

CASE STUDY

Balance Billing and Reassignment of Benefits: Managed Care Takes Aim at Non-Contracting Emergency Physicians

Issue

Insurance companies are implementing legislative and procedural strategies designed to increase burdens and reduce compensation for non-contracting emergency physicians. Strategies include legislative action to implement prohibitions against balance billing and procedural maneuvers to stop patients from reassigning benefits to non-contracting physicians.

ACEP Position

ACEP Position Statement approved by the ACEP Board of Directors in October of 2002:
“ACEP opposes laws that ban the balance billing of commercial, non-contracted, emergency department patients.”

Background Information

Thanks largely to state laws and employer demands, managed care plans typically provide their enrollees with some level of coverage for emergency care, regardless of where the treatment occurs or whether the emergency care provider contracts with the managed care company. This key provision protects patients from being refused insurance coverage for emergency treatment but limits the ability of the managed care companies to exercise control over the costs associated with providing this coverage.

In an effort to reduce payments and increase emergency physician participation in their networks, managed care companies have devised legislative and procedural strategies to limit the compensation available to non-contracting emergency physicians who treat patients that are enrollees in those managed care plans. These efforts include expanding the number of states that prohibit non-contracting physicians from balance billing patients, requiring non-contracting, hospital-based physicians to accept in-network rates as payment in full for emergency cases, requiring hospital-based physicians to contract with the managed care plans that contract with their hospitals, and requiring non-contracting emergency care providers to collect all payments directly from the patient.

Legislative and Procedural Developments in 2003-2004

In 2003, legislative and regulatory efforts surfaced in at least three states (Texas, New York and California) to ban the practice of balance billing. Prohibitions against balance billing managed care patients already existed in several other states, including Maryland, Delaware, Florida and Utah, but the activity in 2003 signified a potential new effort to expand this prohibition to other parts of the country. The proposed legislation in Texas and New York prohibited non-contracting providers from balance billing patients and required managed care companies to reimburse providers at the usual and customary rate. No definition of “usual and customary” was provided and no mechanism was identified for providers to appeal in the event reimbursement was inadequate. Under these proposals, the managed care companies could essentially use their own discretion in defining “usual and customary” and reimburse non-contracting providers

accordingly. Providers would then have no recourse to challenge those decisions, except through the managed care companies' own internal procedures or through costly court action. Removing the balance billing option would prevent non-contracting providers from any expectation of collecting full charges for the services they provided and, by removing patients from the process, eliminated any leverage in assuring that managed care companies would reimburse in a fair and equitable manner. The Texas ACEP chapter actively opposed the bill and testified against it in committee hearings. The bill died in committee. The New York bill never moved out of the Senate Insurance Committee in 2003 and was reassigned to that committee in 2004. (However, the bill has received more attention in 2004 and garnered support of some key legislators. Another measure was also introduced in New York that would ban balance billing of patients in state-funded health programs. The New York chapter is actively engaged in opposing the balance billing bans as of this writing.)

California faced a serious regulatory challenge to the rights of non-contracting providers to balance bill managed care enrollees. An attorney for the Department of Managed Health Care issued a letter in 2003 advancing the opinion that balance billing violated state law because an "implied contract" existed between non-contracting emergency care providers and managed care companies. The opinion stated in part that since federal and state law mandated that emergency care providers treat all patients presenting with an emergency condition and since state law required managed care companies to provide coverage for emergency care, then a contract implied in law existed and the existence of such a contract would prohibit the balance billing of patients. The Department of Managed Health Care contemplated filing an emergency regulation to prevent balance billing, however CAL/ACEP managed to prevent that filing through discussions with officials within the outgoing administration of Governor Grey Davis. In 2004, in another tactic to coerce physicians into participating in network plans, legislation has been introduced that would require hospitals to ensure that their hospital-based physicians have contracts with the network plans that the hospitals contract with. Efforts are now underway by CAL/ACEP to exempt emergency physicians from that requirement.

In 2004, the Senate majority leader in Colorado was asked to amend an omnibus health bill to include a provision that would require non-contracting, hospital-based physicians providing emergency care to accept in-network payments from managed care companies and prevent them from balance billing the plans' enrollees. All other non-contracting providers wishing to balance bill would have to provide, within 24 hours of an encounter, written proof of disclosure to the patient as to the provider's non-participating status. Under this proposal, non-contracting emergency physicians would have no choice but to accept what the managed care company paid them as payment in full. The Colorado chapter and the Colorado Medical Society reacted quickly and strongly and the amendment was withdrawn.

On the flip side of the balance billing prohibition, specific managed care companies in Virginia and Massachusetts engaged in efforts to force non-contracting providers to collect all payments directly from patients. Essentially, the insurers enacted new procedures that would refuse to allow patients to assign benefits to non-contracting providers. The plans would pay the patient directly, typically an amount below billed charges. The providers would then have to incur the billing and collection expense, as well as the uncertainty and risk involved, in trying to recover all charges directly from the patients. In Massachusetts, the managed care company sent a letter to non-contracting emergency physicians offering them a bonus to join their network or prepare to face the prospect of collecting all fees directly from the patients. By accepting the bonus, physicians would be locked into a three-year agreement to accept terms for all of the insurers products. The Massachusetts chapter introduced legislation that would require benefits to be assigned to non-contracting providers. Additionally, the chapter met with various state regulatory

officials to see if the insurer's actions might violate state regulations. The chapter also engaged in discussions with the insurer in an effort to dissuade the company from enacting this procedure. As of this writing, the issue has not yet been resolved, but the insurer has temporarily delayed implementation of the procedure and offered some increased reimbursement for EM codes.

In Virginia, in response to the actions of the managed care company, a physician group (not representing VaACEP) introduced legislation that would require the assignment of benefits to all providers. However, as had occurred in a previous attempt to pass similar legislation, the managed care industry successfully attached an amendment to the bill, which would prohibit balance billing by non-participating physicians. The bill subsequently died in the legislature. This remains an ongoing issue, as at least one other insurer is now directing payments to patients instead of non-participating physicians. As of this writing, legal action is being contemplated in Virginia, where the insurer in question may be in violation of a portion of the state prudent layperson law, requiring that "a health maintenance organization shall reimburse a hospital emergency facility and provider" for screening and stabilization services rendered to meet EMTALA requirements.

While the refusal to assign benefits is a quite different approach from the balance billing prohibition, the intent is largely the same. Through these strong-arm tactics, managed care companies are creating new financial disincentives for non-contracting providers in an effort to persuade more providers to contract with them and accept the reduced rates they offer. Providers who refuse to join a network will face new financial consequences.

Arguments in Favor of this Position

Retaining the right to balance bill patients protects the fundamental right of physicians to set their own fees and to decide whether or not they want to participate in a managed care network. Without this ability, compensation for non-contracting physicians would be set either by the state (through a state-mandated formula) or, in the absence of specific state instructions, by the managed care companies themselves. Whether fees are restricted by the state or by the managed care companies, physician compensation will suffer. In an environment where emergency care providers already provide inordinate amounts of uncompensated and undercompensated care, further erosion of physician compensation could greatly exacerbate the problems associated with attracting and retaining emergency physicians.

While the bill purports to help patients, it would ultimately hurt them by reducing their access to quality emergency care, as fewer physicians would be able or willing to practice.

Prohibiting balance billing is not a patient protection initiative; it is a profit protection initiative for managed care companies. This would replace a free and open market, based on competitive pricing, to protect already profitable HMOs

Removing the right to balance bill patients also removes a key incentive for managed care companies to negotiate with physicians in a good faith effort to convince physicians to join a managed care network. Without balance billing capabilities, negotiating power would be stripped from physicians.

Due to EMTALA, emergency care providers are uniquely and severely punished by a ban on balance billing. Emergency physicians cannot choose to see or not see patients because of their insurance status.

The overcrowding problem at Emergency Departments could easily worsen as the ED becomes the de facto in-network option for everyone.

Prohibitions of balance billing raises potential legal concerns, especially in those cases where non-contracting providers are required to accept whatever rates the managed care company chooses to pay. Such actions could violate due process provisions by requiring providers to accept compensation that a third party unilaterally sets. Additionally, giving insurers the right to unilaterally set provider fees may be an inappropriate delegation of the state's ratemaking power. (However, providers should not have an expectation that a legal challenge would be successful. There is no known precedent for success in challenging balance billing laws.)

For the reassignment of benefits issue, managed care companies are engaging in a practice to force providers to either join their network and accept reduced compensation for their services or incur new billing and collection costs to collect money directly from the patient. This coercive tactic removes money from the financially strapped health care system and places more money in coffers of the managed care companies.

Patients are placed in the middle of the billing process, which they expect to be handled between the provider and the managed care company. Patients pay their insurance companies to cover their costs and handle the paperwork. Consumers will have to deal with increased hardships and headaches.

Patients have no way of knowing whether an emergency care provider is contracted with their managed care company. To avoid the hassles and uncertainties of billing, some patients may be more reluctant or hesitant in seeking emergency care.

When insurers have a policy of refusing to honor reassignment requests, patient access to appropriate emergency care is jeopardized.

Patients who have failed to pay bills they've received from emergency care providers may be less likely to seek emergency care when they need it because of their concerns over the unpaid bill.

Providers may bill patients directly (and not submit a claim to the insurer), and the patient will view the bill as a financial obligation that they must sort out, with resulting inhibitions of seeking emergency care. Unlike when a patient makes a choice to go to a non-participating primary care provider, patients do not choose to go to a non-participating emergency physician, and will have concerns when they seek emergency care that it will be paid at out of network levels of participation.

Patients that get billed directly from the providers may well pay the full bill, and then later submit the bill for recoupment from the insurer, and the insurer may pay less to the patient than what the patient had paid to the provider. Some states have prudent layperson laws in which the insurer is obliged to cover the emergency services; in such states what happens when the patient paid the provider the full charges and the HMO only reimbursed for less than full charges? Would such actions violate contracts with patients? State regulators may have some concern, because such issues "put the patient in the middle" and will inhibit subsequent access to emergency services, which was likely not the intent of prudent layperson legislation.

Refusing to honor reassignment requests of patients will inhibit patient's appropriate use of emergency services in many ways. For instance, patients accessing emergency services by dialing 911 may find themselves being cared for by a non-participating physician, with the resulting burdens of dealing with the billing issues. After experiencing the burdens of being cared for by a non-participating provider, some patients will subsequently choose to delay accessing 911 services and/or may choose to try to get to their "preferred" hospital by driving when they could be calling 911. Additionally EMS personnel will find themselves being requested by patients to break with EMS protocols due to financial concerns of the patient of which hospital they are being taken to. EMS protocols are developed to promote public health and optimal care, and injecting patient financial burdens in to the decision making of where to transport patients adversely affects the public health system.

Customers of managed care plans will be treated differently by their managed care company depending on whether they receive emergency or non-emergency care and depending on who happens to treat them in an emergency situation.

Fraud would be encouraged as anyone could present at an emergency department with a false complaint, be screened and treated as required by federal law, wait for a check to arrive from the managed care company and never pay the emergency care provider. In fact, Virginia physicians report that members of one family made 42 visits to the some ED, received payments from their managed care company and pocketed every cent.

Patients treated for true emergencies may receive significant payments from their managed care companies and could easily be tempted to keep the money and not pay the provider. Similarly, well-intentioned patients could be confused upon receipt of the payment and spend the money before realizing that they are personally accountable for the cost of their emergency care. This increased potential for fraud, abuse and confusion could intensify current problems plaguing the emergency care system, including excessive levels of uncompensated and undercompensated care and overcrowding of emergency departments.

For states that have prudent layperson laws, refusal to reassign benefits may violate provisions of that law. In Virginia, for example, legal challenges were under consideration at the time of this writing. Virginia's prudent layperson law includes a provision that "a health maintenance organization shall reimburse a hospital emergency facility and provider" for screening and stabilization services rendered to meet EMTALA requirements. It would appear that this provision directs HMO's to pay the provider, not the patient. While it is too early to know how a court would rule on this question, many state prudent layperson laws may have similar provisions that could be the basis for a legal challenge. Additionally, demonstrating that refusal to reassign benefits may violate prudent layperson laws could serve as a deterrent to insurers to begin with, or help in legislative efforts to stop the practice.

Arguments Against this Position

Prohibitions against balance billing are typically defended on the grounds of patient protection. Unsuspecting patients who are covered by managed care plans assume that the costs of emergency department visits are covered by the plans. They are often unpleasantly surprised to learn that the plans do not cover the full costs of care provided by non-contracting providers. Often, they may first become aware of this fact when they receive a bill from an emergency care provider.

In refusing to reassign benefits to non-contracting providers, managed care plans argue that since they have no contractual relationship with the provider, they should not be required or expected to devote time and resources in the adjudication and reimbursement of claims from non-contracted providers. This is a benefit they choose to reserve for their in-network providers.

Potential Opponent Organizations

Managed Care Organizations
Consumer Protection Organizations
Business Organizations

Potential Proponent Organizations

State Medical Societies
State Hospital Associations
Other Specialty Societies (representing on-call specialists)

Possible Strategies

If government officials accept the concept that a balance billing prohibition is as an important consumer protection, there may be alternative plans that could incorporate this prohibition but still protect non-contracted emergency physicians. The California chapter is considering a legislative initiative that would eliminate balance billing, but require plans to pay billed charges to non-contracting physicians. The proposal would call for the creation of an administrative panel under the auspices of the state medical board, which would hear any appeals from managed care companies that wanted to contest the reasonableness of a non-contracting physician's fees.

Chapters may want to investigate whether refusal to assign benefits might violate language in a state's prudent layperson law. A group of members in Virginia is considering legal action against an insurer, arguing that the insurer is violating that portion of the law which states that "a health maintenance organization shall reimburse a hospital emergency facility and provider" for screening and stabilization services rendered to meet EMTALA requirements. Since many state prudent layperson laws are quite similar, this could provide an avenue of relief.

Whether it's a balance billing ban or a refusal to reassign benefits, the intent is to discourage non-participation by providers and enhance a managed care company's network and profits. Arguments can and should be made regarding the negative impact of these initiatives on patients and the emergency care system.