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SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

CALIFORNIA MEDICAL ASSOCIATION, et al. ,

Petitioners & Plaintiffs,

v.

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

Respondents & Defendants.

Case No. 34-2008-80000059

PETITIONERS' OMNIBUS RESPONSE TO THE AMICUS CURIAE BRIEFS OF THE CALIFORNIA ASSOCIATION OF PHYSICIANS GROUPS AND KAISER FOUNDATION HEALTH PLAN, ET AL.

Assigned for All Purposes:
Hon. Michael Kenny
Dept. 31

DATE: November 21, 2008
TIME: 9:00 A.M.
DEPT. 31
Action Filed: September 26, 2008

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INTRODUCTION

Having sided with the Department of Managed Health Care ("DMHC") and all other HMOs on the balance billing debate, *amici* California Association of Physicians Groups ("CAPG") and Kaiser Foundation Health Plan *et al.* ("Kaiser Health Plan") (collectively, "*Amici*") would have this Court believe that, given their "provider" roles, they only wish to protect their enrollees from alleged "*in terrorem*" provider billing practices. Like the DMHC, *Amici* push for an absolute ban of balance billing in emergency care, contrary to the nuanced approaches the Legislature has taken. No doubt *Amici* can contribute, and have contributed, to the policy debates concerning balance billing; but their proffered analyses concerning the *legality* of the Balance Billing Regulation is off-point and unpersuasive.

These *Amici* come before the Court not to provide helpful legal analysis, but to root for a policy-oriented result – *i.e.*, validating the DMHC's campaign to apply a meat-axe rather than a scalpel to address balance billing in emergency care. It is important to air out each *Amici*'s motivations for seeking this result, which as Petitioners will show, is not based only on a desire to protect patients but rather also on greater financial motives identical to those of the HMOs. When it comes to balance billing, these *Amici* stand in the same shoes as HMOs and thus stand to financially benefit just like HMOs under the Balance Billing Regulation. Their opinions therefore must be put in their proper context. Petitioners note this to emphasize that, although *Amici* may have the interests of enrollees in mind, just like providers of life-saving emergency care, there is a difference in opinion as to the best solution to the balance billing issue. Much more work needs to be done *before the Legislature*, but as to the issues before this Court concerning the legality of the Balance Billing Regulation, *Amici* are simply wrong.

I. *AMICI* PRESENT A DISTORTED AND INCOMPLETE INTERPRETATION OF SECTION 1371.39[1]

Amici ignore and fail to address most of the legal contentions Petitioners have presented demonstrating that the Balance Billing Regulation must be struck down. They focus on one legal issue – whether the DMHC has authority to promulgate the regulation – and, like the DMHC, rely

[1]Unless otherwise indicated, all statutory references are to the Health and Safety Code.

generally on the powers of the DMHC to define provisions of the Knox-Keene Act and, more specifically, upon Health & Safety Code section 1371.39 and its enacting bill, AB 1455.

Petitioners explained in their Reply brief that section 1371.39 cannot bear the weight for which the DMHC and *Amici*'s interpretation demands. Petitioners incorporate by reference, as if fully set forth herein, the discussion and arguments in their Reply brief at pages 18 through 29 relating to AB 1455 and section 1371.39. By way of summary, a plain and complete reading of section 1371.39 and AB 1455 reveals that the Legislature did not intend for the DMHC to issue any regulations defining balance billing as an unfair billing pattern. Nor did the Legislature intend that balance billing be prohibited outright as the Balance Billing Regulation does. These points are evident by the stark differences between section 1371.39 and section 1371.37 (relating to unfair payment patterns by HMOs). That is, section 1371.37 establishes a comprehensive statutory scheme, including full definitions, a clear prohibition against unfair payment patterns and statutory penalties. Section 1371.39, on the other hand, includes none of these important details and instead establishes planning scheme.

As the DMHC's arguments based on section 1371.39 fail, *Amici*'s same arguments based on this statute also fail.

II. AMICI'S PRIMARY INTERESTS IN A PROHIBITION ON BALANCE BILLING ARE NOT TO PROTECT ENROLLEES

Both *Amici* stress that they represent providers and, by urging a ban on balance billing, both *Amici* claim they are acting in the best interests of their enrollees. Although *Amici*'s members do provide health care services in some contexts, with respect to the balance billing issue and in the context of this litigation, *Amici* are not motivated solely by their role as providers but also by their role as managed care payors. And when it comes to balance billing, *Amici*'s financial interests and stake in seeing balance billing forever outlawed are the same as the HMOs.

A. CAPG Represents Risk-Bearing Organizations That Have Contractually And Legally Assumed The Role Of HMOs

CAPG members are risk-bearing organizations ("RBOs"), some of which are also referred to as independent physician associations or IPAs, who have contracted with HMOs to

functionally and legally stand in the shoes of HMOS by assuming the burdens and benefits of the managed care "bargain." The Knox-Keene Act describes RBOs as follows:

> For the purposes of this section, a "risk-bearing organization" means a professional medical corporation, other form of corporation formed by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or health care service plan, and that does all of the following:
>
> (A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.
>
> (B) Receives compensation for those services on any capitated or fixed periodic payment basis.
>
> (C) Is responsible for processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment basis.

(Health & Saf. Code § 1375.4(g)(1).)

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."[2] RBOs are paid a capitated amount by an HMO, and then must draw from this fixed revenue source to make the expenditures necessary to provide health care to the HMO's enrollees, including the administrative costs of processing claims and reimbursing the providers who actually furnish care, such as Petitioners' members. It is apparent then that RBOs stand to benefit under the scheme of the Balance Billing Regulation because, just like any other HMO payor, RBOs can unilaterally underpay emergency providers (thereby increasing the amount of the capitated payment they can keep as profit) with little impunity, knowing that emergency providers have no meaningful and speedy recourse.

It is curious that CAPG favors the DMHC assuming jurisdiction over, and asserts that AB

[2] *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."

1455 has application to, non-contracted providers. CAPG does not provide any legal support for this position (because none exists). In fact, CAPG's position in its *amicus* brief contradicts the DMHC's public pronouncements and CAPG's own public testimony concerning AB 1455. The DMHC has admitted that it does not and cannot regulate RBOs directly but rather is limited to regulating HMOs. The "Frequently Asked Questions" guide on the DMHC's website 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*. [Emphasis added.]

Furthermore, during the public comment stage for the Balance Billing Regulation (available in the Rulemaking File), CAPG's CEO testified that AB 1455 has no application beyond HMOs:

> BOARD MEMBER MEYERS: So, Don, a couple of times this morning, there's been concerns expressed that where an issue has come up and it turns out it's the capitated provider that's – that the debate is going on between the ER group. [sic] But the Department has no authority to go directly to the capitated medical group.
>
> How would you feel about legislative authority that gave the Department direct authority enforcement action over the medical group to enforce the 1455 versus through the delegated arrangement?
>
> MR. CRANE: We don't think that's necessary or appropriate.
>
> (Audience laughing.)
>
> MR. CRANE: And to answer your rhetorical question, you know, clearly the method used right now is via the contracts and the -- those kind of strictures and so forth are visited upon delegated groups through the health plan contracts. And we're not looking forward, frankly, to more regulations. So we would oppose that.

(Transcript, Department of Managed Health Care, Public Hearing for Continuing Implementation of AB 1455–2000, Adoption of Rule 1300.71.39, Revision of Rule 1300.71.38, Revision of Rule 300.71, Burbank, Cal., Sept. 13, 2006, at 166:8-25; 167:1-4, attached as Exhibit 12 to Petitioners'

Second Supplemental Request for Judicial Notice.)

CAPG is speaking from two mouths. When it would benefit RBOs financially, CAPG claims AB 1455 should apply to non-contracted providers. However, CAPG takes the complete opposite and contradictory position when faced with the question whether AB 1455 applies to RBOs in an adverse manner.

These vacillating positions reveal CAPG's lack of candor in pushing its position on balance billing. CAPG goes to lengths to portray a world that does not exist, where providers allegedly "extort" unreasonable payments by balance billing. In public comment on the Balance Billing Regulation, one of CAPG's own members admitted that the fantasy world in CAPG's brief does not exist in the real world:

> DEPUTY DIRECTOR DONOHUE: Keith Puglese.
>
> MR. PUGLESE: Hello, Director Ehnes and Board Members. I'm Keith Puglese. I'm here representing Brown and Toland Medical Group. . . . The *vast majority* of non-contracted providers charge and receive fair reimbursement for their health care services. There are, however, some *outliers*. . . .

(*See* Exhibit 12, Tr. at 131:4-7 and 132:1-4)

To the extent CAPG's *amicus* brief has any value, it cannot be viewed as presenting the provider perspective on balance billing. Rather, CAPG's position is one and the same as HMOs, whose rally for a ban on balance billing is motivated more by financial self-interest than any other motive.

B. ***Amici* Kaiser Foundation Health Plan Et Al. Are Animated By Financial Self-Interest In Urging A Ban Of Balance Billing**

Similar to CAPG, *amici* Kaiser Foundation Health Plan claims it represents a provider perspective in supporting the DMHC's Balance Billing Regulation. However, like CAPG, in the context of the balance billing debate, these *amici* operate on a business model that will benefit financially on account of the Balance Billing Regulation. Kaiser Foundation Health Plan has a unique business model in which it operates a self-contained health plan, hospital and medical group. This business model calls for Kaiser Foundation Health Plan to provide health care services to its enrollees "in-house," to be served by providers that contract exclusively with the

Kaiser Foundation Health Plan. It is within this self-enclosed world that Kaiser Foundation Health Plan presents its perspective. When its enrollees receive emergency care by non-Kaiser providers, the Kaiser Foundation Health Plan, like all other HMOs, has a financial incentive to pay less than the billed amount after the emergency services have been provided to Kaiser's enrollees. A balance billing prohibition obviously works to Kaiser Foundation Health Plan's financial advantage.

Kaiser Foundation Health Plan's financial motives with respect to its payment practices for emergency care and its stance on prohibiting balance billing was revealed when one of the chronically underpaid providers, the University of California, Irvine, Medical Center ("UCI Medical Center"), sued Kaiser Foundation Health Plan for underpayments in Orange County Superior Court (case no. 05CC08314). UCI Medical Center alleged that after it treated Kaiser Foundation Health Plan enrollees, the plan unilaterally decided to pay steadily declining percentages of the bills. Kaiser Foundation Health Plan paid 91% of the billed amount in 2004, 85% in 2005, and 75% in 2006. Kaiser claims that these self-claimed discounts were allowed by application of the DMHC's reasonable and customary ("R&C") regulation that states HMOs pay the "reasonable and customary" rate to providers. (28 C.C.R. §1300.71 *et seq.*) (*See* Notice of Motion and Motion for Leave to File Third Amended Complaint, attached as Exhibit 13 to Petitioners' Second Supplemental Request for Judicial Notice, at 4:11-5:10.)

In the deposition of Steven J. Peiser, a former Kaiser Foundation Health Plan employee, Mr. Peiser testified that Kaiser Foundation Health Plan interpreted the R&C regulation (section 1300.71) to allow it to develop an R&C rate schedule. (*See* Peiser deposition testimony, first page, lines 22-25, attached as Exhibit B to the Lovich decl. in support of the Notice of Motion and Motion attached as Exhibit 13 to Petitioners' Second Supplemental Request for Judicial Notice.) Mr. Peiser testified that Kaiser Foundation Health Plan wanted to develop the R&C rate schedule for cost savings purposes and estimated that his employer could save $37 million annually by adopting this rate schedule. (*See* Exhibit 13, Peiser deposition testimony, second page, lines 2-24.) Specifically, Mr. Peiser testified as follows:

///

Q. And what is your understanding as to why Kaiser wanted to do that [develop the R&C rate schedule]?

A. For purposes of reducing medical expenses.

Q. Reducing medical expenses as they relate to noncontracted providers?

A. Yes.

Q. Were any estimates discussed at that first seminar with regard to the potential savings to Kaiser related to the development of the usual and customary pricing schedules?

A. Not at that seminar.

Q. At any subsequent seminar?

A. Not at a seminar at internal meetings and the amount that was initially thrown was in the range of $37,000,000.

Q. Over what period of time?

A. Annually at least first year annually.

Q. Was it your understanding that Kaiser chose to interpret the regulation allowing it to develop reasonable and customary pricing schedules to allow it to sa[v]e somewhere around this $37,000,000 annually?

A. I think that's one of the focal points that they had yes.

(*See* Exhibit 13, Peiser deposition testimony, second page, lines 2-24.)

When asked about other reasons Kaiser Foundation Health Plan developed the R&C rate schedule for hospitals, Mr. Peiser testified as follows:

Q. What were some of the focal points they had?

A. The over all ability to – let me say this let me go back for a second. It was our intent to develop a usual and customary rate schedule not solely for the purpose of penalizing a hospital but for those hospitals that did not –that we did not have a contractual relationship for it would hope to serve the purpose of further entertaining discussions between the facilities or between the organizations so as to engage in contract discussions and to agree upon a rate schedule that both parties could go forth. The desire, myself, Steve Balalian, whatever, was that we really only were creating the rate schedule for purposes of paying providers and getting them to the table so that we could eliminate over all this whole usual and customary rate schedule and serve a purpose of contracting with those providers, one on one discussions. It was not our innocent [sic "intent"] to continue to use a usual and customary rate schedule in the way that it was initially formulated

> it was our intent to initiate discussions with providers to move them off that UCR [usual, customary, reasonable] schedule and into a letter of agreement or for noncontracted providers that would allow us to have a rate schedule and basically paid them that we all agreed on. A long answer but that was the intent.

(*See* Peiser deposition testimony, third page, line 25 to fourth page, line 25.)

Kaiser Foundation Health Plan implemented its R&C methodology during a time in which balance billing was not prohibited and therefore knowingly put its members in the middle of plan-provider disputes. If Kaiser Foundation Health Plan really wanted to keep its members out of the middle, it would have paid providers the full amount of the bill and pursue the providers for any amounts it considered to be over the reasonable and customary value of the services. Instead, it used the R&C regulation as leverage to gain cost savings and to force providers to enter into contracts because providers lack cost-effective recourse in the face of a pattern of underpayment by plans. The only monkey-wrench in this plan was the ability of providers to balance bill.

The Balance Billing Regulation offers Kaiser Foundation Health Plan a way to continue to use its R&C methodology to unilaterally discount the cost to provide out-of-network care to its HMO members whie at the same time "take its members out of the middle" by prohibiting providers from billing its members. If the Balance Billing Regulation is effective, Kaiser Foundation Health Plan, like any other HMO payor, can have its cake and eat it too. This is a real motivation underlying Kaiser Foundation Health Plan's support of the Balance Billing Regulation.

III. THE ALLEGATIONS FROM THE *PRIME HEALTHCARE* LITIGATION ARE IRRELEVANT

Kaiser Foundation Health Care also uses its *amicus* brief to air its allegations in a lawsuit against a Southern California hospital management company called Prime Healthcare Services, Inc. Kaiser Foundation Health Care has been embroiled in a billing dispute with Prime Healthcare for a number of years. Despite the fact that this dispute has yet to be adjudicated to conclusion, and neither party has yet been vindicated or found to be in the wrong, Kaiser Foundation Health Care uses its *amicus* brief to vilify Prime Healthcare and to suggest by implication that all providers engage in the similar alleged practices. The allegations from this

pending lawsuit are irrelevant for the following reasons.

First, no final judgment has been entered, and insufficient evidence has been presented to this Court for it to reach a conclusion as to any of the evidentiary issues raised in that litigation.

Second, the primary dispute in Kaiser Foundation Health Plan's litigation does not involve balance billing for emergency services, but rather the billing of patients for post-stabilization services. This is an important distinction. In emergency situations in which an enrollee is brought to an out-of-network hospital, the hospital usually notifies the enrollee's HMO of the admission, and, further, notifies the HMO when the enrollee's condition has been stabilized so that the enrollee's HMO can decide whether or not to transfer the enrollee to an in-network hospital. Once the enrollee has been transferred, the HMO can pay the contracted rate to the hospital who has assumed the post-stabilization care for the patient. Kaiser Foundation Health Care alleges that Prime Healthcare had a business practice of failing to notify Kaiser Foundation Health Care that its enrollee was in a Prime hospital, and then billing the enrollee when Kaiser Foundation Health Care refused to pay the post-stabilization bill because it had not authorized the post-stabilization treatment. The heart of the dispute involves whether Kaiser Foundation Health Care received timely notice after its enrollee had been stabilized. This is a fundamentally different situation from cases involving emergency services, since in emergency situations, providers are obligated to treat the emergency before obtaining authorization, and the HMO is obligated to pay for the emergency services regardless of authorization.

Third, the Legislature has addressed the alleged problem of the Prime Healthcare litigation in its most recent legislative session when it enacted (and the Governor signed) AB 1203. As noted in Petitioners' opening brief, AB 1203, as amended in the Assembly on January 9, 2008, would have prohibited *all* balance billing by non-contracted hospitals. (*See* AB 1203 (Salas, 2007), as amended January 9, 2008, Petitioners' Exhibit O.) The Senate rejected this approach and instead passed a statute that requires a non-contracting hospital to attempt to contact the HMO for authorization prior to providing post-stabilization care. The new law gives the HMO a 30-minute window to either authorize post-stabilization care or inform the non-contracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital. If the HMO

does not notify the non-contracting hospital of its decision within 30 minutes, the post-stabilization care shall be deemed authorized, and the HMO is obligated to pay charges for the care. If the patient refuses to consent to transfer, the provider is required to give the patient written notice that the patient will have to pay the full cost of the post-stabilization care. Thus, under the new law, the HMO enrollee can be billed by a non-contracting hospital for the post-stabilization services if (1) the patient refuses to consent to transfer to a contracting hospital, or (2) the hospital is unable to obtain the name and contact information of the patient's HMO. The HMO is liable for payment if (1) the HMO authorizes the non-contracted hospital to provide post-stabilization care, or (2) if the HMO fails to notify the hospital of its decision to authorize post-stabilization care or arrange for transfer of the patient within 30 minutes of notification by the hospital. (New section 1262.8 of the Health & Safety Code, *see* Petitioners' Exhibit P.) In the legislative history for AB 1203, the Senate Rules Committee, among others, referenced as background for the bill that Respondent Ehnes, in remarks made at a public hearing on May 14, 2008, stated, "The Schwarzenegger Administration condemns the hospital chain, Prime Healthcare, for forcing patients into the midst of billing disputes between hospitals, doctors and insurance companies." (*See* Senate Rules Committee bill analysis of AB 1203, page 6 of 8, Exhibit 14 to Petitioners' Second Supplemental Request for Judicial Notice.) The Senate Rules Committee also noted that "[o]n May 16, 2008, a Los Angeles County Superior Court granted a temporary restraining order requested by Kaiser, which ruled that Primer Healthcare must stop its bill collection activities against Kaiser members." (*Id.*) The Legislature clearly had the Prime Healthcare litigation in mind when enacting AB 1203 and has taken the action it believes is necessary to address that situation.

CONCLUSION

Amici CAPG and Kaiser Foundation Health Plan prove Petitioner's point that the Legislature is the best forum to address the differing viewpoints on balance billing. Petitioners accordingly submit that their *amicus* briefs should be given little, if any, weight in this case. Certainly, the briefs are not illuminating on the legal issues presented, and therefore should not

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alter the Court's conclusion that the Balance Billing Regulation is invalid for the reasons stated in Petitioners' opening and reply briefs.

Dated: November 19, 2008

MURPHY AUSTIN ADAMS SCHOENFELD LLP

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Dated: November 19, 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 19, 2008, I served the following document(s) described as:

PETITIONERS' OMNIBUS RESPONSE TO THE AMICUS CURIAE BRIEFS OF THE CALIFORNIA ASSOCIATION OF PHYSICIANS GROUPS AND KAISER FOUNDATION HEALTH PLAN, ET AL.

☐ 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.

☒ by causing a true copy thereof to be personally delivered to the person(s) at the address(es) set forth below.

☐ by sending via facsimile a true and correct copy thereof to the facsimile number(s) set forth below (A transmission report was properly issued by the sending facsimile machine, and the transmission was reported as complete and without error).

☒ by shipping a true copy thereof via overnight mail (Federal Express, United Parcel Service, Express Mail), in accordance with this firm's usual practice, to the person(s) at the address(es) set forth below.

☒ 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.

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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 19, 2008, at Sacramento, California.

PAMELA GARTMAN