



BNA, INC.

HEALTH PLAN & PROVIDER



REPORT

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

By WILLIAM G. SCHIFFBAUER, ESQ.

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

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

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

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agreement—on what providers can bill as patient. Providers, however, often resist "network" agreements.

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

Medicare's Balance Billing Model

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

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

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

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

Wide and Unexpected Variations in Provider Charges

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

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

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

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

Outside of the Medicare Market

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

A Harvard University study examined 1,771 personal bankruptcy filers in five federal courts and found that

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

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

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

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

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

Network Protections for Policyholders

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

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

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

State Laws Limit Some Balance Billing

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

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

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

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

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

Health Care Provider Response

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

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

Fair Payments to Out-of-Network Providers

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

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

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

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

Conclusion

Pending federal health care reform legislation would only provide protection to individuals that enroll in the “public health insurance option” proposed in the House version of the bill. Other policyholders of private insurance are not afforded this “reform” protection feature

in the legislation for out-of-network “balance billing.” This legislation also proposes to require nearly “\$1 trillion” that will be paid over to the health care providers.

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