HEALTH ACCESS

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FACSIMILE TRANSMITTAL SHEET

TO: Mary Daniels	FROM: Marin Nakasone
COMPANY: DMHC	DATE: 12/12/2008
FAX NUMBER: (916) 322-3968	TOTAL NO. OF PAGES INCLUDING COVER: 16
PHONE NUMBER:	SENDER'S REFERENCE NUMBER: (916) 497-0923 x200
RE: Health Access Application for an Award of Advocacy and Witness Fees 2008-1536 Definition of Unfair Billing Patterns	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS

Hi Mary,

Attached is Health Access' application for award of advocacy and witness fees for 2008-1536, Unfair Billing Patterns.

Thank you so much for all your help!

Best,
Marin

1127 11TH STREET, SUITE 234
SACRAMENTO, CALIFORNIA 95814

Application for an Award of Advocacy and Witness Fees

For which proceeding are you seeking compensation? ☆
2008-1536 Definition of Unfair Billing Patterns

What is the amount requested? ☆ **$30,567.87**

Proceeding Contribution: ☆
Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 22, Section 1010(b)(8), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

Health Access, a coalition of more than 200 consumer, community and other organizations, offered comments on the proposed regulations on Unfair Billing Patterns, Control # 2008-1536 based on AB 1455 by Senator Jack Scott (D-Pasadena). Health Access gave oral testimony at public hearings and submitted written testimony regarding revisions to DMHC's regulation which banned unfair billing patterns. Some, but not all, of our comments and testimony resulted in changes to the regulation.

- Health Access supported an absolute prohibition on balance billing and believed the Department had the statutory authority to do so. We saw no reason for consumers with coverage who obtained emergency care to be billed for anything other than co-pays and deductibles. We supported DMHC's contention that nothing is gained by placing the patients in the middle of what is essentially a billing dispute between providers and health service plans. We argued that there is never justification for actions that can result in sending a consumer to Collections.
- We supported the Department's efforts to undertake policies and remedies that promote adequate reimbursement for doctors and help stabilize emergency departments and trauma centers. Plans maintain these frequently-disputed specialty services are hard to contract for which results in gaps where those services are not provided for or not paid for. We believe this directly contradicts their obligation to provide basic health care services to their members in exchange for the members' enrollment in their plan. We further believe that these payment disputes and the lack of specialist participation on their panels actually masks a clear manifestation of the serious problem of the inadequacy of provider networks in many plans.
- We also argued that DMHC should help reduce the incidence of balance billing disputed charges by increasing their oversight of the plans' own Dispute Resolution Processes, make the results of their reviews publicly available on their website, and take appropriate enforcement and/or administrative actions.
- We also urged these provisions should be clear that they apply to delegated providers, medical groups, and other contracted entities, as well as plans. The language should also be plain that the regulation applies to both contracting and non-contracting providers so there is no possibility of misunderstanding.

Award # 1228952509859

Proceeding:	2008-1536 Definition of Unfair Billing Patterns
Date Requested:	12/10/2008 3:41:50 PM
Amount Requested:	$30567.87
Status:	Incomplete

HEALTH ACCESS
INTERVENER FEES : DEPARTMENT OF MANAGED HEALTH CARE
Regulation Number: 2008-1536
Unfair Billing Patterns

2008-1536	**Time recorded for:**	**Beth Capell, Health Care Policy Expert**			
Date	Time	Activity	Time Elapsed Number of Hours	Hourly Rate	Billed Amount
10/3/2006	4:00PM-5:00PM	Researched and assisted with preparation of written testimony for the DMHC Public Hearing and Financial Solvency Standards Board Meeting in Burbank	1	$ 350.00	$ 350.00
10/23/2007	6:00am-6:45am	Research and preparation of talking points for testimony at the DMHC Public Hearing on October 24, 2007	.75	$ 350.00	$ 262.5
11/29/2007	12pm-1pm	Review of comments due November 20, 2007	1	$ 350.00	$ 350.00
		Total; Beth Capell	*2.75*		*$ 962.50*
2008-1536	**Time recorded for:**	**Elizabeth Abbott, Health Care Policy Expert**			
8/9/2006	12:00pm-1:45pm	Attended Financial Solvency Standards Board Meeting in Sacramento	1.75	$ 350.00	$ 612.50
9/12/2006	11:00am-12:00pm 1:00pm-5:00pm	Researched and prepared testimony for the DHMC Public Hearing and Financial Solvency Standards Board Meeting in Burbank	5	$ 350.00	$ 1,750.00
9/13/2006	6:00am-6:00pm	Traveled to and gave testimony at the DMHC Public Hearing and Financial Solvency Standards Board Meeting in Burbank (including transportation time)	12	$ 350.00	$ 4,200.00
9/13/2006		Expenditures for 9/13/2006 DMHC Public Hearing: Airfare, Southwest Airlines, RT from Sacramento: $98.60 Sacramento Airport Parking: $12.00 Meal, Hilton Burbank: $14.94 Mileage (42 miles RT, residence to airport): $18.69			$ 144.23

10/3/2006	9:00am-12:00pm 1:00pm-6:00pm	Researched and prepared written testimony for the DMHC Public Hearing in Sacramento on October 4, 2006	8	$ 350.00	$ 2,800.00
10/4/2006	8:00am-5:00pm	Traveled to and attended the DMHC Public Hearing in Sacramento on proposed balance billing regulations	9	$ 350.00	$ 3,150.00
10/23/2007	1:00pm-4:30pm	Prepared written comments to the DMHC on Plan and Provider Claims Settlement Control #2007-1253	3.5	$ 350.00	$ 1,225.00
10/24/2007	7:30am-5:00pm	Traveled to and attended the DMHC Public hearing on Plan and Provider Claims Settlement #2007-1253 in Burbank	9.5	$ 350.00	$ 3,325.00
10/24/2007		Expenditures for 10/24/2007 DMHC Public Hearing: Airfare, Southwest Airlines, RT from Sacramento: $258.80 Sacramento Airport Parking: $12.00 Meal, Marriott Burbank: $19.13 Mileage (42 miles RT, residence to airport): $20.37			$ 310.30
11/29/2007 11/30/2007	2:00pm-4:00pm 1:00pm-2:30pm	Prepared written comments from Health Access on DMHC Plans and Provider Claims Settlement Regulation #2007-1253	3.5	$ 350.00	$ 1,225.00
5/14/2008	6:00am-6:00pm	Traveled to and attended the DMHC Public Hearing on balance billing in Irvine, CA to listen to the proceeding and give testimony on behalf of consumers	12	$ 350.00	$ 4,200.00
5/14/2008		Expenditures for 5/14/2008 DHMC Public Hearing: Airfare, Southwest Airlines, RT from Sacramento: $190.00 Sacramento Airport Parking: $12.00 Meals, Marriott Irvine: $27.72 Mileage (42 miles RT, residence to airport): $21.12			$ 250.84
5/19/2008 5/20/2008	1:00pm-4:45pm 9:00am-9:30am	Prepared written comments from Health Access on Third Amended Notice of DMHC Regulation 2008-1536	4.25	$ 350.00	$ 1,487.50
5/20/2008	10:00am-1:15pm	Attended DMHC Public Hearing on balance billing in Sacramento, CA to listen to the proceeding and give testimony on behalf of consumers	3.25	$ 350.00	$ 1,137.50
6/20/2008	2:00pm-3:15pm	Met with Ed Heidig and Rick Martin to discuss balance billing issues including plan grievance processes	1.25	$ 350.00	$ 437.50
		Total; Elizabeth Abbott	73		$ 26,255.37

2008-1536	Time recorded:	**Anthony Wright, Health Care Consumer Advocate; Executive Director, Health Access**			
9/12/2006 9/14/2006	5:00pm- 6:00pm 3:00pm-4:00pm	Gave direction, reviewed testimony, heard reports and provided feedback on balance billing testimony around the Burbank hearing on September 13	2	$ 200.00	$ 400.00
10/3/2006 10/4/2006	3:00pm-5:00pm 5:00pm-6:00pm	Gave direction, reviewed proposed testimony, heard reports and provided feedback on balance billing testimony around the Sacramento hearing on October 4	3	$ 200.00	$ 600.00
7/19/2007	3:00pm-4:30pm	Informal meeting with Rick Martin, DMHC, about the status of balance billing regulations (on the same day as the Blue Cross DMHC hearing in Los Angeles). Reported and discussed policy option with staff afterwards.	1.5	$ 200.00	$ 300.00
July-September, 2007	Varies	Coalition conversations with AARP, CalPIRG, CPEHN, and others, and with Western Center on Law and Poverty separately, about the content of balance billing regulation, coordinating activity, and engaging in preliminary research regarding how other states deal with the issue. Consulting with HA staff on the issue, and providing direction	5	$ 200.00	$ 1,000.00
5/14/2008-5/20/2008	Varies	Gave direction, reviewed proposed testimony, heard reports and provided feedback on balance billing hearings in Irvine and Sacramento in May 2008	2.5	$ 200.00	$ 450.00
10/3/2008-10/14/2008	Varies	Conversations with Lynne Randolph, DMHC, about the finalizing of the balance billing regulations, talking with staff and Elizabeth Landsberg, Western Center on Law and Poverty, about the content of the regulation and about participating in the October 14 press conference call announcing and supporting their adoption	3	$ 200.00	$ 600.00
		Total; Anthony Wright	*17*		*$ 3,350.00*
		Total Time & Amount Billed	**92.75**		**$ 30,567.87**

HEALTH ACCESS CALIFORNIA

May 20, 2008

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Rick Martin, Deputy Director
Financial Solvency Standards Board

Re: **Control # 2008-1536** Unfair Billing Patterns

Dear Ms. Ehnes,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on the proposed regulations on Unfair Billing Patterns. These regulations result from AB 1455 by Senator Jack Scott (D-Pasadena).

We have the following comments as outlined below:

1. **Health Access supports an absolute prohibition on balance billing**. There is no reason for consumers with coverage obtaining emergency care to be billed for anything other than co-pays and deductibles. We believe the Department does have the statutory authority to prohibit balanced billing and it is proper for them to do so. The Department is correct in stating that nothing is gained by placing the patients in the middle of what is essentially a billing dispute between providers and health service plans.

   At the Department's public hearings, several people said that they believed it was essential for patients to be balance billed for disputed charges between providers and health service plans. They asserted that in many cases this financial threat motivated patients to intervene with the health service plans to ensure fair payment to providers. We strongly believe there is never justification for actions that can result in sending a consumer to Collections.

2. **The patient is most frequently balance billed for services rendered in an emergency care situation and which have been part of managed care in California since its inception.** These

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LOS ANGELES: 1930 Wilshire Blvd., Suite 1210, Los Angeles, CA 90057 PH: 213.413.3587, FAX: 213.413.8631
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services are defined as basic health care services as listed in section §1345 of the law. They are, as such, part of the fundamental contract between the consumer who signs up for managed care in exchange for a more limited network of providers. In return, the plans agree to provide all basic services, not just some services. Indeed existing California law requires health plans to pay for emergency care so long as the care was actually delivered and unless the enrollee reasonably should have known that an emergency did not exist.

3. **We believe the Department should undertake policies and remedies that promote adequate reimbursement for doctors and help stabilize emergency departments and trauma centers.** Plans maintain these frequently-disputed specialty services are hard to contract for which results in gaps where those services are not provided for or not paid for. We believe this directly contradicts their obligation to provide basic health care services to their members in exchange for the members' enrollment in their plan. We further believe that these payment disputes and the lack of specialist participation on their panels actually masks a clear manifestation of the serious problem of the inadequacy of provider networks in many plans. It also lends increased urgency to DMHC's implementation of their long-delayed Timely Access to Care regulations.

   Furthermore, the Department received testimony at their public hearings that where the compensation for doctors is sufficient, plans do not experience difficulty in maintaining fully-staffed panels in specialty and sub-specialty care. This lends credence to the general principle that this does not represent a provider shortage, only a shortage of wages or working conditions.

4. **We support the creation of an expedited payment that is based on a fee schedule or a multiplier of Medicare.** We note that virtually all providers accept Medicare and certainly all providers of emergency services do so. When providers accept Medicare, they accept it as payment in full and are precluded from balance billing any patient. Federal law is quite clear on this. We think that paying providers 150% of what Medicare pays is generous given these facts.

   The Department can protect consumers from balance billing by requiring that health plan contracts with providers preclude balance billing if the provider accepts **any payment** for **any service** from **any health plan**. Only a provider that accepts no payment of any sort from any plan is beyond the reach of DMHC regulations.

5. **DMHC could help reduce the incidence of balance billing disputed charges by increasing their oversight of the plans' own Dispute Resolution Processes, make the results of their reviews publicly available on their website, and take appropriate enforcement and/or administrative actions.** It is important that plans provide a meaningful review of their own decisions. This would seem to be a prerequisite for ensuring that payments to providers are fair and paid on a timely basis. Ensuring that health service plans have workable dispute resolution mechanisms would contribute to the perception of a genuine appeals review at the plan level. In addition, a fair process would reduce the number and contentiousness of disputes between the providers and the health plans that must be resolved at a higher level or in other forums.

   At the DMHC public hearings, there was considerable testimony that the health plans' own dispute resolution processes seldom resulted in changes in payments to providers, regularly rubber-stamped the plans' original decisions, and were poorly administered. It is essential that the Department increase its oversight of the plans in this important area, including the interjection of consequences for the plans that do not have an effective dispute resolution mechanism. This would enable the Department to concentrate on "outliers" or disputes involving amounts beyond certain agreed-upon monetary parameters or below established benchmarks.

   Existing law (S.1371.38) provides that the Department ensure that plans have adopted a dispute resolution mechanism that is "fair, fast and cost-effective for contracting and non-contracting providers". If the plan dispute resolution mechanisms are generating "incentives for such providers to balance bill enrollees" as stated in the notice of rulemaking, then perhaps the dispute resolution mechanisms fail to meet the standards of the law as being "fair, fast or cost-effective" and by definition, further Departmental action is justified. Section 1300.71 (m) requires the Department to take enforcement actions against health plans that fail to set up and maintain a meaningful dispute resolution mechanisms(s). The health plans must submit to the Department an annual report describing the utilization of their own dispute resolution procedures, data regarding the disposition of these cases, and any emerging or established patterns of provider disputes. This should provide an abundance of information regarding the effectiveness of the plans' own processes. The failure of a plan to comply with the requirements of this regulation shall be a basis for disciplinary action against the plan. This section clearly authorizes the

Department to undertake civil and criminal disciplinary actions and administrative remedies to enforce the provisions of this regulation.

The Department should also place detailed plan- and issue-specific information about the plans' own Dispute Resolution Systems on the DMHC website. This would promote public scrutiny by enrollees, advocates, employers, physicians, hospitals, other state agencies, and purchasers as to which plans consistently pay claims on a timely basis and administer effective dispute resolution mechanisms.

6. **These provisions should be clear that they apply to delegated providers as well as plans.** DMHC should strengthen the specific language in the regulation by reiterating that this ban on balance billing applies to medical groups as well as the plans. The language should also be plain that the regulation applies to both contracting and non-contracting providers so there is no possibility of misunderstanding.

As supporters of the original legislation, Health Access offers these comments. Health Access looks forward to working with the Department on the implementation of these rules. If you have questions or need more information, please contact Elizabeth Abbott, Project Director, Health Access at (916) 497-0923, extension 201 or Beth Capell, Capell & Assoc., at (916) 497-0760.

Sincerely,

Anthony Wright
Executive Director

cc: Senator Jack Scott, author, AB1455, C.827 of 2000
Sheila Kuehl, Chair, Senate Health Committee
Mervyn Dymally, Chair, Assembly Health Committee
Cindy Ehnes, Director, Department of Managed Health Care

HEALTH ACCESS
CALIFORNIA

November 30, 2007

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Rick Martin, Deputy Director
Financial Solvency Standards Board

Re: **Control # 2007-1253** Plan and Provider Claims Settlement

Dear Ms. Ehnes,

Health Access, the statewide consumer advocacy coalition of more than 200 consumer, community and other organizations, offers comments on and amendments to the proposed regulations on Plan and Provider Claims Settlement. These regulations result from AB 1455 by Senator Jack Scott (D-Pasadena).

We have the following comments as outlined below:

1. **Health Access supports an absolute prohibition on balance billing**. There is no reason for consumers with coverage obtaining emergency care to be billed for anything other than co-pays and deductibles. We believe the Department does have the statutory authority to prohibit balanced billing and it is proper for them to do so. The Department is correct in stating that nothing is gained by placing the patients in the middle of what is essentially a billing dispute between providers and health service plans.

   At the Department's public hearings, several people said that they believed it was essential for patients to be balance billed for disputed charges between providers and health service plans. They asserted that in many cases this financial threat motivated patients to intervene with the health service plans to ensure fair payment to providers. We strongly believe there is never justification for actions that can result in sending a consumer to collections.

   The Department can protect consumers from balance billing by requiring that health plan contracts with providers preclude balance

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SACRAMENTO: 1127 11th Street, #234, Sacramento, CA 95814 PH: 916.497.0923, FAX: 916.497.0921
LOS ANGELES: 1930 Wilshire Blvd Suite 1210 Los Angeles CA 90057 PH: 213.413.3587 FAX: 213.413.8631

billing if the provider accepts **any payment** for **any service** from **any health plan**. Only a provider that accepts no payment of any sort from any plan is beyond the reach of DMHC regulations.

2. **We support the creation of an expedited payment that is based on a multiplier of Medicare.** We note that virtually all providers accept Medicare and certainly all providers of emergency services do so. When providers accept Medicare, they accept it as payment in full and are precluded from balance billing any patient. Federal law is quite clear on this. We think that paying providers 150% of what Medicare pays is generous given these facts.

3. **AB1455 clearly contains the authority for the Department to vigorously oversee the plans' own dispute resolution mechanisms.** This would seem to be a prerequisite for ensuring that payments to non-contracted providers are fair and paid on a timely basis. Ensuring that health service plans have workable dispute resolution mechanisms would contribute to the perception of a genuine appeals review at the plan level. In addition, a fair process would reduce the number and contentiousness of disputes between the providers and the health plans.

   At the DMHC public hearings, there was considerable testimony that the health plans' own dispute resolution processes seldom resulted in changes in payments to providers, regularly rubber-stamped the plans' original decisions, and were poorly administered. It is essential that the Department increase its oversight of the plans in this important area, including the interjection of consequences for the plans that do not have an effective dispute resolution mechanism. This would enable the Department to concentrate on "outliers" or disputes involving amounts beyond certain agreed-upon monetary parameters or below established benchmarks.

4. **Existing law (S.1371.38) provides that the Department ensure that plans have adopted a dispute resolution mechanism that is "fair, fast and cost-effective for contracting and non-contracting providers".** If the plan dispute resolution mechanisms are generating "incentives for such providers to balance bill enrollees" as stated in the notice of rulemaking, then perhaps the dispute resolution mechanisms fail to meet the standards of the law as being "fair, fast or cost-effective" and by definition, further Departmental action is justified.

5. **Section 1300.71 (m) requires the Department to take enforcement actions against health plans that fail to set up and maintain a meaningful dispute resolution mechanisms(s).** The health plans must submit to the Department an annual report describing the utilization of their own dispute resolution procedures, data regarding the disposition of these cases, and any emerging or established patterns of provider disputes. This should provide an abundance of information regarding the effectiveness of the plans' own processes. The failure of a plan to comply with the requirements of this regulation shall be a basis for disciplinary action against the plan. This section clearly authorizes the Department to undertake civil and criminal disciplinary actions and administrative remedies to enforce the provisions of this regulation.

6. **We are unable to find statutory authority for the Department to establish an independent dispute resolution process (IDRP)** operated by or contracted for by the Department. While it may be desirable from a provider or plan perspective for such an independent process to exist, if the statute does not provide for it, then additional statutory authority is required to create an IDRP. AB 1455, section 1371.38 (b) specifically includes language instructing the Department to make recommendations to the Governor and the Legislature regarding "any additional statutory requirements relating to plan and provider dispute resolution mechanisms." From a consumer perspective, given the proposal by the Governor to ban balance billing without the creation of either an expedited payment level or an independent dispute resolution mechanism, we suggest that a simple prohibition on balance billing may be sufficient to meet the needs of consumers.

7. **There is an established health care statute model that would instructional for physicians and other providers to resolve billing disputes.** Hospitals are subject to a specific statute on billing and collections with respect to all Californians, insured and uninsured alike. These landmark consumer protections sponsored by Health Access should serve as a model for practices by other providers as well. Specifically, existing law requires that hospitals attempt to determine whether a person is insured or uninsured first, allow 150 days for an uninsured person to obtain public coverage or negotiate a payment plan, and also allow those with insurance to assure that payment is made on their behalf. We encourage physicians and other providers to follow similar practices.

F O U N D A T I O N

October 4, 2006

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Suzanne Chammout, RN, JD, Regulation Coordinator

Re: **Control # 2006-0777** Unfair Billing Patterns; Prohibition Against Billing Enrollees for Emergency Services; Independent Dispute Resolution Process
Control # 2006-0782 Claims Settlement Practices; Reasonable and Customary Criteria

Dear Ms. Ehnes,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on and amendments to the proposed regulations on Unfair Billing Patterns; Prohibition Against Billing Enrollees for Emergency Services; Independent Dispute Resolution Process and Claims Settlement Practices; Reasonable and Customary Criteria. These regulations result from AB 1455 by Senator Jack Scott (D-Altadena).

We have the following concerns as outlined below:

A. Adoption of Rule 1300.71.39 Definition of Unfair Billing Patterns; Prohibition Against Balance Billing by Emergency Services Providers.

•We believe **the Department does have the statutory authority to prohibit balanced billing** and it is proper to do so.

• **The Department is correct in stating that nothing is gained by placing the patients in the middle of what is essentially a billing dispute between providers and health service plans.** At the Department's public hearings, several people said that they believed it was essential for patients to be balance billed for disputed charges between providers and health service plans. They asserted that in many cases this billing motivated patients to intervene with the health service plans to ensure fair payment to providers. However, the Department repeatedly questioned people giving this testimony as to why inserting a fair administrative process into the billing disputes could not take the

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place of the perceived role the patient plays in providing leverage with health service plans. There was no convincing testimony to answer this challenge.

B. Revision of Rule 1300.71.39 Independent Dispute Resolution Process

•AB1455 specifically contains the statutory authority for requiring <u>each health care service plan</u> to:

- Ensure a **dispute resolution mechanism is accessible to non-contracting providers.**
- Mandate that they meet explicit **standards for timeliness of payments and notices.**
- Enumerates **penalties and other enforcement remedies** the Department may impose.

However, **we question whether the underlying statute authorizes the Department to set up its own dispute resolution process.** This rule amounts to private rate-setting regulation where there is no role for consumers or purchasers in the determination of disputed payments.

• AB1455 clearly contains the authority for the Department to vigorously oversee the plans' own dispute resolution mechanisms. This would seem to be a prerequisite for ensuring that payments to non-contracted providers are fair and paid on a timely basis. Section 1367 (h) requires plans to report annually to the Department regarding the <u>utilization</u> of their own dispute resolution procedures and requires data regarding the <u>disposition</u> of these cases. This should provide an abundance of information regarding the effectiveness of the plans' own processes.

Ensuring that health service plans have workable dispute resolution mechanisms would contribute to the perception of a genuine appeals review at the plan level and a fair process would reduce the number and contentiousness of disputes between the providers and the health plans. At the DMHC public hearings, there was considerable testimony that the health plans' own dispute resolution processes seldom resulted in changes in payments to providers, regularly rubber-stamped the plans' original decisions, and were poorly administered. It is essential that the Department increase its oversight of the plans in this important area, including the interjection of consequences for the plans that do not have an effective dispute resolution mechanism. This would enable the Department to concentrate on "outliers" or disputes involving amounts beyond certain agreed-upon monetary parameters or below established benchmarks.

• **The Department should re-establish the DMHC Advisory Commission.** Its absence for the last several years has meant there has been no role for consumers or purchasers, both of whom represent essential constituencies in receiving and paying for health care services.

• **"Baseball Arbitration" is an unclear term** for many participants and is an inappropriate title or description for a regulation because of its informality.

• **The language in (n) (3) (ii) appears to be incomplete or is unclear.** It should read: "If a non-contracted provider elects to participate in the IDRP, the plan's capitated providers to whom they have delegated shall also participate.

C. Revision of Rule 1300.71: Criteria for Determining Reasonable and Customary Payment for Non-Contracted Providers

• **It is clear that the section added (vii) "any other relevant documentation necessary to determine reasonable and customary value" is appropriate.** This would enable the determination to correctly take into consideration the amounts that Medicare and Medi-Cal paid. It is essential that these public payment amounts be one of the factors taken into account because these payment sources constitute payment for more than one-half (52.3%) of all emergency room bills paid. They represent a significant percentage of payments made and should be part of the factors that determines "reasonable and customary payments for non-contracted providers."

The Governor has recently agreed that patients should not be paying "sticker prices" for prescription drugs and hospital charges. While Medi-Cal should not be the sole determinant of the reasonable and customary rates, it should be one of the factors taken into consideration as the largest single payer of emergency room care.

• Health Access believes that (3) (B) which defines the determination of "reasonable and customary value" should take into consideration the provider's training, qualifications, length of time in practice, the nature of services provided as written. However, **(iii) and (iv) should reflect payments instead of charges.** Specifically, (iii) should reflect the fees paid to the provider and (iv) the prevailing provider rates paid in the general geographic area in which the services were rendered.

As supporters of the original legislation, Health Access offers these comments. Health Access looks forward to working with the Department on the implementation of these rules. If you have questions or need more information, please contact Elizabeth Abbott, Project Director, Health Access at (916) 497-0923 or Beth Capell, Capell & Assoc., at (916) 497-0760.

Sincerely,

Anthony Wright
Executive Director

CC: Senator Jack Scott
Cindy Ehnes, Director, Department of Managed Health Care

Transmission Report

Date/Time	12-12-2008	04:20:22 p.m.	Transmit Header Text
Local ID 1	9163223968		Local Name 1
Local ID 2			Local Name 2

This document : Confirmed
(reduced sample and details below)
Document size : 8.5"x11"

The Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

980 9th Street, Suite 500
(916) 323-7381
(916) 322-3968
mdaniels@dmhc.ca.gov

Fax

To: Marin – Health Access **From:** Mary Daniels

Fax: (916) 497-0921 **Pages:** 2 (including cover)

Phone: **Date:** December 12, 2008

Re: Application for Award of Advocacy & Witness Fees

☐ **Urgent** ☐ **For Review** ☒ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• Comments:

Hi Marin,

Here is your confirmation that Health Access' Application for an Award of Advocacy & Witness Fees, 2008-1536 Definition of Unfair Billing Patterns, has been received by DMHC and date stamped.

Thank you,

Mary

DMHC, Legal Services
(916) 323-7381
FAX # (916) 322-3968

If you have any problems or questions regarding this fax please call Mary Daniels **at** (916) 323-7381

Total Pages Scanned : 2 Total Pages Confirmed : 2

No.	Job	Remote Station	Start Time	Duration	Pages	Line	Mode	Job Type	Results
001	663	916 497 0921	04:19:31 p.m. 12-12-2008	00:00:20	2/2	1	EC	HS	CP28800

Abbreviations:
HS: Host send
HR: Host receive
WS: Waiting send
PL: Polled local
PR: Polled remote
MS: Mailbox save
MP: Mailbox print
CP: Completed
FA: Fail
TU: Terminated by user
TS: Terminated by system
RP: Report
G3: Group 3
EC: Error Correct

1127 – 11th Street, Suite 234, Sacramento, CA 95814
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Email: rpavich@health-access.org

Health Access

FAX

To:	Mary Daniels	**From:**	Rick Pavich
Fax:	322-3968	**Date:**	November 6, 2008
CC:		**CC Fax:**	
Re:	Regulation Number 2008-1536	**Pages:**	3

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Attached are the bios for Elizabeth Abbott, Beth Capell, and Anthony Wight to be included with Health Access' Application for Award & Witness Fees for Regulation 20078-1536; Definition of Unfair Billing Patterns.

HEALTH ACCESS

ELIZABETH ABBOTT joined Health Access in January 2006 as their Project Director where she focuses on federal health programs and the impact they have on beneficiaries and public policy in California. She previously served as the Regional Administrator of the Centers for Medicare and Medicaid Services (CMS) in Region IX which serves the states of California, Arizona, Nevada, Hawaii, and the Far Pacific (including the Pacific Trust Territories of Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.)

She was responsible for the oversight of State Medicaid agencies, State survey and provider certification operations, State Children's' Health Insurance Programs, and managed care organizations. The San Francisco Region spans a vast geographic area, has one of the most culturally diverse populations in the nation, serves over 10 million beneficiaries, and has a programmatic budget exceeding $30 billion per year.

Ms. Abbott joined CMS as the Associate Regional Administrator for Medicare in 1993 where she managed technical, clinical, and financial staff and oversaw Medicare contractors that serve providers and beneficiaries in the West. Prior to joining CMS, she worked in progressively more responsible positions with the Social Security Administration (SSA) in 17 field and regional offices in Massachusetts, Connecticut, Illinois, Indiana, and throughout California.

Ms. Abbott has a B.A. in psychology from the University of Redlands in Redlands, California and has done graduate work in public administration at the University of Southern California.

BETH CAPELL, PH.D., *Capell & Assoc.* has been the principal and owner of Capell & Assoc. since its founding in 1995. She has thirty years of experience in Sacramento, working in the Legislature, various Administrations, and with various interest groups.

She represents Health Access California; Health Access Foundation; the California Physicians Alliance; State Council of Service Employees International Union, AFL-CIO; and other consumer and labor organizations in both legislative activity and regulatory action.

Health Access California sponsored the package of legislation known as the HMO Patient Bill of Rights from 1995 to its enactment in 1999. Health Access Foundation led a collaborative of consumer groups that monitored initial implementation of the more than 20 pieces of legislation enacted between 1995 and 2000 intended to protect consumers from HMOs. Health Access Foundation has continued to work on implementation and ongoing monitoring of the law with respect to consumer protections against HMOs. Beth Capell has been an architect and active advocate throughout this decade of efforts.

Beth Capell has worked on issues including prescription drugs, universal access, hospital overcharging, balance billing by physicians, nursing home regulations, hospital standards, health insurance regulation, and other health care issues.

Prior to establishing Capell & Assoc. Beth Capell represented the California Nurses Association from 1986 to 1995, first as the legislative advocate and later as the Director of Government Relations for the association. From 1983 to 1986, Ms. Capell worked at the California Manufacturers Association, working on job training and human resource issues, including health insurance. From 1977 to 1983, Ms. Capell worked in various positions in the Legislature, the Administration, and other efforts.

Ms. Capell has Ph.D. in political science from the University of California, Berkeley, and continues to publish articles and present papers on political science, specifically interest groups, legislatures, and the impact of legislative term limits.

ANTHONY WRIGHT serves as Executive Director for Health Access California, the statewide health care consumer advocacy coalition, working on behalf of the insured and uninsured, made up of over 200

organizations representing seniors, children, working families, people with disabilities, immigrants, people of faith, labor, and communities of color.

Under Wright's leadership since 2002, Health Access has been a leader in efforts to fight health care budget cuts, to expand both employer-based coverage and public insurance programs, to advance consumer protections, and to address the causes of medical debt. For example, his work on hospital overcharging and abusive billing and collections practices led to both to legislative action and hospital guidelines on the issue. Recently, he served as co-chair and campaign manager for the No on 78/Yes on 79 initiative effort, facing the prescription drug industry and the most expensive ballot campaign in the nation's history.

Wright's background is as a consumer advocate and community organizer, and he has been widely quoted in local and national media on a range of issues. He served as Program Director for New Jersey Citizen Action. As coordinator of New Jersey's health care consumer coalition, he ran successful campaigns to win HMO patient protections, defeat for-profit takeovers of nonprofit hospitals and Blue Cross Blue Shield, pass a law to govern hospital conversions and acquisitions, and expand coverage for low- and moderate-income children and parents.

Wright also worked at the Center for Media Education in Washington, DC, *The Nation* magazine in New York, and in Vice President Gore's office in the White House. Born and raised in the Bronx, Wright graduated from Amherst College magna cum laude in both English and Sociology.