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October 24, 2008

Honorable Ronald M. George, Chief Justice
and Associate Justices
California Supreme Court
350 McAllister Street
San Francisco CA 94102

**RE: *Prospect Medical Group v. Northridge Em. Med. Group,*
Supreme Court No. S142209; Ct. of Appeal Nos. B172737; B172817
*Opening Letter Brief Concerning Balance Billing Regulations***

Dear Chief Justice George and Associate Justices:

Please accept the following letter brief submitted on behalf of *amicus curiae* California Department of Managed Health Care (Department) in response to this Court's invitation to brief the relevance of the recently effective California Code of Regulations, title 28, section 1300.71.39, upon this case. The Department is uniquely qualified to respond to the Court's inquiry as it is the regulatory body charged with enforcement of the Knox-Keene Health Care Service Plan Act of 1975¹ (the Knox-Keene Act) and the author of the subject regulation.

Introduction

The primary issue presented on appeal is the proper interpretation of Health and Safety Code section 1379.² The formal enactment of Rule 1300.71.39 is highly relevant to the interpretation of section 1379 because this Court's prior opinions suggest greater deference should be afforded to the Department's interpretation of the Knox-Keene Act now that the interpretation has taken the form of a formal rule promulgated under the

¹ California Health and Safety Code, section 1340, et seq.

² Hereinafter, unless otherwise specified, all references to "section" are to sections of the Health and Safety Code, and all references to "Rule" refer to the regulations promulgated by the Department at California Code of Regulations, title 28.

Administrative Procedures Act (APA). (*Sara M. v. Superior Court* (2005) 36 Cal.4th 998, 1014; *Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 12-13.) The new Rule is pertinent because it codifies the Department's conclusion that the practice commonly known as *balance billing* is inconsistent with the Knox-Keene Act's creation of a prepaid health plan that is required to assume the full financial risk associated with emergency medical care. Thus, it is Appellants' interpretation of section 1379 which is the correct one, because only an interpretation which bans all balance billing in the context of emergency care is at harmony with the whole system of law found in the Knox-Keene Act.

The Regulation

The Department is the public entity responsible for the execution of the laws of this state relating to health care service plans and the health care service plan business. (Health & Saf. Code, § 1341.) In section 1344, the Legislature delegated to the Department the authority to make law by issuing regulations as necessary to carry out the provisions of the Knox-Keene Act. In section 1371.39(b)(1), the Legislature specifically directed the Department to further define the term "unfair billing pattern."³ The Department promulgated the Rule pursuant to the formal rulemaking process specified in the APA. (Gov. Code, §§ 11343.6 and 11346 et seq.; Department's Request for Judicial Notice (DRFJN) at Exh. A.)

In the new Rule, the Department identified the practice of *balance billing* as an unfair billing pattern.⁴ The Regulation is consistent with the other provisions of the Knox-Keene Act and is necessary to implement the Act's text and consumer protection intent. (See Health & Saf. Code, § 1342(d).) Absent co-pays and deductibles, the Knox-Keene Act requires every plan to fully cover an enrollee's emergency services, whether

³ Section 1371.39(b)(1), reads, " 'Unfair billing pattern' means engaging in a demonstrable and unjust pattern of unbundling of claims, up coding of claims, **or other demonstrable and unjustified billing patterns, as defined by the department.**" (Emphasis added.)

⁴ Subsection (a) of Rule 1300.71.39, reads, "Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services."

obtained from a network provider or not. (Health & Saf. Code, §§ 1367(i), 1345(b)(6), 1371.4(b), 1375.1.) The plan has a duty to remit payment directly to the emergency provider for all recoverable charges associated with said services. (Health & Saf. Code, § 1371.4(b); *Bell v. Blue Cross*, *supra*, 131 Cal.App.4th 211, 220.) Such a scheme can only be consistent with a prohibition on balance billing.⁵ Indeed, billing the enrollee is inconsistent with the entire concept of *prepaid* emergency health coverage. (Health & Saf. Code, § 1345(f)(1).)

The Rule was the Department's response to the ongoing crisis that balance billing represents in the health care marketplace. The effects of balance billing are so harmful to consumers, the Department was compelled to action by its legislative mandate to "protect and promote the interests of enrollees." (Health & Saf. Code, § 1341.) Providers are already entitled to full reimbursement from health plans for all reasonable charges associated with a medical emergency and have the right to seek recovery for those charges directly from the plans. (Health & Saf. Code, § 1371.4; *Bell v. Blue Cross*, *supra*, 131 Cal.App.4th 211, 219-220.) And yet providers continue to use their patients as inexpensive leverage in an effort to elicit higher payments from plans, often turning the enrollees into an additional source of revenue in the process. The providers argue vehemently in support of the practice, claiming it is the only way they can even the bargaining power between themselves and health plans. However, their argument ignores the most contemptible aspect of balance billing, which is the harm it causes to their patients, who unquestionably have far less bargaining power than either the plan *or* provider. The enrollee, when faced with collection proceedings relative to medical care for which they prepaid, is left with two miserable choices: pay a bill they do not owe, or risk severe harm to their credit while waiting for their doctor to obtain satisfaction from their health plan. With such aggressive tactics, a provider can elicit unreasonable rates, distort the market, and drive up the price of health care, all discouraging future care.

The problem does not exist in the abstract, but is very real, affecting thousands of patients in California. Recently, the Department was forced to intervene when a Southern California hospital chain balance billed as many as 6,000 enrollees as part of a campaign against a specific health plan. The provider followed those bills with

⁵ The Department specifically identified the authorities for the regulation, including: sections 1344 [right of rulemaking], 1371.39 [instruction to define "unfair billing pattern"], and 1371.4 [requires plans to reimburse non-network emergency providers at a reasonable rate (*Bell v. Blue Cross* (2005) 131 Cal.App.4th 211, 219-220)]. (Rule 1300.71.39.)

thousands of collection letters sent directly to enrollees, threatening to ruin their credit ratings if the provider was not paid its billed charges, despite the fact their health plan had already paid the provider a reasonable and customary amount for the services. (DRFJN at Exh. B.) That matter was recently stayed in anticipation of this Court's ruling on the present case, underscoring the urgency with which guidance is needed from this Court.⁶

The Impact of the Regulation on *Prospect*

While this Court consistently grants a measure of deference to an administrative construction of a statute, this Court has a tradition of according "great weight" to interpretive rules adopted in accordance with the APA. (*Sara M. v. Superior Court*, *supra*, 36 Cal.4th at pp. 1012-1014; See also *Yamaha Corp. of America v. State Bd. of Equalization*, *supra*, 19 Cal.4th at 10-14.) This deference is based upon the agency's special familiarity and expertise with the underlying law. (*Sara M.*, *supra*, 36 Cal.4th at pp. 1012-1013; *Yamaha*, *supra*, 19 Cal.4th at p. 11.) In particular, the greater degree of deference given to interpretive rules promulgated under the APA is due to the statutory procedures which are designed to enhance the accuracy and reliability of the conclusion.⁷ (*Sara M.*, *supra*, 36 Cal.4th at p. 1013; *Yamaha*, *supra*, 19 Cal.4th at p. 13.) This Court has explained that according "great weight" to an administrative construction of a legislative system means the construction "will be overturned only if it is clearly erroneous." (*Sara M.*, *supra*, 36 Cal.4th at p. 1014.) At the same time, this Court has unquestionably preferred interpretations of statutes that yield harmony with the other provisions of the subject law:

The meaning of a statute may not be determined from a single word or sentence; the words must be construed in context, and provisions relating to the same subject matter must be harmonized to the extent possible... The

⁶ Rather than rule on the Defendant's recent demurrer, on October 23, 2008, the trial court stayed the case, pending the outcome of *Prospect*. The judge explained, "it would be a waste of judicial resources and the resources of the parties to rule at his time." (DRFJN at Exh. C.)

⁷ "If an agency has adopted an interpretive rule in accordance with Administrative Procedure Act provisions--which include procedures (e.g., notice to the public of the proposed rule and opportunity for public comment) that enhance the accuracy and reliability of the resulting administrative 'product'--that circumstance weighs in favor of judicial deference." (*Sara M. v. Superior Court*, *supra*, 36 Cal.4th at p. 1013, citing to *Yamaha Corp. of America v. State Bd. of Equalization*, *supra*, 19 Cal.4th at p. 13)

intent prevails over the letter, and the letter will, if possible, be so read as to conform to the spirit of the act. [E]ach sentence must be read not in isolation but in the light of the statutory scheme; and if a statute is amenable to two alternative interpretations, the one that leads to the more reasonable result will be followed. (*Lungren v. Deukmejian* (1988) 45 Cal.3d 727, 735, citations omitted.)

The new Rule is the logical result of the same analysis employed by both Appellants and the Department, to conclude that the protections of section 1379 are triggered by contracts implied-in-law as well as contracts implied-in-fact. No other result can harmonize the prepaid nature of health plans with the requirement that those plans fully cover emergency medical care, regardless of whether that care is supplied within the plan's network of providers. (See Health & Saf. Code, §§ 1345(b)(6) [defining basic services to include emergency services], 1345(f)(1) [plan is prepaid entity], 1367(i) [plan obligated to pay for all basic healthcare services], 1371.4(b) [plan obligated to reimburse non-network emergency providers a reasonable value], 1375.1 [plan assumes full financial responsibility on prospective basis].)

In section 1342, the Legislature codified its intent with respect to the Knox-Keene Act, including the objective of “[h]elping to ensure the best possible health care for the public at the lowest possible cost by **transferring the financial risk of health care from patients to providers.**” (Health & Saf. Code, § 1342(d), emphasis added.) Respondents’ interpretation of section 1379 is in irredeemable conflict with that objective. Given the Legislature’s stated intent, taken in connection with the plain meaning of the statute, the logical implication of the legislative scheme, and the absence of evidence in support of the Respondents’ position, it follows that the “great weight” accorded to the Department’s interpretation is determinative of this case in favor of the Appellant.

The Regulation Offers No Support to the Respondents’ Case

Respondents, and the *amici curiae* supporting their position, are likely to argue the new Regulation is proof that balance billing must not have been illegal before it was issued. That argument has no merit. To grant credence to such a position would render all legislative and quasi-legislative bodies in this State impotent out of fear that their lawmaking actions could somehow be construed to invalidate older law. Such a blow to the rulemaking process would undermine the delegated legislative function held by regulatory agencies as well as the separation of powers between legislators and the courts. (See *Western States Petroleum v. Sup. Court* (1995) 9 Cal.4th 559, 572-573.) Most importantly, the new Rule and section 1379 are consistent. It is logical that a

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billing practice which is prohibited by the Legislature would properly be included within the Department's definition of unfair billing patterns. Balance billing can be prohibited by section 1379 at the same time it is an unfair billing pattern under section 1371.39(b)(1), while doing no offense to the enforceability of the other.

Conclusion

Under the constitutional doctrine of the separation of powers, the courts alone are charged with the task of statutory interpretation. Nonetheless, this Court has consistently granted great weight in matters of statutory construction to interpretive rules formally promulgated by the regulatory body charged with enforcement. Based upon such precedent, the Department respectfully requests this Court continue that practice here, and apply an appropriate measure of deference in light of the new Regulation.

Respectfully Submitted,



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in Support of Plaintiffs/Appellants

HAB:avb

cc: See attached Proof of Service

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CASE NAME: *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*

CALIFORNIA SUPREME COURT CASE NUMBER: **S142209**

ENFORCEMENT MATTER NO.: **06-164**

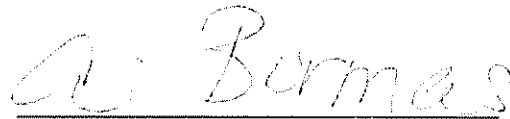
I Aviva Burmas declare, I am employed in the County of Sacramento, California; I am over the age of 18 years, and not a party to the within action; my business address is 980 Ninth Street, Suite 500, Sacramento, California 95814-7243. I am readily familiar with my employer's business practice for collection and processing of correspondence for mailing with the United States Postal Service and Fed Ex Delivery. On October 24, 2008, following ordinary business practice, I served the within:

**OPENING LETTER BRIEF CONCERNING BALANCE BILLING
REGULATIONS BY AMICUS CURIAE, CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE, IN SUPPORT OF
PLAINTIFFS AND APPELLANTS**

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AVIVA BURMAS
Legal Secretary

SERVICE LIST

Prospect Medical Group, Inc. v. Northridge Emergency Medical Group

California Supreme Court Case No. S142209

**OPENING LETTER BRIEF CONCERNING BALANCE BILLING
REGULATIONS BY AMICUS CURIAE, CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE, IN SUPPORT OF
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