No. S 142209
(Court of Appeal Nos. B172737, B172817)
(Los Angeles County Super. Ct. Nos. BC 300850, SC076909)

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

PROSPECT HEALTH SOURCE MEDICAL GROUP, ET AL.
***Plaintiff and Appellant*,**
v.

NORTHRIDGE EMERGENCY MEDICAL GROUP,
***Defendants and Respondents*.**

After Decision By the Court of Appeal,
Second Appellate District, Division Three

AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF DEFENDANTS AND RESPONDENTS

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I. INTRODUCTION

The way Appellants paint the picture, the multibillion dollar managed care industry is the victim in this case. They would like this Court to believe that this industry is being held hostage by "greedy" physicians, and should receive the sympathy that would be given to a helpless dying patient on a hospital gurney. This fiction, however, has nothing to do with reality.

With their tremendous market power and attendant aggressive business practices, health plans are making more and more money each year, but continue to reduce the percentage of revenue they spend on health care by, among other things, dictating unfair reimbursement terms to physicians.[1] But this is not a case just about money. With these unfair payment tactics, patients are being hurt. Fair and prompt physician payment is a crucial prerequisite to fulfillment of the Knox-Keene Act's promise of accessible quality of care as physicians must be paid appropriately to protect the public interest in a viable health care delivery system. *See, for example,* Health & Safety Code §1371 (requiring prompt payment) and other authorities cited below.

Treating physicians are extremely dedicated to their patients and go to great lengths to provide necessary medical care, even when health plans refuse to meet their payment obligations. But un- and under-reimbursement cannot continue forever, and there are already signs that even primary care physicians can no longer take it. They, like many of their specialist colleagues, are dropping out of managed care plans altogether, creating access problems for patients. *See* Carnahan, Sandra J., *Law Medicine, and Wealth: Does Concierge Medicine*

[1] Bethely, Jonathan, *Health Plans Make More, Spend Less in 2005,* AMNews, March 6, 2006, www.ama-assn.org/amednews/2006/03/06bisd0306.htm.

Promote Health Care Choice, or Is It a Barrier to Access? (2006) 17 Stan.L.&Pol'yRev. 121, and numerous studies cited below.

As is discussed below, there are numerous avenues that the health plans can and should pursue to protect patients from billing disputes. But, the relief sought in this case, prohibiting physicians providing often life-saving emergency medical services who have no contract with the health plan from looking to the patient for the unpaid balance of their reasonable fee does nothing more than provide health plans with the "carte blanche" ability to underpay physicians. This is not the solution to protecting patients. Indeed, to the contrary, allowing plans to dictate unilaterally what non-contracted physicians providing emergency services receive would:

- ***Encourage plans to avoid their responsibility under the Knox-Keene Act to ensure access to care.*** The existence of adequate contracted networks is the best solution to eliminating the concern that insured patients will receive a bill they do not expect. Allowing health plans to set their own rates for non-contracted physicians destroys any real chance of bargaining, and eliminates the plans' incentive to maintain contracted networks to ensure adequate patient access to medical care, especially emergency care, as the law requires.

- ***Deteriorate the quality of care.*** If health plans can rely on emergency departments to provide care, they will not be incentivized to keep their patients healthy at the outset. Further, physicians already have fewer resources to devote to patient care because of health plan abuses. If physicians are forced to accept unreasonably low rates, the courts have recognized that "the economic realities of this scenario mean that something has to give, i.e., the level of service." *See HCA Health Services*

of Georgia v. Employers Health Insurance Co. (11th Cir. 2001) 240 F.3d 982 (recognizing importance of free negotiation over contract terms).

- ***Destroy even the vestiges of a competitive market by arming plans with even greater market power.*** Granting Appellants' request for relief will only increase the already enormous market power enjoyed by the health plans. They will not need to enter into good faith negotiations with physicians, knowing that in the end, non-contracted emergency care physicians must accept their unreasonably low contract rates, or provide care under the EMTALA mandate and beg for payment later.

- ***Ensure the closure of Emergency Departments throughout the state.*** As is discussed in more detail in the Amici Curiae brief of the emergency physician professional organizations, further underfunding would provide the death knell to already cash-strapped emergency departments and will result in even more emergency departments closing their doors to patients needing life-saving services.

- ***Curtail, if not eliminate, the availability of anesthesiologists, radiologists and pathologists at hospitals***. Mandating that these physicians accept health plan arbitrary payments for services will result in their leaving hospital practices entirely and providing care on an outpatient basis only.

- ***Force more physicians off on-call panels***. The extremely low rates and hassles of getting paid already make it difficult for many on-call specialist physicians to maintain a viable practice. Physicians who are forced to accept even lower payments will no longer be able to provide back-up to the emergency department and still survive financially.

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

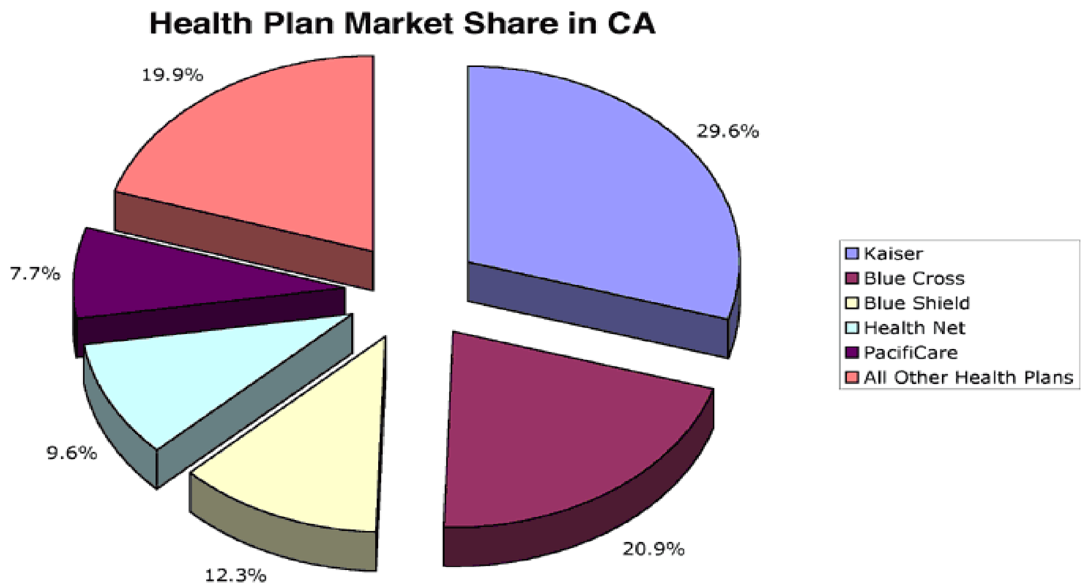
II. HEALTH PLANS, NOT PHYSICIANS, HAVE CREATED AN ENVIRONMENT FRAUGHT WITH PROBLEMS FOR BOTH PATIENTS AND PHYSICIANS

A. Health Plans in California Already Have Tremendous Market Power

Given the mergers, acquisitions and conversions over the last two decades, HMO market concentration is extremely high, removing basic fairness and healthy competition from the environment. Indeed, according to the 2005 update to the AMA comprehensive study of U.S. markets entitled, *Competition in Health Insurance*,[2] it is "unequivocal that physicians across the country have virtually no bargaining power with dominant health insurers and that those health insurers are in a position to exert monopsony power." The report continues that, "In 280 of the 294 markets surveyed, one health insurer accounts for at least 30 percent of the combined HMO/PPO market." According to the report, California's largest plan (outside of the non-profit Kaiser system), Blue Cross, had far in excess of what was considered dominant, with 47% of the PPO market and 14% of the HMO market. (*Id.* at 14.)

Based on data from the DMHC, in California, just five companies control 80% of the HMO market, with Blue Cross having significantly more market share than estimated by the AMA.

[2] *See* www.ama-assn.org/ama/pub/category/9573.html.



Outside the Kaiser Permanente system, where the physician members of the Permanente Medical Groups have a significant voice, these plans have enormous market strength in their dealings with physicians—and they have used it.[3] Indeed, as will be discussed further below, these plans have engaged in unfair, abusive and illegal practices that have caused, and will continue to cause, severe hardships for physicians and their patients throughout the state. It is little wonder that a study conducted in California concluded that, generally speaking, the larger the HMO penetration, the fewer medical specialists there are to treat patients. *See* Brown, et al., *Do Physicians Always Flee from HMOs? New Results Using Dynamic Panel Estimation Methods* (April 2006) HSR: Health Services Research 41:2.

[3] None of these comments pertain to the Kaiser health plan, which in conjunction with the Permanente Medical Groups, operates with a different model than that used by the other health plans doing business in California.

B. High Health Plan Profit Levels Are Maintained at the Expense of Patient Protection and Physician Availability

1. Plan Profits Soar

At a time where patient access to care is becoming severely constrained, physician payment problems are increasing, contracting abuses remain rampant and the emergency medical system is on the verge of collapse, (*see* discussion below) health plans are making record profits. Consider the following summaries of California's Wall Street HMO Superstars:

> In 2003, California HMOs had net income (after taxes and including investment income) of $2.195 billion, or 3.5 percent of revenues of $62.3 billion. That compares to net income of $827.1 million in 2002, or 1.6 percent of revenues of $51.5 billion, and represents the highest profits for California HMOs in at least the past decade. HMO profitability has improved for the past three years. In the five years from 1999 through 2003, California HMOs had net income of $5.048 billion. Some of the large HMOs had consistently strong earnings from 1995 to 2003.
>
> *California Health Care Market Report 2005 (www.chcf.org)*
>
> *Allan Baumgarten for the California HealthCare Foundation, September 2005*

> "Last year, the top seven U.S. health insurers earned a combined $10 billion -- nearly triple their profits of five years earlier. The windfall came as insurers raised their prices faster than underlying health costs."
>
> *Wall Street Journal, July 31, 2006*

> "The nation's HMOs reported a $6.98 billion profit for the first six months of 2005, representing a $1.2 billion, or 21.2 percent, increase over the $5.76 billion earned during the same period in 2004, according to Weiss Ratings, Inc., the nation's leading independent provider of ratings and analyses of financial services companies, mutual funds, and stocks. Despite a slowdown in earnings growth, industry profitability remains strong. With premium rate increases leveling off, insurers will look for more innovative cost control measures to remain competitive and financially secure.
>
> *Weiss Ratings Study, January 2006 (www.weissratings.com)*

2. Plans Are Spending Less on Medical Care

Yet as health plans are making more, they are spending less on medical care. The medical cost ratio (or medical *loss* ratio, the industry's surprisingly forthright term reflecting its true view of the provision of medical services) is the key number for measuring health plan "success"—the level of profitability. That ratio is the percentage of dollars these companies spend on health care, including physician reimbursement. Knox-Keene regulations require that no more than 15% of premium revenues go to non-health care related expenses. (28 C.C.R. §1300.78.)[4]

This vital law to ensure that premiums go to where they are intended is being routinely and seriously violated. For example, for the fifth year running, Blue Cross of California (the largest health plan outside of the Kaiser system) has spent less than 80% of premium dollars on patient care, with 21% going to profits and administration. *See* CMA's 13th Annual Report examining health plan expenditures, a copy of which can be found at http://www.cmanet.org/upload/knox_keene_06.pdf. Indeed, where the health plans delegate payment responsibilities to risk bearing organizations (RBOs), the plans themselves should incur lower administrative costs to account for the administrative costs of the RBO. Unfortunately, that is not necessarily the case. Indeed, Appellant Prospect Medical Group itself also spends substantially less than 85% of its revenue on medical care as is shown from its SEC filing:

[4] Unfortunately, not only does the Department fail to enforce the law as written, but it interprets the law in a manner that overwhelmingly favors the financial interests of the for-profit health plans—the DMHC excludes health plan profits from its calculations when determining the medical loss ratio. Not only has that interpretation insulated the health plans from regulatory scrutiny, by excluding profits the DMHC has improperly skewed the law to give preferential treatment to for-profit plans, since non-profits are bound by the 15% cap on administrative and other non-health care related costs, but for-profits are not.

Medical Loss Ratio	2001	2002	2003(1)	2004(2)	2005
	75.6%	74.2%	71.8%	80.6%	78.9%

See Prospect Medical Holdings, Inc. 2005 SEC 10-K Annual Report.

3. Physician Income Has Declined

Eliminating any doubt as to the managed care industry's dominant power, in the face of the record profits health plans are enjoying, physician income is declining. According to a study recently released by the Center for Studying Health System Change, between 1995 and 2003, average physician net income from the practice of medicine declined about 7% after adjusting for inflation. *See Losing Ground: Physician Income, 1995-2003*, Tracking Report No. 15 (June 2006), Center for Studying Health System Change, a true and correct copy of which may be found at http://www.hschange.com. The report notes that flat or declining fees from both public and private payors are the major factor underlying the declining incomes for physicians, and that even though private insurers are not subject to budgetary constraints as is the Medicare program, the trend for "private insurer payments to physicians has lagged even more." (*Id*. at pp. 4-5.) This downward trend in incomes is likely an important reason for growing physician unwillingness to undertake charity care, *id*., a phenomenon in and of itself which will cause even further strain on the emergency system. *See also* Carnahan, Sandra J., *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice or Is It a Barrier to Access?* 17 Stan.L.&Pol'y.Rev. (2006) 121, 127, observing, "Data from the American Academy of Family Physicians (AAFP) show that the mean yearly income before taxes of family physicians decreased 12.4% or $20,000 between 1995 and 2003."

C. Knox-Keene Laws Promoting Enrollee Access Are Being Defeated Through Inadequate Networks, Unfair Contracting and Poor Reimbursement Practices

The focus of the DMHC's jurisdiction under the Knox-Keene Act is health care service plans. Health & Safety Code §1345(f) defines a "health care service plan" as, in part:

> Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

With California's adoption of the Knox-Keene Act, the Legislature intended that health plans deliver and patients actually receive quality medical care. (Health & Safety Code §§1341, 1342; *see also* Health & Safety Code §1367, stating that all services must be readily available at reasonable times to each enrollee, consistent with good professional practice.) This requirement goes to the heart of the Act—without access to physicians, patients are unable to receive medically necessary and potentially life-saving services.

1. Inadequate Networks

To ensure access, regulations governing health plans mandate that there be "a complete network of contracting or plan-employed primary care physicians and specialists each of whom has staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide." (28 C.C.R. §1300.51(c)(H)(iii).) This obligation extends to emergency services. (*Id.*) The DMHC itself recognized that "the provider network is the most crucial component of the plan's health care delivery system" and that "changes in a plan's provider reimbursement strategies necessarily result in fundamental changes to a plan's delivery model and operations." *See* DMHC brief in *California Hospital Association v. Blue Cross of*

California Los Angeles Super. Court, No. BL 353609 (condemning Blue Cross's policy providing for higher physician payment for endoscopic procedures being performed in less expensive out-patient settings without giving the Department the ability to determine first whether the policy jeopardized patient care).[5]

a. Patients Are Experiencing Difficulties Accessing Care Generally

Unfortunately, studies are uncontroverted that enrollees are having trouble accessing care due to inadequate networks. Because of health plan administrative hassles and poor payment practices, health care professionals and other providers are dropping out of managed plans altogether, leaving enrollees with limited, if any, access to care. *See Proportion of U.S. Physicians Without Any Managed Care Contracts Ticks Up* (May 4, 2006) Tracking Report No. 14, Center for Studying Health System Change, a true and correct copy of which is found at http://www.hschange.com/content/838/. Undoubtedly because of the aggressive behavior of these plans in California, physicians in the West have by far the largest rate of non-participation (14.8%) than in any other region in the country. (*Id.*) As the contracts become increasingly unfair, more physicians refuse to sign. (Carnahan, Sandra J., *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice or Is It a Barrier to Access?* 17 Stan.L.&Pol'y.Rev. 121 (2006), *supra*, (Being buried in paperwork, fearing disagreements with plans over appropriate care, losing income, and having too little time to spend with patients have led many physicians, but primary care physicians in particular, to leave managed care altogether). (*Id.*)

[5] If, in fact, out-of-network physicians are treated the same as in-network physicians, as Appellants would like to see, then this statement would make no sense as there would be no need for "networks," let alone reimbursement strategies that impact those networks.

Independent studies confirm the problems patients are having accessing care in California due to inadequate networks. For example, evidence from the past four years shows that patients are having tremendous difficulties just getting seen by an appropriate physician. Despite the law requiring that health plans have an adequate number of physicians in their panels:

- In 2002, researchers at the University of California, San Francisco found that only 58% of physicians and specialists reported accepting new patients covered by HMOs, thereby “effectively limiting access to care for many Californians.”[6]

- In 2004, the Department of Managed Health Care reported in its annual report (the most recent one available) that nearly 42% of its urgent complaints related to access/referral issues. *See* www.dmhc.ca.gov.

- In 2005, an “Access to Doctors” survey published by Consumer Reports found that some of California’s largest HMOs rated "worse," Many respondents who suffered serious medical conditions reported difficulty finding care. *See* www.consumerreports.org.

- In 2005, U.S. News & World Report ranked 257 plans nationwide. California’s for profit plans were ranked in the bottom half, in general, and with respect to access, mostly scored with the lowest or second lowest rating. *See* www.usnews.com.

Not surprisingly, due in part to the fact that insured patients are facing longer waiting times for appointments with physicians (most likely due to insufficient networks), there has been an increase in emergency department use by the insured in some communities. *See* Cunningham, *What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities* (July 18, 2006) Health Affairs. In California, lack of access to routine and immediate medical care is a key driver of emergency department use.

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[6] *See* Grumbach, et al., *California Physicians 2002: Practice and Perceptions* (December 2002) Center for the Health Professions, University of California, San Francisco. *See* www.futurehealth.ucsf.edu/CWI/Phass2.html.

See Overuse of Emergency Departments Among Insured Californians, California Healthcare Foundation, October 2006, www.chcf.org.

b. Patients Are Experiencing Increasing Problems at Emergency Departments

The emergency medical system is already strained and will only collapse if there is even further license for health plans to continue to underpay for the emergency medical services provided daily to their enrollees. CMA will not repeat the unassailable evidence presented by the emergency physician professional organizations on the impact of what Appellants seek on the emergency system. With fewer, less well-staffed emergency departments, patients will experience even longer waits, increased crowding, and diversion to ever more distant hospitals. Of necessity, the quality of care they receive will decline even more.

Another significant problem is ensuring that emergency departments have an adequate panel of on-call physicians to handle those medical emergencies that are beyond the capability of the emergency department. According to the California Healthcare Foundation, approximately 1/4 of all visits to an emergency department requires the involvement of a specialist—a total of more than 2.5 million potential consults each year. *See On-call Physicians at California Emergency Departments: Problems and Potential Solutions,* January 2005, California Healthcare Foundation. Unfortunately, fewer physicians are taking call, and a major reason cited for this phenomenon is inadequate reimbursement. Call problems related to lack of payment include orthopedics (75%); general surgery (57%); ENT (44%); and OB/Gyn (39%). (*Id.* at p. 3.) *See also Stretched Thin: Growing Gaps in California's Emergency Room Backup System*, California Senate Office of Research (May 2003), stating, "Problems with access to emergency

room on-call services . . . are adversely impacting the quality of patient care . . . and are primarily the result of problems with reimbursement." www.sen.ca.gov/.)

In 2003, the Senate Office of Research presented to California's Legislature a comprehensive study of the hospital emergency department on-call coverage issue, as required by A.B.2611 (Stats. 2000, Ch. 828). (http://sinet2.sen.ca/sor/reports/REPORTS_BY_SUBJ/HEALTH/AB2611.pdf. This study warned three years ago that, due principally to reimbursement problems, fewer and fewer medical specialists were willing to take call and at the same time, more and more specialists were leaving not only managed care networks, but also the practice of medicine altogether (or at least in this state). Rather than accept the recommendations of the Senate Office of Research—the legislative body charged with convening a working group of affected California stakeholders to address the issue, the Appellants seek to go in the opposite direction by reducing reimbursement and increasing administrative hassles even further.

If such relief is granted, it is difficult to assess how much further plans will lower their payments for emergency medical services, but we know that plans look at other payors' rates to **reduce** what they pay, and that few physicians can afford to pursue underpayments of $37.19 or less.[7] Given the California Healthcare Foundation's estimate of 2.5 million consults a year, a per claim reduction of $37.19 alone would result in a transfer of over $90 million per year from on-call physicians to health plans. A loss of this magnitude would cause on-call specialists to:

- limit or curtail their on-call availability;
- stop participating in managed care plans;

[7] The $37.19 figure represents the average amount billed patients in the HealthNet Consent Decree proceeding, discussed below.

- limit the provision of charity care;
- retire or otherwise leave the practice of medicine.

Unfortunately, the net effect of the health plans' overreaching behavior impacts every Californian—whether covered by a Knox-Keene plan or not. Not only does the exodus of physicians from managed care plans increase patients' out-of-pocket costs,[8] as was recently observed by the California Healthcare Foundation, as their frustration with medical practice grow, physicians are:

> …slowing down, relocating, or leaving practice altogether.

See On-call Physicians at California Emergency Departments, California Healthcare Foundation (January 2005) www.chcf.org.

California cannot afford to lose more doctors because of plan misbehavior. As was recently stated by the Association of American Medical Colleges in its April 2006 study entitled, *Recent Studies and Reports on Physician Shortages in the U.S.*:

> The University of California, Office of Health Affairs, and the University of California Health Sciences Committee commissioned a report on California's physician workforce conducted by the University of Albany's Center for Health Workforce Studies. The report concludes that "growth in physician demand is likely to outpace growth in physician supply by between 4.7% and 15.9%." The population of California is growing rapidly which will place great strains on the healthcare delivery system and the physician workforce. More than one-fourth of the state's practicing physicians were over the age of 55 in 2000. In addition, the state has a mal-distribution of physicians with 60% of the current physicians practicing in only five counties.

(www.aamc.org/workforce/rentwrkfce.pdf.)

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[8] Short, et al., *Provider Network Instability: Implications for Choice, Costs, and Continuity of Care,* Center for Studying Health System Change (June 2001) No.39.

2. Unfair Contracts

To promote the existence of a complete network, the Act requires that contracts with physicians be "fair and reasonable." (Health & Safety Code §1367.) Assuming the contracting environment is fair, physicians decide to enter into plan contracts for a number of reasons. For example, in return for the promise to accept as payment in full a pre-negotiated (or at least disclosed) discounted fee from the plan, physicians contracting with plans receive benefits such as patient steerage and referrals, advertising, easier payment (freedom from the cost of collection/bad debt associated with collecting from patients), access to certain other networks, and sometimes exclusive provider status. *See HCA Health Services of Georgia v. Employers Health Insurance Co.* (11 Cir. 2001) 240 F.3d 982 (stating: "We cannot imagine that even a poorly represented [provider] entity would promise to discount its fees in return for nothing.").

"Fair and reasonable" contracting by and large does not exist in California. Despite Health & Safety Code §1367's requirement that contracts with providers be "fair and reasonable," they are far from it. Plans in California enjoy enormous bargaining power, leaving physicians with the inability to negotiate fair and reasonable contracts as the law demands. Many physicians must take these contracts on a "take it or leave it basis" as a practicable matter to be able to provide care to their patients. However, as the discussion above demonstrates, they are increasingly being forced to say no. Despite their deep commitment to their patients, physicians are increasingly finding it impossible to provide appropriate medical care under the fiscal and procedural constraints these contracts impose. Physicians are greatly frustrated by and should not be forced to make such Hobson choices.

3. Inadequate Payment

Once contracted (and even if not contracted) the Legislature understood the need for physicians to be paid fairly and promptly so that there is a stable environment for patients to access care.[9] For that reason, the Legislature enacted a plethora of laws in response to unfair plan payment practices to prevent abuse and promote physician practice viability. *See,* for example, Health & Safety Code §§1371 (prompt payment); 1371.1 (due process for overpayment of claims); 1371.2 (same); 1371.35 (emergency services claims); 1371.36 (prohibitions on denial of payment); 1371.37 (unfair payment patterns); 1371.4 (payment for emergency services); and 1371.8 (prohibited rescission of modification of authorization.)

a. Poor Payment Practices Proliferate

Poor payment practice issues proliferate and only add to unduly high administrative costs for physicians. *See, for example,* DMHC Quarterly Claims Settlement Practices Report Summary, www.dmhc.ca.gov/psc/otresp.pdf. Despite the Legislature's enactment of A.B.1455 (Stats. 2000 Ch. 827) to address widespread payment abuses engaged in by health plans, unfair payment practices have not ceased. Indeed, in the last year alone, CMA has gone to the Department on numerous occasions to complain about such unfair practices as:

- unfairly and unlawfully recouping payments from physicians;
- paying claims late and refusing to pay interest
- denying payment after providing prior authorization for the service;

[9] The courts similarly recognize the imperative for providers to get paid fairly and promptly for the health care system to survive. *See Doctor's Medical Laboratory, Inc. v. Connell* (1999) 69 Cal.App.4th 891, 898 (Medi-Cal); *see also Ameri-Medical Corporation v. W.C.A.B.* (1996) 42 Cal.App.4th 1260 (workers' compensation).

- pending claims indefinitely pending the receipt of information from third parties;
- forcing physician office staff to wait on hold endlessly for assistance.

These complaints were supported by concrete examples of abuse consisting of approximately 1,000 pages.[10]

b. DMHC Enforcement Is Insufficient

Unfortunately, neither the law itself nor the DMHC's implementation of what law exists to protect physicians from unfair payments is adequate. Physicians have found that appealing to the health plans themselves to be burdensome, costly and futile. The DMHC's Provider Complaint Program does not address individual complaints, but rather looks "for patterns or systemic problems." *See* www.dmhc.ca.gov/providers/gen/gen_faq.asp. Only **once** has the DMHC taken action against a plan for underpaying physicians and, as the following summary confirms, that enforcement action neither made the physicians whole nor imposed a sanction sufficient to deter further wrongdoing.[11]

The Department did fine HealthNet for failing to correctly reimburse emergency room providers of medical care. However, a review of that case and its ultimate outcome demonstrates the extent of health plan abuse that is allowed to occur in California's regulatory environment. In that case, HealthNet acknowledged that it failed to pay correctly on approximately 65,000 claims for emergency services. (According to the consent agreement, HealthNet had paid

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[10] No DMHC enforcement action has been taken to address these concerns.

[11] What the DMHC now belatedly proposes to do through the regulatory process, albeit unlawfully, is to establish yet another costly after the fact dispute resolution mechanism that similarly places the onus on physicians rather than the managed care industry the DMHC is charged with regulating.

these claims at a rate that was equal to 80% of the Medicare value—a level that indisputably is not reasonable.)[12] The fine imposed was token at best, a mere $250,000. This means that for each of the 65,000 claims wrongfully paid, HealthNet was required to pay less than $3.85 for each violation of the law. Certainly, this amount cannot be deemed sufficient to deter wrongdoing, and will be treated as if it is nothing more than a cost of doing business in this state.

In its press release on this enforcement action, the DMHC stated that $6-7 million would be due physicians as a result of the underpayment of the 65,000 claims. However, the consent decree did not require that HealthNet locate those physicians that it underpaid and pay them appropriately. Rather, it placed the burden on physicians themselves to submit claims, along with appropriate documentation, demonstrating their entitlement to the payment. Since the vast majority of these physicians lacked the time or resources to engage in further administrative hassles to secure the payment they should have received in the first place, particularly where the cost of making the second submission equaled or exceeded the potential recovery, this apportionment of the burden was very unfair.

Not surprisingly, most of the aggrieved physicians were not made whole. In the final report submitted by HealthNet to the Department of Managed Health Care on December 30, 2005, HealthNet received a mere 2,628 claims, and processed adjustments totaling slightly more than $670,000—a far cry from the $6 or $7 million figure the DMHC advertised. ***Indeed, even when combined with the fine, HealthNet walked away from this illegal activity netting over $5 million in ill-gotten gains.*** Compared to the massive losses that physicians endured in that case, it is also noteworthy that the average amount of "balance billing" to a

[12] The relevant documents for this proceeding can be found in the DMHC's website at www.dmhc.ca.gov.

patient to recover HealthNet's underpayment as reported in the final report was $37.19.

c. Poor Payment Practices Increase a Physician's Administrative Costs

Where a health plan engages in poor or abusive payment practices, the value of the un- or underpaid claim is not the only money at stake. Those physicians who have not just given up chasing after health plan underpayments spend untold hours and dollars in time and administrative costs in their efforts to obtain what is justly due them. In fact, average administrative costs for physicians related to billing and insurance-related functions in California is 14%. (Khan, et al., *The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals.* Health Affairs, Vol. 24, No. 6 (2005).)

Under these circumstances, any system that places physicians in the position of appealing many of their claims destabilizes the system. First and foremost, even appealing a claim to the health plan itself, as opposed to a court, is extremely expensive. For example, National Healthcare Exchange Services, Inc., an independent health care management firm, estimates that it costs an average of $22 to appeal each claim.[13] These costs barely cover the expenses to appeal internally with the plan, and are just a fraction of what it takes to go to court. Yet, given that the health plans themselves are the ultimate decisionmakers in these internal appeals and often still fail to remit what is lawfully due to physicians, physicians' only real option to obtain fair payment is to go to court. This is a prohibitively expensive undertaking just to secure fair payment.

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[13] Based on its survey of clients, underpayments by commercial health plans average 9% of paid claims. Where a claim is underpaid, the average dispute amount is $32.

D. Strong Legal and Ethical Prohibitions Already Exist Against Excessive Physician Fees

The vast majority of physician bills are reasonable and the courts presume them to be reasonable as a matter of law. See *Southern California Edison, Co. v. W.C.A.B.* (2000) 65 C.C.C. 100, 101 (stating, "the court assumes any bill presented by medical professional is one they believe and assert is reasonable. If defendant does not agree, defendant can offer proof of unreasonableness.") Indeed, even the Office of the Inspector General of the Department of Health and Human Services believes that the vast majority of physicians are honest.[14]

Regrettably, there are a few bad apples in every profession. However, there are a plethora of remedies available to punish physicians who charge excessive fees. These remedies go well beyond a health plan's right to recover the amount of any excessive payment. (Health & Safety Code §1371.1.)

1. Laws Prohibiting Fraud

Both federal and California law contain a number of strong mechanisms to eradicate excessive charges and other forms of fraud. Federal law contains a number of criminal and civil sanctions against providers who commit fraud. *See, for example*, 42 U.S.C. §1320a-7b (prohibiting, among other things, excessive charges and false claims submitted to federal health programs). There is now a specific federal offense for health care fraud that has been interpreted to extend to fraud against private third party payers, not just federal health care programs. *See U.S. v. Baldwin* (D.D.C. 2003) 277 F.Supp.2d 67. California too has a number of anti-fraud provisions, which can result in imprisonment (e.g., Penal Code §550). Courts have ruled that Penal Code §550 can also be enforced privately by insurers

[14] *See* OIG Compliance Program Guidance for Individual and Small Group Physician Practices, Federal Register (2000), Vol. 65, No. 194.

alleging fraud. *See People ex rel. Allstate Insurance Co. v. Muhyeldin* (2003) 112 Cal.App.4th 604.

Further, the Medical Board of California (MBC), the regulatory body that licenses and disciplines physicians, is vested with statutory authority to punish bad actors. For example, any physician who knowingly presents or endorses a false insurance claim has committed unprofessional conduct and is subject to disciplinary action by the MBC, including the suspension or revocation of a physician's license. (Business & Professions Code §2273.) Business & Professions Code §810 similarly authorizes the revocation or suspension of a physician's license if the physician engaged in conduct prohibited under the fraud provisions of the Insurance Code or the Penal Code. Additionally, the Fraud Division of the Department of Insurance has been mandated to pursue aggressively all reported incidents of possible fraud, and forward to the Medical Board the name of any physician who is convicted of engaging in fraudulent activity. *See* Insurance Code §1872.85. The Medical Board is required to designate employees to investigate and report on possible fraudulent activities by physicians relating to workers' compensation, motor vehicle or disability insurance, and to report yearly to the legislative insurance committees the number of cases investigated and forwarded to the Fraud Division and the outcome of all cases (Insurance Code §1872.95). Finally, pleading guilty to a misdemeanor in a Medi-Cal or Medicare fraud case can result in a physician's automatic suspension from both programs, and may lead to disciplinary action from the MBC.

2. Laws Protecting Patients

Further, there are statutory protections specifically for patients. If a third party payor makes a duplicative payment subsequent to payment made by the patient, the physician has a duty to refund the overpaid amount to the patient.

(Business & Professions Code §732.) Specifically, if the patient has not requested the refund, within 90 days of the date when the physician discovers, or should have discovered, the receipt of the duplicate payment, the physician must notify the patient of the duplicate payment. Within 30 days of that, the physician must refund the overpaid amount. If, on the other hand, the patient brings the overpayment to the physician's attention and requests a refund, the overpayment must be refunded within 30 days following the request if the duplicate payment has already been received. If the duplicate payment has not yet been received at the time of the patient's request for refund, the refund must be made within 30 days of receipt of the duplicate payment.

3. Ethical Prohibition Against Excessive Fees

In addition, AMA Ethics forbid physicians from charging an excessive fee. AMA Ethical Opinion E-6.05 provides, in part:

> A physician should not charge or collect an illegal or excessive fee.

In light of all these legal and ethical restraints, physicians voluntarily take a number of steps to ensure their billings are appropriate, through such measures as the maintenance of compliance programs and retention of billing and coding experts. In fact, CMA has specifically designed a tool for physicians to use in this regard entitled "*ACT SMART*, *Strategies for Physician's Offices to Avoid Billing Coding Problems*. In addition, a number of CMA's component medical societies operate grievance committees which are designed to resolve disputes over physician fees, consistent with extensive FTC guidance on how this activity must be conducted to comply with the antitrust law. Finally, physicians routinely take

into account a patient's financial hardship, and voluntarily reduce their fees in appropriate cases.[15]

III. EXISTING LAW PROHIBITS A BAN ON BILLING PATIENTS[16]

A. The DMHC Has No Jurisdiction to Regulate Physicians Who Have No Contracts with DMHC Licensees

The DMHC simply has no jurisdiction to regulate non-contracting physicians. Again, the DMHC's jurisdiction extends only to "health care service plans," that is:

> Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

See Health & Safety Code §1345(b).

Physicians, licensed and under the disciplinary authority of the Medical Board of California, who have no contracts with licensed health plans, cannot be considered plans and therefore the DMHC has no nexus to regulate them, either directly or indirectly.

Indeed, it would be ludicrous to argue that the DMHC has the authority to regulate non-contracting providers given its official position with respect to the contracting medical groups and other risk-bearing organizations that actually pay and administer claims on behalf of the health plans themselves, such as Appellant

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[15] Significantly, this year California's Legislature examined the issue of patient billings and opted not to ban patient billing by physicians and other providers, but rather required that hospitals disclose their discount and charity policies. *See* A.B. 774 (Chan) Stats. 2006, ch. 755.

[16] CMA adds these legal points to illustrate further the impropriety of Appellants' arguments and fully supports the compelling legal analysis by Defendants and Respondents.

Prospect Medical Group. According to the DMHC, "HMOs contract with approximately 240 risk-bearing organizations (RBOs) which actually deliver or manage a large portion of the health care services to consumers."[17] Even though these RBOs (otherwise known as medical groups or IPAs) are, in essence, responsible for fulfilling health plan functions, including paying the claims of treating providers, the DMHC admits that it does not regulate them directly. The DMHC's Frequently Asked Questions concerning claim payment problems states as follows:

> What if I have a problem with a medical group?
>
> While the Department does not regulate medical groups, you may report problems with a medical group using the methods described above, if the medical group is the payer. If you report a problem regarding a medical group, we will monitor the organization through the health plans with which it contracts.

Thus, the best the DMHC can do with the actual payer of claims is to monitor it through the licensed health plan. Under these circumstances, Section 1379 cannot be interpreted to extend to non-contracted physicians.

B. Existing Knox-Keene Provisions Authorize Non-Contracted Physicians to Bill Enrollees

Any relief purporting to prohibit non-contracted physicians from billing enrollees would be inconsistent with the Knox-Keene Act, as its statutory provisions and implementing regulations are replete with authorizations for non-contracted physicians to bill enrollees for services provided, including those provided in an emergency context.

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[17] *See* www.dmhc.ca.gov/providers/gen/gen_default.asp. The statement goes on to state: "Plans provide about 50% of the revenues to RBOs to provide health care."

For example, the Knox-Keene Act, as well as the DMHC regulations, recognize the status of non-contracting providers and the fact that enrollees may be required to incur added financial liability if a non-contracting provider's services are utilized. HMOs must identify to the Department of Managed Health Care each physician and group that provides covered services as "contracting providers" to the plan. (28 C.C.R. §1300.52(b)(k).) Health plans must also, upon request, provide a list of contracting providers within an enrollee's general geographic area. (Health & Safety Code §1367.26.) Further, the Knox-Keene Act requires that each plan disclose to the public, subscribers and enrollees, in readily understood language, information regarding benefits, services and terms of the plan contract including, information concerning "the nature and extent of choice permitted [under the plan] and the financial liability that is, or may be, incurred by the subscriber, enrollee, or third party by reason of the exercise of that choice." (Health & Safety Code §1363.) The plan's evidence of coverage must further include a statement to the effect that in the event that the health plan fails to pay a non-contracting provider, the member may be liable to the non-contracting provider for the cost of service. (28 C.C.R. §1300.63.1(b)(15).) *See also* Health & Safety Code §1394.2 recognizing billing of patients by non-contracted physicians.

While we will not detail each and every one of the Knox-Keene provisions dealing with non-contracting providers, and the rights accorded to them, the Legislature has enacted a number of laws with respect to the issue of billing by non-contracted providers for services rendered. Continuity of care laws provide for completion of a reasonable transition for covered services by a terminated or non-contracted participating provider. *See* Health & Safety Code §§1373.95 and 1373.96. As can be seen, these provisions, consistent with the interpretation of the

medical community (as well as the DMHC), recognize that non-participating providers cannot be obligated to accept whatever the plan dictates.

Even for emergency services, the Knox-Keene Act recognizes that it is lawful for non-contracted physicians to bill enrollees. For example, the Legislature expressly recognized that enrollees can incur costs in connection with out of plan emergency or urgent circumstances, and thus required plans to promptly reimburse enrollees for those costs where they have been found by an independent medical review organization to be medically necessary. (Health & Safety Code §1374.34.) Further, "to protect patients with health benefits coverage from being billed in the event of a dispute" between a non-contracting hospital and plan, the Legislature enacted a law designed to ensure that non-contracting hospitals contact an enrollee's health plan under certain circumstances. *See* Health & Safety Code §§1262.8, 1371.4. Billing patients for post-stabilization care only is prohibited, and only then where the non-contracting hospital fails to make the contact. (*Id.*) While the Legislature intended to protect patients from billing disputes, it did not prohibit billing by non-contracted providers for emergency services, or even billing for post-stabilization services if the health plan failed to take over the responsibility for the patient after notification.

Where the Legislature did limit billing of patients for non-contracted emergency services, it expressly said so. For example, Health & Safety Code §1367.11 expressly prohibits non-contracted medical transportation providers from billing enrollees until they receive payment from the plan. Once plan payment is received, the provider may "demand payment from the enrollee" for any unpaid balance. Had the Legislature intended to impose a similar limitation, let alone an absolute prohibition as the Appellants seek, it no doubt would have done so. (*People v. Cole* (2006) 38 Cal.4th 964 (Legislature did not authorize

plans to violate the law so broadly where only limited exception in Knox-Keene was enacted).)

C. A Ban on Billing Conflicts with *Bell v. Blue Cross*

Further, a ban on billing patients would be inconsistent with the most recent and citable Court of Appeal opinion on this issue—*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, reaffirming one of the basic tenets of California common law since its inception—the right of a party providing services without a contract to be paid for the reasonable value of his or her services—and opining that allowing a plan to unilaterally set rates, as the Appellants request, would be unconstitutional, aside from being unconscionable. *See also Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693 (non-contracting health care providers have a right to seek reimbursement directly from health plan under certain circumstances and Knox-Keene Act does not preclude lawsuit seeking reimbursement based on breach of contract theories and unfair competition law, Business & Professions Code §17200).

D. A Ban on Billing Patients Violates the Federal Antitrust Laws

Ensuring that markets remain competitive is a core value of our country. Rivalry between companies for customers is the key component to any competitive market and is at the heart of our economic, and ultimately political, freedom. Competition ensures that resources are allocated efficiently and that economic output reflects the demands of consumers.

The antitrust laws are designed to protect consumers and other market participants from the practices that reduce output or result in prices that are not determined by the free play of market forces. While the antitrust laws are typically implicated by the actions of privately owned companies, the most enduring and harmful anticompetitive practices are those demanded by

governments. Recognizing this fact, courts routinely condemn anticompetitive practices that are demanded by state laws. While the U.S. Supreme Court has occasionally upheld a state's decision to override the federal antitrust laws, it has done so only in carefully circumscribed situations, noting that "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful …" *Parker v. Brown* (1943) 317 U.S. 341, 351.

Recognizing the crucial importance of a free market, "state action immunity" from the federal antitrust laws is disfavored. (*FTC v. Ticor Title Ins. Co.* (1992) 504 U.S. 621, 636.) States are authorized to substitute a regulatory system for market-place competition only where the state has made a clear determination that the anticompetitive acts actually further the state's interests, and then engages in ongoing supervision to make sure that the conduct continues to further the state's economic policy. (*Id.*)

The relief sought, if granted, will have many anticompetitive effects. Overall, it will destroy the pricing mechanism for physician emergency room services, and give health plans the unilateral power to set whatever price they deem appropriate for those services. Further, it will also eliminate any competition between health plans with respect to the payment of emergency room services provided by non-network providers.

The relief Appellants seek gives significant market power to health plans to the detriment of physicians and, more importantly, patients. Further, it does not provide any effective state oversight over the actions of these plans, and does not take responsibility for displacing competition. Accordingly, it would fail under both elements of the state action immunity doctrine. First, the California Legislature has nowhere "clearly articulated and affirmatively expressed" a policy to grant health plans to right to extract what are essentially monopoly rents from

physicians providing emergency services to patients who have paid health plans to insure them against the cost of those services. (*California Rental Liquor Dealers Assn. V. Medical Aluminum, Inc.* (1980) 445 U.S. 97, 105.) If anything, the California Legislature has expressed the opposite intent. Health & Safety Code §1367 (DMHC has no authority to establish rates) and §1371.4 (health plans must reimburse providers for emergency services and care provided to its enrollees).

Second, the relief sought does not provide for the "active state supervision" necessary to ensure that the anticompetitive activity is indeed furthering the State's economic policy. (*Id*.)

As the U.S. Supreme Court has pointed out:

> Where prices or rates are set as an initial matter by private parties, subject only to a veto if the state chooses to exercise it, the party claiming immunity must show that state officials have undertaken the necessary steps to determine the specifics of the price-fixing or rate-setting scheme. The mere potential for state supervision is not an adequate substitute for a decision by the state.

(*FTC v. Ticor Title Insurance Co*., 504 U.S. at 638.)

Without such supervision, the potential for private parties to take improper advantage of the protection from market forces the state has granted is simply too high. To use the U.S. Supreme Court's language:

> The active supervision requirement stems from the recognition that where a private party is engaging in the anticompetitive activity, there is real danger that he is acting to further his own interests, rather that the governmental interests of the state.

(*Patrick v. Burget* (1988) 486 U.S. 94, 100-101.) A ban on patient billing is nothing more than an invitation for already market dominant health plans to take further advantage of physicians and patients.

California simply cannot, consistent with the Sherman Act, delegate monopoly price-setting power to private health plans in the absence of a statute clearly expressing the California Legislature's determination that it is the policy of the state to grant this power, coupled with a regulatory system ensuring the rates paid by these health plans "have been established as a product of deliberate state intervention." (*FTC v. Ticor Title Insurance Co.* 504 U.S. at 634.) The existence of after the fact appeals to regulatory bodies or the courts does not meet this test. (*Id*. at 638.)

E. A Ban on Billing by Non-Contracting Physicians Would Violate the Constitution

A holding by the Court that California law prohibits billing by non-contracted physician would raise serious constitutional issues in a number of respects.

1. Unlawful Delegation

First, the relief sought would result in the unlawful delegation to a private entity of the ability to decide how much to pay for emergency services, no matter how unreasonable that fee is. It is up to the Legislature to make the fundamental policy determination that non-contracting physicians be bound to seek payment from health plans, and if it does so, to establish a constitutional payment system. *See Wilkinson v. Madera Community Hospital* (1983) 144 Cal.App.3d 436 (stating, in order to avoid an unlawful delegation of its authority, Legislature must first resolve truly fundamental issues and must then establish an effective mechanism to assure proper implementation of its policy decisions). Here, the Legislature has done neither.[18]

[18] Thus, this situation is entirely different from the federal Medicare context, where Congress has imposed significant price controls on non-participating providers in order to protect both the public fisc and the elderly

Allowing private entities to exercise legislative power violates basic democratic principles of representative government by conferring legislative powers on entities not accountable to the people. As more and more constraints are imposed on government resources, this issue is becoming increasingly important as agencies, such as the DMHC, search for new ways to accomplish regulatory duties by privatizing more regulatory functions.

The United States Supreme Court renounced the delegation of public functions to a private entity in *Carter v. Carter Coal Company* (1936) 298 U.S. 238, 80 L.Ed. 1660. In *Carter*, the Court rejected the constitutionality of the Bituminous Coal Conservation Act which, among other things, delegated power to fix maximum hours of labor and minimum wages to producers and miners. The Court held these provisions unconstitutional as an unlawful delegation of public power. The Court held that this is "legislative delegation in its most obnoxious form; for it is not even delegation to an official or an official body, presumptively disinterested, but to private persons whose interests may be and are often adverse to the interests of others in the same business." (*Id*. at 311.)

The Court's hostility towards this delegation of powers to financially interested persons went so far as to reject the suggestion that its review should focus upon actual bias. Rather the Court invalidated such delegations as per se violations of due process. As the *Carter* court stated:

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participating in a public health program. Thus, the case cited by Appellants in their Response Brief, *Valley Hospital v. Kroll* (2003) 847 A.2d 636, expressly noting that California adopted legislation banning balance billing in the Medicare Supplement area pursuant to federal law, is irrelevant to the question posed. Here, the Legislature has been completely silent on the issue of how much non-participating providers in private health plans should be paid. Thus, it has established no mechanism to assure proper implementation of its non-existent policy decision.

> The difference between producing coal and regulating its production is, of course, fundamental. The former is a private activity; the latter is necessarily a governmental function, since, in the very nature of things, one person may not be entrusted with the power to regulate the business of another, and especially of a competitor. And a statute which undertakes to confer such power undertakes an intolerable and unconstitutional interference with personal liberty and private property. The delegation is so clearly arbitrary, and so clearly a denial of rights safeguarded by the due process clause of the Fifth Amendment, that it is unnecessary to do more than refer to decisions of this Court which foreclose the question.

(*Id*. at 311.)

The dangers inherent in private delegation are particularly acute in this case. As has already been demonstrated above, a competitive environment does not exist between physicians and health plans, and physicians have no level playing field with the very few plans that dominate and rule California's marketplace.[19] Given the fact that there is not even the slightest hint of underlying fairness (such as rates being set through a collective bargaining process), the unconstitutionality of the delegation is manifest. *See Kugler v. Yochum* (1968) 69 Cal.2d 371, 71 Cal.Rptr. 687 (ordinance decreeing that fire department salaries should be no less than the average of those of the adjoining county was not an unlawful delegation of legislative power where a competitive market existed due to fair bargaining that occurred between labor and the employer).

2. The Relief Would Constitute Improper Rate-making

Further, if this Court were to rule that non-contracting physicians were prohibited from billing patients for the reasonable value of their services, there are no standards established by Health & Safety Code §1379 or any other standards or

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[19] Further, granting these plans the ability to set low rates in the absence of appropriate oversight would only further skew the already unfair playing field in favor of the health plan monopsony in California.

regulations to ensure a fair and reasonable return, and thus, such a ruling would potentially deprive physicians of protected liberty and property rights.

The taking clause limits the power of states to regulate, control or fix prices that consumers are charged for goods or services. *See Twentieth Century Insurance Company et al. v. Garamendi* (1994) 8 Cal.4th 216, 32 Cal.Rptr.2d 807. The critical question under this constitutional provision is whether the rate set is just and reasonable. (*Id*. at 292.) As the court stated:

> If it is not just and reasonable, it is confiscatory. (*Ibid*.) If it is confiscatory, it is invalid. (*Ibid*.) "It is the result reached, not the method employed which is controlling." (Citations omitted.) (*Id.*)

Thus, the goal of a proper rate making system is to avoid effectuating a taking in the first place. (*Id*. at 278.)

A requirement that physicians either accept the discounted rates offered by health plans in adhesion contracts, or in the event the physician decides not to agree to the health plan's terms, whatever a health plan in its uncontrolled discretion decides to be reasonable, unconstitutionally subjects non-contracting physicians to potentially confiscatory rates, as there are no procedures whatsoever at the outset to ensure prompt rate relief. If plans and other payors are entitled to unilaterally set provider rates in the absence of some “meeting of the minds,” there is no assurance that the physician’s fee would be fair and reasonable, as California law has long demanded. *See Bell v. Blue Cross* (2005) 131 Cal.App.4th 211, 31 Cal.Rptr.3d 683 at 695 (stating, Blue Cross’s interpretation that it could set potentially confiscatory rates, ‘aside from being unconscionable, would be unconstitutional.’) Indeed, even before *Bell*, under the principles set forth in *CalFarm Insurance Co. v. Deukmejian* (1989) 48 Cal.3d 805, any restriction against billing patients by non-contracting physicians is violative of the Constitution in the absence of procedural safeguards ensuring adequate payment.

In *CalFarm Insurance Co., supra,* the court reviewed the constitutionality of Proposition 103—a 1988 voter-approved ballot initiative that created a new system for the regulation of insurance rates in California. Among the schemes involved was a "temporary regulatory regime," whereby a rate reduction and freeze on increases was implemented for a one-year period. The court explained that the rate rollback requirement "would be facially invalid because [it would be] confiscatory if rate adjustments necessary to avoid confiscation were not available for individual insurers." The court recognized that to be constitutional, price controls must provide "a just and reasonable return" and that whether a regulation produces a return that is "confiscatory or fair depends ultimately on the results." The court therefore would "focus less on the rates specified in the statute than on the ability of the seller to obtain relief if that rate proves confiscatory." (*Id*. at 816.) Put another way, what was important to the court was whether the seller would have an adequate remedy for relief from confiscatory rates. The *CalFarm* court concluded that the scheme at issue generally was valid as it provided procedures for adjustment of insurance rates, which included application to the Insurance Commissioner, an opportunity to seek interim relief, a hearing in accordance with the California Administrative Procedure Act, and judicial review. (*Id*. at 824-826.) Thus, even where the law provides for a "reasonable fee," there must be safeguards in place to ensure a just amount is received.

The relief sought fails to seek such safeguards and under these circumstances, if granted, would be unconstitutional.

IV. HEALTH PLANS HAVE MANY OPTIONS FOR PROTECTING PATIENTS FROM BEING BILLED FOR EMERGENCY SERVICES

The Legislature's overriding concern about the financial stability of the emergency system resulted in the enactment of Health & Safety Code §1371.4. That provision, stating in part that "a health care service plan shall reimburse

providers for emergency services and care provided to its enrollees, until the care results in a stabilization of the enrollee," represents a reflection of the Knox-Keene Act's core purpose to ensure that physicians and other health care providers that care for enrollees get paid so that they can keep their doors open and provide medically necessary and often life-saving health care. This provision was sponsored by the California Chapter of the American College of Emergency Physicians and supported by CMA.

Everyone at the time Health & Safety Code §1371.4 was enacted understood that the obligation imposed was to ensure that physicians and other emergency medical service providers were paid for the emergency services they provided to health plan enrollees. There is simply nothing in the legislative history of Health & Safety Code §1371.4 to suggest it was intended to supplant the right of non-contracted providers of emergency services to bill the patient who received those services. It is inconceivable that the Legislature intended that the statute be used by the DMHC and its licensees to *reduce* provider payment.

Health plans can and should reduce the likelihood their enrollees will receive bills for emergency medical care those enrollees properly expect to be covered by their health insurance premiums, and these plans have an arsenal of lawful strategies they could employ, if they truly wanted to protect patients. For example, they could maintain robust contracted provider panels, as the law requires. If patients in fact had sufficient access to primary and specialty care, emergency admissions would be reduced. Further, if plans contracted with a sufficient number of physicians providing emergency services, the likelihood that a patient would receive emergency services from a non-contracted physician would be small.

Further, plans can and should keep their enrollees who nonetheless receive emergency services from non-contracted providers "out of the middle" by paying

the amount charged or, if the plan thinks the charge is too high, either negotiating a lower charge, or paying the bill as submitted and then seeking to recover any overpayment as the law permits. (*See* Health & Safety Code §1371.1.) 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:[20]

> Billed 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 www.dmhc.ca.gov.

This solution is consistent with that recommended by California's Senate Office of Research following its extensive analysis mandated by the Legislature of the problems with California's on-call system. (*Id.*)

In addition, the health plans themselves could support their own urgent care centers, or even separately staff emergency departments so long as patients are treated equally. *See* 64 Fed.Reg. 217, Nov. 10, 1999.

Finally, the health plans can certainly indemnify their enrollees when they fail to pay emergency care providers directly.

The suggestion that the managed care industry in California is being held hostage by non-contracted physicians is simply not true.

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[20] In addition to those already pointed out by Respondents, this is yet another example of how the DMHC is taking different positions with respect to this issue.

V. CONCLUSION

For the foregoing reasons, Amicus Curiae urges that the lower court's opinion be affirmed.

Dated: December 20, 2006

Respectfully submitted,
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By:________________________
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Certification Under Section 14 of the California Rules of Court

I, Catherine I. Hanson, am an attorney at law licensed to practice before all courts of the State of California. I am Counsel of Record for amicus curiae herein, the California Medical Association. I hereby certify that the word counting feature on the computer word processing program with which this brief was written indicates that the actual text of this brief, excluding the cover page and addresses of counsel, the Table of Authorities, the Table of Contents, this certification, and the Proof of Service, is 9480 words.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my knowledge and that this Declaration was executed on December 20, 2006 in San Francisco, California.

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Catherine I. Hanson