No. S218497

In the Supreme Court of the State of California

CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATION, ET AL.

Plaintiffs and Appellants

vs.

HEALTH NET OF CALIFORNIA, INC., ET AL.,

Defendants and Respondents

ANSWER TO PETITION FOR REVIEW

After An Opinion By The Court of Appeal
Second Appellate District, Division Three, No. B238867

Service on Attorney General and the Los Angeles District Attorney
Required by Bus. & Prof. Code § 17209 and
Cal. Rules of Court, rule 8.29(a) and (b)

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INTRODUCTION AND SUMMARY OF ARGUMENT

Emergency physicians are statutorily required to examine and stabilize any patient requiring emergency care, regardless of the patient's ability to pay. These physicians unquestionably deserve compensation for their services. This case arose because Petitioners ("Plans")[1] failed to maintain "financially sound" arrangements for health care services as all plans have been required to for nearly fifty years pursuant to their licensure scheme,[2] specifically Health & Safety Code §1375.1, and therefore failed to properly monitor their delegatees. This in turn, forced emergency physicians to work for free. Consistent with *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, and *Bell v. Blue Cross of California* (2005) 131 Cal. App. 4th 211, the Court of Appeal in this case recognized a private right of action that would give the Emergency Physicians a chance to

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[1] Petitioners are Health Net of California, Inc., Blue Cross of California dba Anthem Blue Cross, PacifiCare of California dba Secure Horizons Health Plan of California, Physicians' Service dba Blue Shield of California, Cigna HealthCare of California, Inc., Aetna Health of California, Inc., and Scan Health Plan. In this answer, "Plans" with a capital P refers to the petitioners specifically, while "plans" with a lower case p refers to managed health care plans (including health insurers participating in the California managed care system) generally or to a plan discussed in another case.

"Emergency Physicians" with capital Es and Ps refer to the plaintiffs/respondents in this case, while "emergency physicians" with no capitalization refers to emergency physicians generally.

[2] The Knox-Keene Health Care Service Plan Act, codified at Health and Safety Code sections 1340 et seq. ("Knox-Keene Act") is the statutory scheme governing managed health care plans

recover their compensation. The Plans want this Court to eliminate the only remedy available. For the reasons discussed below, this Court should deny review and preserve the remedy.

In this case ("*Centinela*"), the Court of Appeal understood that many recipients of emergency services are enrollees in managed care plans ("plans"), and expressly recognized that a core component of California's regulatory framework was and is to ensure the financial stability of a plan's health care arrangements through regulatory procedures. *See* Health & Safety Code §§ 1342, 1375.1. While plans are statutorily required to pay emergency physicians who treat the plan's enrollees, they are statutorily permitted to delegate their payment obligations to independent practice associations ("IPAs"). After delegation, the IPAs become responsible for the emergency physicians' compensation. The Court of Appeal, however, also recognized that this arrangement collapses when a delegatee IPA becomes financially unable to pay the physicians. Even when this occurs, according to Petitioners, plans have no obligation to resume their previously delegated payment obligations, the emergency physicians (including plaintiffs in this case and others similarly situated) should continue to work for free, and emergency physicians should have no access to the court system to recover compensation from the plans – even when a plan knew or should have known that the IPA delegatee was or had become financially unsound.

The Court of Appeal correctly disagreed, holding that, based on long-standing Knox-Keene provisions requiring plans to maintain financially sound arrangements for health care, a plan has a duty to refrain from delegating its payment obligation to an IPA if the plan

knew or should have known that the IPA was financially unsound. Finding that the duty is a continuing one, the Court of Appeal held that the duty may be breached by a plan's failure to act when it learns post-delegation that the IPA is no longer able to meet its payment obligations. However, the Court of Appeal did not create a blanket private right of action against plans that breach this duty. Rather, the Court of Appeal narrowly tailored it only to emergency physicians with no contracts with plans covering the treated enrollees ("non-contracted emergency physicians"). This private right of action for this limited class of medical providers is necessary because non-contracted emergency physicians lack a contractual partner from whom they could recover payment, they are prohibited by California Supreme Court authority from "balance billing" their patients, and they are prohibited by statute from refusing to treat patients.[3] Without this private right of action, which is consistent with existing law, emergency physicians and other emergency care providers would have no remedy of any kind. The Court of Appeal reached the correct result and thus this Court should decline review.

Petitioners first ask this Court to resolve a purported conflict in appellate authorities, even though no real conflict exists. The case allegedly in conflict with the *Centinela* decision ("Decision"), and cases consistent therewith, is *California Emergency Physicians Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127 ("*CEP*"). However, *CEP*'s current precedential value is questionable at best in light of later developed case law.

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[3] "Balance billing" is the practice of billing patients for the difference between the amount paid by the IPA and the amount billed by the physician.

Additionally, while *CEP* declined to impose a general duty upon plans to conduct their affairs so as to avoid damaging non-contracted emergency physicians' interests, *CEP* did not consider or decide whether a plan has a duty to ascertain the financial soundness of a delegatee IPA. In fact, this issue was not even briefed.[4] *CEP* cannot be read as contradicting the duty found by the *Centinela* Court of Appeal, and thus, the purported conflict in authority urged by the Plans simply does not exist.

The Plans next argue that the *Centinela* Decision undermines California's entire managed healthcare system. This contention is a red herring. The only participants in the managed healthcare system (a vast universe of persons, entities, and facilities) affected by the Decision are emergency physicians and emergency care providers who lack contracts with plans, and are unable to collect from an IPA that is financially unsound. Further, the Plans bolster their scare campaign with arguments that are wholly speculative and not based on any evidence in the record. Therefore, the *Centinela* Decision's effect on the managed healthcare system as a whole does not warrant this Court's review.

Similarly, the Plans' contention that the *Centinela* Decision is inconsistent with the statutory/regulatory scheme governing managed healthcare does not warrant review. Existing statutory and case law specifically allows non-contracted emergency physicians to sue plans in civil courts under appropriate circumstances; and the case upon which the Plans rely is distinguishable and thus non-controlling. Accordingly, California's managed healthcare

[4] *See* opening, respondents' and reply briefs filed in the Court of Appeal.

statutory/regulatory scheme needs no rescue from the *Centinela* Decision.

Finally, the Plans ignore the great care the Court of Appeal took with the Decision. The Plans neglect to tell this Court that they filed a petition for rehearing in the Court of Appeal, that the Court of Appeal granted rehearing on its own motion, or that the Decision after rehearing specifically and expressly addressed the issues raised in the petition for rehearing but nevertheless wholly retained the substance of the original decision. The Court of Appeal's thoroughness weighs against review.

For these reasons, the Emergency Physicians respectfully request this Court to deny the Plans' petition for review.

ARGUMENT AGAINST SUPREME COURT REVIEW

I. CONTROLLING APPELLATE AUTHORITY DOES NOT CONFLICT.

The Plans argue that this Court must resolve a conflict between *CEP* and *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782 ("*Ochs*"). (Petition ("Pet.") 1-2, 21-26.) Like the plaintiffs/respondents in this case, the *CEP* and *Ochs* plaintiffs were non-contracted emergency physicians not paid by insolvent IPAs. The *Ochs* court permitted the non-contracted emergency physician in that case to amend his complaint to allege a cause of action for the plan's negligent delegation of its compensation obligation to a financially unsound IPA. (*Ochs*, *supra*, 115 Cal.App.4th at pp. 796-797.) By contrast, the *CEP* court disallowed a negligence cause of

action. (*CEP*, *supra*, 111 Cal.App.4th at pp. 1135-1136.) However, these decisions are not contradictory, because subsequent case law diminishes *CEP*'s precedential effect, and because *Ochs* and *CEP* decided different types of negligence claims. Therefore, no cognizable conflict exists.

A. Subsequent Case Law has Eroded *CEP*'s Precedential Value.

CEP was published in 2003. (*CEP*, *supra*, 111 Cal.App.4th at p. 1127.) When the *CEP* court decided that non-contracted emergency physicians may not sue plans to recover compensation that should have been paid by IPAs, emergency physicians were permitted to bill their patients for the difference between the amounts paid by the IPAs and the amounts the physicians had billed – a practice commonly called "balance billing."[5]

The *CEP* plaintiffs sought compensation from the plans pursuant to Health and Safety Code section 1317.4 and also alleged causes of action for unfair competition (Bus. & Prof. Code § 17200), implied contract, negligence, quantum meruit, and third party beneficiary of a contract. The *CEP* court systematically and specifically denied recovery under each of these theories (*CEP*, *supra*, 111 Cal.App.4th at pp. 1131-1138) – in an apparent attempt to categorically bar physicians from suing plans for compensation

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[5] Indeed, the *Ochs* opinion, issued approximately six months after *CEP*, observed that under then-current law, the emergency physician plaintiff "may have [had] a remedy against the individual patients, and those patients a remedy against [the plan]." (*Ochs*, *supra*, 115 Cal.App.4th at p. 782, 796.)

that should have been paid by IPAs. However, *CEP* did not foreclose balance billing and thus left the unpaid emergency physicians with an avenue of recovery.

The *Ochs* plaintiff also asserted multiple theories of recovery – violations of the Knox-Keene Act, unfair business practices (Bus. & Prof. Code § 17200), negligence, declaratory and injunctive relief, quantum meruit, and third-party beneficiary of contract. (*Ochs*, *supra*, 115 Cal.App.4th at p. 788.) Like the *CEP* court, the *Ochs* court specifically denied recovery on each of the theories pleaded. (*Id.* at pp. 789-796.) However, the *Ochs* court also held that the emergency physician plaintiff had the right to assert a cause of action for the plan's negligent delegation of its compensation obligation to an IPA that the plan knew or should have known was financially unsound, and that the trial court erred in denying leave to amend to allege a negligent delegation cause of action. (*Id.* at p. 797.) Thus, to the extent *CEP* could have been read to ban all superior court lawsuits by non-contracted emergency physicians to recover compensation from plans, *Ochs* began the erosion of *CEP*'s precedential effect.

In 2005 (more than two years after CEP), the Court of Appeal decided *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211 ("*Bell*"). In contrast to the *CEP* and *Ochs* plaintiffs who had not been paid at all for their services by the Plans, the *Bell* plaintiffs were non-contracted emergency physicians who contended that the amounts the plan paid to them were unreasonably low. (*Id.* at p. 214.) Like the *CEP* plaintiffs, the *Bell* plaintiffs alleged several causes of action – i.e., for declaratory and injunctive relief, violations of Business and Professions Code section 17200, and quantum meruit. (*Id.*)

However, unlike in *CEP*, the *Bell* court held that the plaintiffs had standing to pursue court actions against the plan and held that the plaintiffs could proceed with all of the causes of action advanced by them. (*Id.* at p. 221.) Thus, to the extent *CEP* could have been read to ban all superior court lawsuits by non-contracted Emergency Physicians to recover compensation from plans, *Bell* continued the erosion of *CEP*'s precedential effect.

Approximately six years after *CEP*, the California Supreme Court decided *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497. The *Prospect* court observed: "Because emergency room doctors prevailed in *Bell* [citation] and won the right to resolve their disputes directly with HMO's, no reason exists to permit balance billing." (*Id.* at p. 508.) Accordingly, *Prospect* eliminated balance billing. (*Id.* at pp. 508-509.) Thus, the compensation landscape for non-contracted emergency physicians was dramatically different when *CEP* was decided in 2003 (when these physicians were allowed to balance bill) and after *Prospect* was decided in 2009 (when balance billing ceased).[6]

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[6] The Court of Appeal below acknowledged the *Prospect* opinion's footnote 5, which states that the *Prospect* holding is "limited to the precise situation before us – billing the patient for emergency services when the doctors have recourse against the patient's HMO. We express no opinion regarding the situation when no such recourse is available; for example, if the HMO is unable to pay or disputes coverage." (*Prospect*, *supra*, 45 Cal.4th at p. 507, fn. 5.) The Court of Appeal then opined that if the California Supreme Court had been required to decide whether non-contracted emergency physicians not paid by IPAs could continue to balance bill, the Supreme Court would have disallowed balance billing for these physicians as well. (Opn. 26-27, 41, fn. 38.)

The combined effect of *Ochs* and *Bell* allowing non-contracted emergency physicians to pursue compensation claims against plans in civil courts and *Prospect*'s elimination of balance billing diminishes, if not eliminates, *CEP*'s value as judicial precedent. "'The authority of an older case may be as effectively dissipated by a later trend of decision as by a statement expressly overruling it.' [Citation.]" (*Frisk v. Superior Ct.* (2011) 200 Cal.App.4th 402, 411.) In colloquial terms, if *CEP* is still alive, it is taking its final quiet breaths. Therefore, there is no significant precedential conflict between *CEP* and this case; and therefore no conflict in appellate authority warranting this Court's review.

B. Because *CEP* Neither Addressed Nor Decided the Existence or Absence of Specific Duty Found in *Centinela*, *CEP* Cannot Conflict with *Centinela*.

A case is not authority for a proposition not actually considered and decided. (*City of Clovis v. County of Fresno* (2014) 222 Cal.App.4th 1469, 1479.) Contrary to Respondents' argument, *CEP* did not consider or decide whether non-contracted emergency physicians may have a cause of action for a plan's negligent delegation of its payment responsibility to an IPA or whether the duty to avoid negligent delegation is a continuing duty. Therefore, *CEP* does not control the issue decided by the Court of Appeal below and does not conflict with the *Centinela* Decision.

The *CEP* emergency physicians asserted a negligence cause of action against the plans, alleging that the plans had a duty to "'use

due care so as not to cause harm to [Emergency Physicians'] financial interest. . . .'" (*CEP*, *supra*, 111 Cal.App.4th at p. 1135 (brackets and ellipses by court).) The *CEP* court declined to find such a duty on the grounds that businesses generally have no duty to manage their affairs so as to prevent economic injury to third parties, and because the Legislature has approved risk sharing arrangements. (*Id.* at p. 1136.)

By contrast, the Emergency Physicians in this case do not allege that the Plans owed them a broad duty to look after their financial interests generally. Instead, the duty the Emergency Physicians allege in this case is a Plan's continuing duty to avoid and/or reverse delegation of its compensation obligation to an IPA that the plans knew or should have known is financially unsound. This duty is much narrower and more specific than the duty alleged in *CEP*.[7]

Thus, the *Centinela* and *CEP* courts decided the existence/absence of different duties. The fact that the *CEP* court found no duty in that case does not conflict with the Court of Appeal's finding of a duty in this case. Accordingly, even if *Prospect* had not diminished the precedential value of *CEP*, no conflict between *CEP* and this case would exist.

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[7] The *Ochs* opinion confirms that the viability of negligence claims is evaluated according to the specific duties claimed rather than according to a one-size-fits-all standard. The *Ochs* court held that the plaintiff's cause of action for negligence based on the plan's alleged duty to pay for emergency services was subject to demurrer (*Id.* at p. 794), but that a cause of action for negligence based on the plan's pre-delegation duty to ascertain the financial soundness of the delegatee IPA could proceed (*Id.* at p. 797).

II. THE PLANS' CONTENTION THAT THE *CENTINELA* DECISION UNDERMINES CALIFORNIA'S ENTIRE MANAGED HEALTHCARE SYSTEM IS A RED HERRING THAT DOES NOT SUPPORT SUPREME COURT REVIEW.

The medical providers affected by the Decision – emergency care providers who have no contracts with plans or IPAs -- constitute a very narrow slice of the managed-care-provider pie. The Plans' insinuation that allowing this relatively small group to pursue a civil action for compensation will destabilize California's entire managed care system is alarmist at best, and an attempt to distort at worst.

While the Plans argue that, without a review of *Centinela*, the sky will fall on California's managed care system, the reality is that *Centinela* actually strengthens it. A financially strong IPA is in everyone's best interests – the patients, the providers, and the plans. With plans responsible for monitoring their delegated entities, and being held liable if they fail to ensure that IPAs fulfill their obligations in this narrow case, the potential IPA financial meltdown decreases significantly.

Moreover, the Plans support their end-of-managed care contention with arguments that were not raised previously, and are unsupported, by the record. For example, the Plans argue that "a health plan that re-assumes payments from an IPA will have to adjust its capitation payments to that IPA accordingly," and that "some IPAs that might have emerged intact from a corrective action plan may go under because of the decrease in capitation payments." (Pet. 31.) This argument does not support this Court's review

because (1) the argument is entirely speculative, and (2) the Court of Appeal did not have the opportunity to consider it.

The Plans also argue for the first time in their petition that allowing non-contracted Emergency Physicians to sue Plans for compensation when failed IPAs cannot pay "elevat[es] the emergency physicians' interests above the interest of contracted physicians of all specialties," and "creates a perverse economic incentive for emergency physicians to avoid contracted arrangements and penalizes those doctors who have entered into such arrangements." (Pet. 32.) Again, this argument does not support a grant of review because it makes numerous assumptions for which there is no record. The argument assumes that emergency physicians have the opportunity to contract fairly with IPAs, non-contracted arrangements are more lucrative than contracted arrangements, and that non-contracted physicians would prefer to sue for their compensation rather than receive payments pursuant to a binding contract. This and other unsupported arguments do not support Supreme Court review.

III. BECAUSE EXISTING CASE LAW DEFEATS THE PLANS' ARGUMENT THAT A RIGHT TO SUE FOR NEGLIGENT DELEGATION IS INCONSISTENT WITH MANAGED HEALTH CARE'S STATUTORY SCHEME, SUCH PURPORTED INCONSISTENCY DOES NOT WARRANT THIS COURT'S REVIEW.

A. Existing Case Law Establishes Non-Contracted Emergency Physicians' Right to Pursue Court Actions for Compensation.

The Plans' petition argues that the negligent delegation cause of action permitted by *Centinela* is inconsistent with Health and Safety Code section 1371.4, subdivision (e) (the statute permitting plans' delegation of their obligations to pay emergency physicians to IPAs), with the Knox-Keene Act as a whole, and with the "comprehensive statutory system" governing managed health care. (Pet. 26-36.) Existing law has already invalidated these arguments.

First and fundamentally, the Knox-Keene Act specifically contemplates that the Department of Managed Health Care ("DMHC") will resolve many – but not all – issues arising under this statutory scheme:

> A plan, any entity contracting with a plan, and providers are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in a contract with a provider is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part of a plan, an entity

> contracting with a plan, or a provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability.

(Health & Safety Code § 1371.25 (emphasis added).)

Additionally, even *CEP* -- the case finding no viable private right of action among the several causes of action alleged therein – recognizes that emergency physicians have access to courts for the purpose of securing their earned compensation. The *CEP* court observed that "the Knox-Keene Act itself contemplates that a health care plan may be held liable under theories based on other law." (*CEP*, *supra*, 111 Cal.App.4th at p. 1134 (quoting *Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693, 702).)

In 2004, *Ochs* contradicted the Plans' arguments in this case by implication in holding that the non-contracted emergency physician plaintiff in that case had the right to prove that the plan negligently delegated its payment responsibilities to an IPA that the plan knew or should have known was financially unsound. (*Ochs*, *supra*, 115 Cal.App.4th at pp. 782, 797.) However, the *Ochs* court did not expressly address the compatibility of a negligent delegation cause of action with a specific statute or a statutory scheme.[8]

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[8] It appears from the *Ochs* decision that the plan in that case opposed the viability of this cause of action on the ground that a negligent delegation cause of action would require a showing that the allegedly negligent conduct was intended to affect Dr. Ochs specifically (as opposed to the class of emergency physicians who treated the plan's enrollees). The *Ochs* court rejected this argument on the ground that negligence liability may be imposed when a duty

(Footnote continued on next page.)

In 2005, *Bell*, *supra*, confirmed the compatibility of non-contracted emergency physicians' civil causes of action against plans for compensation and the statutes governing managed care in California. In contrast to *Ochs*, *Bell* specifically addresses and explains the compatibility. *Bell* holds that the DMHC does not have exclusive jurisdiction over non-contracted emergency physicians' compensation levels and that these physicians are "free to pursue alternate theories to recover the reasonable value of [their] services" in civil courts. (*Bell*, *supra*, 131 Cal.App.4th at p. 215.) The *Bell* court did not fabricate these conclusions out of proverbial whole cloth, but instead based them on Health and Safety Code statutes and the DMHC's position on the issue.

Bell relied in part on Health and Safety Code section 1731.4, subdivision (b) (*id.* at p. 216) which provides in relevant part: "A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee[.]" The *Bell* court held:

> Subdivision (b) of section 1371.4 was enacted in 1994 to impose a mandatory duty upon health care plans to reimburse non-contracting providers for emergency medical services. [Citations.] Although the [DMHC] has jurisdiction over the subject matter of section 1371.4 (as well as the rest of the Knox-Keene Act), its jurisdiction is not exclusive and there is nothing in section 1371.4 or in the Act generally to preclude a

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is owed to a plaintiff or a class of which the plaintiff is a member. (*Id.* at p. 797.)

> private action under the UCL or at common law on a quantum meruit theory. [Citation.]

(*Id.* at p. 216.) Relying on Health and Safety Code section 1371.25 (quoted above) and *CEP*, *supra*, *Bell* stated that the Knox-Keene Act specifically provides for a health care plan's potential liability under laws and theories (including common law theories) extraneous to the Knox-Keene Act. (*Bell*, *supra*, 131 Cal.App.4th at pp. 216-217 (citing *CEP*, *supra*, 111 Cal.App.4th at p. 1134).)

The *Bell* court then turned to the DMHC's position on the extent of its jurisdiction:[9]

> Any doubt about Dr. Bell's standing dissolves in light of the [DMHC's] support of private enforcement. [Fn. 8] An uncontroverted record establishes (1) that the [DMHC] "has consistently taken the position that a provider is free to seek redress in a court of law if he disputes a health plan's determination of the reasonable and customary value of covered services as required by section 1371.4," (2) that "providers are free to pursue alternate theories of recovery to secure the reasonable value of their services based on common law theories of breach of contract and *quantum meruit*," and that a "provider's private action for reimbursement under the . . . UCL does not infringe upon the Department's jurisdiction over the Knox-Keene Act."

(*Id.* at pp. 217-218 (ellipses by *Bell* court).)[10] The *Bell* court continued:

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[9] The DMHC appeared as amicus curiae in *Bell*. (*Bell*, *supra*, 131 Cal.App.4th at p. 215.)

In the [DMHC's] words, "[t]he fundamental flaw in the trial court's ruling is that it allows a health plan to unilaterally determine the level of reimbursement for non-contracted emergency providers without further recourse which can lead to the payment of less than the reasonable and customary value of the providers' services. If providers are precluded from bringing private causes of action to challenge health plans' reimbursement determinations, health plans may receive an unjust windfall . . . .

"The prompt and appropriate reimbursement of emergency providers ensures the continued financial viability of California's health care delivery system. The trial court's decision, denying emergency providers judicial recourse to challenge the fairness of a health plan's reimbursement determination, allows a health plan to systematically underpay California's safety-net providers . . . . [¶] . . . The [DMHC], unlike the courts, lacks the authority to set specific reimbursement rates under theories of *quantum meruit* and the jurisdiction to enforce a reimbursement determination on both the provider and the health plan. Because the [DMHC] cannot provide an adequate forum, health care providers must be allowed to maintain a cause of action in court to resolve individual claims-payment disputes over the reasonable value of their services."

In short, it is the [DMHC's] view that Dr. Bell has standing under the UCL to pursue his allegations that [the plan] violated section 1371.4 and standing to pursue his common law claim of quantum meruit for a

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[10] The *Bell* opinion's footnote 8 reads: "The construction of a statute by the executive department charged with its administration is entitled to great weight and substantial deference. [Citations.]" (*Bell*, *supra*, 131 Cal.App.4th at p. 217.)

> fair and reasonable reimbursement based on the implied-in-law contract created by Dr. Bell's statutory duty to provide stabilizing medical care, and [the plan's] concomitant statutory duty to pay for emergency services rendered to its enrollees.

(*Id.* at p. 218 (some ellipses added).)

B. The Plans Rely on an Inapplicable Case.

The Plans attempt to avoid *Bell* and *Ochs* by relying on *Loeffler v. Target Corp.* (May 1, 2014) 58 Cal.4th 1081 [2014 WL 1714947] ("*Loeffler*"). The Plans' reliance is misplaced – primarily because *Loeffler* is wholly unrelated to managed health care. The *Loeffler* plaintiff alleged that a large multi-product retail vendor wrongfully charged sales tax on hot coffee "to go." (*Loeffler, supra*, 2014 WL 1714947 at p. *1.)[11] "[T]he language of a court's opinion must be construed in light of the facts of the particular case; an opinion's authority is no broader than its factual setting, and the parties cannot rely on a rule announced in a factually dissimilar case. (*Woods v. Fox Broadcasting Sub., Inc.* (2005) 129 Cal.App.4th 344, 352 (citations and internal quotation marks omitted).) Thus, this basic overarching factual dissimilarity between *Loeffler* and *Centinela* alone renders *Loeffler* inapplicable.

Centinela and *Loeffler* are also factually distinguishable in other respects. The primary issue in *Loeffler* was whether the end

[11] The California Reports pagination of *Loeffler* was not yet available when this answer was drafted. Therefore, the page cites for this case are to the Westlaw version.

recipient had the right to litigate the taxability of the product in the superior court. In *Loeffler*, the end recipients were the consumers who purchased the hot coffee to go. However, the court observed that under California law the retailer is the taxpayer – not the consumer -- and that the consumer's/end recipient's remedy is generally limited to seeking a refund from the Board or compelling the Board to compel the taxpayer/retailer to seek a refund. (*Loeffler*, *supra*, 2014 WL 1714947 at pp. *1, *5, *10, *24.) In contrast to *Loeffler*, the end recipients in the managed healthcare context are the patients – and *Prospect* ensures that patients will have no involvement in the compensation of emergency physicians and will not be parties to compensation lawsuits such as *CEP*, *Ochs*, *Bell*, and/or *Centinela*. Therefore, this second factual distinction renders *Loeffler* irrelevant.

Moreover, *Loeffler* does not support the Plans' argument of the DMHC's exclusive jurisdiction over Knox-Keene Act issues. The *Loeffler* court did not hold that the relevant agency (the California Board of Equalization) had exclusive jurisdiction over the taxability of hot coffee. Rather, the *Loeffler* court held that the agency must determine the taxability of an item in the first instance and that the agency's determination would then be subject to judicial review. (*Loeffler*, *supra*, 2014 WL 1714947 at pp. *9, *13.) By contrast, the Plans do not even suggest that non-contracted emergency physicians have any administrative remedy for non-payment for their services, let alone an administrative remedy that could be exhausted before judicial review is available. Further, as set forth in *Bell* and *Prospect*, the DMHC does not have exclusive jurisdiction.

Because *Loeffler* and *Centinela* are factually and substantively very distinct, *Loeffler* does not support this Court's review of *Centinela*.

IV. THE COURT OF APPEAL'S GREAT CARE WITH THE DECISION WEIGHS AGAINST SUPREME COURT REVIEW.

By omitting the decisional history in the Court of Appeal below, the Plans apparently attempt to insinuate that the Court of Appeal cavalierly decided this matter. The opposite is true.

The Court of Appeal's original decision was 42 pages long and was issued on February 19, 2014. On March 6, 2014, the Plans filed a petition for rehearing ("PFR") in the Court of Appeal. The Court of Appeal granted rehearing on its own motion and denied the PFR as moot. (Exh. 1 below.)

The Court of Appeal issued its final Decision on April 2, 2014. The final Decision wholly retained the substance of the original and made only grammatical and stylistic alterations to the original's text. The final Decision also added several footnotes and, in one instance, added language to a footnote, addressing the concerns raised in the PFR.[12]

In summary, the Court of Appeal made a considered and reasoned decision, and on its own motion evaluated the Plans' concerns about the decision. After further review and consideration, the Court of Appeal's final Decision addressed the Plans' concerns

[12] The final Decision's footnotes 16, 25, 30, 32, and 34 (opn. 12, 22-23, 31, 35, 36-37) are additions to the original decision. The last four sentences of footnote 24 (opn. 21) were also added.

and remained substantively unchanged from the original decision. This circumstance weighs against this Court's involvement.

CONCLUSION

For the reasons stated above, this Court should deny the Plans' petition for review.

Respectfully submitted this 2nd day of June, 2014.

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Centinela Freeman Emergency
Medical Associates, et al.

WORD COUNT CERTIFICATION

I, Damaris L. Medina, certify as follows:

I am an attorney licensed to practice in California. I am an associate with the law firm Michelman & Robinson, LLP, counsel of record for plaintiffs and appellants, Centinela Freeman Emergency Medical Associates, et al. in Supreme Court Case No. S218497.

This brief was prepared on a computer using the Word processing program. This program's word count feature shows that this Answer to Petition for Review contains *5,099* words. This count excludes the cover pages, signature, Table of Contents, Table of Authorities, and this Word Count Certification.

I have personal knowledge of the facts stated in this certificate and could and would competently testify to them if called upon to do so. I declare under penalty of perjury, under the laws of the State of California, that all of the foregoing is true and correct, and that this certification was executed on June 2, 2014 in Encino, California.

Damaris L. Medina

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES et al., Plaintiffs and Appellants, v. HEALTH NET OF CALIFORNIA, INC., et al., Defendants and Respondents.	B238867 (Los Angeles County Super. Ct. No. BC449056) ORDER GRANTING PETITION FOR REHEARING

THE COURT:

On its own motion, the court grants rehearing in this matter. No further written or oral argument is required. The matter is resubmitted as of this date.

Jason O Cheuk
Michelman & Robinson, LLP
15760 Ventura Blvd 5th Fl
Encino, CA 91436

Case Number B238867
Division 3

CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES et al.,
Plaintiffs and Appellants,
v.
HEALTH NET OF CALIFORNIA, INC. et al.,
Defendants and Respondents.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES et al.,

Plaintiffs and Appellants,

v.

HEALTH NET OF CALIFORNIA, INC., et al.,

Defendants and Respondents.

B238867

(Los Angeles County
Super. Ct. No. BC449056)

ORDER GRANTING REHEARING

THE COURT:

On March 19, 2014, this court issued an order captioned "Order Granting Petition for Rehearing." Said caption contains a clerical error and it should read "Order Granting Rehearing." The order is corrected nunc pro tunc to so provide.

CROSKEY, Acting P.J.

Jason O Cheuk
Michelman & Robinson, LLP
15760 Ventura Blvd 5th Fl
Encino, CA 91436

Case Number B238867
Division 3

CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES et al.,
Plaintiffs and Appellants,
v.
HEALTH NET OF CALIFORNIA, INC. et al.,
Defendants and Respondents.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION: 3

DATE: March 21, 2014

Jason O Cheuk
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CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES et al.,
Plaintiffs and Appellants,
v.
HEALTH NET OF CALIFORNIA, INC. et al.,
Defendants and Respondents.

B238867
Los Angeles County No. BC449056
Los Angeles County No. BC415203

THE COURT:

Respondents' Petition for Rehearing filed March 6, 2014 is denied as moot.

cc: File

PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of 18, and not a party to the within action. My business address is 15760 Ventura Blvd., 5th Floor, Encino, California 91436.

On **June 2, 2014**, I served the foregoing document(s) described as: **ANSWER TO PETITION FOR REVIEW** on the interested parties by placing a true copy thereof in a sealed envelope(s) addressed as follows:

- SEE ATTACHED SERVICE LIST -

☒ **(BY ELECTRONIC MAIL)** By personally transmitting an electronic copy for E-Submission to the Supreme Court of California.

☒ **(BY MAIL)** By placing a true copy thereof enclosed in a sealed envelope(s) addressed as above, and placing each for collection and mailing on that date following ordinary business practices. I am "readily familiar" with this business's practice for collecting and processing correspondence for mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in Encino, California, in a sealed envelope with postage fully prepaid.

☒ **(STATE)** I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on June 2, 2014 at Encino, California.

Lisa M. Tucker

SERVICE LIST

CENTINELA FREEMAN EMERG. MED. ASSOC., ET AL. vs. HEALTH NET OF CALIFORNIA, ET AL.

(Supreme Court of CA Case No. S218497; CA Court of Appeal, Second Appellate District, Division Three, Case No.: B238867)

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Honorable John Shepard Wiley Los Angeles Superior Court Central Civil West, Dept. 311 600 S. Commonwealth Avenue Los Angeles, CA 90005	Case No. BC449056
Court of Appeal Second Appellate District, Div. Three 300 South Spring Street Second Floor, North Tower Los Angeles, CA 90013-1213	Case No. B238867