

On Your Behalf ...

Legislative and Practice Affairs Division

The Political Clout of Managed Care

By William E. Barnaby, CSA Legislative Counsel

Remarkable political power is wielded in California by health insurance companies, be they Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or the remaining few indemnity health carriers. This is despite a constant stream of critical news stories, adverse court verdicts, and regulatory penalties stemming from abuses and profiteering on the part of health insurance carriers and their “risk bearing” collaborators.

Health insurers may lose some limited skirmishes, but their massive resources are used to wage extremely effective public relations and lobbying campaigns on the big issues. And it doesn't hurt when a state agency charged with policing the industry defines itself, instead, as the industry's “partner.”

The situation is all the more regrettable since it affects access to healthcare for millions of people. At the same time, doctors and other health caregivers are being paid less for doing more, but health insurance seems to be an island of profitability amid troubled economic waters.

It would appear the general public lays most of the blame for rising health care costs on the health insurance industry. For example, the well-respected Harris Poll recently reported:

ROCHESTER, N.Y. – October 28, 2008 – Many more people blame the insurance industry for rising health care costs than blame anyone else. When asked who is most to blame, 41% of adults blame insurance companies, compared to far fewer who blame the pharmaceutical companies (16%), the government (16%), hospitals (6%), or physicians (4%).

These are some of the results of The Harris Poll®, a new nationwide survey of 2,119 U.S. adults surveyed online between October 16 and 20, 2008, by Harris Interactive®.

Bearing public blame for rising costs, health insurers also are seen by doctors as interfering with patient access and the quality of patient care. For example, the *Toledo Blade*¹ published an “unscientific” survey of Ohio State Medical Association members on the impact of health insurers on the doctor/patient relationship. Of 920 respondents:

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- ✓ 99% reported interference by insurers in their treatment of patients.
- ✓ 95% said insurers interfered with decisions about prescriptions, 91% with testing, 74% with referrals, and 69% with hospitalization decisions.
- ✓ 86% said interference compromised patient care, 76% said it affected their patients adversely, and 65% said they were unable to protest denials successfully.
- ✓ 70% noted they experience interference at least once a week, with 92% answering that interference increased during the past five years.
- ✓ 14% believed interference from an insurer had contributed to the death or serious injury of a patient.

In fairness, the survey questioned doctors about interference from all manner of insurers, including insurance companies, self-insurance funds, Medicare, Medicaid, and prescription drug plans. Representatives of the Ohio Association of Health Plans countered that doctors “really don’t like it when we ask questions about what they’re doing.” Another reason for discounting the results from medical association members, it was asserted, was “they primarily join because they are interested in lobbying for changes.”

All that said, the health insurance industry has managed to prosper financially and to succeed politically despite being disliked by the public and physicians. What is the practical effect?

One need only look at a listing of defeated managed-care-reform legislation to see proof of the awesome political clout of managed care in California. Of eight managed care bills identified of interest to CSA, only one was enacted into law. (See the CSA Final Legislative Report for 2008 on the CSA Web Site at www.csaq.org/pdf/legal_issues/Legislative_Status_Final_2008.pdf).

Among the reforms defeated were bills to:

- ✓ Force payment to providers of sums determined by the Department of Managed Health Care (DMHC) as having been lawfully underpaid, in addition to administrative fines and penalties. Thanks to a veto by the Governor, HMOs are able to continue paying fines that are a fraction of under payments to caregivers.
- ✓ Require HMOs and their fiscal agents to pay providers directly, rather than sending payment checks to enrollees, since some managed care entities refuse to accept their enrollees’ assignment of benefits.

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- ✓ Require medical necessity to be disproved in any legal action challenging a denial or modification of services requested by the treating provider.
- ✓ Require 85% of collected premiums to be spent on patient care.
- ✓ Limit insurer investigation of enrollment application to six months and ban cancellation of coverage after that period for reasons of medical history.
- ✓ Establish standard information and health history questions for use on health-coverage applications.
- ✓ Control “post claims underwriting” by restricting policy rescissions (cancellations) to limited specified conditions.
- ✓ Rein in the authority of the DMHC Director to waive rules and Knox-Keene Act requirements.

The one reform that made it into law got there by indirection and, perhaps, some embarrassment. The California Medical Association initiated SB 1379 (Ducheny) to help fund the Steven M. Thompson Loan Repayment Plan for newly licensed physicians who agree to serve in medically underserved areas. In searching for funding options, Francisco Silva of CMA found that existing law deposits fines imposed on misbehaving HMOs into the same “Managed Care Fund” as HMO licensing fees which, in turn, finances the DMHC administrative budget. In effect, fines against wrongdoers offset license fees for all the DMHC licensed plans. How about that? It would be like using the total fines against drunk driving to reduce everyone’s drivers’ license fees.

When CMA lobbyist Lisa Folberg first broached the idea of using collected fines to help repay student loans of new doctors, suddenly other uses were advanced by others, including staffers to the Governor, who insisted they were aware of the HMO-license offset and were preparing to do something about it. But the fact is, CMA was the first to make a move. DMHC evidently was perfectly content with the offset, since it has never even suggested using fine monies to increase enforcement—a tack used by some agencies to generate more fines and also curtail wrongdoing.

Late in the session, SB 1379 was amended to create a “Managed Care Administrative Fines and Penalties Fund” into which all fines and penalties will be deposited. Each year, the first \$1 million will go to help with new physician student loan repayments. Amounts in excess of that total will be transferred to the Major Risk Medical Insurance Program (MRMIP) that subsidizes health insurance premiums for a few thousand otherwise uninsurable Californians.

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Specifically prohibited is use of this Fund “to reduce the assessments imposed on health care service plans” under the basic licensing fee law.

Initially, the California Association of Health Plans (CAHP) argued that “in any given year, fines and penalties make up 5 percent to 10 percent of the DMHC budget, and diverting these revenues would create a shortfall in the DMHC budget that would be filled by increased assessments on health plans by as much as \$4.5 million.” CAHP stated it was opposed to bills that “increase health care costs and raise premiums” for its enrollees, according to the staff analysis written for the Assembly floor vote on SB 1379.

Follow the CAHP logic for a moment, if you will. Fines for wrongdoing will “increase health care costs and raise premiums for enrollees.” Fines must not, heaven forbid, reduce profits, or shareholder dividends, or CEO bonuses, or administrative management costs, or advertising expenses, or lobbying expenditures, or campaign contributions. The inescapable bottom line is enrollee (patient) premiums pay for everything, including the “utilization reviews” that deny care sought by treating doctors. Left unexplained, however, is how breaking the rules can “increase health care costs.”

One way to hold down health care costs, of course, is to limit payment for the medical care rendered by physicians and other providers. There is no better target in this regard than emergency medical care that **must** be rendered under penalty of law for “out of network” non-contracted services. The only protection for physicians in this context is the legal ability to balance bill. Take away the ability to balance bill, managed care could pay whatever it felt “reasonable” and there would be no need or ability to negotiate fair and reasonable rates.

The ability to shortchange caregivers seems important to health insurer profitability. This would explain the unremitting attack on the temerity of those physicians who seek fair payment through balance billing for the emergency care necessary to save lives and relieve suffering. In this attack, DMHC Director Lucinda Ehnes has proudly proclaimed her agency’s “good partnership”² with CAPG (California Association of Physician Groups, the HMOs’ “delegated” fiscal agents), the very entities her agency is charged with regulating.

Another troubling reflection of DMHC’s enforcement attitude toward the managed care licensees under its regulatory jurisdiction took place over the last July 4 holiday. On that Friday Independence Day, the Associated Press reported:

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California regulators admitted Thursday that for more than a year they didn't even try to enforce a million-dollar fine against health insurer Anthem Blue Cross because they feared they would be outgunned in court.

In early 2007, the Department of Managed Health Care pledged to fine the state's largest insurer for "routinely rescinding health insurance policies in violation of state law," but it never sent a bill. The department's director, Cindy Ehnes, told *The Associated Press* on Thursday that the agency has had success in forcing smaller insurers to reinstate illegally canceled policies and pay fines, but Blue Cross is too powerful to take on.

"In each and every one of those rescissions, (Blue Cross has) the right to contest each, and that could tie us up in court forever," Ehnes said of the approximately 1,770 Blue Cross rescissions between Jan. 1, 2004, and now.

Anthem Blue Cross, a unit of Indianapolis-based WellPoint Inc., acknowledged in a statement Thursday that it had seen the March 22, 2007, announcement of the \$1 million fine, but noted that "Anthem Blue Cross has not been fined by the DMHC."³

The \$1 million firecracker may have misfired in the Governor's office, however, as within a few days the Governor's Deputy Chief of Staff (and former DMHC Director) Daniel Zingale was taking a tougher line. He referenced a recent court decision to say the penalty could be stiffer—"as much as \$200,000 per violation on about 1,700 disputed rescissions."⁴

Had Director Ehnes remained quiet about the DMHC \$1 million surrender, no one might have been the wiser. Instead, others within the Schwarzenegger Administration had to step up to pull down the white flag. Even so, Ehnes remains as Director and continues to cozy up to managed care "partners." DMHC continues to side with CAHP and CAPG on HMO reforms before the Legislature. It also continues to try to ban balance billing through legislation and, when that fails, through administrative rule-making. The health insurance industry certainly is not cowering in fear from an overbearing regulator in DMHC. Instead of a regulator making sure patients get the care premiums they have paid for, and medical care providers are paid reasonably for the care rendered, the industry has a "partner." That, in our book, is political clout.

¹ *Toledo Blade*, Steve Eder and Julie McKinnon, August 24, 2008

² CAPG HEALTH, Fall 2008, pages 36 – 38

³ *Associated Press*, Shaya Tayefe Mohajer, July 4, 2008

⁴ *Los Angeles Times*, Lisa Girion, July 8, 2008

Last year's movie *Sicko* was panned by many as merely a promotion of a single-payer, governmental takeover of healthcare in America. Better access to healthcare is favored by many Americans who, at the same time, are wary of government control. Perhaps a subtext of the movie may be more to the point: Private health insurer abuses and greed may prove to be the driving political force that brings about a single-payer system quicker than anything else.

Overreaching and greed by Wall Street, banks, hedge funds, and other self-described "masters of the universe" recently led to the near meltdown of many major financial institutions. Unprecedented government intervention in the national and world economy has been the result, and has been welcomed. Will the political clout of the health insurance industry lead to its undoing due to similar overreaching and greed?

Balance Billing and Constitutional Government

A Perfect Storm

By David E. Willett, Esq., CSA Legal Counsel

The three branches of government—legislative, judicial, and executive—are the introductory description of our constitutional system. Seldom is there an example of their interaction as vivid as recent events addressing balance billing. Balance billing occurs when a physician whose only contract is the implied contract between physician and patient bills the patient for the balance of a reasonable fee, which the patient's insurer or health plan has failed to pay. Balance billing affects patients whose health plans don't contract with some likely treating physicians, and also don't pay reasonable fees for services rendered.



During the last four months of 2008, California's Legislature, the Supreme Court, and the Department of Managed Health Care in the executive branch all took action aimed at balance billing. The Legislature passed a bill (SB 981) prohibiting balance billing by physicians contracting with a hospital to provide emergency services. On September 30, in the finale of the legislative process, the bill was vetoed by the Governor. Even as the Legislature was addressing balance billing concerns, DMHC continued down a dogged path trying to prohibit balance billing. After a number of false starts, DMHC finally adopted

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a regulation, effective on October 15, labeling balance billing for emergency services as an “unfair billing practice,” and thus presumably illegal.¹ On November 5, the day after the election, the California Supreme Court heard oral arguments in the case of *Prospect Medical Group vs. Northridge Emergency Medical Group*, in which the Prospect Group challenged the right of emergency physicians to balance bill for their services.

Observers of constitutional government in action may wonder why this single issue occupied the attentions of all three branches at this same time. There was no sudden event or circumstance precipitating a crisis demanding attention on all fronts. The answer probably lies in the failure of the executive branch, through administrations controlled by both political parties, to properly deal with the issue, despite clear legislative instructions. The lesson is less about politics than about the power of an entrenched bureaucracy and relationships regulators inevitably develop with the regulated.

Balance billing of health plan enrollees has been an issue in California for quite a few years. The Knox-Keene Health Care Service Plan Act contemplates a delivery system in which health plans contract with hospitals and physicians to provide services to enrollees. There are provisions addressing the impact of noncontracted services, including provisions addressing plan financial reserves for those events. However, the universe addressed in the Knox-Keene Act is limited to relationships between plans and the enrollees and providers who enter into written contracts with plans. There is a provision prohibiting balance billing by *contracting physicians*, but only by contracting physicians. One of Knox Keene's requirements has been that plans contract with sufficient providers to ensure patient access. This is a subject DMHC has been loath to address. In late 2007, DMHC promulgated regulations purporting to govern plan arrangements for access. The Legislature earlier had directed DMHC to do so by January 1, 2004. When the proposed access regulations were finally announced, CSA responded, objecting to DMHC's failure to address access to services provided by facility-based physicians, including anesthesiologists. DMHC has long been resolute in turning a blind eye to health plan refusal to enter into reasonable contracts with hospital-based physicians, despite consequences to the public, and DMHC ignored those objections. Previously, in

¹ On December 2, the Sacramento Superior Court denied the injunction sought by CMA and other plaintiffs, including CSA, thus permitting DMHC to proceed with its regulation. The court justified its decision by saying that DMHC's adoption of a definition does not by itself determine when the DMHC characterization applies, which leaves physicians in a great grey zone. The next step, unless the Supreme Court decision in the *Prospect* case resolves the balance billing issue, will be prosecution of an appeal to the California Court of Appeal, or the pursuit of other potential remedies.

2000, problems attributable to the manner in which DMHC regulated health plans led to the passage of major reform legislation requiring DMHC and plans to do a number of things. Balance billing was not specifically addressed, since neither Knox-Keene nor the bill deal with noncontracting providers. However, the bill did include a provision directing DMHC to report back to the Legislature and to the Governor as to the need to define any unfair billing patterns presenting concern. DMHC has never bothered to make this report, even though it was required by December 31, 2001. Instead, DMHC went on to unilaterally adopt the rule, now being challenged in court, labeling balance billing as an unfair billing practice. DMHC has routinely ignored directions from the Legislature regarding its oversight of health plans.

It is a basic constitutional principle that the executive branch cannot legislate, and that the executive arm must be given specific authority by the legislature to adopt a rule having the force of law. The fact that the Legislature has never given DMHC authority to regulate physicians, except in the context of contractual relationships with health plans, is fundamental in California's health care system. DMHC has tried to extend its authority by creating a contractual relationship out of whole cloth, saying that there is an "implied contract" with hospital-based physicians. This argument was brushed aside by the lower courts upholding the right to balance bill, in *Prospect*. Significantly, a letter from a DMHC senior counsel that was offered by Prospect to support its claim that balance billing is illegal was dismissed by the Court of Appeal in a withering footnote. Prospect Medical Group should not be confused with a practicing medical group. It is an IPA, typical of California Association of Physician Groups (CAPG) members, whose interests are aligned with the health plans they serve as subcontractors. That is why CAPG, in the *Prospect* case and in other settings, makes appearances to oppose CMA and other physician organizations (including CSA) arguing for physicians' rights.

Prospect's suit against the emergency group was brought after the emergency group, like other informed physicians, ignored strong-arm tactics by payers—abetted by DMHC threats—to force noncontracting physicians to accede to "take it or leave it" tactics. Prospect also requested a ruling that noncontracting physicians should be required to accept Medicare rate schedules, a claim lower courts also summarily denied. In the meantime, the Legislature continued to seek solutions to the underlying concerns, culminating with the passage of SB 981. It is fair to say that more diligent administration of existing laws, and an even-handed approach placing physicians and their patients in parity with health plans, would have made these legislative efforts unnecessary, particularly if DMHC had not so regularly ignored direction from the legislature.

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When this article was prepared, neither the legislature, the courts, nor the executive branch had resolved balance billing issues. A Supreme Court decision in *Prospect* could arrive at about the same time as this issue of the *Bulletin*, but it may take longer. The Legislature will have convened for the 2009-2010 session, but it will not have turned its attention to workaday issues. Only the posture of the executive branch, specifically DMHC, is predictable. The bureaucracy that controls DMHC will remain opposed to balance billing, but will be unwilling to address the reason balance billing occurs, which is the refusal of health plans and their subcontractors to offer reasonable contracts to hospital-based physicians who have no practical choice in caring for their enrollees. DMHC will continue to favor health plans, and to ignore public concerns. This is idiomatic of relationships in which the regulated (health plan) capture their regulator (DMHC), through daily contact, the cultivation of those contacts, and even the opportunity for attractive employment at the end of a government tour, as has happened in the past.

This grand collision within the framework of constitutional government presents important lessons for anesthesiologists as well as other physicians. The playing field is not even. Health plans have very deep pockets. They can easily absorb the risk of losing case-by-case disputes with the physicians who have treated their patients if the patients have no interest in the outcome, beyond remote concern for fairness and availability of care. Their patronage attracts legislators, and even public employees looking to their own futures. Litigation is but one weapon in their arsenal. When an issue arises that does seem to threaten the public, health plans are prepared to use that issue to advance their own interests. Physicians, in turn, must be careful to align their interests with the public interest. For example, an early tactic by one anesthesiology group to put pressure on health plans was to employ an attorney to send collection letters to patients, along with balance bills. That did not engender patient understanding or support. In contrast, efforts to work with patients to explain the problem, and to enlist their help, have received a good reception. Similar efforts will be needed again in the Legislature. It is probably inevitable that the Legislature will once more take up this subject. It can surface again in the courts at any time. CSA, in concert with CMA, has so far been successful in meeting and defeating the opposition in all these settings, despite health plan resources and a compliant regulator. Your CSA membership and support has made the difference.

Francisco J. Silva, Esq., CMA's New V.P. of Legal Affairs and General Counsel

By *William E. Barnaby III, Esq., CSA Legislative Advocate*

There's a new sheriff in town, and his name is Francisco Javier Silva, Esq. He is now the new chief lawyer for the House of Medicine. Earlier this year Francisco was named Vice President of Legal Affairs and General Counsel of the California Medical Association. Prior to the promotion by the CMA Board, he was an Associate Director (staff lobbyist) in CMA's Center for Government Relations, headed by CMA V.P. of Government Relations (chief lobbyist) Dustin Corcoran.

Bill Sr. and I first worked with Francisco when he was lobbying "balance billing" and other issues for CMA. His talent, calm temperament under pressure, and keen legal mind were apparent from the start. In fact, much like Dustin several years earlier, we tried to lure Francisco away from CMA to work with us. And just like our experience several years ago with Dustin, CMA recognized Francisco's talent and made him an offer we could not match. In another similarity to Dustin's earlier promotion, some thought Francisco might be too young for such an important post. But after working with him for several years, we are certain Francisco is up to the task—and then some.

As CMA's General Counsel, Francisco's goal is to combine his political and legal experience to advocate for California's physicians and their patients. For instance, to stop the Medi-Cal cuts, he and CMA organized a coalition that sued as a broad-based consumer and provider group while also lobbying against the cuts. He intends to use the same CMA-led coalition approach to advocate for physicians and their patients against health insurance interests.

Regarding balance billing, Francisco first lobbied the issue and then wrote CMA's comments opposing the Department of Managed Health Care's proposed 2007 regulations. Now as General Counsel he has led the challenge in the courts against the 2008 regulation DMHC adopted effective October 15, 2008. He has also aggressively pursued transparency within DMHC by filing Public Record Act requests.

Of special pride to Francisco is his involvement in this year's SB 1379 (Ducheny). As more fully described in Bill Sr.'s article, "The Political Clout of Managed Care," fines imposed by DMHC upon its regulated health insurers have been used to offset the regular licensing fees required of all DMHC licensed health plans. CMA was looking for funding options for the "Steven M. Thompson Loan Repayment Plan," a fund that assists new physicians in repaying student loans if they practice in medically underserved areas.



*William Barnaby, Sr., CSA Legislative Counsel, and Francisco Silva, Esq.,
CMA General Counsel*

Francisco discovered this mechanism that will fund the new (SB 1379) law while he was still a lobbyist for CMA.

Moreover, he carries himself with a calm sense of confidence and sincerity quite often lacking in other high-powered attorneys and lobbyists in the Capitol community. In sum, he's calm, confident, and sincere in an environment where many are arrogant, curt, and full of self-importance.

Prior to joining CMA, Francisco was Vice President and Counsel for Government Affairs for the California Apartment Association, and a litigation attorney at prominent law firms in San Francisco and Sacramento. As a litigation attorney, he handled matters involving corporate, contract, antitrust and unfair competition law. Francisco also was a judicial law clerk for a Federal District Court Judge and a consultant to the California Assembly Budget Committee. He holds a Bachelor of Arts degree from Santa Clara University and a law degree from UCLA.

Francisco is married to Soyla Fernandez, one of Sacramento's top lobbyists, who also represents physicians and with whom we work very closely. Francisco and Soyla have a 6-year-old son, Israel, and they live in Sacramento.

With Francisco, and his very capable team at CMA, protecting physicians and their patients for the entire House of Medicine, and David Willett, Phillip Goldberg, and the Hassard Bonnington law firm serving as CSA legal counsel, California's anesthesiologists and their patients have a legal advocacy team second to none. And while we were unable to recruit Francisco or Dustin to our firm, they remain close associates on the same physician advocacy team.