Filed 2/17/06

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

PROSPECT MEDICAL GROUP, INC., et al., Plaintiffs and Appellants, v. NORTHRIDGE EMERGENCY MEDICAL GROUP et al., Defendants and Respondents.	B172737 (Los Angeles County Super. Ct. No. BC300850)
PROSPECT HEALTH SOURCE MEDICAL GROUP, Plaintiff and Appellant, v. SAINT JOHN'S EMERGENCY MEDICINE SPECIALISTS, INC., et al., Defendants and Respondents.	B172817 (Los Angeles County Super. Ct. No. SC076909)

APPEAL from judgments of the Superior Court of Los Angeles County. Gerald Rosenberg, Judge. Affirmed in part, reversed in part, and remanded.

Miller & Holguin, Kenneth E. Johnson and Stacey L. Zill for Plaintiffs and Appellants.

Fulbright & Jaworski, Carol K. Lucas; Buchalter, Nemer, Fields & Younger, Carol K. Lucas; and Buchalter Nemer for California Association of Physicians Groups as Amicus Curiae on behalf of Plaintiffs and Appellants.

Law Offices of Andrew H. Selesnick and Andrew H. Selesnick for Defendants and Respondents.

Catherine I. Hanson and Astrid G. Meghrigian for California Medical Association as Amicus Curiae on behalf of Defendants and Respondents.

I. INTRODUCTION

Plaintiffs and appellants, Prospect Medical Group, Inc., Prospect Health Source Medical Group, Primary Medical Group, Inc., doing business as Sierra Medical Group (collectively Prospect), appeal a judgment in favor of defendants and respondents, Northridge Emergency Medical Group and Saint John's Emergency Medicine Specialist, Inc. (collectively Emergency Physicians), following an order sustaining separate demurrers without leave to amend. We reverse in part, affirm in part and remand.

This case concerns the business/financial relationship of emergency room physicians and health care service plans and delegates of health care service plans. In some cases, emergency room physician groups have contracts with health care service plans (or their delegates) to provide medical services to patients who are subscribers of the plans. In other emergency situations, health care service plans subscribers are not able to procure the services of contracted emergency physicians (i.e., physicians who

have contracts with the subscriber's health care service plan or its delegate).[1] In these cases, the subscribers may procure the services of non-contracted emergency room physicians, who must treat all patients in emergency situations without regard to ability to pay, pursuant to state and federal law. (Health & Saf. Code, § 1317, subds. (a) & (d);[2] 42 U.S.C. § 1395dd.) After treatment, the health care service plan (or its delegate) must reimburse the non-contracted emergency room physicians for their services. (§ 1371.4, subds. (b) & (e).) At times, this reimbursement is less than the amount billed by the physicians.

The first issue in this case is whether section 1379 prohibits non-contracted emergency room physicians from "balance billing" individual patient/subscribers for the balance of the physician's fee not paid by the health care service plan or its delegate. We hold that section 1379 does not prohibit balance billing by non-contracted emergency room physicians.

The second issue is whether the emergency room physicians must accept the Medicare rate as full reimbursement from a health care service plan or its delegate. We hold that the physicians are not required to accept that amount as payment in full.

The third issue is whether the health care service plan (or its delegate) may litigate the reasonableness of the amount charged by emergency room physicians. We hold that a health care service plan (or its delegate) has standing to litigate the reasonableness of the amount of reimbursement sought by emergency room physicians.

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[1] Prospect and the Emergency Physicians did not have a pre-existing oral or written contractual relationship for the provision of emergency room services to the patients/subscribers. In its regulations, the Department of Managed Health Care, the California state agency statutorily empowered "to ensure that health care service plans provide [subscribers] with access to quality heath care services and protect and promote the interests of [subscribers]," (Health & Saf. Code, § 1341, subd. (a)), refers to the relationship between Prospect and Emergency Physicians as "non-contracted." (See Cal. Code Regs., tit. 28, §§ 1300.71, subd. (a)(1), (3) & 1300.71.38, subd. (a)(2).)

[2] Unless otherwise indicated, all unspecified statutory references are to the California Health and Safety Code.

II. STANDARD OF REVIEW

As this is an appeal from a judgment following the sustaining of a demurrer, we accept as true properly pleaded material factual allegations (*Roman v. County of Los Angeles* (2000) 85 Cal.App.4th 316, 321-322; *Gervase v. Superior Court* (1995) 31 Cal.App.4th 1218, 1224), as well as facts that may be implied or inferred from those expressly alleged. (*Lazar v. Hertz Corp*. (1999) 69 Cal.App.4th 1494, 1501.)

In *Roman v. County of Los Angeles*, *supra*, 85 Cal.App.4th 316, the court set forth the appropriate standard of review: "A demurrer tests the legal sufficiency of the complaint, and the granting of leave to amend involves the trial court's discretion. Therefore, an appellate court employs two separate standards of review on appeal. [Citations.] [¶] The complaint is reviewed de novo to determine whether it contains sufficient facts to state a cause of action. [Citation.] . . . [¶] Where a demurrer is sustained without leave to amend, the reviewing court must determine whether the trial court abused its discretion in doing so. [Citation.] It is an abuse of discretion to deny leave to amend if there is a reasonable possibility that the pleading can be cured by amendment. [Citation.]" (*Id*. at pp. 321-322.)

III. FACTUAL AND PROCEDURAL BACKGROUND

A. *The Parties*

Prospect is an independent physician association (IPA),[3] which manages patient care by executing written contracts with health care service plans.[4] Prospect provides for

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[3] Section 1373, subdivision (h)(6), defines IPA by reference to title 42 United States Code section 300e-1(5), which provides in pertinent part: "The term 'individual practice association' means a . . . legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine . . . ."

[4] Section 1345 defines health care service plans in pertinent part as follows: "(f) 'Health care service plan' or 'specialized health care service plan' means either of the following: [¶] (1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees."

medical care to individuals (i.e., the patient/subscribers of health care service plans), who select a Prospect physician. Prospect also provides billing services to the health care service plans contracted with Prospect.

Pursuant to section 1371.4, subdivision (e), Prospect is a "delegate" of the health care service plans. As such, it is statutorily obligated to pay for emergency services provided to patient/subscribers of the health care service plans contracted with Prospect. (§ 1371.4, subds. (b) & (e).)

Emergency Physicians have exclusive licenses at two California hospitals to provide emergency room physician care. Emergency Physicians are statutorily required to provide emergency room care without regard to an individual's insurance or ability to pay. (§ 1317, subd. (d); see also 42 U.S.C. § 1395dd(a).)

Pursuant to section 1345, subdivision (i), it appears that both Prospect and Emergency Physicians are "providers" of health care services.[5] The language in the statute governing the issue of balance billing, section 1379, subdivision (a), refers to "a provider of health care services." For purposes of this opinion, when we refer to a provider of health care services, we are referring to Emergency Physicians, not Prospect.

B. *The Practice of Balance Billing*

When patient/subscribers of health care service plans schedule medical services in advance, the services may be provided by physicians with whom the health care service plan or its delegate, like Prospect, has a pre-existing contractual relationship. On occasion, as in this case, when patient/subscribers of health care service plans need emergency medical care, they may be taken to a hospital where the physicians staffing the emergency room department do not have a pre-existing contractual relationship with the health care service plan or its delegate, like Prospect.

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[5] Section 1345, subdivision (i), provides: " 'Provider' means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services."

In this case, after Emergency Physicians provided emergency medical services to the patient/subscribers, Emergency Physicians submitted reimbursement claims to Prospect. In some cases, Prospect paid to Emergency Physicians less than the amounts shown on the invoices. In these cases, Prospect paid to Emergency Physicians an amount reflecting what Prospect believed was the "reasonable" amount for the emergency room medical services. Emergency Physicians then billed the patient/subscribers directly for the difference. The parties refer to this practice as "balance billing."

The parties, however, have not indicated to this court whether a physician seeking a co-payment or deductible amount from a patient constitutes balance billing. For purposes of this opinion, we look to the operative statute, section 1379, for guidance. Given an appropriate contractual relationship between a provider of health care services and a health care service plan, or its delegate, section 1379 bars providers of health care services from seeking to collect from a patient "sums owed by the plan." (§ 1379, subds. (a) & (b).) We therefore assume for purposes of this opinion that the practice of balance billing involves billing a patient only for "sums owed by the plan." In contrast, a physician seeking to collect a sum owed by a patient, such as a co-payment obligation, would not constitute the practice of balance billing.

C. *Prospect Files Suit*

Prospect filed two lawsuits,[6] seeking declaratory relief that Emergency Physicians were entitled only to "reasonable" compensation for the medical services rendered to the patient/subscribers. Prospect identified specific emergency room physician services provided by Emergency Physicians between September 2002 and July 2003 for which Emergency Physicians allegedly charged an unreasonable rate. Prospect alleged that reasonable compensation for the services provided by Emergency Physicians was equivalent to 100 percent of the Medicare rate.

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6 The superior court found the two lawsuits were "related," and assigned the actions to the same judge.

Prospect further alleged that section 1379, subdivision (b), prohibited Emergency Physicians from balance billing patient/subscribers for amounts not paid by Prospect. Prospect alleged that based upon Emergency Physicians statutory obligation to treat the patients without regard to insurance or ability to pay, and Prospects' corresponding statutory obligation to reimburse Emergency Physicians for the emergency care provided, Prospect and Emergency Physicians had an implied contractual relationship (in law or fact), which was within the scope of section 1379, subdivision (b), thus barring Emergency Physicians from balance billing the patient/subscribers for sums owed by the plan.

Prospect alleged that the practice of balance billing constituted an unfair, unlawful, or fraudulent business practice within the meaning of Business and Professions Code section 17200. Prospect sought disgorgement, restitution, attorney fees and costs, as well as injunctive relief.

The trial court sustained Emergency Physicians' demurrers without leave to amend and entered judgment accordingly. Prospect timely filed notices of appeal. This court consolidated the appeals.

IV. ISSUES PRESENTED

The issues presented are: (1) whether section 1379 includes within its scope the alleged implied contractual relationship (in law or fact) between Prospect and Emergency Physicians, and thus bars Emergency Physicians from engaging in the practice of balance billing patient/subscribers; (2) whether Prospect is entitled to a judicial declaration mandating that Emergency Physicians must accept the Medicare rate as a reasonable rate for the services rendered; and (3) whether Prospect has standing to litigate whether Emergency Physicians sought more than a reasonable amount as reimbursement for the medical services rendered.

V. DISCUSSION

A. *Section 1379 Does Not Prohibit Emergency Physicians, Who Have No Pre-Existing Contractual Relationship with Prospect, from Balance Billing*

Prospect argues that section 1379, subdivision (b), includes within its scope the alleged implied contractual relationship between Prospect and Emergency Physicians, and therefore prohibits the practice of "balance billing." We disagree.

Section 1379 is contained in the Knox-Keene Health Care Service Plan Act of 1975. (§ 1340.) The Knox-Keene Act provides a comprehensive system for licensing and regulating health care service plans. (*Van De Kamp v. Gumbiner* (1990) 221 Cal.App.3d 1260, 1284.) "All aspects of the regulation of health plans are covered, including financial stability, organization, advertising and capability to provide health services." (*Ibid.*)

Section 1379 provides: "(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 sums owed by the plan. [¶] (b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan. [¶] (c) No contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan."

Prospect claims that, pursuant to subdivision (b) of section 1379, it has a "contract [that] has not been reduced to writing" (i.e., an implied contract in law or fact) with Emergency Physicians. Prospect bases the assertion of an implied contract upon two statutory obligations. First, under federal law (42 U.S.C. § 1395dd) and state law (§ 1317, subd. (d)), Emergency Physicians are obligated to provide emergency room services without regard to a patient's insurance or ability to pay. Second, pursuant to section 1371.4, subdivisions (b) and (e), as a delegate of health care service plans,

Prospect is obligated to reimburse providers of health care services, like Emergency Physicians, for the emergency health services received by the patients/subscribers.

As we discuss below, we conclude that section 1379, subdivision (b), applies only to voluntarily negotiated contracts and does not include within its scope such implied contracts (in law or fact).

When construing a statute, we begin with the words of the statute. If necessary, we look to extrinsic aids. In *California Emergency Physicians Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127, the court explained: "We review de novo the construction of a statute because it presents a pure question of law. [Citation.] 'The primary duty of a court when interpreting a statute is to give effect to the intent of the Legislature, so as to effectuate the purpose of the law. [Citation.] To determine intent, courts turn first to the words themselves, giving them their ordinary and generally accepted meaning. [Citation.] If the language permits more than one reasonable interpretation, the court then looks to extrinsic aids, such as the object to be achieved and the evil to be remedied by the statute, the legislative history, public policy, and the statutory scheme of which the statute is a part. [Citation.] . . . Ultimately, the court must select the construction that comports most closely with the apparent intent of the Legislature, with a view to promoting rather than defeating the general purpose of the statute, and it must avoid an interpretation leading to absurd consequences.' " (*Id.* at p. 1131.)

We find that the language of section 1379 refers to and includes within its scope only voluntarily negotiated contracts between providers of health care services, like Emergency Physicians, and health care service plans or their delegates, like Prospect, based upon traditional contractual principles such as a meeting of the minds. It does not include within its scope the "implied contract" as Prospect argues.

1. *Section 1379, Subdivision (a), Does Not Apply Because There Is No Written Contract*

Section 1379, subdivision (a), requires that contracts between a health care service plan and a provider of health care services shall be in writing and shall set forth that in

the event that a health care service plan fails to pay for a health care service, the patient/subscriber shall not be liable to the provider of health care services for "sums owed by the plan." In this case, there is no written contract; therefore section 1379, subdivision (a), does not apply.

2. *Section 1379, Subdivision (b), Also Does Not Apply Because Emergency Physicians Are not "Contracting Providers" Under the Statute*

The language of section 1379, subdivision (b), refers to "contracting" providers. Subdivision (b) of section 1379 prohibits a contracting provider (i.e., physicians who have contracted with a health care service plan), from attempting to collect from a patient/subscriber "sums owed by the plan." In this case, pursuant to the plain meaning of the statute, Emergency Physicians are not "contracting providers" because they did not contract with the patient/subscribers' health care service plans or their delegate, Prospect. Rather, we interpret the term "contacting provider" as physicians who have freely negotiated a contract with health care service plans (or their delegates) based upon traditional contractual principles such as a meeting of the minds.

3. *Reading Subdivisions (a) and (b) of Section 1379 Together, They Include Within Their Scope Only Freely Negotiated Contracts, Not Implied Contracts*

According to the rules of statutory construction, we do not examine statutory language in isolation. Instead, we examine statutory language in the context of the statutory framework as a whole in order to determine the scope and purpose of a particular statute and harmonize it with the various parts of the statutory scheme. (*Coalition of Concerned Communities, Inc. v. City of Los Angeles* (2004) 34 Cal.4th 733, 737.) In addition, "words should be given the same meaning throughout a code unless the Legislature has indicated otherwise." (*Hassan v. Mercy American River Hospital* (2003) 31 Cal.4th 709, 716.) Applying these rules of statutory construction, we conclude that subdivisions (a) and (b) of section 1379 refer only to voluntarily negotiated contracts based upon a meeting of the minds.

We find that subdivision (a) of section 1379 applies to traditional voluntarily negotiated contracts. Subdivision (a) requires that every contract between a health care service plan and a provider of health care services shall be in writing. Requiring a contract to be reduced to writing strongly suggests that the parties must have entered into a freely negotiated contract with a traditional meeting of the minds.

Subdivision (a) of section 1379 also states that if the health care service plan (or its delegate) "fails to pay for health care services as set forth in the subscriber contract, the subscriber . . . shall not be liable to the provider [of health care services] for any sums owed by the plan." The language "sums owed by the plan" suggests that the health service provider and the plan (or its delegate) have reached an agreement as to how much the plan will pay for a particular medical procedure in advance of the medical procedure.

In addition, the reference to the subscriber contract is important. It shows that the method of determining "sums owed by the plan" is to look to the subscriber contracts. Prospect has not explained how the alleged implied contracts in this case can reference the subscriber contracts. In other words, Prospect has not explained how the subscriber contracts identify the "sums owed by the plan" for emergency medical services provided by physicians with whom Prospect has no pre-existing contractual relationship.

Giving the words of subdivision (b) of section 1379 the same meaning as subdivision (a), we conclude that when subdivision (b) refers to "the contract," it must be referring to the same type of voluntarily negotiated contract based upon a meeting of the minds as referenced in subdivision (a) with one difference. Either the contract has not been reduced to writing or the written contract does not contain the prohibition against billing the patient/subscriber for "sums owed by the plan." Thus, when subdivision (b), states that "[i]n the event that the contract has not been reduced to writing," and "or that the contract fails to contain the required prohibition," it must be referring to the contract referenced in subdivision (a), which is a freely negotiated contract, not an implied contract. In addition, when subdivision (b) uses the phrase "sums owed by the plan," we must assume that the phrase in subdivision (b) has the same meaning as the phrase in

subdivision (a). We therefore look to the subscriber contract to determine the "sums owed by the plan."

Based upon the foregoing, we find that the language of subdivision (b) of section 1379 refers to and includes within its scope only voluntarily negotiated contracts between providers of health care services, like Emergency Physicians, and health care service plans or their delegates, like Prospect, based upon traditional contractual principles such as a meeting of the minds. Subdivision (b) does not include within its scope the implied contract as Prospect asserts.

Interpreting section 1379 to include within its scope only freely and voluntarily negotiated contracts based upon a meeting of the minds allows the contracting parties to know their express contractual rights at the time they execute the contract.

A contrary interpretation of section 1379, subdivision (b), would be untenable because the parties would be forced to negotiate their contractual rights after the provision of medical services. Such an interpretation would mean that every time an emergency room physician provided medical services to a patient/subscriber of a health care services plan with which the physician did not have a pre-existing contractual relationship, the physician would be legally deemed to have entered into an implied contract with the subscriber's health care services plan or its delegate.[7]

In *Ochs v. PacifiCre of California* (2004) 115 Cal.App.4th 782 (*Ochs*), the court explained in dicta that in circumstances like those presented in this case in which the provider of health care services, like Emergency Physicians, did not have a pre-existing contractual relationship with a health care plan or its delegate, like Prospect, section 1379

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[7] Notably, section 1351 sets forth a number of disclosures that an entity must make to the Department of Managed Health Care when applying for a license as a health care service plan. Subdivision (d) requires the applicant for the license to disclose "[a] copy of any contract made, or to be made, between the applicant and any provider of health care services." Prospect has not explained how they could disclose all the alleged implied contracts with physician groups each time a subscriber visits an emergency room.

did not apply to bar the practice of balance billing patient/subscribers of the health care service plans.

In *Ochs*, the plaintiff, an emergency room physician, sought declaratory relief that he could directly bill patients pursuant to section 1379. The Court of Appeal affirmed the trial court order sustaining the demurrer to the declaratory relief cause of action because the plaintiff had not joined the patient/subscribers to the lawsuit. (*Ochs*, *supra*, 115 Cal.App.4th at p. 796.) On the issue presented in this case, the *Ochs* court explained: "We observe, however, that section 1379 appears only to limit 'balance billing' of insured patients by physicians who have contracted with the patients' plans. Ochs may have a remedy against the individual patients, and those patients a remedy against PacifiCare." (115 Cal.App.4th at p. 796.)

4. *The Department of Managed Health Care Recognizes Balance Billing*

The Department of Managed Health Care (DMHC), the department charged with protecting plan subscribers and ensuring access to quality health care, has promulgated a regulation requiring health care service plans to advise subscribers in an Evidence of Coverage document that "in the event the health care plan fails to pay a noncontracting provider, the member may be liable to the noncontracting provider for the cost of the services." (Cal. Code Regs., tit. 28, § 1300.63.1, subd. (c)(15).)[8]

Although not binding, the regulations of the DMHC are entitled to great weight and deference. (*Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 11.) This regulation shows that the DMHC recognizes the practice of balance billing by providers of health care services which do not have a pre-existing voluntary contractual relationship with a health care service plan (or its delegate).

Moreover, in this case, the trial court judicially noticed a regulation proposed by the DMHC, which was never adopted. The proposed regulation would have prohibited balance billing under the facts of this case. The proposed regulation, California Code of

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[8] The "History" of Calfiornia Code of Regulations, title 28, section 1300.63.1, shows that it became operative sometime prior to 1978.

Regulations, title 28, section 1300.79, provided: "(a) 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 [subscriber] may not collect or attempt to collect from the [subscriber] any amount due the provider and instead must seek reimbursement directly from the health plan for the provision of covered services."

The trial court also took judicial notice of public comments and DMHC responses to proposed regulations concerning claim disputes and dispute resolution mechanisms. There, during the second comment period, which ended December 29, 2002, on the issue of balance billing by non-contracted physicians, the DMHC stated: "The prohibition on non-contracting providers to balance bill has been deleted." (Cal. Dept. of Managed Health Care, Comments to Cal. Code Regs., tit. 28, § 1300.71, Claims Settlement Pracs. & Dispute Res. Mechanisms (hereafter Comments to Title 28, Section 1300.71), DMHC Response to Comment No. 63.)

The fact that the DMHC did not adopt the regulation to prohibit balance billing further indicates that section 1379 does not prohibit Emergency Physicians from balance billing in cases in which the physicians do not have voluntarily negotiated contracts with health care service plans (or their delegates). (Cf. *Federal National Mortgage Assn. v. Bugna* (1997) 57 Cal.App.4th 529, 540 [" '[T]he Legislature's omission of a provision from the final version of a statute which was included in an earlier version "constitutes strong evidence that the act as adopted should not be construed to incorporate the original provision." ' "]; *Ventura v. City of San Jose* (1984) 151 Cal.App.3d 1076, 1080 ["The courts have repeatedly concluded that when the Legislature has rejected a specific provision which was part of an act when originally introduced, the law as enacted should not be construed to contain that provision."].)[9]

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[9] Prospect relies upon a May 12, 2003 letter from a senior counsel of the DMHC to the Legislative Advocate of the American College of Emergency Physicians in support of the argument that the DMHC concluded that the practice of balance billing under the facts alleged in this case is prohibited. There, DMHC counsel explained that the statutory relationship between an otherwise non-contracted emergency room physicians and a

We conclude that section 1379, subdivision (b), was not intended to, and does not, prohibit the balance billing practices alleged in this case. Emergency Physicians have not violated section 1379, and thus there is no violation of Business and Professions Code section 17200. (*California Emergency Physicians Medical Group v. PacifiCare of California, supra,* 111 Cal.App.4th at p. 1133.) Prospect therefore is not entitled to injunctive relief prohibiting Emergency Physicians from engaging in the practice of balance billing the patient/subscribers of health care plans with which Emergency Physicians did not have a pre-existing contractual relationship.

B. *Prospect Is Not Entitled to a Judicial Declaration Imposing the Medicare Rate as the Reasonable Rate*

Section 1371.4, subdivision (b), states that "[a] health care service plan [or its delegate] shall reimburse providers for emergency services and care provided to its [subscribers], until the care results in stabilization of the [subscriber]."

Prospect asserts that it is entitled to a judicial declaration imposing the Medicare rate as the rate for reimbursing Emergency Physicians for the emergency room services. We disagree.

Prospect has provided no authority, statutory or otherwise, for this court to conclude that it can set the rates of emergency rooms physicians pursuant to any across-the-board rate mechanism, whether the Medicare rate or any other rate.

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health care plan created an implied in law contract, which was within the scope of section 1379, subdivision (b). This letter provides no guidance because it is not based upon controlling California statutes or case law. DMHC counsel referred to non-controlling and non-published authority, a California federal district trial court decision, and an unpublished Tennessee Court of Appeal opinion. The conclusion of the letter also conflicts with an express regulation of the DMHC, California Code of Regulations, title 28, section 1300.63.1, subdivision (c)(15), quoted above, which recognizes the practice of balance billing by otherwise non-contracted emergency physicians. We find that the letter is not entitled to the weight accorded the above-referenced regulation (Cal. Code Regs., tit. 28, § 1300.63.1, subd. (c)(15)), because it does not appear to have been the result of the quasi-legislative rule making authority and responsibility statutorily imparted to the DMHC. (*Yamaha Corp. of America v. State Bd. of Equalization*, *supra*, 19 Cal.4th at pp. 10-11; *Campbell v. Arco Marine, Inc*. (1996) 42 Cal.App.4th 1850, 1860.)

The DMHC promulgated a regulation, operative as of August 23, 2003, setting forth six factors to be considered when determining the method for reimbursing non-contracting providers, like Emergency Services, for health care services provided to the patient/subscribers. (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B).)[10] The fact that the DMHC adopted a six-part test to determine the rate for reimbursing non-contracted physicians strongly indicates that employing any sort of across-the-board rate mechanism, such as the Medicare rate, would be inappropriate. As explained above, although not binding, the regulations of the DMHC, which are the product of its quasi-legislative, rule-making authority, are entitled to great weight and deference. (*Yamaha Corp. of America v. State Bd. of Equalization, supra,* 19 Cal.4th at p. 11.)

Prospect concedes that any future fee disputes must be resolved pursuant to this newly promulgated six-part regulation. Prospect states, however, that the fees disputes in this case occurred prior to implementation of California Code of Regulations, title 28, section 1300.71, subdivision (a)(3)(B). Prospect suggests that it would be appropriate to require Emergency Physicians to charge the Medicare rate for services rendered prior to implementation of section 1300.71, subdivision (a)(3)(B), and to grant Prospect declaratory relief.

We reject this argument because in 2002 the DMHC opined as part of its rule-making authority that the Medicare rate was not appropriate. In 2002, the DMHC held a

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10 California Code of Regulations, title 28, section 1300.71, subdivision (a)(3) provides: " 'Reimbursement of a Claim' means: [¶] . . . [¶] (B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (1) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and [¶] (C) For non-emergency services provided by non-contracted providers to PPO and POS [subscribers]: the amount set forth in the [subscriber's] Evidence of Coverage."

public comment period on a number of newly proposed regulations concerning claims settlement practices and dispute resolution mechanisms. During the First Comment Period, a public comment stated: "Plans should be required to pay according to Medicare." (Comments to Title 28, Section 1300.71, Comment No. 3.) The DMHC responded that the proposed regulation does not "require consistency with Medicare [because of] the provider's concern that mandating payment consistent with the Medicare guidelines would result in mandatory acceptance of Medicare payment schedules." (Comments to Title 28, Section 1300.71, DMHC Response to Comment No. 3.)

During the second public comment period ending December 29, 2002, a public comment was submitted to the DMHC which stated: "Recommend that non-contracted provider claims be based solely on Medicare or Medicaid fee schedules." (Comments to Title 28, Section 1300.71, Comment No. 62.) The DMHC responded to this comment as follows: "REJECT: ***The Department recognizes that these government programs are not designed to reimburse the provider for the fair and reasonable value of the services rendered and are[,] therefore, an inappropriate criteria*****. [Italics added.]"**

In addition, as the DMHC explained in its rule-making process, the six-part test for determining what constitutes a reasonable fee has been the decisional law in California since *Gould v. Workers' Comp. Appeals Bd.* (1992) 4 Cal.App.4th 1059. Prospect has presented no authority to conclude otherwise.

Moreover, a statute pre-dating the *Gould* case, section 1317.2a, which was operative in 1987, requires "reasonable" compensation to be paid to certain transferring hospitals or physicians which provide emergency medical care services. (See § 1317.2a, subd. (d).)[11]

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[11] Section 1317.2a, subdivision (d), provides in pertinent part: "Any third-party payor, including, . . . [a] health care service plan, . . . which has a[n] . . . obligation to . . . indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation to the patient, *for the reasonable charges of the transferring hospital and the treating physicians for the emergency services*. [Italics added.]"

In *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211 (*Bell*), the court reached an analogous conclusion on related facts. The reasoning of the *Bell* court is persuasive.

There, plaintiff Bell, an emergency physician, did not have a pre-existing contractual relationship with Blue Cross, a health care service plan. Like Emergency Physicians in this case, Dr. Bell was required to treat patients without regard to insurance or ability to pay. (*Bell*, *supra*, 131 Cal.App.4th at p. 214.) Like Prospect in this case, Blue Cross was statutorily required to reimburse Dr. Bell for the emergency room services. (*Ibid*.)

Dr. Bell filed a class action lawsuit against Blue Cross asserting that Blue Cross had " 'a practice of paying non-participating emergency care providers arbitrary amounts that are substantially below the cost, value, and common range of fees for the services . . . the providers render.' " (*Bell*, *supra*, 131 Cal.App.4th at p. 214.)

The *Bell* court examined the following language of section 1371.4, subdivision (b), "health care service plan shall reimburse providers for emergency services and care provided to its [subscribers]," and rejected the assertion by Blue Cross that because the statute did not specify a rate, Blue Cross was free to reimburse emergency care providers at whatever rate it selected. (*Bell*, *supra*, 131 Cal.App.4th at p. 220.) The *Bell* court explained that Blue Cross's interpretation of section 1371.4, subdivision (b), allowing it to unilaterally determine rates, "would mean the emergency care providers could be reimbursed at a confiscatory rate that, aside from being unconscionable, would be unconstitutional. [Citations.] In short, the statute must be read to require *reasonable* reimbursement. [Italics added.]" (131 Cal.App.4th at p. 220.)

Based upon the foregoing, Prospect is required to reimburse Emergency Physicians a "reasonable" amount for the emergency services provided, whether the services occurred before or after implementation of California Code of Regulations, title 28, section 1300.71, subdivision (a)(3)(B). In addition, Prospect has failed to present any authority that this court can or should judicially determine that the Medicare constitutes an across-the-board "reasonable" rate for all emergency medical services

provided. Thus, Prospect is not entitled to a judicial declaration imposing an across-the-board Medicare rate upon Emergency Physicians.[12]

C. *Remand*

Prospect claims that trial court abused its discretion by denying its request for leave to amend the complaint. Prospect seeks the opportunity to litigate whether the rates charged by Emergency Physicians for particular emergency room services were reasonable. We agree.

By statute, Prospect is obligated to reimburse Emergency Physicians for emergency room services provided. (§ 1371.4, subds. (b) & (e).) Based upon this statutory obligation, Prospect must have a forum in which to contest whether Emergency Physicians have sought more than a reasonable rate for reimbursement for the emergency services.

The DMHC expressed the concern that rates unilaterally charged by providers of health care services, such as Emergency Physicians, may not constitute reasonable rates. In relation to proposed regulations concerning claims settlement practices, during the Second Comment Period ending December 29, 2002, the DMHC responded to one public comment (Comment No. 63) as follows: "However, emergency services are to be compensated at reasonable and customary value. Provider's usual charges are not determinative of the fair and reasonable value of the services rendered." (Comments to Title 28, Section 1300.71, DMHC Response to Comment No. 63.)

In *Bell, supra,* 131 Cal.App.4th 211, the court reached a similar conclusion. As noted above, in that case Dr. Bell was an emergency physician who did not have a pre-existing contractual relationship with Blue Cross, a health care service plan. The *Bell* court concluded that Dr. Bell had standing and could proceed with a lawsuit against Blue

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[12] We do not intend by this opinion to prohibit Prospect from asserting with respect to a particular fee dispute involving a specific injury or medical diagnosis that the Medicare rate was the reasonable rate. Instead, we conclude that Prospect is not entitled to declaratory relief requiring Emergency Physicians to charge the Medicare rate as an across-the-board rate.

Cross to contest the amount of the reimbursement. (*Id*. at pp. 217-219.) The *Bell* court explained that the jurisdiction of the DMHC was not exclusive and that "there is nothing in section 1371.4 or in the [Knox Keene] Act generally to preclude a private action under the [Unfair Competition Law] or at common law on a quantum meruit theory." (131 Cal.App.4th at p. 216.)

The *Bell* court also noted that as a matter of administrative policy, the DMHC had consistently concluded that providers of health services, like Emergency Physicians, can seek redress in court in a dispute with a plan's determination of the reasonable and customary value of the services rendered. (*Bell*, *supra*, 131 Cal.App.4th at pp. 217-218.)

Based upon the foregoing, given that emergency care service providers, like Dr. Bell, have standing to litigate whether a health care services plan (or its delegate) is reimbursing too little, a delegate, like Prospect, must be able to litigate whether providers of health services, including emergency services, are charging a reasonable rate.

Therefore, we conclude that a delegate like Prospect, which is statutorily obligated to pay for emergency services, must be permitted to contest the reasonableness of the reimbursement amounts charged by Emergency Physicians. On remand, we do not mean to bar Prospect from alleging other theories or causes of action not expressly precluded by this opinion.

DISPOSITION

The trial court judgments dismissing Prospect's cause of action for declaratory relief is reversed. On remand, Prospect may amend the complaints to litigate whether Emergency Physicians charged more than a reasonable rate for a specific medical procedure.

We affirm the trial court judgments denying Prospect's claim for declaratory relief to require Emergency Physicians to charge no more than 100 percent of the Medicare rate as an across-the-board rate.

We also affirm the trial court judgments dismissing Prospect's second cause of action for alleged violations of section 17200 of the Business and Professions Code based upon the practice of balance billing patient/subscribers.

The action is remanded to the trial court for proceedings consistent with this opinion. Each party to bear its own costs on appeal.

TO BE PUBLISHED IN THE OFFICIAL REPORTS

KITCHING, J.

We concur:

CROSKEY, Acting P. J.

ALDRICH, J.