the

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82. *Bell*, 31 Cal. Rptr. 3d at 695.

83. *Id.* at 694.

84. See Chamberlain, *supra* note 24, at 28; see also ANNE S. KIMBOL, THE BATTLE OVER BALANCE BILLING COMES TO A HEAD IN CALIFORNIA (2008), [http://www.law.uh.edu/healthlaw/perspectives/2008/\(AK\)%20balance%20billin g.pdf](http://www.law.uh.edu/healthlaw/perspectives/2008/(AK)%20balance%20billin g.pdf).

85. Exec. Order No. S-13-06, *reprinted in* CAL. HEALTH & SAFETY CODE § 1340 app. at 5–6 (West 2008).

86. See CAL. CODE REGS. tit. 28, § 1300.71.39(b)(1) (2009).

87. Cal. Med. Ass'n et al. v. Dep't of Managed Health Care et al., No. 34-2008-80000059 (2007), <http://www.calacep.org/advocacy/legal/index.php> (follow "CMA v. DMHC – Tentative Ruling November 2008" link, located under CMA v. DMHC).

88. See *id.*

balance billing issue, the General Assembly passed A.B. 2220 on August 29, 2008.<sup>89</sup> Likewise, the California Senate passed S.B. 981 on September 3, 2008.<sup>90</sup> The legislature's primary purpose for enacting both bills was to protect HMO enrollees from billing disputes between HMOs and physicians over services the HMO is obligated to pay.<sup>91</sup> Both bills purported to effectively ban the practice of balance billing, providing noncontracting physicians with alternative measures to collect any disputed payments.<sup>92</sup> One bill proposed a mediation process where physicians could discuss reimbursement amounts.<sup>93</sup> Another bill suggested that all insurance plans should adopt an alternative dispute resolution process that would accommodate physicians more effectively than the traditional judicial forum.<sup>94</sup>

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89. A.B. 2220, 2007-2008, Reg. Sess. (passed by Assembly Aug. 29, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab\\_2201-2250/ab\\_2220\\_bill\\_20080905\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_2201-2250/ab_2220_bill_20080905_enrolled.pdf).

90. S.B. 981, 2007-2008, Reg. Sess. (passed by Senate Sept. 3, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb\\_0951-1000/sb\\_981\\_bill\\_20080903\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0951-1000/sb_981_bill_20080903_enrolled.pdf).

91. *Id.* ("It is the intent of this act to protect enrollees of health care service plans from being billed when the plans, or their contracting risk-bearing organizations, and noncontracting emergency physicians dispute the amount of a claim."); *see also* A.B. 2220, 2007-2008, Reg. Sess., at 3 (passed by Assembly Aug. 29, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab\\_2201-2250/ab\\_2220\\_bill\\_20080905\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_2201-2250/ab_2220_bill_20080905_enrolled.pdf) ("Mutually agreed-upon contracts between emergency physicians and health care service plans or risk-bearing organizations avoid the problem of balance billing where consumers are placed in the middle of payment disputes between emergency physicians and health care service plans or risk-bearing organizations.").

92. *See* S.B. 981, 2007-2008, Reg. Sess., at 4 (passed by Senate Sept. 3, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb\\_0951-1000/sb\\_981\\_bill\\_20080903\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0951-1000/sb_981_bill_20080903_enrolled.pdf); A.B. 2220, 2007-2008, Reg. Sess., at 3 (passed by Assembly Aug. 29, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab\\_2201-2250/ab\\_2220\\_bill\\_20080905\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_2201-2250/ab_2220_bill_20080905_enrolled.pdf).

93. A.B. 2220, 2007-2008, Reg. Sess., at 3 (passed by Assembly Aug. 29, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab\\_2201-2250/ab\\_2220\\_bill\\_20080905\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_2201-2250/ab_2220_bill_20080905_enrolled.pdf) ("The purpose of this act is to encourage the successful negotiation of contracts between emergency physicians and health care service plans or risk-bearing organizations via the use of mediation between the parties.").

94. S.B. 981, 2007-2008, Reg. Sess., at 4 (passed by Senate Sept. 3, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb\\_0951-1000/sb\\_981\\_bill\\_20080903\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0951-1000/sb_981_bill_20080903_enrolled.pdf) ("It is further the intent of this act to establish a fair, fast, and cost-effective dispute resolution process, administered by an independent third party and overseen by the Department of Managed Health Care, for the resolution of claim payment disputes between noncontracting emergency physicians and health care service plans, or their contracting risk-bearing organizations.").

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On September 30, 2008, however, Governor Schwarzenegger vetoed S.B. 981 and A.B. 2220.<sup>95</sup> The Governor concluded that the bills would not protect insured patients from billing disputes because the legislation failed to effectively transfer the financial risk and cost of health care from patients to providers.<sup>96</sup> The Governor's vetoes indicate that although he opposed balance billing, he found both bills objectionable on other grounds.<sup>97</sup> As these bills demonstrate, the California legislature attempted to resolve the pressing issue of balance billing.<sup>98</sup> The California Supreme Court later resolved this issue in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*.<sup>99</sup>

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95. Letter from Arnold Schwarzenegger, Cal. Governor, to Cal. State Senate (Sept. 30, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb\\_0951-1000/sb\\_981\\_vt\\_20080930.html](http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0951-1000/sb_981_vt_20080930.html) [hereinafter S.B. Veto]; Letter from Arnold Schwarzenegger, Cal. Governor, to Cal. State Assembly (Sept. 30, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab\\_2201-2250/ab\\_2220\\_vt\\_20080930.html](http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_2201-2250/ab_2220_vt_20080930.html) [hereinafter A.B. Veto].

96. S.B. Veto, *supra* note 95 (“Our health care system relies on physicians, hospitals and health plans to work together. The patient that pays health insurance premiums should not be part of a payment dispute between these sophisticated market players.”). In vetoing the bills, the Governor likely sought to comply with the purpose of the Knox-Keene Act, which is “to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.” See CAL. HEALTH & SAFETY CODE § 1342(d) (West 2008).

97. *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 87 Cal. Rptr. 3d 299, 308 (2009) (stating that the Governor indicates in his letters that he opposes balance billing); see S.B. Veto, *supra* note 95 (“I cannot agree to a measure that is a piecemeal approach to our broken health care system . . . . It is unfortunate that this bill takes sides in the dispute within the health care industry instead of taking the side of patients.”); A.B. Veto, *supra* note 95 (“This bill attempts to change the market dynamic in a way that encourages contracts between health plans and providers. It is a good starting point. Unfortunately, it does not contain the comprehensive solution that patients need and deserve when it comes to addressing the disgraceful practice of balance billing.”).

98. See S.B. 981, 2007-2008, Reg. Sess. (passed by Senate Sept. 3, 2008), [http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb\\_0951-1000/sb\\_981\\_bill\\_20080903\\_enrolled.pdf](http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0951-1000/sb_981_bill_20080903_enrolled.pdf).

99. See 87 Cal. Rptr. 3d at 306 (prohibiting the practice of balance billing for noncontracting emergency room physicians when HMOs are obligated to pay for patients' services).

#### 4. *The California Supreme Court Weighs in on Balance Billing: Prospect Medical Group*

Through the enactment of the Knox-Keene Act, the California legislature prohibited the practice of balance billing by emergency room physicians who have *contractual* agreements with patients' HMOs.<sup>100</sup> In viewing the statutory language of the Knox-Keene Act in isolation the court concluded that it is clear the legislature did not contemplate billing disputes would arise in cases where no preexisting contract exists.<sup>101</sup> But disputes do arise in cases where noncontracting emergency room physicians provide emergency care to HMO enrollee patients, without regard to whether the patient can pay for the service, and the HMO fails to reimburse the emergency room physician for the full cost of the services provided.<sup>102</sup>

In 2009 the California Supreme Court released its much-anticipated opinion in *Prospect*.<sup>103</sup> The court's holding prohibits noncontracting emergency room physicians from engaging in balance billing if the doctors are able to seek recourse against the patient's HMO.<sup>104</sup> The court noted that finding otherwise would be inconsistent with the decision in *Bell*, where the court of appeals determined that physicians retain the right to resolve their disputes directly with HMOs, rather than through a state agency adjudicate, such as the DMHC.<sup>105</sup>

The court also acknowledged that the physician may not be entitled to the amount requested, but to a more reasonable

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100. See CAL. HEALTH & SAFETY CODE § 1379(a), (b); *Prospect*, 87 Cal. Rptr. 3d at 305.

101. *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 39 Cal. Rptr. 3d 456, 461 (Cal. Ct. App. 2006) (concluding that CAL. HEALTH & SAFETY CODE § 1379 prohibits balance billing only where there is a voluntary negotiation contract between plan and provider, but not where an implied contract existed between a plan and an out-of-network physician).

102. CAL. HEALTH & SAFETY CODE § 1371.4(a), (b); *Prospect*, 87 Cal. Rptr. 3d at 302.

103. *Prospect*, 87 Cal. Rptr. 3d at 299.

104. *Id.* at 306, 306 n.5. A patient's HMO may not be obligated to pay for the medical services when a patient intentionally seeks medical services from a noncontracting provider. *Id.* at 308. Depending on the exact terms of the contract between the HMO and the provider, the HMO is not contractually obligated to pay for those services and the member would be liable for the cost of the services rendered. *Id.*

105. *Id.* at 307 (citing *Bell v. Blue Cross of Cal.*, 31 Cal. Rptr. 3d 688, 691 (Cal. Ct. App. 2005)).

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reimbursement.<sup>106</sup> Regardless of the requested payment amount, HMOs do not have full discretion to decide the amount it will reimburse physicians.<sup>107</sup> Rather, insurance companies must determine the reasonable amount from guidelines set forth by the DMHC.<sup>108</sup>

In *Prospect*, the California Supreme Court did not give any weight to the legislative bills or the Governor's vetoes in making its decision.<sup>109</sup> The court simply stated: "[f]ailed attempts to provide some such legislation do not help us interpret the existing statutory scheme."<sup>110</sup> Consequently, noncontracting emergency room physicians may not bill patients directly if their HMO is obligated to pay the cost of the services rendered.<sup>111</sup> To resolve payment disputes, physicians may file a complaint with the DMHC,<sup>112</sup> utilize an insurance plan's alternative dispute resolution process,<sup>113</sup> or sue the insurance company directly for unreasonable compensation.<sup>114</sup> Because it is uncertain whether a physician will receive reimbursement through these procedures, the court's decision in *Prospect* effectively leaves noncontracting physicians without adequate recourse to collect just compensation for the services they perform.

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106. *Id.*

107. *Id.* (upholding that HMOs do not have "unfettered discretion to determine unilaterally the amount it will reimburse a noncontracting provider . . .") (quoting *Bell*, 31 Cal. Rptr. 3d at 695).

108. *See Bell*, 31 Cal. Rptr. 3d at 691-92 (quoting CAL. CODE REGS. tit. 28, § 1300.71(a)(3)(B) (2009)).

109. *See Prospect*, 87 Cal. Rptr. 3d at 308 (noting that the bills were insignificant as to the issue and that the Governor's reasoning to veto the bills had no bearing on the court's holding).

110. *Id.*

111. *Id.* at 306.

112. CAL. CODE REGS. tit. 28, § 1300.71.39(b)(2) (2009) (suggesting insurance plans promulgate a dispute resolution process for noncontracting physicians to arbitrate claim disputes with insurance companies, although some plans may have yet to implement such processes).

113. CAL. CODE REGS. tit. 28, § 1300.71.38 (2009).

114. *Bell v. Blue Cross of Cal.*, 31 Cal. Rptr. 3d 688, 691 (Cal. Ct. App. 2005) (establishing a physicians' private right of action against insurance companies by way of the judicial system); *see also Chamberlain*, *supra* note 24, at 28 (noting that physicians may file a DMHC complaint, or pursue arbitration or litigation when seeking reimbursement).

## II. POST-*PROSPECT*: THE POTENTIAL ECONOMIC AND SOCIETAL EFFECTS OF THE BAN ON BALANCE BILLING

As health care costs rise and emergency rooms in heavily populated areas threaten to close their doors,<sup>115</sup> emergency room physicians in California face the dilemma of trying to obtain adequate compensation for the emergency services they provide.<sup>116</sup> The ban on balance billing creates numerous negative effects for physicians, as it increases the financial burdens on noncontracting emergency room physicians, discourages physicians from taking emergency cases, and may cause physicians to leave emergency practice altogether.<sup>117</sup> Even though the intent of the ban on balance billing is to protect patients from payment disputes, it may inadvertently create access problems for emergency room patients.<sup>118</sup>

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115. Multiple factors are contributing to hospital and emergency room closures, such as California's current budget deficit, low Medi-Cal and Medicare reimbursement rates, and the number of patients receiving medical services in emergency rooms, who are uninsured and unable to pay. See Kimi Yoshino, *Emergency Room Doctors Sue State of California*, L.A. TIMES, Jan. 29, 2009, <http://www.latimes.com/news/science/la-me-erdoctors28-2009jan28,0,2227172.story>; *infra* text accompanying notes 203–04. Because physicians cannot make up for the shortfall in insurance payments through balance billing, the ban will also contribute to fewer funds, a decreased number of working physicians, and thus hospital closures.

116. See Chamberlain, *supra* note 24, at 27.

117. See Sandra J. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or is it a Barrier to Access?*, 17 STAN. L. & POL'Y REV. 121 (2006) (discussing the concern that concierge medicine is creating a barrier to patient treatment because physicians are leaving managed care plans and providing medical services for cash payment); CHF, *supra* note 50, at 3–4 (stating that when insurance companies insufficiently reimburse physicians, those physicians have no incentive to take on call assignments); Brief for Cal. Med. Ass'n as Amici Curiae Supporting Respondents at 3, 19, *Prospect Medical Group, Inc. v. Northridge Emergency Group*, 87 Cal. Rptr. 3d 299 (No. S142209) [hereinafter Amici Curiae Brief].

Physicians who are forced to accept even lower payments will no longer be able to provide back-up to the emergency department and still survive financially . . . . Those physicians who have not just given up chasing after health plan underpayments spend untold hours and dollars in time and administrative cost in their efforts to obtain what is justly due them.

*Id.*

118. See *Prospect*, 87 Cal. Rptr. 3d at 306–07; CHF, *supra* note 50, at 3–4 (indicating that fewer physicians are taking call assignments, due to inadequate

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*A. Noncontracting Physicians in California's Emergency Rooms*

In light of the current ban on balance billing, some noncontracting physicians may expect low reimbursement rates and, thus, may be unwilling to continue practicing emergency medicine in California.<sup>119</sup> The legal consequences and economic pressures physicians face create disincentives for them to continue accepting emergency cases for little or no money.<sup>120</sup> Consequently, physicians may be unwilling to remain on-call in California emergency rooms, limiting patients' access to emergency medical care, and drastically impacting California's health care industry.<sup>121</sup>

*1. Emergency Room Physicians' Legal Obligation to Provide Emergency Services*

In emergency cases, physicians are subject to liability under federal and state law if they fail to administer adequate medical services.<sup>122</sup> Insurance plans are obligated to pay for emergency services if a "reasonable" person would deem the patient's condition an emergency.<sup>123</sup> In addition, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires that physicians treat emergency room patients regardless of their ability to pay for services.<sup>124</sup>

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reimbursement); AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, THE NATIONAL REPORT CARD ON THE STATE OF EMERGENCY MEDICINE 25 (2008), <http://www.emreportcard.org/uploadedFiles/States/California/California.pdf> [hereinafter ACEP REPORT CARD].

119. *See Prospect*, 87 Cal. Rptr. 3d at 306. Because emergency room physicians are unable to bill their patients for services that HMOs refuse to pay, this will likely decrease physicians' reimbursement and, in turn, discourage physicians from practicing in California emergency rooms. *See id.*

120. CHF, *supra* note 50, at 4.

121. *See id.*

122. *See* 42 U.S.C. § 1395dd(d)(1)(B) (Supp. V 2000); CAL. HEALTH & SAFETY CODE § 1371.4(b) (West 2008 & Supp. 2009).

123. *See* CHF, *supra* note 50, at 4 (stating that insurance plans may deny reimbursement for emergency services when the insurance plan reasonably determines the patient's condition was not an emergency).

124. *See* 42 U.S.C. § 1395dd(a), (b) (2000) (requiring that an individual receive a medical screening and stabilization in the case of an emergency, even if that individual is not eligible for insurance benefits or cannot pay for the service out of pocket).

a. The Common Law and a Physician's Duty to Provide  
Emergency Services

Generally, physicians only have a duty to treat patients when a patient-physician relationship exists, even in emergencies.<sup>125</sup> This legal relationship between a patient and physician exists when either an express or an implied contract to provide medical services is present.<sup>126</sup> If an emergency room physician is within a jurisdiction that follows the common law approach, he can arbitrarily refuse to treat a patient in urgent need of medical care when no express or implied contractual agreement exists.<sup>127</sup> But, in most cases, federal and state statutes require that contracting physicians render emergency medical care to health plan members regardless of the existence of a patient-physician relationship.<sup>128</sup>

b. EMTALA: Physicians' Federal Statutory Obligation to  
Provide Emergency Services

Congress enacted EMTALA in the mid-1980s to ensure emergency care was available to patients regardless of a patient's insurance coverage.<sup>129</sup> Congress hoped EMTALA would prevent hospitals from "dumping" patients at nearby charity or county hospitals because of the patient's inability to pay for services.<sup>130</sup> To prevent such discriminatory health care practices, EMTALA requires emergency room physicians to screen and

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125. See FURROW, *supra* note 25, at 521.

126. Childs v. Weis, 440 S.W.2d 104, 107 (Tex. Civ. App. 1969).

127. *Id.*

128. See, e.g., CAL. HEALTH & SAFETY CODE § 1371.4(b) (West 2008 & Supp. 2009); CHF, *supra* note 50, at 4 (indicating that health insurance plans must reimburse physicians for services rendered when a "prudent layperson" would determine that the patient's condition was an emergency).

129. See 42 U.S.C. § 1395dd; FURROW, *supra* note 25, at 530 (indicating a study that further motivated Congress to enact 42 U.S.C. § 1395dd based on an increase in the number of patients being transferred from hospitals without proper stabilization).

130. See Scott v. Hutchinson Hosp., 959 F. Supp. 1351, 1357 (D. Kan. 1997) (stating that Congress meant for EMTALA to cure patient "dumping," and defining the practice as hospitals transferring or refusing to treat a patient for economic reasons); FURROW, *supra* note 25, at 530 (describing an important study regarding the lack of patient care when hospitals considered a patient's economic situation before treatment, encouraging Congress to enact EMTALA).

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stabilize all patients before they are transferred to another hospital.<sup>131</sup> Even though EMTALA itself only applies to hospitals that accept payment from Medicare, the law concerning emergency care applies to all patients who use such hospitals, regardless of whether they are Medicare beneficiaries.<sup>132</sup>

Emergency room physicians assess a wide range of symptoms and diagnose patients with varying conditions and degrees of severity in a short period of time.<sup>133</sup> While physicians continue to treat patients according to their duties under EMTALA, they are also concerned about reimbursement for services rendered.<sup>134</sup> Even with EMTALA, HMOs frequently deny coverage to patients for necessary visits to the emergency room.<sup>135</sup> Further, some patients have received necessary treatment that the HMO preauthorized, but the HMO later denied reimbursement for the services provided.<sup>136</sup>

EMTALA places great responsibility on emergency room physicians to provide necessary treatment to the poor, uninsured, and the underinsured.<sup>137</sup> This responsibility creates tension between the physicians' duty to treat patients and their right to receive payment for providing necessary medical

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131. 42 U.S.C. § 1395dd(a), (b)(1).

132. FURROW, *supra* note 25, at 531.

133. *See* 42 U.S.C. § 1395dd(e)(1)

The term 'emergency medical condition' means . . . (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant women [sic] who is having contractions—(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

*Id.*

134. *See, e.g.,* Bell v. Blue Cross of Cal., 31 Cal. Rptr. 3d 688, 690 (Cal. Ct. App. 2005) (illustrating Dr. Bell's concern as to his reimbursement for medical services due to his statutory obligation to render services under EMTALA).

135. *See, e.g.,* Wickline v. California, 239 Cal. Rptr. 810, 812 (Cal. Ct. App. 1986); *see also* Diane Hoffman, *Emergency Care and Managed Care—A Dangerous Combination*, 75 WASH. L. REV. 315, 332–34 (1997).

136. *See* Hoffman, *supra* note 135, at 332–33.

137. *See* 42 U.S.C. § 1395dd(a), (b), (d).

treatment.<sup>138</sup> The holding in *Prospect* requires emergency room physicians to accept unreasonable payment for services rendered, if they choose not to litigate or file claims with the DMHC.<sup>139</sup> For emergency room physicians, the time, expense, and uncertainty of litigation may be enough to deter them from filing lawsuits against HMOs.<sup>140</sup> Further, physicians' skepticism of insurance companies' interpretation of "reasonable" reimbursement may indirectly decrease their efforts to maintain quality health care in emergency rooms.<sup>141</sup>

## 2. *The Ban's Impact on On-Call Physicians in California Hospitals*

Most hospitals rely on noncontracting physicians to participate in the assignment of emergency cases.<sup>142</sup> This means that emergency departments maintain a twenty-four hour staff of emergency room physicians or require their physicians to be available within half-an-hour or less.<sup>143</sup> In order to maintain efficiency, hospitals maintain a list of physicians who remain on-call for patient care or consultation.<sup>144</sup>

Many California communities benefit from emergency room physicians volunteering to participate in on-call assignments.<sup>145</sup> In some cases, hospitals require physicians to be on-call as a part

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138. See, e.g., *Bell*, 31 Cal. Rptr. 3d at 690; see Lisa Girion, *Ruling Removes Billing Headache From Emergency Room Visits*, L. A. TIMES, Jan. 9, 2009, <http://www.latimes.com/business/la-fi-emergency9-2009jan09,0,2344359.story>.

139. See *Prospect Med. Group, Inc. v. Northridge Med. Group*, 87 Cal. Rptr. 3d 299, 306 (2009) (failing to define the minimum "reasonable" amount that HMOs should reimburse for emergency services, which suggests that unless physicians dispute over claims, the DMHC or the courts will not consider whether HMOs' payments are fair); Chamberlain, *supra* note 24, at 28 (indicating the three options for physicians to dispute reimbursement amounts is to file claims with the DMHC, litigate in court, or arbitrate in a dispute resolution process, if available).

140. See Girion, *supra* note 138.

141. See *id.*; CHF, *supra* note 50, at 3.

142. See CHF, *supra* note 50, at 1, 5.

143. *Id.* at 2 ("Emergency departments typically are staffed around-the-clock by emergency physicians or, at standby facilities, by physicians who are available within 30 minutes or less.").

144. *Id.* Hospitals must place physicians on the list in accordance licensing regulations found under EMTALA. *Id.*

145. *Id.* at 5 ("Two thirds [of community hospitals] use a volunteer system . . .").

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of their staffing agreement.<sup>146</sup> Hospitals prefer mandatory on-call systems, as opposed to voluntary systems, when hospitals assign physicians to cases that require specialized services.<sup>147</sup> A small number of physicians, however, volunteer for on-call assignments because they claim reimbursement is insufficient.<sup>148</sup> A large deterrent for on-call specialists is inadequate payment or the lack of payment entirely for unassigned patients.<sup>149</sup> Accordingly, most health care providers view insurance reimbursement for unassigned patients as insufficient and choose not to participate in on-call assignments.<sup>150</sup>

The inability of physicians to bill HMO members directly for unpaid emergency services creates another disincentive for physicians to participate in on-call services.<sup>151</sup> Hospitals with voluntary on-call systems cannot compel a physician to participate in on-call assignments, even if the physician's reason for abstaining from such work is economic.<sup>152</sup> In some instances, reimbursement rates may be so inadequate that efforts to collect the payments are not worth the physicians' time or expense.<sup>153</sup> As a result, the ban on balance billing deters physicians from participating in on-call assignments because they cannot ensure that the HMO or the patient will pay them for the cost of the service provided.<sup>154</sup>

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146. *Id.* at 3, 8 (“[O]ne-third of California hospitals may . . . mandate call-panel coverage as a condition of medical staff privileges . . .”). Some of the mandates are conditions within physician employment contracts. *Id.*

147. *Id.* at 8 (noting that some hospitals “invoke mandatory call only if service cannot be provided on a voluntary basis”).

148. *Id.* at 3.

149. *Id.* at 3–4. Unassigned patients are those who enter the emergency room “without a designated physician or medical group for backup coverage. . . . Trauma patients usually are unassigned. Unassigned patients also may include managed care enrollees for whom no designated specialist is available and patients whose primary-care physician is not on the hospital staff.” *Id.* at 3.

150. *Id.* at 3.

151. *Id.*; *Prospect Med. Group, Inc. v. Northridge Med. Group*, 87 Cal. Rptr. 3d 299, 306 (2009).

152. CHF, *supra* note 50, at 2.

153. *Id.* at 3. Emergency room physicians already experience relatively low reimbursement rates for Medi-Cal and Medicare. Yoshimo, *supra* note 115. In 2007 alone, physicians subsidized more than one-hundred million dollars in services given to Medi-Cal patients because the reimbursement rates covered only half of the cost of treatment. *Id.*

154. See discussion *infra* Part II.C.

3. *Cost Containment Measures in Emergency Departments:  
Utilization Review Panels*

The purpose of utilization review panels is to manage health care costs for MCOs.<sup>155</sup> While state legislatures and statutory laws typically prohibit incentives that deny or limit necessary medical care, utilization review can act as a barrier for patients to access emergency medical treatment.<sup>156</sup> Further, the review process may provide physicians with incentives to render services under budget, and can result in a physician providing care to which the panel deems unnecessary.

The utilization review process provides an opportunity for a health insurance plan to review patients' medical treatment. In general, insurance companies implement utilization review programs by assembling a group of medical examiners to evaluate cases and determine whether a patient's treatment is necessary.<sup>157</sup> The purpose of utilization review is to control the cost of medical care by decreasing the length of hospital stays and denying unnecessary, costly procedures.<sup>158</sup> This process is highly criticized by patients and providers because the panel's decisions determine whether or not a patient will actually receive medical treatment.<sup>159</sup>

Physicians often face great difficulty convincing utilization review panels that a patient should receive a particular treatment.<sup>160</sup> The utilization review process frustrates many physicians because, in most instances, the review panel makes

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155. FURROW, *supra* note 25, at 593, 596.

156. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1348.6 (West 2008); *see* FURROW, *supra* note 25, at 597 ("While incentives are an effective way to hold down costs, they can also result in underservice if the responses they elicit from providers are excessive.").

157. *See* FURROW, *supra* note 25, at 593. The utilization review process is also instituted by hospitals to decrease their overhead costs, *id.*, but the discussion of a hospital's utilization review process is not relevant to this Note.

158. *See id.* at 593–94.

159. *See id.* at 593.

160. *Id.* (determining that even though a physician may be intimidated by initial denials from insurance payers, he or she is not paralyzed to act appropriately); *see also* *Murphy v. Bd. of Med. Examiners of the State of Ariz.*, 949 P.2d 530, 532–33, 536 (Ariz. Ct. App. 1997) (finding that the utilization review physician was practicing medicine while regulating coverage decisions). *But see* *Morris v. D.C. Bd. of Med.*, 701 A.2d 364, 368 (D.C. 1997) (holding that Blue Cross medical director was not practicing medicine in utilization review situation).

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the final determination of whether a patient will receive treatment. This process may result in the review panel substituting their own judgment for that of the physician.<sup>161</sup> Utilization review panels also aggravate patients because they serve as an additional barrier when accessing treatment.<sup>162</sup> Patients may suffer bodily injury, emotional distress, or lost wages because of a utilization review panel's decision to deny preauthorization.<sup>163</sup> Depending on the type of insurance plan the patient has, he or she may have little recourse against the insurance company for its medical decisions.<sup>164</sup>

People seek emergency services for a variety of reasons. By reviewing patient treatment on a case-by-case basis, utilization reviews preserve costs by permitting treatment only when the panel deems it necessary.<sup>165</sup> Two types of utilization reviews require analysis as to emergency services: retrospective and prospective. Under the retrospective utilization review process, emergency room physicians or hospitals request payment after rendering medical services.<sup>166</sup> Since the insurer will only deny payment for unnecessary or experimental treatment, this review process poses no risk to patients who are in need of necessary medical care.<sup>167</sup> Rather, physicians are at risk of absorbing the cost of care if denied payment by the patient's insurance plan for the services rendered.<sup>168</sup>

Conversely, under prospective utilization review, physicians

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161. See FURROW, *supra* note 25, at 593–94; see also *Frontline: Sue the Doctor* (PBS television broadcast Jan. 28, 1986) (illustrating the tension between physicians and prospective utilization review decisions, resulting in malpractice litigation against physicians for decisions influenced by utilization review panels). Whether utilization review employees are actually engaged in the unauthorized practice of medicine when making coverage decisions is beyond the scope of this Note.

162. See Hoffman, *supra* note 135, 332 (noting patients' complaints regarding insurance denials).

163. See *id.* at 353–54. There are some reported occurrences where an insurance company's review panel has denied preapproval for or delayed emergency care to an insurance plan member, resulting in physical, emotional, or economic injury to that person, as well as a lawsuit against the plan. *Id.*

164. See *id.* at 354; see, e.g., *Wickline v. California*, 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986).

165. FURROW, *supra* note 25, at 593.

166. See *id.*

167. See *id.* at 593–94.

168. *Id.* at 594; see *Wickline*, 239 Cal. Rptr. at 811.

obtain authorization from health insurance plans before rendering health care services.<sup>169</sup> The prospective utilization review may be detrimental if an erroneous decision by the insurer results in the doctor withholding necessary care—a decision that can potentially lead to a patient’s death or permanent disability.<sup>170</sup> While emergency room physicians should comply with the utilization review panels’ decisions in order to receive payment for services, the physicians are ultimately responsible to the patient for withholding necessary treatment—even if treatment was withheld at the direction of the insurance company.<sup>171</sup> Thus, physicians walk a fine line between providing patient care and ensuring that they will be reimbursed for the expense of providing medical treatment that may be classified as “unnecessary.”

MCOs argue that they place cost containment measures on physicians in order to eliminate unnecessary treatments, rather than influence physicians’ decisions or affect the quality of services they provide.<sup>172</sup> But from a physician’s perspective, managed care plans control health care decisions too frequently.<sup>173</sup> Utilization review requires physicians to take multiple administrative steps in order to be compensated for their work.

Medical professionals—doctors, nurses, therapists, even administrators—do not like to think of themselves as businessmen. Many do choose this line of work because the income potential is high, but even they could make more money in banking or real estate, and they are drawn to their

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169. *Wickline*, 239 Cal. Rptr. at 811.

170. *See id.* at 812. *Wickline* involved a nonemergency patient who was a member of Medi-Cal, California’s welfare benefit plan. *Id.* at 819–20. It is illustrative of the effects on patient care when insurance plans’ utilization review prospectively deny treatment. The circumstances in *Wickline* involved a patient, discharged by her physician because her insurance plan’s utilization review refused to extend her stay. *Id.* at 814–15. As a result, her condition deteriorated and physicians needed to amputate her leg when she returned to the hospital. *Id.* at 816–17.

171. *Id.* at 819.

172. *See* FURROW, *supra* note 25, at 597.

173. *See Frontline: Dr. Solomon’s Dilemma* (PBS television broadcast Apr. 4, 2000); *see also* Tom Jennings, *Inside Dr. Solomon’s Dilemma*, PBS Website, <http://www.pbs.org/wgbh/pages/frontline/shows/doctor/etc/inside.html> (highlighting the interview with Dr. Solomon in regards to health insurance companies’ control of medical providers’ decisions).

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jobs, at least in part, by the idea that they are doing good. They are not alone in this image of their profession. The public doesn't want to think of doctors as businessmen, either. And they certainly don't want to think that money makes a difference in the type of treatment they receive.<sup>174</sup>

It is unfortunate that managed care limitations have shifted the physician's role of providing medical care to that of a businessperson practicing medicine.

Because the purpose of utilization review is to promote cost efficiency, the panels' decisions often conflict with those of the treating physician concerning necessary patient care. For those conflicting decisions, *Prospect's* holding prevents physicians from collecting from their patients,<sup>175</sup> and utilization review often makes it difficult for physicians to collect from the patients' HMOs. Accordingly, the California legislature should revise applicable health care statutes to ensure that emergency room physicians do not assume a business role that adversely affects their medical decisions and guarantees adequate reimbursement of those decisions. California's current health care laws, including the *Prospect* decision, not only put emergency physicians in difficult economic positions, but could burden hospitals and emergency rooms as well.

*B. The Ban's Impact on California's Distressed Hospitals and Emergency Departments*

The ban on balance billing is hardly the correct measure to place on the health care system without the appropriate measures to regulate the conduct of HMOs. The ban increases the likelihood that more emergency rooms will be forced to close their doors because of gross underpayment for services provided.<sup>176</sup> In addition, emergency room closures create access problems for *all* patients,<sup>177</sup> whether or not HMOs have contractual agreements with the closing hospitals' emergency room physicians.

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174. LISA BELKIN, *FIRST DO NO HARM* 169 (1993).

175. *Prospect Med. Group, Inc. v. Northridge Med. Group*, 87 Cal. Rptr. 3d 299, 306 (2009).

176. See Girion, *supra* note 138; see also *supra* note 115.

177. ACEP REPORT CARD, *supra* note 118, at 25 (indicating the limited number of open hospital facilities in California licensed to provide emergency care contributes to the poor access to emergency services).

### 1. *Economic Hardships Facing California's Urban Hospitals*

In November 2008, the California Hospital Association (“CHA”) conducted a survey of the current economic concerns in California’s urban hospitals.<sup>178</sup> The CHA’s survey indicated that hospitals have experienced a seventy-three percent increase in the number of people that struggle to pay for medical services out of pocket.<sup>179</sup> Similarly, thirty-three percent of hospitals have seen an increase in the number of uninsured patients seeking emergency services.<sup>180</sup>

California hospitals currently bear the financial burden of treating elderly and low-income patients.<sup>181</sup> The state’s welfare program, Medi-Cal, recently decreased its payments to hospitals, forcing hospitals to find alternative means of finance to keep providing medical care to thousands of California residents.<sup>182</sup> As a result, a number of California hospitals, for example, have decreased the amount of services they provide and the number of staffed beds.<sup>183</sup> The ban on balance billing will increase this financial burden on hospitals and emergency room physicians, further affecting the economic state of hospitals’ emergency rooms.<sup>184</sup>

### 2. *California's Overcrowded Emergency Rooms*

California emergency departments have always had a problem with overcrowding, but this problem has worsened over

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178. CALIFORNIA HOSPITAL ASSOCIATION, A REPORT ON CALIFORNIA HOSPITALS AND THE ECONOMY 1 (2009) <http://www.calhospital.org/Download/CHASpecialReport.pdf> [hereinafter CHA REPORT].

179. *Id.* at 2.

180. *Id.*

181. CHA REPORT, *supra* note 178, at 2.

182. *Id.* at 1.

183. *Id.* (“[T]he majority of California hospitals have already made cutbacks or anticipate reducing services, including closing subacute units and psychiatric units; eliminating skilled nursing beds and [emergency room] beds; reducing cardiology, obstetrics and other clinical services; and laying off staff or reducing pay.”).

184. *See* Yoshino, *supra* note 115. In January 2009, Kiesel Bloucher Larson (“Larson”) filed a class action lawsuit against the State of California and the DMHC. *Id.* On behalf of emergency physicians, Larson alleges that the emergency departments’ poor financial structure is at risk of the system’s collapse, requesting the state provide a remedy for emergency rooms’ current economic situation. *Id.* Unless the legislature or courts regulate the conduct of HMOs, insurance companies will likely increase the economic burden on emergency physicians and hospitals. *See also* discussion *infra* Part III.

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the last few years.<sup>185</sup> Contributing to the problem of overcrowding is the lack of hospitals available to provide emergency services.<sup>186</sup> For instance, California has 7.1 emergency departments per one million people, compared to an average of 19.9 departments in other states.<sup>187</sup> The small number of hospitals open for emergency services is due, in part, to recent hospital closures.<sup>188</sup>

Patient boarding is a common administrative practice that contributes to the growing trend of overcrowding in emergency departments.<sup>189</sup> Boarding is the practice of hospital staff admitting emergency room patients in excess of the hospital's available rooms or beds.<sup>190</sup> Because most California hospitals do not have a sufficient number of staffed beds or specialists, patients end up lining the hallways and waiting rooms in order to receive any kind of medical treatment.<sup>191</sup>

California's current budget restraints make it difficult for state or local governments to establish or expand reimbursement for noncontracting emergency room physicians.<sup>192</sup> Moreover, political interests and economic concerns complicate the process of eliminating federal or state regulatory or statutory boundaries.<sup>193</sup> Despite the unstable budget and current national economic deficit, however, California should strive to improve its emergency care system because patients' quality of care is at risk.

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185. Yoshino, *supra* note 115; see ACEP REPORT CARD, *supra* note 118, at 25.

186. See ACEP REPORT CARD, *supra* note 118, at 25.

187. *Id.*

188. Yoshino, *supra* note 115.

189. ACEP REPORT CARD, *supra* note 118, at 25.

190. *Id.*; Zachary F. Meisel & Jesse M. Pines, *Waiting Doom: How Hospitals are Killing E.R. Patients*, Slate, July 24, 2008, <http://www.slate.com/id/2195851>.

[Patient boarding occurs] when patients who come to the [emergency room] need to be admitted overnight. If there are no inpatient beds in the hospital (or no extra inpatient nurses in the hospital) then the patient stays in the [emergency room] long past the completion of the initial emergency work.

*Id.*

191. ACEP REPORT CARD, *supra* note 118, at 25; Meisel & Pines, *supra* note 190 (stating emergency room overcrowding has worsened such that emergency rooms are "unsafe and even deadly").

192. CHF, *supra* note 50, at 6.

193. *Id.*

*C. Patients' Access to Emergency Treatment: The Potential Decrease of Noncontracting Physicians in Emergency Rooms*

Due to inadequate hospital staffing, overcrowded emergency rooms, and hospital closures, patients already have difficulty accessing emergency services.<sup>194</sup> In addition, cost containment measures, such as the utilization review process, may serve as additional barriers to patient treatment.<sup>195</sup> As such, the ban on balance billing may cause patients' access to emergency treatment to decline even further, compromising the quality of care patients receive in emergency rooms.

If physicians believe HMOs are not reimbursing claims at a reasonable rate, they have the option of suing the insurance company directly in federal court or filing a claim with the DMHC.<sup>196</sup> This is an inundating process, and due to the length and expense of the dispute process, many emergency room physicians are unwilling to pursue payment disputes with HMOs, choosing to opt out of the dispute process entirely.<sup>197</sup> Consequently, shifting the burden onto health care professionals to cover HMOs' underpayments may cause emergency room physicians to relocate or leave emergency medicine all together.<sup>198</sup>

*1. Relocation of Emergency Room Physicians to Other States*

In December 2008, the American College of Emergency Physicians ("ACEP") ranked California last in the nation when it came to providing access to emergency medical care.<sup>199</sup> The

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194. ACEP REPORT CARD, *supra* note 118, at 25.

195. See discussion *supra* Part II.A.3.

196. CAL. CODE REGS. tit. 28, § 1300.71.38 (2009) (requiring health care service plans to establish a dispute resolution process); Chamberlain, *supra* note 24, at 28.

197. CHF, *supra* note 50, at 3–4 (noting reimbursement rates are sometimes so low that pursuing payment is not worth physicians' time and expense); see Girion, *supra* note 138 (quoting the president of the California Medical Association at Arrowhead Regional Medical Center in Colton, California, who stated "Me, the little trauma surgeon, going up against Blue Cross of California is like David against Goliath—no chance").

198. See CHF, *supra* note 50, at 4.

199. See ACEP REPORT CARD, *supra* note 118, at 25 (showing that California was ranked 51st in the category of "Access to Emergency Care," receiving the grade "F"); Press Release, American College of Emergency Medicine, Emergency Care System A "Ticking Time Bomb" Accelerated By The Financial Crisis And Physician Shortages (Dec. 9, 2008),

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national report card gave California's emergency medical departments an average grade of D+ overall.<sup>200</sup> In particular, the ACEP noted that California's understaffed hospitals lack specialists and registered nurses to account for the number of people who seek emergency treatment.<sup>201</sup>

The recent ban on balance billing and the current financial shape of California's emergency departments are factors that will deter medical professionals from practicing in the state.<sup>202</sup> Moreover, these factors likely cause emergency room physicians to actively relocate to other states or change the manner in which they practice medicine.<sup>203</sup> As a result, fewer physicians will elect to participate in on-call assignments,<sup>204</sup> and patient access to emergency treatment will become even more difficult because hospitals will not have adequate back-up coverage for particular specialists.<sup>205</sup>

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<http://www.emreportcard.org/newsroom.aspx?id=534> (identifying California's 51st position as the last rank).

200. ACEP REPORT CARD, *supra* note 118, at 25.

201. *Id.*

202. *See* Prospect Med. Group, Inc. v. Northridge Med. Group, 87 Cal. Rptr. 3d 299, 306 (2009) (banning balance billing in California); Amici Curiae Brief, *supra* note 117, at 2–4 (noting several factors concerning the current state of the health care industry that would discourage physicians from practicing in California, such as decreased pay, and the possible closure of emergency departments); ACEP REPORT CARD, *supra* note 118, at 25 (stating the current health care system's financial problems are caused by "high rates of uninsured adults and children and relatively low Medicaid reimbursement rates for office visits" and recommending that California "should implement measures to draw more medical professionals to California").

203. *See* Carnahan, *supra* note 117, at 122 ("Some physicians [are] lured by the possibility of fewer patients, greater income, and more leisure time . . ."); Erin Madigan, *Legislators Mull Pros, Cons of Boutique Hospitals*, STATELINE.ORG, Oct. 16, 2003, <http://www.stateline.org/live/ViewPage.action?siteNodeId=136&languageId=1&contentId=15412> (discussing legislators' concern about the growing number of boutique clinics in the U.S., likely at the expense of general hospitals); Amici Curiae Brief, *supra* note 117, at 2–4 (noting several factors concerning the current state of California's health care industry that would cause physicians to seek employment elsewhere, such as decreased pay, and the possible closure of emergency departments).

204. *See* CHF, *supra* note 50, at 3; Carnahan, *supra* note 117, at 126 (noting that administrative burdens placed on physicians while working under managed care plans encourage them to leave general hospitals and practice concierge medicine, and thus they will likely no longer participate in on-call assignments).

205. ACEP REPORT CARD, *supra* note 118, at 25; Amici Curiae Brief, *supra* note 117, at 3.

## 2. *Change in Profession: Boutique and Concierge Services*

A growing trend in the health care industry is that medical professionals are seeking employment through boutique and concierge services.<sup>206</sup> Boutique hospitals are for-profit, physician-owned facilities that specialize in certain expensive procedures.<sup>207</sup> Physicians who practice boutique medicine may accept only certain insurance carriers, or they may only provide services for a flat fee.<sup>208</sup> The legislatures of Arizona, Louisiana, New Mexico, and Washington attempted to require that boutique hospitals provide emergency services, but the bills failed to pass.<sup>209</sup> In these states, the current law guarantees that boutique hospitals need only treat patients who can and will pay for medical services.<sup>210</sup> This demonstrates that boutique hospitals operate as an economic safe-haven for physicians, eliminating their fear of inadequate reimbursement.

With boutique emergency medicine on the rise and the ban on balance billing in full effect, some emergency room physicians may decide not to accept certain insurance plans and provide services on an outpatient basis only.<sup>211</sup> This situation will likely create an access problem for patients in need of certain specialists. Some patients cannot afford the expense of boutique services, and the lack of emergency room physicians will increase the wait period for patients seeking treatment at hospitals where contracting providers are available.<sup>212</sup> To resolve the issue

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206. See Madigan, *supra* note 203.

207. *Id.*

208. See Carnahan, *supra* note 117, at 130–32 (describing three different forms of flat fee reimbursement that physicians utilize to charge patients for boutique services).

209. Madigan, *supra* note 203.

210. *See id.*

211. Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, 87 Cal. Rptr. 3d 299, 306 (2009) (banning the practice of balance billing); see ATUL GAWANDE, BETTER 120–24 (2007) (recounting the situation where physicians leave hospitals to operate private cash-only practices, avoiding the frustration of insurance nonpayment and manage care control); Madigan, *supra* note 203 (“The number of specialty hospitals has *tripled* since 1990 . . . .”) (emphasis added).

212. Madigan, *supra* note 203 (establishing that boutique services are expensive); ACEP REPORT CARD, *supra* note 118, at 25. Many hospitals are currently understaffed, causing overcrowding in hospital waiting rooms, and a delay in the provision of medical services. *Id.* The growing number of boutique hospitals will surely worsen this situation, as physicians who previously provided emergency services can choose to only practice medicine

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affecting patient access to health care, the legislature should amend the Knox-Keene Act to guarantee noncontracting physicians more adequate reimbursement.

### III. FULL AND FAIR REIMBURSEMENT: ADEQUATE COMPENSATION FOR EMERGENCY ROOM PHYSICIANS THROUGH DETAILED FEE SCHEDULES

*“A key to legislative remedies is instilling the belief that emergency medical care is a basic public service, a responsibility which must be shared by all players.”<sup>213</sup>*

In *Prospect*, the California Supreme Court prohibited emergency room physicians from engaging in the practice of balance billing, but failed to consider the detrimental effects the holding will have on California’s health care system. The case did not address what constitutes “adequate compensation” for emergency room physicians and left this determination for the legislature to consider.<sup>214</sup> The following sections provide the California legislature with an appropriate amendment to the Knox-Keene Act that would decrease the economic burden on emergency room physicians and hospitals, while ensuring patient access to emergency treatment.

#### *A. Supplementing the Ban on Balance Billing with Legislation Requiring Full Reimbursement*

The California Legislature should amend the Knox-Keene Act to require that health insurance companies reimburse physicians in full for the cost of services rendered. This legislation would provide noncontracting emergency room

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at such hospitals.

213. CHF, *supra* note 50, at 7 (citing PETER HANSEL, CALIFORNIA SENATE OFFICE OF RESEARCH, STRETCHED THIN: GROWING GAPS IN CALIFORNIA’S EMERGENCY ROOM BACKUP SYSTEM (2003), <http://sor.govoffice3.com/> (follow “publications” tab; then follow “By Publication Date” hyperlink; then follow “2003 Publications” hyperlink; and then click on “Stretched Thin: Growing Gaps in California’s Emergency Room Backup System” hyperlink)).

214. *Prospect*, 87 Cal. Rptr. 3d at 308.

Emergency room doctors *are* entitled to reasonable payments for emergency services rendered to HMO patients. All we are holding is that this entitlement does not further entitle the doctors to bill patients for any amount in dispute . . . . This area of the law might benefit from comprehensive legislation.

*Id.*

physicians with adequate compensation for their medical services, replacing the inadequate reasonable reimbursement standard. In Delaware, the legislature enacted similar legislation, leaving it to insurance companies—as the administrative body responsible for payment of emergency services—to raise any disputes after payment of services.<sup>215</sup> The California legislature should adopt a similar position concerning reimbursement from health plans, and amend the text of section 1371 of the Knox-Keene Act as follows:

- (a) This section applies to every insurance plan that provides services through a health maintenance program for its enrollees, excluding those under managed care contracts with the Medi-Cal and Medicare programs.
- (b) All health insurance plans shall insure persons covered under those plans for all emergency care services. For contracting health care providers, the reimbursement rate shall be the rate at which the parties agree upon in the contract. For noncontracting providers, the reimbursement rate shall be the amount determined by those providers, not exceeding one hundred ten percent of the amount billed by that insurance plan's contracting providers for the same emergency service in the same geographical area.
- (c) In the event that a noncontracting provider of emergency services and the insurer disagree as to the amount billed, the provider shall be entitled to those charges and rates determined by the Insurance Commissioner and the Director of the Department of Managed Health Care.<sup>216</sup> Such charges shall be based upon the average reimbursement amount for medical services provided by contracted providers in the geographical area. Under no circumstances may the noncontracting provider balance bill the insured.
- (d) Plans described in subsections (a) and (b) of this section shall cover emergency services as defined in section 1371.1 of this Act.

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215. DEL. CODE ANN. tit. 28, § 3565 (Supp. 2008). The Delaware legislature intended for their statute to apply to group and blanket health insurance policies, but its form and function are instructive. *Id.* at § 3565(a).

216. The Insurance Commissioner is included in the amendment because his or her consultation with the DMHC is necessary in order for the DMHC to adopt any regulations regarding health insurance plans. CAL. HEALTH & SAFETY CODE § 1342.5 (West 2008).

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The proposed amendment exempts Medi-Cal and Medicare programs from its application because the legislature has already addressed the issue of balance billing with respect to those programs.<sup>217</sup> Furthermore, the amendment allows noncontracting physicians to bill insurance companies within ten percent of contracting physicians' charges so that physicians are generally free to make medical decisions with only the patient's immediate health in mind.<sup>218</sup> However, in order for health insurance companies to profit there must be some fiscal constraint on reimbursement, which the ten percent window maintains.<sup>219</sup> Finally, the statute codifies the holding in *Prospect* and provides California with a statute that resolves the issue of balance billing while ensuring the economic and social impact on physicians and patients is minimal.

*B. Rationale of the Proposed Reimbursement Schema:  
Eliminating the Need for Balance Billing*

As discussed above,<sup>220</sup> the DMHC provides that HMOs must pay noncontracting physicians a reasonable and customary value for health care services, depending on an annual fee schedule promulgated by the DMHC.<sup>221</sup> From these fee schedules, HMOs generally reimburse noncontracting physicians at a lesser rate than contracting physicians depending on the service provided.<sup>222</sup> In accordance with the proposed amendment to the Knox-Keene Act, insurance companies would reimburse noncontracting emergency room physicians in one of two ways: (1) pay the amount billed, or (2) if the bill exceeds what a contracting provider would receive by more than ten percent, then the health care service plan would pay an average fee determined by the DMHC. Accordingly, the DMHC should develop a detailed fee schedule for noncontracting emergency room physicians to establish the lowest possible reimbursement

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217. See CAL. INS. CODE § 12693.55(f) historical and statutory notes (Supp. West 2009) ("The practice of balance billing Medicare and Medi-Cal enrollees is prohibited under existing federal and state law.").

218. See *infra* text accompanying notes, 224.

219. See discussion *supra* Part I.A.1.

220. See discussion *supra* Part I.B.1.

221. *Bell v. Blue Cross of Cal.*, 31 Cal. Rptr. 3d 688, 691-92 (Cal. Ct. App. 2005) (citing CAL. CODE REGS. tit. 28, § 1300.71(a)(3)(B) (2009)).

222. *Id.*

rate of physician services. In effect, the amendment would serve two distinct purposes: (1) attract qualified physicians to practice in California; and (2) regulate HMO conduct.

First, the amendment would provide emergency room physicians a reasonable window of expected rates for their services, thereby attracting more emergency room physicians to remain or relocate to California. As indicated by ACEP's National Report Card, California should strive to attract qualified medical professionals to practice emergency medicine in California.<sup>223</sup> Providing noncontracting emergency room physicians with equitable incentives through fair and guaranteed reimbursement rates will help achieve this goal.

Second, if the DMHC creates detailed fee schedules for noncontracting physicians, it will help regulate the conduct of HMOs to ensure they do not leverage fee amounts in favor of insurance companies. Although the Knox-Keene Act protects noncontracting providers' interests by prohibiting HMOs from unfair payment reductions,<sup>224</sup> without penalties against HMOs the regulation is not enough to curb HMOs' unfair practices. Therefore, the legislature and the DMHC should implement a health care reform package that supplements the ban on balance billing. This reform package should mandate that HMOs pay noncontracting physicians in full based on a detailed fee schedule created by the DMHC.

### *C. Public Policy Considerations Supporting the Amendment*

Various policy considerations support the proposed amendment. First, as the holding in *Prospect* identifies, it is inherently unfair to involve patients in payment disputes between physicians and HMOs.<sup>225</sup> Supplementing the ban with a detailed fee schedule will fully protect patients from billing disputes, as physicians will be guaranteed fair pay and will no longer have a fiscal reason to bill patients or leave emergency room positions. The amendment will also ensure adequate

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223. ACEP REPORT CARD, *supra* note 118, at 25 (one recommendation from ACEP is to increase Medi-Cal fee levels).

224. See CAL. HEALTH & SAFETY CODE §§ 1371.37, 1371.39 (West 2008) (authorizing providers to report to the DMHC the HMOs that engage in unfair payment patterns).

225. *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, Inc.*, 87 Cal. Rptr. 3d 299, 306 (2009).

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patient care because more physicians will be available to alleviate treatment delay in overcrowded emergency rooms.

Second, the immediate medical needs of the patient should be the emergency room physician's primary concern when making treatment decisions. Unaffected decision-making is necessary to appropriately practice emergency medicine. The current legal schema improperly interjects physicians' economic considerations into their emergency medical practice by reimbursing them at different rates for the same medical procedure. Similarly, the current schema forces physicians into the position of a businessperson or litigant in order to obtain adequate reimbursement. By adopting a detailed fee schedule, payments to every physician will no longer be a question, and finance will not be a consideration when a physician contemplates the appropriate medical treatment for his or her patient.

Finally, HMOs are in a better position to carry the burden of unexpected medical costs than physicians because HMOs can adjust plan premiums in order to spread medical care costs.<sup>226</sup> If a physician is unable to collect payment from a single patient or from an HMO, the physician cannot simply spread the cost among his or her other patients. By dictating expected reimbursement rates for noncontracting physicians, the detailed fee schedule will appropriately shift any economic risk onto the HMO: the party who can more readily adjust for fiscal loss.

### CONCLUSION

In California's attempts to resolve the balance billing issue, the Supreme Court finally resolved the DMHC's most problematic concern: bringing patients into billing disputes when noncontracting emergency room physicians are not compensated

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226. See Elizabeth Festa, Note, *Pro-Rating Defense Costs to an Insured For Periods of Uninsurance; What Happened to the Duty to Defend?*: Security Insurance Co. of Hartford v. Lumbermens Mutual Casualty Co., 11 CONN. INS. L. J. 207, 233 (2004–2005) (quoting Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 992 (N.J. 1994)) (“[I]nsurance companies can spread costs throughout an industry and thus achieve cost efficiency . . . .”); see also Wendy Lovejoy, Note, *Ending the Genetic Discrimination Barrier: Regaining Confidence in Preconception, Prenatal, and Neonatal Genetic Testing*, 74 S. CAL. L. REV. 873, 895 (2001) (“To remain fiscally solvent, insurance companies must spread health-care costs associated with medically needy individuals to other insureds, thereby raising health insurance premiums.”).

at a reasonable fee for their services.<sup>227</sup> Physicians should not be concerned about reimbursement amounts while providing medical treatment to patients. Further, physicians should not have to fight with insurance companies to be reimbursed for the cost of services rendered. In light of the Court's holding in *Prospect*, the legislature should consider appropriately revising the current compensatory scheme for noncontracting emergency room physicians.

The legislature should amend the Knox-Keene Act to provide that HMOs pay noncontracting physicians at the physicians' billed rate, not to exceed ten percent of that paid to contracting physicians. By promising a set range of reimbursement rates to noncontracting physicians, the amendment will prevent balance billing issues all together. In addition, the detailed fee schedule monitors physician expense without overburdening insurance companies attempting to control costs. In effect, the proposed amendment effectively resolves the tension between the health care industry's fiscal risk with adequate physician reimbursement, providing the most reasonable solution to what could otherwise develop into a major health care crisis.

*Andrea M. Maestas\**

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227. *Prospect*, 87 Cal. Rptr. 3d at 306.

\* B.A. Classics, University of Arizona, Tucson, 2005. J.D. Candidate, Thomas Jefferson School of Law, May 2010. Special thanks to all my editors: Shima Kalaei, Donald Glista, Kara Shacket, Jeffrey Bright, and Stephen Zeller for comments on earlier drafts. I am indebted to Hayley Clair and Jessica Flynn for their invaluable suggestions and stellar dedication to help assemble the final manuscript. I am grateful to Professor Marybeth Herald for her mentorship and scholarly guidance, and Professor Joy Delman for sharing her expertise on the health care industry and providing the intellectual resources to support this Note. Thanks to my family, in particular my mom and dad, for encouraging me to pursue my education with enthusiasm and vigor. Thanks to all my friends, especially Raquel Smith, Erik Bruner, and Adam Brewer, for support during the writing process. I also wish to thank my fiancé, Justin Hickman, for his encouragement this past year and always; I could not have done it without your friendship, patience, and those long nights filled with laughter.