

## **INSTRUCTIONS FOR FILING COMMENTS AND TESTIFYING ON THE DMHC'S PROPOSED REGULATIONS BANNING PATIENT BILLING**

Templates are attached for physicians and physician groups to utilize when preparing formal comments on the two regulatory packages. Use them as models only, as each letter should be tailored to a physician's particular circumstances. It is essential that commenters submit separate letters responding to each regulation so that they are separately included in each rulemaking file. The regulations can be viewed on the DMHC website (go to [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov), then click on the announcement regarding "unfair billing pattern" regulations). Questions concerning these templates or the regulatory process in general should be directed to Francisco Silva at (916) 551-2884 or [fsilva@cmanet.org](mailto:fsilva@cmanet.org). **The deadline for formal comments is October 4, 2006.** Transmit them in either of the following ways:

Via website: [www.dmhc.ca.gov](http://www.dmhc.ca.gov)  
Via e-mail: [regulations@dmhc.ca.gov](mailto:regulations@dmhc.ca.gov)  
Via fax: (916) 322-3968  
Via mail: Emilie Alvarez, Regulations Coordinator  
Department of Managed Care  
Office of Legal Services  
980 9th Street, Suite 500  
Sacramento, CA 95814

Send a copy to CMA at [legalinfo@cmanet.org](mailto:legalinfo@cmanet.org) or fax to (415) 882-5143.

### **Address the Following Issues In Your Written Comments:**

1. facts supporting the reasonableness of the physician's charges for emergency services;
2. facts concerning the frequency with which health plans or other payers refuse to pay the physicians' billed charge for emergency services, including an estimate of the average yearly underpayment;
3. facts concerning the speed, fairness and cost of the plan's internal dispute resolution process as a remedy for fee disputes;
4. facts concerning the increased costs of providing emergency services as required by EMTALA as opposed to non-emergency services, including without limitation the costs of providing on-call back-up coverage to the emergency department;
5. facts concerning the physicians existing billing practices, including without limitation the average amount of patient bills and consideration of patient financial hardship;
6. facts concerning the harm the physician practice would suffer if a prohibition on billing patients covered by Knox-Keene plans for emergency services were implemented, including without limitation, as relevant:

- a. practical issues with respect to identifying and establishing a separate billing system for emergency services provided to Knox-Keene Act beneficiaries;
  - b. impact of reduced revenue for emergency services on ability to provide services, charity care, serve on-call, participate in public programs like Medicare and Medi-Cal, etc.;
  - c. other potential harm as applicable.
7. facts concerning any difficulties the practice has encountered recently in negotiating fair managed care contracts;
  8. facts concerning increased practice expenses;
  9. facts concerning difficulties recruiting new physicians to the practice;
  10. facts concerning difficulties to the practice as a result of physicians retiring or otherwise leaving the practice;
  11. facts concerning difficulties in referring to specialists, including without limitation on-call physicians to the emergency department;
  12. facts concerning problems with emergency services availability in the physician practice's community (ED closures, overcrowding, diversion, wait times, on-call issues, etc.);
  13. any other facts that (a) support the need for prompt payment of reasonable charges for emergency services, (b) support the need for a presumption as to the reasonableness of the physician's billed charge and (c) document the harms that will flow if physicians have no recourse for obtaining fair payment other than by bearing the burden of challenging the amount the payor unilaterally decides to pay;
  14. whether the physician practice has annual gross revenue of less than \$2 million.

### **Information on Testifying at DMHC Hearing on October 4<sup>th</sup>**

Physicians will be able to provide 5 minutes of personal testimony on the three agenda items (balance billing, dispute resolution and criteria for determining a reasonable fee) in the order they appear.

Because each regulation will be considered separately, physicians will likely be required to spend the entire day at the hearing. The CMA will establish a lounge for physician testifiers, and the ACCMA will

provide transportation to Sacramento. The CMA is hoping 120-140 physicians will attend the hearing.  
The details regarding the hearings are:

**October 4 – 9:00 am – 5:00 pm (or until last speaker testifies)**  
CALPERS Headquarters, 400 P Street, Lincoln Plaza North, Room 1190, Sacramento

Main Points to Address in Oral Testimony:

Address the severe economic impact of the regulations on your medical practice and the community, such as:

a reduction in services – [please explain]

willingness/ability to serve on-call [also explain added costs of on-call, that is, the need to cancel patient visits, etc.]

a reduction in charity care to the uninsured

consideration of early retirement or moving to another state

***Physicians who are interested in testifying should call SMCMA staff: 650-312-1663***

## ***TEMPLATE Letter 1 – Billing Prohibition and Independent Dispute Resolution Process***

Emilie Alvarez, Regulations Coordinator  
Department of Managed Care  
Office of Legal Services  
980 9th Street, Suite 500  
Sacramento, CA 95814

RE: Proposed Rulemaking Action Concerning Unfair Billing Patterns and Independent Dispute Resolution Process, Control No. 2006-0777

Dear Ms. Alvarez:

The [Name of physician/practice] appreciates the opportunity to comment on the above-referenced rulemaking file. [Name of commenter]'s interest in these regulations is [describe nature of physician practice]. For the reasons described below, [I][we] urge that these regulations not be adopted by the Department of Managed Health Care (DMHC) as these proposals violate the law and would have a significant adverse impact upon [our community][our profession][my practice]. [My][Our] comments are set forth below.

## **I. UNFAIR BILLING REGULATIONS**

There is absolutely no authority in the Knox-Keene Act, or anywhere else in California law, for the Department to adopt regulations prohibiting non-contracting physicians from obtaining from enrollees the reasonable value of their services. The Legislature only granted the DMHC jurisdiction to issue regulations regulating its own licensees – health plans, not individuals that have no contract or other connection with a health plan, and, given their EMTALA obligations under the law, no knowledge of whether a patient to whom they have provided emergency services has any health insurance, let alone whether they happen to be covered by a Knox-Keene plan. The Legislature has clearly not authorized DMHC to act in this area. In fact, the statute upon which the DMHC relies upon for “authority” for issuing this proposal, Health & Safety Code §1371.79, expressly requires that the DMHC go to the Legislature with its recommendations with respect to “unfair billing practices.”

Further, the proposed regulations concerning “unfair billing practices” are wholly inconsistent with California law. The Knox-Keene Act is replete with references to allowing non-contracting physicians to bill enrollees for the reasonable value of their services. *See*, for example, Health & Safety Code §1363 (enrollees should be informed of financial liability); 28 C.C.R. §1300.63 (in event the health plan fails to pay for the non-contracting provider, the member may be liable to the non-contracting provider for the cost of the service); Health & Safety Code §§1373.95 and 1373.96 (non-contracted physicians do not need to accept health plan rates); Health & Safety Code §§1374.34 and 1262.8 (recognizing right of non-contracted emergency care providers to seek reimbursement from enrollees).

These statutes recognize a non-contracted physician's common law right to seek reimbursement from the person who directly benefited from the physician's services, and are fully consistent with the most recent, citable California court decision on this issue. *See Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 31 Cal.Rptr.3d 688. Indeed, the *Bell* decision recognized the constitutional infirmity of the type of regulation the DMHC proposes, that is, by proposing to allow the health plans to unilaterally set rates, health plans would be empowered to pay at confiscatory levels in violation of the Constitution.

Finally, there is no need for regulation of this sort. The DMHC already has a number of powers within its scope of authority to address what it sees as the problem—patients being placed in the “middle” of billing disputes. Health plans are getting more and more aggressive in their contracting practices, making it more and more difficult for physicians to contract with them. Despite the fact that enrollees are increasingly having significant problems finding contracted

physicians willing and able to treat them, the DMHC has not taken a single enforcement action to ensure that health plans have adequate networks of physicians to assure access to care, as required by law. *See* Health & Safety Code §1367.

Under these circumstances, the DMHC could adopt a regulation codifying what it has done in the past, that is, require that the health plans either (1) pay the full charge, (2) negotiate the rate, or (3) pay the bill charged and then institute litigation against the provider to the extent they believe that charge is unreasonable. The latter approach incentivizes everyone to pay and bill fairly at the outset, and would have the least economic burden to the emergency medical providers in this state. The DMHC could also enforce the laws regarding adequate networks, thus reducing the likelihood of out-of-network services in the first place. Thus, there are reasonable alternatives for the Department to exercise here that are more effective and less burdensome.

## II. INDEPENDENT DISPUTE RESOLUTION PROCESS

[I][we] question whether the DMHC has the authority in the absence of clear statutory authority to propose regulations concerning an independent dispute resolution process. Moreover, there are significant problems with this dispute process as proposed. First, it must not be tied to a billing prohibition. Indeed, as drafted, the process is not sufficient to assure that [I][we] will be paid fairly for emergency services we are mandated by law to provide, as the Constitution requires.

If anything, an independent claims dispute resolution process should be instituted on a pilot project basis first to see that it works in a manner that best protects physicians and patient care. Further, non-contracted physicians should not be required to exhaust a plan's internal dispute resolution process first. This process has been shown to be futile for physicians and a waste of time. [Add specific facts concerning the futility of this process, as appropriate.] In addition, [I am][we are] very concerned about the delegation of critical factors to this private organization, factors that are more properly left to the Department itself, if not the Legislature, such as funding, fees, standards for the appointment of the arbitrator, etc. Under these circumstances, the proposed regulations lack consistency with the law requiring that fundamental decisions be made by the Legislature itself, *see Wilkinson v. Madera Community Hospital* (1983) 144 Cal.App.3d 436, and clarity. Further, they lack clarity to the extent they do not properly advise physicians of the specifics of the proposed process and assure the medical community of its fairness.

Finally, the independent dispute resolution process will not create a viable mechanism to ensure that I am able to maintain my practice. Currently, given my staff and other practice costs, it costs me approximately \$\_\_\_\_\_ to process each appeal with a plan's internal dispute process, no matter the size of the claim. Providing me with a dispute resolution process which imposes even more costs will not provide any benefit to me in obtaining fair and prompt payment, particularly when it is tied to a system that will incentivize health plans to challenge even more of my bills. [Explain any other reasons why the dispute process does not work for physicians.]

## III. THE PROPOSED REGULATIONS WILL HAVE A SIGNIFICANT ADVERSE IMPACT

This proposal will have a severe economic impact on [my practice][my community][this specialty]. (If the physician practice has annual receipts of less than \$2 million, you should add that you are a "small business" for the purpose of the California Administrative Procedures Act.)

[Include only that of the following which is true and applicable to your practice.]

Health plans routinely fail to pay me my reasonable rate, leaving me no real alternative but to seek payment from enrollees. A conservative estimate of the amount that I am routinely underpaid on a yearly basis by health plans is \$ \_\_\_\_\_. While I do not routinely bill enrollees for the excess, a carte blanche prohibition against me from doing that will cause my practice to endure extreme suffering, resulting in:

- a reduction in my services – [please explain]
- my willingness to serve on-call [also explain added costs of on-call, that is, the need to cancel patient visits, etc.]
- a reduction in my charity care to the uninsured
- my thinking about an early retirement or moving to another state

Further, such a prohibition will allow health plans to even further reduce their contracted rates with me, knowing that in the end, they will be able to pay whatever low amounts they desire. The contracted rates are already reduced as they are generally offered on a take-it or leave-it basis, and in any event take into account the efficiencies that I obtain through the contract itself, such as more patients and faster payment. Moreover, I financially am unable to contract with some plans because plans have enormous bargaining power and I am not able to negotiate a contract with fair reimbursement terms. Indeed, my contracted rates have not increased for \_\_\_\_ years, despite significant increases in my practice costs. [Elaborate on increased costs as appropriate.] [If health plans have recently refused to contract or stalled negotiations, please describe that here.]

I am also concerned about what this regulation will do to my ability to refer to other specialists, including those that serve on-call to the emergency department. Already, not enough specialists contract with plans in my community and there is a shortage of those willing to serve on-call. If this regulation is adopted, I fear that even more specialists will be forced to practice elsewhere. [Add specific facts concerning referral problems as appropriate, protecting patient confidentiality.]

[As applicable, describe the strain on emergency medical system.]

California's emergency departments are already operating at a critical capacity and risk jeopardizing quality of care. In this regard, the proposed regulations only exacerbate that situation and will create suffering for us all, as well as increased state and local expenditures to ensure the viability of that system. [Explain availability of emergency services in your community/specialty—overcrowding, diversion, wait times, on-call issues, etc.]

These regulations undoubtedly will create more costs to both the state and local governments. Because on-call physicians will be able to do less charity care, more of the uninsured will go to the emergency department. This will increase a county's financial obligation under Welfare & Institutions Code §17000. Further, because of the financial strain on the emergency system resulting from the provision of more uncompensated care, Medi-Cal rates will need to be increased, causing added costs to the state.

Thank you very much for your consideration of [my][our] comments.

Sincerely,

cc: California Medical Association  
Governor Arnold Schwarzenegger

## *TEMPLATE Letter 2* – **Expansion of *Gould* Criteria**

Emilie Alvarez, Regulations Coordinator  
Department of Managed Care  
Office of Legal Services  
980 9th Street, Suite 500  
Sacramento, CA 95814

RE: Proposed Rulemaking Action Concerning Claims Settlement Practices, Control No. 2006-0782

Dear Ms. Alvarez:

The [Name of physician/practice] appreciates the opportunity to comment on the above-referenced rulemaking file. [Name of commenter]'s interest in these regulations is [describe nature of physician practice]. For the reasons described below, [I][we] urge that the regulations not be adopted by the Department of Managed Health Care (DMHC) as these proposals violate the law and would have a significant adverse impact upon [our community][our profession][my practice]. [My][Our] comments are set forth below.

### **I. EXPANSION OF *GOULD* CRITERIA**

The Department of Managed Health Care lacks authority to expand the criteria as to what relevant information constitutes “reasonable” payment beyond that which the court carefully circumscribed in *Gould v. W.C.A.B.* No information beyond that listed by the *Gould* decision is reasonably relevant for the purposes of determining whether a non-contracted physician’s billed charge for emergency services is reasonable. The DMHC has already recognized that the Medicare and Medi-Cal fee schedules are inappropriate guideposts to challenge the reasonableness of a physician’s billed charge, and the other factors that the payors have proposed, such as accepted charges and average contract rates, are equally inappropriate and their consideration would be even more burdensome.

I am bound by the AMA's Principles of Medical Ethics not to charge or collect an excessive fee. I have set my charges accordingly to reflect the reasonable value of my services, and I am entitled to be paid the amounts I have billed in the absence of a contract to accept a lower rate. Thus, expansion of the *Gould* criteria is not necessary; to the contrary it will only incentivize payors to refuse to contract with me, pay me less than my fair charge, or both.

Physicians voluntarily accept rates far below the reasonable value of services for a number of reasons, including their professional commitment to serve the poor and participate in underfunded public programs, and the need for prompt payment and freedom from administrative hassles, among others. In a non-contracted setting, contract rates are not relevant to the reasonable value of services provided since there are no attendant societal or practice benefits, and in any event contract rates generally do not reflect arms length bargaining but rather the take-it or leave-it proposals of the oligopolistic managed care industry. Further, if the DMHC and plans are authorized to consider this information, physicians will be forced to disclose proprietary information and spend potentially untold hours in discovery and defense of their charges. Indeed, adoption of this regulation would only promote unfair payment practices.

Finally, there is no need for this expansion and the Department has failed to show one. The DMHC has already authorized, albeit illegally, the automation of discounted payments to non-contracted physicians by virtue of its September 2005 compliance statement. Under these circumstances, the addition here does nothing but reduce the likelihood health plans will pay non-contracted physicians fairly.

## II. THE PROPOSED REGULATIONS WILL HAVE A SIGNIFICANT ADVERSE IMPACT

This proposal will have a severe economic impact on [my practice][my community][this specialty]. (If you have annual receipts of less than \$2 million, you should add that you are a "small business" for the purpose of the California Administrative Procedures Act.) Allowing the introduction of any evidence the DMHC or plans determine to be "relevant" will create undue burden and financial havoc on my practice. As discussed above, contract rates or other discounts that I voluntarily or am forced to accept do not represent the reasonable value of my non-contracted emergency services, and this proposed regulation will only allow plans to force me to engage in lengthy and expensive discovery disputes concerning sensitive financial information. This would be an unwarranted burden and bad public policy.

[Include only that of the following which is true and applicable to your practice.]

Health plans routinely fail to pay me my reasonable rate, leaving me no real alternative but to seek payment from enrollees. A conservative estimate of the amount that I am routinely underpaid on a yearly basis by health plans is \$\_\_\_\_\_. While I do not routinely bill enrollees for the excess, an authorization for plans to invade the financial aspect of my practice will cause my practice to endure extreme suffering, resulting in:

- a reduction in my services – [please explain]
- my willingness to serve on-call [also explain added costs of on-call, that is, the need to cancel patient visits, etc.]
- a reduction in my charity care to the uninsured
- my thinking about an early retirement or moving to another state

Further, such a prohibition will allow health plans to even further reduce their contracted rates with me, knowing that in the end, they will be able to pay whatever low amounts they desire. The contracted rates are already reduced as they are generally offered on a take-it or leave-it basis, and in any event take into account the efficiencies that I obtain through the contract itself, such as more patients and faster payment. However, I financially am unable to contract with some plans because plans have enormous bargaining power and I am not able to negotiate a contract with fair reimbursement terms. Indeed, my contracted rates have not increased for \_\_\_\_ years, despite significant increases in my practice costs. [Elaborate on increased costs as appropriate.]

I am also concerned about what this regulation will do to my ability to refer to other specialists, including those that serve on-call to the emergency department. Already, not enough specialists contract with plans in my community and there is a shortage of those willing to serve on-call. If this regulation is adopted, I fear that even more specialists will be forced to practice elsewhere. [Add specific facts concerning referral problems as appropriate, protecting patient confidentiality.]

[If applicable, describe the strain on emergency medical system.]

California's emergency departments are already operating at a critical capacity and risk jeopardizing quality of care. In this regard, the proposed regulations only exacerbate that situation and will create suffering for us all, as well as increased state and local expenditures to ensure the viability of that system. [Explain availability of emergency services in your community/specialty—overcrowding, diversion, wait times, on-call issues, etc.]

These regulations undoubtedly will create more costs to both the state and local governments. Because on-call physicians will be able to do less charity care, more of the uninsured will go to the emergency department. This will increase a county's financial obligation under Welfare & Institutions Code §17000. Further, because of the financial strain on the emergency system resulting from the provision of more uncompensated care, Medi-Cal rates will need to be increased, causing added costs to the state.

Thank you very much for your consideration of [my][our] comments.

Sincerely,

cc: California Medical Association  
Governor Arnold Schwarzenegger