By Sarah G. Benator, Esq.,
Patricia M. Kosich, Esq.,
Nathaniel M. Lacktman, Esq.,
with contributions by
Jeffrey R. Bates, Esq.,
of Foley & Lardner LLP

HEALTH PLANS ARBITRATION

Failure to comply with the arbitration disclosure requirements under Health & Safety Code Section 1363.1 renders an arbitration agreement unenforceable.

Petitioner Mark Zembsch was employed by the City of Berkeley and eligible for group health insurance coverage under a group hospital and professional service agreement between the city and Health Net of California ("Health Net"). On May 9, 2002, Zembsch signed a form enrolling himself, his wife, and his two children in a Health Net HMO plan. Alta Bates Medical Group ("Alta Bates") was the contracting physician group for the Zembsch family's plan. Health Net's plan permitted members to receive a standing referral to a specialist without first receiving a specific referral from the member's primary care physician for each visit. A standing referral is authorized by the plan if it is determined to be necessary by the primary care physician, Health Net's medical director, and the member.

The enrollment form Zembsch signed when he joined the Health Net plan was a one-page document titled, "Member Enrollment and Change Form." Beneath a boldface black line at the very bottom of the page were two single-spaced, unindented paragraphs printed in the smallest typeface used on the form. The first and longer paragraph concerned the enrollee's authorization for the release of medical information. Immediately above the signature line, the following paragraph appeared: "Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and Health Net, Health Net Life Insurance Company or any Participating Physician Group/Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration."

The Zembschs' five-year-old son suffered from a rare, life-threatening condition known as metatropic dysplasia. Because very few physicians have any substantial experience in treating the disease, the Zembschs sought a standing referral to the leading expert in the field. Alta Bates denied the Zembschs' request because the specialist was an out-of-network provider and Alta Bates determined that the services requested were available within the Alta Bates Medical Group Network. The Zembschs filed multiple appeals of Alta Bates' decision, all of which Health Net denied. The Zembschs filed an action against Health Net and Alta Bates in Superior Court, and later filed an amended complaint alleging breach of contract and a number of other causes of action arising from the defendants' alleged refusal to honor obligations under the Health Net plan.

Both Health Net and Alta Bates moved to compel arbitration and stay the action. The Zembschs opposed the motions, contending that the arbitration disclosure on Health Net's enrollment form failed to comply with Health & Safety Code Section 1363.1 ("Section 1363.1"), which requires arbitration disclosures to be "prominently displayed." The trial court concluded that the disclosure did not violate Section 1363.1(b) and granted defendants' motions to compel arbitration. The Zembschs filed a petition for writ of mandate seeking review of the trial court's order.

The California Court of Appeal granted the Zembschs' petition, holding that Health Net and Alta Bates could not compel arbitration of an insurance coverage dispute because Health Net's arbitration disclosure failed to substantially comply with the statutory requirements of Section 1363.1. Therefore, the arbitration provision was unenforceable. The Court found that the Health Net enrollment form failed to comply with Section 1363.1(b), which provides that health care service plans that require binding arbitration must provide a disclosure of arbitration "prominently displayed on the enrollment form signed by each subscriber or enrollee." The Court found that Health Net's enrollment form did not comply with the statutory requirement because the arbitration disclosure was not prominently displayed. The Court gave several reasons for its finding: The language did not stand out or project beyond a surface or line and was not readily noticeable. It was printed in the same font as most of the enrollment form. The disclosure heading actually appeared to be in faint boldface type. It was the second of two single-spaced paragraphs of small, condensed type

located at the bottom of the enrollment form. Neither the disclosure nor the preceding paragraph was indented, and the two paragraphs were not separated from each other by any lines or spacing. The disclosure was in the same font as the preceding paragraph, and was not bolded, underlined or italicized. The Court noted that in contrast, some of the other text on the form was printed in boldface type, in all capitals or in larger fonts, so Health Net could have made the disclosure's text more prominent had it chosen to do so. The Court cited other case law where the disclosure language was more prominent than in Health Net's form, and where the courts still found that those disclosures failed to comply with Section 1363.1(b).

The Court next found that the purpose of Section 1361.1 was to safeguard against enrollees unknowingly waiving their constitutional right to a jury trial. Health Net's failure to display the disclosure language with the prominence required by statute cast doubt on whether the Zembschs knowingly waived their rights and consented to arbitration. The Court rejected Health Net's argument that the arbitration agreement may be enforced despite the statutory violation because, according to Health Net, the only remedies for violations of Section 1363.1 are the administrative remedies contained in the Knox-Keene Act and enforced by the Department of Managed Care. The Court instead held that the administrative remedies in the Knox-Keene Act are not exclusive and that Health Net's noncompliance with Section 1361.1 rendered the arbitration provision unenforceable. The Court of Appeal issued a peremptory writ of mandate directing the trial court to vacate its order compelling arbitration and to enter a new order denying Health Net's motion to compel arbitration. The court also awarded recovery of costs to the Zembschs.

Zembsch v. Superior Court,
146 Cal. App. 4th 153 (2006).

CONFIDENTIALITY

When a patient sues, or threatens to sue, a health plan for medical malpractice, the plan may disclose the patient's entire medical record to its defense attorneys without obtaining the patient's consent for such disclosure.

The California Consumer Health Care Council ("CCHCC"), a California nonprofit public benefit corporation representing California health care consumers, sued on behalf of the general public to enjoin Kaiser Foundation Health Plan's ("Kaiser") practice of transmitting to its attorneys allegedly irrelevant medical information concerning Kaiser patients who were either making or contemplating making medical malpractice claims against Kaiser. CCHCC alleged that Kaiser (1) discloses medical information regarding patients without first obtaining the patient's authorization or otherwise being authorized to do so under the law; (2) shares, sells or otherwise uses medical information regarding such patients for a purpose not necessary to provide health care services to the patients; and (3) conceals these practices from patients. CCHCC further alleged that whenever a patient makes a legal claim against Kaiser, Kaiser uses and discloses "all of the patient's medical information ... including medical information which is irrelevant to the patient's claim." According to CCHCC, Kaiser's alleged practices are unlawful under the California Business and Professions Code Sections 17200 *et seq.* (California's Unfair Competition Law ("UCL")) because they violate California Civil Code Sections 56 *et seq.*, the Confidentiality of Medical Information Act ("CMIA"), as well as the affected patients' State constitutional right to privacy. CCHCC further alleged the challenged conduct (1) is unfair because the harm to patients outweighs the "utility" of Kaiser's acts and practices; (2) is fraudulent because Kaiser has made representations that it uses and discloses patient medical information only in accordance with the law; and (3) renders untrue and misleading Kaiser's advertising regarding its alleged protection of confidential patient information.

The trial court sustained Kaiser's demurrer without leave to amend after finding that the conduct alleged was not unlawful under the UCL because it did not violate the CMIA or the California constitution. The court further found that, in the absence of any alleged unlawful conduct, CCHCC failed to state a UCL cause of action based on unfair or fraudulent conduct or a cause of action for false advertising. Finally, the trial court held that the challenged practices were, in fact, authorized by the CMIA. CCHCC appealed the trial court's decision.

The California Court of Appeal affirmed the trial court's dismissal. The Court held that Kaiser may disclose a patient's entire medical record to its attorneys to defend against a patient's threatened or filed medical malpractice claim, without first obtaining the patient's consent, and that such disclosures do not violate the patient's right to privacy under the California constitution, do not violate the UCL, and do not violate the CMIA. The Court specifically found that Kaiser's conduct satisfies the express exception set forth in Section 56.10(c)(4) of the CMIA, which authorizes the disclosure of medical information regarding a patient to persons defending professional liability matters on behalf of a provider. The Court rejected CCHCC's argument that Kaiser shared more patient information than was necessary for defending against liability claims. The Court noted that unlike several other enumerated exceptions in Section 56.10(c), subsection (4) does not include disclosure parameters which limit the extent to which patient information may be provided for defense of liability claims. The Court concluded that the absence of

such limitations in Section 56.10(c)(4) evidences the legislature's intent to allow full disclosure between a provider and its counsel. The Court highlighted that such restrictions would have created an intolerable barrier between healthcare organizations and their attorneys, emphasizing that attorneys must have access to a wide variety of information about a case in order to prepare legal theories and strategies. The Court also rejected CCHCC's claim that Kaiser's disclosure practices violated a patient's constitutional right to privacy, reasoning that a patient who puts at issue his medical condition and his relationship with the provider has no reasonable expectation of privacy.

The Court also affirmed the trial court's finding that Kaiser's practices do not violate the UCL, and further found that Prop 64 precluded CCHCC from bringing this action. The Court explained that Prop 64 amended the UCL such that claims can no longer be brought on behalf of the general public. Instead, Prop 64 limited the parties who can bring claims under the UCL to (1) certain public prosecutors; (2) persons who have suffered injury in fact and lost money or property as a result of unfair competition; and (3) persons who pursue a class action suit which meets the requirements of California Code of Civil Procedure Section 382. Prop 64, therefore, precludes CCHCC's authority to maintain the UCL action against Kaiser because CCHCC sued on behalf of the general public and did not represent an actual Kaiser patient who was, or likely would be, injured by Kaiser's practices.

California Consumer Health Care Council v. Kaiser Foundation Health Plan, Inc., 47 Cal. Rptr. 3d 593 (2006).

LABOR RELATIONS

The National Labor Relations Board must consider evidence of anti-union animus when reviewing a hospital's decision to outsource the provision of services when the outsourced department is the subject of union organizing activities, and must not consider the ultimate outcome of such outsourcing.

St. Vincent Medical Center ("St. Vincent") is an acute care hospital. Before subcontracting out the work of the Respiratory Care ("RC") Department in February 2000, St. Vincent employed 27 RC therapists. In July 1999, the Healthcare Employees Union, Local 399, affiliated with the Service Employees International Union ("Union"), began a campaign to organize St. Vincent's technical staff, including the RC therapists. St. Vincent officials were aware of the Union's activity at the hospital. On January 5, 2000, the Union filed a petition for an election with the NLRB for the bargaining unit of one hundred technical staff employees, which included the 27 RC therapists. St. Vincent officials were aware that RC Department employees were the core of the Union's supporters among St. Vincent's employees. On January 21, 2000, the parties stipulated to an election to be conducted by the NLRB on February 18, 2000.

During the time that the Union engaged in its organizing activities, St. Vincent initiated a review of the RC Department, including an analysis of whether the department should be outsourced to an independent provider. The performance of the RC Department had been among the lowest at St. Vincent for over 13 years. Although the root problems of the RC Department were attributed to the RC Department management, St. Vincent officials concluded that the entire department should be contracted out in order to avoid dividing the accountability of the RC Department staff and management. On January 3, 2000, St. Vincent contacted outside RC providers and began soliciting proposals for outsourcing the RC Department. Two companies joined together and submitted a combined proposal because neither company by itself was able to begin work by February 15, 2000, the start date St. Vincent required. According to St. Vincent representatives, outsourcing the RC Department was a business decision motivated by concerns about quality issues. Although the proposal was open until March 26, 2000, St. Vincent officials agreed to the proposal on January 26, 2000, the same day it was received. St. Vincent representatives acknowledged that they knew about the Union's election scheduled for February 18, 2000, when they made their final decision to outsource the RC Department. St. Vincent notified the RC Department employees about the outsourcing decision on February 1, 2000. St. Vincent also informed them that the outsourcing would take effect on February 5, 2000, at which time no RC Department employees would be employed by St. Vincent; rather, they would be employed by the new contractor. On February 2, 2000, the Union filed an unfair labor practice claim against St. Vincent with the NLRB.

NLRB General Counsel ("General Counsel") issued a complaint against St. Vincent on March 22, 2000. St. Vincent denied the allegations and alleged as an affirmative defense that its contracting decision was based on valid business reasons unrelated to the Union organizing effort. In the administrative hearing on the matter, the Administrative Law Judge ("ALJ") found that the alleged motivation behind

St. Vincent's outsourcing decision lacked plausibility and noted that "on its surface it appeared to be a fabrication, and not a very good one at that." The ALJ credited the General Counsel with "clear evidence" that St. Vincent knew that the RC Department was the core of the Union's organizing drive, and that the Union's organizing campaign burgeoned in July 1999. The ALJ also concluded that the timing of the outsourcing militated in favor of the General Counsel. Notwithstanding these findings, the ALJ reluctantly found in favor of St. Vincent based on the fact that the RC Department's longstanding problems were eliminated shortly after the department was outsourced and that the General Counsel therefore failed to meet his burden of persuasion that St. Vincent was motivated by anti-union animus. The General Counsel appealed the ALJ's decision to the NLRB.

In its decision, the NLRB affirmed the ALJ's rulings and findings and found further that pursuant to the decision in *Wright Line*, 251 N.L.R.B. 1083, *enforced*, 662 F.2d 899 (1st Cir. 1981), St. Vincent had established that regardless of the Union activities involving the RC Department, it would have taken the action anyway. Specifically, St. Vincent implemented its contracting decision within the 30-to-60-day timeframe that it had announced. The Union petitioned for review of the NLRB's decision.

The United States Ninth Circuit Court of Appeals held that the NLRB disregarded substantial evidence of anti-union animus by St. Vincent when it held that the hospital's outsourcing of its RC Department was based on a legitimate business purpose and did not violate the National Labor Relations Act. The Court further held that the NLRB improperly considered the ultimate positive business effects that such outsourcing had on the RC Department and erroneously concluded that the business purpose for outsourcing mitigated the effects of any anti-union animus.

First, the Court found that the General Counsel met his burden when he established that St. Vincent harbored anti-union animus when it outsourced the RC Department. The Court reasoned that Section 8(a)(3) of the National Labor Relations Act, 29 U.S.C. Section 158(a)(3), prohibits an employer from discriminating against employees "in regard to hire or tenure of employment ... to discourage membership in any labor organization." The Court identified circumstantial evidence that it found amply established that St. Vincent harbored anti-union animus. For example, the head of St. Vincent's human resources department directed hospital managers to monitor all Union activity. Further, St. Vincent managers and the president testified that they knew about the impending Union election when the outsourcing decision was made. Moreover, the Court found the timing of the outsourcing decision raised an unmistakable inference of animus because St. Vincent's outsourcing decision disenfranchised RC Department employees, who comprised 25 percent of those employees supporting unionization. The Court determined that the mere fact that St. Vincent implemented its contracting decision within its announced timeframe failed to overcome the strong circumstantial evidence of anti-union animus. The Court noted that St. Vincent's timing coincided with the Union's election activity of which St. Vincent was aware. The Court also rejected the ALJ's emphasis on the improvements in the RC Department after outsourcing as irrelevant to the question of whether St. Vincent harbored anti-union animus.

The Court also found evidence of pretext in St. Vincent's justification for outsourcing the RC Department as further evidence of its anti-union animus. Specifically, the Court noted that outsourcing the entire RC Department to avoid dividing the accountability of RC staff and managers was not achieved. Rather, the final joint outsourcing contract resulted in RC management employed by one of the contracting entities and RC staff employed by the other. Moreover, St. Vincent management testified that outsourcing RC staff was not necessary to remedy the problems which existed with RC Department management. Finally, the Court noted that St. Vincent made only vague reference to quality issues and never fully established why the department was outsourced. Therefore, the Court concluded that (1) the General Counsel presented unrebutted evidence concerning St. Vincent's knowledge of Union activity, (2) the timing of St. Vincent's decision raised a compelling inference of anti-union animus, (3) the ALJ mistakenly relied on post-contracting evidence to establish the rationale for the contracting decision, and (4) St. Vincent's business justification was unreliable, therefore raising the inference that its justification was merely a pretext for anti-union animus.

Next, the Court rejected the NLRB's conclusion that St. Vincent had established its affirmative defense, finding instead that substantial evidence did not exist on the record as a whole to support the NLRB's conclusion. The Court reasoned that the NLRB relied too heavily on the fact that St. Vincent implemented its contracting decision within the 30-to-60-day timeframe that it had announced, and ignored other important facts. Rather, the Court noted that St. Vincent had experienced problems in its RC Department for over 13 years, but only began addressing such problems the same month as the Union began its full-scale organizing campaign. Moreover, as the Court already noted, the timing of the outsourcing in relation to the Union election was highly suspect. Therefore, the Court held that the NLRB's conclusions were not supported by substantial evidence on the record as a whole, and granted the Union's petition for review and remanded the case to the NLRB for further proceedings consistent with the Court's decision.

Healthcare Employees Union, Local 399 v. National Labor Relations Board, 463 F.3d 909 (2006).

MEDI-CAL

The cost of an employee health care self-insurance program is not an allowable Medi-Cal cost unless the program complies with Section 2162 of the Provider Reimbursement Manual.

Oroville Hospital ("Oroville") provided health benefits to its employees through a combination of commercial insurance and a reserve fund, which it referred to as "self-insurance." Oroville used money from the reserve fund to pay health claims for services provided to its employees outside of its own facility. To supplement this program, Oroville purchased a commercial insurance policy that paid medical expenses in excess of $100,000 per individual employee, as well as expenses in excess of $3,800,000 for all employees during the entire year.

Under the Medi-Cal program, hospitals that do not have a contracted rate with the program, such as Oroville, are paid on the basis of the reasonable costs incurred in providing services to Medi-Cal patients. One of these costs is the cost of employee health care benefits, including commercial health care insurance. If the provider is self-insured for those benefits, the costs are allowable only if the self-insurance program meets specific requirements set forth in the Provider Reimbursement Manual ("PRM"), sections 2162.7(B)-(E). In a Medi-Cal cost report it submitted to the California Department of Health Services ("DHS"), Oroville claimed $3,486,311 in health care costs for employees, including $1,870,088 paid to outside providers. DHS audited the report and determined that Oroville's reserve fund did not meet the self-insurance requirements set forth in PRM Section 2162.7. DHS therefore concluded that Oroville was not entitled to reimbursement for the full amount claimed. Instead, DHS treated the amounts paid as insurance deductibles pursuant to PRM Section 2162.5, which limits the reimbursable amount. DHS allowed reimbursement of only $893,496 for services from outside providers.

Oroville filed a request for a formal administrative hearing, asserting that the costs were for reimbursable self-insurance and claiming that DHS erred in determining that the health care payments were deductibles. The Administrative Law Judge ("ALJ") issued a proposed decision, in which he found that Oroville's reserve fund did not meet the requirements of Section 2162.7 for a self-insurance program because the fund was maintained by Oroville, rather than an independent fiduciary, and annual certified statements prepared by an independent actuary, insurance company, or broker were not filed with an intermediary. The ALJ concluded that the health care payments were deductibles within the meaning of Section 2162.5 and sustained DHS' audit adjustment, but did so "with some reluctance" because he believed that Oroville's costs were not excessive and that the reimbursement amount DHS allowed was inadequate. In fact, it appeared that the cost for Oroville's method of insuring its employees was lower than the cost of commercial health care insurance or of a self-insurance program that meets the requirements of Section 2162.7.

DHS adopted the ALJ's decision as DHS' final decision, and Oroville filed a petition for writ of mandate in Superior Court. The trial court found that Oroville's self-insurance program did not comply with the PRM requirements for a self-insurance program, and that the health care expenses more closely resembled the payment of deductibles within the meaning of Section 2162.5. The trial court denied Oroville's petition for writ of mandate. Oroville appealed the trial court's order on the grounds that: (1) the trial court and DHS construed and applied pertinent PRM guidelines improperly; (2) the PRM guidelines should not be followed because they violate statutory authority; and (3) DHS' decision is invalid because it was based on the current version of the PRM, which was not promulgated in accordance with the Administrative Procedure Act ("APA").

The California Court of Appeal affirmed the trial court's judgment. The Court held that Oroville was entitled to only partial reimbursement of the employee health care self-insurance costs because the program did not comply with the PRM requirements. It was undisputed that Oroville did not maintain the fund with an independent fiduciary, as required by the PRM. The Court recognized that nothing in the PRM's language permits a provider to avoid the requirement that the fund be established with a recognized independent fiduciary. Consequently, Oroville was entitled only to partial reimbursement for such costs as deductibles. The Court also rejected Oroville's contention that DHS' definition of a deductible should be disregarded because it is unreasonably restrictive; instead, the Court found that if Oroville disagreed with the definition, its remedy is to ask the branch of government responsible for those rules to change them. The Court declined to address Oroville's remaining arguments (that the PRM guidelines should not be followed because they violate statutory authority, and that the current version of the PRM violates the APA) because Oroville failed to raise those arguments in the administrative hearing or in the trial court.

Oroville Hospital v. California Department of Health Services, 146 Cal. App. 4th 468 (2006).

PATIENT ADVOCACY
PHYSICIAN TERMINATION

Business and Professions Code Section 2056 does not apply to a physician terminated principally for insubordination.

Petitioner George Sarka, M.D., was employed as a primary care physician at the student health services center of the University of California at Los Angeles ("University"). Dr. Sarka's superiors had, over the course of fifteen months, asked Dr. Sarka to modify his practice by decreasing the number of diagnostic tests he ordered and to better use and manage the health services' resources. One such superior, Assistant Vice Chancellor Edward Wiesmeier, M.D., specifically asked Dr. Sarka to rely more on optimal clinical judgment, rather than diagnostic tests. Dr. Sarka failed to comply with these requests, and received notice that his employment would be terminated. Dr. Sarka filed a grievance and requested an administrative fact-finding hearing in front of an independent party reviewer ("IPR").

At the IPR hearing, the University presented evidence that Dr. Sarka ordered significantly more diagnostic tests than his colleagues; that Dr. Sarka's case mix was not different from that of his colleagues; and that the patients at the University health center were predominantly young, healthy, and with infrequent and insignificant chronic problems. The University also presented evidence regarding the community standards of practice; the deleterious effect that Dr. Sarka's practice had on other physicians and staff; the utilization of resources by all of the other primary care physicians at the health center; and some comparisons to other University of California campuses. Dr. Sarka's performance evaluations over time reflected the University's concerns, and Dr. Sarka's superiors repeatedly had counseled him about his overuse of resources and requested that he modify his patient management and care-delivery patterns. The University concluded that Dr. Sarka's practice style was not only wasteful and unjustified, but also had a negative impact on patients because it wasted their time and confused and alarmed them. Because Dr. Sarka was unwilling to accept direction and had no intention of changing his practice, the University terminated his employment. In response, Dr. Sarka asserted that he used his clinical judgment when treating patients and was discharged for advocating for patients. Dr. Sarka presented witnesses at the IPR hearing who testified that his practice was within the standard of care and that he exercised good clinical judgment.

In its ruling, the IPR noted that the case ultimately was about the issue of authority, and that Dr. Sarka was terminated for failing to comply with Dr. Weismeier's requests. The IPR specifically noted that the record did not support Dr. Sarka's contentions that he was terminated principally because he advocated for medically appropriate care. As Dr. Sarka noted in his brief to the IPR, terminating a physician principally in retaliation for advocating for medically appropriate patient care would be prohibited by Business and Professions Code Section 2056 ("Section 2056"). Dr. Sarka filed a petition for administrative mandamus. The trial court denied the petition and ruled that Dr. Sarka was fired for insubordination, not patient advocacy. Dr. Sarka appealed.

The California Court of Appeal affirmed the trial court's judgment, holding that substantial evidence supported the determination that Dr. Sarka was fired primarily for insubordination, not medical advocacy. The Court rejected Dr. Sarka's argument that the IPR and the trial court erred in their application of Section 2056. The Court found that both the IPR and the trial court considered Dr. Sarka's argument, and found that the weight of the evidence supported the finding that he was not terminated principally for advocating for medically appropriate care. Rather, he was terminated for refusing to modify his practice in response to requests that he be less wasteful of resources and student time. The Court noted that Dr. Sarka failed to provide evidence that his advocacy was "medically appropriate" for primary care physicians in a large university's student health service. Even assuming Dr. Sarka' practice style to be medically appropriate, Dr. Sarka failed to show that the University's requirements were medically inappropriate. The Court found the evidence supported the trial court's conclusion that Dr. Sarka was discharged for insubordination.

Sarka v. Regents of the University of California, et al., 146 Cal. App. 4th 261 (2006).