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The Abyss of Managed Care and its 40-Year Impact on Payer/ Provider Relations

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*"God hates violence. He has ordained that all men fairly possess their property, not seize it."*²

Modern American health care affords every hospital patient the inalienable right to emergency treatment,³ although this same system has yet to create any parallel infrastructure beyond the clinical delivery of such care. While today's emergency department physicians across the nation have access to cutting-edge, integrated technology-based tools⁴ designed to improve patient outcomes by combining advances in medicine with evidence-based clinical guidelines,⁵ the science of overseeing managed care patients often appears to be light years removed from the era in which it was born.⁶ As a result, American health care has become a system of fundamental brilliance that finds itself limited by gross inefficiencies,⁷ a combination that has led to a symbolic, if not actual, nationwide revolution.⁸

At their core, the 2010 Patient Protection and Affordable Care Act⁹ and the amendments set forth in the 2010 Health Care and Education Reconciliation Act¹⁰ address the concept of *patient access*, one of health care's greatest challenges in recent years.¹¹ Notwithstanding the 961¹² regulatory pages known as the Affordable Care Act, or "Obamacare,"¹³ the relationship between the patient and the entity responsible for covering the cost of care has received surprisingly less attention in comparison.¹⁴

In California, the recent decision in *Children's Hospital Central California v. Blue Cross of California*¹⁵ has been seen by many as the culmination, and by some as the resolution, of conflict between providers and payers within the managed care system.¹⁶ This article focuses on events preceding the *Children's Hospital Central California* decision, how the managed care system of private payers has evolved over the past 40 years, and the challenges faced by payers and providers simply trying to coexist.

The Rise of the HMO

Henry J. Kaiser was responsible in large part for the growth and eventual success of health maintenance organizations ("HMOs") in the United States, and since the mid-1930s Kaiser and his self-named network have controlled the HMO market.¹⁷ HMOs grew slowly at first as they faced staunch opposition from the American Medical Association ("AMA"), which contended that such health plans were tantamount to the beginning of socialized medicine. As a result, many physicians who worked within the HMO infrastructure were excluded from participation within medicine's mainstream.¹⁸ Despite this resistance, HMOs endured, and began to win the support of those in favor of using standardization to reduce medical costs. By the 1960s, HMOs had begun to attract new money, new supporters, and new names. By 1970 there existed 37 HMOs in 14 states, with a total of 3 million enrollees and a tested work model that appealed to many who sought greater regulation over health providers. This change in conservative perception of HMOs opened the door for increased federal involvement.¹⁹

In 1973, Congress passed the Health Maintenance Organization Act,²⁰ creating a partnership of sorts between the Federal Government and certain health care providers. The HMO Act offered government subsidies and loans to HMOs, helping these managed care entities to attain much needed financial stability, in part so they could carry Medicare's increasing burden. More significant, however, was a new power extended to HMO administrators that authorized their ability to challenge the medical judgment of licensed physicians, regardless of the clinical acumen (or lack thereof) held by these corporate executives. In doing so, the HMO Act represents the first instance of business concerns gaining the upper hand over medical judgment within the health care system, and marked the first step toward the discrepancy of power between the two that continues to exist today.²¹

From the perspective of the employer, managed care plans appeared to be less expensive than individual insurance packages, which



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often resulted in the elimination of plan choices for their employees.²² In theory, the HMO Act sought to create cheaper health coverage for working Americans by focusing almost exclusively on HMOs, which represented but a small portion of the health care sector in the early seventies. By fostering the growth of HMOs across the country, the HMO Act not only legitimized its model, but also spurred widespread corporate sponsorship from entities such as Prudential and several Blue Cross Blue Shield partners. Growth in the private sector continued, and by 1992 forprofit HMOs surpassed their non-profit counterparts.²³

Thanks to the consistency of government subsidies, the growth of this particular arm of health care has continued to be pronounced, with the HMO model expanding itself as the preeminent template for American health providers. 1978 saw 168 HMOs in operation, with 6 million enrolled. By 1990, there were 652 HMO plans, covering 34.7 million people. In 1996, the number of enrollees grew to 60 million. Last year, an estimated 154 million people were enrolled in managed care (109.7 million in preferred provider organizations, and 44.3 million in HMOs).²⁴

California's Response

Enacted in 1975, the Knox-Keene Health Care Service Plan Act ("Knox-Keene") regulates all aspects of health care service plans in California. Over the years, Knox-Keene expanded to include section 1371, which oversees the payments of claims by plans to health care providers.²⁵ Section 1371's primary function is to require health plans to promptly reimburse providers for services rendered. Under section 1371, health plans must reimburse a hospital (or other provider) within 30 working days, or within 45 working days if the plan is an HMO.²⁶ Interest starts to accrue for those plans in violation of these prompt pay requirements on the 31st or 46th day, as appropriate, at the rate of 15 percent per year.²⁷ At the same time, health plans must refrain from "practicing medicine," or face the ire of the Medical Board of California and a charge alleging the violation of California's prohibition on the corporate practice of medicine.²⁸

One limited exception to this statutory payment mandate provides that a health plan may avoid its payment obligation if it "contests or denies" the provider's claim. To contest a claim under the statute, the plan must give timely written notice that the claim is being contested. The notice must contain two important pieces of information: It "shall identify [1] the portion of the claim that is contested and [2] the *specific reasons* for contesting the claim."²⁹ Regulations promulgated by the California Department of Managed Health Care, the agency responsible for overseeing health plans, clarify these requirements: "For each claim that is either denied, adjusted, or contested, the plan . . . shall provide an accurate and clear written explanation of the *specific reasons* for the action taken within the timeframes specified in sections (g) and (h)."³⁰

California's legislature originally passed Knox-Keene in part "to ensure that residents of California receive quality, low-cost health care."³¹ Prompt payment of claims and speedy resolution of payment disputes are critical to the smooth operation of California's managed health care system and indispensable components consistent with the overall mission to keep costs down.³²

Section 1371 was added to the Knox-Keene Act in 1986 to help providers correct the "increasing difficulty with claims when insurers and plans withhold payments for unknown reasons and for lengthy time periods."³³ The proponents of the bill referred to the "cash flow problem" that the hospital industry as a whole was experiencing, "directly effected [sic] by market practices of claims payment," and opined that "[p]rompt notice of disputed claims would facilitate prompt payment to enhance claims processing."³⁴

When first adopted, section 1371 merely prescribed the time period within which a service plan had to pay, or notify providers that it was contesting, a claim.³⁵ The Legislature found this minimal requirement unsatisfactory, because the statute had no teeth and was routinely disregarded by health plans.³⁶ Under the original law, a plan was required to give notice of a contested claim, but was under no obligation to explain why the claim was being contested. As a result, a plan could still "withhold payment for unknown reasons."³⁷

The 1989 amendments were designed to remedy these deficiencies. As amended, the statute requires a health plan to deliver a compliant written notice that it is contesting a claim if it desires to avoid its obligation to reimburse a provider. The notice must "identify the portion of the claim that is contested and the specific reasons for contesting the claim." The amended statute also required plans to add 10 percent interest to payments of uncontested claims or uncontested portions of claims.³⁸ In 2000, the section was again amended to increase the interest rate to 15 percent.³⁹

The Legacy of Non-Contracted Providers

The most significant challenge to the relationship between health care plans and providers began when providers opted out of written agreements with HMOs and other payers, yet still treated the same patients for which the obligation existed under EMTALA.⁴⁰ With or without a contract, hospitals must treat patients presenting at the emergency department.⁴¹ Without a contract, however, the rate at which a payer must reimburse the hospital is not as clear.⁴² Not surprisingly, California courts have opined on this issue, and the State's legislature has passed laws to address the rights and interests of non-contracted providers almost as much as those contractually bound to any one or more payers.⁴³

Regardless of any contractual terms, since 2009 hospitals in California are prohibited from billing patients enrolled in a health care service plan for poststabilization care, with the exception of copayments, coinsurance, or other deductibles.⁴⁴ Hospitals are mindful of certain limitations in available remedies for emergency department providers,⁴⁵ yet enjoy the assignment of patients' rights under their policies when a health plan fails to pay, delays payment, or underpays in violation of the unfair competition law.⁴⁶ Hospitals also benefited from certain court-imposed limitations on preemption rights under the Employee Retirement Income Security Act of 1974 ("ERISA").⁴⁷

Before the *Children's Hospital* decision, the best that 40 years of managed care could offer to noncontracting providers was a marginally useful California regulation.⁴⁸ The remaining ambiguities resulted in a myriad of published opinions spanning the entire gamut of payer and provider disputes,⁴⁹ most of which were not necessarily resolved by the *Children's Hospital Central California* decision.⁵⁰ Whether future payer/provider disputes will be addressed by the judicial system or through California legislation remains to be seen. Until such clarity is forthcoming, however, the abyss is where California managed care will most likely remain.

Endnotes

- 1 Between 2002 and 2011, the author held the post of Chief Executive Officer of Coast Plaza Doctors Hospital. Although cases in which Coast Plaza Doctors Hospital was a plaintiff are referenced in this article, the author was not counsel of record in any such instance. [Back](#)
- 2 Euripides IV : Helen, The Phoenician Women, Orestes 59 (David Grene et al. eds., Univ. of Chicago Press 2013). [Back](#)
- 3 Under the 1986 Emergency Medical Treatment and Active Labor Act ("EMTALA"), Pub. L. No. 99-272, federal law defines a medical emergency as "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 . . . placing the health of the individual . . . in serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A)(i). EMTALA requires every hospital that receives federal funding to treat any patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of his or her condition is likely. No hospital may release a patient with an emergency medical condition without first determining that the patient has been stabilized, even if the hospital properly admitted the patient. Under EMTALA, patients requesting emergency treatment can only be discharged under their own informed consent or when their condition requires the services of another hospital better equipped to treat the patient's concerns. [Back](#)
- 4 New computed tomography ("CT") scanners have 320 detector rows capable of completing an entire rotation in 275 milliseconds, allowing them to capture a multi-dimensional, radiant image of the entire heart in the span of a single heartbeat. [Back](#)
- 5 One such example is McKesson's InterQual® Criteria Product, which is designed to standardize the delivery of emergency medical care irrespective of geography. [Back](#)
- 6 President Richard M. Nixon signed the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, (codified at 42 U.S.C. § 300(e)) into law the same year Motorola released its first handheld mobile phone. See *Mobile phone's 40th anniversary: from 'bricks' to clicks*, The Guardian (Apr. 3, 2013), available at <http://www.theguardian.com/technology/2013/apr/03/mobilephone-40th-anniversary>. [Back](#)
- 7 See, e.g., Thomas L. Greaney, *The Tangled Web: Integration, Exclusivity, and Market Power in Provider Contracting*, 14 Hous. J. Health L. & Pol'y 59, 77-79 (2014). [Back](#)
- 8 See generally *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014) (holding that plaintiff did not have to provide contraception coverage for its employees); *Nat'l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (upholding the ACA by identifying the taxing authority as the basis for the individual mandate and approving Medicaid Expansion with certain modifications); *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), cert. granted, 135 S. Ct. 475 (determining the constitutionality of subsidies for health insurance exchanges controlled by the Federal Government). [Back](#)
- 9 Pub. L. No. 111-148, 124 Stat. 119. [Back](#)
- 10 Pub. L. No. 111-152, 124 Stat. 1029. [Back](#)
- 11 Margot Sanger-Katz, *Is the Affordable Care Act Working*, N.Y. Times (Oct. 26, 2014), available at http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?_r=0#/.
- 12 The Patient Protection and Affordable Care Act is 906 pages, and the Health Care and Education Reconciliation Act is 55 pages. [Back](#)
- 13 Gregory Wallace, *'Obamacare': The word that defined the health care debate*, CNN (June 25, 2012), available at http://www.cnn.com/2012/06/25/politics/obamacare-word-debate/index.html?_s=PM:POLITICS. [Back](#)
- 14 Michael Hiltzik, *This Democratic 'reform' would make Obamacare more expensive*, L.A. Times (Oct. 28, 2014), available at <http://www.latimes.com/business/hiltzik/la-fi-mhreform-obamacare-20141028-column.html>. [Back](#)
- 15 226 Cal. App. 4th 1260 (2014). For a discussion of the *Children's Hospital Central California* decision and its aftermath, see David D. Johnson, *In the Absence of Agreement: California Courts Define Pricing for Non-contracted Medical Services*, Bus. L. News (State Bar of Cal., S.F., Cal.) Issue 2, 2015. [Back](#)
- 16 Barbara Anderson, *Anthem Blue Cross wins appeal over Children's Hospital Central California bill*, The Fresno Bee (June 16, 2014), available at <http://www.fresnobee.com/2014/06/16/3980961/anthem-blue-crosswins-appeal.html>. [Back](#)
- 17 See generally Steph en B. Adams, *Mr. Kaiser Goes to Washington* (1997). Kaiser found success in its early years by providing health insurance to workers building the Grand Coulee Dam in 1938. [Back](#)
- 18 See generally Jan Coombs, *The Rise and Fall of HMOs* (2005). [Back](#)
- 19 *Id.* [Back](#)
- 20 Pub. L. No. 92-603. [Back](#)
- 21 *Id.*; Joseph Falkson, *HMO s and the Politics of Health System Reform* (1980). [Back](#)
- 22 What was at the time considered to be a seemingly insignificant interjection into the corporate world by the Federal Government would

eventually come to be one of the pillars of modern health care reform. [Back](#)

23 See generally Robert Cunningham III, *The Blues: A History of the Blue Cross and Blue Shield System* (1997). [Back](#)

24 See generally Coombs, *supra* note 18. [Back](#)

25 See Cal. Health & Safety Code §§ 1367(h), 1371.35 (emergency services), 1371.37, 1371.4. [Back](#)

26 "A health care service plan . . . shall reimburse claims . . . no later than 30 working days after receipt of the claim . . . or . . . 45 working days [if the plan is an HMO] (emphasis added) . . ." Cal. Health & Safety Code § 1371. [Back](#)

27 Cal. Health & Safety Code § 1371. [Back](#)

28 See Cal. Bus. & Prof. Code §§ 2052, 2400; *Bd. of Med. Exam's v. Pac. Health Corp.*, 12 Cal. 2d 156, 158 (1938); but see Cal. Bus. & Prof. Code §§ 2400, 2401 (providing a statutory exception for hospitals and clinics); but cf. Cal. Health & Safety Code § 1395(b), (f) (creating an exception for corporate health care service plans, but only so these plans can employ and contract with professionals). [Back](#)

29 *Id.* (emphasis added). [Back](#)

30 Cal. Code Regs. tit. 28, § 1300.71(d). (emphasis added). The "timeframes specified in sections (g) and (h)" track the 30 and 45-day periods specified in the statute. Cal. Code Regs. tit. 28, § 1300.71(g), (h). [Back](#)

31 See, e.g., *Delta Dental Plan of Cal. v. Rockwell Int'l Corp.*, 139 F.3d 1289, 1291 (9th Cir. 1998); Cal. Health & Safety Code § 1342. [Back](#)

32 See Cal. Health & Safety Code § 1342. [Back](#)

33 A.B. 4206, 3d Reading, as amended May 13, 1986. [Back](#)

34 *Id.* [Back](#)

35 See Cal. Health & Safety Code § 1371 (Supp. 1990). [Back](#)

36 A.B. 865, Cal. S. Ins., Claims & Corps. Comm., as amended Aug. 21, 1989, at 2. [Back](#)

37 A.B. 4206, 3d Reading, as amended May 13, 1986, at 2. [Back](#)

38 Cal. Health & Safety Code § 1371 (Supp. 1990). [Back](#)

39 Cal. Health & Safety Code § 1371 (Eff. Jan. 1, 2010). [Back](#)

40 See *supra* note 3. [Back](#)

41 *Id.* [Back](#)

42 28 C.C.R. § 1300.71(a)(3)B) provides some guidance for the amounts non-contracting providers should receive from payers:

For contracted providers without a written contract and non-contracted providers . . . the payment of the reasonable and customary value for the health care services (is) 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.

Determination of this "reasonable and customary value" is not resolved by this regulation, and perhaps not even by the *Children's Hospital Central California* decision. This issue is further addressed in a separate article. See *supra* note 15. [Back](#)

43 See, e.g., Cal. Health & Safety Code § 1371 ("The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent

practice associations, or other contracting entities to pay claims for covered services."). In some instances, however, a plan may avoid liability when it properly delegates certain responsibilities to medical groups and independent practice associations, as in the case of emergency services. Cal. Health & Safety Code § 1371.35(k); *Cal. Emergency Physicians Med. Group v. PacifiCare of Cal.*, 111 Cal. App. 4th 1127 (2003) (applying specifically to emergency services and the obligations that arise thereunder). Plans remain responsible for their own acts or omissions, irrespective of any delegation of authority, "based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability." See Cal. Health & Safety Code § 1371.25; *Watanabe v. Cal. Physicians' Serv. DBA Blue Shield of Cal.*, 169 Cal. App. 4th 56, 64 (2008) (in denying a claim for vicarious liability, the Court still noted that "an entity that has committed an act or omission for which it is liable remains liable for that act or omission, even if it shares liability with another entity (emphasis in original)); see also *Coast Plaza Doctors Hosp. v. UHP Healthcare*, 105 Cal. App. 4th 693, 706 (2002) (confirming the interpretation of section 1371.25). The *Coast Plaza Doctors Hospital* Court also noted: "[section 1371.37] prohibits and defines unfair payment patterns, which includes engaging in a demonstrable and unjust pattern of denying complete and accurate claims, and provides for sanctions to be imposed by the Director of the Department of Managed Health Care. But subdivision (f) of section 1371.37 states: "The penalties set forth in this section shall not preclude, suspend, affect, or impact any other duty, right, responsibility, or obligation under a statute or under a contract between a health care service plan and a provider." *Id.* (emphasis in original). The very nature of this relationship—referred to at times as a "silent PPO"—is strictly prohibited under California law: "[I]t is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care

services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance." Cal. Health & Safety Code § 1395.6. [Back](#)

44 Cal. Health & Safety Code § 1262.8(a); *see also Prospect Med. Grp., Inc. v. Northridge Emergency Med. Grp.*, 45 Cal. 4th 497, 507 (2009) (prohibiting non-contracting emergency department health care providers from balance billing enrollees of health plans for sums that the health plan has failed to pay for the member's emergency department treatment). [Back](#)

45 *See Prospect Med. Grp., Inc.*, 45 Cal. 4th at 507. [Back](#)

46 *Coast Plaza Doctors Hosp.*, 105 Cal. App. 4th at 699-700 ("Section 17200 of the UCL defines unfair competition to mean and include any unlawful, unfair, or fraudulent business act or practice, any unfair, deceptive, untrue, or misleading advertising, and any act prohibited by section 17500. The California Supreme Court confirmed that the test for determining a violation of the unfair competition law is a disjunctive one; namely, a plaintiff may show that the acts or practices at issue are either unlawful or unfair or deceptive."). [Back](#)

47 Pub. L. No. 93-496; *see, e.g., Coast Plaza Doctors Hosp. v. Blue Cross of Cal.*, 173 Cal. App. 4th 1179, 1189 (2009) (holding that section 1371.4 is not subject to ordinary preemption under ERISA.). [Back](#)

48 *See supra*, note 42. [Back](#)

49 *See, e.g., supra*, notes 43-47. [Back](#)

50 *See generally supra*, note 14. [Back](#)

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