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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	)	FILE NO.: 04-300
HEALTH NET OF CALIFORNIA, INC.	)	CONSENT AGREEMENT

THIS CONSENT AGREEMENT is entered into as of the 12th day of January, 2005, by and between HEALTH NET OF CALIFORNIA, INC., a California corporation ("Health Net" or "Plan") and the CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE ("Department" or "DMHC").

WHEREAS, Health Net is a full service health care service plan ("plan"), subject to the regulatory jurisdiction of the Department under the Knox-Keene Health Care Service Plan Act (Health and Safety Code sections 1340 et seq.) (the "Act"); and

WHEREAS, on or about June 1, 2004, the Department commenced its investigation of Health Net's compliance with the Act and related regulations, particularly including the sections of the regulations related to AB 1455 ("AB 1455 Regulations") and the payment of reasonable and customary value for health care services rendered by non-contracted physician providers and contracted physician providers without a written contract (collectively, "NCPPs"); and

WHEREAS, the Department has determined that the payment methodology used by Health Net to reimburse NCPP claims with dates of service on and after January 1, 2004, and processed through October 12, 2004 ("relevant period"), did not comply with the Act and the AB 1455 Regulations; and

WHEREAS, Health Net has indicated its willingness to enter into this Consent Agreement in order to reach a full and complete settlement and resolution with the Department regarding the payment of reasonable and customary value for health care services rendered by NCPPs during the relevant period, and to make available to the affected NCPPs, under the auspices of the Department, the readjudication of their claims consistent with the requirements of the Act and the AB 1455 Regulations. In addition, the Plan has indicated its willingness to reimburse members (the term "members" as used herein shall include both the enrollee and the enrollee's subscriber) who may have been adversely affected;

NOW, THEREFORE, the Department and Health Net mutually agree to enter into this Consent Agreement as follows:

I. Findings of the Department.

A. For services rendered on and after January 1, 2004, the AB 1455 Regulations require that the reimbursement of claims of non-contracted providers be the reasonable and customary value for the health care services rendered. During the relevant period, Health Net reimbursed many NCPP claims at a value equal to 80% of its Medicare (RBRVS) value. The Department has determined that reimbursement at this valuation does not comply with the requirements of the AB 1455 Regulations.

B. Prior to January 1, 2004, the regulations did not specifically define "reimbursement of a claim" for NCPPs, but other regulatory requirements applied, including the requirement that plans reimburse emergency health care services under Health and Safety Code section 1371.4 and the prohibition on balance billing under Health and Safety Code section 1379.

C. The Department acknowledges and has considered in mitigation Health Net's actions: (1) before and during 2004 to protect its members from inappropriate balance billing by the NCPPs, (2) to correct its reimbursement methodology for NCPP claims processed on and after October 13, 2004; and (3) to cooperate with the Department in its investigation of this matter. The Department acknowledges Health Net's assertion that its noncompliance was not willful or intentional.

D. Health Net represents that NCPP claims processed after October 12, 2004 have been adjudicated pursuant to Health Net's revised reimbursement methodology. The use of the commercial database selected by Health Net as a component of this methodology, if updated at least annually, is not inconsistent with the requirements of the AB 1455 Regulations that require plans to pay such NCPPs the reasonable and customary value of their service.

E. Nothing in this Consent Agreement shall be deemed to have changed Health Net's responsibility for the payment of the claims of NCPPs that are the financial responsibility of a risk-bearing provider organization ("RBO") that has contracted with Health Net to accept the risk of such liability.

II. Plan's Acknowledgements.

A. Plan acknowledges that, during the relevant period, its payment of NCPP claims based on 80% of RBRVS was not consistent with the Department's interpretation of the AB 1455 Regulations.

B. Plan acknowledges that there may be Plan members who have been balance-billed and who have paid sums (amounts currently unknown to Plan) to the NCPPs in excess of their financial responsibilities as defined in the evidences of coverage or as otherwise limited by law.

III. Corrective Actions by Health Net for the Benefit of NCPPs.

A. Plan will open its existing provider dispute resolution process to allow NCPPs, who were reimbursed based on 80% of RBRVS for services rendered on or after January 1, 2004, to obtain a readjudication of such claims pursuant to the Plan's revised methodology for such claims. Plan may require the NCPP, in a form subject to Department approval, to (1) identify the original claim, by date and number, and if available, the remittance advice, explanation of benefits, or other evidence of payment determination and (2) certify whether the member was balance billed and the amount, if any, collected from the member in excess of the member's applicable copayment, co-insurance and deductible. Plan will extend the time period for filing any such appeals to the later of (i) 365 days from the date of the Plan's payment or (ii) 90 days from the date that Plan provides notice to the NCPPs, as defined below.

B. NCPP claims will be readjudicated based on the Plan's revised methodology, less applicable copayment, deductible or co-insurance paid or payable by the member. If Plan determines through the provider appeal process that the member has paid the NCPP an amount in excess of the applicable copayment, deductible or co-insurance, then Plan may offset that amount from the additional payment otherwise due to the NCPP, and the Plan shall promptly reimburse the member such excess amount, regardless of whether the member submits a claim under Section IV below.

C. Recognizing that this process is in the nature of a settlement of a contested matter, any claim for interest will be deemed settled by payment of the readjudicated amount, if any, under Section III.B. Notwithstanding the foregoing, Plan shall pay interest at the statutory rate (Health and Safety Code sections 1371 *et seq.*) on any readjusted amount paid under this Section III commencing as follows: (a) if the NCPP had previously appealed the claim on the grounds that the reimbursement rate was less than the reasonable and customary value of the services rendered, then commencing on the 46th working day after the date Plan received the complete original claim or (b) if not previously appealed on such basis, then commencing on the 60th working day after the Plan's receipt of complete information to initiate the readjudication. The Plan's failure to timely process the appeals, disputes or requests for readjudication under this Agreement may be deemed by the Department to be a separate and distinct violation of this Agreement and/or the Knox-Keene Act and the AB 1455 Regulations. Appeals processed under this Section III shall be evaluated, for purposes of claims and appeals timeliness audits, pursuant to the time periods set forth herein.

D. Plan shall give written notice in a form approved by the Department to those NCPPs who had previously appealed claims payments from the relevant period on the grounds that the reimbursement rate was less than reasonable and customary value of the services. Such notice will be sent to the NCPP at its last known address no later than 90 days after the date of this Agreement. The notice will describe the relevant circumstances and background, the NCPP's appeal right, the procedure for such appeal and the appeal form and supporting documentation necessary to complete the appeal.

E. Plan will continue to use its revised methodology as provided for herein, updated at least annually, to reimburse future claims of NCPPs unless and until another database or methodology is approved by the Department, or until such time as the Department, following 90 days' prior written notice to the Plan, determines that the use of the revised methodology will no longer be approved. If another database or methodology is approved for another plan or RBO, Plan shall have the option to change to such approved database or methodology upon notice to the Department. This Consent Agreement does not prohibit Health Net, from applying appropriate editing and reimbursement policies consistent with national standards if available, and the AB 1455 Regulations.

F. Because the number of appeals as provided above may be large, it may not be possible for Health Net to remain compliant with the timely resolution portions of the AB 1455 Regulations in regard to provider appeals under this Agreement. Health Net will complete the processing, and payment where appropriate, of these appeals as soon as practical but no later than

90 days after receipt of a complete appeal including required documentation, and the Department agrees that such time frame will not be deemed a violation of the timeliness standards for claims or appeals under the Knox-Keene Act or the AB 1455 Regulations.

IV. Corrective Actions for the Benefit of Members.

A. Within 90 days of the execution of this Agreement, the Plan will give written notice to the appropriate members whose NCPP claims were processed based on 80% of RBRVS. Such notice, as approved by the Department, will describe the relevant circumstances and background, the member's right to seek reimbursement from Plan, and the process by which to do so, including the form and all documentation necessary to submit a complete request. Such notice will be sent to the appropriate member's current address of record with Plan and may be in the form of a publication containing other information, such as a member newsletter; provided however, that if other information is included, the notice required hereunder shall be of sufficient prominence that the reasonable reader would notice it, whether by size of type or font, placement in the document or exclusivity on a page. Such notice will inform the appropriate member, in substance, that the allowed amount for certain claims for services by NCPPs may have resulted in an underpayment by Plan. The notice shall also state that therefore the member may have been balance billed by the provider for a higher amount than appropriate; and that the Plan will review any such claims and reimburse the member for any such excess amounts paid by the member, including costs and expenses arising out of the NCPPs collection efforts as further described in this Section IV.

B. Any Health Net member who has been subject to balance billing by a NCPP shall be entitled to full reimbursement by Health Net of any amount paid in excess of the applicable copayment, co-insurance or deductible. Plan shall establish a reasonable process, acceptable to the Department, for members to submit documentation of the member's balance billing payment. Plan will then reimburse the member that amount within 60 working days of the receipt of documentation.

C. Plan will pay interest at the rate of six percent (6%) per annum on any payments made under this Section IV where the payment is made more than 60 working days following the Plan's receipt of balance billing documentation. The Plan's failure to timely process the balance billing requests pursuant to this agreement may be deemed by the Department to be a separate and distinct violation of this agreement and/or of the Knox-Keene Act and the AB 1455 Regulations.

E. Members will be allowed a minimum of 120 days following the Plan's mailing of the notice to complete and submit their requests for reimbursement.

F. This Section IV applies to NCPPs claims for services rendered on or after January 1, 2000.

G. In connection with the administration of the corrective actions set forth in Sections III and IV hereof, Health Net is authorized to utilize the services of one or more third party vendors; provided, however, that the use of such vendors shall not reduce or eliminate Health Net's responsibility for such corrective actions.

V. Administrative Penalty.

A. The Department has determined that an administrative penalty of $250,000 is warranted in this matter. Plan has agreed to pay the penalty within ten days after the date of this Consent Agreement.

B. The Plan shall submit a preliminary written report on or before August 31, 2005, on the status of all corrective action activities, including a summary of the additional reimbursements paid to NCPPs and the status of member reimbursement regarding balance-billing activities. A final written report will be due no later than December 31, 2005.

C. In the event that the Plan materially fails to timely institute the required corrective action or materially fails to timely reimburse NCPPs or members as stated above, the Department, in its sole discretion, may assess a liquidated penalty not to exceed fifty percent of the amount of the fine set forth in section V.A. above.

VI. General

A. The Department finds the corrective action in Section IV is appropriate to ascertain and reimburse affected members who were balanced billed by NCPPs between January 1, 2000 and October 12, 2004. If the Plan completes the corrective actions in sections III. and IV., the regulatory requirements of the Act to pay the reasonable and customary value for services by NCPPs are satisfied, provided the Plan has a process for considering and does consider any additional information submitted by the NCPP regarding reasonable and customary value. The Plan is not relieved of its obligations to protect members from balance billing by the collection activities of NCPPs; however, the Plan will not be subject to further enforcement action or additional administrative penalties for the balance billing of members by NCPPs between January 1, 2000 and October 12, 2004.

B. The NCPP claims that are covered by this Agreement are claims paid on a non-contracted basis. This Consent Agreement does not consider or include: (1) claims that the Plan paid based on a direct or indirect written agreement with a provider and, (2) claims that have been released in writing by the provider.

C. As part of its general jurisdiction over the Plan, the Department retains jurisdiction over the Plan's compliance with this Agreement including without limitation any issues regarding whether the Plan's corrective action pursuant to Sections III. and IV. complies with this Agreement.

D. Subject to the need for the Department's approvals as referenced above, this Agreement contains the entire, complete, and integrated statement of each and every term and provision agreed to by and between the parties; and it supersedes any prior agreements or understandings, whether written or oral, between the parties regarding the subject matter hereof. This Agreement shall not be modified in any respect except by a writing executed by both parties.

E. Neither party waives any applicable attorney-client privilege or work product protection for any negotiations, statements or proceedings relating to this Agreement.

F. Neither party shall be considered to be the drafter of this Agreement or any provision hereof for the purpose of any statute, case law, or rule of interpretation or construction that would cause any provision to be construed against the drafter. This Agreement was drafted with substantial input by both parties and their counsel, and no reliance was placed on any representations other than those contained herein.

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IN WITNESS WHEREOF, the parties hereby execute this Consent Agreement by the signatures of their respective duly authorized officials.

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

By _____
Amy L. Dobberteen
Assistant Deputy Director and
Chief of Enforcement

HEALTH NET OF CALIFORNIA, INC.,
a California corporation

By _____
Franklin Tom
Vice President, Legal