SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES

DATE: 12/22/03			DEPT. WEQ
HONORABLE LINDA K. LEFKOWITZ	JUDGE	V. JAIME	DEPUTY CLERK
HONORABLE	JUDGE PRO TEM		ELECTRONIC RECORDING MONITO
D. GAMBILL CT ASST	Deputy Sheriff	NONE	Reporter

8:30 am BC300850

PROSPECT MED. GRP., INC. ETAL
VS
NORTHRIDGE EMERGENCY ETC.

Plaintiff Counsel: NO APPEARANCE

Defendant Counsel:

RELATED TO LEAD CASE SC076909

NATURE OF PROCEEDINGS:

RULING ON SUBMITTED MATTER
(HEARING ON DEMURRER OF DEFENDANT, SAINT JOHN'S EMERGENCY MEDICINE SPECIALIST, INC., TO PLAINTIFF'S FIRST AMENDED COMPLAINT) argued and submitted on December 11, 2003

The matter having been taken under submission, the Court rules as upon as follows:

Plaintiffs, hereafter "Prospect," have filed the above-referened actions. The two cases have been related and raise identical issues of first impression surrounding the relationship between health maintenance organizations and non-contracting emergency medical providers. Plaintiffs are Independent Practice Associations ("IPA") who contract with health plans for managed patient care, and bear fiscal responsibility for payment of physicians and hospitals for services, including emergency medical services, rendered to their enrolled members. Contracting providers are commonly termed "network" providers. Defendants St. John's Emergency Medical Specialists, Inc., (SC076909) and Northridge Emergency Medical Group (BC300850) provide emergency medical services. Plaintiffs have no contracts with defendants for the provision of such services to their enrollees. Defendants, thus, may be termed "non-network" providers.

Plaintiffs have not attached or otherwise incorporated

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8:30 am	BC300850	Plaintiff Counsel	
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the terms of contracts with their enrolled patients other than as referred to in the complaints. They generally allege that enrollees are referred to particular contracting emergency service providers. However, the gravamen of the complaint is the not surprising allegation that patients who require emergency services often have no time to travel to a network emergency provider, but typically go to the nearest emergency facility without prior notice to or approval by the plaintiffs. Plaintiffs allege that under their contracts and by statute, they remain obligated to pay the reasonable costs of nessary emergency services even if provided by a non-network emergency provider. Plaintiffs seek a judicial declaration that the Medicare allowable rate is, as a matter of law, the "reasonable compensation for emergency medical services." In oral argument, they conceded that the Medicare rate is the maximum rate they will pay on behalf of an enrollee to a non-contracting emergency medical provider and concede they have not paid the entire amount biiled by defendants in many non-network cases.

They contend that by acceptance of partial payment at the Medicare allowable rate and by operation of applicable statutes, an "implied contract" has been created whereby defendant emergency medical services are precluded from billing the patient for any excess ("balance billing").

The Court has reviewed the statutory and decisional authority provided by the parties, and matters of

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which the Court has taken judicial notice. The Court invited the parties to provide additional evidence of the legislative history of relevant sections of the Knox-Keene Health Care Service Plan Act (Health and Safety Code §§ 1375, et seq.). None has provided. The Court sustains the demurrer without leave to amend. The Court finds no basis for the claim in the absence of clear direction from the California Legislature or regulatory authority.

Plaintiffs first look to federal law as a basis for their claim. 42 U.S.C. § 1395 is a component of the Emergency Medical Treatment and Active labor Act (EMTALA). Its purpose is to prevent the "dumping" of emergency patients who are unable to pay for services. 42 U.S.C § 1395dd; Hardy v. New York City Health and Hospital Corporation (2d Cir., 1999) 164 F.3d 789. Plaintiffs have cited the Court to no case authority, nor has the Court's review of related annotations revealed any decision extending the EMTALA to proscribe balance billing in the private insurance context. Federal law only appears to expressly prohibit balance billing to the extent that a medical provider accepts Medicaid or Medi-Cal payments for less than the full billed amount. 42 U.S.C. § 1396a(a)(25)(C); Brooks v. St. Mary Hospital(1997) 57 Cal.App.4th 241, 244, n. 2. Health and Safety Code section 1317 is the California analogy to the federal EMTALA. It provides that while emergency services shall be provided without question as to the ability to pay, ". . . the patient . . . shall execute an agreement to pay therefore or otherwise supply insurance or credit information

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promptly after the services are rendered . . ." The Court is not inclined to read this provision as excluding balance billing from the term "otherwise supply insurance . . . information," in absence an an express proscription of such.

Plaintiffs place greater emphasis upon Health and Safety Code § 1379, sub. (b) as the statutory basis for their implied implied claim. Section 1379 provides that:

> (a) Every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sum owed by the plan.
>
> (b) In the event that the contract has not been reduced to writing as required by this chapter . . .the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan.

Plaintiffs contend subd. (b) expressly proscribes non-network emergency providers from balance billing, arguing that the relationship between them and non-network providers constitutes a contract not "reduced to writing" within subd. (b). The Court does

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not read the subdivision so broadly. To the contrary, the Court finds that traditional principles of statutory construction, as well as rules of grammer require the subd. (b) be interpreted as referring to traditional contracts between a plan and a provider of health care services which is for sufficient term, reflects a meeting of the minds and otherwise sufficiently certain to otherwise reflect the elements of a contract. It is certain from the pleadings that defendants have not acceded to any contractual terms with the plaintiffs, most notably the very crux of the declaratory relief claim is a dispute regarding the settling of the Medicare rate as the defined "reasonable" rate for emergency medical services. "It is a rule of grammatical construction and one of the simplest canons of statutory construction that a limiting clause is to be confined to the last antecedent." Home Depot, USA, Inc. v. Contractors' State License Board (1996) 41 Cal.App.4th 1592, 1602. Thus the Court construes subd. (b) to apply to govern the creation and operation of network provider network provider contracts, albeit not in writing.

Plaintiffs also focus upon the May 10, 2003, letter opinion from the Department of Managed Health Care ("DMHC") finding in relevant part that "balance billing enrollees violates the Knox-Keene Act, even if the emergency physicians do not have a written contract with the health plan." Plaintiffs' Exhibit A. The DMHC is the agency charged with regulation of managed care under the Knox-Keene Act. Its opinion is, thus, a matter of great weight unless clearly

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erroneous Cannon v. Industrial Accident Commission (1959) 53 Cal.2d 17, 22. The Court does not find this letter dispositive. The DMHC opinion appears to rest California statutory or regulatory law and more upon two cited court decisions. Neither decision is discussed in any detail within the DMHC letter. The purported decision in San Joaquin Community Hospital v. Health Net of California, Inc., CV-243929 RDR appears to be an unpublished federal trial court decision. The Court has Shepardized the case citation without result. The second decision, River Park second decision, River Park Hospital, Inc. v. Bluecross Blueshield of Tennessee, Inc., et al. 2002 Tenn App., Lexis 723, is also an unpublished opinion. It bears no citation to a Tennessee or other official Tennessee or other official reporter. (See California Rules of Court, Rule 977(a), unpublished opinions of of the California Court of Appeal may not be cited.) However, in any event, the Court has reviewed the decision and finds it distinguishable from the instant case. The critical distinguishing factor is that River Park construes a Tennessee statue which expressly bars non-network emergency providers from balance billing of enrollees.

Tennessee Rule 1200-13-12-.08, subd. (1) provides that,
"In situations where a managed care organization authorizes a service rendered by a provider who who is not under contract with the managed care organization, payment to the provider cannot be

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> cannot be less than the amount that would have been paid to a provider under contract with the managed care organization for the same service. As a condition of payment, non-contract providers shall accept payment from managed care organization as payment in full . ."(Emphasis added.)

Neither California statutory law nor regulation has adopted a like provision. To the contrary, the parties agree that a regulation was proposed on 2003 which, if adopted, would have imposed regulatory language analogous to the Tennessee regulation. Plaintiffs' Exhibit C: With the exception of copayments deemed permissible by the Department, an emergency service and care provider who provides emergency service and care to a health plan enrollee may not collect or attempt to collect from the enrollee any amount due the provider and instead must seek reimbursement directly from the health plan for the provision of covered services." Proposed Regulation 1300.79(a). The proposed regulation has not been adopted, to date, by the DMHC.

Certainly, every resident of California has concerns regarding the cost of medical services. However, in the absence of the exercise of legislative and/or regulatory imposition of a proscription against balance billing in the non-contracting emergency service context, and in light of the legislative and/or regulatory inaction regarding a proposal to expressly so proscribe, the Court finds plaintiffs'

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claims do not survive demurrer. The Court further finds no basis for defining as a matter of law that the Medicare rate is the "reasonable" rate for emergency services see commentary of the DMHC at Exhibit 1, Item 3; Cannon v. Industrial Accident Commission,
Commission supra; see also River Park Hospital, Inc. v Bluecross Blueshield of Tennessee, Inc., supra; CCR, Rule 1300.171(a)(3)(B).

The Court rules as follows on defendants' evidentiary objections to the declaration of Kenneth E. Johnson:

1. Sustained on the grounds asserted.
2. Sustained on the grounds asserted.
3. Sustained on the grounds asserted.
4. Sustained on the grounds asserted.

DATED: December 22, 2003.

LINDA K. LEFKOWITZ
Judge of the Superior Court

Ruling on Demurrer is signed and filed this date.

CLERK'S CERTIFICATE OF MAILING/
NOTICE OF ENTRY OF ORDER

I, the below named Executive Officer/Clerk of the above-entitled court, do hereby certify that I am not a party to the cause herein, and that this date I served Notice of Entry of the above minute order of 12-22-03 upon each party or counsel named below by

MINUTES ENTERED
12/22/03
COUNTY CLERK

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depositing in the United States mail at the courthouse in Santa Monica, California, one copy of the original entered herein in a separate sealed envelope for each, addressed as shown below with the postage thereon fully prepaid.

MILLER & HOLGUIN
KENNETH E. JOHNSON
1801 CENTURY PARK EAST,
SEVENTH FLOOR
LOS ANGELES, CALIFORNIA 90067

CALIFORNIA LAWYERS GROUP, LLPE 204
ANDREW H. SELESNICK
16601 VENTURA BOULEVARD, SUITE 204
ENCINO, CALIFORNIA 91436-1921

Date: December 22, 2003

John A. Clarke, Executive Officer/Clerk

By: _____
V. Jaime

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