



Arnold Schwarzenegger, Governor  
State of California  
Business, Transportation and Housing Agency  
**Department of Managed Health Care**  
Office of Legal Services

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**ACTION:** Notice of Proposed Rulemaking Action  
Title 28, California Code of Regulations

**SUBJECT:** Plan and Provider Claims Settlement: Criteria for Determining Reasonable and Customary Value of Health Care Services; Expedited Payment Pending Claims Dispute Resolution; Definition of Unfair Billing Patterns; Independent Dispute Resolution Process; Revising Sections 1300.71 and 1300.71.38, and Adopting Section 1300.71.39 in Title 28, California Code of Regulations; Control No. 2007-1253.

**PUBLIC PROCEEDINGS:** Notice is hereby given that the Director of the Department of Managed Health Care (Director) proposes to promulgate regulations under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) relating to claims settlement practices between health plans and providers of health care services, including: clarifying the existing criteria for determining reasonable and customary payment of health care providers, establishing requirements for “expedited” payment of specified health care providers when the provider’s claim is disputed by a health plan; defining unfair billing patterns by providers of health care services; and establishing a new Independent Dispute Resolution Process for providers who lack written contracts with health plans.

This rulemaking action proposes to revise existing sections 1300.71 and 1300.71.38, and adopt new section 1300.71.39, at title 28, California Code of Regulations. Before undertaking this action, the Director will conduct written public proceedings, during which time any interested person, or such person’s duly authorized representative, may present statements, arguments, or contentions relevant to the action described in this notice.

This rulemaking action relates to similar subject matter addressed in two prior rulemaking actions, both recently withdrawn, titled Claims Settlement Practices, Control # 2006-0782 and Unfair Billing Patterns, Control # 2006-0777. The topics addressed in those two former rulemaking actions are now consolidated into this single rulemaking action.

**PUBLIC HEARING:** No public hearing is scheduled. Any interested person, or his or her duly authorized representative, may submit a written request for a public hearing, pursuant to section 11346.8(a) of the Government Code. The written request for hearing must be received by the Department’s contact person, designated below, no later than 15 days prior to the close of the written comment period.

**WRITTEN COMMENT PERIOD:** Any interested person, or his or her authorized representative, may submit written statements, arguments or contentions (hereafter referred to as comments) relevant to the proposed regulatory action by the Department. Comments must be received by the Department of Managed Health Care, Office of Legal Services, by 5 p.m. on Monday, **October 1, 2007**, which is hereby designated as the close of the written comment period.

Please address all comments to the Department of Managed Health Care, Office of Legal Services, Attention: Regulations Coordinator. Comments may be transmitted by regular mail, fax, email, or via the Department's website:

Website:	<a href="http://www.dmhc.ca.gov">www.dmhc.ca.gov</a>
Email:	<a href="mailto:regulations@dmhc.ca.gov">regulations@dmhc.ca.gov</a>
Mail:	Emilie Alvarez, Regulations Coordinator Department of Managed Health Care Office of Legal Services 980 9 <sup>th</sup> Street, Suite 500 Sacramento, CA 95814
Fax:	(916) 322-3968

Please note, if comments are sent via the website, email or fax, there is no need to send the same comments by mail delivery. All comments, whether sent via the website, email, fax or mail, should include the author's name and U.S. Postal Service mailing address so the Department may provide commenters with notice of any additional proposed changes to the regulation text.

Inquiries concerning the proposed adoption of this regulation may be directed to:

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**CONTACTS:** In your comments or inquiries, please use the Department's regulation title and control number: **Plan and Provider Claims Settlement; Control #2007-1253.**

**AVAILABILITY OF DOCUMENTS:** The Initial Statement of Reasons, the text of the proposed regulation and all information upon which the proposed regulation is based (rulemaking file) are available for public review. All the information upon which the proposed regulation is based is contained in the rulemaking file, which is available for public inspection by contacting the Regulations Coordinator listed above. Please call (916) 322-6727 to make an appointment.

The Notice of Proposed Rulemaking, proposed text of the regulation, and the Initial Statement of Reasons are also available via the Department's website at <http://wpsso.dmhc.ca.gov/regulations/>, under the heading "Open Pending Regulations."

**INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW:** California Health and Safety Code sections 1341.9, 1344, and 1346 vest the Director with the power to administer and enforce the provisions of the Act. California Health and Safety Code section 1344 authorizes the Director to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Act, including rules governing applications and reports, and

defining any terms, whether or not used in the Knox-Keene Act, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director has the discretion to waive any requirement of any rule or form in situations where, such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to the Knox-Keene Act.

These regulations are intended to implement, interpret, and/or make specific Health and Safety Code sections 1367(h), 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4 and 1379. More specifically, this rulemaking action will clarify the requirements for fair provider billing practices and fair health plan payment practices by: clarifying the criteria for health plans to consider in determining the reasonable and customary value of health care services rendered by providers who lack written contracts with the health plans; clarifying the nature of activities that constitute unfair billing practices by health care providers who render services to enrollees of health plans but lack written contracts with the health plans; establishing a fair and balanced approach to payment of providers pending resolution of a disputed provider claim; and implementing an independent claims payment dispute resolution process to provide health care providers with a fast, fair and cost-effective process to resolve claims payment disputes with health plans, which will provide specific determinations for claims payment amounts.

#### Non-Severability

The amendments proposed in this rulemaking action are designed to provide for a balanced comprehensive and integrated approach to correct and eliminate the problems in the plan-provider claims settlement systems which generate incentives for providers, especially providers of emergency services, to balance bill enrollees of health plans. Each of the proposed amendments to Title 28 is directed to a particular aspect of the claims settlement processes between health plans and physicians that has been identified as contributing to the fundamental problem, including provider billing patterns, plan payment determinations and processes, and effective provider recourse for meaningful and swift resolution of disputed claims. If one or more of the amendments proposed in this rulemaking action are held invalid, the operation of the remaining proposed amendments may have detrimental unintended consequences that will exacerbate, rather than correct, existing problems in plan-provider claims settlement systems. Accordingly, it is the Department's intent that, if any one of amendments to Title 28 adopted by the Department through this rulemaking action is held invalid by a court or agency of competent jurisdiction, the other adopted amendments shall also be invalid.

#### Health Care Industry Context

The most significant and frequent balance billing problems occur in the context of delivering emergency care services. Existing federal and state law require emergency care providers to provide emergency care without regard to a patient's ability to pay.<sup>1</sup> Emergency care providers are entitled to be paid fairly and promptly for the lifesaving services rendered whenever and wherever needed. Emergency care providers have expressed concerns regarding the level of reimbursement that they receive from health plans with which they do not contract, and this concern has led to the practice of emergency care providers, who lack written contracts with

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<sup>1</sup> Emergency Medical Treatment and Active Labor Act (EMTALA) 42 USC 1395dd et seq.; California Health and Safety Code section 1317 et seq.

health plans, seeking reimbursement directly from health plan enrollees rather than the health plans.

Health plans are legally responsible, pursuant to the Knox-Keene Act, for paying emergency care providers for covered services rendered to their enrollees. The cost of emergency services can be extraordinarily high, and Californians who prudently purchase the financial protections of health care coverage should be able to trust that their health plans will fairly and promptly reimburse medical providers who provide them care when they are seriously ill or injured and in need of emergency care.

Health plans and the Department have dispute resolution processes available for providers who lack written contracts with health plans. Even if a health plan has paid the provider less than the reasonable and customary value for services rendered, the health plan remains financially responsible for appropriate reimbursement, not the enrollee. In addition to these dispute resolution processes, the Second District Court of Appeal confirmed in *Bell v. Blue Cross* (2005) 131 Cal. App. 4<sup>th</sup> 211 that emergency providers have the common law right to sue health plans for restitution when they believe they have not been adequately reimbursed for their services.

Nevertheless, providers of emergency and other medically necessary services, who have not contracted with a health plan generally ignore the processes available to them for submitting claims to, and obtaining payment from, health plans, and to resolve disputes regarding claims payment and claims settlement. Instead, they continue to seek reimbursement of their claims directly from health plan enrollees. As a result, innocent enrollees are routinely leveraged as bargaining chips in an unfair provider billing pattern, which often leads to detrimental health care decisions by the enrollee and aggressive collection activities by the provider, with long-term harm to the enrollee's health, safety, and financial stability.

The system weaknesses that generate the need for providers lacking written contracts with health plans to balance bill enrollees include the lack of an independent, fast, fair and cost-effective mechanism for resolving claims payment disputes between such providers and health plans. Providers currently have well established systems in place for billing patients to whom they have provided services. When a health plan pays a provider an amount that is less than the provider considers fair and reasonable, the provider may pursue additional reimbursement by suing the health plan in civil court. However, the cost of such a lawsuit greatly exceeds the cost of balance billing the enrollee. Therefore, to address, in a meaningful manner, the problem of health care providers balance billing enrollees, it is necessary for the Department to develop and implement a mechanism by which providers lacking written plan contracts can obtain a fast, fair and cost-effective alternative to traditional high-cost civil remedies and to balance billing enrollees. The proposed revision to existing section 1300.71.38 will provide this fast, fair and cost-effective dispute resolution process for such providers.

In addition, the criteria and factors set forth in section 1300.71 of title 28, to be applied in determining reasonable and customary value of health care services rendered, have been criticized as inadequate for their intended purpose, and as resulting in confused and inconsistent application, and affected stakeholders have urged further clarification.

### Existing Law and Authority

- Health plans are obligated to provide or arrange for the provision of all basic health care services, including emergency health care services,<sup>2</sup> to enrollees. (Health and Safety Code, section 1367(i).)
- Health care service plans, and their contracting medical providers, are required to provide 24-hour access to emergency care and must “reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee.” (Health and Safety Code, section 1371.4 (a) and (b).)
- Health plans are required to encourage their enrollees to utilize the 911 emergency response system as appropriate and to go to the nearest emergency room if they believe they are having an emergency medical condition. (Health and Safety Code sections 1363.2, 1371.4 and 1371.5.)
- Hospitals and providers of emergency services are required to provide care necessary to stabilize an emergency medical condition without regard to the patient’s ability to pay. (Health & Safety Code, section 1317(d).)
- Third party payors, including health plans, that have a contractual obligation to pay for emergency services on behalf of their enrollees, are liable for the reasonable charges of non-contracted hospitals and treating emergency physicians, except for co-payments and other amounts that are the financial obligation of the enrollee. (Health and Safety Code section 1317.2a(d).)
- A health plan may only deny payment for emergency services and care if the health plan reasonably determines that emergency services and care were never performed. (Health and Safety Code, section 1371.4(c).)<sup>3</sup>
- The obligation of a health plan to pay claims submitted by emergency services providers, who lack written contracts with the plan, are not waived when the plan delegates the financial risk for such claims to its contracting medical groups. (Health & Safety Code Section 1371.35(f).)
- Health care service plans must ensure that a dispute resolution mechanism is accessible to providers lacking written plan contracts for the purpose of resolving billing and claims disputes. (Health and Safety Code, section 1367(h)(2).)

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<sup>2</sup> Section 1300.67(g) of title 28 of the California Code of Regulations further clarifies this statutory requirement.

<sup>3</sup> Section 1371.4(c) also provides that a health plan may deny reimbursement to a provider for a medical screening examination in cases where those services are not covered services because the enrollee did not require emergency services and care, and the enrollee reasonably should have known that an emergency did not exist. However, this regulation addresses only those situations for which a health plan is obligated to provide coverage to enrollees and reimbursement to providers.

- The legislature expressly authorized the Department to adopt regulations that ensure that plans have adopted a dispute resolution mechanism pursuant to Section 1367(h). (Health and Safety Code Section 1367.38.)
- Contracting providers are prohibited from directly billing health plan enrollees for payment owed by the health plan for covered services, and emergency services are covered services. (Health and Safety Code, sections 1345(b)(6) and 1379; title 28, California Code of Regulations, section 1300.67(g).)
- With the exception of co-payments, co-insurance and deductibles approved by the Department, contracting providers are expressly required to look solely to the health plan for amounts due the provider by the health plan. (Health and Safety Code, section 1379(b).)

Existing law provides express authority for the proposed revisions to sections 1300.71 and 1300.71.38, and the proposed adoption of new section 1300.71.39. In 2000, through adoption of Assembly Bill 1455 (AB 1455; Scott; stats 2000, ch. 827) the California State Legislature enacted a comprehensive set of statutes intended to reform the claims submission and payment systems of California's health care industry. These amendments to the Knox-Keene Act expressly authorized the Department to adopt regulations to implement and clarify the new statutes. AB 1455 was enacted to refine the dispute resolution process between health plans and health care providers. The bill prohibited health care service plans from engaging in unfair payment patterns, and increased the penalties for doing so.

Recognizing that providers also engaged unfair billing practices, AB 1455 also empowered the Department to define "unfair billing patterns" utilized by health care providers. Because these unfair billing patterns impact the ability of plans to process claims within the statutorily mandated timeframes, and have extreme detrimental impact on enrollees, it is essential for the Department to address, in its continuing effort to improve the claims submission process for all parties, unfair billing patterns by health care providers who lack written plan contracts. The Independent Dispute Resolution Process proposed in this rulemaking action is intended to provide a fast, fair and cost-effective dispute resolution process for providers lacking written plan contracts by providing specific determinations for claims payment amounts, and to ensure that such providers are paid fairly and consistent with the health plan's obligations to pay for covered services pursuant to Sections 1371, 1371.35 and 1371.4.

The Department's initial efforts to promulgate regulations required by AB 1455 were met with aggressive litigation initiated by medical provider professional associations. The Department ultimately prevailed, and the Department's regulations implementing AB 1455 were successfully adopted in August 2003, establishing standards and requirements for plans to timely pay provider claims; a process for providers and plans to report to the Department regarding unfair claims payment and billing patterns and practices; and requirements for plan processes to resolve provider disputes.

Despite these regulatory measures, and as described above, providers of emergency and other medically necessary services, who lack written plan contracts, continue to directly seek payment of claims directly from enrollees. It is clear to the Department that additional rulemaking is

necessary, and the Department has identified Sections 1371.38 and 1371.39 as crucial statutes requiring clarification to address these continuing serious problems.

In enacting AB 1455, including Sections 1371.38 and 1371.39, the Legislature found that:

- (a) Health care services must be available to citizens without unnecessary administrative procedures, interruptions, or delays.
- (b) The billing by providers and the handling of claims by health care service plans are essential components of the health care delivery process and can be made more effective and efficient.
- (c) The present system of claims submission by providers and the processing and payment of those claims by health care service plans are complex and are in need of reform in order to facilitate the prompt and efficient submission, processing, and payment of claims. Providers and health care service plans both recognize the problems in the current system and that there is an urgent need to resolve these matters.
- (d) To ensure that health care service plans and providers do not engage in patterns of unacceptable practices, the Department of Managed Health Care should be authorized to assist in the development of a new and more efficient system of claims submission, processing, and payment.

(Stats. 2000, c. 827, §1 (AB 1455).)

Section 1371.39(b)(1) provides in pertinent part:

Unfair billing pattern means engaging in a demonstrable and unjust pattern of unbundling of claims, up coding of claims, or other demonstrable and unjustified billing patterns, *as defined by the department.* (Emphasis added.)

Section 1371.38 directs the Department to:

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

The Department has identified many situations in which a plan’s dispute resolution process for providers lacking written plan contracts may be fast, fair and cost-effective, yet still generate incentives for such providers to balance bill enrollees. The Department’s independent dispute resolution process to be established by this proposed revision to section 1300.71.38, is intended to provide providers lacking written plan contracts with an alternative to balance billing enrollees in these situations, through the Independent Provider Dispute Resolution Process to provide specific determinations for claims payment amounts, and to ensure that providers lacking written

plan contracts are paid fairly, including in accordance with the health plan's obligation to pay for covered services pursuant to Sections 1371, 1371.35 and 1371.4.

When a health plan adjudicates a health care provider's claim to adjust for the provider's inappropriate unbundling of claims or up-coding of services, unfair billing patterns as defined in Section 1371.39, the amount the plan pays to the provider is correspondingly reduced. This subjects the enrollee to the provider's balance billing activities for the difference between the amount the provider billed and the amount reimbursed by the plan. With the proposed revision of section 1300.71.38, providers will have the opportunity to access an independent process, and receive a fast, fair and cost-effective adjudication on whether the plan's reimbursement was fair and reasonable.

The broad authority granted the Department by Section 1371.39(b)(1) to identify demonstrable and unjustified billing patterns in addition to unbundling and up-coding reasonably must include the authority to address additional situations where the provider of health care services, though coding and bundling the claim appropriately, has billed an unreasonable and unjustifiable amount for the services rendered. In all of these situations, the provider has billed an amount in excess of what is reasonable and customary for the services rendered, and billing the enrollee for any excessive charges is unjust. Based on the express and broad language of Section 1371.39, the Department has clear authority to prohibit balance billing by providers of emergency and other medically necessary services, even though they may lack written contracts with health plans, by defining the practice as a demonstrable and unjust billing pattern. The Department has similarly interpreted and applied other sections of AB 1455 in defining and prohibiting unfair payment patterns by health plans. In 2003, the Department finalized and implemented its "Claims Settlement Practice Regulations" at title 28, California Code of Regulations, section 1300.71. This regulation defined twenty different payment activities by health plans that constituted "demonstrable and unfair payment patterns," substantially expanding and specifying the few generalized categories of unfair payment activities enumerated in the legislation, such as reviewing and processing activities that result in delays, reducing the amount of payment, denying complete claims and failing to pay on the uncontested portion of a provider's claim. (Health and Safety Code, section 1371.37.) In defining unfair billing practices by providers, it is critical for the Department to take a similarly balanced but broad approach and enumerate unfair billing practices as they are identified.

Significantly, balance billing not only impacts enrollees medically and financially, it undermines any meaningful billing dispute resolution process, including those processes required by statute. By pursuing collection directly against the enrollee, providers use unfair and oppressive tactics, holding enrollees as virtual financial hostages, to pressure health plans to pay their full-billed charges, irrespective of whether their full-billed charges do, in fact, reflect the reasonable and customary value of the treatment provided. This practice allows the provider to thwart the statutorily mandated dispute resolution process that plans are required to maintain for non-contracted providers to resolve billing and claims disputes. (Health and Safety Code, section 1367(h); title 28, California Code of Regulations, section 1300.71.38.)

Based on the above factual and legal analysis, the Department has determined that:

- When health plans are obligated to pay for covered services provided by an emergency services provider, and the provider collects or attempts to collect from a health plan enrollee payment for amounts owed the provider by the health plan, the provider is engaging in an unfair billing pattern.
- Unfair billing patterns by providers of emergency and other medically necessary services must be eliminated.
- Sufficient administrative processes, within plans and the Department, including the additional independent, fast fair and cost-effective independent dispute resolution process proposed by this regulation, and legal processes through the courts, are readily available to non-contracting providers to provide fair and reasonable recourse to resolve claims payment disputes.

Accordingly, the Department has determined that the amendments to title 28 proposed in this rulemaking action are essential to enable the Department to execute its statutory mandate to protect California consumers and the stability of the health care delivery system.

**AVAILABILITY OF MODIFIED TEXT:** If the text of regulations proposed in this rulemaking action is modified after this notice is issued, unless the modification is non-substantive or solely grammatical in nature, the modified text will be made available to the public at least 15 days prior to the date the Department adopts the proposed regulations. A request for a copy of any modified regulation(s) should be addressed to Emilie Alvarez, Regulations Coordinator, at (916) 322-6727. The Director will accept comments on the modified regulation(s) via the Department's website, mail, fax, or email for 15 days after the date on which they are made available. The Director may thereafter adopt, amend, or repeal the foregoing proposal as set forth above without further notice.

**AVAILABILITY OF THE FINAL STATEMENT OF REASONS:** You may obtain a copy of the final statement of reasons, once it has been prepared, by making a written request to the contact person named above.

**ALTERNATIVES CONSIDERED:** Pursuant to Government Code section 11346.5(a)(13), the Department must determine that no reasonable alternative considered by the Department or that has otherwise been identified or brought to its attention, would be more effective in carrying out the purpose for which the above action is proposed, or would be as effective and less burdensome to affected private persons than the proposed actions. The Department invites the public to present statements or arguments with respect to alternatives to the proposed regulation during the public comment period.

**FISCAL IMPACT DETERMINATIONS:**

- Mandate on local agencies and school districts: None
- Cost or savings to any state agency: None
- Cost to local agencies and school districts required to be reimbursed under part 7 (commencing with Section 17500) of division 4 of the Government Code: None

- Other non-discretionary cost or savings imposed upon local agencies: None
- Direct or indirect costs or savings in federal funding to the state: None
- Significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states: None
- Costs to private persons or businesses directly affected: The Department is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.
- Significant effects on housing costs: None
- Adoption of these regulations will not:
  - (1) create or eliminate jobs within California;
  - (2) create new business or eliminate existing businesses within California; or
  - (3) affect the expansion of businesses currently doing business within California.

The Department has determined that the regulations do not affect small businesses. Health care service plans are not considered a small business under Government Code section 11342(h)(2).

**FINDING REGARDING REPORTING REQUIREMENT:**  
Government Code section 11346.3(c) provides as follows:

No administrative regulation adopted on or after January 1, 1993, that requires a report shall apply to businesses, unless the state agency adopting the regulation makes a finding that it is necessary for the health, safety, or welfare of the people of the state that the regulation apply to businesses.

This rulemaking action does not propose reporting requirements.

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SUZANNE CHAMMOUT  
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