SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

DATE/TIME	**: 9:00 a.m. 11/21/07**	**DEPT. NO**	**: 31**
JUDGE	**: HON. MICHAEL P. KENNY**	**CLERK**	**: LEE**

CALIFORNIA MEDICAL ASSOCIATION et al.,
Petitioners and Plaintiffs,

Case No.: 34-2008-80000059

VS.

DEPARTMENT OF MANAGED HEALTH CARE et al.,
Respondents and Defendants.

Nature of Proceedings: **PETITION FOR WRIT OF MANDATE AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

TENTATIVE RULING ON:

1) **PETITION FOR WRIT OF MANDATE;**
2) **COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF;**
3) **REQUESTS FOR JUDICIAL NOTICE AND EVIDENTIARY OBJECTIONS.**

The following shall constitute the Court's tentative ruling on the Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief filed by Petitioners California Medical Association, California Hospital Association, California Chapter of the American College of Emergency Physicians, California Orthopeadic Association, California Radiological Society, and California Society of Anesthesiologists, set for hearing in Department 31 on Friday, November 21, 2008 at 9:00 a.m. The tentative ruling shall become the final ruling of the Court unless a party wishing to be heard so advises the clerk of this Department no later than 4:00 p.m. on the court day preceding the hearing, and further advises the clerk that such party has notified the other side of its intention to appear.

In the event that a hearing is requested, oral argument shall be limited to no more than 20 minutes per side.

I. Requests for Judicial Notice and Evidentiary Objections

DMHC's Objections to the Declaration of Andrea Brault, M.D. are overruled. DMHC objects on grounds of improper or untimely authentication, irrelevance, and

hearsay. However, DMHC has provided no argument supporting said objections. On reviewing Petitioners' papers, the Court sees that the failure of timely proper authentication was caused by Ms. Brault's geographical distance from Petitioners' counsel, and counsel submitted her faxed signature on time along with a declaration explaining the situation. Ms. Brault's original signature was received shortly thereafter. On such facts, the Court declines to find the authentication improper. As to relevance, the Court finds the Brault Declaration relevant to Petitioners' claim that the regulation in dispute is impermissibly vague. As to hearsay, DMHC has not indicated which portions of the Brault Declaration it believes contain hearsay. The Court has reviewed the Declaration and concludes it does not contain hearsay – the only statements that may be considered potential hearsay are hypothetical, not actual, health plan bills, and such "statements" are not offered for the truth of the hypothetical bill but rather to illustrate the effect of such bills on the declarant (e.g., whether such bills are written in such a way as to cause the recipient difficulty complying with the regulation at issue).

Petitioners' request for judicial notice of the Rulemaking File is granted

Petitioners seek judicial notice of Exhibits A-NN submitted in support of their petition. DMHC interposes several objections to the exhibits. The Court notes that it may judicially notice only those exhibits that are relevant to the case. (*Mangini v. R.J. Reynolds Tobacco Co.* (1994) 7 Cal.4th 1057, 1063, overruled in part on other grounds by *In re Tobacco Cases II* (2007) 41 Cal.4th 1257, 1276.) With that principle in mind, the Court rules on Petitioners' Request for Judicial Notice and DMHC's Objections to Petitioners' Exhibits to Petition for Writ of Mandate and Related Request for Judicial Notice as follows:

> Objection 1, to Petitioners' Exhibit D (containing a portion of the DMHC website), is sustained. The exhibit is offered to substantiate Petitioners' argument that the Legislature has not delegated authority to DMHC to regulate providers with respect to their practices in billing HMOs and HMO enrollees. The document is not relevant, however, as governing statutes, rather than agency materials, should be reviewed to determine the scope of an agency's delegated authority. (*Baldwin v. County of Tehama* (1994) 31 Cal.App.4th 166, 177 n.6.)
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> Objections 2-4 and 6, to Petitioners' Exhibits E-G and I (containing legislative history of AB 1455), are sustained. The exhibits are offered to substantiate Petitioners' proffered interpretation of Health and Safety Code § 1371.39 and related statutes. As the Court has determined, below, that § 1371.39 is unambiguous, it will not consider such extrinsic evidence of legislative intent. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.)
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> Objection 5, to Petitioners' Exhibit H (letter from Senator Jack Scott to DMHC Director Cindy Ehnes dated July 16, 2008), is sustained. The letter of an author of legislation is irrelevant to the construction of the

legislation absent some reliable indication that the Legislature as a whole was aware of the author's objectives and believed the language of the legislation would accomplish those objectives. (*People v. Johnson* (2002) 28 Cal.4th 240, 247; see also *Cal. Teachers Ass'n v. San Diego Comm. College Dist.* (1981) 28 Cal.3d 692, 701.) The letter does not contain any indication that Senator Scott's view was shared by the other legislators voting on AB 1455. In addition, the Court declines to consider such extrinsic evidence of legislative intent in light of its conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.)

Objections 7-10, to Petitioners' Exhibits J-M (containing bills proposed after passage of AB 1455 but not enacted – AB 1321 (Yee, 2005), SB 364 (Perata, 2005), AB 1x (Nunez, 2007), and SB 289 (Yee, 2007)), are sustained. The exhibits are offered to substantiate Petitioners' proffered construction of § 1371.39 and related statutes. DMHC argues that the legislative history of later proposed bills that are never enacted is irrelevant to the interpretation of § 1371.39, citing *Delaney v. Baker* (1999) 20 Cal.4th 23, 29 n.3, in which the court declined judicial notice of non-enacted proposed bills on grounds of irrelevance. The Court agrees that bills proposed but not enacted after enactment of § 1371.39 cannot shed light on the Legislature's intent in enacting that statute. In addition, the Court declines to consider such extrinsic evidence of legislative intent in light of its conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.)

Objections 11-13, to Petitioners' Exhibits N-P (containing 2 bills enacted after AB 1455, as enrolled (SB 697 (Yee, 2007) and AB 1203 (Salas, 2007)) and some legislative history of AB 1203) are sustained. The exhibits are offered to substantiate Petitioners' proffered construction of § 1371.39 and related statutes. The Court declines to consider such extrinsic evidence of legislative intent in light of its conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.)

Objection 14, to Petitioners' Exhibit Q (containing legislative history for a post-AB 1455 bill which passed in the legislature but was vetoed by the Governor (AB 981 (Perata, 2008)), is sustained. The exhibit is offered to substantiate Petitioners' proffered construction of § 1371.39 and related statutes. The Court declines to consider such extrinsic evidence of legislative intent in light of its conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.)

Objections 15 and 16, to Petitioners' Exhibits R and S (containing legislative history for one of the bills enacting the Knox-Keene Act (AB 138 (Knox 1975)), is sustained. The exhibit is offered to substantiate Petitioners' proffered construction of § 1371.39 and related statutes. The Court declines to consider such extrinsic evidence of legislative intent in light of its conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.)

Objection 17, to Petitioners' Exhibit U (containing "Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?" (1988) 51 LAW & CONTEMPORARY PROBLEMS 195), is sustained. The article is an item of extrinsic evidence irrelevant to the issues regarding the scope of DMHC's statutory authority. There is no indication that the article was considered by the Legislature in enacting the relevant statutes. Moreover, such extrinsic evidence will not be considered in light of the Court's conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.) The article is also irrelevant to the other issues in the case – it does not shed light on whether the regulation at issue is impermissibly vague or unsupported by substantial evidence in the rulemaking record. While Petitioners advance policy arguments to which the article is arguably relevant (regarding the soundness of the regulation), the Court has no power to rule on such an argument in this action, as explained below.

Objection 18, to Petitioners' Exhibit V (containing Wigmore, EVIDENCE IN TRIALS AT COMMON LAW, vol. 2, § 442), is overruled.

Objections 19-23, to Petitioners' Exhibits W-AA (containing DMHC's "Final Report Re: Routine Examination of Universal Care," dated September 13, 2002; DMHC's "Final Report Re: Routine Examination of PacifiCare of California," dated December 31, 2002; "Final Report Submitted by Health Net of California, Inc. to the California Department of Managed Health Care" dated December 30, 2005; *In re Health Net of California, Inc.* Consent Agreement between DMHC and Health Net, dated January 12, 2005; and DMHC's "Compliance Statement for the Payment of Non-Contracted Provider Claims under Rule 1300.71," dated September 2, 2005), are sustained. The exhibits are extrinsic evidence irrelevant to the scope of DMHC's statutory authority. There is no indication that they were considered by the Legislature in enacting the relevant statutes. Moreover, such extrinsic evidence will not be considered in light of the Court's conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.) The exhibits are also irrelevant to the other issues in the case – they do not

shed light on whether the regulation at issue is impermissibly vague or unsupported by substantial evidence in the rulemaking record. While Petitioners advance policy arguments to which the exhibits are arguably relevant (regarding the soundness of the regulation), the Court has no power to rule on such an argument in this action, as explained below.

Objection 24, to Petitioners' Exhibit BB (containing the New Jersey Department of Banking and Insurance's Order A07-59, dated July 23, 2007), is sustained. The order is extrinsic evidence irrelevant to the issues regarding the scope of DMHC's statutory authority. There is no indication that the order was considered by the Legislature in enacting the relevant statutes. Moreover, such extrinsic evidence will not be considered in light of the Court's conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.) The order is also irrelevant to the other issues in the case – it does not shed light on whether the regulation at issue is impermissibly vague or unsupported by substantial evidence in the rulemaking record. While Petitioners advance policy arguments to which the order is arguably relevant (regarding the soundness of the regulation), the Court has no power to rule on such an argument in this action, as explained below.

Objections 25 and 26, to Petitioners' Exhibit CC (containing a bill enacted after AB 1455, as enrolled AB 1155 (Huffman, 2007) and an L.A. Times article by Marc Lifsher entitled "Bill Puts Bite on Deadbeat Insurers," dated July 15, 2008) are sustained. The exhibit is an item of extrinsic evidence irrelevant to the issues regarding the scope of DMHC's statutory authority. There is no indication that the article was considered by the Legislature in enacting the relevant statutes. Moreover, such extrinsic evidence will not be considered in light of the Court's conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.) The article are also irrelevant to the other issues in the case – it does not shed light on whether the regulation at issue is impermissibly vague or unsupported by substantial evidence in the rulemaking record. While Petitioners advance policy arguments to which the article is arguably relevant (regarding the soundness of the regulation), the Court has no power to rule on such an argument in this action, as explained below.

Objection 27-33, to Petitioners' Exhibits FF-MM (containing several items in the rulemaking file), are overruled. These items are part of the rulemaking file and are thus properly before the Court in this action challenging whether substantial evidence supported DMHC's adoption of the regulation at issue.

Objection 34, to Petitioners' Exhibit NN (containing an article prepared by the California Healthcare Foundation entitled "Insurance Markets, Regulatory Oversight of Health Insurance in California," dated June 2003) is sustained. The article is an item of extrinsic evidence irrelevant to the issues regarding the scope of DMHC's statutory authority. There is no indication that the article was considered by the Legislature in enacting the relevant statutes. Moreover, such extrinsic evidence will not be considered in light of the Court's conclusion that § 1371.39 is unambiguous. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.) The article is also irrelevant to the other issues in the case – it does not shed light on whether the regulation at issue is impermissibly vague or unsupported by substantial evidence in the rulemaking record. While Petitioners advance policy arguments to which the article is arguably relevant (regarding the soundness of the regulation), the Court has no power to rule on such an argument in this action, as explained below.

Summing up, DMHC's objections to Petitioners' Exhibits D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, U, W, X, Y, Z, AA, BB, CC, and NN are sustained. Petitioners' requests for judicial notice of the remaining exhibits (A, B, C, T, V, DD, EE, FF, GG, HH, II, JJ, KK, LL, and MM) are granted.

DMHC's requests for judicial notice of: (1) the Complaint filed by DMHC against Prime Healthcare Services, Inc., Orange County Case No. 30-2008-00108627, (2) Governor Arnold Schwarzenegger's Executive Order S-13-06 (issued July 25, 2006), and (3) collection letters received by DMHC in connection with complaints from consumers-enrollees after being balance billed for emergency care are denied. The evidence is not part of the rulemaking record and is not relevant to the issues presented (whether the regulation is valid under the APA and whether the regulation is unconstitutionally vague).

Petitioners' "Supplemental Request for Judicial Notice," submitted with their reply brief, and "Second Supplemental Request for Judicial Notice," submitted two days before the hearing, are denied in their entirety as untimely. The items of which notice is requested appear similar in kind to many submitted in Petitioners' original judicial notice request and objected to by DMHC. Other items are either irrelevant to the issues before the Court or have been taken from the rulemaking file and are thus already before the Court.

Petitioners' Objections to the Declaration of Andrew J. Hefty In Support of Kaiser Foundation Hospitals' Amicus Brief are sustained. Exhibits A, B, C, D, and E (an internal Kaiser policy and various documents from a separate litigation involving Kaiser) are irrelevant to the issues before the Court in this action, as none bears on DMHC's regulatory authority or compliance with the APA or the alleged vagueness of the regulation.

II. Background

This case challenges DMHC's promulgation of 28 CCR § 1300.71.39 (the "Balance Billing Regulation"). The Balance Billing Regulation was enacted under the authority purportedly granted to DMHC by provisions in the Knox-Keene Act, Health and Safety Code §§ 1340 et seq., in which the Legislature delegated certain regulatory authority with regard to health care service plans ("HMOs") to DMHC. Of particular interest here is Health and Safety Code § 1371.39, which was added to the Act as part of Assembly Bill 1455 (Scott, 2000). Among other things, § 1371.39 allows HMOs to report "instances in which the plan believes a provider is engaging in an unfair billing pattern" to DMHC.

The Balance Billing Regulation defines "unfair billing pattern" to include a practice known as "balance billing" when that practice is engaged in with respect to emergency care recipients who are enrollees in a health care service plan (an "HMO"). Balance billing occurs when a provider receives less than the total amount billed from a patient's HMO and subsequently bills the unpaid balance directly to the patient. The Balance Billing Regulation provides:

> (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 section 1345(b)(6), 1367(i), 1371.4, 1371.5 and Title 28, California Code of Regulations,, sections 300.67(g) and 1300.71.4.
>
> (2) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed to 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).

Petitioners contend that DMHC acted unlawfully in promulgating the Balance Billing Regulation and seek a writ of mandate (under CCP § 1085) ordering DMHC to repeal the

Balance Billing Regulation, a declaration that the Balance Billing Regulation is invalid, and an injunction stopping DMHC from implementing and enforcing the Balance Billing Regulation.

III. Analysis

A. *Standard of Review.*

In reviewing the legality of a regulation adopted pursuant to a delegation of legislative authority, the Court's inquiry is limited to three questions: (1) whether the regulation is within the agency's delegated authority; (2) whether the regulation is reasonably necessary to effectuate and not in conflict with the purposes of the statute being implemented; and (3) whether the regulation was promulgated pursuant to proper procedure. (*Moore v. Cal. State Bd. of Accountancy* (1992) 2 Cal.4th 999, 1014-15; Cal. Gov't Code §§ 11342.1, 11342.2, 11350(b).) The Court accords the regulation a strong presumption of regularity, and Petitioners bear the burden of showing its invalidity. (*Moore*, 2 Cal.4th at 1014-15; *Credit Ins. Gen'l Agents Ass'n v. Payne* (1976) 16 Cal.3d 651, 657.)

B. *Discussion.*

Petitioners challenge the Balance Billing Regulation under each of the three areas of Court review listed above, and additionally challenge the regulation as unconstitutionally vague. Petitioners' many arguments can be organized into the following categories: (1) that the regulation was not within DMHC's delegated authority to enact; (2) that DMHC did not follow proper procedures under the California Administrative Procedure Act in promulgating the regulation because its economic impact statement conflicts with substantial record evidence; (3) that the record lacks substantial evidence that the Balance Billing Regulation was reasonably necessary to effectuate the statutory purpose; (4) that the regulation conflicts with the Knox-Keene Act's purpose that contracts between HMOs and providers be "fair and reasonable to ensure adequate networks"; and (5) that the regulation violates due process because it is overly vague. The Court will address each category of argument in turn.

1. The DMHC Acted Within Its Delegated Authority in Promulgating the Balance Billing Regulation.

Petitioners first argue that the DMHC lacks statutory authorization to regulate balance billing by non-contracting providers. According to Petitioners, DMHC is authorized at most only to advise the Legislature with regard to what it believes are "unfair billing practices" by providers rather than to directly define such practices by regulation, DMHC lacks authority to regulate providers, and balance billing is not a "billing pattern" as that term is used in Health and Safety Code § 1371.39(b)(1).

a. Health and Safety Code § 1371.39(b)(1) Plainly Authorizes DMHC to Define Unfair Billing Practices.

Petitioners contend that DMHC lacks statutory authorization to define the term "unfair billing practice." Petitioners' argument is primarily based on an interpretation of Health and Safety Code § 1371.39. Petitioners argue the section shows that the Legislature intended to define "unfair billing practice" through statute based on DMHC's recommendations rather than to delegate to DMHC the task of defining the term.

To determine the Legislature's intent in a given statute, courts must first examine the statute's words, "because they are generally the most reliable indicator of intent." (*Wirth v. California* (2006) 142 Cal.App.4th 131, 139.) If the statute's language is clear and unambiguous, no construction is necessary and the court need not resort to other indicia of intent. (*Id.*) If the language is ambiguous, however, the court may use extrinsic construction aids, including legislative history. (*Id.*) The court must adopt constructions that harmonize related statutes to the extent possible and, where uncertainty exists, consider the practical consequences flowing from particular interpretations in adopting reasonable, common sense constructions. (*Id.* at 139-40.) Courts accord great respect to administrative agency interpretations of controlling statutes and follow such interpretations unless they are clearly erroneous. (*Id.* at 138.)

Health and Safety Code § 1371.39 provides:

> (a) Providers may report to the department's Office of Plan and Provider Relations . . . instances in which the provider believes a plan is engaging in an unfair payment pattern.
>
> (b) Plans may report to the department's Office of Plan and Provider Relations . . . instances in which the plan believes a provider is engaging in an unfair billing pattern.
>
> (1) "Unfair billing pattern" means engaging in a demonstrable and unjust pattern of unbundling of claims, upcoding of claims, or other demonstrable and unjustified billing patterns, as defined by the department.
>
> (2) The department shall convene appropriate state agencies to make recommendations by July 1, 2001, to the Legislature and the Governor for the purpose of developing a system for responding to unfair billing patterns as defined in this section. This section shall include a process by which information is made available to the public regarding actions taken against providers for unfair billing patterns and the activities that were the basis for the action.

(c) On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unfair billing pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption.

According to Petitioners, subdivision (c) of § 1371.39 means that DMHC was not to define "unfair billing pattern" itself, but was required to recommend a definition to the Legislature by December 31, 2001, which it did not do. Petitioners argue that this construction is bolstered by Health and Safety Code § 1371.37's more detailed statutory definitions of "unfair payment patterns," although the rationale behind that contention is unclear.

The Court is not persuaded by Petitioners' construction of § 1371.39. First, subdivision (b)(1) expressly delegates authority to DMHC to define unfair billing patterns. That subdivision unambiguously states: "'Unfair billing pattern' means engaging in . . . other demonstrable and unjustified billing patterns, *as defined by the department*" (emphasis added). Second, subdivision (c) again states that it is DMHC who is to develop the definition of "unfair billing pattern" and nowhere states that the definition may not be developed without Legislative approval or that failure to report to the Legislature regarding the definition renders the definition unauthorized. The fact that the Legislature sought recommendations for statutory adoption does not show that it intended any definition developed by the department to be ineffective unless statutorily adopted; in fact, such a construction would conflict with the plain language of both subdivisions (b)(1) and (c), which state that DMHC is to develop the definition. If the Legislature wanted to reserve all definitions of "unfair billing pattern" to itself, it could have easily said so. Instead, it plainly stated that the term includes "other demonstrable and unjustified billing patterns, as defined by the department." (See also Cal. Health & Saf. Code § 1344(a) [delegating authority to DMHC to "adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including . . . defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of this chapter."].)

As the Court concludes that the plain language of § 1371.39 delegates authority to DMHC to define "unfair billing patterns," the Court will not consider the extrinsic evidence of legislative intent offered by Petitioners. (*People v. Otto* (1992) 2 Cal.4th 1088, 1100; *Comm. Dev. Comm'n v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.)

b. Health and Safety Code § 1371.39(b)(1) Authorizes DMHC to Regulate Providers With Regard to Unfair Billing Practices.

Petitioners next argue that DMHC is without statutorily-delegated authority to regulate emergency services providers because such individuals and entities (doctors and

hospitals) are regulated by other agencies. The scope of DMHC's regulatory jurisdiction extends to the "execution of the laws of the state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees." (Cal. Health & Saf. Code § 1341(a).)

Petitioner contends that this provision, in addition to the regulatory authority granted to the Medical Board over physicians and the Department of Public Health over hospitals, limits DMHC's regulatory authority to HMOs to the exclusion of all other entities. However, Petitioners have not shown any conflicts between DMHC's regulation of balance billing by providers and the regulatory jurisdiction of other agencies. More fundamentally, however, the plain language of § 1341(a) is not so limited. It gives DMHC authority to execute laws "*relating to*" HMOs and does not limit that authority to laws directly *regulating* HMOs. Moreover, as discussed above, the Legislature expressly stated in § 1371.39 that DMHC was to define certain provider conduct. As § 1371.39's provisions regarding "unfair billing patterns" engaged in by providers in submitting bills to HMOs are plainly laws "related to" HMOs, it is within DMHC's jurisdiction to regulate providers with respect to such billing patterns.

c. DMHC's Determination that Balance Billing Can Constitute a Billing Pattern is Reasonable.

Petitioners contend that balance billing is not a "billing pattern" as that term is defined in § 1371.39 because it is not "upcoding" or "unbundling" and because those terms regulate *how* a provider bills whereas the Balance Billing Regulation regulates *who* a provider bills. Nothing in the express language of § 1371.39, however, limits what can constitute an unfair billing pattern in terms of who and how. DMHC's conclusion that balance billing can constitute a demonstrable and unjust billing pattern is reasonable and not in conflict with § 1371.39.

2. The DMHC's Economic Impact Statement Does Not Conflict with Substantial Record Evidence.

Government Code § 11346.5(a)(8) requires an agency that makes an initial determination, in adopting a regulation, that the regulation "will not have a significant, statewide adverse economic impact directly affecting businesses," to include in its notice of proposed action a declaration to that effect. Section 11346.5(a)(8) further requires the agency, in making the declaration, to "provide in the record facts, evidence, documents, testimony, or other evidence upon which the agency relies to support its initial determination." Government Code § 11350(b)(2) provides that a court, in an action seeking a declaration on the validity of the regulation, may declare the regulation invalid where the agency's declaration under § 11346.5(a)(8) is "in conflict with substantial evidence in the record."

Petitioners contend that DMHC's conclusion that the Balance Billing Regulation would not have a significant, statewide adverse impact on business conflicts with substantial evidence in the record and that DMHC failed to cite the record facts, evidence, documents, testimony, or other evidence it relied on to support its conclusion.

DMHC complied in some measure with § 11346.5(a)(8) – its Notice of Proposed Rulemaking includes a declaration that the Balance Billing Regulation will result in no significant statewide adverse economic impact directly affecting businesses. (Rulemaking Record, RMF000014-15.) DMHC failed, however, to include citations to the record supporting that declaration, as it was required to do. DMHC argues, nevertheless, that substantial evidence in the record supports its determination of no adverse economic impact.

The Court finds that DMHC's determination of no significant statewide adverse economic impact is not in conflict with substantial evidence in the record. Petitioners and others submitted comments during the rulemaking process raising their concerns that the Balance Billing Regulation would have a "widespread and severe" adverse economic impact. One comment quantified that impact as a yearly loss to providers of $448 million. (RMF0000461-65.) In responding to the comments, DMHC noted that the Balance Billing Regulation would not impact other laws requiring plans to reimburse providers for the reasonable and customary value of the services rendered and creating dispute resolution mechanisms for resolving billing disputes between HMOs and providers. (E.g., Rulemaking Record, RMF004283-88.) DMHC concluded that, because HMOs are legally mandated to pay the reasonable and customary value of services rendered, and because providers who receive less than full payment "have multiple mechanisms available to obtain timely and meaningful resolution of the disputed claim," the Balance Billing Regulation was expected to have a neutral economic impact on providers. (*Id.*)

The Court finds that DMHC considered the evidence of adverse economic impact provided in comments and reasonably concluded, based on the presence of available remedies other than balance billing, that the Balance Billing Regulation would not impose a significant adverse economic impact. None of the comments asserting drastic economic impacts considered the mitigating force of the alternative dispute resolution process or quantified the portion of lost provider profits attributable to overbilling practices. It was therefore reasonable for DMHC to conclude that such factors would neutralize the economic impact of the Balance Billing Regulation. The Court further finds that, while DMHC failed to provide citations to the portions of the record supporting its economic impact declaration, DMHC substantially complied with the APA by considering and responding to the economic impact arguments raised in the comments, and its failure to cite those comment responses in its declaration does not warrant invalidating the Balance Billing Regulation. (*Pulaski v. Occupational Safety & Health Stds. Bd.* (1999) 75 Cal.App.4th 1315, 1330 [noting that an agency's failure to comply with every procedural facet of the APA does not automatically invalidate a regulation, and that a court may only invalidate the regulation where the agency has "substantially failed" to comply with the act].)

3. The DMHC's Conclusion that the Balance Billing Regulation Was Reasonably Necessary Is Supported by Substantial Evidence.

A regulation may also be invalid if it is not reasonably necessary to effectuate the statute it is intended to implement. (Cal. Gov't Code §11342.2.) The Court reviews the reasonable necessity of a regulation for substantial evidence. (*Id.* § 11350(b)(1).) Petitioners contend that DMHC's determination that the Balance Billing Regulation was reasonably necessary to effectuate the purposes of the Knox-Keene Act is unsupported by substantial evidence. Petitioners argue that, while DMHC stated in its Notice of Proposed Rulemaking that the Balance Billing Regulation was necessary "to enable the Department to execute its statutory mandate to protect California consumers and the stability of the health care delivery system" (see Cal. Health & Saf. Code §§ 1341, 1342), that statement failed to consider the record evidence opposing the regulation.

The Court finds that substantial evidence in the record supports DMHC's conclusion that the Balance Billing Regulation was reasonably necessary to effectuate the purposes of the Knox-Keene Act. That Act was enacted with the express intent that "health care for the public [be provided] at the lowest possible cost by transferring the financial risk of health care from patients to providers." (Cal. Health & Saf. Code § 1342(d).) DMHC was granted authority to execute "the laws of the state relating to health care service plans and the health care service plan business including . . . those laws directing the department to . . . protect and promote the interests of enrollees." (Cal. Health & Saf. Code § 1341(a).) That authority includes an express grant of authority to define "unfair billing patterns," as discussed above. The rulemaking record here contains substantial evidence of the harm that balance billing causes to HMO enrollees. (E.g., Rulemaking Record RMF000100, RMF000117, RMF000118, RMF000139, RMF000163, RMF000174-75, RMF000191-92, RMF000311, RMF000 RMF003316-31, RMF003708-10.)

4. The Balance Billing Regulation Does Not Conflict with the Knox-Keene Act's Requirements for HMO-Provider Contracts.

Petitioners contend that the Balance Billing Regulation conflicts with Health and Safety Code § 1367(h)(1)'s requirement that "[c]ontracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter." According to Petitioners, the Balance Billing Regulation allows HMOs to unilaterally set provider rates rather than pay the rates determined by the market. Petitioners contend that this change means that contracts between HMOs and providers will no longer be "fair and reasonable." Much of this argument veers into policy territory not within the Court's power to adjudicate – the Court is not the arbiter of the Balance Billing Regulation's wisdom or the wisdom of previous DMHC regulations complained of by Petitioners. (*Moore*, 2 Cal.4th at 1015 [in reviewing the propriety of an agency's adoption of a regulation, the court may not pass on the wisdom of the regulation].)

To the extent Petitioners ask the Court to rule on the wisdom of the Balance Billing Regulation, the Court declines to do so. In any event, the Court concludes that Petitioners have not met their burden of showing that the Balance Billing Regulation is in conflict with § 1367(h)(1). While Petitioners assert that the Balance Billing Regulation will allow HMOs to unilaterally set provider rates, such an argument is premised on the assumption that HMOs will be able to underpay non-contracted providers and ignores the legal provisions mandating both full payment and a provider's ability to obtain full payment through the dispute resolution mechanisms or the legal system. The Court is not willing to make that assumption.

5. The Balance Billing Regulation Is Not Unconstitutionally Vague.

Petitioners finally challenge the Balance Billing Regulation as unconstitutionally vague on four fronts: (1) providers cannot tell whether the services they have provided are subject to the Balance Billing Regulation, (2) the phrase "amounts owed to the provider" is vague, (3) it is unclear whether the Balance Billing Regulation applies to claims for services rendered before October 15, 2008 but billed after that date, and (4) the term "pattern" is vague.

The law governing unconstitutional vagueness of administrative regulations has been aptly summarized by one Court of Appeal as follows:

> A statute violates due process of law if it forbids or requires the doing of an act in terms so vague that persons of common intelligence must necessarily guess at its meaning and differ as to its application. While vagueness challenges arise most commonly in the criminal context, the prohibition against vagueness extends to administrative regulations as well. However, when an administrative regulation is challenged, the standard of constitutional vagueness is less strict than when a criminal law is challenged.
>
> In considering a vagueness challenge to an administrative regulation, we do not view the regulation in the abstract; rather, we consider whether it is vague when applied to the complaining party's conduct in light of the specific facts of the particular case. If it can be given a reasonable and practical construction that is consistent with probable legislative intent and encompasses the conduct of the complaining party, the regulation must be upheld.
>
> A regulation is not unconstitutionally vague simply because alternative constructions may be proposed. Standards under a regulation may be refined and developed on a case-by-case basis. This is neither unusual nor unconstitutional.

(*Teichert Constr. v. Cal. Occupational Safety & Health Appeals Bd.* (2006) 140 Cal.App.4th 883, 890-01 [internal citations and quotation marks omitted].)

Under the foregoing principles, the Court finds that the Balance Billing Regulation is not so vague as to violate due process. Petitioners argue that the Balance Billing Regulation is too vague because a provider often does not know whether the patient is an enrollee in a DMHC-regulated plan and thus may not be balance billed. The Court does not view this issue as a vagueness problem – the Balance Billing Regulation is clear that it does not apply to services provided to a non-HMO-enrollee. Moreover, the Court is skeptical of Petitioners' claims of difficulty in this regard. While the initial payment sent from the insurer to the provider may not indicate whether the insurer is an HMO, the provider can presumably obtain such information through further communication with the insurer or DMHC.

Petitioners next contend that "amounts owed" is overly vague because it is not clear, when a provider receives payment for less than the total amount billed, whether the amount not paid by the HMO is a disputed amount (which may or may not be an "amount owed") or an amount the enrollee owes under the plan terms (such as a deductible, which is not an "amount owed"). The Court disagrees that any lack of clarity created by some unclear payment remittances renders the Balance Billing Regulation unconstitutionally vague. Again, the provider can presumably obtain clarification from the HMO regarding whether the balance of the bill is disputed (as allegedly exceeding the reasonable and customary amount for the services rendered, for example) or the responsibility of the enrollee pursuant to the plan contract between the enrollee and the HMO.

With regard to the temporal reach of the Balance Billing Regulation, any uncertainty may be resolved through communication with DMHC or further refined by the courts on a case-by-case basis. The implementation of a new law and its consequent application often results in some need for minor clarification. Such problems do not necessarily rise to the level of unconstitutional vagueness.

Lastly, the Court disagrees that the term "pattern" is unconstitutionally vague. The term is a common part of the language and is easily defined by any number of references. Absent an as-applied challenge showing that DMHC has enforced the Balance Billing Regulation in such a way as to call into question the ordinary meaning of that term, the Court will not invalidate the regulation on vagueness grounds.

IV. Disposition

The petition is denied. The requests for declaratory and injunctive relief are denied. DMHC, as the prevailing party, is directed to prepare a formal order, incorporating the Court's ruling herein verbatim or attaching it as an Exhibit, and a judgment consistent with the ruling; submit them to opposing counsel for approval as to form; and thereafter submit them to the Court for signature and entry of judgment in accordance with Rules of Court 3.1312 and 3.1590.