No. S274927

IN THE

Supreme Court

OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA,

Petitioner,

vs.

SUPERIOR COURT OF SANTA CLARA

Respondent,

DOCTORS MEDICAL CENTER OF MODESTO *et al.*,

Real Parties in Interest.

APPLICATION OF THE CALIFORNIA MEDICAL ASSOCIATION AND THE CALIFORNIA HOSPITAL ASSOCIATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF; *AMICUS CURIAE* BRIEF IN SUPPORT OF REAL PARTIES IN INTEREST

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Certificate of Interested Entities or Persons

Pursuant to California Rules of Court, rule 8.208, the undersigned, counsel for the California Medical Association and the California Hospital Association, certifies that there are no disclosures to be made.

DATED: March 3, 2023

LONG X. DO

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Pursuant to rule 8.520(f) of the California Rules of Court, the California Medical Association and the California Hospital Association hereby request leave to file the attached *amicus curiae* brief in support of Doctors Medical Center of Modesto, Inc. and Doctors Medical Center of Manteca, Inc., the real parties in interest in the above-captioned action.

There are no persons or entities to be identified under rule 8.520(f)(4) of the California Rules of Court.

INTERESTS OF THE *AMICUS CURIAE* APPLICANTS

The California Medical Association ("CMA") is a non-profit, incorporated professional physician association of nearly 50,000 members, most of whom practice medicine in all modes and specialties throughout California. CMA's primary purposes are "to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, safe, and cost-effective health care for the people of California.

The California Hospital Association ("CHA"), representing more than 400 hospitals throughout California, advocates for better, more accessible health care for all Californians. Through its 35-plus member Board of Trustees composed of the leaders of California's hospitals and health systems, CHA ensures that hospitals will continue to be able to provide exceptional care to patients and comprehensive health services to communities. Established in 1935, CHA provides information, resources, and perspective to state and federal policy makers to inform decisions that affect 40 million Californians.

PURPOSE OF THE *AMICUS CURIAE* BRIEF

CHA and CMA (collectively, the "Provider Associations") believe their proposed *amicus curiae* brief can assist the Court by bringing the expertise and experience of California's broad provider community to bear on the important managed care issues raised in this case. For decades, both CMA and CHA have been active advocates and contributors in heated public debates

over the provision and reimbursement for emergency medical care in the managed care market. The organizations believe accessibility and affordability of medical care go hand in hand with fair reimbursement to providers. Adequate compensation to stabilize health care networks is especially important in the out-of-network emergency care context, where both patients and providers may have little choice in their involvement in an episode of medical care.

The proposed *amicus curiae* brief can help the Court to evaluate the nature of the cause of action at stake in this case and whether the hospitals assert any legal claims that fall subject to the section 815 immunity of the Government Claims Act. In resolving the issue, the Provider Associations urge the Court to consider the broad statutory scheme created under the Knox-Keene Health Care Service Plan Act of 1975 to regulate reimbursement of out-of-network emergency medical care at a reasonable and customary rate. CMA and CHA explain the history and contours of that regulatory scheme to contextualize and confirm the statutory nature of the claims asserted by the hospitals here. The Provider Associations also explain the relevant public policy considerations and the real-world consequences of the legal positions asserted by the parties around application of immunity under the Government Claims Act to a county-operated Knox-Keene health plan.

Accordingly, CHA and CMA believe their proposed *amicus curiae* brief offers helpful information and perspectives not

currently represented or adequately addressed in the parties' briefing.

CONCLUSION

For the foregoing reasons, CHA and CMA respectfully request that the Court accept and file the attached *amicus curiae* brief.

DATED: March 3, 2023

Respectfully,

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AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION AND THE CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF REAL PARTIES IN INTEREST

I
INTRODUCTION

Emergency departments in hospitals ("ED") are indispensable. They provide lifesaving care to people with medical emergencies. EDs also provide an accessible and important entry point for inpatient hospital care and, in certain communities, serve as the primary, if not the sole, site of contact between the state's health care delivery system and its most underserved residents.[1] Recognizing EDs as a pillar of society,

[1] Research has found a correlation between non-urgent ED usage and poor access to non-emergency health care services. *See, e.g.*, H. Xin, "Patient Dissatisfaction With Primary Care and Nonurgent Emergency Department Use" (Oct/Dec. 2019) 42(4) J. AMBUL. CARE

the California Department of Managed Health Care ("DMHC") has asserted that "[t]he prompt and appropriate reimbursement of emergency providers ensures the continued financial viability of California's health care delivery system." *Bell v. Blue Cross of California* (2005) 131 Cal. App. 4th 211, 218 (quotation from DMHC amicus brief).

Two hospitals in this case seek reimbursement for emergency medical care pursuant to the statutory scheme carefully designed to realize the DMHC's vision of a health care delivery system that fairly compensates providers. Specifically, the hospitals assert claims under Health and Safety Code section 1371.4(b) and California Code of Regulations, title 28, section 1300.71(a)(3), to recover "payment of the reasonable and customary value for the health care services rendered" to enrollees of Valley Health Plan, a Knox-Keene licensed health plan operated by petitioner the County of Santa Clara ("County"). With noticeably overzealous sharpness, the County opens its briefing on the merits accusing the hospitals of "exploit[ing] their resulting effective monopoly [in emergency care] to pursue inflated sticker prices" (p. 12), followed with a background section with the inflammatory title "the Current, Escalating Crisis Resulting from Hospital Pricing and Billing Practices" to lament that "[w]hile health plan profits are now circumscribed by law,

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MGMT. 284; J. Sarver *et al.*, "Usual Source of Care and Nonurgent Emergency Department Use," (Sept. 2002) 9 ACAD. EMERG. MED. 916; G. Young *et al.*, "Ambulatory Visits to Hospital Emergency Departments – Patterns and Reasons for Use" (Aug. 14, 1996) 276(6) J. AMER. MED. ASS'N 460.

the same is not true for hospitals." Answer Brief at 25-30.[2]

The tenor and substance of the County's public policy arguments may be novel as applied to the Government Claims Act questions in this case, but they are not at all unfamiliar. Those and other similar arguments have been repeatedly raised before the Legislature, the DMHC, and the courts on bills, proposed regulations, and cases under the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act") regarding the obligations and rights of health plans, patients, and providers around emergency medical care. They have consistently been rejected.

The Legislature considered and rejected health plan arguments warning of provider price manipulation when it passed Senate Bill no. 1832 in the 1993-94 legislative session

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2 One need look no further than the current news headlines to see the baselessness of the County's depiction of price gouging hospitals. *See, e.g.*, J. Commins, "After 2 Years of Pandemic, CA Hospitals Face Massive Financial Losses" (April 27, 2022) HEALTHLEADERS; L. McClurg, "Half of California Hospitals Are in the Red: Pandemic Troubles Pile Up for ERs" (Feb. 13, 2023) KQED; M. Montalvo, "Hospitals in 'crisis' in Central Valley as Fresno County ends its emergency declaration" (Feb. 8, 2023) FRESNOLAND. As McClurg reports:

> In Madera County near Yosemite, the area's only general hospital closed in January. That left 150,000 residents without an emergency room or specialty care, and many of the hospital's 700 employees without a job. State lawmakers and industry officials warn many more facilities will be forced to reduce services and some will shutter.

Contrary to the County's suggestions, California hospitals and emergency care providers operate on thin margins and have been forced out of business due to persistent under-compensation in the managed care marketplace.

("S.B. 1832") to enact Health and Safety Code section 1371.4 and required that "[a] health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees . . . ." Proponents of S.B. 1832 argued, "[s]ince emergency physicians are required to evaluate and treat all those who present themselves at the emergency room, it is essential that plans pay for a routine medical screening exam." Cal. Bill Analysis, Senate Floor, S.B. 1832 (June 1, 1994). Nearly all major health plans in California opposed the new statutory payment obligation and argued (like the County here) that emergency care providers could manipulate their bills and cause premiums to skyrocket. *Id.*; *see also* Cal. Bill Analysis, Senate Floor, S.B. 1832 (Aug. 31, 1994) ("California Association of Health Maintenance Organizations states that emergency physician payment require[ment]s would thwart cost control and the claims review provisions would ultimately . . . increase health plan costs and the overall cost of health care coverage").

The same debate around mandatory reimbursement for emergency medical care was aired two decades later before this Court when it considered and rejected the practice of balance billing patients by out-of-network providers who provide emergency medical care and are dissatisfied with the payments they receive from health plans. *See Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal. 4th 497. The Court observed, "[b]y the very nature of things, disputes may arise regarding how much the emergency room doctors may

charge and how much the HMO must pay for emergency services." *Id.* at 505. And it reasoned, "[i]nterpreting the applicable statutory scheme as a whole . . . we conclude that billing disputes over emergency medical care must be resolved solely between the emergency room doctors, *who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment*." *Id.* at 502 (emphasis added).

The County in this case seeks to marshal the health plan arguments in the debate around payment for out-of-network emergency care to compel application of the Government Claims Act's immunity provision, Government Code section 815, to its Valley Health Plan. But the Legislature has settled that debate. As this Court recognized, the debate engendered a broad statutory and regulatory scheme under the Knox-Keene Act that "(1) intends to transfer the financial risk of health care from patients to providers; (2) requires emergency care patients to agree to pay for the services or to supply insurance information; (3) requires HMO's to pay doctors for emergency services rendered to their subscribers; (4) prohibits balance billing when the HMO, and not the patient, is contractually required to pay; (5) requires adoption of mechanisms to resolve billing disputes between emergency room doctors and HMO's; and (6) permits emergency room doctors to sue HMO's directly to resolve billing disputes." *Prospect*, 45 Cal. 4th at 507. In other words, the hospitals here seek to assert statutory claims to recover what the DMHC has determined they are entitled to receive for services rendered pursuant to a Knox-Keene scheme evincing "a clear

legislative policy not to place patients in the middle of billing disputes between doctors and HMO's." *Id.*

The California Medical Association ("CMA") and the California Hospital Association ("CHA"), representing a large majority of the health care providers in California, were active participants in the debates underlying health plans' obligation to pay out-of-network providers for emergency medical care. Indeed, CMA sponsored S.B. 1832 to codify the obligation, and both organizations filed amicus briefs in key cases that clarified or advanced the laws around reimbursement for emergency care, including *Prospect*, *supra*; *Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.* (2016) 1 Cal. 5th 994; *Bell v. Blue Cross of California* (2005) 131 Cal. App. 4th 211; and *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal. App. 4th 1260, among others.

By this *amicus curiae* brief, CMA and CHA provide a broader perspective to bolster the hospitals' position that Government Code section 815.6, and not the immunity of section 815, applies to any claim for reimbursement under section 1371.4 of the Knox-Keene Act.[3] To hold otherwise is to create a two-

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[3] The hospitals in this case assert an implied-in-fact contract claim under section 1371.4 for quantum meruit, but a direct claim would be equally viable. Where, as here, a statute obligates one party to pay money to another, it thereby creates a private right of action to assure that the payment is made and received. *Goehring v. Chapman University* (2004) 121 Cal. App. 4th 353, 377-78; *accord Lu v. Hawaiian Gardens Casino, Inc.* (2010) 50 Cal. 4th 592, 603 n.8. Therefore, Health and Safety Code section 1371.4 confers on providers of emergency services a private right of action against health care service plains to recover the reimbursement required by statute. Health and Safety Code section 1399.5 assures that public entity

tiered scheme of regulation divided between public and private health plans. There is no support for such a bifurcated approach under the Knox-Keene Act. What is more, as shown below, exempting public health plans from Knox-Keene claims will introduce uncertainty and instability in the health care marketplace that is anathema to the statute's goals of fostering health care accessibility and affordability for millions of Californians.

II
INTERESTS OF *AMICI CURIAE*

The California Medical Association ("CMA") is a non-profit, incorporated professional physician association of nearly 50,000 members, most of whom practice medicine in all modes and specialties throughout California. CMA's primary purposes are "to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, safe, and cost-effective health care for the people of California.

The California Hospital Association ("CHA"), representing more than 400 hospitals throughout California, advocates for better, more accessible health care for all Californians. Through its 35-plus member Board of Trustees composed of the leaders of California's hospitals and health systems, CHA ensures that

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health plans are subject to such actions. In any event, there should be no Government Claims Act immunity shielding the County from any such statutory claims for fair reimbursement.

hospitals will continue to be able to provide exceptional care to patients and comprehensive health services to communities. Established in 1935, CHA provides information, resources, and perspective to state and federal policy makers to inform decisions that affect 40 million Californians.

CHA and CMA share a particular interest implicated in this case to preserve the ability of California physicians and hospitals to deliver critical emergency care services to all who need it. A robust emergency safety net system must include protections for health care providers that better secure their viability in a challenging marketplace, especially the right to judicial enforcement of fair and reasonable reimbursement from all third-party payors, including publicly owned health plans.

III
DISCUSSION

A. Government Claims Act Section 815 Immunity Does Not Apply to a Claim for Reimbursement Authorized by Statute.

The Government Claims Act regulates what types of claims can be asserted against public entities and how such claims are to be brought. *See Quigley v. Garden Valley Fire Protection Dist.* (2019) 7 Cal. 5th 798, 803 ("[T]he Government Claims Act . . . is a comprehensive statutory scheme governing the liabilities and immunities of public entities and public employees for torts"). Government Code section 815 is "[t]he basic architecture of the Act" and "makes clear that under the GCA, there is no such thing as common law tort liability for public entities." *Id.* This Court and intermediate appellate courts have explained and

underscored the Act's immunity applies exclusively to money claims arising in torts. *See, e.g.*, *City of Dinuba v. County of Tulare* (2007) 41 Cal. 4th 859, 867 ("[T]he immunity provisions of the [Government Claims] Act are only concerned with shielding public entities from having to pay money damages for torts"); *Kizer v. County of San Mateo* (1991) 53 Cal. 3d 139, 145 n.4 ("Clearly, the emphasis of the Tort Claims Act is on *torts*") (emphasis in original); *Green Valley Landowners Assn. v. City of Vallejo* (2015) 241 Cal. App. 4th 425, 441-42 ("It is a well-settled rule that '[t]here is no common law governmental tort liability in California; and except as otherwise provided by statute, there is no liability on the part of a public entity for any act or omission of itself, a public employee, or any other person'") (citation omitted); *Schooler v. State of California* (2000) 85 Cal. App. 4th 1004, 1013 ("Government Code immunities extend only to tort actions that seek money damages").

A tort action to recover money damages subject to the immunity of the Government Claims Act is entirely separate and distinct from an action to recover fair and reasonable reimbursement for out-of-network emergency services as mandated by the Knox-Keene Act. *Kizer v. County of San Mateo*, *supra*, well illustrates this distinction. The county defendant there operated a long-term health care facility that was assessed citations and civil penalties under the Long-Term Care, Health, Safety and Security Act of 1973 (Health & Safety Code §§1417 *et seq.*) (the "Long-Term Care Act"). The county sought to apply section 815 immunity against the assessments, but this Court

held the common law tort immunity did not apply. *Id.*, 53 Cal. 3d at 144.

The Court noted important distinctions between a tort claim subject to Government Claims Act immunity and an assessment under the Long-Term Care Act. First, "the essential prerequisite to liability [under the Long-Term Care Act] is a violation of some minimum health or safety standard rather than 'injury' or 'damage'." *Id.* at 146. Furthermore, tort "damages are normally awarded for the purpose of compensating the plaintiff for injury suffered, *i.e.*, restoring the plaintiff as nearly as possible to his or her former position, or giving the plaintiff some pecuniary equivalent" (*id.* at 146-47), whereas under the Long-Term Care Act, a statutory assessment's "primary purpose is to secure obedience to statutes and regulations imposed to assure important public policy objectives." *Id.* at 147-48. Indeed, "[c]ivil penalties under the Act, unlike damages, require no showing of actual harm per se." *Id.* at 147.

In rejecting Government Claims Act immunity as applied to the Long-Term Care Act, the Court spurned the notion that there could be "a two-tiered system of enforcement of the Health and Safety Code provisions," one tier for privately operated nursing facilities and another tier for publicly operated facilities. *Id.* at 148. The Court explained:

> We find nothing in the statutory scheme that suggests that state and other government health facilities should be treated differently than private facilities. The statutory scheme regulating nursing homes clearly contemplates that a single standard of care apply to all long-term skilled nursing facilities whether privately or publicly owned.

> [citations] Section 1277, subdivision (d) states: "The state department shall apply the same standards to state and other governmental health facilities that it licenses as it applies to health facilities in private ownership" . . . . [W]e can "perceive no significant public policy reason to exempt a state licensed health-care facility from liability for penalties under the [Long-Term Care, Health, Safety, and Security] Act simply because it is operated by a public rather than a private entity . . . .

Id. *Kizer* is apt in many ways in evaluating a tort claim subject to Government Claims Act immunity and a claim to recover fair and reasonable reimbursement for emergency services under the Knox-Keene Act.

B. The Knox-Keene Act Establishes a Robust Regulatory Scheme to Secure Efficient and Affordable Health Care for Californians.

This Court has observed that health plans operate and function differently than traditional indemnity health insurance, requiring specialized governmental oversight. *See California Physicians' Servs. v. Garrison* (1946) 28 Cal. 2d 790, 811 (holding a health plan was not subject to Insurance Commissioner oversight). Focused on California's first statewide health plan, the CMA-created California Physicians' Service (now Blue Shield of California), the Court observed:

> Certainly the objects and purposes of the corporation organized and maintained by the California physicians have a wide scope in the field of social service. Probably there is no more impelling need than that of adequate medical care on a voluntary, low-cost basis for persons of small income. The medical profession unitedly is endeavoring to meet that need. Unquestionably this is 'service' of a high order and not 'indemnity.'

Id. at 809.

At the heart of the distinction between health insurance and a health plan is the former's "promise to pay" versus the latter's "promise to deliver care." Health and disability insurers protect against (indemnify) the covered expenses or charges that insureds incur associated with illness or injury. By contrast, health plans are licensed under the Knox-Keene Act to arrange for and organize the delivery of health care and services through providers and facilities for a monthly, prepaid fee collected from the patient. *See* Health & Safety Code §1345((f)(1). Such an arrangement requires health plans to delve deeper into the health care delivery system, where they can have a larger impact on the manner, quantity, and quality of care received by plan members. The Knox-Keene Act must be viewed in light of this unique characteristic of health plans.

1. The Knox-Keene Act Broadly Aims to Improve Affordability and Accessibility to Health Care.

"The Knox–Keene Act is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care." *Prospect*, 45 Cal. 4th at 504 (quoting *Bell*, 131 Cal. App. 4th at 215). The Legislature has declared its intent and purpose that the goals of the act include "[e]nsuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional," "[h]elping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers," "[e]nsuring the financial stability thereof by means of proper regulatory procedures," and

"[e]nsuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care." Health & Saf. Code §1342.

Like the Long-Term Care Act in *Kizer*, the Knox-Keene Act makes no distinction between health plans operated by a private or public entity. *See* Health & Saf. Code §1399.5. Just like any private health plan, a public entity that wants to operate a commercial health plan in the marketplace must secure a Knox-Keene license from the DMHC. *See generally id.* at §1351. When so licensed, the public health plan is expressly subject to the provisions of the act, which apply without any regard to the public or private nature of the health plan (with respect to commercial enrollees, as opposed to Medi-Cal enrollees, *see* footnote 4, *infra*). *See* Health & Saf. Code §1343(a) ("This chapter shall apply to health care service plan and specialized health care service plan contracts"). To be sure, the Legislature has declared its intent "that the provisions of th[e] [Knox-Keene Act] shall be *applicable to any private or public entity* or political subdivision which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, as defined in this chapter, unless such entity is exempted from the provisions of this chapter by, or pursuant to, Section 1343." *Id.* at §1399.5 (emphasis added).

The Knox-Keene Act sets robust rules governing mandatory basic services to be provided by health plans, financial stability of health plans, availability and accessibility of networks of

providers, review of provider contracts, administrative organization, and consumer disclosure and grievance requirements. *See, e.g.*, Health & Saf. Code §§1367 (health plan requirements), 1367.002 (required coverage and limitations on cost-sharing requirements); 1367.03-1367.035 (network adequacy standards); 1374.30 (independent medical review system); 1389.1-1389.8 (underwriting practices and standards). Through such a statutory scheme, the Legislature has crafted a comprehensive regulatory structure that is designed to carry out the State's public policy goal "to ensure that the citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible." *Id.* at §1342.6.

2. Out-of-Network Providers May Not Be in Contractual Privity with Health Plans but Nevertheless Are Subject to Knox-Keene Regulation.

One active area for regulation has been the relationship between health plans and providers who are out of network. Such providers have no express contractual relationship with health plans and, in some instances, fall outside the purview of the Knox-Keene Act. Nevertheless, because out-of-network providers' involvement in the managed care ecosystem is inevitable and vital, courts have turned to the overall scheme and purposes of the Knox-Keene Act, rather than to its express terms, to resolve disputes over out-of-network reimbursement.

Most recently, this Court focused on the delegation model by which health plans contract with risk-bearing organizations for the latter to assume responsibility for delivering and arranging care to a certain subset of plan members. The Court

held that health plans can be liable for negligently delegating their responsibilities to subcontractors who cannot reimburse out-of-network emergency care providers, even though no such claim is expressly found in the Knox-Keene Act or its implementing DMHC regulations. *See Centinela*, *supra*, 1 Cal. 5th at 1002. In reaching this result, the Court did not mince words in condemning the potential for health plans to abuse their powers over out-of-network providers:

> We believe it is unfair and morally blameworthy for a health plan to take advantage of the statutory compulsion requiring noncontracting emergency service providers to continue providing their services in such a way. Because the emergency care providers rely exclusively on health care service plans to arrange payment for services received by their enrollees, plans that transfer those responsibilities onto an IPA they know or should know will not make those payments have not only shirked their statutory obligations, but have essentially withheld from emergency care providers the fair compensation to which they are entitled. Forcing others to provide professional services for the benefit of one's own customers, without any reasonable prospect of payment, is morally blameworthy.

Id. at 1016-17.

The Court in *Prospect* held that patients must be kept out of the middle of payment disputes between out-of-network providers of emergency care and health plans. Balance billing of such patients by the providers is prohibited under the Knox-Keene Act. *See Prospect*, *supra*, 45 Cal. 4th at 507. Here as well, the Court found no explicit statutory basis for the ban but found footing in the overall purpose of the Knox-Keene Act:

> The only reasonable interpretation of a statutory scheme that (1) intends to transfer the financial risk of health care from patients to providers; (2) requires emergency care

> patients to agree to pay for the services or to supply insurance information; (3) requires HMO's to pay doctors for emergency services rendered to their subscribers; (4) prohibits balance billing when the HMO, and not the patient, is contractually required to pay; (5) requires adoption of mechanisms to resolve billing disputes between emergency room doctors and HMO's; and (6) permits emergency room doctors to sue HMO's directly to resolve billing disputes, is that emergency room doctors may not bill patients directly for amounts in dispute. Emergency room doctors must resolve their differences with HMO's and not inject patients into the dispute. Interpreting the statutory scheme as a whole, we conclude that the doctors may not bill a patient for emergency services that the HMO is obligated to pay.

Id.

Several important opinions in the courts of appeal have bolstered the comprehensive nature and broad reach of the Knox-Keene regulatory scheme. For example, the court in *California Physicians' Serv. v. Aoki Diabetes Rsch. Inst.* (2008) 163 Cal. App. 4th 1506, 1517, held providers have a private right of action to challenge a health plan's determination that a treatment is not a covered service. The court in *Children's Hospital Central California*, *supra*, 226 Cal. App. 4th at 1276, clarified the scope of evidence that can prove reasonable value for reimbursement under the Knox-Keene Act to include evidence of the full range of fees that a provider charges and accepts as payment. In *Blue Cross of California, Inc. v. Superior Court* (2009) 180 Cal. App. 4th 1237, 1257, the court expanded Knox-Keene enforcement and held that city attorneys have standing to sue health plans under the Unfair Competition Law for Knox-Keene violations.

3. Settling a Heated Controversy, the Legislature Has Determined that Out-of-Network Providers Are Entitled to Fair Compensation from Health Plans for Emergency Care.

Nearly two decades ago, *Bell v. Blue Cross of California*, cited by this Court with approval (see *Prospect*, 45 Cal. 4th at 505-08), recognized the type of claim that the hospital providers in this case seek to assert: a claim in quantum meruit by out-of-network providers to seek reasonable reimbursement for emergency services from health plans.

Bell observed that allowing a health plan to "reimburse emergency care providers at whatever rate it unilaterally and arbitrarily selects" would "render illusory the protection the Legislature granted to the [emergency] providers" and "would mean the emergency care providers could be reimbursed at a confiscatory rate, that aside from being unconscionable, would be unconstitutional." *Id.* at 220. This observation is based on several requirements applicable to emergency medical care:

> Today, by statute, when emergency room doctors provide emergency services, [Knox-Keene health plans] are required to reimburse those doctors for the services rendered to their subscribers or enrollees. As *Bell* explained, the Knox–Keene Act "compels for-profit health care service plans to reimburse emergency health care providers for emergency services to the plans' enrollees.... [S]ection 1371.4 provides that a for-profit 'health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). . . . (*Bell*, *supra*, 131 Cal. App. 4th at p. 215, 31 Cal.Rptr.3d 688.) "Subdivision (b) of section 1371.4 was enacted in 1994 to impose a mandatory duty upon health care plans to reimburse noncontracting providers for

> emergency medical services. [Citations.]" (*Id.* at p. 216, 31 Cal. Rptr. 3d 688.)
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> Regulations of the Department of Managed Health Care provide that the HMO must pay "the reasonable and customary value for the health care services rendered . . . ." (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B); *see Bell*, *supra*, 131 Cal. App. 4th at p. 216, 31 Cal. Rptr. 3d 688.) Thus, the HMO has a "duty to pay a reasonable and customary amount for the services rendered." (*Bell*, *supra*, at p. 220, 31 Cal. Rptr. 3d 688.) But how this amount is determined can create obvious difficulties. In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between. In *Bell*, *supra*, 131 Cal. App. 4th 211, 31 Cal. Rptr. 3d 688, the Court of Appeal interpreted the Knox–Keene Act to permit, when disputes arise, emergency room doctors to sue the HMO directly for the reasonable value of their services.

Prospect, 45 Cal. 4th at 504-05.

These cases and the related Knox-Keene Act provisions help to ensure a stable marketplace for out-of-network providers to participate in the managed care ecosystem. As the DMHC explained to the *Bell* court, "prompt and appropriate reimbursement of emergency providers ensures the continued financial viability of California's health care delivery system." *Bell*, 131 Cal. App. 4th at 218 (quoting DMHC amicus brief). Without the full protection afforded to providers under the Knox-Keene Act, health plan networks would shrink and access to medical care would decline. In other words, the protection of health care for patients hinges on a robust regulatory scheme that ensures all health plans fairly and consistently reimburse all providers who care for health plan members. These rules can only

be effective if they apply consistently to all health plans, including those owned by public entities.

Kizer teaches that the claim asserted by the hospital providers in this case bears no resemblance to the sort of tort claims for money damages that are subject to the Government Claims Act's immunity provision. The claim for reimbursement, at an amount prescribed by DMHC regulation, for out-of-network emergency services arises entirely out of a statutory scheme that seeks to ensure providers are fairly compensated for services they are legally obligated to provide. Such fair reimbursement serves the greater purposes of the Knox-Keene Act to guarantee affordability and accessibility of health plan health care services. The hospitals here do not seek compensation for injuries caused by tortious wrongdoing by anyone; rather, they seek reasonable and customary remuneration for professional services rendered irrespective of any wrongful intent by the health plans in denying or underpaying the claims. Government Code section 815.6 squarely applies in these circumstances, not the immunity of section 815. Like all health plans that hold a Knox-Keene license, Valley Health Plan and all other public health plans must be subject to the statutory obligations of fair reimbursement for out-of-network emergency care services rendered to their commercial enrollees.

C. Exempting Knox-Keene Licensed Public Health Plans from Section 1371.4 Reimbursement Claims Would Introduce Uncertainty and Instability that Disserves the Goals of the Knox-Keene Act.[4]

There are practical and policy reasons too why public health plans should not be immune from legal claims to compel compliance with the Knox-Keene statutory scheme mandating fair reimbursement of out-of-network emergency care claims. As *Kizer* rejected a two-tiered public versus private enforcement scheme for regulation of long-term care facilities, so too should the Court turn down the County's tacit push for a separate Knox-Keene enforcement scheme for public health plans. There is no basis to bifurcate the Knox-Keene Act because there is no meaningful distinction between public and private health plans from the perspective of patients and providers. More importantly, special consideration for county health plans will reverberate throughout the marketplace to the detriment of affordability and accessibility to health care, twin goals of the Knox-Keene Act.

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[4] This case does not involve reimbursement of emergency care to Medi-Cal enrollees who participate in the Medi-Cal managed care program, including those enrolled in a Knox-Keene licensed Medi-Cal managed care health plan. In such cases, federal and state Medicaid laws govern to determine the reimbursement rate to be paid to out-of-network emergency care providers. *See Dignity Health v. Local Initiative Health Care Authority of Los Angeles County* (2020) 44 Cal. App. 5th 144, 156 (discussing federal and state laws that require out-of-network providers to be compensated for the emergency care of managed care patients at the same rate the providers would receive under a Medicaid fee-for-service system). This amicus brief therefore is directed at out-of-network reimbursement for emergency medical care provided to an enrollee of a county health plan's commercial Knox-Keene licensed product.

1. County Health Plans Are Like All Other Health Plans Subject to Knox-Keene Licensure.

The County's Valley Health Plan is a Knox-Keene licensed, full-service health plan that covers more than 200,000 enrollees as of the end of 2022. *See* DMHC Health Plan Dashboard for Valley Health Plan. This is a 4,000 percent increase in enrollment from 2002 when the health plan was first introduced. *See id.* Enrollment has steadily increased year over year.

A full-service license enables Valley Health Plan to engage in the business of providing or arranging for health care services to enrollees in exchange for a preset, periodic fee. *See* Health & Saf. Code §§1345(f) and 1349. It thus functions like any other full-service, Knox-Keene licensed health plan in the commercial managed health care market. As reported in the DMHC's periodic survey report, Valley Health Plan has an established network of providers, established quality assurance, utilization management processes, and claims adjudication systems. *See generally* DMHC, "Final Report Routine Survey of Santa Clara County dba Valley Health Plan" (Nov. 7, 2019). Valley Health Plan also "must ensure that emergency medical and behavioral health services are accessible and available, and that reimbursement for these services are made as appropriate." *Id.* at 4.

There is no material distinction between Knox-Keene plans offered by a county, like Valley Health Plan, and those offered by commercial corporations. The Legislature has made clear that the Knox-Keene Act "shall be applicable to any private or public entity or political subdivision" that engages in the health plan

business under license conferred by the DMHC. Health & Saf. Code §1399.5.

2. Insulating Commercial County Health Plans from the Knox-Keene's Carefully Crafted Reimbursement Requirements Will Adversely Affect Plan and Provider Behavior.

Treating county health plans different from other Knox-Keene commercial health plans would significantly impact the marketplace, given the growing prevalence of public plans. As the DMHC explained in an amicus brief in *Bell*, "allow[ing] a health plan to unilaterally determine the level of reimbursement for non-contracted emergency providers without further recourse [] can lead to the payment of less than the reasonable and customary value of the providers' services." *Bell*, 131 Cal. App. 4th at 218. That disserves the goals of the Knox-Keene Act because, according to the DMHC, "[t]he prompt and appropriate reimbursement of emergency providers ensures the continued financial viability of California's health care delivery system." *Id.*

There currently are 17 county health plans operating in 35 counties throughout California. *See* K. Wilson, "2022 Edition – California's County-Based Health Plans" (June 7, 2022) Cal. Health Care Found. They cover 8.2 million enrollees (as of June 2021), which represents 1 in 5 Californians. *Id.* County health plan enrollment statewide has seen a steady increase over the past decade, from 3.65 million in 2012 to 8.16 million in 2021. County health plans also have seen steady revenue growth. Revenue for all county health plans was $9.0 million in 2012 and has grown to $31.8 million in 2020. *Id.*

Given their significant market share, county health plan behaviors can and will have substantial consequences on the market. For hospital emergency services, the ability of providers to enforce adequate reimbursement by health plans is particularly important. Hospitals and emergency medicine doctors must provide emergency services without questioning whether the patient can pay or is a member of an in-network versus out-of-network health plan. *See Prospect*, *supra*, 45 Cal. 4th at 504. That is why, since *Bell*, California case law has confirmed that out-of-network emergency care providers can pursue adequate compensation in the courts from health plans.

Underpayments for emergency services by county health plans would significantly deplete the financial resources for emergency-services providers in California. Systematic underpayment by these commercial health plans would undercut the financial viability of emergency-services providers, could drive some emergency medicine doctors and specialists supporting emergency departments to other practice areas, could discourage doctors from entering emergency medicine practice, and would impede the ability of hospitals to maintain and expand their emergency-room care.

CHA and CMA know first-hand how routine under-compensation of safety net and specialist providers contributes to a rise in inadequate access to critically necessary specialty services, particularly in emergencies. When payments fail to cover the costs of delivering services, emergency medicine doctors and other specialist practices that serve emergency departments

may be forced to close or relocate. It also will be difficult for specialists – particularly neurosurgeons, orthopaedic surgeons and general surgeons – to serve "on-call" at hospitals. Such on-call specialists are critical to patient care, ensuring the highest possible quality of service and patient safety for a variety of medical services, including life-saving emergency services. This will have dire implications for patients needing these services as emergency departments face physician shortages. EDs were critical in the COVID pandemic and will continue to provide life-saving care to all Americans regardless of their ability to pay.

Emergency departments also serve as the site for primary care for many Americans, who will lose access to basic care when emergency room physicians and other on-call specialists are no longer available. Additionally, because certain specialists, such as anesthesiologists or radiologists, are part and parcel of hospital surgical teams, their unavailability in certain localities can deprive patients of needed, if not lifesaving, non-emergency hospital procedures.

California hospitals too will be negatively impacted. They are already under tremendous financial strain and face painful choices about where they must make cuts to continue to remain viable. *See* Carmela Coyle, "Hospitals' Financial Peril Deepens" (California Hospital Association, June 2, 2022) (referencing Kaufman Hall national report and noting pressures in California to complete more than $100 billion in seismic upgrades in little more than seven years and significantly reduce the rate of health care cost growth into the future); *see also* footnote 2, *supra*.

Staffing shortages remain rampant in EDs throughout the state, a vestige of the burdens EDs took on during the COVID pandemic. *See* McClurg, *supra*.

Insulating county health plans from fair reimbursement obligations to out-of-network providers can also create perverse incentives against building robust provider networks. If county health plans can unilaterally determine how much they pay for out-of-network emergency care services, the benefits and stability of contracting for such services dissipate. To put it bluntly, why would a health plan engage in arms-length negotiations with providers to set contracted rates when they can have more discretion to pay what the health plan deems appropriate with little reprisal when the provider is out-of-network? Valley Health Plan does not have provider network agreements with two large hospitals in San Jose, and there would be little incentive for the health plan to bring those facilities in network.

Because Knox-Keene health plans generally do not include out-of-network benefits (i.e., enrollees would not be covered if they see out-of-network providers for non-emergency care), keeping two large providers in the county out of network greatly reduces Valley Health Plan enrollees' access to non-emergency care. These enrollees either would forego medically necessary care or would seek primary care services in emergency rooms, further taxing an already overburdened safety net.

V
CONCLUSION

For the foregoing reasons, CHA and CMA respectfully request the Court to reverse the court of appeal's decision and hold that Government Code section 815 has no application to the claims asserted by real parties in interest for reasonable and customary reimbursement for out-of-network emergency care under the Knox-Keene Act.

DATED: March 3, 2023

Respectfully,

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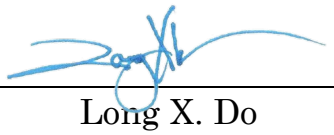
By: 
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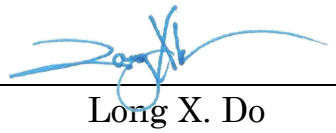
CERTIFICATION OF WORD COUNT

(Cal. R. of Ct., rule 8.520(c))

The text of this brief consists of 6,861 words, exclusive of the cover page, tables, application, signature block, and this certification, as counted by the Microsoft Word word-processing computer application used to generate the brief.

DATED: March 3, 2023



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County of Santa Clara v. Superior Court (Doctors Med. Ctr. of Modesto et al.), Cal. Supreme Ct. case no. S274927

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/s/ Kimberly Parke

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