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14  
15 SUPERIOR COURT OF THE STATE OF CALIFORNIA  
16 COUNTY OF SACRAMENTO

17 CALIFORNIA MEDICAL  
18 ASSOCIATION, et al.,

19 Petitioners & Plaintiffs,

20 v.

21 DEPARTMENT OF MANAGED  
22 HEALTH CARE, AND LUCINDA  
23 EHNES, in her capacity as DIRECTOR OF  
24 THE DEPARTMENT OF MANAGED  
25 HEALTH CARE, and Does 1 through 100,  
26 inclusive,,  
27  
28

Respondents &  
Defendants.

Case No. 34-2008-80000059

**PETITIONERS' REPLY BRIEF IN  
SUPPORT OF PETITION FOR WRIT OF  
MANDATE**

**Assigned for All Purposes:**

**Hon. Michael Kenny**

DATE: November 21, 2008

TIME: 9:00 A.M.

DEPT: 31

Action Filed: September 26, 2008

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## INTRODUCTION

1  
2 The Department of Managed Health Care's (the "DMHC") opposition brief is remarkable  
3 in its emphasis on public policy rather than the law, despite the DMHC's averment that the Court  
4 is asked by the Petition only to determine the legality of the Balance Billing Regulation, "not its  
5 wisdom." (See Opposition brief at 40:17-18.) In its brief, the DMHC presents a spirited  
6 campaign against balance billing. But it fails profoundly to accurately address, much less  
7 successfully rebut, the following key points Petitioners have asserted demonstrating that the  
8 Balance Billing Regulation cannot stand.

9 Key Point Number One: Nothing in the Knox-Keene Act empowers the DMHC to  
10 prohibit balance billing by non-contracted emergency care providers, because neither the intent  
11 nor the statutory scheme of the Knox-Keene Act extinguishes the firmly established common law  
12 relationship between a patient and a health care provider who has no contractual relationship with  
13 the patient's HMO. The DMHC attempts an end-run around this critical issue in claiming that it  
14 has authority to *define* "unfair billing patterns" to include balance billing. But make no mistake  
15 about it, the DMHC expressly and publicly has avowed that the Balance Billing Regulation  
16 affirmatively *prohibits* non-contracted providers of emergency care from balance billing. There  
17 is no support for the DMHC's claim that attaching a label to a practice automatically prohibits  
18 that practice, especially when such a prohibition would be inconsistent with the Knox-Keene Act.  
19 The DMHC has not (and cannot) rebut Petitioners' contention that it simply does not have  
20 authority to promulgate the Balance Billing Regulation.

21 Key Point Number Two: The DMHC now has placed all its bets on Health and Safety  
22 Code Section 1371.39<sup>1</sup> as the authorizing statute for the Balance Billing Regulation. It claims the  
23 terms of this statute unambiguously authorizes a prohibition of balance billing by the DMHC, and  
24 demands that this Court must accept its reading. However, deference to the DMHC is not  
25 warranted because Section 1371.39, albeit clear in its terms, simply does not support the DMHC's  
26 position. Nothing in Section 1371.39 prohibits balance billing in particular or unfair billing

27 \_\_\_\_\_  
28 <sup>1</sup> Unless otherwise indicated, all statutory references are to the California Health & Safety Code.

1 patterns in general. Rather, by its plain terms, the statute merely establishes a scheme for the  
2 DMHC to develop and recommend a system for dealing with unfair billing patterns for  
3 consideration by the Legislature. For years, the DMHC ignored this Legislative directive. The  
4 DMHC now returns to Section 1371.39 not to discharge its duties hereunder, but wrongly to  
5 conscript Section 1371.39 into its campaign against balance billing. The DMHC's misapplication  
6 of Section 1371.39 cannot be accepted because it would contradict not only the Legislature's  
7 intent behind Section 1371.39 but also the intent and scheme of the Knox-Keene Act. There is  
8 abundant proof that the Knox-Keene Act does not extend to non-contracted providers of  
9 emergency medical services, and when it comes to regulating balance billing, the Legislature has  
10 adopted an approach that invariably includes measures to protect providers against HMO  
11 payment abuses. Compared to the Legislature's and the Knox-Keene Act's intent, the DMHC  
12 stands apart and alone in its desire to absolutely and categorically prohibit balance billing, while  
13 leaving non-contracted providers to fend for themselves against the payment abuses of the  
14 HMOs.

15 Key Point Number Three: Whether viewed as a mere definition or a prohibition, the  
16 Balance Billing Regulation is fatally vague. The DMHC effectively has no response and leaves  
17 uncontroverted the evidence from provider billing experts who explained clearly why and how it  
18 is virtually impossible to comply with the Balance Billing Regulation given the realities of billing  
19 procedures and practice. Rather than address this evidence, the DMHC ignores the real-life  
20 problems providers are facing and responds in conclusory fashion that the Balance Billing  
21 Regulation is not vague because its terms are clear. Such circular reasoning, unsupported by  
22 evidence, falls far short of saving the Balance Billing Regulation from Petitioners' vagueness  
23 challenge.

24 It is apparent that when it comes to the balance billing issue, the DMHC has abandoned  
25 any pretense of serving in the role of the regulator of health care service plans (*i.e.*, HMOs),  
26 consistent with the authority granted to it by the Legislature. Instead, the DMHC appears to have  
27 adopted the role of a zealous regulator of out-of-network, non-contracted providers rather than  
28 HMOs, determined to prevent balance billing in complete disregard of whether it has the statutory

1 authority to do so and in further disregard of the current expressions of legislative intent on the  
2 issue of balance billing. The DMHC and the *amici* parties that support the DMHC's regulation  
3 seek to convince the Court that the Petition should be denied based on public policy  
4 considerations. In doing so, they paint a misleading picture that unfairly and inaccurately casts  
5 providers -- that is, the hospitals and physicians that save the lives of the HMOs' enrollees -- as  
6 the villains in the balance billing drama. Petitioners will in their reply brief refocus the discussion  
7 on the legal issues of statutory interpretation and legislative intent, which are the only issues  
8 properly before the Court. However, because the DMHC and *amici* have engaged in a blatant  
9 public policy discussion, Petitioners cannot stand silent and will briefly address the public policy  
10 arguments in order to dispel the myth that the providers are responsible for putting the patients in  
11 the middle of disputes between the HMOs and the providers.

12 The Petition should be granted.

## 13 DISCUSSION

### 14 I. COMMON LAW AND THE KNOX-KEENE ACT RECOGNIZE THE 15 ABILITY OF A PROVIDER TO SEEK PAYMENT FOR SERVICES FROM 16 A PATIENT AND EXISTING LEGISLATION RECOGNIZES THAT AN OUT-OF-NETWORK PROVIDER MAY SEEK PAYMENT FROM A PATIENT AS WELL AS AN HMO

17 The DMHC's discussion of balance billing is so rife with hyperbole and emotion that it  
18 overlooks the fundamental fact that providers have always been, and currently are still, permitted  
19 to look to the patient for payment of medical services rendered. The Knox-Keene Act does not  
20 alter this fact where medical services are rendered outside of the managed care "bargain."  
21 Petitioners hereby fill in the gaps of the DMHC's skewed presentation of the managed care  
22 "bargain" and where non-contracted providers stand within this environment.

#### 23 A. Under The Common Law Quantum Meruit Theory Of Recovery, A 24 Provider Has Historically Been Able To Seek Payment For Medical Services Rendered From A Patient

25 It has always been and continues to be that when a patient without health insurance  
26 obtains medical services, that patient is obligated to pay for the services provided. If a written or  
27 oral contract is formed between the patient and the provider, the patient is contractually bound to  
28 pay. If there is no contract, the provider may seek payment from the patient in quantum meruit.

1 (*See Reichle v. Hazie* (4<sup>th</sup> Dist. 1937) 22 Cal.App.2d 543, 547 (“Where, as here, a patient was  
2 admitted to a hospital without an express contract to pay for his care and treatment, ‘The law,  
3 ...in the absence of evidence to show gratuitous service, would imply an agreement ...to pay the  
4 reasonable value’ of the services rendered ...”) (omissions in original, citation omitted)); *Medina*  
5 *v. Van Camp Sea Food Co.* (1946) 75 Cal.App.2d 551 (where one performs for another a useful  
6 service of the character usually charged for, a promise to pay the reasonable value of the services  
7 is implied).)

8 Thus, under California common law, a provider has a direct remedy against a patient to  
9 seek payment of the reasonable value of medical services provided.

10 **B. The Knox-Keene Act Does Not Limit An Out-Of-Network Provider’s**  
11 **Ability To Seek Payment From A Patient But Rather Allows The**  
12 **Provider To Look To The Patient’s HMO For Payment**

13 With the rise of managed care in California, HMOs became involved in the traditional  
14 relationship between the patient and the provider but did not displace it entirely. HMOs are  
15 obligated to provide for their enrollee’s health care needs in return for the enrollee’s payment of a  
16 premium under a health care plan contract. Associated with this obligation of HMOs is the duty  
17 to establish and maintain an adequate and accessible network of health care providers for  
18 enrollees. HMOs must establish such networks of care by contracting with a necessary number of  
19 providers to render health care services to the HMOs’ enrollees. The provider contracts must set  
20 fair and reasonable rates of reimbursement to the provider. In sum, the managed care “bargain”  
21 consists of a contract between the HMO and its enrollee (which creates a duty on the HMO to  
22 provide and pay for the enrollee’s health care services) and a contract between the HMO and in-  
23 network providers (which provides for fair and reasonable reimbursement of such contracted  
24 providers for rendering services to the HMO’s enrollee).

25 The DMHC glosses over the fact that the managed care “bargain” does not cover all  
26 instances in which patients receive medical services. When the HMO’s enrollee obtains services  
27 from in-network providers, the HMO must pay these providers at the rate set in the contract  
28 between the HMO and the in-network provider. Within this scheme, the Knox-Keene Act  
prohibits the in-network provider from seeking any payment from the HMO’s enrollee for “sums

1 owed by the plan.” (Health & Saf. Code § 1379.) In other words, an in-network provider may  
2 not balance bill the HMO’s enrollee. However, within the managed care “bargain,” HMO  
3 enrollees are not precluded from obtaining treatment out-of-network from a provider who has not  
4 contracted with the enrollee’s particular HMO. In these situations, the common law applies and  
5 the Knox-Keene Act consistently contemplates that enrollees will be personally responsible to  
6 pay for any out-of-network care they receive; indeed, managed care contracts invariably include  
7 terms to such effect.

8 The issue in this case arises when an enrollee obtains out-of-network emergency medical  
9 services. The out-of-network provider does not have a contract with the enrollee’s HMO, and  
10 there is no agreement for the HMO to pay that out-of-network provider at any specific rate. In  
11 these situations outside the managed care “bargain,” just as the HMO is not contractually  
12 obligated to pay the non-contracted provider at any particular rate, existing law does not prohibit  
13 the non-contracted provider from balance billing his or her patient. It does not matter that the  
14 patient is an HMO enrollee because the non-contracted provider is not a part of the managed care  
15 “bargain” between the HMO and the enrollee.

16 The DMHC also glosses over an important reality concerning non-contracted providers.  
17 In lambasting the supposed evils of balance billing, the DMHC presumes that the guilty  
18 physicians and hospitals are categorically non-contracted, *i.e.* they have no contractual  
19 relationship with any HMO. The reality is that the most providers are contracted with certain  
20 HMOs but not with others, depending on the types and quality of HMO contracts available to the  
21 provider. It therefore is not true that there are large populations of providers who seek to exploit  
22 balance billing by never entering into contracts with HMOs. The DMHC’s paranoia over the  
23 “crisis” of balance billing is unfounded in reality.

24 Recognizing the need to protect non-contracted emergency care providers from HMO  
25 payment abuses, in 1994 the Legislature enacted a provision of the Knox-Keene Act designed to  
26 ensure that HMOs adequately pay non-contracted emergency services providers. Specifically,  
27 Section 1371.4 provides that “[a] health care service plan shall reimburse providers for  
28 emergency services and care provided to its enrollees ....” (Health & Saf. Code §1371.4(b).)

1 The obligation created under Section 1371.4, however, is not immutable. Two districts of the  
2 California Court of Appeal have held that an HMO's obligation to reimburse providers for  
3 emergency services is delegable, and that an HMO is not liable to pay providers for emergency  
4 services rendered to the HMO's enrollees if that responsibility has been properly delegated to  
5 risk-bearing organizations such as physician groups and independent practice associations, like  
6 the members represented by *amicus* California Association of Physician Groups ("CAPG"). (*See*  
7 *Ochs v. PacifiCare of Cal.* (2<sup>nd</sup> Dist. 2004) 115 Cal.App.4<sup>th</sup> 782 (HMO's delegation of its  
8 payment responsibilities to IPA absolved it of financial responsibility for claim that the IPA could  
9 not pay due to insolvency); *Cal. Emergency Physicians Medical Group v. PacifiCare of Cal.* (4<sup>th</sup>  
10 Dist. 2003) 111 Cal.App.4<sup>th</sup> 1127 (same).)

11 The DMHC is wrong in claiming that Section 1371.4 extinguishes the enrollee's  
12 obligation under common law to pay for emergency services provided by non-contracted  
13 providers. The *Ochs* court expressed a contrary view, noting that although the HMO had  
14 delegated its obligation to reimburse the provider to the insolvent IPA, "section 1379 appears  
15 only to limit 'balance billing' of insured patients by physicians who have *contracted* with the  
16 patients' plans. [The out-of-network provider] *may have a remedy against the individual*  
17 *patients, and those patients a remedy against PacifiCare.*" (*Ochs, supra*, 115 Cal.App.4<sup>th</sup> at p. 796  
18 (emphasis added) [dicta].) The court's view is consistent with the principle that, "[u]nless  
19 expressly provided, statutes should not be interpreted to alter the common law, and should be  
20 construed to avoid conflict with common law rules." (*Cal. Assn. of Health Facilities v. Dept. of*  
21 *Health Services* (1979) 16 Cal.4<sup>th</sup> 284, 297; *see also City of Moorpark v. Moorpark Unified*  
22 *School Dist.* (1991) 54 Cal.3d 921 (holding the Naylor Act did not supplant the common law  
23 regarding contract formation even though it dictated the particular entities to which offers for  
24 schools sites could be made; thus, under common law principles, the district's notice of intent to  
25 sell, lease, or exchange the property constituted an invitation to deal rather than a binding offer to  
26 contract).)

27 A plain reading of Section 1371.4 reveals that the DMHC overextends the application of  
28 the statute. Section 1371.4 is directed only to an HMO's obligation to pay for out-of-network

1 emergency care services rendered to its enrollees. It speaks nothing of the obligation of patients  
2 to pay non-contracted providers for emergency medical services. More importantly, nothing in  
3 Section 1371.4 or its legislative history relieves the patient of this common law obligation. (See  
4 legislative history, attached as Exhibits 1 to 4 to Petitioners' Supplemental Request for Judicial  
5 Notice.) Rather, Section 1371.4 creates a separate obligation of HMOs (in addition to the  
6 obligation of patients, under the common law) to pay for these out-of-network emergency  
7 services.

8 Nor is there any support for the DMHC's broader argument that the Knox-Keene Act  
9 generally preempts an out-of-network emergency care provider's common law rights to collect  
10 payment for services from HMO enrollees. Citing *Van de Kamp v. Gumbiner* (1990) 221  
11 Cal.App.3d 1260, the DMHC suggests that the Knox-Keene Act is "so pervasive" it "preempt[s]  
12 common law" without qualification. The DMHC misrepresents *Van de Kamp*. That case  
13 involved a challenge against the Attorney General's authority to supervise and regulate non-profit  
14 health plans. As the *Van de Kamp* court correctly observed, historically, the Attorney General did  
15 have common law authority to enforce charitable trust obligations, and prior to the enactment of  
16 the Knox-Keene Act, plans were required to register with the Attorney General and meet certain  
17 tangible net equity requirements. Any person or entity holding assets in charitable trusts also was  
18 subject to regulation by the Attorney General. In 1975, with the enactment of the Knox-Keene  
19 Act, however, the Legislature greatly expanded the licensing and regulatory structure concerning  
20 health plans and "transferred regulatory authority from the Attorney General to the Department"  
21 of Corporations (now the DMHC). Given the explicit statutory transfer of authority and the  
22 "comprehensive" legislative scheme of the Knox-Keene Act covering health plans, the *Van de*  
23 *Kamp* court held that the Legislature intended to supersede the Attorney General's common law  
24 authority to regulate *health plans*. *Van de Kamp's* holding is narrower than the DMHC paints it to  
25 be. The court there did *not* conclude that the Knox-Keene Act displaced all common law relating  
26 to *providers*.

27 In fact, no court has ever concluded that the Knox-Keene Act preempts all of common  
28 law, much less the common law right of non-contracted providers. Courts that have considered

1 whether non-contracted providers had a right to rely upon common law to obtain adequate  
2 reimbursement have concluded that the Knox-Keene Act did *not* bar such common law remedies.  
3 In *Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693, a non-  
4 contracted health care provider – Coast Plaza – provided medically necessary services to an  
5 HMO’s enrollees. When the HMO’s enrollees were admitted to Coast Plaza for medical care,  
6 they signed an assignment to the hospital of their right to reimbursement from the HMO. The  
7 HMO refused to recognize the assignment of benefits and refused to pay for Coast Plaza’s  
8 medical services. In defense of a lawsuit seeking reimbursement, the HMO argued, among other  
9 things, that only the Department of Corporations (the DMHC’s predecessor) had regulatory  
10 authority over HMOs. In other words, similar to the DMHC here, the HMO argued that the  
11 Knox-Keene Act preempts application of contract common law to invalidate the assignment of  
12 benefits. The *Coast Plaza* court rejected this argument, just as this Court should reject the  
13 DMHC’s preemption argument. In addition to stating that the Knox-Keene Act did not preclude  
14 lawsuits seeking reimbursement based upon the unfair competition law, Business & Professions  
15 Code Section 17200, the *Coast Plaza* court squarely rejected the notion that the Knox-Keene Act  
16 precluded lawsuits based on common law breach of contract. It reasoned, “We conclude that the  
17 Department *does not have exclusive jurisdiction*, and that common law and other statutory causes  
18 of action may be brought by Coast.” (*Id.* at 706 (emphasis added).) The court additionally  
19 declined to defer to the DMHC “in the area of health care finance [since] [t]he Knox-Keene Act  
20 itself contemplates that a provider may have a cause of action under a statutory or common law  
21 theory ....” (*Id.* at 707.)

22 Similarly, in *Bell v. Blue Cross* (2005) 131 Cal.App.4<sup>th</sup> 211, the court held that,  
23 notwithstanding the Knox-Keene Act, a non-contracted provider has a contractual right to obtain  
24 payment for out-of-network emergency care services from an HMO. The *Bell* court stated, “We  
25 agree with the Department of Managed Health Care (*amicus curiae* on this appeal, as is the  
26 California Medical Association) that the Knox-Keene Act leaves the Dr. Bell free to pursue  
27 alternative theories to recover the reasonable value of his services, that Dr. Bell’s claim under the  
28 [Unfair Competition Law] does not infringe on the Department’s jurisdiction, that there is no bar

1 to Dr. Bell's common law *quantum meruit* claim, and that Blue Cross's obligation to reimburse  
2 includes an obligation to do so reasonably." (*Bell, supra*, 131 Cal.App.4<sup>th</sup> at 215.) It is  
3 inconsistent for the DMHC, which supported the result in *Bell*, to now contend that the Knox-  
4 Keene Act preempts this common law right. Accordingly, existing law does not support but  
5 rather contradicts the DMHC's claim that the Knox-Keene Act preempts the common law right of  
6 non-contracted emergency care providers to obtain payment from HMO enrollees.

7 **C. The Knox-Keene Act Recognizes That A Noncontracted Provider Can**  
8 **Seek Payment From A Patient As Well As From The Patient's HMO**

9 The Knox-Keene Act is replete with provisions recognizing that a patient is primarily  
10 liable to an out-of-network provider for medical services rendered, including emergency care  
11 services. In fact, numerous provisions of the Act contradict the DMHC's suggestion that balance  
12 billing – in all contexts and by non-contracted and contracted providers alike – is an anathema to  
13 the Knox-Keene Act.

14 Section 1379 states that balance billing for emergency care services is prohibited only by  
15 contracted providers. By its terms, Section 1379's prohibition has no application to non-  
16 contracted providers. Furthermore, Section 1394.2 clearly recognizes an enrollee's obligations to  
17 pay a non-contracted provider even if the enrollee's HMO goes bankrupt. Under Section 1394.2,  
18 the claims of an HMO enrollee for reimbursement for services rendered by non-contracted  
19 providers are fourth in priority in a proceeding involving the involuntary dissolution of the HMO:

20 Notwithstanding any other provision of law, in any  
21 involuntary dissolution of a health care service plan as provided for  
22 in Section 1394.1, or other insolvency proceeding involving a health  
23 care service plan, the following expenses and claims have priority in  
24 the following order: ...

25 (d) Fourth, claims of health care service plan subscribers  
26 and enrollees for reimbursement for services rendered by  
27 noncontracting providers. Upon proper showing, the superior court  
28 may make an order relieving subscribers and enrollees from liability  
or stay any proceeding to secure payment for any services rendered  
by a noncontracting provider upon payment, in whole or in part, of  
the claim or claims of those noncontracting providers. (Health & Saf.  
Code §1394.2(d).)

The Knox-Keene Act also requires that each HMO disclose to the public, subscribers and

1 enrollees, in readily understandable language, information regarding benefits, services and terms  
2 of the HMO contract with its enrollees, including information concerning “the nature and extent  
3 of choice permitted [under the plan] and the financial liability that is, or may be, incurred by the  
4 subscriber, enrollee, or third party by reason of the exercise of that choice.” (Health & Saf. Code  
5 § 1363(a)(8).) The HMO’s evidence of coverage must further include a statement to the effect  
6 that in the event the HMO fails to pay a non-contracted provider, the member may be liable to the  
7 non-contracted provider for the cost of service:

8 (c) The evidence of coverage shall contain at a minimum the  
9 following information: ...

10 (15) A statement to the effect that in the event the health plan fails  
11 to pay a noncontracting provider, the member may be liable to the  
12 noncontracting provider for the cost of the services. (28 C.C.R.  
13 §1300.63.1(b)(15).)

14 In addition, continuity of care laws provide for completion of a reasonable transition for  
15 covered services by a terminated or non-contracted participating provider. (*See* Health & Saf.  
16 Code §§ 1373.95 & 1373.96.) These provisions, consistent with the interpretation of the medical  
17 community (as well as the DMHC), recognize that non-contracted providers cannot be obligated  
18 to accept whatever the HMO dictates. (*See* Health & Saf. Code § 1373.96(e)(2) (“Neither the  
19 plan nor the provider group is required to continue the services of a nonparticipating provider if  
20 the provider does not accept the payment rates provided for in this paragraph.”).)

21 Finally, the Legislature also expressly recognized that enrollees can incur costs in  
22 connection with out-of-network emergency or urgent circumstances, and thus requires HMOs to  
23 promptly reimburse enrollees for those costs where they have been found by an independent  
24 medical review organization to be medically necessary. (Health & Saf. Code § 1374.34(a) (“In  
25 the case of reimbursement for services already rendered, the plan shall reimburse the provider *or*  
26 *enrollee, whichever applies*, within five working days.” [Emphasis added.])) While the  
27 Legislature intended to protect patients from billing disputes, it did not prohibit billing by  
28 noncontracted providers for emergency services, or even billing for post-stabilization services if  
the HMO failed to take over the responsibility for the patient after notification.

1           **D. Since The Patient Has Prepaid A Premium To The HMO, The Patient**  
2           **Should Look To The HMO To Keep The Patient Out Of The Middle**  
3           **Of Any Dispute Over The Value Of Medical Services**

4           The DMHC argues that balance billing “is an unfair practice because the enrollee prepaid  
5           for all of their emergency care.” (Opposition brief at 1:15-16.) This is fundamentally flawed  
6           reasoning because it overlooks the question of *who* received the prepayment for the enrollee’s  
7           emergency care. The *HMO*, not the noncontracted provider, contracted with the enrollee to  
8           provide emergency care and the *HMO* received the “prepayments” from the enrollee. Since the  
9           HMO is the entity with the contractual obligation to “take care” of the patient and the entity that  
10          has been prepaid to “take care” of the patient, the HMO should also be responsible for “taking  
11          care of the bills” and “taking the patient out of the middle” of any dispute over the amount of a  
12          provider’s fees. The Balance Billing Regulation and the DMHC’s current attack on providers,  
13          which allows HMOs to unilaterally decide what is the “reasonable and customary” value of  
14          medical services, encourages HMOs to pay providers less than full billed charges. Patients  
15          consequently are left unprotected, which is a result that is antithetical to the DMHC’s professed  
16          mission to protect healthcare consumers.

17          The DMHC recognizes the HMO’s role in the managed care scheme when it stated that  
18          “plans must assume full financial risk on a prospective basis for the provision of all ‘basic  
19          healthcare services,’” which includes emergency health care services. (Opposition brief at 4:8-  
20          12.) The DMHC also correctly noted that the law resolved the tension between the necessity of a  
21          defined network of providers and the unpredictable nature of medical emergencies “in favor of  
22          the enrollee by confirming that plans must assume the full financial risk associated with  
23          emergency services, *even if those services are rendered by a provider outside the plan’s*  
24          *network.*” (Opposition brief at 4:14-16 [emphasis in original].) However, despite recognizing  
25          that the HMO is the entity that the law requires must assume the financial risk on behalf of the  
26          enrollee, it is curious and inconsistent that the DMHC here seeks to relieve the HMO from that  
27          financial risk. The DMHC is adamant that the HMOs should not bear the burden of first paying a  
28          non-contracted provider’s full billed charges and then disputing the reasonableness of the charges  
29          with the provider, which is the way the industry worked before the DMHC adopted the Balanced

1 Billing Regulation and which is consistent with the reality and the legal presumption that  
2 physician bills are reasonable. (*See Southern California Edison Co. v. WCAB* (4<sup>th</sup> Dist. 1999) 65  
3 Cal. Comp. Cas. 100, 101 (“the Court assumes any bill presented by medical professionals is one  
4 they believe and assume is reasonable. If defendant does not agree, defendant can present proof  
5 of the unreasonableness.”) In its Balance Billing Regulation, the DMHC has shifted the burden  
6 of disputing the bills the wrong way, to the out-of-network, non-contracted providers who have  
7 not received any prepayments from the patient and do not have a contract with the HMO to take  
8 care of the patient. This approach is inconsistent with the burden-shifting provisions of the Knox-  
9 Keene Act that the DMHC is supposed to be implementing.

10 **II. THE DMHC IS NOT ENTITLED TO DEFERENCE IN THIS CASE**

11 The DMHC repeatedly demands that the Court defer to its “expertise” in reviewing the  
12 validity of the Balance Billing Regulation. The law is clear, however, that agency action is not  
13 always and automatically entitled to deference. And more importantly, deference is not  
14 appropriate where, as here, the Court is equally or more capable of ascertaining legislative intent  
15 as the DMHC, and where there are clear indications that the DMHC’s interpretation is incorrect.  
16 Nor is deference appropriate where, as here, the regulation at issue was not promulgated  
17 contemporaneously with the statute it supposedly implements, interprets or defines.

18 In *Yamaha Corp. of America v. State Board of Equalization* (1998) 19 Cal.4<sup>th</sup> 1, the  
19 California Supreme Court held that the amount of “judicial deference to an agency’s  
20 interpretation is appropriate and, if so, its extent – the ‘weight’ it should be given – is thus  
21 fundamentally *situational*.” (*Id.* at 12 [emphasis in original].) In other words, “[w]here the  
22 meaning and legal effect of a statute is the issue, an agency’s interpretation is one among several  
23 tools available to the court. Depending on the context, it may be helpful, enlightening, even  
24 convincing. It may sometimes be of little worth.” (*Id.* at 7-8.)

25 In *Yamaha*, the court of appeal listed two sets of factors that govern the degree of  
26 deference owed by a court to an interpretive rule: whether the agency has “a comparative  
27 interpretive advantage over the courts” and whether there are indications “that the interpretation  
28 in question is probably correct.” (*Id.* at 12 [citations and internal quotation marks omitted].)

1 Application of both factors here demonstrate that the Balance Billing Regulation is not entitled to  
2 deference.

3 The California Supreme Court held in *People v. Cole* that the agencies charged with  
4 interpreting the Knox-Keene Act have no “comparative interpretive advantage over the courts in  
5 interpreting the relevant statutes.” (*People v. Cole* ( 2006) 38 Cal.4<sup>th</sup> 967, 987, [citation and  
6 internal quotation marks omitted].) That is particularly true here. The question of whether the  
7 DMHC has the authority to promulgate the Balance Billing Regulation turns on legislative intent;  
8 DMHC has less experience than the courts in discerning such intent. (*See Interinsurance Exch. of*  
9 *the Auto. Club v. Superior Court* (4<sup>th</sup> Dist. 2007) 148 Cal.App.4<sup>th</sup> 1218, 1236-37 (Department of  
10 Insurance “did not have any special expertise that we or other courts lack in construing the  
11 underlying legislative intent”); *Farmers Ins. Exch. v. Superior Court* (2<sup>nd</sup> Dist. 2006) 137  
12 Cal.App.4<sup>th</sup> 842, 859 [40 Cal.Rptr.3d 653] (courts, not agency, have greater expertise in  
13 determining whether voters intended in initiative to create private right of action).) In short,  
14 while an agency may have “an interpretive advantage with respect to matters within the agency’s  
15 expertise and technical knowledge” (*Farmers Ins., supra*, 137 Cal.App.4<sup>th</sup> at 859), nothing about  
16 the statutory interpretation issues presented by this case turns on health plan economics or other  
17 specialized expertise. Consequently, there is no “comparative interpretative advantage” in this  
18 case that requires deference to the regulation.

19 Nor do the other issues in this case suggest that the DMHC’s interpretation of its authority  
20 is “probably correct.” (*See Yamaha, supra*, 19 Cal.4<sup>th</sup> at 12.) No deference is warranted where  
21 the interpreting regulation was not “‘contemporaneous with’ enactment of the relevant statutes.”  
22 (*People v. Cole, supra*, 38 Cal.4<sup>th</sup> at 987 (citation omitted).) Obviously, a regulation promulgated  
23 in 2008 is not contemporaneous with a statute (AB 1455) enacted in 2000. Indeed, the DMHC’s  
24 position on the general issue of balance billing has neither been longstanding or consistent. The  
25 DMHC itself distinguished between contracted and non-contracted physicians in its claims  
26 settlement practices. (*See* AB 35-36.) These changes of position matter because a “vacillating  
27 position is entitled to no deference.” (*Yamaha*, 19 Cal.4<sup>th</sup> at 13 [ellipses, internal quotation marks  
28 and citation omitted].) Consequently, *all* the other factors identified by the *Yamaha* court as

1 supporting deference militate against any such presumption in this case.

2 Finally, the DMHC's interpretation is irrelevant for two additional reasons. *First*, even an  
3 interpretative rule that is entitled to maximum deference cannot overcome contrary evidence of  
4 legislative intent. For example, in *Green v. State* (2007) 42 Cal.4<sup>th</sup> 254, a majority of the  
5 California Supreme Court held that even if the administrative agency's interpretation of the  
6 relevant statute, embodied in a regulation, supported the plaintiff's position, that position could  
7 not prevail because it was contrary to the Legislature's intent. (*Id.* at 266; see *N. Gualala Water*  
8 *Co. v. State Water Res. Control Bd.* (1<sup>st</sup> Dist. 2006) 139 Cal.App.4<sup>th</sup> 1577, 1589 (agency  
9 regulation entitled to no deference where it was inconsistent with legislative intent).) Here, there  
10 is *no* evidence that the legislature which enacted AB 1455 intended to regulate provider billing of  
11 patients generally or balance billing in particular. Moreover, the Legislature's recent approval of  
12 SB 981 and AB 2220 demonstrates its understanding that balance billing is not prohibited by  
13 existing law and its intent regarding the manner in which balance billing should be regulated.

14 *Second*, the law is settled that "[a]dministrative regulations that later amend the statute or  
15 enlarge or impair its scope are void." (*Dyna-Med, Inc. v. Fair Employment & Hous. Comm'n*  
16 (1987) 43 Cal.3d 1379 1389 (citation and internal quotation marks omitted).) The Balance  
17 Billing Regulation violates this rule because it enlarges the provisions of the Knox-Keene Act far  
18 beyond the statute's scope. A void regulation is not entitled to deference (*Gattuso v. Harte-*  
19 *Hanks Shoppers, Inc.* (2007) 42 Cal.4<sup>th</sup> 554, 563, 574; *Tidewater Marine Western, Inc. v.*  
20 *Bradshaw* (1996) 14 Cal.4<sup>th</sup> 557, 572.)

### 21 **III. THE DMHC LACKS AUTHORITY TO REGULATE NONCONTRACTED** 22 **PROVIDERS**

23 A fundamental flaw of the Balance Billing Regulation, as Petitioners have noted, is that  
24 the DMHC does not have authority to insert itself into the relationship between a patient and a  
25 physician or hospital who has not contracted with that patient's HMO, *i.e.*, a non-contracted  
26 provider. The DMHC presents no legal authority to overcome this problem.

27 The DMHC's jurisdiction extends only so far as the reach of the Knox-Keene Act. By its  
28 own terms, the Knox-Keene Act applies only to "health care service plans and specialized health

1 care service plan contracts,” not to providers who have no contractual relationship with a health  
2 plan. (Health & Safety Code §1343(a); *see also Hollister v. Benzl*, 71 Cal. App. 4th 582, 587  
3 (1999) (“On its face, the [Knox-Keene] Act applies to ‘Health Care Service Plans’ defined as  
4 ‘[a]ny person who undertakes to arrange for the provision of health care services to subscribers or  
5 enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a  
6 prepaid or periodic charge paid by or on behalf of such subscribers or enrollees’”) (citing Health  
7 & Safety Code §1345(f)).) In other words, the “Department of Managed Health Care [] has  
8 charge of the execution of the laws of this state relating to health care service plans and the health  
9 care service plan business.” (Health & Safety Code § 1341(a).) Courts have recognized that  
10 “[t]he Legislature vested this responsibility in the Commissioner of Corporations [the DMHC’s  
11 predecessor] to ensure proper fiscal management of *health care service plans* by giving regulation  
12 of those plans a strong financial and business orientation.” (*Rakestraw v. California Physicians’*  
13 *Service*, 81 Cal. App. 4th 39, 46 (2000) (emphasis added).) Nothing in the Knox-Keene Act vests  
14 authority in the DMHC to reach beyond the managed care environment to regulate the established  
15 practices and rights that arise from a provider-patient relationship formed without reference to  
16 any HMO contract. (*See Scripps Clinic v. Superior Court*, 108 Cal. App. 4th 917, 938 (2003)  
17 (“The Knox-Keene Act applies only to health maintenance organizations and not to physician  
18 groups”) (citing Health & Saf. Code §§1343(a), 1345(f), (o)); *Coast Plaza Doctors Hospital*, 105  
19 Cal.App.4th 693 (holding the Knox-Keene Act does not apply to a provider in the absence of a  
20 contractual arrangement between the provider and the plan).)

21 *Hollister, supra*, is instructive of the limits of the Knox-Keene Act’s reach, which in turn  
22 denotes the limits of the DMHC’s authority. There, an HMO enrollee sued her gynecologist for  
23 malpractice and sought to bar enforcement of an arbitration agreement between the gynecologist  
24 and the patient. (*Hollister*, 71 Cal.App.4th at 584.) The patient’s primary care physician had  
25 referred her to the gynecologist, who had not contracted with the HMO. (*Id.* at 587.) The  
26 enrollee nevertheless contended that the arbitration agreement was unenforceable because the  
27 gynecologist and her HMO had violated certain notice provisions of the Knox-Keene Act relating  
28 to arbitration. The *Hollister* court disagreed and held the gynecologist “has no statutory duty to

1 comply with the arbitration predisdisclosure requirements of the Knox-Keene Act. . . . [because]  
2 [t]he Act was simply not intended to apply to him.” (*Id.*) “Moreover,” according to the court,  
3 “[the gynecologist] cannot be considered [the HMO’s] agent because . . . he is an independent  
4 contractor hired by an autonomous Plan Medical Group, not [the HMO].” (*Id.*)

5 The import of *Hollister* is that the Knox-Keene Act simply does not reach providers who  
6 have no contractual relationship with an HMO, who, in other words, are not directly involved  
7 with “the health care service plan business.” (Health & Safety Code § 1341(a); *accord Ochs*, 115  
8 Cal.App.4th at 795 (“Generally speaking, a health care service provider’s agreement to pay for  
9 medical care is intended to benefit the enrollees, not treating physicians with whom there is no  
10 contractual relationship. Under ordinary circumstances, noncontracting health care providers  
11 such as *Ochs* would be only incidental beneficiaries of a contractual agreement to pay for an  
12 enrollee’s medical care”).) This point is underscored by the very provisions the DMHC cites as  
13 supposed illustration that the Knox-Keene Act applies to providers. (*See* Opposition brief at 29.)  
14 All of the provisions cited by the DMHC – Sections 1379, 1371.25, 1381(a) and 1371.1 – govern  
15 when there is a contractual relationship between a provider and an HMO. They do not apply to  
16 non-contracted providers who have no relationship to an HMO.

17 The DMHC has not cited one regulation or provision of the Knox-Keene Act that imposes  
18 obligations on non-contracted providers<sup>2</sup> because none existed prior to the Balance Billing  
19 Regulation. In fact, Section 1379 proves that the Knox-Keene Act does not reach noncontracted  
20 providers. The statute prohibits balance billing by *contracted* providers and has been interpreted  
21 not to reach, and in no way limits, the right of a noncontracted provider to balance bill. (*See*  
22 *Ochs*, 115 Cal.App.4th at 796 (“We observe, however, that section 1379 appears only to limit  
23 ‘balance billing’ of insured patients by physicians who have contracted with the patients’ plans.  
24 [The non-contracted provider] may have a remedy against the individual patients, and those  
25 patients a remedy against [their HMO]”).)

26 \_\_\_\_\_  
27 <sup>2</sup>Section 1371.39, discussed more at length *infra*, does not create any *obligations* on non-  
28 contracted providers. It in fact creates no obligations on anyone except the reporting obligations  
of the DMHC.

1           *California Medical Ass'n v. Lackner*, 124 Cal.App.3d 28 (1981), upon which the DMHC  
2 heavily relies, is unavailing. At issue there was a Department of Health Services (“DHS”)   
3 regulation that imposed requirements (with threat of sanctions) on hospitals when obtaining   
4 informed consent for human sterilizations. (*Id.* at 33.) The regulation also provided that   
5 noncomplying physicians be reported to the Medical Board. (*Id.*) The plaintiff argued that   
6 DHS’s authority to license hospitals does not extend to regulating the doctor-patient relationship   
7 and the practice of medicine, which includes matters of informed consent. Furthermore, the   
8 plaintiff argued in *Lackner* that DHS’s assertion of rule-making authority over informed consent   
9 invades the responsibility of the Medical Board. The *Lackner* court disagreed and held that there   
10 was no jurisdictional conflict. (*Id.* at 40.)

11           *Lackner* is a red-herring and amounts to a straw man that the DMHC has set up to easily   
12 refute an issue that does not exist in this case. Petitioners did not cite *Lackner* and in no way rely   
13 on the arguments that were asserted in that case. Petitioners do not contend that the DMHC has   
14 usurped the jurisdiction of the Medical Board through the Balance Billing Regulation. The   
15 jurisdictional contention Petitioners assert is more direct: the Knox-Keene Act (the sole Act from   
16 which the DMHC’s authority arises) does not reach a noncontracted provider’s relationship with   
17 an HMO enrollee and accordingly does not empower the DMHC to prohibit a practice between   
18 the noncontracted provider and the patient, not an HMO. On this point, the DMHC has given no   
19 adequate rebuttal.

20           Indeed, it would be illogical to accept that the DMHC has the authority to regulate non-   
21 contracting providers given its official position with respect to the contracting medical groups and   
22 other risk-bearing organizations that actually pay and administer claims on behalf of the health   
23 plans themselves, such as the members of *amicus* CAPG. According to the DMHC, “HMOs   
24 contract with approximately 240 risk-bearing organizations (RBOs) which actually deliver or   
25 manage a large portion of the health care services to consumers.”<sup>3</sup> Even though these RBOs   
26

27 <sup>3</sup>See [www.dmhc.ca.gov/providers/gen/gen\\_default.asp](http://www.dmhc.ca.gov/providers/gen/gen_default.asp). The statement goes on to state: “Plans   
28 provide about 50% of the revenues to RBOs to provide health care.”

1 (otherwise known as medical groups or IPAs) are, in essence, responsible for fulfilling health  
2 plan functions, including paying the claims of treating providers, the DMHC admits that it does  
3 not regulate them directly. The DMHC's "Frequently Asked Questions" guide on its website  
4 concerning claim payment problems states as follows:

5 What if I have a problem with a medical group?

6 While the Department *does not regulate* medical groups, you may  
7 report problems with a medical group using the methods described  
8 above, if the medical group is the payer. If you report a problem  
9 regarding a medical group, *we will monitor the organization*  
10 *through the health plans with which it contracts.* (Emphasis added.)

11 Thus, in the DMHC's own words, the most it has authority to do with RBOs acting as the  
12 payor of claims is to monitor them *through* the health plan, not take any direct enforcement  
13 action. This logic necessarily extends to non-contracted providers as well, who obviously are not  
14 health plans and do not fall within the reach of the Knox-Keene Act.

15 **IV. THE BALANCE BILLING REGULATION IS FACIALLY INVALID**  
16 **INSOFAR AS IT APPLIES TO NONCONTRACTED PROVIDERS**

17 **A. Section 1371.39 Does Not Authorize The DMHC To Unilaterally**  
18 **Define Balance Billing As An Unfair Billing Pattern**

19 **1. The haphazard history of the DMHC's attempts to**  
20 **prohibit balance billing undermines the DMHC's**  
21 **argument that AB 1455 unambiguously provided it with**  
22 **the authority to prohibit balance billing**

23 AB 1455, the statute that the DMHC claims to be implementing in promulgating the  
24 Balance Billing Regulation, became law in 2000. Section 1371.39 is one part of AB 1455 and  
25 required the DMHC to "report back" to the Legislature and the Governor on or before December  
26 31, 2001, with recommendations with respect to unfair billing patterns.

27 The DMHC failed to report back by December 31, 2001, or apparently ever. In fact, the  
28 DMHC appears to have taken little interest in taking action with respect to "unfair billing  
patterns" until July 25, 2006, when the Governor issued Executive Order S-13-06, which among  
other things, directed the DMHC to "[t]ake all steps necessary to protect Californians from  
balance billing, including the full and complete enforcement of existing regulations and the  
promulgation of additional regulations to further protect Californians from balance billing, if

1 necessary.” (See Exhibit 2 to Respondents’ Request for Judicial Notice.)

2 In response to this Executive Order, the DMHC issued emergency regulations to prohibit  
3 balance billing. These regulations were withdrawn. The DMHC subsequently initiated three  
4 rulemaking actions to prohibit balance billing. These also were withdrawn. These unsuccessful  
5 attempts to promulgate regulations to prohibit balance billing are noted in the Initial Statement of  
6 Reasons for the current regulation:

7 This rulemaking action relates to and replaces prior rulemaking  
8 actions on the same subject, which were withdrawn. Two prior  
9 rulemaking actions, entitled Claims Settlement Practices, Control  
10 #2006-0782 and Unfair Billing Patterns, Control #2006-0777,  
11 respectively, were withdrawn on August 17, 2007. A subsequent  
12 rulemaking action entitled Plan and Provider Claims Settlement  
13 Practices, Control #2007-1253, was withdrawn on March 28, 2008.

14 (See Petitioners’ Exhibit DD, Initial Statement of Reasons, at RMF000020.)

15 In the unsuccessful rulemaking Control # 2006-0777, the DMHC’s proposed section  
16 1300.71.39(a) (an earlier version of the Balance Billing Regulation) provided, “Unfair billing  
17 patterns and practices as defined in Section 1371.39 and this section are prohibited.” (See Notice  
18 of Proposed Rulemaking Action and Proposed Text for Control #2006-0777, attached as Exhibit  
19 10 to Petitioners’ Supplemental Request for Judicial Notice.) The DMHC retreated from this  
20 position, and is now taking the position that all it is doing is defining balance billing as an unfair  
21 billing pattern rather than prohibiting balance billing or unfair billing patterns in its current  
22 regulation.

23 In the unsuccessful rulemaking Control #2007-1253, the DMHC proposed to establish a  
24 minimum “expedited payment” equal to 150% of Medicare, that an HMO would be required to  
25 pay an out-of-network provider if billed charges were disputed. This protection for out-of-  
26 network providers is not part of the current regulation. (See Proposed Text for Control #2007-  
27 1253, attached as Exhibit 11 to Petitioners’ Supplemental Request for Judicial Notice.)

28 In its Initial Statement of Reasons for the Balance Billing Regulation, the DMHC states,  
“This rulemaking action is intended to further implement, interpret, and/or make specific Health  
and Safety Code Sections 1367(h), 1371, 1371.35, 1371.39 and 1371.4.”

However, in other venues, the DMHC has taken the position that Health and Safety Code

1 Section 1379 prohibits balance billing by non-contracted out-of-network providers.

2 Section 1379 provides, in pertinent part, as follows:

3 (a) Every contract between a plan and a provider of  
4 health care services shall be in writing, and shall set forth that in  
5 the event the plan fails to pay for health care services as set forth  
6 in the subscriber contract, the subscriber or enrollee shall not be  
7 liable to the provider for any sums owed by the plan.

8 (b) In the event that the contract has not been reduced  
9 to writing as required by this chapter or that the contract fails to  
10 contain the required prohibition, the contracting provider shall  
11 not collect or attempt to collect from the subscriber or enrollee  
12 sums owed by the plan.

13 Having been unable to make headway to prohibit balance billing in the rulemaking arena,  
14 in early 2007, the DMHC obtained leave to file an amicus brief in the pending case *Prospect*  
15 *Medical Group, Inc. v. Northridge Emergency Medical Group*, which was then and is currently  
16 pending before the California Supreme Court (No. S142209). The California Supreme Court has  
17 framed the issue in the *Prospect* case as follows: “Does Health and Safety Code Section 1379  
18 prohibit emergency room physicians who are not in contract with a health care service plan from  
19 ‘balance billing’ plan member patients for the balance of the physician’s fee not paid by the  
20 health care service plan or its delegate?” In the *Prospect* litigation, the DMHC has taken the  
21 position that balance billing by out-of-network providers is already prohibited by Health and  
22 Safety Code Section 1379. (See DMHC letter, attached as Exhibit 5 to Petitioners’ Supplemental  
23 Request for Judicial Notice.) If this were truly the case, then the Balance Billing Regulation  
24 would have been unnecessary and should have been rejected by the Office of Administrative Law  
25 for violation of the “nonduplication” standard of the Administrative Procedures Act. (See Gov’t  
26 Code §11349(f) (APA “requires that an agency proposing to amend or adopt a regulation must  
27 identify any state or federal statute or regulation which is overlapped or duplicated by the  
28 proposed regulation and justify any overlap or duplication.”).) The plain meaning of Section  
1379 is to prohibit balance billing by contracted network providers, and the statute is not  
applicable to non-contracted out-of-network providers. However, the DMHC’s *amicus* position  
in the *Prospect* case is inconsistent with its position in this litigation in which, as noted above, it  
does not rely upon Section 1379 at all.

1 Similarly, on June 27, 2008, the DMHC filed a complaint against Prime Healthcare  
2 Services, a hospital management company, seeking civil penalties and injunctive relief against  
3 Prime Healthcare for balance billing Kaiser enrollees for out-of-network emergency services  
4 provided by hospitals managed by Prime Healthcare. In the *Prime Healthcare* litigation, the  
5 DMHC has alleged that it has the authority to seek civil penalties and injunctive relief against  
6 Prime based on Section 1379. (*See Prime* First Amended Complaint, attached as Exhibit 1 to  
7 Respondents' Request for Judicial Notice.)

8 The DMHC is taking the position that Section 1379 unambiguously prohibits balance  
9 billing by out-of-network providers while simultaneously taking the position that Section 1371.39  
10 unambiguously gives it the authority to define unfair billing practices to include balance billing  
11 by out-of-network providers. Adding to record of the DMHC's vacillations, the DMHC removed  
12 an express prohibition of balance billing from the 2006 version of the Balance Billing Regulation.  
13 These vacillations concerning the DMHC's authority to prohibit balance billing by noncontracted  
14 providers reveals a desperate campaign to overreach beyond its jurisdiction to satisfy an executive  
15 directive without regard for the rulemaking process.

16 2. **A Comparison Between The AB 1455 Sections**  
17 **Concerning "Unfair Payment Patterns" And "Unfair**  
18 **Billing Patterns" Illustrates Why The DMHC's Attempt**  
19 **To Ban Balance Billing By "Defining" It As An "Unfair**  
20 **Billing Pattern" Must Fail**

21 Notwithstanding its previous differing justifications, the DMHC – along with its  
22 supporting *amici* parties – has now identified Sections 1344 and 1371.39 as the two statutory  
23 provisions that it claims authorize it to define balance billing as an unfair billing pattern. Section  
24 1344 reads, in pertinent part, as follows:

25 The director may from time to time adopt, amend, and rescind such  
26 rules, forms, and orders as are necessary to carry out the provisions  
27 of this chapter, including rules governing applications and reports,  
28 and defining any terms, whether or not used in this chapter, insofar  
as the definitions are not inconsistent with the provisions of this  
chapter. ...

(Health & Saf. Code § 1344(a).)

Section 1371.39 reads, in its entirety, as follows:

1 (a) Providers may report to the department's Office of  
2 Plan and Provider Relations, either through the toll-free provider line  
3 (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.

4 (b) Plans may report to the department's Office of Plan  
5 and Provider Relations, either through the toll -free provider line  
6 (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.

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

10 (2) The department shall convene appropriate state  
11 agencies to make recommendations by July 1, 2001, to the  
12 Legislature and the Governor for the purpose of developing a system  
13 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.

14 (c) On or before December 31, 2001, the department  
15 shall report to the Legislature and the Governor information  
16 regarding the development of the definition of "unfair billing  
17 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.

18 (Health & Saf. Code § 1371.39.)

19 The DMHC points to the phrase in Section 1344(a) that gives the DMHC the general  
20 discretion to define terms and the phrase in Section 1371.39(b)(1) that says that the department  
21 may define unjustified billing patterns as "unfair billing patterns" and concludes that these two  
22 sections, reviewed in isolation, allow the DMHC to promulgate a regulation defining balance  
23 billing as an unfair billing pattern. However, a court is not bound by the literal meaning of  
24 isolated words or phrases from a statute if such meaning is inconsistent with the construction of  
25 the statutory scheme as a whole.

26 The "plain meaning" rule does not prohibit a court from determining  
27 whether the literal meaning of a statute comports with its purpose or  
28 whether a construction of one provision is consistent with the other  
provisions of the statute. *The meaning of a statute may not be determined  
from a single word or sentence; the words must be construed in context,*

1        *and provisions relating to the same subject matter must be harmonized to*  
2        *the extent possible. Literal construction should not prevail if it is contrary*  
3        *to the legislative intent apparent in the statute. The intent prevails over the*  
4        *letter, and the letter will, if possible, be read as to confirm to the spirit of*  
5        *the act.*

6        (*People v. King* (1993) 5 Cal.4<sup>th</sup> 59, 69 (emphasis added).)

7        Here, the general authority to define terms contained in Section 1344 and the phrase in  
8        Section 1371.39(b)(1) that states that the department may define “unfair billing patterns” must be  
9        read in the broader context of the entirety of Section 1371.39 and AB 1455.

10       Section 1371.39 did not begin and end with defining of the term “unfair billing pattern.”  
11       In enacting Section 1371.39, the Legislature recognized that not only would the phrase “unfair  
12       billing pattern” need to be defined, but that an entire system for responding to unfair billing  
13       patterns would need to be developed for this definition to have meaning. The express idea  
14       underlying Section 1371.39 was for the DMHC to spend the first seven months of 2001  
15       convening appropriate state agencies to make recommendations to the Legislature and the  
16       Governor regarding the development of a system for responding to unfair billing patterns. The  
17       DMHC was then to spend the final months of 2001 preparing a report to the Legislature and the  
18       Governor regarding the development of the definition of “unfair billing pattern,” presumably  
19       because the Legislature had given only vague guidance as to what would constitute an unfair  
20       billing pattern (unbundling and upcoding of claims) and wanted to give the proper definition  
21       further consideration before taking legislative action. The purpose of this two-step process was to  
22       ensure that the Legislature continued to play an active role in the development of the definition of  
23       unfair billing patterns and the system for responding to providers who engaged in such patterns.

24       Not only did the DMHC disregard the explicit instructions of the Legislature found in  
25       Section 1371.39, by going out on its own and promulgating a regulation that prohibits balance  
26       billing by non-contracted providers, the DMHC usurped the authority retained by the Legislature  
27       to determine whether and, if so, how it would regulate balance billing. The DMHC took such  
28       unauthorized action seven years after missing its reporting obligations, and clearly is attempting  
29       to use Section 1371.39 in a grossly distorted manner. Nothing in Section 1371.39 is directed to  
30       the billing practices of non-contracted providers and their patients. Nothing in Section 1371.39

1 contemplates that unfair billing patterns, much less balance billing, shall be absolutely prohibited.

2 The DMHC's distorted reading of Section 1371.39 is most egregious in its statements  
3 about subdivision (b)(2), which directs the DMHC to conceive of a "system" for dealing with  
4 unfair billing patterns for the Legislature's consideration. Not surprisingly, the DMHC relies  
5 most heavily on the misinterpretation of this subdivision as justification for the Balance Billing  
6 Regulation. The DMHC argues that subdivision (b)(2), by mentioning "actions taken against  
7 providers for unfair billing patterns," is proof-positive that section 1371.39 authorizes the DMHC  
8 to prohibit balance billing. (See Opposition brief at 30:9-23.) Far from it. Subdivision (b)(2)  
9 read in its entirety clearly means that the Legislature only intended for the DMHC to consult with  
10 proper agencies and develop and conceive of a system for dealing with unfair payment patterns  
11 for further consideration by the Legislature. The Legislature also clearly intended that any  
12 conception of a "system" that is recommended to the Legislature must include a process for  
13 reporting "actions taken against providers for unfair billing patterns."<sup>4</sup> It would be a stretch  
14 beyond logic to believe that these instructions "for the purpose of developing a system for  
15 responding to unfair billing patterns" authorized the DMHC to unilaterally give itself the power  
16 to prohibit any practice that it deems is an unfair billing pattern, without any further action taken  
17 by the Legislature. Section 1371.39 establishes a planning scheme, not affirmative Legislative  
18 enactment against balance billing.

19 Likewise, a review of Section 1371.37, the provision addressing "unfair payment  
20 patterns" (the flip side of "unfair billing patterns") provides further context to bolster Petitioners'  
21 interpretation of the legislative intent underlying Section 1371.39.

22 Section 1371.37 provides as follows:

23 \_\_\_\_\_  
24 <sup>4</sup>There is an apparent typo in subdivision (b)(2), which is not relevant to this analysis. After  
25 dictating that the DMHC must "convene appropriate state agencies to make recommendations by  
26 July 1, 2001, to the Legislature and the Governor *for the purpose of* developing a system for  
27 responding to unfair billing patterns as defined in this section," the subdivision states "[t]his  
28 *section* shall include a process by which information is made available to the public regarding  
actions taken against providers for unfair billing patterns . . . ." "Section" is a typo, and the  
Legislature obviously meant to say "system" because otherwise the sentence following mention  
of the "system" would make no sense.

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

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

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

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

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

14 (3) Failing on a repeated basis to pay the uncontested  
15 portions of a claim within the timeframes specified in Section 1371,  
16 1371.1, or 1371.35.

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

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

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

24 (B) Require the health care service plan for a period of  
25 three years from the date of the director's determination, or for a  
26 shorter period prescribed by the director, to pay complete and  
27 accurate claims from the provider within a shorter period of time  
28 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

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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.

There is a marked and telling contrast between the level of detail contained in Section 1371.37, in which the Legislature (1) expressly prohibits HMOs from engaging in an unfair payment pattern, (2) identifies four types of “unfair payment pattern”, and (3) establishes penalties for engaging in an unfair payment pattern, and the level of detail contained in Section 1371.39. Notably, in Section 1371.39, the Legislature did not (1) expressly prohibit providers from engaging in an unfair billing pattern, (2) define “unfair billing pattern”, or (3) establish penalties for engaging in an unfair billing pattern. Section 1371.37 established a full blown statutory scheme for regulating and prohibiting unfair payment patterns by HMOs. By contrast, Section 1371.39 involved a vague concept of unfair billing patterns that the Legislature clearly considered needed considerable fleshing out before any definition, much less, a prohibition and penalties, became law.

The DMHC’s attempt to define “unfair billing pattern” in the absence of an express prohibition on unfair billing pattern, a defined system for responding to alleged unfair billing patterns, or express penalties for engaging in alleged unfair billing patterns is contrary to the legislative intent apparent from AB 1455. The DMHC’s adoption of only one part of what was intended to be an overall regulatory scheme to address provider billing is confusing and

1 nonsensical. Under the regulation, balance billing (and only balance billing – what happened to  
2 unbundling and upcoding?) is an unfair billing pattern, but it is entirely unclear what happens  
3 when a provider engages in balance billing. Unfair billing patterns are not prohibited by section  
4 1371.39 the way unfair payment patterns are prohibited by section 1371.37 and there are no  
5 established penalties. For these reasons, the DMHC’s Balance Billing Regulation is not only  
6 confusing, but also vague, as shown in section C below.

7           In construing statutory language, a court must consider the  
8 language in the context of the entire statute and the statutory  
9 scheme of which it is a part. The court is required to give effect to  
10 statutes according to the usual, ordinary import of the language  
11 employed in framing them. If possible, significance should be  
12 given to every word, phrase, sentence, and part of an act in  
13 pursuance of the legislative purpose. When used in a statute, words  
14 must be construed in context, keeping in mind the nature and  
15 obvious purpose of the statute where they appear. Moreover, the  
16 various parts of a statutory enactment must be harmonized by  
17 considering the particular clause or section in the context of the  
18 statutory framework as a whole.

14 (*Dubois v. Workers' Comp. Appeals Board* (1993) 5 Cal.4<sup>th</sup> 382, 288.)

15           In the full context of the entirety of Section 1371.39 and by way of comparison to Section  
16 1371.37, it is clear that the Legislature did not intend for the DMHC to simply define “unfair  
17 billing pattern” outside of a comprehensive statutory scheme to address “unfair billing patterns.”  
18 The DMHC is proposing to single out one phrase of a statute, interpret it out of context, and use it  
19 for unintended, self-serving purposes (regulating non-contract provider billing of HMO  
20 enrollees), while ignoring the remainder of the statute and the clear legislative intent.<sup>5</sup>

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24 <sup>5</sup>Apparently, the Legislature has abandoned the reliance it placed on the DMHC in section  
25 1371.39. Ignoring the DMHC, over the past few years, the Legislature has moved forward and  
26 considered and passed numerous bills that carefully regulated balance billing in manners that  
27 protected providers from the abuses by HMOs of underpayment. SB 981 is a prime example, as  
28 well as the numerous other bills Petitioners enumerated in their Opening brief at pages 18. These  
instances of actual legislative action reveals how out of touch the DMHC is with the Legislature  
when it comes to dealing with balance billing.



1           C.     The DMHC's Responses To The Vagueness Problems Are Conclusory  
2                     And Unpersuasive

3           Petitioners have presented evidence demonstrating the significant problems due to  
4           vagueness that providers' billing agents have encountered when trying to determine how they  
5           could comply with the Balance Billing Regulation. By way of summary, given the realities of  
6           billing practices, (1) providers cannot determine if the Balance Billing Regulation even applies to  
7           a given bill because there is no way to determine if the payor is a Knox-Keene product, and (2)  
8           there is no explanation in the regulation how to determine "amounts owed" by the plan. (*See*  
9           Declarations of Andrea Brault and Patrice Palmier, filed concurrently with Petitioners' Opening  
10          Brief; *see also* Declaration of Dave Fruci, filed concurrently herewith.)

11          As to the first vagueness problem, the DMHC retorts only that the Explanation of Benefits  
12          ("EOB") that payors submit with a payment provides "ample notice and clarity of whether [a  
13          provider's] patient is a health plan enrollee." (Opposition brief at 39:10-11.) There is no  
14          evidence that an EOB provides such notice. On the contrary, as Dr. Brault, Ms. Palmier and Mr.  
15          Fruci explain, EOBs do not indicate the type of product (whether Knox-Keene, a PPO, an ERISA  
16          plan or some other insurance product) that underlies the payment. Such identifying information is  
17          not relevant to, and thus not provided with, bills and EOBs. The evidence stands uncontroverted  
18          that providers cannot know whether the Balance Billing Regulation applies to a particular bill and  
19          thus would have to guess at how to comply with it.

20          The DMHC responds to the second vagueness problem in similarly conclusory fashion. It  
21          first raises the point that providers "have a direct claim for breach of implied contract and unfair  
22          business practices against the plan in the event the plan has not paid the reasonable and customary  
23          amount required by law." (Opposition brief at 39:14-16.) This is a non sequitur and utterly fails  
24          to address how a provider can determine whether, and how much of, an amount that is unpaid by  
25          a plan is still owed by the plan. The evidence Petitioners presented explains that information  
26          contained in an EOB does not provide any clues as to how or why the plan decided to pay less  
27          than the full billed amount. Without knowing the reasons for a plan's refusal to pay, providers  
28          cannot determine whether the unpaid amount is owed by the plan or whether the paid amount is

1 intended to represents the providers' reasonable and customary charges. Nothing in the Balance  
2 Billing Regulation can remedy this uncertainty. Here as well, the evidence stands uncontroverted  
3 that providers cannot comply with the Balance Billing Regulation due to its fatally vague and  
4 confusing term "amounts owed by the plan."

5 The DMHC's dismissive attitude to Petitioners' vagueness contentions, unsupported by  
6 evidence, cannot be accepted. Petitioners have presented evidence of real uncertainty and  
7 confusion caused by the Balance Billing Regulation's vagueness. The Balance Billing Regulation  
8 suffers from a constitutional defect, which alone warrants striking it down. *See Teichert*  
9 *Construction v. California Occupational Safety and Health Appeals Bd.*, 140 Cal. App. 4th 883,  
10 890 (2006) ("A statute violates due process of law if it forbids or requires the doing of an act in  
11 terms so vague that persons of common intelligence must necessarily guess at its meaning and  
12 differ as to its application . . . . [T]he prohibition against vagueness extends to administrative  
13 regulations").

14 **V. THE ONLY WAY TO HARMONIZE THE BALANCE BILLING**  
15 **REGULATION WITH THE KNOX-KEENE SCHEME IS TO INTERPRET**  
16 **IT TO BE CO-EXTENSIVE WITH SECTION 1379**

17 The DMHC correctly notes that the Court should strive if possible to interpret the Balance  
18 Billing Regulation in a manner that best comports with the purpose and scheme of the Knox-  
19 Keene Act, if the regulation is to be saved at all. (*See Allen v. Sully-Miller Contracting Co.*, 28  
20 Cal. 4th 222, 227 (2002).) By this principle, the Balance Billing Regulation can stand only if it is  
21 interpreted as being co-extensive with section 1379, and nothing more.

22 Section 1379 is the only provision of the Knox-Keene Act that affirmatively regulates  
23 balance billing for emergency care services. Unlike Section 1371.39 which imposes no  
24 prohibition, Section 1379 expressly prohibits *contracted* providers from balance billing HMO  
25 enrollees for emergency care services. The Balance Billing Regulation likewise seeks to prohibit  
26 balance billing by "providers" who provide emergency care services. It therefore closely matches  
27 Section 1379 more than any other provision of the Knox-Keene Act because, as Petitioners have  
28 shown, no other provision of the Knox-Keene Act regulates balance billing by providers.  
Accordingly, to the extent the Balance Billing Regulation could implement any provision of the

1 Knox-Keene Act, it must be interpreted to implement only Section 1379.

2 As an implementation of Section 1379, the Balance Billing Regulation must be interpreted  
3 to apply only to contracted providers of emergency care services. By its terms, Section 1379  
4 applies only to contracted providers. It does not apply to non-contracted providers, and thus does  
5 not regulate or otherwise restrict a provider's right to seek from a patient the reasonable value of  
6 his or her services in the absence of an agreement with the health plan. *See Coast Plaza Doctors*  
7 *Hospital*, 105 Cal. App. 4th 693 (holding the Knox-Keene Act is not a bar for non-contracting  
8 physician to pursue common law theories of recovery).

9 Furthermore, Section 1379's limitation to contracted providers would be consistent with  
10 the plain terms of the Balance Billing Regulation. The regulation states only that it applies to  
11 "providers," leaving no barrier to interpreting it to apply only to contracted providers, consistent  
12 with Section 1379. Interpreting such a restriction on the Balance Billing Regulation not only  
13 comports with Section 1379, but also would be consistent with the scheme of the Knox-Keene  
14 Act. As Petitioners have amply explained, the Knox-Keene Act was not intended to apply to  
15 providers who have no contractual relationship with a health plan.

16 Under the DMHC's conception of the Balance Billing Regulation, which would apply to  
17 non-contracted providers and effect a prohibition of balance billing, the Balance Billing  
18 Regulation is invalid. However, insofar as the Balance Billing Regulation can be saved at all, it  
19 must be made co-extensive with Section 1379.<sup>6</sup>

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22 <sup>6</sup>In *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et al.* (No. S142209),  
23 the California Supreme Court will soon determine whether section 1379 applies to non-contracted  
24 providers, notwithstanding its express terms limiting its reach only to "contracted" providers.  
25 This Court need not wait on a decision from the Supreme Court to hold that the Balance Billing  
26 Regulation implements and is co-extensive with section 1379. How the Supreme Court rules in  
27 *Prospect* will not affect such a holding by this Court. That is, if the Supreme Court ultimately  
28 holds that section 1379 does apply to non-contracted providers, then the Balance Billing  
Regulation too would automatically apply to non-contracted providers. On the other hand, if the  
Supreme Court holds section 1379 cannot be applied to non-contracted providers, then the  
Balance Billing Regulation too would be so limited. In either scenario, a holding by this Court  
linking the Balance Billing Regulation to section 1379 would stand unaffected.

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1 **VI. THE BETTER PUBLIC POLICY WOULD BE FOR THE DMHC TO**  
2 **REQUIRE THE ENTITIES IT REGULATES, THE HMOs, TO TAKE**  
3 **CARE OF THEIR ENROLLEES BY PAYING PROVIDERS AND**  
4 **RESOLVING ANY DISPUTES WITH PROVIDERS**

5 In support of its position that health care providers must bear the expense of fighting it out  
6 with HMOs each and every time that the HMO underpays them (the vast majority of cases), the  
7 DMHC resorts to maxims of jurisprudence that in fact support Petitioners' position. Rather  
8 callously, the DMHC suggests that an emergency care provider, one who potentially provided  
9 life-saving measures in the middle of the night with the utmost dedication and skill, who accepts  
10 an HMO underpayment "must bear the burden" of disputing that amount since "he who takes the  
11 benefit must bear the burden". (See DMHC brief, at pg. 17, Civil Code § 3526.) The problem  
12 here is that when they are underpaid, these emergency providers never got the "benefit"<sup>7</sup> and the  
13 Knox-Keene Act has shifted the burden of proper payment to the HMOs.

14 The Legislature's overriding concern about the financial stability of the emergency care  
15 system resulted in the enactment of Section 1371.4. That provision, stating in part that "a health  
16 care service plan shall reimburse providers for emergency services and care provided to its  
17 enrollees, until the care results in a stabilization of the enrollee," represents a reflection of the  
18 Knox-Keene Act's core purpose to ensure that physicians and other health care providers that  
19 care for enrollees get paid so that they can keep their doors open and provide medically necessary  
20 and often life-saving health care. This provision was sponsored by the California Chapter of the  
21 American College of Emergency Physicians and supported by CMA. At the time Section 1371.4  
22 was enacted, it was understood that the obligation imposed was to ensure that physicians and  
23 other emergency medical service providers were paid for the emergency services they provided to  
24 health plan enrollees. It is inconceivable that the Legislature intended that the statute be used by  
25 the DMHC and its licensees to *reduce* provider payment and then place the burden on them to be

25 <sup>7</sup>This is not a case where physicians are accepting the benefits of an agreement but rejecting the  
26 obligations. (See *Melchior v. New Line Productions* (2003) 106 Cal App 4<sup>th</sup> 779.) If anything,  
27 non-contracted providers "benefit" HMOs when they provide emergency care to enrollees and  
28 thus have an implied in law right to recover from HMOs for the reasonable value of their  
services. (See *Bell v. Blue Cross of California* (2005) 131 Cal App 4<sup>th</sup> 211.)

1 made whole.

2 A better approach to protecting enrollees would involve requiring that HMOs pay the  
3 billed charges as they have done in the past<sup>8</sup> and follow the blueprint mapped out by the  
4 Legislature on this matter. Any other result would actually (1) discourage HMOs from meeting  
5 their statutory obligations to have an adequate network of contracting physicians and other  
6 providers and pay for covered services (*see* Health & Saf. Code §§1345, 1367, 1371.4 and (2)  
7 encourage HMOs to rely on the EMTALA obligations of physicians and hospitals to provide  
8 emergency care.

9 For this reason, the Knox-Keene Act expressly contemplates situations where HMOs  
10 believe providers have been overpaid and grants HMOs the right to contest such overpayment  
11 actions in a full and open hearing. Section 1371.1 provides, in part:

12 Whenever a health care service plan, including a specialized health  
13 care service plan, determines that in reimbursing a claim for  
14 provider services an institutional or professional provider has been  
15 overpaid, and then notifies the provider in writing through a  
16 separate notice identifying the overpayment and the amount of the  
17 overpayment, the provider shall reimburse the health care service  
18 plan within 30 working days of receipt by the provider of the notice  
19 of overpayment unless the overpayment or portion thereof is  
20 contested by the provider in which case the health care service plan  
21 shall be notified, in writing, within 30 working days. The notice  
22 that an overpayment is being contested shall identify the portion of  
23 the overpayment that is contested and the specific reasons for  
24 contesting the overpayment.

25 This statute has been broadly written to encompass overpayments for any conceivable  
26 reason, including, but not limited to, a dispute over whether the non-contracting provider's fee  
27 was unreasonable.

28 The DMHC can and should reduce the likelihood their enrollees will receive bills for

<sup>8</sup>As recently as 2002, the DMHC found this to be the proper solution, as is set forth in the  
December 31, 2002 DMHC routine examination of PacifiCare of California that states:

[B]illed charges should be paid in full unless an arrangement exists between  
the plan and non-contracting provider to allow for a discounted payment.  
Denying a portion of the claim may result in the provider making a claim  
against the enrollee for the balance.

(*See* Petitioners' Opening Brief at 30:22-18 [fn.4])

1 emergency medical care those enrollees properly expect to be covered by their health insurance  
2 premiums, and the DMHC has an arsenal of lawful strategies it could employ. The most obvious  
3 strategy, but the one the DMHC seems reluctant to employ, is to require HMOs who receive the  
4 enrollees' premiums to pay the providers' billed charges in order to keep the enrollees out of the  
5 middle of any HMO-provider dispute.

6 While the focus of this Court should not be on the policy merits of prohibiting balance  
7 billing, because the DMHC has attacked Petitioners view of balance billing, Petitioners must, at  
8 least briefly, tell the other side of the story. As its opposition brief demonstrates, the DMHC's  
9 policy analysis focuses exclusively on the HMO market. This makes sense since it is responsible  
10 for regulating HMOs. Petitioners, on the other hand, provide services in all types of practice  
11 settings and to any patient that needs emergency services—whether or not the patient is  
12 uninsured, underinsured, insured by Medi-Cal, Medicare or an insurance product regulated by the  
13 Department of Insurance. Accordingly, Petitioners must consider and deal with the impact the  
14 Balance Billing Regulation has on the entire health care delivery system. Petitioners are  
15 sympathetic to the plight of HMO enrollees when their HMO refuses to pay for out-of-network  
16 emergency care. However, the DMHC's regulation will transfer the financial burden of paying  
17 for the emergency health care delivery system to physicians and patients (who have no-insurance  
18 or are not enrolled in an HMO), would exacerbate an already under-funded emergency medical  
19 care delivery system, and threaten patient care and access.

20 The adverse economic impact of the Balance Billing Regulation will be widespread and  
21 severe, potentially causing havoc in the entire emergency care system in California. The  
22 regulation will require physicians to accept any payment the HMO or Risk Bearing Organization  
23 unilaterally decides to make, to whom the HMO delegate emergency-care risk, and then chase  
24 HMOs or RBOs for reasonable payment. HMOs that pay more in contract rates will have no  
25 reason to continue contracting with providers and instead terminate their contracts. As the  
26 administrative record demonstrates, in payments to ER physicians alone, the regulation represents  
27 a transfer of millions in revenues from ERs and into the pockets of the HMOs. (*See* Exhibit 9 to  
28 Petitioners' Supplemental Request to Judicial Notice.) This means less resources to provide care

1 to the uninsured and patients on woefully underfunded public programs such as Medi-Cal.

2       Indeed, as the testimony and comments in the hearings on the Balance Billing Regulation  
3 demonstrate, providers are alarmed by the threat the proposed regulations pose to California's  
4 emergency care delivery system, which currently teeters at the brink of insolvency. Inadequate  
5 reimbursements are stretching ER wait times and triggering physician shortages. Sixty-five  
6 emergency rooms in California have closed in the last 10 years, and more ERs, particularly those  
7 that serve the most underserved populations, are at the brink of closure. The Balance Billing  
8 Regulation would effectively set payment rates for emergency services at an arbitrarily set  
9 amount, reduce compensation levels and result in a transfer of hundreds of millions of dollars  
10 from providers to HMOs, forcing the closure or curtailing of emergency medical services  
11 throughout the state. The DMHC could easily avoid this disastrous result by alternative  
12 regulatory means. It can, for instance, require HMOs (which it is authorized to regulate) to pay  
13 billed charges in full and then have disputes of "overpayments" subject to an independent dispute  
14 resolution system or litigation. This approach has worked in other states, such as Colorado and  
15 New Jersey. With billings paid in full, there is no need to seek any "balance" from HMO  
16 enrollees. But, instead of protecting patients in a manner that promotes access to care, the  
17 DMHC's Balance Billing Regulation protects the financial interests of the HMOs, to patients'  
18 ultimate detriment.

19       A "slow water torture" is how a California board-certified internist recently described the  
20 practice of medicine in this state when being interviewed by U.S. News and World Reports for its  
21 article, *Doctors Vanish from View*. (See Exhibit 8 to Petitioners' Supplemental Request to  
22 Judicial Notice.) This article details the phenomenon of California physicians limiting or leaving  
23 their practices altogether due to the administrative hassles and declining reimbursements from  
24 insurance companies and the corresponding inability to devote themselves to the provision of  
25 continuous, quality patient care. Yet, the Balance Billing Regulation would add even more  
26 toxicity to the environment.

27       In addition to being invalid, the regulation would:  
28

- 1       • ***Deteriorate the quality of care.*** Physicians and hospitals already have fewer resources  
2       devoted to patient care because of health plan abuses. If these providers are forced to  
3       accept low rates, the courts have recognized that “the economic realities of this scenario  
4       mean that something has to give, i.e., the level of service.” (*See HCA Health Services of*  
5       *Georgia v. Employers Health Insurance Co.* (11th Cir. 2001) 240 F.3d 822 (recognizing  
6       importance of free negotiation over contract terms).)
- 7       • ***Encourage plans to avoid their responsibility under the Knox-Keene Act to ensure***  
8       ***access to care.*** The existence of adequate contracted networks is the only proper solution  
9       to eliminating the issues raised by non-contracting providers. Allowing plans to set their  
10      own rates for non-contracted providers destroys any real chance of bargaining, and  
11      eliminates the plans' incentive to maintain contracted networks to ensure adequate patient  
12      access to medical care, especially emergency care, as the law requires.
- 13     • ***Destroy a competitive free market by arming plans with even greater market power.***  
14      The Balance Billing Regulation will only increase the already enormous market power  
15      enjoyed by the plans as they will not need to enter into good faith negotiations with  
16      physicians or hospitals, knowing that in the end, non-contracted emergency care providers  
17      must accept their low contract rates, or provide care under the EMTALA mandate and beg  
18      for payment later.
- 19     • ***Ensure the closure of Emergency Departments throughout the state.*** The Balance  
20      Billing Regulation represents a death knell to already under-funded emergency  
21      departments and will result in emergency departments closing their doors to patients  
22      needing life-saving services.
- 23     • ***Curtail, if not eliminate, the availability of anesthesiologists, radiologists and***  
24      ***pathologists at hospitals.*** Mandating that these physicians accept health plan arbitrary  
25      rates for services will result in their leaving hospital practices entirely and providing care  
26      on an outpatient basis only.
- 27     • ***Force more physicians off on-call panels.*** The extremely low rates and hassles of getting  
28      paid already make it difficult for many on-call specialist physicians to maintain a viable

1 practice. Physicians who are forced to accept even lower rates will no longer be able to  
2 provide back-up to the emergency department and still survive financially.

- 3 • **Require physicians to subsidize health plan profits.** By sanctioning the ability of health  
4 plans to underpay physicians, physicians are in effect being required to forego reasonable  
5 reimbursement to boost health plan profits that are already sky high.

6 As can be seen, contrary to what the DMHC and its supporting *amici* parties would have  
7 this Court believe, there are substantial and compelling public policy reasons why balance billing  
8 fosters protection of patients and the guarantee that their HMOs provide accessible and adequate  
9 networks of care.

10 **CONCLUSION**

11 Whether balance billing should be prohibited by the Balance Billing Regulation is a hotly  
12 contested debate in the public policy arena. But in terms of legality, the only issues that are for  
13 this Court to decide, the question is not close. The Balance Billing Regulation suffers from  
14 numerous legal shortcomings that the DMHC cannot overcome, and accordingly cannot stand.  
15 Petitioners therefore respectfully urge the Court to grant the Petition and the relief that it requests.

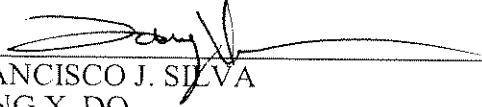
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17 Dated: November \_\_\_\_\_, 2008

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**PROOF OF SERVICE**

*CALIFORNIA MEDICAL ASSOCIATION, et al. v. DEPARTMENT OF MANAGED HEALTH CARE, et al.*  
*Sacramento County Superior Court Case No. 34-2008-80000059*

I, Pamela Gartman, declare:

I am a citizen of the United States and employed in the County of Sacramento, California. I am over the age of eighteen (18) years and not a party to the within action. My business address is 304 "S" Street, Sacramento, California 95811-6906.

I am familiar with the business practice at my place of business for collection and processing of correspondence for mailing with the United States Postal Service. Correspondence so collected and processed would be deposited with the United States Postal Service that same day in the ordinary course of business.

On November 14, 2008, I served the following document(s) described as:

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- by placing a true copy thereof in a sealed envelope with first-class postage thereon fully prepaid, in the United States Postal Service Mail at Sacramento, California addressed as set forth below.
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- by transmitting via e-mail or electronic transmission the document(s) listed above to the person(s) at the e-mail address(es) set forth below.

**Via hand delivery:**

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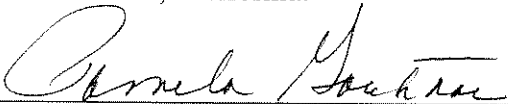
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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

Executed on November 14, 2008, at Sacramento, California.

  
\_\_\_\_\_  
PAMELA GARTMAN