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HEALTH CARE SERVICE PLANS

Health Insurer May Not Raise Defense Of Fraud Based On Statements Insureds Made In An Application When The Application Had Been Neither Attached To, Nor Endorsed On, The Policy When Issued.

The California Court of Appeal reversed and remanded a trial court's denial of class certification for a plaintiff's Unfair Competition Law ("UCL") complaint. The Court of Appeal ruled that equitable defenses cannot be used to defeat a UCL cause of action, and that an insurer may not raise the defense of fraud based on statements that insureds made in an application for insurance where the application had been neither attached to, nor endorsed on, the policy when issued.

Plaintiff Augusto Ticconi ("Ticconi") applied for a policy of short-term health and accidental death insurance from Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"). Ticconi alleged he answered truthfully all health questions in the policy application. Blue Shield Life issued Ticconi a policy effective January 1, 2004, which had a duration of one year and was non-cancelable after 10 days. The policy contained language that encouraged Ticconi to examine the policy during this 10-day period. His application was neither attached to the policy nor endorsed onto it when the policy was issued.

Once the 10-day period lapsed, Ticconi paid his monthly premiums. During the policy period, Ticconi required significant health care services which resulted in bills totaling over $100,000. After he submitted the bills to Blue Shield Life for payment, Blue Shield Life rescinded his policy based on its view that Ticconi had made material misrepresentations in his application for insurance about the condition of his health. Ticconi denied he made any material misrepresentations in the application and alleged that a reasonable investigation would have shown this.

Blue Shield Life's alleged unlawful conduct was post-claims underwriting by rescinding health insurance policies based on alleged misrepresentations in the applications, which applications were incorporated by reference, but neither endorsed on nor attached to the insureds' policies. Insurance Code Section 10113 ("Section 10113") prohibits incorporating applications into a disability insurance policy by reference unless they are endorsed on, or attached to, the policies when issued.

Failing to comply with Section 10113 has important consequences. Not only is any attempted waiver of the prohibition against attachment by reference void, but under Insurance Code Section 10381.5 ("Section 10381.5"), the insurer who omits to attach the application to, or endorse it on, the policy when issued may not bind the insured to "any statements made in [those] application[s]."

The thrust of Ticconi's complaint was that Blue Shield Life's rescission of the policy violated Sections 10113 and 10381.5. Hence, the rescission of the policy was an unfair and unlawful business practice under the UCL. Ticconi also moved for class action certification.

The trial court denied Ticconi's motion for class certification on the grounds that Blue Shield Life's defenses of fraud and unclean hands raised individual issues that predominated over the common issues related to liability. Ticconi appealed.

The Court of Appeal focused solely on whether the trial court erred in denying class certification, and did not address whether Ticconi's lawsuit was legally or factually meritorious. The Court of Appeal disagreed with the trial court and held that Blue Shield Life should not be entitled to raise the equitable defense of unclean hands to defeat the UCL cause of action. The Court reasoned that to allow Blue Shield Life to argue, as a defense to the UCL claim of post-claims underwriting, that Ticconi has unclean hands because he misrepresented material medical information on unattached and unendorsed insurance applications, would be to sanction Blue Shield Life's unlawful and unfair conduct.

The Court also found that fraud was not an available defense to defeat Ticconi's cause of action. Insofar as Blue Shield Life failed to attach its insureds' applications to or endorse them on the policies, those insureds would "not [be] bound by any statements made in [those] application[s]" and "[a]ny waiver of the provisions of this section shall be void." To raise unclean hands and fraud based on statements in the application

to defeat the UCL claim, Blue Shield Life would need to hold insureds to those statements. Not only would that defense violate Section 10113's anti-waiver provision and the very sanction Section 10381.5 provides for failure to attach or endorse the applications to the policy, but that defense is specifically denied to insurance companies under California law.

The Court found that the trial court relied on erroneous legal assumptions when it weighed the legal and factual issues of fraud and unclean hands in deciding to deny Ticconi's motion for class certification. On July 30, 2007, the Court of Appeal reversed the trial court's order and remanded it with instructions. The trial court denied class certification and Ticconi again appealed. On February 27, 2008, the Court of Appeal again reversed and remanded the trial court's denial of class certification. The Court ruled that the trial court erred as a matter of law on the motion for class certification. The Court's later ruling was consistent with its July 2007 ruling.

Ticconi v. Blue Shield of California Life & Health Insurance Company, 63 Cal.Rptr.3d 698 (Cal.App. 2nd Dist. Div. 3) (July 30, 2007), 160 Cal. App. 4th 528 (Cal.App. 2d Dist. Div. 3) (February 27, 2008).

LICENSING

The California Department of Health Care Services Does Not Have The Authority To Require Physician-Owned Surgical Clinics To Obtain Licenses.

The California Court of Appeal affirmed a trial court's judgment that the California Department of Health Services ("DHS"), now the California Department of Public Health ("CDPH"), does not have the authority to require physician-owned surgical clinics to obtain licenses. In doing so, the Court ruled that DHS exceeded its authority under Health and Safety Code Section 1204(b)(1) ("Section 1204(b)(1)") in purporting to require a physician to obtain a license for a surgical clinic that he intended to wholly own and operate, but in which non-owner, non-lessee, physicians would practice.

Dr. Daniel Capen planned to build a surgical clinic that he would wholly own and operate, in which non-owner, non-lessee, physicians would practice. DHS informed him that under Section 1204(b)(1), the clinic required a license for operation because it would be used by physicians who did not share in its ownership and operation.

Section 1204(b)(1) defines the surgical clinics subject to licensing by DHS (now CDPH). It includes any "clinic that is not part of a hospital and that provides ambulatory surgical care for patients who remain less than 24 hours," regardless who owns or operates the clinic. It excludes from the definition physician-owned and operated clinics that are "owned or leased and operated as a clinic or office by one or more physicians . . . in individual or group practice . . . ."

Dr. Capen brought a declaratory relief action claiming that the statutory exclusion was ambiguous in that it could be read either to exempt or not to exempt his clinic from licensing by DHS, and that DHS' adverse, generally applicable interpretation was a regulation requiring compliance with the rulemaking procedures of the Administrative Procedure Act ("APA") under Government Code Sections 11340 *et seq.* He argued that exclusion of physician-owned and operated surgical clinics from the definition of Section 1204(b)(1) permitted him to wholly own or lease and operate a clinic at which non-owner, non-lessee, physicians would also practice.

DHS moved for summary judgment, claiming it did not tell Dr. Capen that he could not operate a clinic in a certain way and that no case or controversy existed. Dr. Capen also moved for summary judgment, claiming DHS interpreted the exception narrowly and he had standing to seek invalidation of the underground regulation.

The trial court denied DHS' motion and granted Dr. Capen's motion. The trial court issued a judgment in Dr. Capen's favor voiding the interpretation. The trial court reasoned that Section 1204(b)(1) is ambiguous because it could be read to exempt from licensing either a clinic wholly owned and operated by one doctor but involving the practice of other doctors (Dr. Capen's case), or a clinic owned and operated by more than one doctor in a group practice (DHS' claim). The trial court declared that DHS' "interpretation and/or enforcement . . . requiring licensure for any clinic or office owned or leased by one or more licensed [physicians] and at which non-owner, non-lessee licensed [physicians] also practice is void" for lack of compliance with the APA procedures. The trial court did not decide whether DHS' statutory interpretation was correct. DHS appealed.

The Court of Appeal agreed with the trial court. The Court of Appeal found that the Legislature divided responsibility for oversight of safety of surgical clinics between two different agencies: DHS (now CDPH) and the Medical Board of California. The Court reasoned that this implied that the Legislature distinguished between surgical clinics owned and operated by physicians (which are generally regulated by the Medical Board) and surgical clinics owned and operated by others (which are generally regulated by DHS/CDPH). For those reasons, the Court held that Dr. Capen's clinic was not subject to licensing and regulation by DHS, thus affirming the trial court's judgment voiding DHS' interpretive regulation.

Capen v. Shewry, 65 Cal.Rptr.3d 890 (Cal.App. 3rd Dist.) (September 19, 2007).

MEDICAID

Hospital Groups File Suit Against CMS to Prevent Medicaid Cuts.

A coalition of hospital groups, led by the National Association of Public Hospitals and Health Systems ("NAPH"), the American Hospital Association ("AHA") and the Association of American Medical Colleges ("AAMC"), filed suit in federal court seeking to prevent the implementation of a proposed Centers for Medicare and Medicaid Services ("CMS") rule that would cut funding for public hospitals by $5 billion over five years (CMS 2258-FC, "Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership").

Originally proposed on January 18, 2007, the final rule was released on May 25, 2007 (published May 29, 2007 in 72 Fed. Reg. 29748). The rule narrows the definition of a public health care provider and limits reimbursement to the cost of treating Medicaid patients. Congress prevented the rule from going into effect with a one-year legislative moratorium, set to expire May 25, 2008. The hospital groups now seek an injunction prohibiting CMS from implementing the rule.

The hospital groups have challenged the rule on three grounds:

- The rule defines "units of government" far more narrowly than is permitted under current law and severely restricts options for states to finance the non-federal share of their Medicaid program expenditures. The hospital groups contend CMS' definition usurps states' ability to determine the governmental status of entities within states, severely limiting the type of governmental entities that can make intergovernmental transfers to fund the non-federal share of the program.

- CMS does not have the authority to limit Medicaid payments to public providers to cost-based only while continuing to allow private providers to be paid under a different methodology. Congress rejected cost-based reimbursement and payment requirements in the early 1980s in favor of granting states flexibility to tailor Medicaid reimbursement to their unique needs. The hospital groups argue a cost limit imposed solely on governmental hospitals is counter to clear Congressional intent and is arbitrary and capricious in violation of the Administrative Procedure Act. It also upends decades of Medicaid payment policies established by CMS and relied on by states.

- The moratorium signed by the President on May 25, 2007, effectively prevented CMS from issuing a final rule the same day.

In a press release issued March 11, 2008, Larry S. Gage, president of NAPH, stated "This regulation, together with a number of others proposed in the last several months by CMS, would do nothing less than diminish the historic role of the Medicaid program as a vital safety net for low income children and families. We believe – and our lawsuit maintains – that this devastating action is beyond the scope of CMS' regulatory power under current federal law. The consequences for public hospitals that provide lifesaving trauma care and treat the most vulnerable Americans would be devastating."

Alameda County Medical Center et al. v. Leavitt, U.S.D.C. District of Columbia, No. 1:08-cv-00422 (complaint filed March 11, 2008).

MEDICAL STAFF

Medical Staff Peer Review Hearing Officer May Not Prematurely Terminate Hearing Based On Physician's Failure To Produce Documents.

The California Court of Appeal reversed a trial court's order upholding a hospital's denial of medical staff membership and privileges based on a physician's failure to produce documents at his hearing. The Court of Appeal held that terminating a hearing before it commences does not afford a physician his statutory hearing right. Furthermore, only the trier of fact (*i.e.*, the Judicial Review Committee) may terminate a hearing; the hearing officer is not empowered to do so.

Gil Mileikowsky, M.D., applied for medical staff membership and privileges at West Hills Hospital Medical Center (the "Hospital"). The Hospital denied his application because Dr. Mileikowsky: (1) failed to disclose his privileges had been terminated at a nearby hospital; (2) claimed he voluntarily resigned at a second hospital (though records indicate he had been summarily suspended), and (3) had a demonstrated failure to meet the medical staff's professional and ethical standards. Dr. Mileikowsky requested a hearing under Business and Professions Code Section 809 *et seq.* and the Hospital's Bylaws. The Hospital appointed a Judicial Review Committee ("JRC") and a hearing officer. Hearing dates were scheduled and one day of *voir dire* was completed. Under the Bylaws, the parties were required to exchange documents. Despite multiple requests and extensions, Dr. Mileikowsky refused to produce the documents in his possession, including the documents that the hospital originally requested when evaluating his application for appointment. After eight months, the hearing officer granted the Hospital's request for sanctions based on Dr. Mileikowsky's failure to produce the requested documents. The hearing officer's order terminated the hearing and concluded that Dr. Mileikowsky's refusal to produce the documents constituted voluntary acceptance of the Hospital's action. Dr. Mileikowsky appealed the recommendation to the Hospital's governing board. The board found the hearing officer's ruling was reasonable and warranted, and accepted it as the Hospital's final decision.

Dr. Mileikowsky sought judicial review of the Hospital's decision on the ground that the hearing officer was not empowered to issue an order terminating the hearing as a sanction for his failure to produce the documents. The trial court rejected his contention and offered four reasons in support.

First, the trial court found the hearing officer's decision was authorized by the Bylaws, which provided that the hearing officer "shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires." Second, the trial court found Dr. Mileikowsky's failure to produce the documents prevented the JRC from properly performing its function of evaluating his fitness to practice medicine. Third, the trial court referred to the fact that Dr. Mileikowsky himself had demanded sanctions because the Hospital refused to turn over documents. Fourth, the interests of justice warranted termination of the hearing, because termination ensured that Dr. Mileikowsky would not benefit from his refusal to furnish the documents. Dr. Mileikowsky appealed.

The Court of Appeal reversed the trial court's decision and held the hearing officer did not have the power to prematurely terminate the hearing. The Court reasoned that, under the medical staff peer review statutes, procedural matters should be consigned to the hearing officer, but all decisions affecting the merits must be made by the trier of fact (*i.e.*, the peer review body itself, in this case the JRC). However, a hearing officer's decision to terminate a hearing before a final decision by the trier of fact on the merits, with the attendant effect of allowing the final proposed action to stand, is not merely a procedural decision. It is, effectively, a decision on the merits.

According to the Court, whether peer review could be adequately performed without the requested documents was a matter of medical judgment, requiring the expertise of the trained medical professionals on the JRC. The hearing officer's discretion to control the proceedings does not extend so far as to become a surrogate decision maker in lieu of the JRC. The hearing officer's decision to terminate the hearing thus allowed the Hospital to deny Dr. Mileikowsky's application without affording him any hearing or a decision by the trier of fact.

Although the Court agreed that a physician may forfeit, through his conduct, his right to a hearing, it distinguished prior cases where a hearing was terminated based on a physician's refusal to participate or cooperate. In those cases, the hearing already had commenced, so the physician was not entirely denied his statutory right to a hearing (*i.e.*, it was not a "premature termination"). Also in those cases, the JRC (not the hearing officer), issued the decision to terminate the hearing.

The Court also flatly rejected the Hospital's contention that peer review bodies simply make recommendations and that it is only the governing board that makes the actual decision. The Court stated there is no support in the statutes for the proposition that only the governing board can make a decision regarding privileges. Instead, it is only when the peer review body has failed to take action that the governing board has a mandate under Section 809.05 to intervene. This distinction, explained the Court, "is no mere technicality." The circumstance that the Hospital's governing board approved the ***hearing officer's*** decision is no substitute for a full hearing and plenary discussion by the JRC of the issue posed by the missing documents, the Court reasoned. Thus, "the trial court's conclusion that withholding the documents prevented the JRC from performing its function of evaluating [Dr. Mileikowsky's] fitness to practice medicine is not based on facts found by the body that is charged with the responsibility of determining this issue in the first instance." The Court characterized the Hospital's action as "reflect[ing] only the decision of a single person [the hearing officer], a lawyer by training and profession, that [Dr. Mileikowsky] has not complied with 'discovery orders' and that, for this reason, 'terminating sanctions' were warranted. It does not help the situation that this hearing officer had no authority to issue 'discovery orders' under the Civil Discovery Act and/or to award 'terminating sanctions.' "

The Court of Appeal reversed and remanded the trial court's judgment. The trial court was directed to enter a judgment directing the Hospital: (1) to set aside the decision upholding the hearing officer's termination of the hearing; (2) to convene a hearing pursuant to Section 809.1(c); and (3) to conduct the hearing and further proceedings in accordance with Section 809.2 *et seq.* The trial court also was directed to hear and determine whether Dr. Mileikowsky is entitled to injunctive relief with regard to his privileges.

On October 5, 2007, the Hospital filed a petition for review by the Supreme Court of California. On December 12, 2007, the Supreme Court granted review and the Court of Appeal opinion was superseded. The case is currently being briefed for the Supreme Court.

Mileikowsky v. West Hills Hospital Medical Center, 64 Cal. Rptr.3d 888 (Cal.App. 2nd Dist.) (August 21, 2007) (review granted and opinion superseded on December 12, 2007).

MEDICARE

Medicare Provider Reimbursement Review Board, Once It Has Jurisdiction Over A Dissatisfied Provider's Cost Report, May Decide Whether An Expense Incurred Within The Cost Reporting Period Is Reimbursable, Even Though The Expense Was Not Claimed By The Provider Hospital Nor Considered By The Fiscal Intermediary.

The Ninth Circuit Court of Appeals affirmed a district court's ruling and concluded that once the Provider Reimbursement Review Board ("PRRB") acquires jurisdiction over a dissatisfied provider's cost report on appeal from the Medicare intermediary's final determination of total reimbursement due for a covered year, the PRRB has discretion to decide whether to order reimbursement of a cost that was incurred during the cost reporting period, even though that particular cost was not expressly claimed in the provider's cost report or explicitly considered by the intermediary.

The amount of Medicare reimbursement due to a provider such as Loma Linda University Medical Center ("Loma Linda") is based in part on the costs set forth in the annual cost report that the provider submits to the Medicare program. The Medicare fiscal intermediary audits the cost report and issues a Notice of Program Reimbursement ("NPR") on behalf of the Secretary of Health and Human Services ("HHS").

Over 20 years ago, Loma Linda inadvertently zeroed out reimbursable interest expense in its 1985 cost report, which it timely filed without any claim for interest expense. The Medicare fiscal intermediary, Blue Cross of California ("Blue Cross"), audited the cost report and issued an NPR in 1988. The NPR included no adjustments for interest expense. In an appeal filed with the PRRB in 1989, Loma Linda identified six aspects of Blue Cross' determination with which it was dissatisfied, not including interest expense.

Eventually realizing its error, Loma Linda filed a request with the PRRB in 1996 to add the interest expense issue to its pending appeal. Blue Cross contended the PRRB could not exercise jurisdiction over the interest expense because there had been no intermediary determination concerning the issue and the provider had not filed a request within the three-year cost report reopening period. The PRRB issued a letter decision accepting jurisdiction pursuant to 42 U.S.C. Section 1395oo(a)(1) and 42 C.F.R. Section 405.1841(a)(1).

All appeal issues except interest were resolved and the parties stipulated that if it had been claimed in the 1985 cost report, the allowable interest expense would have been $1,029,279. This left the PRRB's jurisdiction as the dispositive issue. In 1998, the PRRB issued its decision finding that no statutory or regulatory provision makes an intermediary audit adjustment a prerequisite for a PRRB appeal. In its view, the error was clear and obvious, and should have been corrected by the intermediary. Thus, the PRRB concluded that jurisdiction was appropriate under Section 1395oo(a) and Section 405.1841(a)(1), as well as under Section 1395oo(d), because the incurred interest expense was covered by the cost report even if the intermediary had not considered the matter. On the merits, the PRRB found that Blue Cross had incorrectly determined Loma Linda's total reimbursable cost due to the understatement of interest expense in the amount of $1,029,279.

The Administrator of the Health Care Financing Administration ("HCFA"), now the Centers for Medicare & Medicaid Services or "CMS", reversed the PRRB's decision. The Administrator found that a provider cannot be "dissatisfied" with respect to costs which it could have claimed on its cost report but did not. Therefore, the Administrator concluded that the case lacked one of the core requirements of PRRB jurisdiction, *i.e.*, provider dissatisfaction with the NPR issued by the intermediary. The Administrator further observed that other routes are available for providers to correct cost reporting errors, such as requests to reopen the cost report.

Loma Linda sought review of the Administrator's decision in federal district court. The district court held that the Administrator's interpretation of the Medicare Act as precluding PRRB jurisdiction in this case was arbitrary and capricious, as it was contrary to the language and intent of Section 1395oo(a). The district court, noting that the Administrator did not reach the merits of the PRRB decision, ordered that the PRRB's decision be reinstated, subject to the Administrator's review of the merits.

The Ninth Circuit affirmed the district court's decision, and ordered that the PRRB's last decision be reinstated, subject to the Administrator's review of the merits. The Court rejected the Secretary's interpretation of the Medicare Act as precluding PRRB jurisdiction over the interest expense in question. The Ninth Circuit noted that Section 1395oo(a) plainly says that a provider may obtain a PRRB hearing with respect to the cost report when it is dissatisfied with the intermediary's final determination of the amount of total reimbursement. Section 1395oo(a) does not say that a hearing may be obtained only "with respect to items claimed on the cost report," which the statute would do if HHS' interpretation were plausible. Under Section 1395oo(d), a "matter covered by such cost report" is "a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed."

Thus, the Ninth Circuit reasoned, Section 1395oo(d) squarely allows the PRRB to modify an intermediary's final determination based on evidence that was not considered by the intermediary, and to make revisions regarding a cost incurred during the cost reporting year even though the cost was not claimed and the matter was not considered by the intermediary. The Ninth Circuit's decision is consistent with the position taken by the First Circuit, but is contrary to the position taken by the Seventh Circuit, which has held that the provider must give the intermediary "a first shot at the issue."

The Ninth Circuit Court's decision stands as final since the Secretary did not petition for certiorari to the United States Supreme Court, and the time for filing such a petition has expired.

Loma Linda University v. Leavitt, 492 F.3d 1065 (9th Cir.) (July 9, 2007).

MICRA

Statute Of Limitations For Medical Malpractice Lawsuits Against Health Care Providers Covers Medical Students Lawfully Practicing Medicine Under A Statutory Exception To Licensing And Certification Requirements.

The California Court of Appeal held that the statute of limitations for medical malpractice actions against health care providers covers medical students lawfully practicing medicine under a statutory exception to the physician licensing and certification requirements.

Defendant Lynn Valdez ("Valdez"), an optometry student at the University of California, injured plaintiff Eve Chosak's ("Chosak") ankle in a mishap during an eye examination. Valdez was not a licensed optometrist but was a student serving her internship at the University of California's School of Optometry. Chosak waited nearly two years and then filed a malpractice action against Valdez and other defendants.

The trial court dismissed Chosak's lawsuit as barred by the statute of limitations in Business and Professions Code Section 340.5 ("Section 340.5"), which requires a medical malpractice plaintiff to file an action against a health care provider within one year of the date the plaintiff discovered, or should have discovered, the injury. Chosak appealed the trial court's ruling on the grounds that Section 340.5 did not apply to Valdez because, as an unlicensed medical student, she was not a "health care provider" within the meaning of the statute.

The California Court of Appeal affirmed the trial court's ruling and that the term "health care provider" under Section 340.5 includes a medical student lawfully practicing medicine under a statutory exception to the licensing requirements. The Court offered three reasons in support of its conclusion. First, the language and history of Section 340.5 indicates that the Legislature intended the statute to apply to all medical malpractice actions in California, and there is no indication that the Legislature wanted certain medical professionals excluded. Second, the public policy promoted by the Medical Injury Compensation Reform Act ("MICRA"), of which Section 340.5 is a part, would be advanced by including medical students lawfully practicing under an exception. Excluding them would presumably inflate medical malpractice premiums for universities and other institutions employing or instructing medical students. Third, the Court found no legitimate reason to exclude medical students from the statute because they provide the same health care services as licensed professionals.

Because Valdez was practicing lawfully under an express exception to the licensing and certification requirements, the Court concluded she was within the definition of "health care provider" under Section 340.5 and that Chosak's complaint was barred under the statute of limitations.

Chosak v. Alameda County Medical Center, 153 Cal.App.4th 549 (Cal. App. 1st Dist.) (July 27, 2007).

PHYSICIAN/HOSPITAL RELATIONSHIP

Court Of Appeal Finds Physicians Ostensible Agents Of Hospital In Wrongful Life Lawsuit.

The California Court of Appeal affirmed a trial court judgment for defendants on a wrongful life claim, but found the physicians were ostensible agents of the hospital.

Plaintiff Amanda Ermoian ("Ermoian") was born with brain abnormalities that left her severely mentally retarded and unable to care for herself. Her conditions could not have been prevented, treated, or cured in utero. During pregnancy, her mother was treated at Desert Hospital Outpatient Maternity Services Clinic (the "Clinic"), a comprehensive perinatal services program operated by Desert Hospital.

Dr. Morton Gubin and Dr. Masami Ogata treated Ermoian's mother at the Clinic. The physicians were not employees of Desert Hospital; rather, they were physicians with a private practice who contracted with Desert Hospital to perform obstetric services at the Clinic. The written contract between Desert Hospital and the physicians described them as "independent contractors with, and not as employees of, [the] Hospital."

Through her guardian *ad litem,* Ermoian sued Desert Hospital for wrongful life, breach of contract and promissory estoppel, alleging that Desert Hospital was negligent in failing to inform Ermoian's mother of Ermoian's brain abnormalities prior to her birth, and that such negligence deprived her parents the opportunity to make an informed choice to terminate the pregnancy.

The trial court granted Desert Hospital's motion for summary adjudication on the breach of contract and promissory estoppel claims. The wrongful life cause of action was tried by the court, which entered judgment for Desert Hospital. The trial court found that Ermoian failed to meet her burden of proof to establish her wrongful life cause of action. This conclusion was based, at least in part, upon the express findings that Ermoian's medical condition did not result from any negligent care and, because the physicians were independent contractors (and not employees), Desert Hospital was not vicariously liable for their conduct. Ermoian appealed.

The California Court of Appeal disagreed with the trial court's finding that the physicians were not ostensible agents of Desert Hospital. The Court explained that, when examining the issue of ostensible agency, a court does not look to the actual legal relationship between the various parties, but rather whether a hospital holds the physicians out to members of the public as hospital employees.

The Court identified many facts which demonstrated ostensible agency, of which the most notable were: (1) Desert Hospital held out the Clinic and the personnel in the Clinic as part of Desert Hospital; (2) it was objectively reasonable for Ermoian's mother to believe that Drs. Gubin and Ogata were employees of Desert Hospital; (3) the Clinic was located across the street from Desert Hospital, used the same name as Desert Hospital, and labeled itself as an outpatient Clinic; (4) numerous professionals at the Clinic were employees of Desert Hospital; (5) employees of the Clinic indicated they were employed by Desert Hospital and that the program was run by Desert Hospital; (6) the Clinic scheduled the mother's appointments at Desert Hospital rather than giving her a referral for the various tests; and (7) the mother was referred to Dr. Gubin by individuals in the Desert Hospital emergency room.

However, the Court agreed with the trial court on the issues of negligence and causation, and it affirmed the trial court's judgment in favor of Desert Hospital.

Ermoian v. Desert Hospital, 152 Cal. App.4th 475 (Cal.App. 4th Dist.) (June 22, 2007).

Physician's Discrimination Claims Dismissed; Relationship With Hospital Akin to Employee/Employer Rather Than Independent Contractor.

The Ninth Circuit Court of Appeals affirmed a district court order dismissing a racial and sexual orientation discrimination suit brought by a physician who was not reappointed to the Riverside Community Hospital ("RCH") medical staff.

Plaintiff Christopher Johnson, M.D. brought state and federal discrimination claims against RCH when the hospital refused to renew his medical staff membership and privileges. Dr. Johnson, who identifies himself as African American and bisexual, claimed he was discriminated against in violation of California's Unruh Civil Rights Act (Civil Code §51), the Fair Employment and Housing Act (Govt. Code §§12940 *et seq.*) ("FEHA"), and the federal civil rights statute, 42 U.S.C. Section 1981. With regard to the federal claim, the Court acknowledged Dr. Johnson presented evidence of offensive behavior. But it held the two incidents (occurring over a period of two-and-a-half years) were not clearly racially-motivated and did not constitute the severe and pervasive discrimination necessary for a cause of action under Section 1981. With regard to the state claims, Dr. Johnson argued his claims fell within the Unruh Act because he was an independent contractor. The Court rejected that argument and distinguished Dr. Johnson's situation from the 2005 case, *Payne v. Anaheim Memorial Hospital,* 130 Cal. App. 4th 729 (physician permitted to bring claim under Unruh Act). The Court noted, in the context of the Unruh Act, that Dr. Johnson's relationship with RCH was akin to an employee/employer relationship. Unlike the physician in *Payne*: 1) Dr. Johnson was financially compensated for his work, 2) RCH controlled his qualifications and minimum standards for membership, and 3) RCH determined the shifts he was to work. The Unruh Act requires a plaintiff to demonstrate a relationship similar to a customer-proprietor, and Dr. Johnson's employee-like relationship disqualified him from asserting a claim under the statute. Finally, although Dr. Johnson may have had standing to bring a claim under the FEHA, he failed to do so within the statute of limitations.

Johnson v. Riverside Healthcare System, LP, 516 F.3d 759 (9th Cir. (Cal.), February 13, 2008).

PROMPT PAY

Hospital Not Required to Inform Patients of Its Discretionary "Prompt Pay" Discounts.

The California Court of Appeal affirmed a trial court order dismissing, with prejudice, a class action lawsuit against a hospital based on its failure to disclose discretionary discounts for patients who timely paid their balance.

Plaintiff Terry Buller filed a class action suit alleging the billing practices of Sutter Health and Alta Bates Summit Medical Center violated California's Unfair Competition Law (Bus. & Prof. Code §17200) ("UCL"). Sutter Health had an undisclosed billing policy of allowing discounts for patients who promptly paid their bill ("prompt pay discounts"). Buller argued Sutter Health should have disclosed this policy to all patients. Its failure to do so, he claimed, equated to overcharging patients by overstating the amount due on invoices, in violation of the UCL.

The trial court dismissed Buller's suit with prejudice and the Court of Appeal affirmed. The Court found Sutter Health had the discretion to offer discounts, and it had no duty to disclose these discretionary discounts. Patients do not have the expectation of discounts when they seek medical treatment, the court reasoned. Buller's argument, the Court noted, would require complete disclosure of all possible discretionary discounts, which runs counter to the purpose of having discretionary discounts in the first place.

Buller v. Sutter Health, 2008 WL 588399 (Cal. App. 1 Dist., No. A118541) (March 5, 2008).

PUBLIC HEALTH FACILITIES

Violations Of Joint Commission Standards, County Regulations And Medicare Regulations Are Insufficient To Establish Wrongful Death Liability Against Public Mental Health Institution.

The California Court of Appeal affirmed a trial court's judgment that a wrongful death claim against the County of Los Angeles was statutorily barred under Government Code Section 854.8 ("Section 854.8"). There is an exception to Section 854.8, but it applies only to violations of statutes or regulations prescribing minimum standards and issued by the following state departments: (1) the Department of Health Services ("DHS"), now known as the California Department of Public Health ("CDPH"); (2) the Department of Social Services ("DSS"); (3) the Department of Developmental Services ("DDS"); or (4) the Department of Mental Health ("DMH"). Violations of County regulations, Medicare regulations or Joint Commission standards do not qualify for the immunity exception. Additionally, violations of statutes or regulations which simply require "sufficient" equipment, personnel, staffing or facilities are too broad to fit within the narrow immunity exception.

Timothy Lockhart, Sr. ("Lockhart"), now deceased, was an inpatient at Los Angeles County's Augustus F. Hawkins Comprehensive Community Mental Health Center ("Hawkins"). Hawkins was not separately licensed as an acute psychiatric hospital, but rather was the psychiatric unit at the former Martin Luther King Jr./Charles R. Drew Medical Center.

On November 14, 2002, Lockhart was admitted to Hawkins as an inpatient pursuant to Welfare and Institutions Code Section 5150, based on a determination that he was a danger to himself with a history of suicide attempts. He was placed on Level 1 Suicide Prevention Protocol. After his admission, staff observed Lockhart pacing about his room; he then locked himself in his bathroom. Staff attempted unsuccessfully to open the bathroom door and called the Sheriff's Department. Once the sheriff arrived, he looked at the bathroom doorknob and recognized it was a privacy lock with a safety release which could easily be opened with any small item with a straight edge (*e.g.*, flathead screwdriver, coin, or the rounded portion of a key). He immediately opened the lock with the back of a car key. The door opened and staff found Lockhart dead inside, having hanged himself with blankets.

Plaintiff Timothy Lockhart, Jr. ("Plaintiff") filed a complaint against Hawkins, alleging the wrongful death of his father. The complaint alleged that the bathroom door should not have had a lock and that Hawkins staff should have been present to monitor and unlock the door. Hawkins moved for summary judgment on the grounds that the complaint was barred by statutory immunity under Section 854.8 (immunity to public entities for injuries to inpatients of mental institutions).

Plaintiff asserted that an exception to immunity set forth in Government Code Section 855(a) applied. Section 855 creates an exception to immunity for injuries "proximately caused by the failure of the public entity to provide adequate or sufficient equipment, personnel or facilities required by any statute or any regulation of the State Department of Health Services, Social Services, Developmental Services, or Mental Health prescribing minimum standards for equipment, personnel or facilities . . . ."

Plaintiff identified several statutes, regulations, and other sources of authority which he alleged Hawkins violated in Lockhart's care, thereby purportedly justifying liability under Section 855. Plaintiff argued that the exception to immunity provided by Section 855 should not be limited

to the breach of duties set forth in statutes or regulations of DHS, DSS, DDS or DMH, but should instead apply to the breach of duties specified by any authority, including federal regulations, *LPS Designation Standards and Process for Facilities* (a County of Los Angeles Health Department manual), and Joint Commission standards.

Hawkins replied that under the plain language of Section 855, only statutes and regulations of DHS (now CDPH), DSS, DDS or DMH were bases for liability. As federal Medicare regulations fell outside the plain language of the statute, Hawkins argued that those regulations could not be used to avoid immunity. Hawkins also noted that Joint Commission accreditation was simply a voluntary alternative means of proving a hospital met Medicare Conditions of Participation, and not a Medicare requirement.

The trial court granted Hawkins' motion for summary judgment on the basis of governmental immunity and entered judgment in favor of Hawkins. Plaintiff appealed.

The Court of Appeal agreed with the trial court. The Court concluded that the only statutes and regulations that fall within the exception to immunity are those promulgated by DHS (now CDPH), DSS, DDS or DMH. County regulations, federal Medicare regulations, and Joint Commission standards are insufficient bases for liability under Section 855. Moreover, the Court concluded that only statutes and regulations which "prescrib[e] minimum standards" for equipment, personnel or facilities can create liability; regulations that simply require "sufficient" equipment, personnel or facilities are too broad to fit within the narrow immunity exception of Section 855.

The Court found the statutory language of Section 855 to be clear and unambiguous. The Court reasoned that, had the Legislature intended for the exception to apply to violations of any "enactments," it could have said so as it did in the language used in another Government Code section, Section 815.6. Indeed, Section 855 was enacted as part of the same Government Tort Liability Act which enacted Section 815.6 (Stats 1963, ch. 1681). The Legislature chose to use the general term "enactment" in Section 815.6, but the more restrictive "any statute or any regulation of the State Department of Health Services, Social Services, Developmental Services, or Mental Health" in Section 855. According to the Court, there was absolutely no indication that the limited language was meant to encompass any entities other than those specifically described.

The Court also concluded that a regulation requiring "sufficient nursing staff . . . to meet the needs of the patients" sets forth only a ***general*** goal within which a public medical facility may exercise its discretion, not a specific minimum standard giving clear notice of the minimum amount of nursing personnel the facility must supply. Such a regulation sets forth the general policy goal for staffing the psychiatric unit, but does not specifically direct the manner in which that goal is to be attained. This, the Court held, is not the type of regulation "prescribing minimum standards for equipment, personnel or facilities," the breach of which can give rise to liability under Section 855.

In this regard, the Court disagreed with the conclusion reached by the First District Court of Appeal in *Baber v. Napa State Hospital*, 209 Cal.App. 3d 213 (1989). In *Baber*, the plaintiff sought to hold the defendant public entity liable under Section 855 for the violation of DHS regulations providing "[t]here shall be adequate space maintained to meet the needs of the [medical] service," "[a] sufficient number of appropriate personnel shall be provided for the safety of the patients," "[t]he hospital's governing body shall [p]rovide appropriate physical resources and personnel required to meet the needs of the patients," and "[t]he hospital shall be clean, sanitary, and in good repair at all times. Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors." *Id.* at 220. The *Baber* court concluded that these standards were not "insufficiently quantifiable or objective to support liability" under Section 855 and rested its conclusion on the theory that when the Health and Safety Code entrusted rulemaking authority to administrative agencies, it granted authority for broad, variable standards. The *Baber* court stated that "[t]his implies an understanding by the Legislature of the necessity of creating standards flexible enough to meet the variety and changing needs of psychiatric hospitals and patient populations." *Id.*

The Court agreed with the *Baber* court that the Legislature understood flexible standards were justified in this situation. However, the Court disagreed with the *Baber* court's characterization of the main issue. The Court stated that the issue was not the validity or propriety of the regulations promulgated, but instead whether those regulations "prescribe minimum standards for equipment, personnel or facilities" such that their breach gives rise to tort liability. The Court noted that the Law Revision Commission's Recommendations acknowledged that "decisions as to the facilities, personnel or equipment to be provided in public medical facilities involve discretion," but indicated that liability would be imposed only "when minimum standards have been fixed by statute or regulation." Thus, statutory immunity applied to Hawkins and the complaint was properly dismissed. The Court of Appeal thus affirmed the trial court's judgment.

Lockhart v. County of Los Angeles, 66 Cal.Rptr.3d 62 (Cal.App. 2nd Dist.) (September 19, 2007).

SKILLED NURSING FACILITIES

Court May Properly Abstain From Adjudicating Class Action Lawsuit Based On Health And Safety Code Section 1276.5.

The California Court of Appeal affirmed a trial court's decision to abstain from adjudicating a class lawsuit against a nursing home based on Health and Safety Code Section 1276.5 ("Section 1276.5").

Plaintiff and appellant Alvaro Alvarado ("Alvarado"), now deceased, filed a class action lawsuit against a number of defendants which owned or operated more than 20 skilled nursing and/or intermediate care facilities. Alvarado sought to act as a private attorney general seeking restitution and injunctive relief to require defendants to comply with the minimum nursing hour requirements set forth in Section 1276.5. Alvarado alleged unlawful, false and fraudulent business practices in violation of Business and Professions Code Sections 17200 and 17500. Alvarado claimed that defendants falsely advertised that they provided greater nursing levels than those actually provided. He alleged defendants engaged in unlawful business practices by failing to maintain adequate levels of skilled nursing staff and by misrepresenting to residents and family members the level of staffing provided at the nursing centers.

Defendants filed a demurrer and motion to strike, asserting that the trial court should abstain from adjudicating the action or defer to the primary jurisdiction of the Department of Health Services ("DHS"), now known as the California Department of Public Health ("CDPH"). The trial court sustained defendants' demurrer and exercised its discretion to abstain from adjudicating the case. The court entered judgment in favor of all defendants. Alvarado appealed.

The California Court of Appeal upheld the trial court's decision to abstain from adjudicating the controversy and dismiss the complaint. Abstention was proper because adjudicating the dispute would have required the trial court to become involved in complex health care matters concerning the staffing of skilled nursing and intermediate care facilities and assume the regulatory functions of DHS (now CDPH). In addition, granting and enforcing the requested relief would place an unnecessary burden on the trial court, given the power of DHS to monitor and enforce compliance with Section 1276.5. The Court reasoned that the Legislature intended DHS to enforce Section 1276.5. Because DHS has the power, expertise and statutory mandate to regulate and enforce Section 1276.5, the trial court did not abuse its discretion by applying the abstention doctrine to dismiss the class action lawsuit.

Alvarado v. Selma Convalescent Hospital, 153 Cal.App.4th 1292 (Cal.App. 2nd Dist.) (August 1, 2007).

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