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

ANSWERING BRIEF ON THE MERITS

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

Service on the 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)

MICHELMAN & ROBINSON, LLP
*Andrew H. Selesnick – State Bar No. 160516
Damaris L. Medina – State Bar No. 262788
Robin James – State Bar No. 150143
15760 Ventura Blvd., 5th Floor
Encino, California 91436
Telephone: (818) 783-5530
Fax: (818) 783-5507

Attorneys for Plaintiffs, Appellants, and Respondents
Centinela Freeman Emergency Medical Associates, et al.

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Telephone: (818) 783-5530
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QUESTION PRESENTED

Are non-contracted emergency physicians able to maintain a cause of action against health plans that have delegated their duty to reimburse to an independent practice association (IPA) they knew, or had reason to know, was financially unable to satisfy the obligation, and correspondingly, can non-contracted emergency physicians maintain a cause of action against health plans for failure to reassume that duty, when the health plans knew, or had reason to know, that the IPA was financially unable to satisfy that obligation?

INTRODUCTION

Providers of emergency services lie at the core of the safety net of our healthcare system. The law imposes a duty on these providers -- and no others -- to treat all patients seeking emergency medical services regardless of the patient's "insurance status, economic status [or] ability to pay." (Health & Safety Code § 1317, subd. (b).) In recognition of the fact that this requirement places emergency physicians in a unique and often vulnerable position within our system, lawmakers have imposed a corresponding obligation on health plans. This corresponding obligation requires health plans to reimburse emergency physicians for the care they provide to their enrollees regardless of whether or not emergency physicians have a contract with the health plans.

In California, health plans are permitted to delegate their obligation to pay for care provided to their enrollees, to IPAs. Physicians that do not have contracts with health plans therefore depend on a managed health care statutory scheme which (1) requires health plans to pay emergency physicians for the emergency care and services rendered to the health plans' enrollees, but (2) allows the health plans to delegate their emergency care payment obligations to IPAs. Under this system, a non-contracting emergency physician who has provided services to an enrollee of a financially defunct IPA unjustly goes without payment for the emergency services rendered.

Prior to 2009, this situation was untenable. However, emergency physicians could at least bill the patient for the difference between the amount paid by the health plan (or an IPA) and the reasonable value of services if the emergency physician received inadequate compensation from a health plan (or an IPA). This is a practice commonly referred to as "balance billing."

In January 2009, emergency physicians' right to balance bill patients ended with the publication of *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, Inc.* (2009) 45 Cal.4th 497 ("*Prospect*").[1] Due to the fact that emergency physicians could no longer balance bill patients when they received inadequate compensation from a health plan or an IPA, the *Prospect* Court

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[1] Other types of non-emergency health care providers retained the right to balance bill.

found that emergency physicians had recourse against a health plan or an IPA in the form of a civil suit. The *Prospect* decision however, purposefully did not address a foreseeable and untenable consequence of the ban on balance billing – that emergency physicians would be left without recourse if an IPA became unable to fulfill its payment obligations. The result was a system that has the unconscionable consequence of forcing emergency physicians to provide services to health plans' enrollees for free. Although such a situation was foreseen by the *Prospect* Court, a decision on this issue was left for another day.

Prior to the decision in the instant case, the Court of Appeal addressed this issue in two cases reaching contradictory results - *California Emergency Physicians Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127, 1136 ("*CEP*") and later *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782, 797-798 ("*Ochs*"). Faced with a split in authority, the Court of Appeal in the instant case concluded that the Court in *Ochs*, the more recent case, reached the correct result in the context of the current landscape. The Court in *Ochs* held that non-contracted emergency physicians do have a cause of action against health plans for negligent delegation.

The question in front of this Court now is: whether non-contracted emergency physicians are able to maintain a cause of action against health plans that have delegated their duty to reimburse to an IPA they knew, or had reason to know, was financially unable to satisfy the obligation, and correspondingly,

whether non-contracted emergency physicians can maintain a cause of action against health plans for failure to reassume that duty, when the health plans knew, or had reason to know, that the IPA was financially unable to satisfy that obligation.

Although the petitioners in this case (defendants and respondents below) (collectively "Health Plans")[2] initially requested review based on the need for a resolution of the split in authority between the *CEP* and the *Ochs* decisions, they now change course, attempting instead to rehash the faulty argument that the mere existence of a statutory and regulatory framework absolves them of their negligence. The Emergency Physicians (appellants) therefore address this argument first.

The Health Plans essentially argue that, because they have the right under the Knox-Keene Act to delegate their statutory responsibility to pay emergency physicians to an IPA, they can have no liability – under any circumstances or under any theory – to pay the emergency physicians who treat the Health Plans' enrollees after the Health Plans delegate their payment responsibility to an IPA.

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[2] In this brief, "health plans" in all lower case letters refers collectively to managed health care service plans and health insurers generally. "Health Plans" capitalized refers to the managed health care service plans and the health insurer that are the petitioners/respondents/defendants in this case. The "Health Plans" are Blue Cross of California dba Anthem Blue Cross, Health Net of California, Inc., UHC of California f/k/a PacifiCare of California, California Physicians' Service dba Blue Shield of California, SCAN Health Plan, Aetna Health of California, and Cigna HealthCare of California, Inc.

They contend that this is the case even if they knew, or should have known, that the payment responsibility could not be fulfilled.

The Health Plans' attempt to use the regulatory system as an impenetrable shield has already been rejected by the courts and is bellied by their own position in a recent case submitted for review in this Court. Further, the Health Plans' interpretation of the regulations is both incorrect and incomplete. It is well settled that the mere existence of a regulatory system does not foreclose a private right of action, and that the Department of Managed Health Care ("DMHC") does not have exclusive jurisdiction to enforce the provisions of the Knox-Keene Act. Courts have repeatedly allowed parallel civil and regulatory actions. Moreover, the regulatory and statutory framework of the Knox-Keene Act actually supports the imposition of a duty on the Health Plans to reassume responsibility over their payment obligations because it strengthens the managed care system. The regulations and current case law also support a finding that a cause of action against the Health Plans may exist based on common law bases of liability.

Contrary to the Health Plans' assertions, an examination of the regulatory framework as a whole supports the existence of a continuing duty against the Plans to ensure that the IPAs they delegate to are financially capable of carrying out the Health Plans' statutory obligations. This statutory intent is evident in the Knox-Keene Act's requirement that the Health Plans remain engaged in the monitoring of the financial solvency and claims payment compliance of IPAs even after delegation. Further evidence of the

Legislature's intent that the Health Plans retain a continuing obligation exists in the health plans' direct involvement in corrective action plans when IPAs begin to exhibit difficulty fulfilling their financial obligations, and in the regulations' requirement that health plans resume payments when IPAs default.

The Health Plans' response to the proposition that such a duty exists expressly in the regulations is that the procedure the Legislature put in place to monitor the solvency of IPAs and to attempt to rehabilitate troubled IPAs is exhaustive and impenetrable. Therefore, they conclude, the regulations foreclose any private right of action to enforce that duty. The Health Plans employ a misguided interpretation of the regulations that is both unsupported and inconsistent with the Health Plans' own interpretation of the Knox-Keene Act in other cases.

First, the language in the regulations actually expressly contradicts the Health Plans' assertion that no private right of action is available to hold a health plan liable for its actions either at the time of delegation, or after delegation has taken place. The Health Plans rely on the language in the Knox-Keene Act's regulations to support their argument that full liability is transferred at the time of delegation because the Legislature rejected the imposition of vicarious liability on health plans and IPAs in Health and Safety Code Section 1371.25.[3] However, the Health Plans neglected to

[3] All statutory references in this brief are to the California Health and Safety Code unless otherwise specified.

include in their analysis the entire language of the section which specifically states that any limits on vicarious liability, "shall not preclude a finding of liability on the part of a plan...based on the doctrines of equitable indemnity...or other statutory or common law bases for liability."

This case is not about vicarious liability. It is about the Health Plans' own actions – their direct and continuous negligence in delegating to an IPA they knew, or should have known, could not fulfill the Health Plans' statutory obligation to pay for emergency services provided to their enrollees. The provisions of the Knox-Keene Act themselves therefore explicitly permit common-law causes of action against the Health Plans arising out of the Health Plans' own wrongful conduct.

Second, the theory that the statutory scheme is exhaustive, comprehensive, and fully integrated, directly contradicts the Health Plans' own interpretation of the statutes and regulations of the Knox-Keene Act in a case recently submitted for this Court's review. Similarly, the claim that a private right of action that allows emergency physicians to enforce the statutory or regulatory duties health plans have under the Knox-Keene Act does not exist, is inconsistent with the Health Plans' own assertions to this very Court.

Indeed, the Health Plans argued the exact opposite of what they argue in this case in their recent Answer to Petition for Review in case no. S220019, entitled *Children's Hospital Central California v. Blue Cross of California dba Anthem Blue Cross, Inc. et al.* ("*Children's Hospital* Answer"). In the *Children's Hospital* Answer,

the Health Plans argued that the prompt payment regulations promulgated by the DMHC were "not intended to alter or change existing California law." (*Children's Hospital Answer* 28.) Further, the Health Plans assured this Court that a deviation from a strict and literal interpretation of the statutory scheme will not "exempt Blue Cross or any other health care service plan from any statutory regulatory duty it may have under the Knox-Keene Act or immunize Blue Cross from government or private actions to enforce such duties." (*Children's Hospital* Answer 32.) The Health Plans have already admitted that the DMHC does not have exclusive jurisdiction to enforce the provisions of the Knox-Keene Act, and that nothing in the Act forecloses a private right of action to enforce the Health Plans' duties under the Knox-Keene Act. The Health Plans' regulatory arguments simply fail.

Although the Health Plans have curiously chosen to ignore the issue in their brief after having raised it in support of their request for review, the analysis in this case should focus on resolving the split in authority between the holdings in the *CEP* and *Ochs* cases. The analysis of the Court of Appeal in the instant case in invalidating the precedential value of *CEP* was correct and should therefore control. There have been monumental changes in law that have invalidated the holding in the *CEP* case. A year after the *CEP* case, the Court in *Ochs* began the erosion of CEP's precedential effect. Two years later, the decision in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211 ("*Bell*"), essentially gutted the holding in *CEP*, in that, the Court concluded that emergency physicians have a private

right of action against health plans to recover reimbursement for their services. Finally, in 2009, *Prospect* put the proverbial final nail in the coffin when the Court banned the practice of balance billing based on the consideration that, while balance billing was no longer possible, emergency physicians had a remedy against health plans for improper reimbursement in the form of a civil action.

Further, the *CEP* decision does not control because the duty considered was not the one at issue in this case. While *CEP* dealt with a duty not to cause harm to emergency physicians' financial interest, the duty at issue here is the Health Plans' continuing duty to avoid and/or reverse delegation of their reimbursement obligations to an IPA the Health Plans know, or should know, is financially unsound. Therefore, the Health Plans' analysis of the *Biakanja*[4] factors is misplaced. The Court of Appeal underwent a correct analysis of the *Biakanja* factors in reaching its conclusion that a duty against the Health Plans in this case does in fact exist.

In sum, California has a clearly expressed public policy supporting the proposition that professionals are not required to give away their services for free, but rather must be - and deserve to be - fairly paid as a matter of law and sound public policy. This policy supersedes blind adherence to a distorted view of a statutory scheme that the Health Plans themselves have not supported in connection with other cases. The Health Plans here simply seek to shirk their statutory duty to reimburse emergency physicians for the

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[4] *Biakanja v. Irving* (1958) 49 Cal.2d 647.

services they are required to provide, and lay the risk of health care costs on anyone but themselves. Contrary to the Health Plans' contention, requiring the Health Plans to resume payments to non-contracted emergency physicians should IPAs default, will not undermine the Knox-Keene Act or adversely affect the managed health care system. A decision in favor of the Emergency Physicians will instead strengthen the system – making sure that health plans remain responsible for ensuring that IPAs can provide the services they have been entrusted to provide to their patients, and that the safety net of our managed care system remains intact.

FACTUAL AND PROCEDURAL BACKGROUND

The subject of this appeal is a judgment entered after the trial court sustained the Health Plans' demurrer without leave to amend. (V AA 1115-1124.) In reviewing a demurrer ruling, the reviewing court assumes the truth of all material facts pleaded and also considers matters that may be judicially noticed. (*Blank v. Kirwan* (1985) 39 Cal.3d 311, 318.)

"La Vida" refers collectively to La Vida Medical Group & IPA, doing business as La Vida Prairie Medical Group, La Vida Multispecialty Medical Centers, Inc. and Prairie Medical Group. Each La Vida entity was, at all relevant times, a "risk bearing organization" within the meaning of section 1735.4, subdivision (g) and was subject to the Knox-Keene Act. Each of the Health Plans

was, at all relevant times, also subject to the Knox-Keene Act. (I AA 36.)

For emergency care rendered to plan patients, an emergency care provider typically bills the entity responsible for payment. In this case, La Vida was the designated payer and the Emergency Physicians billed La Vida for emergency services rendered to the Health Plans' enrollees. (I AA 37-38.)

However, neither the Emergency Physicians nor the enrollees had a contract with La Vida. Instead, medical care was delivered to enrollees via contracts with the Health Plans ("Plan/Enrollee Contracts"). These Plan/Enrollee Contracts obligated the Health Plans to arrange and pay for covered health care services for the enrollees in exchange for premium payments. (I AA 38.) All emergency services at issue in this lawsuit were provided by the Emergency Physicians, and constituted covered services under the Plan/Enrollee Contracts. (I AA 38.)

During the relevant time period, the Health Plans had contracts with La Vida under which the Health Plans delegated certain responsibilities to La Vida ("Delegation Contracts"). One such delegated responsibility was the obligation to pay for covered health care services rendered to enrollees under the Plan/Enrollee Contracts. In exchange for accepting the delegated responsibilities, La Vida received money on a capitated or fixed periodic payment basis. The Delegation Contracts allocated to La Vida the risk of loss if the Health Plans' capitation payments were insufficient to cover the

costs of the medical services rendered to enrollees.[5] The assigned risk of loss included, but was not limited to, the emergency services rendered by the Emergency Physicians who are parties to this case. (I AA 38.)

Not all emergency physicians are in the same compensation circumstance as the Emergency Physicians in this case. Some emergency care providers agree to accept reduced payments from health plans or delegated payers in exchange for being a "participating provider" of a health plan or delegated payer, a status that affords an expected increase in patient/business volume, or a simpler billing process resulting in lower administrative costs. Participating providers are compensated in a predetermined amount fixed by the terms of their participating provider contracts. Physicians (including emergency physicians) who do not have participating provider contracts with a health plan or delegated payer are considered "non-participating" or "non-contracted" with respect to that health plan or payer. (I AA 38.) At all relevant times, the Emergency Physicians herein were non-contracted providers with the Health Plans and with La Vida. (I AA 38.)

Non-contracted emergency physicians (such as the Emergency Physicians) are particularly vulnerable to the Health Plans' compensation policies because Health and Safety Code §

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[5] Conversely, La Vida would have been entitled to a profit had the Health Plans' capitation payments exceeded the cost of providing care to the Health Plans' enrollees. (I AA 38.)

1317 obligates the Emergency Physicians to treat all patients requiring emergency care regardless of the patients' insurance coverage or ability to pay, and these physicians have no contract that they can enforce against either the Health Plans or their delegatee IPA. The Health Plans know the Emergency Physicians are vulnerable and therefore subject them to wrongful payment practices, including non-payment or inadequate payment for their services. (I AA 39.)

While the Legislature has required emergency physicians to treat all persons in need of emergency services regardless of their ability to pay for the services (Section 1317), the Legislature imposed a parallel requirement on health plans and their delegatee IPAs to pay emergency physicians for the care they provide regardless of their participating or non-contracted status. (§ 1371.4, subds. (b), (d).) (I AA 39-40.) This obligation is confirmed by regulation. (28 Cal. Code Regs. § 1300.71.4, subd. (a).) (I AA 40.)

Until 2007, La Vida paid the Emergency Physicians for the services they rendered to the Health Plans' enrollees. Under the Delegation Contracts, La Vida was required to be financially solvent in order to meet its contractual obligations to the Health Plans and its obligations to the Health Plans' enrollees. A penalty for failure to comply with the financial solvency requirements was termination by the Health Plans. (I AA 41.)

Beginning in 2007, and consistently thereafter, La Vida failed to comply with multiple financial requirements. Specifically, La Vida failed to meet DMHC standards for sufficiency of working capital,

tangible net equity, and cash to pay provider claims. Of those provider claims that La Vida paid, many were paid untimely. (I AA 41.)

The Health Plans were well aware of La Vida's deteriorating financial condition. La Vida submitted quarterly and annual financial statements to the Health Plans for the purpose of informing the Health Plans of La Vida's status. La Vida submitted these reports pursuant to the Delegation Contracts and applicable regulations. (I AA 41.) Moreover, throughout the duration of the Delegation contracts, the Health Plans knew that the Health Plans' capitation payments to La Vida were insufficient to cover the costs of services rendered by the Emergency Physicians and other providers. (I AA 42.)

In October 2009, La Vida's lender filed bankruptcy and withdrew $4 million from La Vida's account. La Vida was unable to obtain replacement funding from other sources. La Vida advised the Health Plans of this development. (I AA 42.)

Despite the Health Plans' knowledge of La Vida's financial troubles, the Health Plans unreasonably continued to delegate their responsibility to pay the Emergency Physicians to La Vida. At all relevant times, the Health Plans knew or should have known that their neglect of La Vida's financial condition would prevent the Emergency Physicians' receipt of reasonable payment for their covered services. The Health Plans failed to resolve the growing number of unpaid non-contracted Emergency Physician provider claims, ignored the warning signs of La Vida's imminent demise, and

nevertheless directed providers to continue submitting claims to La Vida. Additionally, during this period, the Health Plans continued to make capitation payments to La Vida in amounts that did not cover the costs of the services rendered. The Health Plans knew their capitation payments were insufficient and that the Emergency Physicians were rendering services to the Health Plans' enrollees with little to no chance of being paid appropriately. (I AA 42.)

Around May or June of 2010 – approximately three years after La Vida's financial instability became obvious, the Health Plans finally discontinued their capitation payments to La Vida and terminated the Delegation Contracts. Shortly thereafter, La Vida went out of business (I AA 42) – thereby ensuring that the Emergency Physicians would not be paid by La Vida for treating the Health Plans' enrollees.

ARGUMENT

I. THE KNOX-KEENE ACT PERMITS – RATHER THAN FORECLOSES – A CAUSE OF ACTION AGAINST THE HEALTH PLANS FOR NEGLIGENT DELEGATION OF THE HEALTH PLANS' PAYMENT OBLIGATIONS AND/OR NEGLIGENT FAILURE TO RESUME PAYMENTS TO EMERGENCY PHYSICIANS WHEN THE IPAs BECOME UNABLE TO PAY.

A. Health and Safety Code Section 1371.25, Which Expressly Allows Common-Law Suits Against Health Plans, Defeats the Health Plans' Argument that Statutes Exempt Them from Common Law Liability.

The Health Plans devote a substantial portion of their Opening Brief on the Merits ("OBM") to arguing that health plans who delegate their compensation obligations pursuant to rules established in the Knox-Keene Act, and regulations promulgated thereunder, cannot be held liable for emergency physicians' compensation under any circumstances under any theory. (OBM 22-43.) This argument fails.

First, the Health Plans cite to section 1371.25 (OMB 11, fn. 4) to support a theory of statutory preclusion. The first part of section 1371.25 provides:

> 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.

While the above-quoted part of section 1371.25 supports the proposition that there is no vicarious liability after delegation, it does not support the position that the Health Plans cannot be held liable for their own actions. In fact, the remainder of the section, which the

Health Plans fail to cite, explicitly makes this distinction. The language that follows states (with added emphasis):

> 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.[6]

Thus, the Knox-Keene Act expressly allows common-law suits against health plans based on their own wrongful conduct. The regulations would therefore allow a common law action here because the wrong that is alleged is that the Health Plans negligently delegated their duties to an IPA they knew, or should have known, did not have the ability to fulfil the Health Plans' obligations, and that the Health Plans failed to reassume their obligations after the date of delegation when they knew or should have known that the IPA would not be able to pay. The issue here is the Health Plans' direct actions and wrongdoing. The regulations therefore expressly allow common law causes of action against the Health Plans in this case based on the Health Plans' wrongful

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[6] The Court of Appeal noted that a non-contracted emergency physician generally has no recourse against a plan for an IPA's default. In reliance on section 1371.25, the court held that such a physician has a cause of action against the health plan if the IPA's failure to pay the physician is the result of the plan's negligent delegation of its payment obligation to the IPA. (Opn. 36 & fn. 34.)

conduct – i.e. negligent delegation, and their failure to reassume their payment obligations.

The Health Plans have also argued that case law precludes a *per se* cause of action for a health plan's failure to compensate emergency physicians in violation of Section 1317.4. The Emergency Physicians accept that case law precludes a *per se* cause of action for a health plan's failure to compensate emergency physicians in violation of Section 1317.4. (See *Ochs*, *supra*, 115 Cal.App.4th at pp. 789-793; see also opn. 27-28.)[7] However, the Health Plans confuse *per se* liability based on violation of a statute with liability based on negligence, which is at the heart of this action. The unavailability of a statutory cause of action does not mean that a negligence cause of action is also unavailable – especially since Section 1371.25 permits the negligence cause of action that the Health Plans are wrongfully attempting to suppress.[8]

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[7] See also *CEP*, *supra*, 111 Cal.App.4th at pp. 1131-1133.

[8] The availability of a cause of action based only on statutory liability would benefit the Emergency Physicians here: A statutory violation would be simpler to prove than a full-fledged negligence cause of action requiring proof of the existence of a duty owed by the defendant to the plaintiff, the defendant's breach of that duty, a causal connection between the breach and the plaintiff's damages, and the plaintiff's actual damages (*Johnson v. Prasad* (2014) 224 Cal.App.4th 74, 78) – a proof that is inherently more complex than the proof of violation of a statute.

B. The DMHC, in Interpreting its Own Regulatory Scheme, Posits that the Knox-Keene Act and Regulations Promulgated Thereunder Do Not Bar Common Law Causes of Action by Non-Contracted Emergency Physicians.

In *Bell, supra,* a group of non-contracted emergency physicians sued a health plan, alleging that the health plan paid them less than the cost and value of their services. They sought to recover additional amounts as "disgorgement" and "damages" under theories of declaratory and injunctive relief, violations of Business and Professions Code section 17200, and quantum meruit. The health plan in *Bell* argued that the DMHC has exclusive jurisdiction to enforce the Knox-Keene Act and that the *Bell* plaintiff had no right to sue the health plan. (*Id.* at pp. 213-214.)

However, the DMHC submitted an amicus curiae brief in support of the emergency physicians. The DMHC argued that the Knox-Keene Act left the *Bell* plaintiffs free to pursue non-administrative theories of recovery, that the *Bell* plaintiffs' unfair competition claims did not infringe on the DMHC's jurisdiction, that no bar existed to the *Bell* plaintiffs' quantum meruit claim, and that the health plan's obligation to reimburse included an obligation to do so reasonably. (*Id.* at pp. 215, 217-218.) The *Bell* court agreed with the DMHC. The *Bell* court noted that "[t]he construction of a statute by the executive department charged with its administration is

entitled to great weight and substantial deference." (*Id.* at pp. 215, 217, fn. 8.) The *Bell* court held:

> Any doubts about Dr. Bell's standing dissolves in light of the [DMHC's] support of private enforcement. 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 disputed a health plan's determination of the reasonable and customary value of covered services as required by section 1317.4," (2) that "providers are free to pursue alternate theories of recover to secure the reasonable value of their services based on common law theories of breach of contract and *quantum meruit*," and (3) that a "provider's private action for reimbursement under the . . . UCL does not infringe upon the [DMHC's] jurisdiction over the Knox-Keene Act."

(*Bell*, *supra*, 131 Cal.App.4th at pp. 217-218 (ellipses and italics by court).) The *Bell* court continued quoting the DMHC as follows:

> "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."

(*Bell*, *supra*, 131 Cal.App.4th at p. 218.)

The principles articulated by the DMHC and adopted by *Bell* are applicable to this case. It makes little sense to allow non-contracted emergency physicians to sue health plans when they believe they have received insufficient compensation but bar them from suing plans when neither a health plan nor an IPA pays them anything at all.

C. The Health Plans' Authorities Are Distinguishable and Therefore Inapplicable.

The cases cited by the Health Plans do not support preclusion of a negligence cause of action simply because the Health Plans were statutorily permitted to delegate their payment obligations to La Vida.

In *Gentry v. eBay, Inc.* (2002) 99 Cal.App.4th 816 ("*Gentry*") (discussed at page 36 of the OBM), the plaintiffs alleged that they had purchased forged autographed sports items though internet sales facilitator eBay. (*Id.* at p. 821.) The plaintiffs alleged, *inter alia*, that eBay was negligent and had engaged in unfair competition under Business and Professions Code sections 17200 *et seq.* by failing to provide certificates of authenticity for the autographed items, distributing false certificates, permitting false representations to be made on eBay's web site, and making its own misleading representations. (*Id.* at p. 820.) The court held that the unfair competition and negligence causes of action were barred by a federal statute – 47 U.S.C. § 230 – which states that "[n]o provider or

user of an interactive computer service shall be treated as the publisher or speaker of any information provided by another information content provider" and that "[n]o cause of action may be brought and no liability may be imposed under any State or local law that is inconsistent with this section." (*Gentry, supra*, 99 Cal.App.4th at p. 828 (quoting 42 U.S.C. § 230, subds. (c)(1), (e)(3).) The court concluded that section 230 provided immunity to eBay against the plaintiffs' negligence and unfair completion claims. (*Gentry*, *supra*, 99 Cal.App.4th at p. 830.)

In *Harshbarger v. City of Colton* (1988) 197 Cal.App.3d 1335 ("*Harshbarger*") (also discussed at page 36 of the OBM), the plaintiffs contracted with a general contractor to build a residence. Two inspectors employed by the defendant city ("City") periodically inspected the construction and represented after each inspection that the construction complied with applicable building codes. The general contractor stopped working on the house and, shortly thereafter, the City notified the plaintiffs that the house had numerous code violations. The plaintiffs paid approximately $295,000 to another contractor to bring the house up to code standards. The plaintiff sued the individual inspectors and the City for intentional misrepresentation and suppression of fact and sued the City for negligent hiring. (*Id.* at pp. 1338-1339.) The defendants demurred on the ground that Government Code sections 815 *et seq.* gave the City (as a public entity) and the inspectors (as employees of a public entity) immunity against the plaintiffs' claims. (*Id.* at p.

1339.) The trial court sustained the demurrer without leave to amend (*id.*), and the Court of Appeal affirmed (*id.* at p. 1350).

In contrast to *Gentry* and *Harshbarger*, the Health Plans do not cite any statute that immunizes them against the Emergency Physicians' negligence cause of action. Indeed, in light of Section 1371.25, which permits common law causes of action against health plans for their own wrongful conduct, the Health Plans cannot allege such an immunity-granting statute.

The Health Plans also rely on *Williams v. State Farm Fire and Casualty Co.* (1990) 216 Cal.App.3d 1540 ("*Williams*"). The plaintiffs in *Williams* argued that their former insurer breached the implied covenant of good faith and fair dealing by cancelling their policy. However, the *Williams* court rejected this argument, partly because the controlling statute permitted cancellation. (*Id.* at pp. 1543, 1549.) The Health Plans argue that the *Williams* court's rejection of the plaintiffs' breach-of-the-covenant claim supports the Health Plans' claims of total statutory exoneration from liability on any theory. (OBM 36.) This description of *Williams* is vastly oversimplified and contrary to the court's reasoning. The court did not hold in favor of the insurer solely because a statute permitted cancellation. Instead, the *Williams* court also held that the agent told the plaintiffs that the policy would be cancelled before the plaintiffs purchased it and that, therefore, the insurer made no misrepresentation that could support a cause of action. (*Williams*, *supra*, 216 Cal.App.3d at p.1549.)

Moreover, the *Williams* court expressly acknowledged *Spindle v. Travelers Ins. Cos.* (1977) 66 Cal.App.3d 951 ("*Spindle*"), a case in which an insurer was held to have breached the implied covenant of good faith and fair dealing based on the insurer's wrongful cancellation of the plaintiff's medical malpractice insurance policy. The insurer argued that it could have no cancellation-related liability because the policy specifically permitted the insurer to cancel the policy if the insurer followed certain procedures. (*Id.* at pp. 954, 956.) However, the *Spindle* plaintiff had alleged that the insurer cancelled his policy as a result of the insurer's malice towards him and for the purpose of discouraging other physicians/insureds from contesting a large premium increase. (*Id.* at pp. 954-955.) The *Spindle* court held that the complaint stated a cause of action for breach of the covenant of good faith and fair dealing because the allegations, if proven, would constitute cancellation for an improper purpose even though the policy provided for cancellation by the insurer for any reason. (*Id.* at pp. 958-959.) Thus, *Spindle* illustrates that a cause of action exists when expressly permitted conduct is performed without due care or for an improper purpose.

Further, the Health Plans' contention that a statute permitting a type of conduct gives the actor a right to perform the permitted conduct in any manner regardless of the conduct's effect on others is nonsensical. The Court of Appeal best explained the flaw in the Health Plans' reasoning:

> The [Plans'] argument is akin to suggesting that a driver's license provides the driver immunity for

> negligently operating a vehicle or a handgun permit provides the gun owner immunity for negligently storing or discharging the firearm. That Health and Safety Code section 1371.4, subdivision (3) provides the [Plans] with permission to delegate their statutory duties does not immunize the [Plan] for doing so negligently.

(Opn. 36, fn. 33.)

Simply, the Health Plans' argument fails.

D. The Legislature Did Not Assign the Risk of Defaulting IPAs to Emergency Physicians.

The Health Plans note that the Court of Appeal's holding is based largely on statutes requiring emergency physicians to treat all patients regardless of their ability to pay. The Court of Appeal held that because of this requirement, health plans should bear the risk of compensating emergency physicians if an IPA fails to pay them. (OBM 42 (citing opn. 4, 33).) The Health Plans argue that "[t]hese statutes placed [the] burden [of the risk of loss of nonpayment] on emergency physicians as a condition of their holding themselves out as emergency service providers" and that the Court of Appeal usurped the Legislature in lifting this purported burden from emergency physicians and placing it onto health plans. (OMB 42-43.) The Health Plans are incorrect because the statutes upon which they rely simply do not assign to emergency physicians the risk of non-payment when an IPA defaults.

The Health Plans violate United States Supreme Court Justice Felix Frankfurter's "three rules for mastering the meaning of a statute: '(1): Read the statute; (2) read the statute; (3) read the statute.'" (*Enterprise Insurance Co. v. Mulleague* (1987) 196 Cal.App.3d 528, 535 (quoting Friendly, Benchmarks (1967) Mr. Justice Frankfurter and the Reading of Statutes, p. 202).) Read accurately, the statutes cited by the Health Plans – 42 U.S.C § 1395dd *et seq.* and Section 1317 (OBM 42) – do not require emergency physicians to necessarily forego compensation when an IPA financially collapses.

1. **The Federal Emergency Medical Treatment and Labor Act does not require emergency physicians to bear the risk of a delegatee IPA's failure to pay them.**

The federal Emergency Medical Treatment and Labor Act ("EMTALA"), codified at 42 U.S.C. § 1395dd, "regulates emergency room care in hospitals that accept Medicare patients[.]" (*Cherukuri v. Shalala* (6th Cir. 1999) 175 F.3d 446, 448 ("*Cherukuri*").) Thus, even if EMTALA could be read to require emergency physicians to treat patients for free when IPAs default (which it cannot), such requirement would only apply in the context of Medicare. Further, the language of EMTALA does not state that emergency physicians are required to treat patients for free so that health plans may continue to retain funds that would otherwise have compensated the physicians. (42 U.S.C. § 1395dd.)

Moreover, EMTALA "was passed to prevent 'patient dumping' of the uninsured[.]" (*Cherukuri*, *supra*, 175 F.3d at 448.) Thus, to the extent the EMTALA could be read to assume the risk of an emergency physician having to treat a patient who cannot not pay, such risk extends only to treating patients who lack coverage through any type of health care plan. Such risk cannot be deemed to extend to emergency treatment of patients who are covered under health plans but the health plan refuses to pay the emergency physician. Further, nothing in EMTALA suggests that an emergency physician's agreement to treat patients for free when the patient's IPA defaults is a condition for the practice of emergency medicine.

Accordingly, the Health Plans do not – and cannot – cite to any federal authority that supports their contention that emergency physicians necessarily consent to absorbing losses attributable to failed IPAs in exchange for holding themselves out as emergency specialists.

2. Section 1317 does not require emergency physicians to bear the risk of a delegatee IPA's failure to pay them.

Subdivisions (a), (b), and (d) of Section 1317 require hospitals and individual emergency physicians to provide emergency care to patients regardless of their insurance status and/or their ability to pay. However, the Health Plans identify no language within Section 1317 that obligates emergency physicians to forego compensation from plans when their delegatee IPAs become unable to pay them;

indeed, Section 1317 contains no such language. The Health Plans rely on Section 1317.6 subdivision (g) (OBM 42) and correctly note that this subdivision provides for revocation or suspension of licenses of hospitals that violate the statutory scheme of which Section 1317 is a part. However, subdivision (g) says nothing about emergency physician compensation.[9]

If the Legislature intended that emergency physicians must absorb all risks of nonpayment for their services, regardless of the reason for the nonpayment, as a condition of holding themselves out as emergency physicians, then the Legislature would have stated such language within the Knox-Keene Act. Instead, the Legislature included a statute requiring plans to pay emergency physicians who treat the health plans' enrollees. Section 1371.4, subdivision (b) provides that "[a] health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care[.]" (Emphasis added.) Further, Section 1371.4, subdivision (c) provides that "[p]ayment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed[.]" These provisions contradict the notion that non-compensation is a risk that emergency physicians

[9] Section 1317.6, subdivision (c) (which the Health Plans do not cite) governs discipline of "physicians and surgeons" who violate section 1317 *et seq.*

must assume as a condition of practicing emergency medicine.[10] Accordingly, the Health Plans fail to establish that the statute requiring emergency physicians to treat all emergency patients regardless of their ability to pay reflects an intention by the Legislature that emergency physicians must assume the risk of non-payment, regardless of the reasons for nonpayment. Rather, the Legislature has clearly stated its intention that emergency physicians should and must be paid.

II. REGULATIONS PROMULGATED UNDER THE KNOX-KEENE ACT ENCOURAGE – RATHER THAN FORECLOSE – A HEALTH PLAN'S RESUMPTION OF ITS COMPENSATION OBLIGATIONS WHEN AN IPA DEFAULTS.

At pages 27-28 of the OBM, the Health Plans argue that DMHC regulations promulgated under the Knox-Keene Act support the Health Plans' argument that the delegation of their payment responsibilities to La Vida under section 1371.4 bars the Health

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[10] Of course, Section 1371.4 also includes subdivision (e) which permits plans to delegate payment responsibilities to an IPA; and the Health Plans' primary argument is that this subdivision absolves them of all post-delegation liability for compensating emergency physicians. However, subdivision (e) does not expressly provide or implicitly suggest that an emergency physician assumes the risk of a health plan's negligent delegation or of the delegatee's inability to pay.

Plans' obligation to resume their statutory obligations to pay the Emergency Physicians after La Vida ceased paying them. However, one such regulation reads in relevant part:

> The plan's contract with a . . . capitated provider shall include provisions authorizing the plan to assume responsibility for the processing and timely reimbursement of provider claims in the event that the . . . capitated provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties). The plan's obligation to assume responsibility for the processing and timely reimbursement of a capitated provider's provider claims may be altered to the extent that the capitated provider has established an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code.
>
> * * *
>
> The plan's contract with a . . . capitated provider shall not relieve the plan of its obligations to comply with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, **1371.4**, and 1371.8 of the Health and Safety Code and sections **1300.71**, 1300.71.38, **1300.71.4**, and 1300.77.4 of title 28.

(Cal. Code Regs., tit. 28, § 1300.71, subds. (e)(6), (e)(8), emphasis added.) This regulation reflects the DMHC's intention that health plans are required to resume their provider compensation obligations.

The Health Plans argue that the first sentence of subdivision(e)(6) – which requires the health plan/IPA contract to "authorize" the health plan's resumption of its claim-payment obligations – gives the health plan a choice whether to resume the claim payment obligation. (OBM 27-28, fn. 6.) However, the Court of Appeal correctly dispensed with this contention by noting that the second sentence of the subdivision "refers to an 'obligation' to assume that responsibility. In other words, the regulation does not merely direct the [health plan] to contractually guarantee that it *may* resume the obligation, it implies that in some circumstances the [health plan] *must* do so." (Opn. 9, fn. 10 (italics by court).)

The Health Plans further attempt to diminish the effect of this regulation by arguing that its subject matter is the processing and timely reimbursement of provider claims rather than risk shifting, and speculating that "it is extremely implausible" that the DMHC would have "buried" a risk re-shifting provision in a claims-processing regulation. (OBM 28, fn. 6.) The Health Plans are making a linguistic distinction without a substantial difference: Neither a health plan, an IPA, nor any other entity can reasonably be expected to pay a non-contracted emergency physician for his/her services if the emergency physician does not ask for payment; thus, an emergency physician will be paid for his/her services only if he/she makes a claim for payment for those services.

Moreover, the Health Plans' argument that there is no continuing obligation to delegate appropriately is nonsensical in light of the statutory scheme. If health plans were indeed foreclosed from

having a continuing duty to ensure that they are responsible in the delegation of their duties to an IPA, a health plan could delegate to a solvent IPA one day and be absolved of all liability if the IPA went out of business the next. If this were the intent of the Legislature, regulations would not have been enacted to require monitoring of an IPA's financial situation throughout the entire period of delegation, quarterly reporting of an IPA's financial status, the participation of health plans in corrective action plans, or the statutory resumption of payments after an IPA's default.

Accordingly, the Health Plans fail to – and cannot – show that regulations promulgated under the Knox-Keene Act support their position that delegation of a health plan's payment obligation to an IPA is not continuing and categorically irreversible.

III. THE HEALTH PLANS' DUTY ARGUMENTS FAIL.

A. The Health Plans' Duty Argument is Misplaced Because the Duty Addressed by the Court of Appeal is Not a Business-Based Duty to Protect Non-Contracted Emergency Physicians from Economic Losses.

The Health Plans argue that they have no duty to resume their provider payment obligations under any circumstances because the Health Plans have no duty to conduct their business affairs to prevent "'purely economic loss to third parties in their financial

transactions.'" (OBM 43-60 (quoting from *Quelamine Co. v. Stewart Title Guaranty Co.* (1998) 19 Cal.4th 26, 58.) This argument fails for two reasons.

First, the duty discussed in the OBM is not the duty found by the Court of Appeal. The Court of Appeal identified the duty question to be decided as follows:

> The critical question raised by this case is (1) whether [health plans] may delegate their reimbursement duty to *any* IPA, regardless of the financial stability of that IPA, or (2) whether the [Plans] have a duty *not* to delegate their Health and Safety Code section 1371.4 reimbursement obligation to an IPA that the [Plans] know, or have reason to know, is financially unable to meet that duty.

(Opn. 28 (italics by court).) Thus, the core of the duty considered by the Court of Appeal is the financial condition of the delegatee IPA and the Health Plans' actual or constructive knowledge thereof – not the financial condition of the Emergency Physicians.

Second, the Emergency Physicians are not arguing that the Health Plans have a duty to safeguard their investments, back up their bank accounts, or protect them from bad choices in the marketplace. Instead, the Emergency Physicians merely want to be reimbursed for services they have provided to the Health Plans' enrollees.

This case is not a business-loss case. As explained further in section V below, this case has real life and death implications for any

California resident and/or visitor who may require emergency care. This case will necessarily decide whether California will blindly adhere to a distorted interpretation of the Knox-Keene Act which would force non-contracted emergency physicians to bear without recourse the consequences of an IPA's financial failure, a condition which these physicians have absolutely no control over. Thus, the stakes in this lawsuit are not reducible to mere economic business losses. Accordingly, the Health Plans' entire duty analysis lacks a premise.

B. Even if the Health Plans' Duty Analysis had a Viable Premise, the Court of Appeal Correctly Applied the *Biakanja* Duty Factors.

The factors generally employed by courts for establishing a duty in specific cases are set forth in *Biakanja v. Irving, supra,* 49 Cal.2d 647. The Health Plans argue that the *Biakanja* factors go against imposing a duty of non-negligent delegation of payment responsibilities to an IPA and a duty of resumption of the delegated payment obligation if the IPA defaults. (OBM 43-60.) In a detailed discussion of the *Biakanja* factors, the Court of Appeal reached the opposite conclusion. (Opn. 28-35.) The Emergency Physicians agree with the Court of Appeal and adopt that section of the opinion.

C. If this Court is Inclined to Reverse the Court of Appeal Based Solely on the *Biakanja* Factors, this Court Should Defer a Decision on these Factors Until the Parties Have Developed a Record.

Existence of a duty is evaluated on a case-by-case basis. (*Alvarez v. BAC Home Loans Servicing, L.P.* (2014) 228 Cal.App.4th 941, 944.) Although the existence of a duty is a question of law, the facts supporting the existence or absence of such a duty must be proven. (*Laico v. Chevron U.S.A., Inc.* (2004) 123 Cal.App.4th 649, 659.)

As noted above, this case comes to this Court after the trial court sustained a demurrer without leave to amend. (V AA 1115-1124.) Consequently, aside from judicially noticeable materials, no record was (or could have been) developed.

The Health Plans make several pseudo-factual assertions that they do not support, and had no opportunity to support given the stage of the trial court proceeding at the time of entry of judgment. For example, on page 40 of the OBM, the Health Plans describe a theoretical inevitable downward spiral that would occur if a health plan were to re-assume payment obligations previously delegated to an IPA. The Health Plans contend that they (and similarly situated health plans) factor the delegated financial obligations the IPAs will have to medical providers into the capitation payments made to the IPAs; that re-assuming a defaulted IPAs payment obligation would

necessarily reduce the amount of the Health Plans' initial capitation payments in the first instance; that this reduction in revenue could increase the IPAs financial stress and interfere with an administrative corrective action plan; and that a defunct IPA would be unable to pay any of its medical providers.

There is no evidence in the current record that any of these events happen to IPAs as a matter of course or that they happened to La Vida specifically. One would expect that these issues would be the subject of discovery – but this lawsuit must proceed beyond demurrer to develop such a record.

IV. THIS COURT SHOULD DISAPPROVE *CEP*.

Like the Emergency Physicians in this case, the plaintiffs in *CEP* and *Ochs* 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 health 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.) The Court of Appeal below agreed with *Ochs*. (Opn. 35.)

In their petition for review, (at pages 21-26), the Health Plans argued that this Court must resolve the conflict between *CEP* and *Ochs*. Surprisingly, the OBM does not address this conflict or argue

that *CEP* reflects a better rule of law. Nevertheless, the Emergency Physicians urge this Court to adopt the *Ochs* rule and disapprove *CEP* to the extent it is inconsistent with *Ochs*.

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 health plans to recover compensation that should have been paid by failed IPAs, emergency physicians were permitted to balance bill patients for amounts not paid by the IPAs.

The *CEP* plaintiffs sought compensation from the health plans pursuant to Section 1371.4 and also alleged causes of action for violations of Business and Professions Code section 17200, implied contract, negligence, quantum meruit, and third party beneficiary of a contract. (*CEP*, *supra*, 111 Cal.4th at 1130.) The *CEP* court systematically and specifically denied recovery under each of these theories (*id.* at pp. 1131-1138) in an apparent attempt to categorically bar physicians for suing plans for compensation that should have been paid by IPAs. However, *CEP* did not foreclose balance billing and thus left the unpaid emergency physicians with a potential avenue of recovery.

The *Ochs* plaintiff also asserted multiple theories of recovery – violations of the Knox-Keene Act, violations of Business and

Professions Code section 17200, negligence, declaratory and injunctive relief, quantum meruit, and third-party beneficiary of a contract. (*Ochs*, *supra*, 115 Cal.App.4th at p. 788.) Like the *CEP* court, the *Ochs* court 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 health plan's negligent delegation of its compensation obligation to an IPA that the health 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, supra.* The *Bell* plaintiffs were non-contracted emergency physicians who contended that the amounts the health 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 *CEP*, the *Bell* court held that the plaintiffs had standing to pursue court actions against the health plan and held that the plaintiffs could proceed with all of their pleaded causes of action. (*Id.* at p. 218.) Thus, to the extent *CEP* could have been read to ban all superior court lawsuits by non-contracted emergency

physicians to recover compensation from health plans, *Bell* further eroded *CEP*'s precedential effect.

In 2009, approximately six years after *CEP*, this Court decided *Prospect*, *supra*. *Prospect* held that emergency physicians were no longer permitted to balance bill their patients for the difference between the amounts billed to an IPA or a health plan and the amount the IPA or health plan actually paid. (*Prospect*, *supra*, 45 Cal.4th at p. 508-509.) One of this Court's justifications for banning balance billing was the civil lawsuit compensation remedy made available to emergency physicians in *Bell*: "Because emergency room doctors prevailed in *Bell* [citation], no reason exists to permit balance billing." (*Id.* at p. 508.) Thus, the compensation landscape for non-contracted emergency physicians was very 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).[11]

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[11] 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 where no such recourse is available; for example if the HMO is unable to pay or disputes coverage." (*Prospect*, *supra*, 45 Cal.4th at pl. 507, fn. 5.) The Court of Appeal then opined that, if the California Supreme Court had been required to decide whether non-contracting 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.) In any event, after *Prospect*, non-contracting emergency physicians cannot rely on balance billing as a source of compensation.

The combined effect of *Ochs* and *Bell* allowing non-contracted emergency physicians to pursue compensation claims against health plans in civil courts, and *Prospect*'s elimination of balance billing, diminishes *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. (*Frisk v. Superior Ct.* (2011) 200 Cal.App.4th 402, 411.) Therefore, this Court should expressly confirm *CEP*'s obsolescence by disapproving it.

B. This Court Should Not Follow *CEP* Because *CEP* Neither Considered Nor Decided the Duty at Issue in this Case.

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.) *CEP* did not consider or decide whether non-contracted emergency physicians may have a cause of action for a health 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.

The *CEP* plaintiffs' negligence cause of action alleged 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.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 as to prevent economic injury to third parties, and because the Legislature has approved risk sharing arrangements. (*Id.* at p. 1136.)

By contrast, as explained in Section III above, the Emergency Physicians in this case do not allege that the Health Plans owe them a broad duty to look after their financial interests generally. Instead, the duty the Emergency Physicians allege in this case is a Health Plan's continuing duty to avoid and/or reverse delegation of its compensation obligation to an IPA that the Health Plans know or should know is financially unsound.

Moreover, *Ochs* 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 health plan's alleged duty to pay for emergency services was subject to demurrer (*Ochs, supra*, 115 Cal.App.4th at p. 794), but that a cause of action for negligence based on the health plan's pre-delegation duty to ascertain the financial soundness of the delegatee IPA could proceed (*id.* at p. 797).

Thus, the Court of Appeal in the instant case and the *CEP* court decided the existence/absence of different duties. The fact that the *CEP* court found no duty in that case has no bearing on the existence of the duty alleged in this case. Accordingly, even if *Bell* and *Prospect* had not diminished the precedential value of *CEP*, *CEP* would not control in this case.

V. PUBLIC POLICY FAVORS IMPOSING A NEGLIGENCE-BASED DUTY ON THE HEALTH PLANS TO RESUME PAYING EMERGENCY PHYSICIANS WHEN DELEGATEE IPAs DEFAULT.

The Health Plans attempt to convince this Court that requiring health plans to resume payments to emergency physicians after an IPA defaults is a threat to California's public policy favoring a comprehensive managed health care system. The Health Plans are wrong because, (A) they ignore the competing public policy that no person, including emergency physicians, should be required to work for free, and (B) requiring negligent-delegator health plans to resume compensation payments to non-contracted emergency physicians will not induce the collapse of the managed care system.

A. Existing Public Policy Prohibits Forcing Non-Contracted Emergency Physicians to Work Without Compensation.

"For every wrong, there is a remedy" is a maxim of California jurisprudence (Civil Code Section 3523), and a longstanding principle entrenched in the public policy of this State. Section 1317 requires that emergency physicians must treat all patients regardless of their ability to pay. *Prospect* holds that emergency physicians may not bill any patient for the emergency services rendered, thereby removing balance billing from the remedies available to

emergency physicians. (*Prospect*, *supra*, 45 Cal.4th at p. 508.) *Ochs* and *CEP* hold that emergency physicians do not have a *per se* cause of action for a health plan's violation of Section 1371.4. (*Ochs*, *supra*, 115 Cal.App.4th at pp. 789-793; *CEP*, *supra*, 111 Cal.App.4th at pp. 1132-1133.) If the civil suit remedy made available by *Bell* and the negligent-delegation remedy made available by *Ochs* were to disappear, where would non-contracted emergency physicians find their remedy? If the Emergency Physicians may not seek compensation from the patients, if they cannot obtain compensation from La Vida due to its insolvency, and if Section 1371.4, subdivision (e) is interpreted to relieve the Health Plans from any compensation obligation to the Emergency Physicians, how can they be paid? A conclusion that the Emergency Physicians must resign themselves to their uncompensated status is unfair, morally repugnant, and contrary to Civil Code Section 3523.

Interpreting Section 1317.4 so as to deprive the Emergency Physicians of a remedy would be, in the words of *Bell*, "confiscatory," "unconscionable," and "unconstitutional." (*Bell*, *supra*, 131 Cal.App.4th at p. 220.) In reaching this conclusion, the *Bell* court relied in part on *Cunningham v. Superior Ct.* (1986) 177 Cal.App.3d 336 ("*Cunningham*"). *Cunningham* addressed whether a superior court had the right to order an attorney in private practice to perform free pro bono services and held that such a requirement is unconstitutional. (*Id.* at p. 338.)

In *Cunningham*, the County of Ventura commenced a paternity action against an allegedly delinquent noncustodial father. The county sought to obtain reimbursement for public assistance proceeds to support his alleged child and to compel the defendant to pay future child support. The defendant claimed he was indigent. The Ventura County Bar Association and the superior court had designed a program to furnish free representation for indigent defendants, under which any lawyer whose office was in Ventura County could be called upon to contribute his/her legal services on a pro bono basis. The *Cunningham* petitioner was the attorney selected to represent the indigent paternity defendant. The attorney refused to participate on the ground that requiring his participation without compensation was a denial of his constitutional equal protection rights.[12] The superior court held the attorney in contempt, and his writ petition to the Court of Appeal followed. (*Id.* at pp. 338-339.)

The *Cunningham* court held that the superior court order appointing the attorney as the indigent defendant's counsel violated the attorney's constitutional right to equal protection. (Id. at p. 356.) In reaching this conclusion, the appellate court observed:

> It is a legitimate state function to assist the poor [citation], but, under the Constitution, this goal cannot

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[12] The *Cunningham* attorney also argued that his practice was limited to personal injury matters and that he had no experience with paternity cases. (*Cunningham*, *supra*, 177 Cal.App.3d at p. 339.)

> be accomplished at the expense of one particular group of people. It is a denial of equal protection when the government seeks to charge the cost of operation of a state function, conducted for the benefit of the public, to a particular class of persons. [Citations.] To charge the cost of operation of state functions conducted for the public benefit to one class of society is arbitrary and violates the basic constitutional guarantee of equal protection of the law. [Citation.]
>
> An attorney who is appointed to represent an indigent without compensation is effectively forced to give away a portion of his property – his livelihood. Other professionals, merchants, artisans, and state licensees are not similarly required to donate services and goods to the poor.

(*Id.* at p. 348 (internal quotation marks omitted; emphasis added).)

Cunningham's reasoning applies here. Section 1317 requires emergency physicians to render emergency medical services to all patients that require them irrespective of the patients' ability to pay. In enacting this statute, the Legislature intended to create a benefit to the public; and, emergency physicians' compliance with the statute is essential to implementing the public benefit. However, there is no legitimate reason why emergency physicians (the very people who provide the services) should bear the financial burden of this public benefit alone, especially when these patients have already paid premiums to the health plans to cover these services. Under *Cunningham* and *Bell*, assigning this burden to the Emergency Physicians is unconstitutional. Thus, *Cunningham* and

Bell reflect California's public policy that professionals are absolutely entitled to compensation for their work.

More specifically, the *Prospect* court echoed *Bell* by stating: "Emergency room doctors *are* entitled to reasonable payments for emergency services rendered to [health plan] patients." (*Prospect*, *supra*, 45 Cal.4th at p. 509 (italics by court); see also *Bell*, *supra*, 131 Cal.App.4th at p. 219 ("However concerned we may be about spiraling costs for health care service plans and their enrollees, those concerns cannot justify a rule that would single out emergency care physicians and force them to work for something other than a reasonable fee.").)

The Health Plans argue that, although the Court of Appeal noted that the burden of providing emergency services "cannot be accomplished at the expense of one particular group of people," the Court of Appeal nevertheless impermissibly burdens only the Health Plans with the consequences of an IPA's inability to pay the Emergency Physicians. (OBM 42 (citing opn. 4, 33.) However, the Health Plans cite no authority for their assumption that the Health Plans are a "group of people" comparable to the individual lawyers in *Cunningham* or the individual Emergency Physicians in this case. Moreover, to the extent the Health Plans could be deemed a "group of people," their situation is not comparable to that of physicians who must practice their profession whether or not they are paid for their services. Moreover, assigning to health plans the risk of compensating non-contracted emergency physicians when IPAs fail is more equitable than assigning the risk of working for no

compensation to these physicians because the Health Plans freely choose to contract with the IPAs. They have contractual, business, funding, regulatory, and supervisory relationships with their IPAs and therefore have considerable opportunity to influence the IPAs' financial fates. By contrast, non-contracting emergency physicians have no control whatsoever over how IPAs or health plans conduct their financial affairs, and no control over a health plan's relationship with its contractual partner IPA.

B. Requiring the Health Plans to Resume Payments to Emergency Physicians in the Event of an IPA's Default Will Not Adversely Affect the Public Policy of a Comprehensive Managed Health Care System.

The Health Plans characterize the holding of the Court of Appeal below as a "suggested dismantling of the IPA's delegated responsibility[.]" (OBM 39.) They further argue that the post-delegation duty urged by the Emergency Physicians "would undermine the manageability and predictability of health care costs and prove detrimental to the economic efficiency of the health care system." (OBM 41.)

These arguments ignore that non-contracted emergency physicians comprise a small proportion of the many providers within the managed health care system, and that this issue is a narrow one. A managed care health plan's providers include physicians of

many disciplines (including primary care physicians, surgeons, pathologists, dermatologists, etc.), hospitals, laboratories, pharmacies, and others. If a health plan were required to compensate all providers in the event of a delegatee IPA's insolvency, one could reasonably imagine that such requirement might possibly cause the end of managed care as it is now constituted in California. However, such a possibility is not before this Court. Rather, the narrow issue at bench is whether a health plan is obligated to compensate non-contracted emergency physicians when a delegatee IPA fails to meet its payment obligations because of negligent delegation. The significance of the limited exception to the delegation rule is underscored by the Court of Appeal's refusal to extend the exception to non-emergency physicians. (Opn. 37-39.) Therefore, allowing non-contracted emergency physicians to sue plans for negligent delegation of their payment responsibilities to IPAs, and/or negligent failure to reassume these responsibilities when IPAs default, does not offend California's public policy in favor of managed health care.

CONCLUSION

For all of the reasons discussed above, the Emergency Physicians respectfully request this Court to affirm the judgment of the Court of Appeal.

Respectfully submitted this 29th day of January, 2015.

MICHELMAN & ROBINSON, LLP

By: _____

Andrew H. Selesnick
Damaris L. Medina
Robin James
Attorneys for Appellants,
Centinela Freeman Emergency
Medical Associates, et al.

WORD COUNT CERTIFICATION

I, Andrew H. Selesnick, 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 Answering Brief on the Merits contains 11,223 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 January 29, 2015 in Encino, California.

Andrew H. Selesnick

PROOF OF SERVICE

Centinela Freeman Emergency Medical Assoc., et al. vs. Health Net of California, Inc. et al.
(Supreme Court Case No.: S218497)
(Appeal No.: B238867; LASC Case No. BC449056)

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles. I am over the age of eighteen years and not a party to the within entitled action; my business address is 15760 Ventura Boulevard, 5th Floor, Encino, California 91436.

On **January 29, 2015**, I served a copy of the foregoing document(s) described as follows: **ANSWERING BRIEF ON THE MERITS** on the party(ies) in this action as follows:

SEE ATTACHED SERVICE LIST

■ **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.

□ **BY FACSIMILE:** Based on an agreement of the parties to accept service by fax transmission, I faxed the documents to the persons at the fax numbers listed above. The telephone number of the sending facsimile machine was (818) 783-5507. The sending facsimile machine issued a transmission report confirming that the transmission was complete and without error. A copy of that report is attached.

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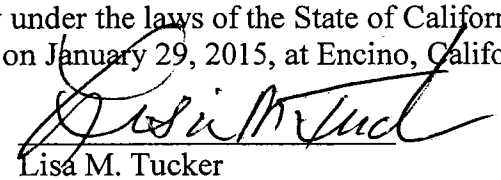
■ **STATE:** I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on January 29, 2015, at Encino, California.



Lisa M. Tucker

295708

SERVICE LIST

William A. Helvestine, Esq.
Crowell & Moring LLP
275 Battery Street, 23rd Fl.
San Francisco, CA 94111
Telephone: (415) 986-2800
Facsimile: (415) 986-2827
whelvestine@crowell.com

Attorneys for Defendant/Respondent
Health Net of California, Inc.

Jennifer S. Romano, Esq.
Crowell & Moring LLP
515 S. Flower Street, 40th Fl.
Los Angeles, CA 90071
Telephone: (213) 622-4750
Facsimile: (213) 622-2690
jromano@crowell.com

Attorneys for Defendant/Respondent
Pacificare of California dba Secure Horizons Health Plan of America

Richard J. Doren, Esq.
Heather L. Richardson, Esq.
Gibson, Dunn & Crutcher LLP
333 South Grand Avenue
Los Angeles, CA 90071-3197
Telephone: (213) 229-7000
Facsimile: (213) 229-7520
kpatrick@gibsondunn.com
hrichardson@gibsondunn.com

Attorneys for Defendant/Respondent
Aetna Health Of California, Inc.

Gregory N. Pimstone, Esq.
Jeffrey J. Maurer, Esq.
Manatt, Phelps & Phillips LLP
11355 West Olympic Blvd.
Los Angeles, CA 90064
Telephone: (310) 312-4000
Facsimile: (310) 312-4224
gpimstone@manatt.com
jmaurer@manatt.com

Attorneys for Defendant/Respondent
California Physicians' Service dba Blue Shield of California

William P. Donovan, Jr., Esq.
Matthew D. Caplan, Esq.
Cooley LLP
1333 2nd Street, Suite 400
Santa Monica, CA 90401
Telephone: (310) 883-6400
Facsimile: (310) 883-6500
wdonovan@cooley.com
mcaplan@cooley.com

Attorneys for Defendant/Respondent
Cigna Healthcare of California, Inc.

295708

Margaret M. Grignon, Esq. Kurt C. Peterson, Esq. Kenneth N. Smersfelt, Esq. Eric C. Schaffer, Esq. Zareh Jaltorossian, Esq. **Reed Smith LLP** 355 South Grand Ave., Suite 2900 Los Angeles, CA 90072 Telephone: (213) 457-8000 Facsimile: (213) 457-8080 kpeterson@ReedSmith.com ksmersfelt@ReedSmith.com ecschaffer@ReedSmith.com	Attorneys for Defendant/Respondent *Blue Cross Of California dba Anthem Blue Cross*
Don A. Hernandez, Esq. Jamie L. Lopez, Esq. **Gonzalez Saggio & Harlan LLP** 2 N. Lake Ave., Suite 930 Pasadena, CA 91101	Attorneys for Defendant/Respondent *Scan Health Plan*
Astrid G. Meghrigian 715 Scott Street San Francisco, CA 94117	Amicus Curiae for Appellant *California Chapter of the American College Of Emergency Physicians*
Long Xuan Do Francisco Javier Silva Michelle Rubalcava **California Medical Association (CMA)** 1201 J. Street, Ste. 200 Sacramento, CA 95814	Amicus Curiae *California Medical Association; Calioornia Hospital Association; California Orthopaedic Association; California Radiological Society; California Society of Pathologists*
John M. LeBlanc, Esq. Sandra I. Weishart, Esq. **Hinshaw & Culbertson LLP** 633 W. 5th Street, 47th Fl. Los Angeles, CA 90071 Telephone: (213) 680-2800 Facsimile: (213) 614-7399 sweishart@mail.hinshawlaw.com	Amicus Curiae *California Association of Health Plans*
Court of Appeal Second Appellate District, Division Three 300 South Spring Street Second Floor, North Tower Los Angeles, CA 90013-1213	

295708

Office of the Attorney General
300 South Spring Street
Los Angeles, CA 90013

District Attorney's Office
210 West Temple Street, #1800
Los Angeles, CA 90012-3210

Los Angeles Superior Court
Central Civil West Courthouse
Honorable John Shepard Wiley
Dept. 311
600 S. Commonwealth Ave.
Los Angeles, CA 90005

295708