APPELLATE CASE SUMMARIES

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CMA's standing to sue health insurer under the UCL based on diverting resources to oppose a business practice presents a triable issue

California Medical Association v. Aetna Health of California Inc. (July 17, 2023) __ Cal.5th __ [2023 WL 4553703]

Insurer Aetna Health of California implemented a policy that threatened to terminate in-network providers' contracts for referring patients to out-of-network providers. The California Medical Association (CMA) sued Aetna, alleging it violated the unfair competition law (UCL) (Bus. & Prof. Code, § 17200 et seq.) by unlawfully interfering with the medical judgment of physicians. The UCL permits a claim by a private plaintiff who "suffered injury in fact and has lost money or property" that was "a result of the unfair competition." (Bus. & Prof. Code, § 17204.) Aetna moved for summary judgment, arguing that CMA lacked UCL standing because it had not lost money or property as a result of Aetna's policy, and the policy applied to physicians, not to CMA. CMA opposed summary judgment, arguing that it diverted resources (primarily staff time) in response to the policy. The trial court granted Aetna's summary judgment motion on standing grounds, ruling that CMA's diversion of resources was not a sufficient "injury in fact." The Court of Appeal affirmed, and the Supreme Court granted review.

The Supreme Court reversed, holding that CMA raised triable issues as to the UCL standing requirements. The Court explained that an organization's diversion of paid staff time and other resources may result in lost "money or property" and thus satisfy the UCL's "injury in fact" requirement. The Court concluded that CMA used staff time to respond to Aetna's policy when it could have used that time for other projects. The Court also held that an organization claiming injury for diverting resources must show that the defendant's actions threatened the organization's preexisting mission, causing it to use resources to address the threat before preparing for litigation. Here, there was a triable issue whether CMA diverted resources in response to a perceived interference with physicians' medical independence and thus public health (both objects of CMA's mission). The Court reasoned that allowing CMA to sue based on its diversion of resources did not subvert the injury requirement or risk abuse of the UCL because CMA is a bona fide organization with an interest in public health, not an organization created for the purpose of litigation.

State-law tort and statutory claims against health insurer are expressly preempted by Medicare Part C

Quishenberry v. UnitedHealthcare, Inc. (July 13, 2023) __ Cal.5th __ [2023 WL 4511572]

Larry Quishenberry's father was insured under Medicare Part C, a federal program that subsidizes the cost of private healthcare plans for beneficiaries. Quishenberry's father was hospitalized for a broken hip, then transferred to a skilled nursing facility where he developed severe pressure sores that were not properly treated. He died after discharge. Quishenberry sued his father's health insurer and the healthcare services

administrator who managed his father's Medicare Advantage (MA) benefits, alleging state common law claims of negligence and wrongful death, and a claim under California's Elder Abuse Act. Quishenberry claimed the insurer and administrator breached their duty to ensure his father received the skilled nursing benefits to which he was entitled under his healthcare plan as outlined by Medicare Part C and federal regulations. The trial court sustained defendants' demurrers, ruling that Quishenberry's state-law claims were preempted by Medicare Part C's preemption provision. The Court of Appeal affirmed. Quishenberry obtained review in the California Supreme Court.

The Supreme Court affirmed. It explained that preemption may be either express or implied, to the extent federal and state laws conflict in addressing the same rights or restrictions. Medicare Part C's express preemption provision states that the "standards established under" Part C "shall supersede any State law or regulation" concerning MA plans. (42 U.S.C. § 1395w26(b)(3).) Accordingly, state-law standards that duplicate federal standards are preempted because the express preemption provision covers "any" duty affecting MA plans, regardless of whether they are based on federal standards. Such language contrasts with other federal laws that explicitly preempt state-law standards that "differ" from federal standards. Overruling prior appellate decisions, the Court held that the phrase "*any* State law or regulation" covers both statutory *and common law duties*, so that claims based on duties found in the Elder Abuse Act are preempted. It explained that the phrase "with respect to MA plans" covers both statutory and regulatory provisions referencing MA plans *as well as* generally applicable state law duties allowing regulation of MA plans. Finally, the Court held that section 1395w26(b)(3) preempted all of Quishenberry's claims because a trier of fact considering those claims would have to decide whether the insurer and plan administrator denied treatment that his father was entitled to receive under Medicare Part C and relevant federal regulations.

Federally qualified health center's educational outreach expenses are reimbursable under Medi-Cal

Family Health Centers of San Diego v. State Dept. of Health Care Services (July 24, 2023, S270326) __ Cal.5th __ [2023 WL 4697232].

Federally qualified health centers (FQHCs) receive federal funding to provide basic health care to underserved communities regardless of patients' ability to pay. Federal law requires FQHCs to educate underserved communities about obtaining needed healthcare. States must fully reimburse FQHCs for the costs of providing medical assistance to Medicaid beneficiaries that are "reasonable and related to the cost of furnishing such services." Family Health Centers of San Diego, which operates several FQHCs, sought reimbursement from the state Medicaid program, Medi-Cal, for outreach expenses, such as sending workers into the community to provide information about available healthcare services. An auditor at the State Department of Health Care Services (DHCS), which administers Medi-Cal, determined that these outreach expenses were nonreimbursable advertising expenses. Family Health administratively appealed, but an administrative law judge (ALJ), relying on the federal Centers for Medicare & Medicaid Services' Provider Reimbursement Manual (Manual), ruled the outreach expenses were nonreimbursable because they did not involve patient care and were advertising aimed at patient recruitment.

Family Health filed a petition for writ of administrative mandamus, which the superior court denied. Family Health appealed. The Court of Appeal affirmed, holding that the ALJ did not abuse its discretion by finding that Family Health's outreach expense had the purpose of recruiting new patients and increasing utilization of the FQHC, making it a nonreimbursable advertising expense under the Manual. The Supreme Court later granted Family Health's petition for review.

The Supreme Court reversed and remanded for further proceedings. The court found nothing in the Manual or regulatory scheme established that outreach costs are nonreimbursable merely because they have the incidental effect of recruiting new patients and increasing utilization of FQHCs. To determine whether an outreach expense is "reasonably related, directly or indirectly, to patient care" requires distinguishing between costs associated with *educating* the public and public relations activities

designed to present a positive public image regarding patient care (which are reimbursable) and *advertising* costs designed to generate revenue by convincing patients to seek care at a particular facility, rather than its competitors (which are nonreimbursable). Here, the ALJ failed to apply that standard, so the court reversed and remanded to allow the DHCS to reconsider the reimbursability of Family Health's outreach expenses under the correct standard.

Personal representative could not compel production of a minor's medical records without proving they were withheld in bad faith

Vilches v. Leao (July 28, 2023, A163638) __ Cal.App.5th __ [2023 WL 4839283]

Frank Vilches, the guardian of his minor daughter, hired therapist Michelle Leao to treat his daughter. Vilches later requested copies of his daughter's therapy records. Leao denied the request based on her determination that releasing the records would adversely affect the daughter's well-being and the patient-counselor relationship. Vilches sued, alleging that Leao violated Health and Safety Code section 123110, which grants a minor's personal representative access to patient records. Vilches sought injunctive relief directing Leao to release the requested records and an award of attorney fees, but did not seek damages. Leao moved for summary judgment on the ground that she made the statutory determination required to prevent disclosure of the records under section 123115, subdivision (a)(2), an exception to the right of access in section 123110. The trial court granted Leao's motion, and Vilches appealed.

The Court of Appeal affirmed. The court explained that the right of access to patient records in section 123110 is subject to the exception in section 123115, subdivision (a)(2), which allows healthcare providers to deny access if it would detrimentally affect the minor. The court held, as a matter of first impression, that a representative seeking to compel disclosure must establish that the provider acted in bad faith in denying access. Here, Leao presented uncontradicted evidence that her decision to block access was based on her clinical judgment that disclosure would have a detrimental effect on the minor daughter's well-being, particularly if Vilches used the notes to "coach" his daughter for an upcoming custody proceeding. The court rejected Vilches' argument that the section 123115 exception applied only to actions seeking damages, construing it to apply equally to actions seeking injunctive relief. The court also declined to second-guess Leao's clinical judgment: "untrained members of the judiciary should not be second-guessing the clinical judgment of therapists concerning their minor patients' well-being and the patient-counselor relationship."

Hospital's failure to provide pretreatment disclosure of emergency medical evaluation fees beyond what is required by statute is not actionable

Moran v. Prime Healthcare Management, Inc. (Aug. 7, 2023, G060920) __ Cal.App.5th __, 2023 WL 5012110

Gene Moran received emergency care at a Prime Healthcare hospital and was charged an emergency room evaluation and management services (EMS) fee in addition to the charges for treatment provided. The fee was listed in the hospital's published chargemaster, as required by state and federal statutes, but was not further disclosed at the time of treatment. Moran sued Prime, alleging that its failure to disclose the EMS fee violated the Unfair Competition Law (UCL) and the Consumer Legal Remedies Act (CLRA) because the fee was effectively hidden from patients who might otherwise seek cheaper treatments. Prime moved to strike, arguing that there was no duty to disclose the fees beyond the requirements of state and federal regulations. The trial court granted the motion and Moran appealed.

The Court of Appeal affirmed. The court observed that several recent opinions addressed UCL and CLRA claims regarding EMS fees, including *Naranjo v. Doctors Medical Center of Modesto, Inc.* (2023) 90 Cal. App.5th 1193, which the Supreme Court accepted for review on July 26, 2023. Most of these cases held either that hospitals had no duty to disclose beyond state and federal regulatory requirements, or that the plaintiff failed to adequately allege reliance under the CLRA. *Naranjo* was the only decision allowing the plaintiff's claim to proceed on the merits. *Naranjo* held that the hospital's exclusive knowledge of its EMS fee, which was not reasonably accessible to the patient, led to an actionable claim under the CLRA and UCL. But the *Moran* court declined

to follow *Naranjo*, and instead followed the majority rule—disclosing chargemaster rates under applicable statutes and regulations forecloses a duty to make additional pretreatment disclosure of the EMS fee. The court explained that numerous state and federal rulemaking bodies have developed an extensive statutory and regulatory scheme to provide price transparency for medical services while avoiding price disclosure requirements that might dissuade patients from receiving urgently needed treatment due to cost. Accordingly, Moran's claims were not actionable under the UCL. In addition, Moran failed to allege a viable CLRA cause of action because the hospital did not conceal its EMS fee (it was in the published chargemaster), and because Moran failed to adequately plead reliance (given the severity of his medical emergencies, there was no reasonable inference that disclosing the EMS fee would have caused him to seek treatment elsewhere).

Health plan's duty to transport conservatee to psychiatric facility for assessment and evaluation is triggered by an authorized professional's custodial determination, not by the conservator's demand

Rhonda S. v. Kaiser Foundation Health Plan (July 28, 2023, B318650) __ Cal.App.5th __ [2023 WL 5318406], ordered published Aug. 18, 2023

Rhonda S. was appointed as the conservator of her adult son (David, who suffers from schizophrenia) under the Lanterman-Petris-Short Act (LPS; Welf. & Inst. Code, § 5350). Both Rhonda and David are Kaiser HMO health plan enrollees. When David's condition worsened, Rhonda asked his psychiatrist to order David transported to a Kaiser facility for admission and treatment, but the psychiatrist declined to do so. Kaiser declined Rhonda's request as "not medically necessary" because no doctor had evaluated David and validated Rhonda's concerns. Kaiser suggested that Rhonda arrange an evaluation by the Psychiatric Mobile Response Team, but Rhonda did not do so. David continued to decline until he was apprehended by police and placed under a LPS section 5150 involuntary hold. Rhonda sued Kaiser seeking a declaration of its obligations to transport and accept for assessment and evaluation conservatees like David upon the conservator's demand. The trial court sustained Kaiser's demurrer, and Rhonda appealed.

The Court of Appeal affirmed. The court rejected Rhonda's argument that section 5150, subdivision (a), required Kaiser to transport and admit David for an assessment and evaluation. The statutory language is permissive, not mandatory, and provides that authorized persons (peace officers and designated professionals) "may, upon probable cause, take . . . the person into custody . . . for assessment, evaluation, and crisis intervention." Kaiser's statutory obligation to perform a minimum assessment and evaluation was not triggered here because no authorized person exercised professional judgment to recommend taking David into custody. Rhonda lacked authority to trigger these statutory requirements. Finally, the court rejected Rhonda's contention that Kaiser had a per se obligation to pay for David's ambulance transportation, assessment, and evaluation whenever she requested it, explaining that Kaiser's obligation arises only when an "Emergency Medical Condition" exists and such a condition is not presumed to exist merely because David had been adjudicated to have a grave disability.

Medical screening business can be liable (as an employer's agent) for FEHA violations.

Raines v. U.S. Healthworks Medical Group (Aug. 21, 2023, S273630) __ Cal.5th __ [2023 WL 4697232]

Kristina Raines was offered employment contingent upon a medical screening by U.S. Healthworks Medical Group (USHW), an agent of her future employer. After she responded to all but one question on an extensive health history questionnaire, USHW terminated the exam. Raines's employment offer was revoked as a consequence. Raines sued USHW in federal court for violating California's Fair Employment and Housing Act (FEHA), which states it is an "unlawful employment practice" for "any employer" "to make any medical or psychological inquiry of an applicant." (Gov. Code, § 12940.) FEHA defines an employer to include "any person acting as an agent of an employer." (*Id.*, § 12926, subd. (d).) In context, these provisions could be read two ways: (1) that liability for violating the statute resides with the employer, not the agent; or (2) that an employer's agents are liable to the same extent as the employer. The district court concluded that FEHA

did not impose liability on USHW. Raines appealed to the Ninth Circuit, which asked the California Supreme Court to resolve whether, under the FEHA, a business entity acting as an agent of an employer may be directly liable for employment discrimination.

The California Supreme Court answered the Ninth Circuit's question in the affirmative—agents such as USHW may be directly liable for FEHA violations in appropriate circumstances. The Court construed section 12926 to mean that an agent of an employer counts as an "employer" under FEHA. The Court found further support for its interpretation in FEHA's legislative history, which showed that the Legislature borrowed from National Labor Relations Act provisions interpreted to impose employer status on certain employer agents. Consulting analogous federal decisions regarding antidiscrimination laws, the Court determined that a business-entity agent could bear direct FEHA liability only when it carried out FEHA-regulated activities on behalf of an employer. The Court further reasoned that public policy supported its construction: extending FEHA liability to the business entity most directly responsible for the violation furthers FEHA's remedial purpose. Finally, the Court distinguished its earlier opinions holding that *individual* employees of the same employers are *not* subject to FEHA liability. The rationale for those opinions did not apply to a business entity employing five or more employees that carries out FEHA-regulated activities on behalf of an employer.

Insurer's delivery to the patient of a check payable jointly to the patient and a hospital in the amount of the hospital's lien fails to satisfy the lien.

Long Beach Memorial Medical Center v. Allstate Ins. Co. (Sept. 19, 2023, B321876) __ Cal.App.5th __ [2023 WL 6115891]

Long Beach Memorial Medical Center (Medical Center) treated Vernon Barnes for injuries he suffered in a car accident. Barnes submitted a personal injury claim to Allstate, which insured the driver who Barnes claimed was at fault for the accident. The Medical Center notified Allstate that it was asserting a $116,714.67 lien against Barnes' recovery under the Hospital Lien Act (HLA). Barnes and Allstate settled the claim for $300,000. Allstate sent Barnes a check payable jointly to Barnes and the Medical Center for the entire lien amount, in addition to another check payable to Barnes and his attorney. The check payable to Barnes and the Medical Center for $116,714.67 was never deposited and eventually expired. The Medical Center sued Allstate, alleging that it violated the HLA (Civ. Code, §§ 3045.1–3045.6) by settling with Barnes without satisfying its lien. The trial court granted Allstate's motion for summary judgment, ruling that Allstate's tender of a check to Barnes payable to Barnes and the Medical Center satisfied its obligations under the HLA. The Medical Center appealed.

The Court of Appeal reversed, holding that Allstate's delivery to Barnes of a check payable to Barnes and the Medical Center for the amount of the hospital lien failed to satisfy its duty under the HLA to satisfy the lien before settling with Barnes. The court noted that, while Allstate may have "constructively delivered" the check to the Medical Center, that did *not* mean that Allstate *actually* made a "payment" to the Medical Center as required under the HLA. The court rejected Allstate's argument that the Medical Center suffered no harm. The court reasoned that "including Barnes as [a] co-payee [on the check] . . . empower[ed] him to negotiate keeping some portion of the amount of the Medical Center's lien for himself. The HLA does not condition the hospital's right to payment on the timing or resolution of a negotiation between the patient and the hospital."

Providers have no private right of action under the CARES Act to enforce health insurers' payment obligations

Saloojas, Inc. v. Aetna Health of Cal., Inc., 80 F.4th 1011 (9th Cir. 2023)

Saloojas, Inc. provides COVID-19 diagnostic testing at a list price published on its website. Aetna is a health insurer that provides COVID-19 tests to its insureds under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Saloojas is not in Aetna's network, so there is no negotiated reimbursement rate for the COVID-19 tests it provides to Aetna's insureds. Saloojas sued Aetna under § 3202(a)(2) of the CARES Act, alleging Aetna paid less than Saloojas's posted cash price for the tests Aetna provided to its insureds. Saloojas sought reimbursement for the difference between what Aetna paid and the full price listed on Saloojas's website. The district

court dismissed Saloojas' complaint, ruling that it had no private right of action under the CARES Act against insurers for violation of § 3202. Saloojas appealed.

The Ninth Circuit affirmed. The court observed that the CARES Act did not expressly create a private right of action, and rejected Saloojas's argument that it had an implied private right of action to seek reimbursement for the full price of its COVID-19 tests. Although the CARES Act states that when there is no negotiated rate an insurer "shall reimburse" the provider for diagnostic testing "in an amount that equals the cash price . . . as listed by the provider," the court explained that such mandatory language alone does not create an implied private right of action. For an implied right of action to exist, there must be "'rights-creating language' that places 'an *unmistakable* focus' on the individuals protected instead of the person regulated." Here, the CARES Act focuses on the regulated party (the insurers), and refers to the providers only as the object of the insurers' obligation. "Accordingly, § 3202(a)(2) of the CARES Act does not contain rights-creating language that would evince Congress's intent to create a private right of action for providers to sue insurers." The court further noted that §3202(b) of the CARES Act includes an enforcement mechanism that is limited to actions by the Secretary of Health and Human Services, which "cuts strongly against a finding of intent to create a private remedy for . . . providers."

MICRA's limitation period applies to third-party's vehicular negligence claim against ambulance driver transporting patient.

Gutierrez v. Tostado (Dec. 1, 2023, H049983)__ Cal.App.5th __ [2023 WL 8296004]

Francisco Gutierrez was rear-ended by an ambulance driven by Uriel Tostado—an emergency medical technician—who was transporting a patient between medical facilities. Nearly two years later, Gutierrez sued Tostado and his employer, a medical transportation company, for negligence. Tostado moved for summary judgment on the ground that Gutierrez's claims were barred by the one-year statute of limitations in MICRA. The trial court granted the motion, and Gutierrez appealed.

The Court of Appeal affirmed in a split decision. Following *Lopez v. American Medical Response West* (2023) 89 Cal.App.5th 336 and *Canister v. Emergency Ambulance Service, Inc.* (2008) 160 Cal.App.4th 388, the majority held that the MICRA limitations period barred Gutierrez's negligence claim because Tostado was a medical provider rendering professional services at the time of the accident. The court explained that MICRA applies to any "negligent act or omission to act by a health care provider in the rendering of professional services." (Code Civ. Proc., § 340.5, subd. (2).) Accordingly, MICRA applied because Gutierrez was injured by Tostado's alleged negligent driving of an ambulance transporting a patient: "transporting a patient in an ambulance qualifies as the provision of medical care . . . [and] driving the ambulance is an integral part of that care." Moreover, the fact that Gutierrez was a third party not receiving medical care was irrelevant because MICRA is not limited to lawsuits by patients or recipients of medical services. The majority reasoned that it would be anomalous if different limitations periods applied to a patient and a third party who were both injured in the same accident.

The dissenting opinion criticized the majority for not following *Lee v. Hanley* (2015) 61 Cal.4th 1225, which construed the legal malpractice limitations period in Code of Civil Procedure section 340.6. *Lee* held that section 340.6 applied only where the attorney violated a professional obligation, rather than a generally applicable nonprofessional obligation. The *Lee* dissent would have held that section 340.6 applied to all negligence claims against an attorney performing professional services, and the dissenting justice in *Gutierrez* faulted the majority for applying the reasoning of the dissent in *Lee*. The *Gutierrez* dissent would apply the same distinction between professional and nonprofessional negligence to the MICRA limitation period that the *Lee* majority adopted. The dissent also reasoned that "it is neither impermissible nor impractical" to apply MICRA's limitations period to some but not all claims involving the same conduct.