



August 27, 2010

Jay Angoff  
Director  
Office of Consumer Information and Insurance Oversight  
U.S. Department of Health and Human Services  
Attention: OCIIO-9994-IFC  
P.O. Box 8016  
Baltimore, MD 21244-1850

INTERIM FINAL RULES RE: PATIENTS' BILL OF RIGHTS (File Code: OCIIO-9994-IFC)

Dear Mr. Angoff:

The California Department of Managed Health Care (DMHC) appreciates the opportunity to comment on the Interim Final Rules (the Rules) issued under Public Health Service Act sections 2704 (prohibiting pre-existing conditions exclusions), 2711 (prohibiting lifetime and annual dollar limits), and 2719A (regarding patient protections), as added or amended by the Patient Protection and Affordable Care Act of 2010 (ACA).

The DMHC is the California agency that licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), California Health and Safety Code section 1340 et seq. There are 108 health plans providing managed health care services to 21 million Californians and operating under this state licensing law.

The DMHC has identified several areas for which additional clarification and guidance would be helpful so that the DMHC and interested parties (health plans, providers, and consumers) can better understand their rights and obligations under federal law.

#### **I. PATIENT PROTECTIONS, 45 C.F.R. 147.138**

The interim final rules concerning patient protections address coverage requirements for emergency services, including cost-sharing requirements. Although enrollees have coverage for both in-network and out-of-network emergency services, the Rules' cost sharing requirements for out-of-network emergency services include the language "in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the plan

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or issuer is required to pay under this paragraph.” Thus, these Rules specifically allow “balance billing” for emergency services, a practice that was prohibited by the California Supreme Court in the case of *Prospect Medical Group, Inc. v Northridge Emergency Medical Group* (2009) 45 Cal.4<sup>th</sup> 497.

Balance billing had long been a problem in California, with out-of-network providers of emergency services routinely placing enrollees in the middle of disputes over the amount of the health plan payment. When seeking emergency services, enrollees do not have the luxury of being able to choose an in-network provider; circumstances usually dictate that they go to the closest emergency room, even if it is out-of-network. Health plans are required to cover such services, regardless of whether the provider is in-network or out-of-network. With balance billing, enrollees could potentially be required to pay providers tens of thousands of dollars simply because the closest emergency facility was out-of-network. Such a result is manifestly unfair. The DMHC respectfully suggests that the Rules be clarified or revised to address the following concerns:

#### A. Prohibition of Balance Billing and Establishment of a Dispute Resolution Process

The DMHC strongly recommends that the Rules be revised to uniformly prohibit balance billing for emergency services altogether. Health plan enrollees should not be unfairly placed in the middle of payment disputes relating to emergency services because the choice of an out-of-network emergency provider is often beyond an enrollee’s control. Balance billing for emergency care could leave an enrollee liable for thousands of dollars for services believed to be covered under his/her health plan contract or policy.

Instead, disputes over the amount of a health plan’s payment should be resolved between the providers of emergency services and the health plans. These Rules could require that a fair, fast and effective dispute resolution process be available for providers of emergency services to dispute the amount of the health plan payment. The result of such process could be made binding on the health plans.

#### B. Pre-emption

California law currently prohibits providers of emergency services from balance billing enrollees of DMHC licensed plans. This approach should be allowed to continue as it is more favorable to consumers. However, because the interim final rules do not address the issue of pre-emption, greater clarity is needed as to whether the ACA and these Rules intend to pre-empt state laws that prohibit balance billing. Accordingly, the Rules should be revised to clarify that they are not intended to pre-empt state laws that prohibit balance billing for emergency services.

## **II. PROHIBITION ON PRE-EXISTING CONDITIONS EXCLUSIONS, 45 C.F.R. 147.108**

The Rules prohibit limitations, exclusions, and denials of coverage based on the presence of a health condition before the effective date of coverage (or date of denial). Consistent with

statements by the Obama Administration, these Rules clarify that children with pre-existing conditions cannot be denied access to coverage based on their health status, closing a potential loophole identified in the ACA. In effect, the Rules provide guaranteed access to coverage for children for plan years (except for grandfathered individual coverage) beginning on or after September 23, 2010.

While the Rules prohibiting pre-existing condition exclusions are clear, the Rules do not address affordability and sustainability concerns that arise when access to health coverage is essentially guaranteed.

#### A. Controlling the Effects of Adverse Selection

A sustainable individual market requires controls that promote a balanced market with fairly distributed risk, and that discourage adverse selection by sick consumers, who may otherwise purchase coverage only when they are sick, then drop it when they are healthy. An individual mandate, “in and out” restrictions, and open enrollment limitations are tools that can provide balance in a guaranteed-issue market. An individual mandate allows health plans to spread risk across a pool of both healthy and sick enrollees. In-and-out rules discourage adverse selection and create stability in the risk pool by penalizing those who fail to maintain continuous coverage and purchase coverage only when they are sick or injured.

#### B. Open Enrollment Periods

The Department of Health and Human Services, the Department of Labor, and the Department of the Treasury recently clarified that the Rules do not preclude health plans from addressing adverse selection by restricting children’s enrollment to open enrollment periods, if permitted under state law.<sup>1</sup> While this does partially address the adverse selection problem, open enrollment limitations may not be enough to prevent parents of sick children from seeking coverage only after their children require expensive health care services.

Moreover, the federal guidance regarding open enrollment periods does not address whether health plans are permitted to decline coverage or rate applicants based on health status during *non*-open-enrollment periods. For example, despite the absolute prohibition contained in the Rules, it has been argued that so long as a health plan holds open enrollment periods during which it does not deny child applicants based on their health status, the health plan would be permitted to selectively enroll applicants *outside* of such open enrollment periods. Additional clarification and guidance would facilitate consistent and appropriate interpretation and implementation of these Rules.

#### C. Withdrawal from Certain Market Segments

Because the Rules do not expressly require that health plans offering individual coverage must also offer “child only” policies or contracts, some health plans will reportedly discontinue selling

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<sup>1</sup> HHS, Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions, <http://www.hhs.gov/ocio/regulations/children19/factsheet.html>, July 27, 2010.

child-only contracts for all children, not just those with pre-existing conditions. This would not violate the letter of Section 2704 or the Rules. However, it would make coverage inaccessible for children of any health status if their parents do not have access to coverage (e.g., due to their own health status). This would also create problems for parents who do have existing individual coverage, but whose current health status would prevent them from obtaining new (non-grandfathered) individual coverage, because the prohibition of pre-existing conditions exclusions for children applies only to new coverage. Since adults can still be medically underwritten and denied coverage, parents applying for new coverage for their children could risk losing coverage for themselves. Further federal guidance or action may be necessary to address these issues.

### **III. PROHIBITION ON LIFETIME AND ANNUAL DOLLAR LIMITS, 45 C.F.R. 147.126**

The Rules establish a three year phase-out approach to annual dollar limits applied to essential health benefits, temporarily allowing the specified minimum annual limits, until annual limits are prohibited altogether in 2014. The Rules require that health plans only take into account essential health benefits received during a plan year to determine if and when the federally designated annual limits are met. The Rules also allow the federal Secretary of Health and Human Services (HHS Secretary) to provide a waiver or exemption for these specific annual limits if compliance would result in a significant decrease in access to benefits or would significantly increase premiums.

The DMHC has identified several areas where additional guidance is helpful or necessary for the DMHC and its licensees to appropriately implement the ACA's prohibition of lifetime and annual limits.

#### **A. Pre-Emption**

These Rules do not specifically address pre-emption of state laws. While the Rules would clearly pre-empt state laws permitting minimum annual limits that are lower than those minimum annual limits designated in the Rules, it is not clear whether the Rules would pre-empt state laws that would require higher minimum annual limits or that would prohibit annual limits altogether.

In California, under the Knox-Keene Act, health plans licensed by the DMHC must cover "basic health care services," which are defined as: physician services, hospital inpatient services, ambulatory care (outpatient) services, diagnostic laboratory and diagnostic and therapeutic radiologic services, home health services, preventive health services, emergency health care services (including ambulance services), and hospice care.<sup>2</sup> Historically, the DMHC has not allowed Health Maintenance Organizations (HMOs) to set annual or lifetime limits for basic health care services or other mandated benefits, but have allowed them for non-mandated health care services. Health and Safety Code section 1367(i) provides:

Nothing in this chapter shall prohibit a health care service plan ...  
from setting forth, by contract, limitations on maximum coverage

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<sup>2</sup> California Health and Safety Code section 1345, subdivision (b); California Code of Regulations, title 28, section 1300.67.

of basic health care services, provided that the ... limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.<sup>3</sup>

The basis for prohibiting lifetime and annual limits has been that annual and lifetime limits are not “fair and reasonable,”<sup>4</sup> and they “deny access to basic health care services.”<sup>5</sup>

It appears that the purpose of the Rules’ temporary annual limits is to facilitate health plans’ transition to the outright prohibition of annual dollar limits in 2014. Pre-emption of more protective state laws during the intervening period is not consistent with this purpose. Clarification of the pre-emption of state laws concerning annual limits will facilitate appropriate implementation of Section 2711 and these Rules.

#### B. Definition of Essential Health Benefits

The Rules do not prevent a group health plan or a health insurance issuer from establishing lifetime or annual dollar limits on non-essential health benefits if such limits are otherwise permitted under federal or state law. While Section 1302(b) of the ACA defines “essential health benefits” by enumerating general categories, further guidance is required as to the scope of the specific items and services covered within those categories, in order to allow accurate compliance and enforcement of the Rules.

Additionally, the Rules do not prevent a group health plan or a health insurance issuer from excluding all benefits for a condition, as long as such exclusions are not prohibited by other federal and state laws. However, if any benefits are provided for a condition, then the requirements of Section 2711 will apply. Under federal and state laws, benefits qualifying as essential health benefits or basic health care services (under the Knox-Keene Act), respectively, may not be excluded. The Rules do not clarify the scope of the specific items or services that may qualify as essential health benefits, which may be critical in determining whether a particular condition-based exclusion is permitted.

Expedient clarification of the scope of essential health benefits will also allow states to craft legislation to conform state law to the requirements of the ACA, in preparation for full implementation of health care reform in 2014. The DMHC is particularly concerned about the difference between “basic health care services” and “essential health benefits,” because the ACA provides that states will be financially responsible for mandated benefits that go beyond the “essential health benefits” defined by the HHS Secretary.

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<sup>3</sup> Health & Safety Code section 1367, subdivision (i).

<sup>4</sup> Health & Safety Code section 1367, subdivision (h)(1).

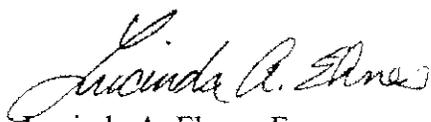
<sup>5</sup> Health & Safety Code section 1367, subdivisions (d) and (e).

### C. Waiver Program

Section 2711 requires the HHS Secretary to ensure that access to needed services is made available with minimal impact on premiums. As a result, the Rules provide the HHS Secretary with the authority to establish a program under which the federally designated annual limits can be waived if compliance would result in a significant decrease in access to benefits under the health plan or health insurance coverage, or would significantly increase premiums for the plan or health insurance coverage. The HHS Secretary has not, as of yet, provided guidance regarding this waiver program, or how a health plan or insurance issuer may qualify for the waiver. Clarification of the waiver procedure will facilitate appropriate implementation and enforcement of these Rules.

Thank you for the opportunity to comment on these Rules. Should you have questions, please do not hesitate to contact me at (916) 322-2012, or [cehnes@dmhc.ca.gov](mailto:cehnes@dmhc.ca.gov).

Sincerely,



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TP:ds

#### Attachments:

1. *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal. 4th 497.
2. California Code of Regulations, title 28, section 1300.71.39, "Unfair Billing Patterns."

## Attachment I



LEXSEE 45 CAL.4TH 497

**PROSPECT MEDICAL GROUP, INC., et al., Plaintiffs and Appellants, v.  
NORTHRIDGE EMERGENCY MEDICAL GROUP et al., Defendants and Respon-  
dents. PROSPECT HEALTH SOURCE MEDICAL GROUP, Plaintiff and Appel-  
lant, v. SAINT JOHN'S EMERGENCY MEDICINE SPECIALISTS, INC., et al.,  
Defendants and Respondents.**

S142209

## SUPREME COURT OF CALIFORNIA

*45 Cal. 4th 497; 198 P.3d 86; 87 Cal. Rptr. 3d 299; 2009 Cal. LEXIS 3*

**January 8, 2009, Filed**

**SUBSEQUENT HISTORY:** Reported at *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 2009 Cal. LEXIS 25 (Cal., Jan. 8, 2009)

**PRIOR HISTORY:**

Court of Appeal Second Appellate District, Division Three, No. B172737, No. B172817. Superior Court of Los Angeles County, No. BC300850, No. SC076909, Gerald Rosenberg, Judge.  
*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 136 Cal. App. 4th 1155, 39 Cal. Rptr. 3d 456, 2006 Cal. App. LEXIS 208 (Cal. App. 2d Dist., 2006)

**SUMMARY:**

## CALIFORNIA OFFICIAL REPORTS SUMMARY

In a declaratory action, the trial court ruled that emergency care providers were not statutorily prohibited from billing patients directly for the differences between the bills submitted and the amounts paid by health care service plans. Individual practice associations alleged that the emergency care providers routinely billed patients for the balance of their bills after having received reimbursement from health care service plans that contracted with the individual practice associations. The trial court sustained the providers' demurrers without leave to amend and entered judgments accordingly. (Superior Court of Los Angeles County, Nos. BC300850 and

SC076909, Gerald Rosenberg, Judge.) The Court of Appeal, Second Dist., Div. Three, Nos. B172737 and B172817, upheld the ruling.

The Supreme Court reversed the judgment of the Court of Appeal and remanded the case for further proceedings. The court held that the Knox-Keene Health Care Service Plan Act of 1975 (*Health & Saf. Code, § 1340 et seq.*) does not permit balance billing. Although the court agreed with the Court of Appeal that *Health & Saf. Code, § 1379*, was inapplicable, the court found that other statutory provisions address balance billing. The language of *Health & Saf. Code, § 1371.4, subd. (b)*, mandates that a health maintenance organization (HMO) pay the provider directly and does not involve the patient in the payment process at all. *Health & Saf. Code, § 1317, subd. (d)*, indicates that when HMO members provide insurance information, they have satisfied their obligation toward the providers. *Health & Saf. Code, § 1342, subd. (d)*, expresses a legislative intent to transfer the financial risk of health care from patients to providers. (Opinion by Chin, J., with George, C. J., Kennard, J., Baxter, J., Moreno, J., Corrigan, J., and McDonald, J., concurring.) [\*498]

\* Associate Justice of the Court of Appeal, Fourth Appellate District, Division One, assigned by the Chief Justice pursuant to *article VI, section 6 of the California Constitution*.

**HEADNOTES**

## CALIFORNIA OFFICIAL REPORTS HEADNOTES

**(1) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--By statute, when emergency room doctors provide emergency services, health maintenance organizations are required to reimburse those doctors for the services rendered to their subscribers or enrollees. The Knox-Keene Health Care Service Plan Act of 1975 (*Health & Saf. Code, § 1340 et seq.*) compels for-profit health care service plans to reimburse emergency health care providers for emergency services to the plans' enrollees. *Health & Saf. Code, § 1371.4*, provides that a for-profit health care service plan shall reimburse providers for emergency services and care provided to its enrollees until the care results in stabilization of the enrollee, except as provided in *§ 1371.4, subd. (c)*. As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition (*§ 1371.4, subd. (b)*). *Section 1371.4, subd. (b)*, imposes a mandatory duty upon health care plans to reimburse noncontracting providers for emergency medical services.

**(2) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--Pursuant to *Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B)*, a health maintenance organization (HMO) has a duty to pay a reasonable and customary amount for the services rendered. But how this amount is determined can create obvious difficulties. In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between.

**(3) Statutes § 49--Construction--Reference to Other Laws--In Pari Materia (Same Subject Matter)--Harmonizing.**--Courts do not examine statutory language in isolation, but in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the various parts of the enactment.

**(4) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--*Health & Saf. Code, § 1317, subd. (d)*, which requires emergency room doctors to render emergency care without questioning a patient's ability to pay, also provides that the patient or his or her legally responsible relative or guardian shall execute an

agreement to pay for the services or otherwise supply insurance or credit information promptly after the services are [\*499] rendered. This provision implies that once patients who are members of a health maintenance organization provide insurance information, they have satisfied their obligation towards the doctors.

**(5) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--The only reasonable interpretation of a statutory scheme that (1) intends to transfer the financial risk of health care from patients to providers; (2) requires emergency care patients to agree to pay for the services or to supply insurance information; (3) requires health maintenance organizations (HMO's) to pay doctors for emergency services rendered to their subscribers; (4) prohibits balance billing when the HMO, and not the patient, is contractually required to pay; (5) requires adoption of mechanisms to resolve billing disputes between emergency room doctors and HMO's; and (6) permits emergency room doctors to sue HMO's directly to resolve billing disputes, is that emergency room doctors may not bill patients directly for amounts in dispute. Emergency room doctors must resolve their differences with HMO's and not inject patients into the dispute.

**(6) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--Doctors cannot bill patients for emergency services that the patients' health maintenance organizations are obligated to pay. Balance billing is not permitted. Thus, individual practice associations could maintain a declaratory action challenging providers' balance billing.

[*Cal. Insurance Law & Practice (2008) ch. 26, § 26.01*; 2 Witkin, Summary of Cal. Law (10th ed. 2005) Insurance, § 126 et seq.]

**(7) Statutes § 42--Construction--Aids--Purpose and Policy Considerations.**--If statutory language permits more than one reasonable interpretation, courts may consider extrinsic aids, including the purpose of the statute, the evils to be remedied, and public policy.

**(8) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--*Health & Saf. Code, § 1371.4, subd. (b)*, does not say that patients must pay emergency room doctors and then turn to their health maintenance organizations (HMO's) for reimbursement. Rather it states that the health care service plan shall reimburse providers for emergency services and care provided to its enrollees. This language does not authorize the round-about route of the doctor's collecting from the patient,

who must then collect from the HMO. Rather, it mandates that the HMO pay the doctor directly. It does not involve the patient in the payment process at all. [\*500]

**(9) Statutes § 44--Construction--Aids--Contemporaneous Administrative Construction--Regulation Adopted While Litigation Pending--**

Although courts give some deference to contemporaneous interpretations of a statute by an agency charged with its administration, especially when the interpretation is in the form of a regulation adopted in accordance with the Administrative Procedure Act, a regulation adopted during the pendency of the litigation is not contemporaneous with the statutory scheme. It is doubtful that a court owes such a regulation any deference.

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Physicians' Advocates and Charles Bond for American Medical Association as Amicus Curiae on behalf of Defendants and Respondents.

Hooper, Lundy & Bookman, Lloyd A. Bookman, Suzanne S. Chou and Felicia Y Sze for California Hospital Association as Amicus Curiae on behalf of Defendants and Respondents.

**JUDGES:** Opinion by Chin J. with George, C. J., Kennard, J., Baxter, J., Moreno, J., Corrigan, J., and McDonald, J., concurring.

**OPINION BY:** Chin

**OPINION**

[\*\*88] [\*\*\*301] **CHIN, J.**--A health maintenance organization (HMO) commonly manages medical care in California. In the typical model, familiar to many, doctors contract to provide medical care to enrolled HMO members. Members generally use the services of one of the contracting doctors. When they do, and except for copayments the members must make when services are rendered, the HMO (or its delegate) pays the doctor under the existing contract. In this way, the parties agree upon, and know in advance, what their obligations and rights are and who must pay, and how much, for medical care.

The typical payment model sometimes breaks down, however, in the case of emergency care. In an emergency, an HMO member goes to the nearest hospital emergency room for treatment. The emergency room doctors at that hospital may or may not have previously contracted with the HMO to provide care to its members. In that situation, the doctors are statutorily required to provide emergency care without regard to the patient's ability to pay. Additionally, when the patient is a member of an HMO, the HMO is statutorily required to pay for the emergency care.<sup>1</sup> For HMO members, it is always clear in advance who has to provide emergency services--any emergency room doctor to whom the member goes in an emergency--and who has to pay for those services--the HMO. The conflict arises when there is no advance agreement between the emergency room doctors and the HMO regarding the *amount* of the required payment.

<sup>1</sup> For ease of discussion, we will sometimes refer rather loosely to those required to provide emergency services without regard to the patient's ability to pay as emergency room doctors, while recognizing that the category is broader than just doctors (*Health & Saf. Code, § 1345, subd. (i)*), and to the entities required to reimburse those

emergency room doctors for services rendered to their subscribers as HMO's, while recognizing that the entities are more technically described as "health care service plan[s]" and include the plans' delegates (*Health & Saf. Code, § 1371.4, subd. (e)*).

Thus, the potential inherently exists for disputes between the emergency room doctors and the HMO regarding how much [\*\*\*302] the HMO owes the doctors for emergency services. When no preexisting contract exists, the doctors [\*502] sometimes submit a bill to the HMO that they consider reasonable for the services rendered but that the HMO considers unreasonably high; conversely, the HMO sometimes makes a payment that it considers reasonable for the services rendered but that the doctors consider unreasonably low. The resolution of such disputes can create difficult problems.

But the question of how to resolve disputes between the doctors and the HMO over the amount due for emergency care is not before us in this case. The issue here is narrow, although quite important for emergency room doctors, HMO's, and their members: When the HMO submits a payment lower than the amount billed, can the emergency room doctors directly bill the *patient* for the difference between the bill submitted and the payment received--i.e., engage in the practice called "balance billing"?

Interpreting the applicable statutory scheme as a whole--primarily the Knox-Keene Health Care Service Plan Act of 1975, *Health and Safety Code section 1340 et seq.* (Knox-Keene Act) <sup>2</sup>--we conclude that billing [\*\*\*89] disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment. A patient who is a member of an HMO may not be injected into the dispute. Emergency room doctors may not bill the patient for the disputed amount.

2 All further statutory references are to the health and safety code unless otherwise indicated.

## I. FACTUAL AND PROCEDURAL BACKGROUND

Because neither party petitioned the Court of Appeal for a rehearing, we take our facts largely from that court's opinion. (*Richmond v. Shasta Community Services Dist.* (2004) 32 Cal.4th 409, 415 [9 Cal. Rptr. 3d 121, 83 P.3d 518]; see *Cal. Rules of Court, rule 8.500(c)(2)*.)

Plaintiffs and appellants, Prospect Medical Group, Inc., et al. (collectively Prospect), are individual practice associations. <sup>3</sup> Prospect manages patient care by executing written contracts with health care service plans. <sup>4</sup> It provides for medical care to persons who are members of

health care service plans and who select a Prospect physician. Prospect also provides billing services to the [\*503] health care service plans contracted with Prospect. As such, it is a "delegate" of those health care service plans and is statutorily obligated to pay for emergency services provided to patients who have subscribed to those health care service plans. (*§ 1371.4, subds. (b), (e)*.)

3 *Section 1373, subdivision (h)(6)*, defines an individual practice association by reference to title 42 *United States Code section 300e-1(5)*, which provides as relevant: "The term 'individual practice association' means a ... legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine ... ."

4 As pertinent here, *section 1345, subdivision (f)(1)*, defines a health care service plan as "[a]ny 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 for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees."

Defendants and respondents, Northridge Emergency Medical Group and Saint John's Emergency Medicine Specialists, Inc. (collectively Emergency Physicians), have exclusive licenses at two California hospitals to provide emergency room physician care. Emergency Physicians [\*\*\*303] are health care providers and are statutorily required to provide emergency care without regard to an individual's insurance or ability to pay. (*§ 1317, subd. (d)*; see also *42 U.S.C. § 1395dd*.)

When patients who are members of health care service plans schedule medical services in advance, they generally go to physicians with whom the health care service plan or its delegate, like Prospect, has an express preexisting contract. On occasion, when these same patients need emergency medical care, they may be taken to a hospital where the doctors staffing the emergency room do not have a preexisting contract with the health care plan or its delegate. In this case, after Emergency Physicians provided emergency medical services to patients who were members of health care service plans that contracted with Prospect, they submitted reimbursement claims to Prospect. Sometimes Prospect paid Emergency Physicians less than the amount billed. In those cases, Prospect paid what it alleged was reasonable for the services rendered. Emergency Physicians then billed the patients directly for the differences between the bills they submitted and what Prospect paid. The parties refer to this practice as "balance billing."

After billing disputes arose between Prospect and Emergency Physicians, Prospect filed two related actions against Emergency Physicians seeking, among other things, a judicial determination that (1) Emergency Physicians were entitled only to "reasonable" compensation for emergency medical care, which Prospect claimed was equivalent to the Medicare rate; and (2) the practice of balance billing is unlawful. In one of the actions, Prospect alleged that Saint John's Emergency Medicine Specialists, Inc., "routinely bills Prospect's patients, threatens to turn over Prospect's patients to an outside collection agency, and threatens to take legal measures against Prospect's patients." The trial court sustained Emergency Physicians' demurrers without leave to amend and entered judgments accordingly. Prospect appealed **[\*\*90]** both judgments, and the Court of Appeal consolidated the appeals.

The Court of Appeal concluded that balance billing is not statutorily prohibited. Second, it concluded that Prospect is not entitled to a judicial declaration imposing the Medicare rate as the reasonable rate. Third, it **[\*504]** concluded the trial court abused its discretion by denying leave to amend the complaint to permit Prospect to allege that Emergency Physicians charged more than a reasonable rate for a specific medical procedure. We granted Prospect's petition for review, which raised the sole question whether Emergency Physicians may engage in balance billing.

## II. DISCUSSION

The Knox-Keene Act governs this case. "The Knox-Keene Act is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care." (*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215 [31 Cal. Rptr. 3d 688] (*Bell*)). In addition, one statute not part of the act is pertinent here. Section 1317 requires emergency care providers to provide emergency services without first questioning the patient's ability to pay. (*Bell, supra*, 131 Cal.App.4th at pp. 215-216 & fn. 4.) Federal law is similar. (42 U.S.C. § 1395dd; see *Bell, supra*, at p. 215, fn. 4.)

(1) Today, by statute, when emergency room doctors provide emergency services, HMO's are required to reimburse those doctors for the services rendered to their subscribers or enrollees. As *Bell* explained, the Knox-Keene Act "compels for-profit health care service plans to reimburse **[\*\*\*304]** emergency health care providers for emergency services to the plans' enrollees. ... [S]ection 1371.4 provides that a for-profit 'health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires

that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.' (§ 1371.4, subd. (b); see § 1371.4, subd. (f).) 'Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed ... .' (§ 1371.4, subd. (c); see § 1371.4, subd. (f); and see *Cal. Code Regs.*, tit. 28, § 1300.71, subd. (a).)" (*Bell, supra*, 131 Cal.App.4th at p. 215.) "Subdivision (b) of section 1371.4 was enacted in 1994 to impose a mandatory duty upon health care plans to reimburse noncontracting providers for emergency medical services. [Citations.]" (*Id.* at p. 216.)

The combination of circumstances that (1) in an emergency a patient might go to emergency room doctors who have no preexisting contractual relationship with the HMO, (2) the doctors are required to render emergency care without asking whether the patient can pay for it, and (3) the HMO is **[\*505]** required to pay the doctors for those services, creates the problem underlying the issue before us. By the very nature of things, disputes may arise regarding how much the emergency room doctors may charge and how much the HMO must pay for emergency services.

(2) Regulations of the Department of Managed Health Care provide that the HMO must pay "the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case ... ." (*Cal. Code Regs.*, tit. 28, § 1300.71, subd. (a)(3)(B); see *Bell, supra*, 131 Cal.App.4th at p. 216.) Thus, the HMO has a "duty to pay a reasonable and customary amount for the services rendered." (*Bell, supra*, at p. 220.) But how this amount is **[\*\*91]** determined can create obvious difficulties. In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between. In *Bell, supra*, 131 Cal.App.4th 211, the Court of Appeal interpreted the Knox-Keene Act to permit, when disputes arise, emergency room doctors to sue the HMO directly for the reasonable value of their services.

Prospect argues that *section 1379*, part of the Knox-Keene Act, prohibits balance billing. That section, enacted in 1975 and never amended, provides:

"(a) Every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

[\*\*305] "(b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan.

"(c) No contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan."

Although no *express* contractual relationship exists between Prospect and Emergency Physicians, Prospect argues that the combination of statutes requiring emergency room doctors to render, and HMO's to pay for, emergency services creates an *implied* contract between emergency room doctors [\*506] and HMO's that has not been reduced to writing under *section 1379, subdivision (b)*. The Court of Appeal disagreed. Interpreting *section 1379* as a whole (but not in the context of the Knox-Keene Act as a whole), it held that this section does not cover the situation here. It found "that the language of *subdivision (b) of section 1379* refers to and includes within its scope only voluntarily negotiated contracts between providers of health care services, like Emergency Physicians, and health care service plans or their delegates, like Prospect, based upon traditional contractual principles such as a meeting of the minds. *Subdivision (b)* does not include within its scope the implied contract as Prospect asserts." Accordingly, it "conclude[d] that *section 1379, subdivision (b)*, was not intended to, and does not, prohibit the balance billing practices alleged in this case."

(3) Reading the language of *section 1379* in isolation, it does not readily apply to the precise situation here. No doubt the Legislature did not contemplate the situation of this case in 1975, when it enacted *section 1379*, for this situation did not exist in 1975. *Section 1371.4*, which obligates HMO's to pay for emergency services to its subscribers, was enacted in 1994, long after the Legislature enacted *section 1379*. But we must not view *section 1379* in isolation. "We do not examine [statutory] language in isolation, but in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the various parts of the enactment." (*Coalition of Concerned Communities,*

*Inc. v. City of Los Angeles* (2004) 34 Cal.4th 733, 737 [21 Cal. Rptr. 3d 676, 101 P.3d 563].)

(4) We have already seen that in 1975, the Legislature banned balance billing when an HMO is contractually obligated to pay the bill (§ 1379); that since 1994, HMO's have been obligated to pay for emergency care (§ 1371.4); and that the Knox-Keene Act permits emergency room doctors to sue HMO's directly over billing disputes (*Bell, supra*, 131 Cal.App.4th 211). These provisions strongly suggest that doctors may not bill patients directly when a dispute arises between doctors and the HMO's. Other provisions point in the same direction. *Section 1317, subdivision (d)*, which requires emergency room doctors to render emergency care without questioning a patient's ability to pay, also provides that "the patient or his or her legally responsible relative or guardian shall execute an agreement to pay [for the services] or otherwise supply insurance or credit information promptly after the services are rendered." (Italics added.) This provision implies that once patients who are members of an HMO [\*\*92] provide insurance information, they have satisfied their obligation towards the doctors. *Section 1342, subdivision (d)*, expresses a legislative intent to "[help] to ensure the best possible health care for the public at the lowest possible cost by [\*\*\*306] transferring the financial risk of health care from patients to providers." [\*507]

Additionally, the Legislature contemplated there may be disputes over the amounts owed to noncontracting providers such as emergency room doctors, and therefore the Knox-Keene Act requires that each HMO "shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes." (§ 1367, *subd. (h)(2)*; see also § 1371.38, *subd. (a)* [directing the Dept. of Managed Health Care to adopt regulations ensuring that each HMO adopt a dispute resolution mechanism that is "fair, fast, and cost-effective for contracting and noncontracting providers"].) Finally, the Legislature has acted to protect the interests of noncontracting providers in reimbursement disputes by prohibiting HMO's from engaging in unfair payment patterns involving unjust payment reductions, claim denials, and other unfair practices as defined, and by authorizing monetary and other penalties against HMO's that engage in these patterns. (§ 1371.37; see also § 1371.39 [authorizing providers to report HMO's that engage in unfair payment patterns to the Dept. of Managed Health Care].)

(5) The only reasonable interpretation of a statutory scheme that (1) intends to transfer the financial risk of health care from patients to providers; (2) requires emergency care patients to agree to pay for the services or to supply insurance information; (3) requires HMO's to pay doctors for emergency services rendered to their sub-

scribers; (4) prohibits balance billing when the HMO, and not the patient, is contractually required to pay; (5) requires adoption of mechanisms to resolve billing disputes between emergency room doctors and HMO's; and (6) permits emergency room doctors to sue HMO's directly to resolve billing disputes. is that emergency room doctors may not bill patients directly for amounts in dispute. Emergency room doctors must resolve their differences with HMO's and not inject patients into the dispute. (6) Interpreting the statutory scheme as a whole, we conclude that the doctors may not bill a patient for emergency services that the HMO is obligated to pay. Balance billing is not permitted.<sup>5</sup>

5 Our holding is limited to the precise situation before us--billing the patient for emergency services when the doctors have recourse against the patient's HMO. We express no opinion regarding the situation when no such recourse is available; for example, if the HMO is unable to pay or disputes coverage.

(7) Any doubt about the meaning of the Knox-Keene Act in this regard is easily resolved when legislative policy is considered. If statutory language permits more than one reasonable interpretation, courts may consider extrinsic aids, including the purpose of the statute, the evils to be remedied, and public policy. (*Torres v. Parkhouse Tire Service, Inc.* (2001) 26 Cal.4th 995, 1003 [111 Cal. Rptr. 2d 564, 30 P.3d 57].) We perceive a clear legislative policy not to place patients in the middle of billing disputes between doctors and HMO's. Indeed, the Department of Managed Health Care argued in *Bell*, and the Court of Appeal concluded, that doctors may directly sue HMO's to [\*508] resolve billing disputes in order to avoid the necessity of balance billing. The *Bell* court quoted the department's argument: "If providers are precluded from bringing private causes of action to challenge health plans' reimbursement determinations, health plans may receive an unjust windfall and patients may suffer an economic hardship when providers resort to balance billing activities to collect the difference between [\*\*\*307] the health plan's payment and the provider's billed charges. If collection actions are pursued, unsuspecting enrollees can be forced to reimburse the full amount of a provider's billed charges even though those charges are in excess of the reasonable and customary value of the services rendered. [¶] The prompt and appropriate reimbursement of emergency providers ensures the continued financial viability of California's health care delivery system. ... [D]enying emergency providers judicial recourse to challenge the fairness of a [\*\*93] health plan's reimbursement determination ... allows a health plan to systematically underpay California's safety-net providers and *unnecessarily* involve[s] the patient[s] in billing disputes between the provider

and their health plan[s]." (*Bell, supra*, 131 Cal.App.4th at p. 218, italics added.)

Because emergency room doctors prevailed in *Bell, supra*, 131 Cal.App.4th 211, and won the right to resolve their disputes directly with HMO's, no reason exists to permit balance billing. Thus, the Department of Managed Health Care, which supported doctors' rights to sue the HMO's directly in *Bell*, has appeared in this case as amicus curiae supporting patients' rights to be free of balance billing.

When a dispute exists between doctors and an HMO, the bill the doctors submit may or may not be the reasonable payment to which they are entitled. The *Bell* court made clear that an HMO does not have "unfettered discretion to determine unilaterally the amount it will reimburse a noncontracting provider ... ." (*Bell, supra*, 131 Cal.App.4th at p. 220.) But the converse is also true; emergency room doctors do not have unfettered discretion to charge whatever they choose for emergency services. Emergency room doctors and HMO's must resolve their disputes among themselves. Interjecting patients into the dispute by charging them for the amount in dispute has only an in terrorem effect. As Prospect notes, although emergency room doctors "are entitled to 'reasonable' compensation for the services rendered, they cannot lawfully seek unreasonable payment from anyone." But a patient will have little basis by which to determine whether a bill is reasonable and, because the HMO is obligated to pay the bill, no legitimate reason exists for the patient to have to do so. Billing the patient, and potentially attempting to collect from the patient, will put unjustifiable pressure on the patient, who will often complain to the HMO, which complaints will in turn pressure the HMO to make the payment even if it is unreasonable. Such a billing practice is not a legitimate way to resolve disputes with an HMO. [\*509]

(8) Relying in part on dicta in *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782 [9 Cal. Rptr. 3d 734], Emergency Physicians argue that they may collect from the patient, who may then collect from the HMO. The *Ochs* court held that it did not have to decide the issue presented in this case, but it went on to "observe, however, that section 1379 appears only to limit 'balance billing' of insured patients by physicians who have contracted with the patients' plans. [The provider] may have a remedy against the individual patients, and those patients a remedy against PacifiCare." (*Id.* at p. 796.) But this is not what the statutory scheme provides. Section 1371.4, subdivision (b), does not say that patients must pay the emergency room doctors and then turn to their HMO's for reimbursement. Rather it states that the "health care service plan ... shall reimburse providers for emergency services and care provided to its enrollees ... ." [\*\*\*308] This language does not authorize the

roundabout route of the doctor collecting from the patient, who must then collect from the HMO. Rather, it mandates that the HMO pay the doctor directly. It does not involve the patient in the payment process at all.

Emergency Physicians and their supporting amici curiae argue that emergency room doctors are entitled to a reasonable fee for their services, and that HMO's must be held accountable and forced to pay a reasonable amount for those services. An amicus curiae brief supporting Emergency Physicians adds arguments that the California Constitution "requires that emergency physicians receive adequate compensation to cover their losses for serving the indigent," and that "California's emergency departments are already operating at capacity and risk jeopardizing quality of care." These arguments do not address the issue before us. Emergency room doctors *are* entitled to reasonable payments for emergency services rendered to HMO patients. All we are holding is that this entitlement does not further entitle the doctors to bill patients for any amount in dispute.

Emergency Physicians argue that two recent bills that the Legislature passed but the Governor vetoed show that the Legislature [\*\*94] believes that balance billing is currently permitted. (Sen. Bill No. 981 (2007-2008 Reg. Sess.); Assem. Bill No. 2220 (2007-2008 Reg. Sess.)) We find no significance in these bills. They were legislative attempts to address broader concerns and, perhaps, clarify what is currently unclear. The Governor's veto messages state that he opposes balance billing but found the bills objectionable in other respects. This area of the law might benefit from comprehensive legislation. Failed attempts to provide some such legislation do not help us interpret the existing statutory scheme.

In support of its conclusion that emergency room doctors may engage in balance billing, the Court of Appeal cited a regulation that became operative sometime before 1978 and requires health care service plans to advise their [\*510] subscribers that "in the event the health plan fails to pay a noncontracting provider, the member may be liable to the noncontracting provider for the cost of the services." (*Cal. Code Regs., tit. 28, § 1300.63.1, subd. (c)(15)*.) This regulation, the Court of Appeal believed, shows that the Department of Managed Health Care "recognizes balance billing." (As noted, that department argues against permitting balance billing in this case.) In our view, the regulation does not support the conclusion that balance billing is permissible in the situation here. It was promulgated long before the statute obligating HMO's to pay for emergency services was enacted in 1994 and governs a different situation. HMO members are not *required* to go to doctors who have contracted with their HMO. In a nonemergency situation, members may, if they choose, seek professional services from anyone. If they obtain services from a noncontract-

ing provider, the HMO might not be obligated to pay all or even part of that provider's bill, depending on the exact terms of the health care plan. If the HMO is not obligated to pay the noncontracting provider, obviously, the member *would* be liable to pay for the services. This circumstance does not change the fact that under the Knox-Keene Act, HMO members are *not* liable to pay for emergency care.

(9) The Court of Appeal also relied on the fact that the Department of Managed Health Care had, in the past, proposed but never adopted a regulation that would prohibit balance billing. While this matter was pending before this court, the Department [\*\*\*309] of Managed Health Care did adopt a regulation that defines balance billing as an unfair billing pattern. (*Cal. Code Regs., tit. 28, § 1300.71.39*.) The parties dispute the meaning and validity of this regulation and whether we should give it deference. We need not get into such matters. Although we have given some deference to contemporaneous interpretations of a statute by an administrative agency charged with its administration, especially when the interpretation is in the form of a regulation adopted in accordance with the Administrative Procedure Act (e.g., *Sara M. v. Superior Court* (2005) 36 Cal.4th 998, 1011-1014 [32 Cal. Rptr. 3d 89, 116 P.3d 550]), here the regulation--adopted during the pendency of this litigation--is not contemporaneous with the statutory scheme. It is doubtful that we owe the regulation any deference. (See *Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1389 [241 Cal. Rptr. 67, 743 P.2d 1323] [not deferring to a noncontemporaneous interpretation]; *Jones v. Tracy School Dist.* (1980) 27 Cal.3d 99, 107 [165 Cal. Rptr. 100, 611 P.2d 441] [not deferring to an interpretation by an agency after the agency had become an amicus curiae in the case].) We base our holding on our interpretation of the relevant statutory scheme and not on the previous absence or current presence of any regulation.

The parties discuss the larger problem of adequate compensation for emergency room doctors. But this larger issue is not before us. Like the *Bell* court, "we reject the parties' suggestion that we can solve the societal and [\*511] economic problems defined by their rhetoric, and emphasize that our decision is limited to the precise issue before us ... ." (*Bell, supra*, 131 Cal.App.4th at p. 222.)

### III. CONCLUSION

We reverse the judgment of the Court of Appeal and remand the matter for further proceedings consistent with this opinion.

George, C. J., Kennard, J., Baxter, J., Moreno, J., Corrigan, J., and McDonald, J., concurring.

45 Cal. 4th 497, \*: 198 P.3d 86, \*\*;  
87 Cal. Rptr. 3d 299, \*\*\*; 2009 Cal. LEXIS 3

\* Associate Justice of the Court of Appeal,  
Fourth Appellate District, Division One, assigned

by the Chief Justice pursuant to *article VI, section  
6 of the California Constitution.*

Attachment II



LEXSTAT CAL CODE OF REGULATIONS, TITLE 28, 1300.71.39

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\* THIS DOCUMENT IS CURRENT THROUGH REGISTER 2010, NO. 32, AUGUST 6, 2010 \*

TITLE 28. MANAGED HEALTH CARE  
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE  
CHAPTER 2. HEALTH CARE SERVICE PLANS  
ARTICLE 8. SELF-POLICING PROCEDURES

28 CCR 1300.71.39 (2010)

§ 1300.71.39. Unfair Billing Patterns

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

(b) For purposes of this section:

(1) "Emergency services" means those services required to be covered by a health plan pursuant to *Health & Safety Code sections 1345(b)(6), 1367(i), 1371.4, 1371.5* and *Title 28, California Code of Regulations, sections 1300.67(g) and 1300.71.4.*

(2) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed the provider by the health care service plan.

(3) "The plan's capitated provider" shall have the same meaning as that provided in section 1300.71(a).

AUTHORITY:

Note: Authority cited: *Sections 1344, 1371.39 and 1371.4, Health and Safety Code.* Reference: *Sections 1317.1, 1317.7, 1342, 1345, 1346, 1362.8, 1367, 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4, 1371.5 and 1379, Health and Safety Code.*

HISTORY:

1. New section filed 9-15-2008; operative 10-15-2008 (Register 2008, No. 38).



LEXSEE 45 CAL.4TH 497

**PROSPECT MEDICAL GROUP, INC., et al., Plaintiffs and Appellants, v. NORTHRIDGE EMERGENCY MEDICAL GROUP et al., Defendants and Respondents. PROSPECT HEALTH SOURCE MEDICAL GROUP, Plaintiff and Appellant, v. SAINT JOHN'S EMERGENCY MEDICINE SPECIALISTS, INC., et al., Defendants and Respondents.**

S142209

## SUPREME COURT OF CALIFORNIA

*45 Cal. 4th 497; 198 P.3d 86; 87 Cal. Rptr. 3d 299; 2009 Cal. LEXIS 3*

January 8, 2009, Filed

**SUBSEQUENT HISTORY:** Reported at *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 2009 Cal. LEXIS 25 (Cal., Jan. 8, 2009)

**PRIOR HISTORY:**

Court of Appeal Second Appellate District, Division Three, No. B172737, No. B172817. Superior Court of Los Angeles County, No. BC300850, No. SC076909, Gerald Rosenberg, Judge.

*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 136 Cal. App. 4th 1155, 39 Cal. Rptr. 3d 456, 2006 Cal. App. LEXIS 208 (Cal. App. 2d Dist., 2006)

**SUMMARY:**

## CALIFORNIA OFFICIAL REPORTS SUMMARY

In a declaratory action, the trial court ruled that emergency care providers were not statutorily prohibited from billing patients directly for the differences between the bills submitted and the amounts paid by health care service plans. Individual practice associations alleged that the emergency care providers routinely billed patients for the balance of their bills after having received reimbursement from health care service plans that contracted with the individual practice associations. The trial court sustained the providers' demurrers without leave to amend and entered judgments accordingly. (Superior Court of Los Angeles County, Nos. BC300850 and SC076909, Gerald Rosenberg, Judge.) The Court of Ap-

peal, Second Dist., Div. Three, Nos. B172737 and B172817, upheld the ruling.

The Supreme Court reversed the judgment of the Court of Appeal and remanded the case for further proceedings. The court held that the Knox-Keene Health Care Service Plan Act of 1975 (*Health & Saf. Code*, § 1340 *et seq.*) does not permit balance billing. Although the court agreed with the Court of Appeal that *Health & Saf. Code*, § 1379, was inapplicable, the court found that other statutory provisions address balance billing. The language of *Health & Saf. Code*, § 1371.4, *subd. (b)*, mandates that a health maintenance organization (HMO) pay the provider directly and does not involve the patient in the payment process at all. *Health & Saf. Code*, § 1317, *subd. (d)*, indicates that when HMO members provide insurance information, they have satisfied their obligation toward the providers. *Health & Saf. Code*, § 1342, *subd. (d)*, expresses a legislative intent to transfer the financial risk of health care from patients to providers. (Opinion by Chin, J, with George, C. J., Kennard, J., Baxter, J., Moreno, J., Corrigan, J., and McDonald, J.,\* concurring.) [\*498]

\* Associate Justice of the Court of Appeal, Fourth Appellate District, Division One, assigned by the Chief Justice pursuant to *article VI, section 6 of the California Constitution*.

**HEADNOTES**

CALIFORNIA OFFICIAL REPORTS HEADNOTES

45 Cal. 4th 497, \*; 198 P.3d 86, \*\*;  
87 Cal. Rptr. 3d 299, \*\*\*; 2009 Cal. LEXIS 3

**(1) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--By statute, when emergency room doctors provide emergency services, health maintenance organizations are required to reimburse those doctors for the services rendered to their subscribers or enrollees. The Knox-Keene Health Care Service Plan Act of 1975 (*Health & Saf. Code, § 1340 et seq.*) compels for-profit health care service plans to reimburse emergency health care providers for emergency services to the plans' enrollees. *Health & Saf. Code, § 1371.4*, provides that a for-profit health care service plan shall reimburse providers for emergency services and care provided to its enrollees until the care results in stabilization of the enrollee, except as provided in *§ 1371.4, subd. (c)*. As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition (*§ 1371.4, subd. (b)*). *Section 1371.4, subd. (b)*, imposes a mandatory duty upon health care plans to reimburse noncontracting providers for emergency medical services.

**(2) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--Pursuant to *Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B)*, a health maintenance organization (HMO) has a duty to pay a reasonable and customary amount for the services rendered. But how this amount is determined can create obvious difficulties. In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between.

**(3) Statutes § 49--Construction--Reference to Other Laws--In Pari Materia (Same Subject Matter)--Harmonizing.**--Courts do not examine statutory language in isolation, but in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the various parts of the enactment.

**(4) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--*Health & Saf. Code, § 1317, subd. (d)*, which requires emergency room doctors to render emergency care without questioning a patient's ability to pay, also provides that the patient or his or her legally responsible relative or guardian shall execute an agreement to pay for the services or otherwise supply insurance or credit information promptly after the services are [\*499] rendered. This provision implies that

once patients who are members of a health maintenance organization provide insurance information, they have satisfied their obligation towards the doctors.

**(5) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--The only reasonable interpretation of a statutory scheme that (1) intends to transfer the financial risk of health care from patients to providers; (2) requires emergency care patients to agree to pay for the services or to supply insurance information; (3) requires health maintenance organizations (HMO's) to pay doctors for emergency services rendered to their subscribers; (4) prohibits balance billing when the HMO, and not the patient, is contractually required to pay; (5) requires adoption of mechanisms to resolve billing disputes between emergency room doctors and HMO's; and (6) permits emergency room doctors to sue HMO's directly to resolve billing disputes, is that emergency room doctors may not bill patients directly for amounts in dispute. Emergency room doctors must resolve their differences with HMO's and not inject patients into the dispute.

**(6) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--Doctors cannot bill patients for emergency services that the patients' health maintenance organizations are obligated to pay. Balance billing is not permitted. Thus, individual practice associations could maintain a declaratory action challenging providers' balance billing.

[*Cal. Insurance Law & Practice (2008) ch. 26, § 26.01*; 2 Witkin, Summary of Cal. Law (10th ed. 2005) Insurance, § 126 et seq.]

**(7) Statutes § 42--Construction--Aids--Purpose and Policy Considerations.**--If statutory language permits more than one reasonable interpretation, courts may consider extrinsic aids, including the purpose of the statute, the evils to be remedied, and public policy.

**(8) Healing Arts and Institutions § 2--Hospitals--Health Maintenance Organizations--Payment for Emergency Services.**--*Health & Saf. Code, § 1371.4, subd. (b)*, does not say that patients must pay emergency room doctors and then turn to their health maintenance organizations (HMO's) for reimbursement. Rather it states that the health care service plan shall reimburse providers for emergency services and care provided to its enrollees. This language does not authorize the round-about route of the doctor's collecting from the patient, who must then collect from the HMO. Rather, it mandates that the HMO pay the doctor directly. It does not involve the patient in the payment process at all. [\*500]

45 Cal. 4th 497, \*; 198 P.3d 86, \*\*;  
87 Cal. Rptr. 3d 299, \*\*\*; 2009 Cal. LEXIS 3

**(9) Statutes § 44--Construction--Aids--Contemporaneous Administrative Construction--Regulation Adopted While Litigation Pending.--**

Although courts give some deference to contemporaneous interpretations of a statute by an agency charged with its administration, especially when the interpretation is in the form of a regulation adopted in accordance with the Administrative Procedure Act, a regulation adopted during the pendency of the litigation is not contemporaneous with the statutory scheme. It is doubtful that a court owes such a regulation any deference.

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**JUDGES:** Opinion by Chin J, with George, C. J., Kennard, J., Baxter, J., Moreno, J., Corrigan, J., and McDonald, J., concurring.

**OPINION BY:** Chin

**OPINION**

[\*\*88] [\*\*\*301] **CHIN, J.**--A health maintenance organization (HMO) commonly manages medical care in California. In the typical model, familiar to many, doctors contract to provide medical care to enrolled HMO members. Members generally use the services of one of the contracting doctors. When they do, and except for copayments the members must make when services are rendered, the HMO (or its delegate) pays the doctor under the existing contract. In this way, the parties agree upon, and know in advance, what their obligations and rights are and who must pay, and how much, for medical care.

The typical payment model sometimes breaks down, however, in the case of emergency care. In an emergency, an HMO member goes to the nearest hospital emergency room for treatment. The emergency room doctors at that hospital may or may not have previously contracted with the HMO to provide care to its members. In that situation, the doctors are statutorily required to provide emergency care without regard to the patient's ability to pay. Additionally, when the patient is a member of an HMO, the HMO is statutorily required to pay for the emergency care.<sup>1</sup> For HMO members, it is always clear in advance who has to provide emergency services--any emergency room doctor to whom the member goes in an emergency--and who has to pay for those services--the HMO. The conflict arises when there is no advance agreement between the emergency room doctors and the HMO regarding the *amount* of the required payment.

<sup>1</sup> For ease of discussion, we will sometimes refer rather loosely to those required to provide emergency services without regard to the patient's ability to pay as emergency room doctors, while recognizing that the category is broader than just doctors (*Health & Saf. Code, § 1345, subd. (i)*), and to the entities required to reimburse those emergency room doctors for services rendered to their subscribers as HMO's, while recognizing that the entities are more technically described as

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"health care service plan[s]" and include the plans' delegates (*Health & Saf. Code, § 1371.4, subd. (e)*).

Thus, the potential inherently exists for disputes between the emergency room doctors and the HMO regarding how much [\*\*\*302] the HMO owes the doctors for emergency services. When no preexisting contract exists, the doctors [\*502] sometimes submit a bill to the HMO that they consider reasonable for the services rendered but that the HMO considers unreasonably high; conversely, the HMO sometimes makes a payment that it considers reasonable for the services rendered but that the doctors consider unreasonably low. The resolution of such disputes can create difficult problems.

But the question of how to resolve disputes between the doctors and the HMO over the amount due for emergency care is not before us in this case. The issue here is narrow, although quite important for emergency room doctors, HMO's, and their members: When the HMO submits a payment lower than the amount billed, can the emergency room doctors directly bill the *patient* for the difference between the bill submitted and the payment received--i.e., engage in the practice called "balance billing"?

Interpreting the applicable statutory scheme as a whole--primarily the Knox-Keene Health Care Service Plan Act of 1975, *Health and Safety Code section 1340 et seq.* (Knox-Keene Act) <sup>2</sup>--we conclude that billing [\*\*\*89] disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment. A patient who is a member of an HMO may not be injected into the dispute. Emergency room doctors may not bill the patient for the disputed amount.

2 All further statutory references are to the health and safety code unless otherwise indicated.

## I. FACTUAL AND PROCEDURAL BACKGROUND

Because neither party petitioned the Court of Appeal for a rehearing, we take our facts largely from that court's opinion. (*Richmond v. Shasta Community Services Dist.* (2004) 32 Cal.4th 409, 415 [9 Cal. Rptr. 3d 121, 83 P.3d 518]; see *Cal. Rules of Court, rule 8.500(c)(2)*.)

Plaintiffs and appellants, Prospect Medical Group, Inc., et al. (collectively Prospect), are individual practice associations. <sup>3</sup> Prospect manages patient care by executing written contracts with health care service plans. <sup>4</sup> It provides for medical care to persons who are members of health care service plans and who select a Prospect physician. Prospect also provides billing services to the [\*\*\*503] health care service plans contracted with Pros-

pect. As such, it is a "delegate" of those health care service plans and is statutorily obligated to pay for emergency services provided to patients who have subscribed to those health care service plans. (*§ 1371.4, subds. (b), (e)*.)

3 *Section 1373, subdivision (h)(6)*, defines an individual practice association by reference to title 42 *United States Code section 300e-1(5)*, which provides as relevant: "The term 'individual practice association' means a ... legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine ... ."

4 As pertinent here, *section 1345, subdivision (f)(1)*, defines a health care service plan as "[a]ny 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 for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees."

Defendants and respondents, Northridge Emergency Medical Group and Saint John's Emergency Medicine Specialists, Inc. (collectively Emergency Physicians), have exclusive licenses at two California hospitals to provide emergency room physician care. Emergency Physicians [\*\*\*303] are health care providers and are statutorily required to provide emergency care without regard to an individual's insurance or ability to pay. (*§ 1317, subd. (d)*; see also *42 U.S.C. § 1395dd*.)

When patients who are members of health care service plans schedule medical services in advance, they generally go to physicians with whom the health care service plan or its delegate, like Prospect, has an express preexisting contract. On occasion, when these same patients need emergency medical care, they may be taken to a hospital where the doctors staffing the emergency room do not have a preexisting contract with the health care plan or its delegate. In this case, after Emergency Physicians provided emergency medical services to patients who were members of health care service plans that contracted with Prospect, they submitted reimbursement claims to Prospect. Sometimes Prospect paid Emergency Physicians less than the amount billed. In those cases, Prospect paid what it alleged was reasonable for the services rendered. Emergency Physicians then billed the patients directly for the differences between the bills they submitted and what Prospect paid. The parties refer to this practice as "balance billing."

After billing disputes arose between Prospect and Emergency Physicians, Prospect filed two related actions against Emergency Physicians seeking, among other things, a judicial determination that (1) Emergency Phy-

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sicians were entitled only to "reasonable" compensation for emergency medical care, which Prospect claimed was equivalent to the Medicare rate; and (2) the practice of balance billing is unlawful. In one of the actions, Prospect alleged that Saint John's Emergency Medicine Specialists, Inc., "routinely bills Prospect's patients, threatens to turn over Prospect's patients to an outside collection agency, and threatens to take legal measures against Prospect's patients." The trial court sustained Emergency Physicians' demurrers without leave to amend and entered judgments accordingly. Prospect appealed **[\*\*90]** both judgments, and the Court of Appeal consolidated the appeals.

The Court of Appeal concluded that balance billing is not statutorily prohibited. Second, it concluded that Prospect is not entitled to a judicial declaration imposing the Medicare rate as the reasonable rate. Third, it **[\*504]** concluded the trial court abused its discretion by denying leave to amend the complaint to permit Prospect to allege that Emergency Physicians charged more than a reasonable rate for a specific medical procedure. We granted Prospect's petition for review, which raised the sole question whether Emergency Physicians may engage in balance billing.

## II. DISCUSSION

The Knox-Keene Act governs this case. "The Knox-Keene Act is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care." (*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215 [31 Cal. Rptr. 3d 688] (*Bell*)). In addition, one statute not part of the act is pertinent here. *Section 1317* requires emergency care providers to provide emergency services without first questioning the patient's ability to pay. (*Bell, supra*, 131 Cal.App.4th at pp. 215-216 & fn. 4.) Federal law is similar. (42 U.S.C. § 1395dd; see *Bell, supra*, at p. 215, fn. 4.)

(1) Today, by statute, when emergency room doctors provide emergency services, HMO's are required to reimburse those doctors for the services rendered to their subscribers or enrollees. As *Bell* explained, the Knox-Keene Act "compels for-profit health care service plans to reimburse **[\*\*\*304]** emergency health care providers for emergency services to the plans' enrollees. ... [S]ection 1371.4 provides that a for-profit 'health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in *subdivision (c)*. As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services

and care necessary to stabilize the enrollee's emergency medical condition.' (§ 1371.4, *subd. (b)*); see § 1371.4, *subd. (f)*.) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed ... .' (§ 1371.4, *subd. (c)*); see § 1371.4, *subd. (f)*; and see *Cal. Code Regs., tit. 28, § 1300.71, subd. (a)*.)" (*Bell, supra*, 131 Cal.App.4th at p. 215.) "*Subdivision (b) of section 1371.4* was enacted in 1994 to impose a mandatory duty upon health care plans to reimburse noncontracting providers for emergency medical services. [Citations.]" (*Id. at p. 216*.)

The combination of circumstances that (1) in an emergency a patient might go to emergency room doctors who have no preexisting contractual relationship with the HMO, (2) the doctors are required to render emergency care without asking whether the patient can pay for it, and (3) the HMO is **[\*505]** required to pay the doctors for those services, creates the problem underlying the issue before us. By the very nature of things, disputes may arise regarding how much the emergency room doctors may charge and how much the HMO must pay for emergency services.

(2) Regulations of the Department of Managed Health Care provide that the HMO must pay "the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case ... ." (*Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B)*); see *Bell, supra*, 131 Cal.App.4th at p. 216.) Thus, the HMO has a "duty to pay a reasonable and customary amount for the services rendered." (*Bell, supra*, at p. 220.) But how this amount is **[\*\*91]** determined can create obvious difficulties. In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between. In *Bell, supra*, 131 Cal.App.4th 211, the Court of Appeal interpreted the Knox-Keene Act to permit, when disputes arise, emergency room doctors to sue the HMO directly for the reasonable value of their services.

Prospect argues that *section 1379*, part of the Knox-Keene Act, prohibits balance billing. That section, enacted in 1975 and never amended, provides:

"(a) Every contract between a plan and a provider of health care services shall be in writing, and shall set forth

that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

[\*\*305] "(b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan.

"(c) No contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan."

Although no *express* contractual relationship exists between Prospect and Emergency Physicians, Prospect argues that the combination of statutes requiring emergency room doctors to render, and HMO's to pay for, emergency services creates an *implied* contract between emergency room doctors [\*506] and HMO's that has not been reduced to writing under *section 1379, subdivision (b)*. The Court of Appeal disagreed. Interpreting *section 1379* as a whole (but not in the context of the Knox-Keene Act as a whole), it held that this section does not cover the situation here. It found "that the language of *subdivision (b) of section 1379* refers to and includes within its scope only voluntarily negotiated contracts between providers of health care services, like Emergency Physicians, and health care service plans or their delegates, like Prospect, based upon traditional contractual principles such as a meeting of the minds. *Subdivision (b)* does not include within its scope the implied contract as Prospect asserts." Accordingly, it "conclude[d] that *section 1379, subdivision (b)*, was not intended to, and does not, prohibit the balance billing practices alleged in this case."

(3) Reading the language of *section 1379* in isolation, it does not readily apply to the precise situation here. No doubt the Legislature did not contemplate the situation of this case in 1975, when it enacted *section 1379*, for this situation did not exist in 1975. *Section 1371.4*, which obligates HMO's to pay for emergency services to its subscribers, was enacted in 1994, long after the Legislature enacted *section 1379*. But we must not view *section 1379* in isolation. "We do not examine [statutory] language in isolation, but in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the various parts of the enactment." (*Coalition of Concerned Communities, Inc. v. City of Los Angeles* (2004) 34 Cal.4th 733, 737 [21 Cal. Rptr. 3d 676, 101 P.3d 563].)

(4) We have already seen that in 1975, the Legislature banned balance billing when an HMO is contractually obligated to pay the bill (§ 1379); that since 1994,

HMO's have been obligated to pay for emergency care (§ 1371.4); and that the Knox-Keene Act permits emergency room doctors to sue HMO's directly over billing disputes (*Bell, supra*, 131 Cal.App.4th 211). These provisions strongly suggest that doctors may not bill patients directly when a dispute arises between doctors and the HMO's. Other provisions point in the same direction. *Section 1317, subdivision (d)*, which requires emergency room doctors to render emergency care without questioning a patient's ability to pay, also provides that "the patient or his or her legally responsible relative or guardian shall execute an agreement to pay [for the services] or otherwise supply insurance or credit information promptly after the services are rendered." (Italics added.) This provision implies that once patients who are members of an HMO [\*92] provide insurance information, they have satisfied their obligation towards the doctors. *Section 1342, subdivision (d)*, expresses a legislative intent to "[help] to ensure the best possible health care for the public at the lowest possible cost by [\*\*\*306] transferring the financial risk of health care from patients to providers." [\*507]

Additionally, the Legislature contemplated there may be disputes over the amounts owed to noncontracting providers such as emergency room doctors, and therefore the Knox-Keene Act requires that each HMO "shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes." (§ 1367, *subd. (h)(2)*; see also § 1371.38, *subd. (a)* [directing the Dept. of Managed Health Care to adopt regulations ensuring that each HMO adopt a dispute resolution mechanism that is "fair, fast, and cost-effective for contracting and noncontracting providers"].) Finally, the Legislature has acted to protect the interests of noncontracting providers in reimbursement disputes by prohibiting HMO's from engaging in unfair payment patterns involving unjust payment reductions, claim denials, and other unfair practices as defined, and by authorizing monetary and other penalties against HMO's that engage in these patterns. (§ 1371.37; see also § 1371.39 [authorizing providers to report HMO's that engage in unfair payment patterns to the Dept. of Managed Health Care].)

(5) The only reasonable interpretation of a statutory scheme that (1) intends to transfer the financial risk of health care from patients to providers; (2) requires emergency care patients to agree to pay for the services or to supply insurance information; (3) requires HMO's to pay doctors for emergency services rendered to their subscribers; (4) prohibits balance billing when the HMO, and not the patient, is contractually required to pay; (5) requires adoption of mechanisms to resolve billing disputes between emergency room doctors and HMO's; and (6) permits emergency room doctors to sue HMO's di-

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rectly to resolve billing disputes, is that emergency room doctors may not bill patients directly for amounts in dispute. Emergency room doctors must resolve their differences with HMO's and not inject patients into the dispute. (6) Interpreting the statutory scheme as a whole, we conclude that the doctors may not bill a patient for emergency services that the HMO is obligated to pay. Balance billing is not permitted.<sup>5</sup>

5 Our holding is limited to the precise situation before us--billing the patient for emergency services when the doctors have recourse against the patient's HMO. We express no opinion regarding the situation when no such recourse is available; for example, if the HMO is unable to pay or disputes coverage.

(7) Any doubt about the meaning of the Knox-Keene Act in this regard is easily resolved when legislative policy is considered. If statutory language permits more than one reasonable interpretation, courts may consider extrinsic aids, including the purpose of the statute, the evils to be remedied, and public policy. (*Torres v. Parkhouse Tire Service, Inc.* (2001) 26 Cal.4th 995, 1003 [111 Cal. Rptr. 2d 564, 30 P.3d 57].) We perceive a clear legislative policy not to place patients in the middle of billing disputes between doctors and HMO's. Indeed, the Department of Managed Health Care argued in *Bell*, and the Court of Appeal concluded, that doctors may directly sue HMO's to [\*508] resolve billing disputes in order to avoid the necessity of balance billing. The *Bell* court quoted the department's argument: "If providers are precluded from bringing private causes of action to challenge health plans' reimbursement determinations, health plans may receive an unjust windfall and patients may suffer an economic hardship when providers resort to balance billing activities to collect the difference between [\*\*\*307] the health plan's payment and the provider's billed charges. If collection actions are pursued, unsuspecting enrollees can be forced to reimburse the full amount of a provider's billed charges even though those charges are in excess of the reasonable and customary value of the services rendered. [¶] The prompt and appropriate reimbursement of emergency providers ensures the continued financial viability of California's health care delivery system. ... [D]enying emergency providers judicial recourse to challenge the fairness of a [\*\*93] health plan's reimbursement determination ... allows a health plan to systematically underpay California's safety-net providers and unnecessarily involve[s] the patient[s] in billing disputes between the provider and their health plan[s]." (*Bell, supra*, 131 Cal.App.4th at p. 218, italics added.)

Because emergency room doctors prevailed in *Bell, supra*, 131 Cal.App.4th 211, and won the right to resolve

their disputes directly with HMO's, no reason exists to permit balance billing. Thus, the Department of Managed Health Care, which supported doctors' rights to sue the HMO's directly in *Bell*, has appeared in this case as amicus curiae supporting patients' rights to be free of balance billing.

When a dispute exists between doctors and an HMO, the bill the doctors submit may or may not be the reasonable payment to which they are entitled. The *Bell* court made clear that an HMO does not have "unfettered discretion to determine unilaterally the amount it will reimburse a noncontracting provider ... ." (*Bell, supra*, 131 Cal.App.4th at p. 220.) But the converse is also true; emergency room doctors do not have unfettered discretion to charge whatever they choose for emergency services. Emergency room doctors and HMO's must resolve their disputes among themselves. Interjecting patients into the dispute by charging them for the amount in dispute has only an in terrorem effect. As Prospect notes, although emergency room doctors "are entitled to 'reasonable' compensation for the services rendered, they cannot lawfully seek unreasonable payment from anyone." But a patient will have little basis by which to determine whether a bill is reasonable and, because the HMO is obligated to pay the bill, no legitimate reason exists for the patient to have to do so. Billing the patient, and potentially attempting to collect from the patient, will put unjustifiable pressure on the patient, who will often complain to the HMO, which complaints will in turn pressure the HMO to make the payment even if it is unreasonable. Such a billing practice is not a legitimate way to resolve disputes with an HMO. [\*509]

(8) Relying in part on dicta in *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782 [9 Cal. Rptr. 3d 734], Emergency Physicians argue that they may collect from the patient, who may then collect from the HMO. The *Ochs* court held that it did not have to decide the issue presented in this case, but it went on to "observe, however, that section 1379 appears only to limit 'balance billing' of insured patients by physicians who have contracted with the patients' plans. [The provider] may have a remedy against the individual patients, and those patients a remedy against PacifiCare." (*Id.* at p. 796.) But this is not what the statutory scheme provides. Section 1371.4, subdivision (b), does not say that patients must pay the emergency room doctors and then turn to their HMO's for reimbursement. Rather it states that the "health care service plan ... shall reimburse providers for emergency services and care provided to its enrollees ... ." [\*\*\*308] This language does not authorize the roundabout route of the doctor collecting from the patient, who must then collect from the HMO. Rather, it mandates that the HMO pay the doctor directly. It does not involve the patient in the payment process at all.

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Emergency Physicians and their supporting amici curiae argue that emergency room doctors are entitled to a reasonable fee for their services, and that HMO's must be held accountable and forced to pay a reasonable amount for those services. An amicus curiae brief supporting Emergency Physicians adds arguments that the California Constitution "requires that emergency physicians receive adequate compensation to cover their losses for serving the indigent," and that "California's emergency departments are already operating at capacity and risk jeopardizing quality of care." These arguments do not address the issue before us. Emergency room doctors *are* entitled to reasonable payments for emergency services rendered to HMO patients. All we are holding is that this entitlement does not further entitle the doctors to bill patients for any amount in dispute.

Emergency Physicians argue that two recent bills that the Legislature passed but the Governor vetoed show that the Legislature [\*\*94] believes that balance billing is currently permitted. (Sen. Bill No. 981 (2007-2008 Reg. Sess.); Assem. Bill No. 2220 (2007-2008 Reg. Sess.)) We find no significance in these bills. They were legislative attempts to address broader concerns and, perhaps, clarify what is currently unclear. The Governor's veto messages state that he opposes balance billing but found the bills objectionable in other respects. This area of the law might benefit from comprehensive legislation. Failed attempts to provide some such legislation do not help us interpret the existing statutory scheme.

In support of its conclusion that emergency room doctors may engage in balance billing, the Court of Appeal cited a regulation that became operative sometime before 1978 and requires health care service plans to advise their [\*510] subscribers that "in the event the health plan fails to pay a noncontracting provider, the member may be liable to the noncontracting provider for the cost of the services." (*Cal. Code Regs.*, tit. 28, § 1300.63.1, subd. (c)(15).) This regulation, the Court of Appeal believed, shows that the Department of Managed Health Care "recognizes balance billing." (As noted, that department argues against permitting balance billing in this case.) In our view, the regulation does not support the conclusion that balance billing is permissible in the situation here. It was promulgated long before the statute obligating HMO's to pay for emergency services was enacted in 1994 and governs a different situation. HMO members are not *required* to go to doctors who have contracted with their HMO. In a nonemergency situation, members may, if they choose, seek professional services from anyone. If they obtain services from a noncontracting provider, the HMO might not be obligated to pay all or even part of that provider's bill, depending on the exact terms of the health care plan. If the HMO is not obligated to pay the noncontracting provider, obviously, the

member *would* be liable to pay for the services. This circumstance does not change the fact that under the Knox-Keene Act, HMO members are *not* liable to pay for emergency care.

(9) The Court of Appeal also relied on the fact that the Department of Managed Health Care had, in the past, proposed but never adopted a regulation that would prohibit balance billing. While this matter was pending before this court, the Department [\*\*\*309] of Managed Health Care did adopt a regulation that defines balance billing as an unfair billing pattern. (*Cal. Code Regs.*, tit. 28, § 1300.71.39.) The parties dispute the meaning and validity of this regulation and whether we should give it deference. We need not get into such matters. Although we have given some deference to contemporaneous interpretations of a statute by an administrative agency charged with its administration, especially when the interpretation is in the form of a regulation adopted in accordance with the Administrative Procedure Act (e.g., *Sara M. v. Superior Court* (2005) 36 Cal.4th 998, 1011-1014 [32 Cal. Rptr. 3d 89, 116 P.3d 550]), here the regulation--adopted during the pendency of this litigation--is not contemporaneous with the statutory scheme. It is doubtful that we owe the regulation any deference. (See *Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1389 [241 Cal. Rptr. 67, 743 P.2d 1323] [not deferring to a noncontemporaneous interpretation]; *Jones v. Tracy School Dist.* (1980) 27 Cal.3d 99, 107 [165 Cal. Rptr. 100, 611 P.2d 441] [not deferring to an interpretation by an agency after the agency had become an amicus curiae in the case].) We base our holding on our interpretation of the relevant statutory scheme and not on the previous absence or current presence of any regulation.

The parties discuss the larger problem of adequate compensation for emergency room doctors. But this larger issue is not before us. Like the *Bell* court, "we reject the parties' suggestion that we can solve the societal and [\*511] economic problems defined by their rhetoric, and emphasize that our decision is limited to the precise issue before us ... ." (*Bell, supra*, 131 Cal.App.4th at p. 222.)

### III. CONCLUSION

We reverse the judgment of the Court of Appeal and remand the matter for further proceedings consistent with this opinion.

George, C. J., Kennard, J., Baxter, J., Moreno, J., Corrigan, J., and McDonald, J., \* concurred.

\* Associate Justice of the Court of Appeal, Fourth Appellate District, Division One, assigned by the Chief Justice pursuant to *article VI, section 6 of the California Constitution*.





LEXSTAT CAL CODE OF REGULATIONS, TITLE 28, 1300.71.39

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TITLE 28. MANAGED HEALTH CARE  
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE  
CHAPTER 2. HEALTH CARE SERVICE PLANS  
ARTICLE 8. SELF-POLICING PROCEDURES

28 CCR 1300.71.39 (2010)

§ 1300.71.39. Unfair Billing Patterns

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

(b) For purposes of this section:

(1) "Emergency services" means those services required to be covered by a health plan pursuant to *Health & Safety Code sections 1345(b)(6), 1367(i), 1371.4, 1371.5* and Title 28, *California Code of Regulations, sections 1300.67(g) and 1300.71.4*.

(2) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed the provider by the health care service plan.

(3) "The plan's capitated provider" shall have the same meaning as that provided in section 1300.71(a).

AUTHORITY:

Note: Authority cited: *Sections 1344, 1371.39 and 1371.4, Health and Safety Code*. Reference: *Sections 1317.1, 1317.7, 1342, 1345, 1346, 1362.8, 1367, 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4, 1371.5 and 1379, Health and Safety Code*.

HISTORY:

1. New section filed 9-15-2008; operative 10-15-2008 (Register 2008, No. 38).