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15 Attorneys for *Amicus Curiae*
16 THE CALIFORNIA ASSOCIATION OF PHYSICIAN
17 GROUPS

18 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**
19 **COUNTY OF SACRAMENTO**

20 CALIFORNIA MEDICAL ASSOCIATION,
21 CALIFORNIA HOSPITAL ASS'N,
22 CALIFORNIA CHAPTER OF THE
23 AMERICAN COLLEGE OF EMERGENCY
24 PHYSICIANS, CALIFORNIA
25 ORTHOPAEDIC ASS'N, CALIFORNIA
26 RADIOLOGICAL SOCIETY, CALIFORNIA
27 SOCIETY OF ANESTHESIOLOGISTS,

28 Petitioners/Plaintiffs,

v.

DEPARTMENT OF MANAGED HEALTH
CARE, AND LUCINDA EHNES, in her
capacity as DIRECTOR OF THE
DEPARTMENT OF MANAGED HEALTH
CARE, and Does 1 through 100, inclusive,

Respondents/ Defendants.

CASE NO. 34-2008-80000059

**EX PARTE APPLICATION OF THE
CALIFORNIA ASSOCIATION OF
PHYSICIAN GROUPS FOR LEAVE TO
FILE AN *AMICUS CURIAE* BRIEF IN
SUPPORT OF OPPOSITION TO
PLAINTIFFS' PETITION FOR WRIT
OF MANDATE AND COMPLAINT
FOR DECLARATORY AND
INJUNCTIVE RELIEF;
MEMORANDUM OF POINTS AND
AUTHORITIES**

Date: November 7, 2008
Time: 9:00 a.m.
Department: 31

Hon. Michael Kenny

Complaint Filed: September 26, 2008
Writ Hearing: November 21, 2008

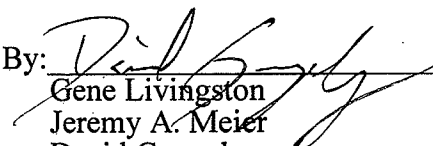
1 Pursuant to Local Rules for the Superior Court of California, County of Sacramento
2 (“Local Rules”), rule 2.04, and California Rule of Court 8.706(b), and through its counsel of
3 record, the California Association of Physician Groups (“CAPG”) requests by this Ex Parte
4 Application (the “Application”) that the Court grant leave to file an *amicus curiae* brief in
5 support of the Respondents’ Opposition to Plaintiffs’ petition for writ of mandate. Counsel for
6 Respondents do not oppose this Application; Plaintiffs do oppose the Application. (Declaration
7 of Jeremy A. Meier (“Meier Decl.”), ¶ 2, Exh. A)

8 This Application is based on the Supporting Declaration, the Memorandum of Points
9 and Authorities, and on the fact that CAPG has an interest in this matter as each of its members
10 are affected by the California Department of Managed Healthcare System’s proposed “Balance
11 Billing Regulation” (which is at issue herein).

12 The Amicus Brief attached hereto as Exhibit “A” is presented for filing in order to offer
13 arguments or views that will otherwise not be presented by the parties.

14 DATED: November 06, 2008

GREENBERG TRAURIG, LLP

15
16 By: 
Gene Livingston
Jeremy A. Meier
David Gonzalez
17 Attorneys for Amicus Curiae
18 THE CALIFORNIA ASSOCIATION
19 OF PHYSICIAN GROUPS
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1 **MEMORANDUM OF POINTS AND AUTHORITIES**

2 **A. GOOD CAUSE EXISTS FOR THE COURT TO EXERCISE ITS DISCRETION**
3 **AND GRANT LEAVE TO FILE THE AMICUS BRIEF.**

4 **1. CAPG's Brief Will Assist The Court In Resolving The Writ Petition.**

5 CAPG is a nonprofit, incorporated professional association of 155 member medical
6 groups throughout the state of California. CAPG's member medical groups are responsible for
7 delivering managed healthcare to an estimated 13,000,000 managed care enrollees in the state
8 of California. CAPG is the primary voice of physician organizations in California and supports
9 its members through public policy advocacy education, communication and other services.
10 Further, CAPG was an active participant and commenter during the rulemaking process
11 establishing Title 28, section 1300.71.39, of the California Code of Regulations. As such,
12 CAPG is uniquely qualified to advise the Court with respect to the managed care marketplace
13 in California and the provisions of the regulation at issue.

14 CMA's writ petition raises complex and significant issues concerning the legality of the
15 Department of Managed Healthcare's "Balance Billing Regulation." CAPG's amicus brief in
16 support of the opposition to the writ petition is offered to assist the Court in deciding the issues
17 before it. The brief contains arguments unique to CAPG and others similarly situated and
18 which may not otherwise be the subject of adequate analysis and briefing. The amicus brief is
19 not intended to be duplicative of the pleadings already on file nor of the opposition to be filed
20 by the Respondents.

21 "With the permission of the court, an amicus curiae may file briefs setting out his or her
22 views and arguments." 48 Cal.Jur. 3d Parties § 19 (2005) (footnote omitted). Such "[b]riefs
23 may be filed in both trial and appellate courts." *Id.* (footnotes omitted).

24 The practice of allowing amicus curiae to participate in proceedings is well established
25 in California trial courts. *See, e.g., Marshall v. Marshall*, 212 Cal.736, 738 (1931) (wherein an
26 amicus curiae brief was filed at the trial court's request); *Padres Hacia Una Vida Mejor v.*
27 *Davis*, 96 Cal.App.4th 1123, 1127-28 (2002) (wherein the superior court granted a request to file
28 amicus curiae brief in a mandamus action); *County of Alameda v Carleson*, 5 Cal.3d 730, 735

1 (1971) (wherein the trial court denied a motion to intervene but granted the appearance as an
2 amicus curiae); *In re Veterans' Industries, Inc.*, 8 Cal.App.3d 902, 924-25 (1970) (discussing
3 that an *amicus curiae* lacks standing to appeal a superior court judgment against the amicus
4 curiae's position); *Connerly v. State Personnel Board*, 37 Cal.4th 1169, 1177 (2006) (amicus
5 curiae serve a valued function for courts as they are nonparties who usually have a different
6 perspective from the litigants); *cf.* Cal. Rules of Court, rule 8.706 (providing that in the appellate
7 division of the Superior Court, an amicus curiae brief "may be filed on permission first obtained
8 from the presiding judge, subject to conditions he or she may prescribe").

9 **B. NO HARM OR PREJUDICE WILL INURE TO PLAINTIFFS BY ALLOWING**
10 **THIS AMICUS FILING.**

11 Further, no genuine harm or prejudice will inure to Plaintiffs from the grant of leave to
12 file CAPG's brief. Plaintiffs applied for an expedited writ hearing date (on October 2, 2008)
13 and the Court granted Plaintiffs' request for a November 21, 2008 hearing date. As part of its
14 scheduling order, the Court apparently set the following filing dates: Moving papers to be filed
15 by October , opposition November 7, 2008, and reply by November 14, 2008. CAPG retained
16 counsel for this filing on or about October 25, 2008. Meier Decl., ¶ 2). Plaintiffs have been on
17 notice since October 28, 2008 that CAPG sought to file an amicus brief in support of the State's
18 position. (Meier Decl., ¶ 2).

19 Plaintiffs are established trade associations, with sophisticated and able legal counsel.
20 CMA's five in-house counsel and outside counsel are listed on Plaintiffs' pleadings as counsel
21 of record, and there is no reasonable basis for believing that any of those five Plaintiffs'
22 attorneys could not adequately respond to CAPG's brief in the time already set for reply.¹

23 Plaintiffs' petition for writ raises significant issues of public interest, and it is important
24 that all aspects of the relevant administrative arguments be addressed and considered. CAPG
25 has a different perspective from Plaintiffs and the State, and its amicus brief is offered solely to

26 _____
27 ¹ Indeed, in California appellate court proceedings the application and brief for amicus
28 filing must be filed within fourteen (14) days of the last appellant's reply brief. CRC
8.200(c)(1). In this instance, Plaintiffs already have the court ordered existing reply
time in which to respond to CAPG's brief.

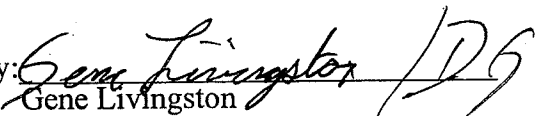
1 help the Court in its analysis of the regulation. The interests of justice and an efficient
2 adjudication of the merits of the writ petition warrant the grant of this Application.

3 **CONCLUSION**

4 CAPG respectfully requests this Court grant it leave to file its amicus brief in support of
5 the opposition to the petition.

6 DATED: November 26, 2008

GREENBERG TRAURIG, LLP

7
8 By: 
Gene Livingston
9 Jeremy A. Meier
David Gonzalez
10 Attorneys for *Amicus Curiae*
THE CALIFORNIA ASSOCIATION
OF PHYSICIAN GROUPS

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3 **DECLARATION OF SERVICE**

4 I am a citizen of the United States, over the age of 18 years, and not a party to or
5 interested in this action. I am employed in the County of Sacramento, State of California and
6 my business address is Greenberg Traurig, LLP, 1201 K Street, Suite 1100, Sacramento, CA
7 95814. On this day I caused to be served the following document(s):

8 **EX PARTE APPLICATION OF THE CALIFORNIA ASSOCIATION OF PHYSICIAN
9 GROUPS FOR LEAVE TO FILE AN AMICUS CURIAE BRIEF IN SUPPORT OF
10 OPPOSITION TO PLAINTIFFS' PETITION FOR WRIT OF MANDATE AND
11 COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF; MEMORANDUM
12 OF POINTS AND AUTHORITIES**

13 by placing the original a true copy into sealed envelopes addressed and served as
14 follows:

15 Frank P. Fedor
16 Kathryn Doi
17 MURPHY AUSTIN ADAMS
18 SCHOENFELD LLP
19 304 "S" Street 95811-6906
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Attorney for Department of Managed
Health Care

25 **ELECTRONIC MAIL (EMAIL):** I caused such document(s) to be delivered to the
26 listed EMAIL address(es) from my computer. The transmission was reported as
27 complete and without error by the computer.

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I declare under penalty of perjury under the laws of the State of California that the
foregoing is true and correct.

Executed on **NOVEMBER 6, 2008** at Sacramento, California.



SUSAN ALDRIDGE

EXHIBIT A

TO EX PARTE APPLICATION FOR LEAVE TO FILE AN AMICUS CURIAE BRIEF

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CASE NO. 34-2008-80000059
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v.
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Respondents/ Defendants.

Date: November 7, 2008
Time: 9:00 a.m.
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Hon. Michael Kenny
Complaint Filed: September 26, 2008
Writ Hearing: November 21, 2008

I.
INTRODUCTION

1
2 The fundamental question presented in this case is whether the California Department
3 of Managed Health Care (DMHC) has the authority to define unfair billing patterns under Title
4 28, section 1300.71.39, of the California Code of Regulations. Based upon the plain reading of
5 Health and Safety Code sections 1344 and 1371.39 the answer is clearly yes.

II.
INTEREST OF AMICUS CURIAE

6
7
8 The California Association of Physician Groups (CAPG) joins as amicus curiae because
9 the case before the court has important implications regarding what constitutes unfair billing
10 patterns by physicians practicing in the State of California. CAPG is a nonprofit, incorporated
11 professional association of 155 member medical groups throughout the state of California.
12 CAPG's member medical groups are responsible for delivering managed healthcare to an
13 estimated 13,000,000 managed care enrollees in the state of California. CAPG is the primary
14 voice of physician organizations in California and supports its members through public policy
15 advocacy, education, communication and other services. Further, CAPG was an active
16 participant and commenter during the rulemaking process establishing Title 28, section
17 1300.71.39, of the California Code of Regulations (§1300.71.39.), copy attached hereto as
18 Exhibit 1. As such, CAPG is uniquely qualified to advise the Court with respect to the
19 managed care marketplace in California and the provisions of the regulation at issue.

20 California leads the nation in managed care penetration. It is estimated that
21 approximately 48% of Californians have health insurance through a managed care plan.
22 Considering that an estimated 6.2% of Californians have no health insurance coverage at all,
23 this means that more than half of Californians who have health insurance are covered under a
24 managed care plan. In 1996, the California Legislature explicitly found and declared that
25 "more than 16 million Californians are enrolled in healthcare service plans and this number is
26 likely to grow significantly over the next decade." (California Health and Safety Code
27 § 1342.1.) That number is currently estimated to exceed 17 million Californians.¹

28

¹ The number of Californians in managed care plans is likely to continue to rise in light of

1 CAPG submits this Amicus Brief in support of the DMHC's authority to define
2 balanced billing as an unfair billing practice, and because the Plaintiffs have presented a
3 misleading description of the applicable industry context of the regulation and the competing
4 policies that the DMHC considered in its rulemaking process.

5
6 **III.**
ARGUMENT

7 **A. CALIFORNIA HEALTH AND SAFETY CODE SECTIONS 1344 AND 1371.39**
8 **CLEARLY GRANT TO DMHC THE DISCRETION TO ADOPT**
9 **REGULATIONS TO DEFINE WHAT CONSTITUTES AN "UNFAIR BILLING**
10 **PATTERN."**

11 The fundamental issue before the court is whether or not DMHC has the authority to
12 define what constitutes an "unfair billing pattern" under Health & Safety Code section 1340, *et*
13 *seq.* (Knox-Keene). Under a plain reading of the relevant provisions of the Knox-Keene Act
14 the answer is clearly yes.

15 The fundamental rule of statutory interpretation is to ascertain the intent of the
16 Legislature as to the purpose of the law by first looking at the plain meaning of the words in the
17 statute. (*In re J.W.* (2002) 29 Cal.4th 200, 209.) The regulation that the Plaintiffs are
18 challenging is section 1300.71.39 of the California Code of Regulations.

19 Section 1300.71.39 states:

20 (a) Except for services subject to the requirements of Section
21 1367.11 of the Act, "unfair billing pattern" includes the practice,
22 by a provider of emergency services, including but not limited to
23 hospitals and hospital-based physicians such as radiologists,
24 pathologists, anesthesiologists, and on-call specialists, of billing
25 an enrollee of a health care service plan for amounts owed to the
26 provider by the health care service plan or its capitated provider
27 for the provision of emergency services.

28 (b) For purposes of this section:

///

California's public policy in support of managed health care: "It is the intent of the Legislature to ensure that the citizens of this state receive high-quality healthcare coverage in the most efficient and cost-effective manner possible. In furtherance of this intent, the Legislature finds and declares that it is in the public interest to promote various types of contracts between public or private payers of healthcare coverage, and institutional or professional providers of healthcare services." (§ 1342.6.)

1 (1) 'Emergency services' means those services required to be
2 covered by a health plan pursuant to Health & Safety Code
3 sections 1345(b)(6), 1367(i), 1371.4, 1371.5 and Title 28,
4 California Code of Regulations, sections 1300.67(g) and
5 1300.71.4.

6 (2) Co-payments, coinsurance and deductibles that are the
7 financial responsibility of the enrollee are not amounts owed the
8 provider by the health care service plan.

9 (3) 'The plan's capitated provider' shall have the same meaning
10 as that provided in section 1300.71(a).

11 The regulation at issue does one thing. It establishes a definition of an "unfair billing
12 pattern."

13 DMHC cites as authority for this regulation, Health & Safety Code sections 1344 and
14 1371.39. (See Exhibit 1, attached hereto.) Health & Safety Code section 1344 (§1344) states,
15 "[t]he director may from time to time adopt, amend, and rescind such rules, forms, and orders
16 as are necessary to carry out the provisions of this chapter, including rules governing
17 applications and reports, *and defining any terms, whether or not used in this chapter, insofar
18 as the definitions are not inconsistent with the provisions of this chapter.*" (Emphasis added.)
19 Therefore, the Director of DMHC has the express broad authority to define terms, *whether or
20 not used in this chapter*, insofar as the definition is *not inconsistent* with the provisions of
21 Knox-Keene.

22 Health & Safety Code section 1371.39 (§ 1371.39) permits health plans to report to
23 DMHC instances of "unfair billing patterns" and then defines an "unfair billing pattern," as
24 "engaging in a demonstrable and unjust pattern of unbundling of claims, up-coding of claims,
25 or *other demonstrable and unjustified billing patterns, as defined by the department.*"
26 (Emphasis added.)

27 Under a plain reading of sections 1344 and 1371.39, DMHC is provided ample and
28 clear statutory authority to define "unfair billing pattern" under section 1300.71.39. First,
section 1344 grants broad discretion to DMHC to define terms "whether or not used" in Knox-
Keene. The term "unfair billing pattern" is clearly used in section 1371.39 of the Knox-Keene
Act.

1 Second, the DMHC's definition of "unfair billing pattern" is completely consistent with
2 Knox-Keene. As noted above, section 1371.39 of the Knox-Keene Act expressly defines an
3 "unfair billing pattern" as including "other demonstrable and unjustified billing patterns, *as*
4 *defined by the department.*" (*Emphasis added.*) Therefore the regulation is completely
5 consistent with the provisions of Knox-Keene.

6 Lastly, DMHC has the authority to define an "unfair billing pattern" even without the
7 broad definitional authority granted by section 1344. In enacting section 1371.39 the
8 Legislature defined an unfair billing pattern as including: 1) a demonstrable and unjust pattern
9 of unbundling claims; 2) a demonstrable and unjust pattern of up-coding claims; and 3) other
10 demonstrable and unjustified billing patterns, *as defined by the department.* Therefore under a
11 plain reading of section 1371.39, the Legislature expressly authorized DMHC to define other
12 actions that would be an "unjust billing pattern."

13 Therefore, under the plain meaning of sections 1344 and 1371.39, DMHC is expressly
14 authorized by the Knox-Keene Act to define an "unfair billing pattern" as it has done in
15 adopting the regulation.

16 **B. PLAINTIFFS' CLAIM THAT ONLY THE LEGISLATURE MAY DEFINE AN**
17 **"UNJUST BILLING PATTERN" IGNORES THE SPECIFIC LANGUAGE IN**
18 **SECTION 1371.39.**

19 Plaintiffs argue in their opening brief that section 1371.39 "provides that the Legislature
20 through 'statutory adoption' controls the process by which 'unfair billing patterns' are defined,
21 rather than delegating this responsibility to the DMHC through regulatory adoption."
(Petitioner's Opening Brief at p. 9.)

22 A plain reading of section 1371.39 contradicts Plaintiffs' conclusion that section
23 1371.39 only permits the Legislature to define "unfair billing patterns." In fact, section
24 1371.39 provides two statutory definitions for unfair billing practices (the unbundling and up-
25 coding of claims) and then specifically authorizes DMHC to define "other demonstrable and
26 unjustified billing patterns" that would constitute an "unfair billing pattern."

27 Another well-settled rule of statutory interpretation is that a statute's every word and
28 clause should be given effect so that no part or provision is rendered meaningless or

1 inoperative. (*Manufacturers Life Ins. Co. v. Superior Court* (1995) 10 Cal.4th 257, 274.)
2 Plaintiffs' interpretation that section 1371.39 only permits the Legislature to define an "unjust
3 billing pattern" would render meaningless and inoperative the phrase, "other demonstrable and
4 unjustified billing patterns, as defined by the department" and therefore cannot stand.

5 C. **ASSEMBLY BILL 1455 (SCOTT), CHAPTER 827, STATUTES OF 2000**
6 **GRANTED SPECIFIC AUTHORITY TO DMHC TO DEFINE BOTH "UNFAIR**
7 **PAYMENT PATTERNS" BY HEALTH PLANS, AND "UNFAIR BILLING**
8 **PATTERNS" BY PROVIDERS.**

8 Assembly Bill 1455 (Scott), Chapter 827, Statutes of 2000 enacted both Health and
9 Safety Code section 1371.37 (§ 1371.37) and section 1371.39, attached hereto as Exhibit 2.
10 Section 1371.37 addresses "unfair payment patterns" by health plans, and section 1371.39
11 addresses "unfair billing patterns" by providers.

12 Plaintiffs argue:

13 [s]ection 1371.37 contains a detailed description of the acts that
14 constitute 'unfair *payment* patterns' on the part of plans.
15 Notably, there is no comparable statute that sets forth a detailed
16 description of acts that constitute 'unfair *billing* patterns' on the
17 part of providers. Instead, the California Legislature provides a
18 general definition of unfair billing pattern and instructed DMHC
19 to *report back* to the Legislature and the Governor information
20 regarding the development of the definition of 'unfair billing
21 pattern including *recommendations for statutory adoption* of
22 additional definitions.

19 However, Plaintiffs again ignore the plain meaning of the relevant statutory provisions.
20 Contrary to Plaintiffs' characterization that section 1731.37 contains a detailed description of
21 unfair payment patterns, and section 1731.39 provides a more general definition of unfair
22 billing patterns, both statutes take a nearly identical approach to defining unfair payment/billing
23 patterns.

24 Section 1371.37 defines an "unfair payment pattern" as:

25 Engaging in a *demonstrable and unjust pattern, as defined by*
26 *the department*, of reviewing or processing complete and
accurate claims that results in payment delays.

27 (2) Engaging in a *demonstrable and unjust pattern, as defined*
28 *by the department*, of reducing the amount of payment or
denying complete and accurate claims.

1 (3) Failing on a repeated basis to pay the uncontested portions of
2 a claim within the timeframes specified in Section 1371, 1371.1,
or 1371.35.

3 (4) Failing on a repeated basis to automatically include the
4 interest due on claims pursuant to Section 1371. (*Emphasis
added.*)

5 Therefore, similar to the approach of section 1371.39, section 1371.37 establishes two
6 statutory definitions for unfair payment patterns (failing to pay uncontested portions of a claim
7 within specified timeframes, and failing to automatically include interest) and then grants
8 discretion to DMHC to define “other demonstrable and unjust” payment patterns.

9 Plaintiffs’ argue that section 1371.39 requires DMHC to report back to the Legislature
10 *before* it can adopt definitions for “unfair billing patterns.” But this characterization again
11 ignores the plain meaning of the provisions of 1371.39. Section 1371.39, subdivision (b)
12 establishes the definition of “unfair billing pattern” and plainly states that this definition
13 includes, “other demonstrable and unjustified billing patterns, as defined by the department.”
14 There is no qualifying language that DMHC must first report to the Legislature before it can
15 exercise its discretion to define an “unfair billing pattern.”

16 In their complaint, Plaintiffs are forced to paraphrase the provisions of section 1371.39
17 because the statute simply does not say what the Plaintiffs want it to. The report requirement
18 referenced by the Plaintiffs for section 1371.39 is in subdivision (c). That provision states:

19 [o]n or before December 31, 2001, the department shall report to
20 the Legislature and the Governor information regarding the
21 development of the definition of ‘unfair billing pattern’ as used
22 in this section. This report shall include, but not be limited to, a
description of the process used and a list of the parties involved
in the department’s development of this definition, as well as
recommendations for statutory adoption.

23 Section 1371.39, subdivision (c) does not contain any language that requires DMHC to
24 issue this report *before* it develops a definition for an “unfair billing pattern.” In fact, section
25 1371.39, subdivision (c) presupposes that DMHC will develop the definition before issuing the
26 report. Section 1371.39, subdivision (c) only requires DMHC to issue a report regarding the
27 “development of the definition of ‘unfair billing pattern’” as well as a “description of the
28 process used and a list of the parties involved in the *department’s* development of this

1 definition.” (*Emphasis added.*) Therefore, DMHC must first go through the process of
2 adopting a definition for “unfair billing pattern” before it can issue the report referenced in
3 section 1371.39 subdivision (c). Moreover, subdivision (c) merely states that this report must
4 include “recommendations for statutory adoption.” This is a very general reference and may
5 include any recommendations generally related to the issue of unfair billing patterns.

6 Sections 1371.37 and 1371.39 both contain nearly identical reporting requirements to
7 the Legislature and the Governor. Section 1371.37, subdivision (i) also requires:

8 [o]n or before December 31, 2001, the department shall report to
9 the Legislature and the Governor information regarding the
10 development of the definition of ‘unjust pattern’ as used in this
11 section. The report shall include, but not be limited to, a
12 description of the process used and a list of the parties involved
13 in the department’s development of this definition as well as
14 recommendations for statutory adoption.

15 Pursuant to section 1371.37, DMHC has exercised its broad discretion to define “unfair
16 payment patterns” and has already adopted Title 28, Section 1300.71, of the California Code of
17 Regulations. That regulation establishes definitions for a “demonstrable and unjust payment
18 pattern.” However, under Plaintiffs’ interpretation this regulation is invalid because DMHC
19 had not first reported recommendations for definitions of “unfair payment patterns” to the
20 Legislature. Further, under Plaintiffs’ interpretation DMHC never had authority to adopt this
21 regulation since the reporting requirements of section 1371.37, subdivision (i) only permits
22 *statutory* adoption of an “unfair payment pattern.” This is clearly an erroneous interpretation
23 of the parallel reporting requirements contained in sections 1371.37 and 1371.39. Instead, both
24 sections grant specific authority to DMHC to further define unfair payment/billing patterns, and
25 merely require DMHC to report back to the Legislature and the Governor the process used for
26 developing these definitions and any recommendations regarding any further statutory changes
27 that may be needed to address the issue of unfair payment/billing patterns.

28 **D. THE PLAINTIFFS’ CHARACTERIZATION OF THE HEALTH CARE
DELIVERY SYSTEM DOES NOT REPRESENT THE VIEW OF ALL
PROVIDERS.**

CAPG members are medical groups that undertake, through contracts with licensed
Knox-Keene Health Plans, to provide healthcare services to populations of enrollees. These

1 enrollees are Californians who are provided health coverage through their employers,
2 Californians who purchase coverage individually and Californians who have health coverage
3 through Medicare or Medi-Cal managed care plans. The CAPG members who provide for
4 these enrollees are committed to making managed care work. Physicians who practice in
5 organized provider systems understand that they can deliver better outcomes for their patients
6 by coordinating their care, as opposed to disaggregated systems where patients are left on their
7 own to self-navigate and self-refer themselves to various providers that have no connection to
8 one another.

9 The Plaintiffs eschew this model. Plaintiffs' action is brought on behalf of the
10 providers who refuse to contract. They view themselves as free agents. Under the Plaintiffs'
11 model, patients who seek emergency services, do so knowing that they will have to pay for
12 them. If their insurance companies or health plans do not pay as much as the provider charges,
13 the patient who received the services must pay the difference. Under this model, there is no
14 limit on how much a provider may collect, as long as there are pockets to collect from. Rather
15 than engage with the patient's health plan or medical group regarding the value of their
16 services, these providers choose to pursue their patients, the party least able to protect
17 themselves because they do not even know what the provider's services *should* cost.

18 **E. BALANCE BILLING IS A BILLING PATTERN.**

19 Plaintiffs assert that balance billing cannot be an "unfair billing pattern" because the
20 statutory definition of "unfair billing pattern" in section 1371.39(b)(1) is "a demonstrable and
21 unjust pattern of unbundling claims, upcoding of claims, *or other demonstrable and*
22 *unjustified billing patterns.*" (*Emphasis added.*) Plaintiffs assert that upcoding and
23 unbundling, address *how* the provider bills, while balance billing addresses *who* the provider
24 bills. To Plaintiffs, this difference in the order of three letters means that balance billing cannot
25 be part of the same group as upcoding and unbundling.

26 This argument ignores the reality that upcoding, unbundling and balance billing are all
27 billing tools employed by noncontracted providers that are intended to result in collections of
28 amounts that are more than usual and customary reimbursement. Balance billing, no less than

1 up-coding and unbundling, is a pattern of billing used to boost the amount of money claimed by
2 the provider. If the non-contracted provider is dissatisfied with its reimbursement, a bill to the
3 enrollee will often cause the payor to make an additional payment. Even if the payor does not
4 pay full billed charges, artificially inflated charges (as a result of up-coding or unbundling) will
5 often result in a higher negotiated payment. Because all three practices are methods to unduly
6 increase reimbursement, the DMHC reasonably included balance billing in “other demonstrable
7 and unjustified billing patterns.”

8 **F. THE DMHC’S DETERMINATION THAT THE REGULATION IS**
9 **REASONABLY NECESSARY TO EFFECTUATE THE PURPOSE OF THE**
10 **STATUTE IS SUPPORTED BY SUBSTANTIAL EVIDENCE.**

11 Plaintiffs assert that the DMHC “apparently ... failed to meaningfully consider the
12 volume of the comments it received from individual physicians, physician groups and hospital
13 providers outlining the alarming impact the regulation will have on the delivery of services to
14 the patients the DMHC allegedly seeks to protect by way of the regulation.” This is “apparent”
15 to Plaintiffs because the DMHC disagreed with their position. In fact, as set forth above, there
16 are two sides to this issue, even within the provider community. The DMHC had both sides
17 before it, and it did what it had to do: it chose between them.

18 CAPG itself submitted written comments in support of the regulation by letter dated
19 May 20, 2008. In that letter, CAPG acknowledged that California physicians are seriously
20 divided on the issue of whether it is right, proper and necessary to leverage the involvement of
21 their patients in the process to obtain fair and timely payment for their services in a non-
22 contracted emergency setting. In its comments CAPG presented evidence that (1) many
23 hospital emergency departments function as profit centers for the hospital, (2) California is a
24 desirable location for emergency physicians and California emergency physician compensation
25 is competitive nationally and (3) noncontracted emergency charges represent a significant
26 premium over usual and customary rates. When these charges are paid in full (because
27 noncontracted providers have used the leverage of billing the patient to extract payment in full
28 from the payor) they drain the finite economic resources of the California healthcare system.
CAPG, in its comment letter, pointed out to the DMHC that these resources could be put to

1 better use for chronic disease management, health education and improved health information
2 technology.

3 Petitioners/Plaintiffs may disagree with the positions taken by commenters such as
4 CAPG, but they cannot assert that the comments and evidence were not part of the record or
5 that the DMHC was not entitled to be persuaded by them.

6 **G. THE DMHC'S DETERMINATION THAT THE REGULATION IS**
7 **REASONABLY NECESSARY TO EFFECTUATE THE PURPOSE OF THE**
8 **STATUTE IS REASONABLE.**

9 The Legislature's stated purpose in enacting Knox-Keene was to "[help] to ensure the
10 best possible health care for the public at the lowest possible cost by transferring the financial
11 risk of healthcare from patients to providers." (Health & Safety Code §1342, subdivision (d).)
12 Taking the patient out of the middle of the payment dispute between provider and payor is
13 likely to assist with the transfer of financial risk from patients to providers, as intended by the
14 Knox-Keene Act.

15 Notwithstanding this overarching purpose of the Knox-Keene Act, Plaintiffs assert that
16 the regulation is inconsistent with the Act's mandate to the DMHC that plan-provider
17 contracting ensure adequate networks. Plaintiffs assert that if they cannot balance bill, payors
18 will have no incentive to pay them what their services are worth and contracting will be
19 adversely affected. This argument, once again, reflects only one side of a complicated issue.
20 On the opposite side is the argument that the DMHC apparently agrees with: if non-contracted
21 providers can use balance billing to enforce payments wildly in excess of usual and customary
22 rates, there is no incentive for them to contract, because contracting will always yield lower
23 reimbursement than they can extract if they resort to unfair billing patterns.

24 Further, section 1371.39 requires DMHC to take multiple actions related to "unfair
25 billing patterns." For example, health plans are permitted to report to the DMHC, "instances in
26 which the plan believes a provider is engaging in an unfair billing pattern." DMHC is also
27 required to convene appropriate state agencies to make recommendations to the Legislature and
28 the Governor for the purpose of "developing a system for responding to unfair billing patterns
as defined in this section." Further, section 1371.39 specifically includes in the definition of

1 “unfair billing pattern,” “other demonstrable and unjustified billing patterns, as defined by the
2 department.” Therefore, DMHC's effort to further define “unfair billing pattern” is absolutely
3 reasonably necessary to effectuate the purpose of section 1371.39 to address “unfair billing
4 patterns” by providers.

5 Plaintiffs manifestly have a different view of the California healthcare marketplace than
6 the view reflected in the regulation. However, such different view does not render the
7 regulation outside of the DMHC's authority to promulgate in the exercise of its regulatory
8 mandate.

9
10 **IV.**
CONCLUSION

11 Based upon the foregoing, Amicus Curiae California Association of Physician Groups
12 respectfully oppose the petition of the Plaintiffs and requests that the Court uphold Title 28,
13 Section 1300.71.39 of the California Code of Regulations.

14 DATED: November 26, 2008

GREENBERG TRAUERIG, LLP

15
16 By:  

Gene Livingston

Jeremy A. Meier

David Gonzalez

Attorneys for *Amicus Curiae*

CALIFORNIA ASSOCIATION OF
PHYSICIAN GROUPS

EXHIBIT 1

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE**

**TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICES PLANS
ARTICLE 8. SELF-POLICING PROCEDURES**

ADOPTION OF SECTION 1300.71.39

Adopt new section of 1300.71.39 as follows:

§ 1300.71.39 Unfair Billing Patterns

(a) Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services.

(b) For purposes of this section:

(1) "Emergency services" means those services required to be covered by a health plan pursuant to Health & Safety Code sections 1345(b)(6), 1367(i), 1371.4, 1371.5 and Title 28, California Code of Regulations, sections 1300.67(g) and 1300.71.4.

(2) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed the provider by the health care service plan.

(3) "The plan's capitated provider" shall have the same meaning as that provided in section 1300.71(a).

Authority: Sections 1344, 1371.39, 1371.4, Health and Safety Code.

Reference: Sections 1317.1, 1317.7, 1342, 1345, 1346, 1362.8, 1367, 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4, 1371.5 and 1379, Health and Safety Code.

EXHIBIT 2

Assembly Bill No. 1455

CHAPTER 827

An act to amend Sections 1367, 1371, and 1371.35 of, and to add Sections 1371.36, 1371.37, 1371.38, and 1371.39 to, the Health and Safety Code, relating to health care service plans.

[Approved by Governor September 28, 2000. Filed with Secretary of State September 28, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1455, Scott. Health care service plans.

The Knox-Keene Health Care Service Plan Act of 1975 provides for the regulation and licensure of health care service plans by the Department of Managed Care and includes provisions pertaining to the payment of provider claims by a health care service plan and to the resolution of claims disputes. Under these provisions, interest at the rate of 10% per annum accrues if an uncontested provider claim is not reimbursed by the plan within a prescribed time period. Under existing law, the director of the department is required to administer and enforce the act and is provided with certain powers in this respect, including the power to conduct investigations affecting the interests of plans, subscribers, enrollees, and the public. The willful violation of the provisions of the Knox-Keene Health Care Service Plan Act of 1975 is a crime.

This bill would prohibit a health care service plan from engaging in an unfair payment pattern, as defined, in its reimbursement of a provider and would authorize the director to investigate a report of this conduct, and would permit a provider to report this conduct to the department. This bill would authorize the director, upon a final determination that a plan has engaged in an unfair payment pattern, to impose sanctions on the plan. This bill would additionally increase the interest rate on an uncontested provider claim that is not paid by the plan within a prescribed time period to 15% per annum and would impose a \$10 charge on a plan that fails to automatically include this interest amount in its payment to a provider.

This bill would require a health care service plan to ensure its dispute resolution mechanism is available to noncontracting providers and to submit an annual report to the Department of Managed Care regarding this mechanism. This bill would additionally require the department, on or before July 1, 2001, to adopt regulations pertaining to the dispute resolution mechanism utilized by health care service plans.

This bill would also provide for a plan to report to the department instances of a provider engaging in an unfair billing pattern. This bill

would require the department to make recommendations to the Legislature and Governor by July 1, 2001, regarding a system to respond to unfair billing patterns.

Because this bill would specify additional forms of prohibited conduct under the Knox-Keene Health Service Plan Act of 1975, the violation of which would be punishable as a criminal offense, it would create new crimes, and would thereby impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares the following:

(a) Health care services must be available to citizens without unnecessary administrative procedures, interruptions, or delays.

(b) The billing by providers and the handling of claims by health care service plans are essential components of the health care delivery process and can be made more effective and efficient.

(c) The present system of claims submission by providers and the processing and payment of those claims by health care service plans are complex and are in need of reform in order to facilitate the prompt and efficient submission, processing, and payment of claims. Providers and health care service plans both recognize the problems in the current system and that there is an urgent need to resolve these matters.

(d) To ensure that health care service plans and providers do not engage in patterns of unacceptable practices, the Department of Managed Health Care should be authorized to assist in the development of a new and more efficient system of claims submission, processing, and payment.

SEC. 2. Section 1367 of the Health and Safety Code is amended to read:

1367. Each health care service plan and, if applicable, each specialized health care service plan shall meet the following requirements:

(a) All facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 10 of the California Code of Regulations.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) Each health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, each health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) Each health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service which health care service plans shall be required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) No health care service plan shall require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

SEC. 3. Section 1371 of the Health and Safety Code is amended to read:

1371. A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically

include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten dollar (\$10) fee.

For the purposes of this section, a claim, or portion thereof, is reasonably contested where the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.

If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working day period.

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.

SEC. 4. Section 1371.35 of the Health and Safety Code is amended to read:

1371.35. (a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is

contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30- or 45-working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) 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. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities.

(g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(i) This section shall not apply to capitated payments.

(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

(l) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

SEC. 5. Section 1371.36 is added to the Health and Safety Code, to read:

1371.36. (a) A health care service plan shall not deny payment of a claim on the basis that the plan, medical group, independent practice association, or other contracting entity did not provide authorization for health care services that were provided in a licensed acute care hospital and that were related to services that were previously authorized, if all of the following conditions are met:

(1) It was medically necessary to provide the services at the time.

(2) The services were provided after the plan's normal business hours.

(3) The plan does not maintain a system that provides for the availability of a plan representative or an alternative means of contact through an electronic system, including voicemail or electronic mail, whereby the plan can respond to a request for authorization within 30 minutes of the time that a request was made.

(b) This section shall not apply to investigational or experimental therapies, or other noncovered services.

SEC. 6. Section 1371.37 is added to the Health and Safety Code, to read:

1371.37. (a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.

(b) Consistent with subdivision (a) of Section 1371.39, the director may investigate a health care service plan to determine whether it has engaged in an unfair payment pattern.

(c) An "unfair payment pattern," as used in this section, means any of the following:

(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.

(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.

(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.

(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

(d) (1) Upon a final determination by the director that a health care service plan has engaged in an unfair payment pattern, the director may:

(A) Impose monetary penalties as permitted under this chapter.

(B) Require the health care service plan for a period of three years from the date of the director's determination, or for a shorter period prescribed by the director, to pay complete and accurate claims from the provider within a shorter period of time than that required by

Section 1371. The provisions of this subparagraph shall not become operative until January 1, 2002.

(C) Include a claim for costs incurred by the department in any administrative or judicial action, including investigative expenses and the cost to monitor compliance by the plan.

(2) For any overpayment made by a health care service plan while subject to the provisions of paragraph (1), the provider shall remain liable to the plan for repayment pursuant to Section 1371.1.

(e) The enforcement remedies provided in this section are not exclusive and shall not limit or preclude the use of any otherwise available criminal, civil, or administrative remedy.

(f) 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.

(g) A health care service plan may not delegate any statutory liability under this section.

(h) For the purposes of this section, "complete and accurate claim" has the same meaning as that provided in the regulations adopted by the department pursuant to subdivision (a) of Section 1371.38.

(i) On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unjust pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption.

(j) The department shall make available upon request and on its website, information regarding actions taken pursuant to this section, including a description of the activities that were the basis for the action.

SEC. 7. Section 1371.38 is added to the Health and Safety Code, to read:

1371.38. (a) The department shall, on or before July 1, 2001, adopt regulations that ensure that plans have adopted a dispute resolution mechanism pursuant to subdivision (h) of Section 1367. The regulations shall require that any dispute resolution mechanism of a plan is fair, fast, and cost-effective for contracting and non-contracting providers and define the term "complete and accurate claim, including attachments and supplemental information or documentation."

(b) On or before December 31, 2001, the department shall report to the Governor and the Legislature its recommendations for any additional statutory requirements relating to plan and provider dispute resolution mechanisms.

SEC. 8. Section 1371.39 is added to the Health and Safety Code, to read:

1371.39. (a) Providers may report to the department's Office of Plan and Provider Relations, either through the toll-free provider line (877-525-1295) or e-mail address (plans-providers@dmhc.ca.gov), instances in which the provider believes a plan is engaging in an unfair payment pattern.

(b) Plans may report to the department's Office of Plan and Provider Relations, either through the toll-free provider line (877-525-1295) or e-mail address (plans-providers@dmhc.ca.gov), instances in which the plan believes a provider is engaging in an unfair billing pattern.

(1) "Unfair billing pattern" means engaging in a demonstrable and unjust pattern of unbundling of claims, upcoding of claims, or other demonstrable and unjustified billing patterns, as defined by the department.

(2) The department shall convene appropriate state agencies to make recommendations by July 1, 2001, to the Legislature and the Governor for the purpose of developing a system for responding to unfair billing patterns as defined in this section. This section shall include a process by which information is made available to the public regarding actions taken against providers for unfair billing patterns and the activities that were the basis for the action.

(c) On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unfair billing pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption.

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.