

THE BATTLE RAGES ON: RECENT DEVELOPMENTS IN REIMBURSEMENT OF NON-PARTICIPATING EMERGENCY SERVICE PROVIDERS

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Introduction

The reimbursement battle between payors and non-contracted providers of emergency services continues to be waged in various forums and venues across the country. The key issue is the proper amount of reimbursement non-contracted providers should receive from payors for providing emergency services. A satisfactory solution to this nationwide problem has thus far proved elusive. Recent legislative initiatives, state enforcement actions, and court decisions, while helpful, have failed to resolve the dispute on a consistent and practical basis. In the absence of clear legislation or uniform state action, these battles will continue, and it will be incumbent on the judiciary to provide definitive guidance. This article discusses several recent legislative initiatives, state enforcement actions, and judicial decisions in this controversial and closely watched area.¹

Competing Payor and Provider Policy Arguments

The countervailing policy arguments regarding the proper reimbursement levels to be paid by payors to non-participating providers of emergency services are well-known and have been well-articulated.² On the one hand, payors argue generally that non-contracted providers should not be paid their “full, billed” charges because such “rack rate” or “retail” charges typically are not paid by any payor and would lead to “windfall” reimbursement. Further, providers have discretion to set their charges, which may or may not bear any

relationship to their cost to provide the services. Moreover, payors argue, payment of “full, billed” charges would disincentivize providers to contract with payors and result in higher healthcare costs.³

In contrast, providers argue that state and federal laws mandate they provide emergency services without regard to or even the ability to inquire about payment.⁴ While providers are obligated to provide emergency services to health plan subscribers, they are also subject to payors’ threshold and often arbitrary decisions regarding the amount of reimbursement to pay for those services. Providers who lack the size, wherewithal and resources to contest what are often small dollar claims are left with little meaningful recourse to challenge the payors’ unilateral payment decisions. Providers argue that this reimbursement framework provides incentives to health plans to terminate existing contracts or not contract at all with providers as a means of generating additional profits for the health plans. Fueling the fire is the decision of some payors to reimburse non-contracted emergency services providers at extraordinarily low levels.⁵

Caught in the middle of the battle are the health plan subscribers. In an emergent situation, a subscriber usually has little or no choice in determining where he or she is brought for treatment and care. Moreover, even if a subscriber is treated at or otherwise able to choose an in-network hospital, the treating emergency room physicians and other hospital-based physicians may not have a contract with the subscriber’s health plan. While some states have enacted legislation to prevent the provider from balance billing the subscriber in these circumstances, the subscriber may otherwise be faced with payment of the entire bill or that portion of the bill that remains unpaid by the subscriber’s health plan.⁶ Subscriber dissatisfaction

ultimately is not beneficial for either the provider or payor.

In the emergency services arena, therefore, the reimbursement payable to non-contracted providers presents a “perfect storm” microcosm of the competing policy arguments on all sides of the current national debate regarding healthcare cost containment.

Legislative Initiatives

Legislative efforts to resolve the dilemma, although admirable, largely have raised more questions than answers, as demonstrated by the statutory schemes in Florida, California and Maryland. In Florida, a statutory framework provides that a non-contracted provider of emergency services is entitled to reimbursement for services provided to a health maintenance organization (“HMO”) member at the lesser of the “provider’s charges” or the “usual and customary provider charges for similar services in the community where the services were provided.”⁷ The statute provides no definitions of key terms and phrases such as “provider’s charges,” “usual and customary provider charges” or “similar services.” Legislative history sheds little light on what those terms were intended to mean. No Florida appellate court has provided definitive guidance as to how the lower courts – much less the payors and non-participating providers – are to interpret and apply the statute’s framework and key words and phrases, and the statute has spawned pending litigation throughout Florida’s state courts, as noted below.

Similarly, California’s regulations require an HMO to pay “the reasonable and customary value” for the healthcare services rendered. The calculation must take 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. California courts have not determined how the amount of reimbursement is to be calculated pursuant to the regulations, however, noting that it will be a fact-based inquiry based on the specific circumstances at issue.⁸ Like the Florida statutes, the California regulations fail to provide objective measures of certainty to the reimbursement analysis.⁹

Maryland has enacted a more definitive, objective statutory scheme. The Maryland framework requires an HMO to pay a provider of emergency services the greater of 125 percent of the rate the HMO pays contracted providers or the rate the HMO paid non-contracted providers as of January 1, 2000. The statute requires payment to hospitals at an approved rate by the Health Services Cost Review Commission¹⁰ and payment to trauma physicians at the greater of 140 percent of the Medicare allowable rate or the rate the HMO paid to similarly licensed providers.¹¹ Although far from perfect, Maryland's statutory scheme nonetheless eliminates many of the subjective analytical factors contemplated by the Florida and California statutory frameworks.

Administrative Agency Actions

Recently, state administrative agencies have intervened in these disputes. For instance, the New Jersey Department of Banking and Insurance issued an Administrative Order regarding Aetna Health, Inc.'s ("Aetna") payment practices for non-participating providers.¹² Aetna had been paying non-participating providers at 125 percent of the Medicare allowable amount, contending that this was "fair payment for the services provided" and notifying providers that it would not consider any additional reim-

bursement.¹³ Under New Jersey law, for emergency services rendered by non-participating providers, the health plan member is not liable for the difference between the provider's billed charges and the reimbursement paid by the HMO.¹⁴ The Department of Banking and Insurance thus concluded that Aetna was required to pay the non-participating provider a benefit large enough to insure that the non-participating provider would not balance bill the patient for the difference between the provider's billed charges and Aetna's payment. The Department ordered Aetna to cease using 125 percent of the Medicare allowable amount as the maximum allowable reimbursement amount and required Aetna to reprocess claims for emergency care so that the total benefit paid equaled the provider's billed charges, less the member's responsibility. Aetna challenged the Order, and in March 2009, entered into a Settlement Agreement and Consent Order. While Aetna agreed to reimburse the affected providers, including the payment of interest, the Consent Order provided that the payments of the providers' full billed charges "do not establish and are not intended to establish generally the level of payment to be paid to out-of-network providers in these circumstances."¹⁵

In July 2008, the California Department of Managed Health Care filed a lawsuit in California state court against Prime Healthcare Services to prevent Prime from balance billing HMO patients for emergency services received at its hospitals. The suit was triggered when the Prime Healthcare system began sending collection notices to large numbers of Kaiser Permanente members who were treated at emergency rooms at one of its nine hospitals in Southern California. In announcing the filing of the lawsuit, the California Department of Managed Health Care issued a press release articulating the parameters and difficulties of the dilemma:

Balance billing is a controversial practice. It pits health care providers, who are seeking reimbursement for emergency services they rendered,

against health plans, who have a duty under the law to pay only the reasonable and customary value of those services, often less than the provider's billed charge, leaving a balance then passed on to the consumer. Health plan members are caught in the middle of this dispute, not knowing if they legitimately owe the amount.¹⁶

Although state agency efforts have attempted to address the issue, they have been unable to provide clear guidance regarding the appropriate reimbursement payable to non-contracted providers for emergency services.

State attorneys general have also weighed in. In January 2009, the New York Attorney General reached a much-publicized agreement with United Healthcare and Ingenix.¹⁷ Ingenix, a wholly-owned subsidiary of United Healthcare, compiled information from some of the largest health insurers in the country, which in turn used the compiled data to create schedules to calculate the reimbursement payable to non-network providers. The New York Attorney General found that Ingenix had a conflict of interest in creating reimbursement schedules used by its parent company to reimburse providers, and that health insurers had a financial incentive to manipulate the data they submitted to Ingenix so as to reduce the reimbursement rates determined through use of the Ingenix schedules. The New York Attorney General has since reached settlements with 12 insurers who previously used the Ingenix database,¹⁸ collecting approximately \$100 million toward the creation of an independent and transparent database.¹⁹ However, the Attorney General did not make any findings²⁰ as to the establishment of the proper levels of reimbursement payable to non-contracted providers.²¹

Private Litigation: The Long and Winding Road

Private litigation has also brought some, albeit limited, resolution of the issues. In a class action filed in Florida federal court, non-contracted emergency

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room physicians sued Aetna alleging it had violated Florida law by improperly paying for emergency services at 125 percent of the Medicare allowable amount.²² In April 2009, the federal district court approved a settlement of the class action whereby Aetna agreed to establish a new Florida ER Fee Schedule, set reimbursement for future emergency services at 239 percent of the applicable Medicare allowable amount through December 14, 2012, and reprocess claims paid under the prior methodology.²³

In another Florida case, an intermediate state appellate court held that Florida's non-contracted emergency services provider statute, section 641.513(5), Florida Statutes, "clearly imposes a duty on HMOs to reimburse non-participating providers according to the statute's dictates, not based on Medicare reimbursement rates."²⁴ The court further held that the "intent of the section is to ensure that the non-participating providers are adequately paid for a service they are required by law to perform." The Florida court did not provide further guidance, however, as to what constituted "adequate payment," the definition of the statute's key terms and phrases, or how the parties or the lower court should establish the "usual and customary provider charges for similar services in the community."²⁵

Litigation between payors and non-contracted providers regarding emergency services reimbursement has also spawned numerous tangential issues arising out of various factual and legal defenses asserted by payors. For example, payors are asserting ERISA preemption as a defense to providers' state common law or statutory claims for reimbursement,²⁶ seeking to substantially limit or deny reimbursement altogether by arguing either that the services are not emergent at all²⁷ or narrowly defining the patient's initial assessment and stabilization for purposes of limiting those services deemed to be emergent,²⁸ and arguing that a determination regarding key terms such as "usual,"

"customary" and "reasonable" requires analysis of the amounts providers receive from all payor sources rather than the amounts providers charge.²⁹ Payors have also taken a hard line in the discovery process.³⁰ The end result is that the litigation of these disputes is protracted, expensive and time-consuming, usually pitting large non-contracted providers, such as hospitals or health systems, against major health plans. Absent participating in claims asserted on a class-action basis, individual physicians and other small provider groups typically do not have the necessary resources to fully litigate these disputes.

Quasi-Administrative Alternative Dispute Resolution Procedures

In an effort to provide a more efficient, cost-effective dispute resolution mechanism to private litigants outside the courtroom, and, in particular, to aid smaller providers with relatively small claims, several states have established quasi-administrative procedures.³¹ The theory is that state agencies, presumably staffed by professionals with industry knowledge and expertise, or in an oversight capacity with regard to retained independent review organizations, are better equipped to address and resolve these payment disputes than the courts. The results have been mixed.

In California, the Department of Managed Health Care established an Independent Dispute Resolution Process ("IDRP") in 2007 to afford non-contracted providers of emergency services an alternative way to resolve claims payment disputes with health plans.³² The IDRP, a voluntary process for both non-contracted providers and payors, is overseen by a governing committee consisting of provider and payor representatives, a consumer representative and two government or Department staff members. The Department retained the Maximus

Center for Health Dispute Resolution ("Maximus") as the IDRP's independent review organization.

The process requires the provider to submit a uniform complaint form and both parties to submit supporting documentation. The IDRP utilizes a "baseball style" arbitration model, whereby the provider's original billed amount and the payor's original paid amount are used to determine which amount better reflects the reasonable and customary value of the services performed. Participating providers must agree not to balance bill members, and participating payors must agree to pay any amounts determined to be due within fifteen (15) days of receipt of notice of such a determination. The decision of the independent review organization carries no precedential weight, prompting one commentator to note that the process "is a nonstarter for hospitals because it cannot establish the legal precedent that will settle how such services should be valued."³³

Florida has a similar voluntary procedure for resolving disputes between health care providers and payors, although, unlike California's IDRP, its availability is not limited to non-contracted providers of emergency services. As with California's IDRP, the Florida process, which is overseen by Florida's Agency for Healthcare Administration, consists of an evaluation by Maximus of the supporting documentation submitted by the parties, with no hearing, no sworn testimony or cross examination of witnesses, no judge, and no identification of the factfinder.³⁴ There is limited review of Maximus' determinations which, unlike in the California IDRP, are binding.

The Florida process has been harshly criticized, however, and has not been a panacea for addressing or resolving the non-contracted provider problem. One Florida intermediate state appellate court declared that the "legal conclusions made by these undisclosed professionals" are

“informal rulings” that have “no precedential value.”³⁵ The court further noted that the process allows for few procedural safeguards and is ill-equipped to address legal issues, and labeled its dispute resolution process “inefficient.”³⁶ The court noted that the process was “not an adequate method to resolve legal issues of first impression that involve the payment of millions of dollars.”³⁷

Thus, while state-sponsored alternative dispute resolution mechanisms may be beneficial to resolve the small claims of small non-contracted providers, they are generally inadequate to address and resolve large, complex claims involving large providers and payors with substantial sums at stake. The most critical defect in these processes with respect to resolution of the non-contracted provider problem is their inability to issue precedential decisions that afford guidance and certainty in future provider-payor disputes. The battles necessary to lead to the development of such precedential guidance can be waged only by the goliaths in the courtroom.

Conclusion

Absent clear legislative direction or state agency enforcement, the establishment of “usual,” “customary” or “reasonable” reimbursement rates to be paid by payors to non-contracted providers of emergency services will continue to be best left to the discretion of the judiciary. In deciding these cases, courts will have to balance a myriad of subjective and objective factors and countervailing policy arguments and considerations. In the end, whether the solution is legislative, administrative or judicial, all parties concerned will benefit from greater certainty regarding this important reimbursement issue.



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Endnotes

- ¹ This article focuses on issues arising out of the reimbursement of emergency services provided by non-contracted providers. While the reimbursement of out-of-network providers in general has gained national attention, the issue is more acute in the emergency services context. This area is unique for several reasons, including the lack of patient choice in selecting the provider, the prevalence of hospital-based physicians who, in contrast to the hospitals for whom they provide services, may be non-contracted with particular payors, and federal and state laws that compel providers to provide emergency services without regard to a patient’s ability to pay. Nevertheless, many of the issues discussed here have general applicability to the reimbursement of non-emergent services provided by out-of-network providers.
- ² A good discussion and overview of the countervailing policy arguments is contained in the majority and dissenting opinions in *Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc.*, 832 A.2d 501 (Pa. Super. Ct. 2003). In *Temple University*, the court found that in the absence of an express agreement, the amount an insurer should pay for emergency services is what the services are ordinarily worth in the community, meaning what people ordinarily pay for them. The court held that the proper reimbursement, or “reasonable fee,” would be the

average reimbursement rate in the provider’s contracts with governmental agencies and insurance companies. *Id.* at 510. In a sharply worded opinion, the dissent argued that the reasonable fee should be the hospital’s billed charges, based on the evidence showing that the hospital’s charges were the same or less than those of other similar hospitals. *Id.* at 511-17. The dissent found that in the absence of a contract, the hospital has no recourse but to rely on its published charges, in part because of its weakened bargaining position resulting from its obligation to treat the patients. *Id.*

- ³ On this point, United Health’s CEO testified that “physician reimbursement based on nothing but the doctor’s bill is simply not economically tenable for consumers nor our healthcare system.” See Staff of Committee on Commerce, Science and Transportation, Office of Oversight and Investigations, Underpayments to Consumers by the Health Insurance Industry (June 24, 2009) at p. 3. In defending its now-prohibited uniform practice of reimbursing non-contracted emergency services providers at 125 percent of Medicare in New Jersey, Aetna’s spokeswoman stated: “[O]ur policy protects our members and customers in the state of New Jersey from excessive billed charges by a small group of physicians who do not participate in insurer networks. . . . We are concerned that this . . . small subset of physicians [will] drive up medical costs and insurance premiums.” See Caroline Procter, *New Jersey Fines Aetna for Fee Schedule, Orders More Pay for Doctors*, *Amednews.com*, August 13, 2007 at p. 2.
- ⁴ See, e.g., Emergency Medical Treatment and Active Labor Act (“EMTALA”), 42 U.S.C. §1395dd.
- ⁵ See, e.g., *Neighborhood Health Partnership, Inc. v. Merkle*, 8 So. 3d 1180 (Fla. Dist. Ct. App. 2009) (HMO adopted a policy of reimbursing non-contracted providers of emergency services at a rate of 120 percent of the Medicare rate). In response to Aetna’s practice of paying 125 percent of Medicare to non-contracted New Jersey providers of emergency services, the American Medical Association (“AMA”) wrote, “The AMA cannot overemphasize its opposition to Aetna’s policy of failing to adequately reimburse nonparticipating physicians, and strongly encourages Aetna to withdraw its policy of creating a ceiling tied to the Medicare fee schedule . . . Physicians must be immediately and correctly reimbursed for their billed charges.” See Pamela Lewis Dolan, *Physicians Fight Aetna Over Caps of Out-of-Network Pay*, *Amednews.com*, January 14, 2008, at p. 1. The general counsel for the Medical Society of New Jersey stated: “When patients come into the office under emergency situations, and they’ve purchased a contract of insurance, the physician expects to work on the patient and not have to chase down bills. We’re not talking about elective procedures; we’re talking about necessary and immediate health care. Physicians should be compensated appropriately for that.” See Procter, *supra* note 5 at p. 2.
- ⁶ For those state agencies that have addressed the subject, consumer protection, rather than adequate provider reimbursement, has been the primary objective and focus. In trumpeting the

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- California Supreme Court's decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 198 P.3d 86 (Cal. 2009) prohibiting out-of-network providers from balance billing health plan subscribers for emergency services, the Director of California's Department of Managed Health Care said in a statement: "With today's ruling, we've started off the New Year right by removing a crushing economic burden off the backs of California health care consumers. . . We've never retreated from protecting patients caught in the middle of billing disputes and, just as vigorously, we won't retreat from efforts to make sure that doctors are fairly paid." See Press Release, California Dept. of Managed Health Care, January 8, 2009.
- 7 See Fla. Stat. Ann. § 641.513(5) (2009).
- 8 See, e.g., *Prospect Medical Group*, 198 P.3d at 90-91 (recognizing that the methodology for determining the reimbursement to non-contracted providers can create obvious difficulties, and that 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).
- 9 In 2008, a bill was passed in California that would have set reimbursement rates at 250 percent of the Medicare allowable amount; however, the legislation was vetoed.
- 10 The Health Services Cost Review Commission is a commission created by the Maryland legislature that sets the rates that Maryland's hospitals may charge.
- 11 See Md. Code. Ann., Health-Gen., § 19-710.1 ("Payment of noncontractually provided services"). This statute has been amended, effective January 1, 2010, further defining "similarly licensed providers," distinguishing reimbursement for evaluation and management services from other services, defining the calculation of average rates paid, and empowering the Insurance Administration to enforce the statute's provisions. See 2009 Md. Laws Ch. 664 (H.B. 255).
- 12 See N.J. Dep't of Banking & Ins. Order No. A07-59, available at: http://www.state.nj.us/dobi/pressreleases/pr070725_ordera07_59.pdf.
- 13 However, if the provider balance billed the member, who in turn complained to Aetna about the balance billing, Aetna would pay the member the difference between the provider's billed charges and 125 percent of the Medicare allowable amount.
- 14 New Jersey law requires: that an HMO limit a member's liability for all services rendered during an admission to a network hospital when admitted by a network physician to the network copayment, deductible or coinsurance (see N.J. Stat. Ann. 11:22-5.6(b)); that an HMO limit a member's liability for emergency care rendered by out-of-network providers to the network copayment, deductible or coinsurance (see N.J. Stat. Ann. 11:24-5.3(b)); and, in the event an HMO refers a member to an out-of-network provider, that the HMO be fully responsible for payment to the provider and limit the member's liability to the network copayment, coinsurance or deductible (see N.J. Stat. Ann. 11:24-5.1(a)(1)).
- 15 The Department of Banking and Insurance also fined Aetna \$9,457,500. As a result of the Settlement Agreement and Consent Order, the amount of the fine was reduced to \$2.5 million. The details of the Consent Order can be found at: http://www.state.nj.us/dobi/division_insurance/insfines.htm.
- 16 Press Release, California Dept. of Managed Health Care, July 1, 2008.
- 17 United and Ingenix reached the agreement without any admission of liability or wrongdoing.
- 18 The insurers included: Group Health Incorporated and HIP Health Plan of New York; United Healthgroup, Inc.; Aetna, Inc.; MVP Health Care, Inc.; Healthnow New York, Inc., d/b/a BlueCross BlueShield of Western New York and BlueShield of Northeastern New York; Independent Health Association, Inc.; Cigna Corporation; Wellpoint, Inc.; Excellus Health Plan, Inc.; Capital District's Physician's Health Plan, Inc.; and the Guardian Life Insurance Company of America.
- 19 In the settlements, Aetna, Cigna and WellPoint agreed to stop using the Ingenix database anywhere.
- 20 Following these settlements, the New York Department of Insurance has proposed regulations requiring insurers that provide out of network benefits to use an independent source for establishing "usual and customary" rates and to respond to consumer requests for the disclosure of the specific amount of reimbursement for a particular procedure within three business days of a request. The proposed regulations can be found at: http://www.ins.state.ny.us/ft_misc/draft_reg_ucr_062009.pdf
- 21 The settlements with the New York Attorney General are not the end of litigation arising out of the use of the Ingenix database. The AMA has filed separate class action lawsuits against Aetna, Cigna, Wellpoint and United Healthcare, alleging that these payors have been systematically understating the calculation of "usual, customary and reasonable" ("UCR") payments for out-of-network medical services. In a statement, the AMA's president stated: "We can no longer ignore the improper business practices of health insurers who decide to play by their own rules without regard to patients, or the legitimate costs required to care for them." See *American Medical Association, Others File Lawsuits Against Aetna, Cigna Alleging Physician Payment Deficiencies*, Medical News Today, February 11, 2009. The AMA reached a settlement with United Healthcare for \$350 million.
- 22 *Weinberger v. Aetna Health, Inc.*, Case No. 1:06-cv-20249-Moreno/Torres, U.S. District Court, Southern District of Florida.
- 23 See *id.*, *Final Approval Order and Judgment*, Docket No. 76, entered April 17, 2009.
- 24 *Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1196 (Fla. Dist. Ct. App. 2006).
- 25 Although Florida's intermediate state appellate courts have elucidated the statutory framework's goals and objectives, these appellate courts have stopped short of providing specific and definitive guidance as to how to practically apply the statute's reimbursement formula and methodology. Such real-world interpretations to date have been left to the sound discretion of Florida's state trial courts, with resulting inconsistencies and variations in the construction of key terms. Unless and until these Florida state trial court cases work their way up to the state's appellate courts, non-contracted providers and payors in Florida will have little clear direction as to the remaining open questions regarding the state's statutory framework.
- 26 *Coast Plaza Doctors Hospital v. Blue Cross of California, et al.*, 93 Cal. Rptr. 3d 479 (Cal. Dist. Ct. App. 2009). The California appellate court reversed the trial court's holding that the non-contracted hospital's claims for reimbursement of emergency services rendered to a health plan beneficiary were subject to ordinary preemption under ERISA, section 514(a), as set forth in 29 U.S.C. § 1144(a). The court held that the hospital's claims under section 1371.4 of California's Knox-Keene Health Care Service Plan Act of 1975, which requires a health plan to reimburse a provider for the cost of emergency care rendered to a health plan enrollee, were not subject to ordinary preemption under ERISA because the statute fell under the purview of ERISA's savings clause. *Id.* at 485-87.
- 27 See Keith Darc, *Hospitals' owner sues Kaiser over ER bills*, *The San Diego Union Tribune*, February 14, 2008. The article details a lawsuit filed in San Diego Superior Court by Prime Healthcare, the owner of several hospitals in Southern California, against Kaiser Permanente for Kaiser's alleged failure to reimburse the non-contracted hospitals for emergency services. One basis upon which Prime alleged Kaiser had denied payment was Kaiser's contention that the condition of some patients did not constitute "true emergencies."
- 28 *Coast Plaza Doctors Hospital*, 93 Cal. Rptr. 3d at 482, n. 4. In denying payment to a non-contracted hospital for emergency services, the health plan asserted that the patient's "condition was not an 'emergency medical condition.'" *Id.* The appellate court's decision dealt only with the ERISA preemption argument raised by the health plan, and did not address whether the services rendered to the patient were emergent in nature.
- 29 *Temple University Hospital*, 832 A.2d at 508-10.
- 30 *Neighborhood Health Partnership*, 8 So. 3d at 1184-85 (Fla. Dist. Ct. App. 2009) (Florida intermediate appellate court upheld trial court's rejection of HMOs' work product privilege objection to require production of HMOs' communications with private consulting company specializing in provider reimbursement and with State of Florida's Agency for Health Care Administration in

connection with non-contracted providers' dispute with HMOs regarding reimbursement of emergency services.).

31 By "quasi-administrative," the authors mean a quasi-judicial or administrative procedure conducted either by a state agency or a private review organization under the auspices of a state agency and enacted or implemented by state statute, rule or regulation. See, e.g., Fla. Stat. Ann. § 408.7057; Cal. Code Regs. Health & Safety Code § 1371.38.

32 The full text of the process can be found at the California Department of Managed Health Care website, http://www.hmohelp.ca.gov/providers/clm/clm_idrp.aspx.

33 Frank P. Fedor, "Independent Dispute Resolution Process: No Cure for the Rate Issue," Journal of the Healthcare Financial Management Association, May 2007, at pp. 44-47.

34 Fla. Stat. Ann. § 408.7057 (2) (e-f); Fla. Admin. Code Ann. Rule 59A-12.030; *Health Options, Inc. v. Agency for Health Care Administration*, 889 So.2d 849, 850 (Fla. Dist. Ct. App. 2004).

35 *Baycare Health Sys. Inc. v. Agency for Healthcare Admin.*, 940 So. 2d 563, 568 (Fla. Dist. Ct. App. 2006).

36 *Id.* at n. 5 ("Even if the Maximus CHDR process was altered and equipped to adequately address legal issues, it would be an inefficient process because the resolution of each claim carries no precedential value. A lawsuit resolves not only the claim before the court, it also provides potentially binding precedent for future claims.").

37 *Id.* at 568.

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