February 3, 2022

Via Email

Mary Watanabe
Director, Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

Re: Draft All Plan Letter – No Surprises Act (NSA) Guidance
Specified State Law for Payment for Out-of-Network Emergency Services

Dear Ms. Watanabe:

The California Hospital Association (CHA), on behalf of its more than 400 member hospitals and health systems, submits these comments in response to the Draft All Plan Letter (APL) issued by the Department of Managed Health Care (DMHC) titled "APL 22-#### —No Surprises Act (NSA) Guidance." CHA asks that, before proceeding any further with the Draft APL, the DMHC hold stakeholder meetings to further consider the issues outlined below.

California hospitals have a special interest in the Draft APL, particularly because they must provide emergency services to any individual who presents at the hospital, whether or not the hospital is in-network or out-of-network with the patient's health/insurance plan. Hospitals must also provide post-stabilization services if the plan fails to timely transfer the patient to an in-network hospital. (*See,* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd; *see also*, Health & Safety Code §§ 1262.8 and 1317 et seq.) Accordingly, hospitals are keenly interested in the DMHC's communications with the federal government about payment for out-of-network emergency and post-stabilization services.

The Draft APL incorrectly states that the Knox-Keene Act prohibition on "plans and providers from balance billing enrollees for out-of-network emergency services … does not constitute a 'specified state law' within the meaning of the NSA." (Draft APL, p. 3, § I.B.) The Draft APL goes on to state that "for out-of-network emergency services, DMHC-licensed health plans must comply with the NSA provisions pertaining to enrollee cost-sharing, provider reimbursement, and the resolution of disputes between plans and providers/facilities." (*Id.*, emphasis added.)

CHA respectfully submits that California **does** have "specified state law" that provides for a method for determining the total amount a plan governed by the Knox-Keene Act must pay an out-of-network hospital for emergency and post-stabilization services, as explained more fully below.

Under the NSA, "specified state law" means:

> with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, ***a State law that provides for a method for determining the total amount payable*** under such a plan, coverage, or issuer, respectively … in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

(42 U.S.C. § 300gg-111(a)(3)(I) (emphasis added); *see also* 45 C.F.R. § 149.30.)

The federal preemption provision applicable to the relevant provisions of the NSA defines the term "State law" broadly to "include[] all laws, **decisions**, rules, regulations, or **other State action having the effect of law**, of any State." (42 U.S.C. § 300gg-23(d)(1) (emphasis added).)

The NSA's definition of "specified State law" also incorporates the Employee Retirement Income Security Act's (ERISA) preemption standard (by referring to Section 1144 of Title 29), and ERISA broadly defines "State law" the same way. (*See,* 29 U.S.C. § 1191(d)(1) (ERISA Section 731); accord Interim Final Rule, Requirements Related to Surprise Billing, Part I, 86 Fed.Reg. 36872, 36886 (July 13, 2021) (recognizing that ERISA Section 731 applies to determine the scope of the phrase "specified State law").)

The preamble to Part 1 of the NSA regulations states:

> The Departments interpret the statutory phrase "a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively" broadly as referring not only to state laws that set a mathematical formula for determining the out-of-network rate, or that set a predetermined amount for an out-of-network item or service. Rather, the Departments interpret that language to also include, for example, state laws that require or permit a plan or issuer and a provider or facility to negotiate, and then to engage in a state arbitration process to determine the out-of-network rate. Such state laws provide a process for determining the total amount payable, and in such instances, the timeframes and processes under such a state law related to negotiations and arbitration would apply, as opposed to the timeframes and IDR process under the No Surprises Act.

(Interim Final Rule, Requirements Related to Surprise Billing, Part I, 86 Fed.Reg. 36872, 36887 (July 13, 2021).)

By contrast, the DMHC's Draft APL ignores this broad definition of "State law" under the NSA, which makes the DMHC's draft inaccurate. We respectfully point this out so that the DMHC can correct and revise its APL and any other communications on this topic.

California law provides several methods for determining the total amount payable to a non-participating provider of emergency and post-stabilization services. As set forth below, depending upon certain circumstances, when health care plans are financially responsible for non-participating hospital services, the methods set forth under California law expressly require them to pay one of the following: (i) billed charges; (ii) reasonable billed charges; or (iii) reasonable and customary charges. (Health & Safety Code §§ 1262.8, 1371, 1371.35, 1371.4; 28 C.C.R. § 1300.71(a)(3)(B).)

California's Statutory Method for Determining the Value of Post-Stabilization Services
California statutory law sets forth a clear and express method for determining the out-of-network rate for post-stabilization services in a number of specified circumstances. Specifically, Health & Safety Code § 1262.8 sets forth a method for determining how much health plans are required to pay for post-stabilization hospital services where the plan fails to timely respond to a request for authorization or to timely arrange for the safe transfer of its member to a network facility. When hospitals know that a patient who needs post-stabilization services is covered by a non-contracted health plan, the statute provides for the hospital to contact the health plan to give the plan an opportunity to either (a) authorize the hospital to provide the services or (b) transfer the patient to another hospital.

After initial contact from the hospital, the health plan has 30 minutes to respond to the hospital and, in that time, either authorize post-stabilization care or inform the provider that the plan will arrange for the prompt transfer of its member to another facility. (Health & Safety Code § 1262.8(d)(1).)
If the health plan fails to respond within 30 minutes, California law requires that the plan "**shall pay charges**" for the post-stabilization care. (Health & Safety Code § 1262.8(d)(2).) This provision was the Legislature's way to make sure that health plans, which had insisted on getting these calls, assign sufficient staff to timely respond to them.

The statute goes on to state that if the health plan opts to transfer the patient, but fails to do so, it is also responsible to pay **charges** for the post-stabilization care provided to the patient. (Health & Safety Code § 1262.8(d)(3).)

In both cases, the duty to "pay charges" is not qualified by the statute in any way. This was the legislative compromise that we and our members lobbied for in exchange for agreeing to notify plans of each noncontracted member seeking hospital care.

Furthermore, the statute goes on to say that if the health plan opts to transfer the patient and does affect the transfer, then the plan is responsible for "**reasonable charges**" associated with transferring the patient. (Health & Safety Code § 1262.8(e).) The term "reasonable" was added to this situation, but not to the others, because the Legislature decided to establish different standards for the failure to timely respond versus the failure to timely transfer when opting to do so.

These rules in Health & Safety Code § 1262.8 specifically prescribe the method for determining the amount of payment a plan must make to an out-of-network provider for post-stabilization services. They require that health plans (a) "pay charges" if the plan fails to respond within 30 minutes to a call

from a hospital for authorization to provide post-stabilization care, or states that it will transfer the patient but does not move the patient and (b) pay "reasonable charges" for services required to transfer the patient when the plan opts to transfer the patient, and does so, to another facility. This statutory method constitutes a "specified state law" under the NSA because it sets forth methods for determining out-of-network payment for post-stabilization services in these circumstances.

California Law's Method for Determining the Reasonable and Customary Value of Emergency Services and Authorized Post-Stabilization Services

California statutes, regulations, and court decisions set forth a clear method for determining the out-of-network rate for emergency and post-stabilization services. (42 U.S.C. § 300gg-23(d)(1).)

In the Draft APL, the DMHC takes the position that some sections of the Knox-Keene Act (the anti-balance billing laws that apply to health professional providers performing non-emergency services found at Health & Safety Code §§ 1371.30 and 1371.31) are "specified state laws" under the NSA, but the immediately adjacent sections of the Knox-Keene Act (the anti-balance billing laws that apply to providers performing emergency services found at Health & Safety Code §§ 1371 *et seq.*) are not specified state laws under the NSA. However, these sections of the Knox-Keene Act are not so different from each other, and do not result in a lack of method for the latter.

Under Assembly Bill (AB) 72, a health plan must make an initial payment to the provider that is the greater of the average contracted rate or 125% of the Medicare reimbursement rate. If the health plan and the provider disagree about the appropriate reimbursement, they may (not "must," as the DMHC states in the Draft APL) utilize the state's independent dispute resolution (IDR) process established by the DMHC. In other words, health professional providers can file a lawsuit to challenge the payments without first going through the IDRP. "In deciding the dispute, the independent organization shall base its decision regarding the appropriate reimbursement on all relevant information." (Health & Safety Code § 1371.30(a)(5).) "If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law." (Health & Safety Code § 1371.30(d).) In other words, California statutory law confirms that the health professional providers can file a lawsuit to challenge the payments if dissatisfied with the IDRP process or outcome.

The Knox-Keene Act statutes, regulations, and case law relating to the reasonable value of emergency services are no less "specified state laws" than the Knox-Keene Act statutes relating to non-emergency services (i.e., AB 72). The California Supreme Court and Courts of Appeal have recognized that "[t]he Knox–Keene Act is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care." (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 503, *citing Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215).)

The courts have been clear: "Among many other things, the Act compels health care service plans to reimburse emergency health care providers for emergency services to the plans' enrollees." (*Bell*, 131 Cal.App.4th 215, citing Health & Safety Code §§ 1371 and 1371.35 [a health care service plan must "reimburse claims … as soon as practical, but no later than 30 working days after receipt of the claim … unless the claim or portion thereof is contested by the plan"].)

The DMHC has established standards for this express statutory requirement. The DMHC is charged with the administration and enforcement of the laws relating to health care service plans. (Health & Safety

Code § 1341.) To carry out its duties, the DMHC was authorized to promulgate regulations. (Health & Safety Code § 1344.) The DMHC has adopted "Claims Settlement Practices" to implement the provisions of the Knox-Keene Act relating to plan requirements to pay for emergency services. (28 Cal. Code Regs. § 1300.71.)

The Claims Settlement Practices, which are arguably more extensive than AB 72, describe the outside claims filing deadlines that plans can establish how and when plans must acknowledge receipt of a claim, when health plans must pay providers, and several specific factors that plans must take into account in determining how much to pay non-contracted providers, what constitutes an unjust or unfair payment pattern, what is reasonably relevant information for a claim, and the limits on plans recovering overpayments.

The DMHC's regulations are no less a "State law" under the NSA than a statute or court decision. The DMHC's regulations spell out that plans must pay a "reasonable and customary value" to emergency care providers "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 …" (28 Cal. Code Regs. § 1300.71(a)(3)(B).)

In *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, the Court of Appeal also confirmed that the Knox-Keene Act provides a **method** for determining the amounts payable by a health plan to an out-of-network emergency care provider. "These statutes impose **procedural requirements** on claim processing and subject health care service plans to disciplinary action and penalties for failure to timely comply with those requirements." (*Id.* at 1271; emphasis added, citing *California Medical Assn. v. Aetna U.S. Healthcare of California, Inc.* (2001) 94 Cal.App.4th 151, 163.)

The *Children's* court also discussed how the DMHC's regulations provide a **method** for determining the amounts payable by a health plan to an out-of-network emergency care provider. "In the final statement of reasons for California Code of Regulations, title 28, section 1300.71, the DMHC explained that the intent was to establish a **methodology** for determining the reasonable value of health care services by noncontracted providers but that the criteria specified do not dictate a specific payment rate. (*Children's,* 226 Cal.App.4th at 1273 (emphasis added)). As *Children's* confirmed: "The DMHC explained in its initial statement of reasons that California Code of Regulations, title 28, section 1300.71 was "necessary to clearly define **terms relating to claim settlement and reimbursement**, and provide **procedures** for plans and providers to prevent unreasonable delays in payment of provider claims." Further, the court found that the DMHC wanted to clarify "the meaning of unfair payment practices and the term 'complete and accurate claim.'" (*Children's,* 226 Cal.App.4th at 1271 (emphasis added).)

Similarly, in reviewing the Knox-Keene Act and regulations related to balance billing, the California Supreme Court recognized how comprehensive California state law is in this field. "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 HMOs 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 HMOs; and (6) permits emergency room doctors to sue HMOs directly to resolve billing disputes, is that emergency room doctors may not bill patients directly for amounts in dispute." (*Prospect*, 45 Cal.4th at 507.)

Moreover, the DMHC adopted regulations requiring health plans to "establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. (28 Cal. Code Regs. § 1300.71.38.) These regulations certainly qualify as a "State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively … in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility." (42 U.S.C. § 300gg-111(a)(3)(I).)

Furthermore, both the DMHC and the courts have recognized that if providers are not satisfied with the "reasonable and customary" payment they receive from health plans, they may pursue their claims in court. This California case law even pointed out that the DMHC is on record confirming that one method a provider can use to pursue payment is through a lawsuit:

> "Indeed, the Department of Managed Health Care argued in *Bell*, and the Court of Appeal concluded, that doctors may directly sue HMOs to 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 the health plan's payment and the provider's billed charges. … **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 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]**.'"

(Prospect, 45 Cal.4th at 507 (emphasis added), *citing Bell, supra*, 131 Cal.App.4th at p. 218); *see also Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc*. (2021) 71 Cal.App.5th 323, 335 ("If a hospital or other medical provider believes that the amount of reimbursement it has received from a health plan is below the 'reasonable and customary value' of the emergency services it has provided, the hospital or provider may assert a quantum meruit claim against the plan to recover the shortfall."); *Children's*, 226 Cal.App.4th at 1273 ("The DMHC further noted that the 'regulations are intended to set forth the minimum payment criteria to ensure compliance with the [Knox-Keene] Act's claims payment and dispute resolution standards', and that, to the extent providers wish to pursue other common law or statutory remedies, they may seek redress in the courts.").

In *Children's*, the Court of Appeal described the evidence that a jury may consider in determining the reasonable value of out-of-network emergency and post-stabilization services:

> The "reasonable value" of the services has been described as the "going rate" for the services or the "reasonable market value at the current market prices." Reasonable market value, or fair market value, is the price that "'a willing buyer would pay to a willing seller, neither being under compulsion to buy or sell, and both having full knowledge of all pertinent facts.'"
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> In determining value in quantum meruit cases, courts accept a wide variety of evidence. For example, the party suing for compensation may testify as to the value of his services or offer expert testimony. However, such evidence is not required and is not binding on the trier of fact. Evidence of value can also be shown through agreements to pay and accept a particular price. "The court may consider the price agreed upon by the parties 'as a criterion in ascertaining the reasonable value of services performed.'" Accordingly, in an action for the reasonable value of services, a written contract providing for an agreed price is admissible in evidence. Additionally, evidence of a professional's customary charges and earnings is relevant and admissible to demonstrate the value of the services rendered. … In a given case, the reasonable and customary amount that the health care service plan has a duty to pay might be the bill the [medical provider] submits, or the amount the [health care service plan] chooses to pay, or some amount in between.

(Children's, 226 Cal.App.4th at 1274-1275.) This is a method California law has established for determining what will be paid in these situations.

The combined impact of the Knox-Keene Act, the DMHC regulations, and the extensive California case law dealing with emergency and post-stabilization services and payment means that California law "**provides for a method for determining the total amount payable***"* by a health plan to an out-of-network emergency care provider. (42 U.S.C. § 300gg-111(a)(3)(I).)

If the DMHC were to take the position that the Knox-Keene Act, regulations thereunder, and cases interpreting them are not a specified state law, such that non-contracted claims are governed by the NSA, it would (a) nullify the Knox-Keene Act, the regulations, and California case law, (b) deprive the California Legislature and the DMHC of jurisdiction to regulate health plans in California, and (c) deprive California courts of their authority to interpret the Knox-Keene Act and regulations promulgated thereunder. For example, if the NSA overcomes the Knox-Keene Act, then the statutes and the DMHC's regulations concerning the prompt timing of payments will have been rendered a nullity. There is too much California legal history at the statutory, regulatory, and court level relating to emergency and post-stabilization services and payment to suggest that California did not intend to address this field.

Moreover, if the only avenue for hospitals to challenge payments made by health plans was to pursue the claims under the NSA's IDR process, it would (as the DMHC argued in *Bell*) result in health plans receiving an unjust windfall.

Under the NSA, health plans could theoretically terminate all their contracts with providers that specify higher rates of reimbursement and keep in place just a few contracts that provide for very low reimbursement, to game the federal statute. The plans could then base their reimbursement on those low contract rates, and in the IDR process, argue that those low rates are the plan's

median contract rate and, therefore, the Qualifying Payment Amount. The result would be that access to care and quality of care in California would be a "race to the bottom."

Unlike some other states, California has gone to great lengths to prohibit balance billing and to establish a clear method for health plans to pay non-contracted providers. We believe it is inaccurate to say otherwise. CHA respectfully requests that the DMHC pause its work on the Draft APL and hold stakeholder meetings to further consider the issues raised in this letter.

Sincerely,

Trina Gonzalez
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cc: Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations, DMHC