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12 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
13 **FOR THE COUNTY OF SACRAMENTO**

14  
15 CALIFORNIA MEDICAL ASSOCIATION,  
16 ET AL.

17 Petitioners / Plaintiffs,

18 vs.

19 DEPARTMENT OF MANAGED HEALTH  
20 CARE, STATE OF CALIFORNIA, ET AL.

21 Respondents / Defendants.  
22  
23  
24

CASE NO: 34-2008-80000059

**APPLICATION AND *AMICUS CURIAE*  
BRIEF OF KAISER FOUNDATION  
HOSPITALS, SOUTHERN CALIFORNIA  
PERMANENTE MEDICAL GROUP, THE  
PERMANENTE MEDICAL GROUP, INC.,  
AND KAISER FOUNDATION HEALTH  
PLAN, INC. IN SUPPORT OF  
OPPOSITION TO PLAINTIFF'S  
PETITION FOR WRIT OF MANDATE  
AND COMPLAINT FOR DECLARATORY  
AND INJUNCTIVE RELIEF;  
MEMORANDUM OF POINTS AND  
AUTHORITIES**

**Hon. Michael Kenny**

**Date: Nov. 12, 2008**

Time: 9:30 a.m.

Dept.: 31

Complaint Filed: September 26, 2008

Writ Hearing: November 21, 2008

1 APPLICATION

2 This Court Should Consider Kaiser’s Amicus Curiae Submission Because Kaiser  
3 Represents A Significant Voice of Dissent From The Petitioners’ Incorrect Assertion  
4 Of Unanimity Among Providers. Not All California Providers Support Balance  
5 Billing.

6 Kaiser Foundation Hospitals is a nonprofit public-benefit corporation that owns and  
7 operates community hospitals as well as outpatient facilities in California and other states,  
8 provides or arranges hospital services, and sponsors charitable, educational, and research  
9 activities. Kaiser Foundation Hospitals is one of the largest hospital systems in California,  
10 currently with 33 hospitals in the state.

11 Southern California Permanente Medical Group consists of a partnership of physicians  
12 within the Kaiser system who assume the responsibility for providing and arranging necessary  
13 medical care for Kaiser’s Southern California members. The Permanente Medical Group, Inc. is  
14 a corporation that employs physicians who assume the responsibility for providing and arranging  
15 necessary medical care for Kaiser’s Northern California members. Collectively these two  
16 entities are the “Kaiser Medical Groups.”

17 Kaiser Foundation Health Plan, Inc. is a nonprofit public-benefit corporation whose  
18 charitable purpose is to improve the health of the communities it serves by, among other things,  
19 providing quality health care at affordable prices. Its California membership presently stands at  
20 over 6.5 million members.

21 For purposes of this *amicus curiae* application and brief the above entities are  
22 collectively referred to as “Kaiser.”

23 As one of the major players in the California health care system, and given its unique  
24 position in that system as an entity that operates on both sides of the issue, Kaiser has insights as  
25 to how the law governing these issues has developed and should be applied. Kaiser also has a  
26 significant interest in the resolution of this case and whether health care providers will be  
27 permitted to balance bill patients for emergency services that are covered by the patients’ health  
28 plans.

1 Accordingly, and under the authority of *Marshall v. Marshall*, 212 Cal. 736 (1931) (trial  
2 court authorized to receive and consider *amicus curiae* briefs), Kaiser respectfully requests that  
3 the Court receive and consider this *amicus curiae* brief in support of the DMHC's recent  
4 regulation and its ability to enforce it, and opposing the Opening Brief submitted by (among  
5 other Petitioners) the California Medical Association (CMA) and the California Hospital  
6 Association (CHA). CMA, CHA, and the other Petitioners certainly do not speak for all  
7 California providers. At a minimum, CHA does not speak for the 33 Kaiser Foundation  
8 Hospitals in California, all of which are CHA members and collectively represent one of CHA's  
9 largest member groups. Similarly, the Kaiser Medical Groups are significant players in CMA,  
10 but the CMA does not speak for them here.

11 DATED: November 7, 2008

EPSTEIN BECKER & GREEN, P.C.

12  
13 By: 

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AMICUS CURIAE BRIEF

A. Balance Billing Is A Significant Problem For The Health Care Delivery System, As Exemplified By Kaiser's Experience With Prime Healthcare Services.

Balance billing of patients for emergency services is a controversial issue among hospitals and indeed among health care providers generally. Even groups that each represent physicians (the California Association of Physician Groups (CAPG) and Petitioner CMA) are not of one mind on these issues.

Some providers seize on the ability to balance bill their patients, not because they expect to collect from the patients, but because the threat of collection actions against the patients creates leverage for the provider to try to collect higher amounts from health plans, and typically amounts that are very much in dispute. Relatively few Californians could actually afford to pay the typical hospital's billed charges, even if balance billing were allowed. The providers grasp at balance billing in the hope that by threatening the individual patients, they can force the health plans to pay more than is due.

In doing so, however, Petitioners are wrong to say (Op. Brf. at 1:20) that they represent the interests of physicians and hospitals throughout California. Kaiser in particular recognizes the unfairness of putting the patients in the middle of disputes between providers and health plans over the payment for emergency services, and contends that balance billing should be, and appropriately has been, outlawed. Kaiser providers do not balance bill and Kaiser Foundation Health Plan opposes balance billing. See Ex. A (Kaiser July 21, 2006 policy). Kaiser's approach, consistent with the DMHC's position in this matter, is the correct approach under the law, and Kaiser urges the Court to uphold the DMHC's recent regulations on balance billing to protect patients and plans alike.

Indeed, Kaiser Foundation Health Plan itself is the recent victim of an unscrupulous balance billing campaign by Prime Healthcare Services, Inc. ("Prime"), one of the CHA member hospital systems. Prime's actions towards Kaiser illustrate just how abusive balance billing can be, particularly when used as it often is as an *in terrorem* extortion device against health plan members to force the payment of sums that clearly are not payable under the law or are at best disputed.

1 For several years, Kaiser and Prime have been engaged in a dispute over extraordinary  
2 charges claimed by Prime hospitals for services provided to Kaiser members. These disputes  
3 culminated in Prime filing five lawsuits against Kaiser in January 2008. However, Prime  
4 apparently grew disenchanted with the pace of those lawsuits. In May 2008, notwithstanding its  
5 pending lawsuits seeking to collect against Kaiser, Prime embarked on a balance billing  
6 campaign against the patients in which it sent thousands of collection notices seeking to recover  
7 the same funds already at issue in Prime’s lawsuits. The collection notices threatened to report  
8 the members’ accounts to credit reporting bureaus within 30 days unless the members paid in full  
9 the outrageous amounts claimed.

10 Prime’s admitted objective in making these unconscionable threats against the patients  
11 was not to actually collect this money from the members – the majority of whom are unable to  
12 pay what Prime demands in any event – but rather to pressure Kaiser to relinquish its defenses  
13 and pay Prime more than it is due. Prime has repeatedly admitted as much in the press, and the  
14 CEO of three Prime hospitals has even given a sworn declaration stating that the bills and  
15 collection notices

16 ...were part of an effort to **encourage Kaiser enrollees to complain** to Kaiser  
17 and/or to the DMHC about Kaiser’s unreasonable claims settlement practices  
18 **with the expectation that such complaints would prompt settlement** of the  
19 Kaiser Lawsuit **and prompt Kaiser to reasonably reimburse the hospitals** so  
20 future lawsuits would not be necessary.

21 See Ex. B at ¶ 5 (Narbutas Decl.; emphasis added).

22 After Prime ignored Kaiser’s request to cease and desist from these efforts to extort  
23 money from Kaiser and its members, Kaiser sued Prime and sought immediate injunctive relief,  
24 which the Los Angeles Superior Court granted on May 16, 2008, along with a subsequent  
25 judicial finding that Prime’s balance billing efforts were “at best a sharp practice and not one to  
26 be condoned.” As that Court found:

27 It seems plain that **Prime’s purpose in sending the bills and demand letters to**  
28 **Kaiser members was not really to obtain payment from them, but rather to**

1           **force Kaiser to settle the Prime lawsuits.** Prime wanted the members to  
2           telephone Kaiser and pressure it to settle with Prime. Indeed, Prime’s collection  
3           demand letter even provides Kaiser’s telephone number for the member to call.  
4           Prime’s purpose has been achieved. Kaiser has, in fact, received the flood of calls  
5           from its members that Prime anticipated. This purpose – sending a collection  
6           letter to a third party in order to force an opposing litigant to settle a lawsuit – **was**  
7           **at best a sharp practice and not one to be condoned . . . . The impact of these**  
8           **dunning collection letters on the members who received them, and the public**  
9           **interest in preventing this kind of *in terrorem* tactic, cannot be overstated.**

10           There simply is no legitimate reason to scare thousands of Kaiser members in an  
11           effort to collect from Kaiser.

12           See Ex. C at 6-7 (transcript of tentative ruling on preliminary injunction; emphasis added).

13           In its balance billing campaign, heedless of the emotional distress it would cause, Prime  
14           demanded payment from patients already suffering from debilitating illnesses, battling financial  
15           distress, or both. For example, Kaiser member Sara Pezeshkpour declared that:

16           Both the bill and the demand notice claim that I owe **\$28,207.33 for services**  
17           **rendered in December, 2006.** I do not owe that sum and was astonished and  
18           frightened to have received these letters as I can not afford to pay this amount. I  
19           just graduated from UCLA law school and am in the process of purchasing my  
20           first home. **When I received the bill and demand notice, I was extremely**  
21           **upset.**

22           See Ex. D at ¶3 (Pezeshkpour Decl.; emphasis added). Similarly, Celina Fuentes – an 80-year-  
23           old Kaiser member – declared that:

24           In the bill and collection notice, the Hospital and Action Collection Services  
25           claim that I owe the Hospital **\$5,239.00** for medical treatment I received in March  
26           2007. [They also] state that they will report me to a credit reporting bureau if I do  
27           not pay the amount demanded within 30 days from the date of the notice. I was  
28           scared when I received [those materials]. **I am 80 years old and my husband is**

1           **84 years old.** We are both Kaiser members. Our health and ability to receive  
2           healthcare are the top priorities in our lives. My husband and I rely on Social  
3           Security for income. **The Hospital is demanding that we pay, what is for us,**  
4           **an insurmountable amount of money.** I do not believe that I personally owe the  
5           Hospital \$5,239 or any amount. I have never been in a legal situation before and  
6           do not want the Hospital and Action Collection Services to pursue any type of  
7           collection against me. **The payment demands and collection threats from**  
8           **Hospital and Action Collection Services have caused me great stress. This**  
9           **experience is emotionally and physically draining.**

10       See Ex. E at ¶¶ 3-7 (Fuentes Decl.; emphasis added).

11           These outrageous practices by Prime illustrate the true reason some hospitals support  
12       balance billing, and illustrate why the DMHC’s authority to promulgate and enforce its recent  
13       regulations concerning balance billing is so important to protect patients from these abusive  
14       tactics and to maintain order in the health care delivery system while keeping emergency care  
15       available to all.

16       **B.     Kaiser Urges The Court To Deny The Petition and Sustain the DMHC’s Authority**  
17       **to Address the Whole Problem of Balance Billing, Instead of Just One Half of the**  
18       **Problem.**

19           **1.     The DMHC’s regulation defining balance billing as an unfair billing pattern**  
20           **is legally justified.**

21           **a.     The phrase “as defined by the department” in § 1371.39 does not**  
22           **prohibit regulation.**

23           As an initial matter, the Court should observe that the mere fact that Health & Safety  
24       Code § 1371.39(c) ordered the DMHC to report back to the Legislature regarding the  
25       development of the definition of “unfair billing pattern” does not mean that the Legislature  
26       meant to handcuff the DMHC and prevent the DMHC from regulating and implementing the  
27       statute pending future amendment. Instead, § 1371.39(b)(1) as of its moment of operation  
28       prohibited “demonstrable and unjustified billing practices, *as defined by the department*”  
(emphasis added), conferring to the DMHC the immediate ability to implement or interpret what

1 an “unfair billing pattern” would prohibit. Gov. Code §§ 11342.1, 11342.2, 11349.1(a)(5),  
2 11349(3).

3 To avoid this conclusion, Petitioners (at Op. Brf. 6:23) attempt to distinguish between §  
4 1371.37 (on “unfair payment pattern”) and 1371.39 (on “unfair billing pattern”) on the basis that  
5 “unfair payment patterns” was completely defined (and thus subject to regulation) but “unfair  
6 billing pattern” was not defined (and thus not subject to regulation). The distinction is only one  
7 of form, not substance.

8 The relevant portions of § 1371.37 read as follows:

9  
10 (c) An “unfair payment pattern,” as used in this section, means  
any of the following:

11 (1) Engaging in a demonstrable and unjust pattern, *as defined by*  
12 *the department*, of reviewing or processing complete and accurate  
claims that results in payment delays.

13  
14 (2) Engaging in a demonstrable and unjust pattern, *as defined by*  
*the department*, of reducing the amount of payment or denying complete  
15 and accurate claims.

16 (3) Failing on a repeated basis to pay the uncontested portions of  
17 a claim within the timeframes specified in Section 1371, 1371.1, or  
1371.35.

18 (4) Failing on a repeated basis to automatically include the  
19 interest due on claims pursuant to Section 1371.

20 (i) *On or before December 31, 2001, the department shall report to*  
21 *the Legislature and the Governor information regarding the*  
22 *development of the definition of “unjust pattern” as used in this*  
23 *section.* This report shall include, but not be limited to, a  
description of the process used and a list of the parties involved in  
the department’s development of this definition as well as  
24 recommendations for statutory adoption.

25 Note that the §1371.37 subsections referencing “a demonstrable and unjust pattern” concerning  
26 claims payment issues both contain the “as defined by the department” language, on which the  
27 DMHC is requested to report back to the Legislature. Section 1371.39 essentially does the same  
28 for “unfair billing pattern”; only the structure of the paragraphs is different in that “unbundling  
of claims,” etc., are not broken out into separate subparagraphs. It states:

1  
2 (b) Plans may report to the department’s Office of Plan and  
3 Provider Relations, either through the toll-free provider line  
4 (877-525-1295) or e-mail address (plans-providers@dmhc.ca.gov),  
instances in which the plan believes a provider is engaging in an  
unfair billing pattern.

5 (1) “Unfair billing pattern” means engaging in a demonstrable and  
6 unjust pattern of unbundling of claims, upcoding of claims, or other  
7 demonstrable and unjustified billing patterns, *as defined by the  
department.*

8 (c) *On or before December 31, 2001, the department shall report to  
9 the Legislature and the Governor information regarding the  
10 development of the definition of “unfair billing pattern” as used in  
11 this section.* This report shall include, but not be limited to, a  
description of the process used and a list of the parties involved in  
the department’s development of this definition as well as  
recommendations for statutory adoption.

12 Petitioners do not contest the DMHC’s ability to issue regulations under § 1371.37(c) on the  
13 basis that the DMHC never reported back or caused the statute to be amended to further define  
14 “unfair payment pattern,” and it is disingenuous to argue that the same “as defined by the  
15 department” language in § 1371.39 operates to prohibit the DMHC from regulating what  
16 qualifies as an “unfair billing pattern.”

17 **b. The provisions of AB 1455 should be interpreted to work in a**  
18 **coordinated manner consistent with its purpose.**

19 Finally, it makes no sense to assume (as Petitioners necessarily do) that when the  
20 Legislature passed AB 1455 it intended that the DMHC could define and oversee plans’ claims  
21 payable practices without also being able to simultaneously address providers’ billing practices.  
22 Under California law, administrative regulations are valid as long as they are not in conflict with  
23 the implementing statute and are reasonably necessary to accomplish the goals or “mandate” of  
24 the statute. AB 1455’s mandate is clear: “to facilitate the prompt and efficient *submission*,  
25 processing and payment of claims,” and to ensure that “[h]ealth care services [will] be available  
26 to citizens without *unnecessary administrative procedures*, interruptions or delays.” AB 1455 §  
27 1 (emphasis added). AB 1455 further states that the DMHC “should be authorized to assist in  
28 the development of a new and more efficient system of claims *submission*, processing and

1 payment...” AB 1455 § 1(d) (emphasis added). The regulations at issue are clearly consistent  
2 with and reasonably necessary to implement this mandate. The DMHC’s regulations are its  
3 efforts to ensure a smooth and efficient billing and payment process, as well as to prevent the  
4 unnecessary – and inappropriate – involvement of patients in that process.

5 A regulation is valid so long as it is 1) “consistent and not in conflict with the  
6 [implementing] statute” and 2) “reasonably necessary to effectuate the purpose of the statute.”  
7 Cal. Gov. Code § 11342.2. The first part of the test requires a court to assess whether the agency  
8 reasonably interpreted the legislative mandate. *Credit Ins. Gen. Agents Assn. v. Payne*, 16  
9 Cal.3d 651, 657 (1976). The second test requires a court to assess whether the regulation is  
10 “reasonably necessary” to effectuate that mandate. *Id.* In determining whether the regulation is  
11 “reasonably necessary,” a court “will defer to the agency’s expertise and will not superimpose its  
12 own policy judgment on the agency in the absence of an arbitrary and capricious decision.”  
13 *Moore v. Cal. State Bd. of Accountancy*, 2 Cal.4th 999, 1015 (1992); *Tomlinson v. Qualcomm,*  
14 *Inc.*, 97 Cal.App.4th 934, 943 n.10 (4th Dist. 2002) (“absence of any specific [statutory]  
15 provisions regarding the regulation of [an issue] does not mean that such a regulation exceeds  
16 statutory authority.... The [agency] is authorized to fill up the details of the statutory scheme.”)  
17 (internal citations omitted).

18 Clearly, the DMHC’s promulgation of regulations are within the scope of the mandate of  
19 AB 1455, and are reasonably necessary in effectuating that purpose. By promulgating  
20 regulations that will protect patients from unwarranted and unnecessary billing by providers, the  
21 DMHC fulfills the statute’s mandate to ensure that “[h]ealth care services [will] be available to  
22 citizens without *unnecessary administrative procedures*, interruptions or delays.” Further, the  
23 regulations eliminate unnecessary and unwarranted involvement of patients in the billing and  
24 payment process, which “assist[s] in the development of a new and more efficient system of  
25 claims *submission*, processing and payment.” Finally, the regulations are in the interest of public  
26 policy by ensuring that patients are not used as bargaining chips between the providers and  
27 insurers, and by restricting the negotiations over the payment of claims between the most  
28 knowledgeable parties in the equation – providers and insurers.

1           It is well-established that regulating agencies have not only the powers granted to them  
2 by statute but also the incidental authority necessary to produce an efficient and effective  
3 administrative enforcement of the public interest. *McHugh v. Santa Monica Rent Control Board*,  
4 49 Cal. 3d 348, 375-376 (1989) (authority to set and regulate rents includes authority to review  
5 rents actually charged and order adjustments to assure compliance with price control  
6 regulations); *Kolnick v. Board of Medical Quality Assurance*, 101 Cal. App. 3d 80, 86-87 (1980)  
7 (administrative agency with licensing power also has authority to revoke licenses). And it is  
8 axiomatic that claims payable for the plans are generated by the bills that the providers submit.  
9 If the claims practices are regulated but the billing practices are not, the providers have an  
10 obvious advantage to exploit. Billing practices need to be regulated, and to be regulated in a  
11 manner that is coordinated with how the claims payable are being regulated.

12           In the absence of synthesized regulation of the inputs to as well as the outputs from the  
13 plans' claims payable systems, the system becomes chaotic and unworkable, like trying to run  
14 and regulate a parking garage only by collecting money and letting cars out in an orderly fashion  
15 when they exit. If there's no coordinated and simultaneous control on the flow of cars coming  
16 into the garage or how long the cars stay in the garage before leaving, cars will inevitably stay  
17 too long, fill up all the spots, double park, block the access to the exits, etc. The providers argue  
18 that the DMHC is only empowered to make suggestions, but this argument puts form over  
19 substance. DMHC has a critical job to do in regulating health plans and protecting California  
20 consumers, and the regulations at issue are critical to carrying out that mandate in a coordinated  
21 fashion.

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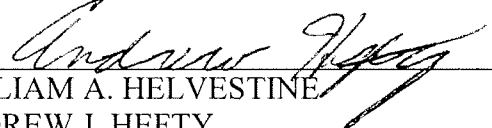
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**C. Conclusion**

For all of the foregoing reasons, the *amicus curiae* Kaiser entities request that the Court reject Petitioners' Petition and allow the DMHC regulation to stand.

DATED: November 7, 2008

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12 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
13 **FOR THE COUNTY OF SACRAMENTO**

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20 CARE, STATE OF CALIFORNIA, ET AL.

21 Respondents / Defendants.  
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23  
24

CASE NO: 34-2008-80000059

**DECLARATION OF ANDREW J. HEFTY  
IN SUPPORT OF APPLICATION AND  
*AMICUS CURIAE* BRIEF OF KAISER  
FOUNDATION HOSPITALS, SOUTHERN  
CALIFORNIA PERMANENTE MEDICAL  
GROUP, THE PERMANENTE MEDICAL  
GROUP, INC., AND KAISER  
FOUNDATION HEALTH PLAN, INC. IN  
SUPPORT OF OPPOSITION TO  
PLAINTIFF'S PETITION FOR WRIT OF  
MANDATE AND COMPLAINT FOR  
DECLARATORY AND INJUNCTIVE  
RELIEF**

**Hon. Michael Kenny**

**Date: November 12, 2008**

Time: 9:30 a.m.

Dept.: 31

Complaint filed September 26, 2008

Writ Hearing: November 21, 2008



# **Exhibit A**

<b>Policy Title:</b>	Balance Billing Non-Members for Non-Contracted Commercial or Medicare Risk Balances	<b>Policy Number:</b>	06_008
<b>Owner Department:</b>	Patient Business Services	<b>Date Last Reviewed:</b>	
<b>Original Approval:</b>	6/30/06	<b>Date Revision Approved:</b>	
<b>Original Communication:</b>	7/21/06	<b>Date Revision Communicated:</b>	
<b>Original Effective:</b>	6/30/06	<b>Revision Effective:</b>	
<b>Next Revision Date:</b>	6/30/08	<b>Page:</b>	1 of 1

Revenue Cycle Function: Billing, Collections & Bad Debt, Payment Processing

## 1.0 Policy Statement

- 1.1 Kaiser Permanente will value services paid by non-contracted providers at an amount equal to Usual and Customary by geographic location. Non members will not be billed for the difference between the billed amount and allowed amount as noted by the non-contracted payor. Any disagreement with payment received from another health care payor will be addressed through that entity's provider dispute resolution process.
- 1.2 Patients will only be billed for those amounts designated by the payor as out of pocket expense.

## 2.0 Purpose

- 2.1 Kaiser Permanente is dedicated to providing high quality medical care to all patients, including emergency and related inpatient care and services to the general community, with the goal of maintaining a leadership role in the medical community. Kaiser Permanente supports the principle of fair and appropriate billing practices and related collection processes.
- 2.2 Kaiser Foundation Hospitals recognizes that some patients have health care coverage outside of Kaiser Permanente and that these outside entities are responsible for all or part of the cost of the care and services provided to those patients by Kaiser Permanente. Neither Kaiser Foundation Hospitals nor the Permanente medical groups contract with these other providers of health care coverage and there are therefore no agreed-upon rates of compensation with these entities. As a result, Kaiser Foundation Hospitals may be reimbursed for care and services to these patients at some rate less than billed charges.
- 2.3 This Policy is intended to establish the practice of Kaiser Foundation Hospitals regarding the collection of payment for care provided to patients with health care coverage outside of Kaiser Permanente, consistent with California law and equitable billing practices and collection processes.

## 3.0 Scope/Coverage

- 3.1 This policy affects the following PBS departments: Revenue and Banking Services (RaBS) and the Central Business Office (CBO).

## 4.0 Definitions

- 4.1 Administrative Adjustment: A credit or debit non-payment transaction on an account due to circumstances other than contractual allowances.

## 5.0 Provisions

- 5.1.1 This policy applies to Non-Contracted Commercial or Medicare Risk accounts.

- 5.1.2 Amounts denied by a Commercial or other payer will be addressed through KP denial management procedures.
- 5.1.3 Administrative adjustment requests will be submitted to the appropriate authority levels(s) to review for accuracy, validity, and proper approval. These approval levels are outlined in the Write-off & Adjustment Policy – Administrative Adjustments.

## 6.0 References/Appendices

- 6.1 Cite references, if any that were used to develop the Policy including other Policies or Regulatory citations. Indicate related Regulatory Citations, National, Regional, Service Area/Local or Departmental Policies and Procedures.

Appendices – Any additional material that will assist in the interpretation or implementation of the Policy and its provisions. List all appendices referred to in the Policy, numbered in the order they are referred to in the Policy. Appendices can include, but are not limited to, templates, charts, guidelines for procedures, sample procedures, frequently asked questions, diagrams, forms, flow charts and other visuals.

Please use the reference table to indicate references used in the development of this Policy.

<b>REGULATORY CITATIONS</b>	
<b>Regulatory Reference Title / Name</b>	<b>Website / Location</b>
CA Health & Safety Code 1262.8	<a href="http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&amp;group=01001-02000&amp;file=1250-1264">http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&amp;group=01001-02000&amp;file=1250-1264</a>
Title 28 California Code of Regulations 1300.71.38	<a href="http://www.hmoHELP.ca.gov/library/regulations/title28/html/title28.htm">http://www.hmoHELP.ca.gov/library/regulations/title28/html/title28.htm</a>
<b>NATIONAL POLICY AND PROCEDURES</b>	
<b>Policy or Procedure Name</b>	<b>Website / Location</b>
N/A	
<b>REGIONAL POLICIES AND PROCEDURES</b>	
<b>Policy or Procedure Name</b>	<b>Website / Location</b>
N/A	
<b>SERVICE AREA / LOCAL / CBO / DEPARTMENTAL POLICIES AND PROCEDURES</b>	
<b>Policy or Procedure Name</b>	<b>Website / Location</b>
Write-Off/Adjustment Approval Document. Policy no. 04-111	<a href="http://kpnet.kp.org/california/pbs/docs/09policy/208.pnp.fm5.htm">http://kpnet.kp.org/california/pbs/docs/09policy/208.pnp.fm5.htm</a>
Posting Adjustments HB Desktops HB 11	<a href="http://kpnet.kp.org/california/pbs/docs/05systems/ramp/214.rmp.fm7.htm#HB11">http://kpnet.kp.org/california/pbs/docs/05systems/ramp/214.rmp.fm7.htm#HB11</a>
<b>Appendices</b>	
<b>Appendix Name</b>	<b>Appendix Topic / Contents</b>
N/A	

## 7.0 Review



7.1 This Policy should be reviewed on a biennial schedule. This Policy establishes the standard for Balance Billing and should be reviewed along the normal biennial review schedule as other Policies.

**8.0 Accountable Executive**

8.1 The National Vice President, Patient Business Services is accountable for implementing and ensuring compliance with this policy.

**9.0 Signature Lines**

Include the signature(s) of the PBS leader that approved the Policy in accordance with the PBS Policy guidelines.

<b>Name</b>	<b>Title</b>	<b>Date</b>

<b>Signature</b>

<b>Name</b>	<b>Title</b>	<b>Date</b>

<b>Signature</b>

# **Exhibit B**

1 Ronald S. Hodges - Bar No. 150586  
Evan W. Granowitz - Bar No. 234031  
2 **SHULMAN HODGES & BASTIAN LLP**  
26632 Towne Centre Drive, Suite 300  
3 Foothill Ranch, California 92610-2808  
Telephone: (949) 340-3400  
4 Facsimile: (949) 340-3000  
Email: RHodges@shbllp.com  
5

6 Attorneys for Prime Healthcare Services, Inc.,  
Prime Healthcare Anaheim, LLC, Prime  
7 Healthcare La Palma, LLC, Prime Healthcare  
Huntington Beach, LLC

8 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
9 **FOR THE COUNTY OF ORANGE, CENTRAL JUSTICE CENTER**  
10

11 **People of the State of California, by and** )  
12 **through their representative Lucinda A.** )  
13 **Ehnes as Director of the Department of** )  
14 **Managed Health Care,** )

15 Plaintiff,

16 vs.

17 **Prime Healthcare Services, Inc., a** )  
18 **corporation; Prime Healthcare Anaheim,** )  
19 **LLC, a limited liability company; Prime** )  
20 **HealthCare La Palma, LLC, a limited** )  
21 **liability company; Prime Healthcare** )  
22 **Huntington Beach, LLC, a limited liability** )  
23 **company; and DOES 1-100, inclusive,** )

24 Defendants.

Case No. 30-2008-00108627

[Assigned for all purposes to the Honorable  
Gregory H. Lewis, Department C26]

**NOTICE OF DEFENDANTS' SPECIAL  
MOTION TO STRIKE AND SPECIAL  
MOTION TO STRIKE PLAINTIFF'S  
FIRST AMENDED COMPLAINT  
PURSUANT TO CCP § 425.16;  
MEMORANDUM OF POINTS AND  
AUTHORITIES; DECLARATIONS OF  
VIRG NARBUTAS AND MICHAEL J.  
SARRAO IN SUPPORT**

Date: September 8, 2008  
Time: 10:30 a.m.  
Dept.: C26

Complaint Filed: June 30, 2008  
Trial Date: None  
Discovery Cutoff: None

[Demurrer and Combined Request for Judicial  
Notice filed concurrently]

25 ///  
26 ///  
27 ///  
28 ///

**DECLARATION OF VIRG NARBUTAS**

I, Virg Narbutas, declare:

1. I am the Regional Chief Executive Officer for West Anaheim Medical Center, Huntington Beach Hospital, and La Palma Intercommunity Hospital. I have personal knowledge of the following facts and could and would testify thereto if called upon to do so.

2. On May 14, 2008, I attended the public hearing held by the Department of Managed Health Care in Irvine, California. In addition to myself, Prime Healthcare objected through Lloyd Wilensky, Prime Healthcare's Vice-President of Operations, and Alan Smith, Chief Financial Officer at West Anaheim Medical Center, who spoke out against the proposed regulations to prohibit balance billing.

3. Prime Healthcare Anaheim, LLC, Prime Healthcare Huntington Beach, LLC, and Prime Healthcare La Palma, LLC are the licensed operators of West Anaheim Medical Center, Huntington Beach Hospital, and La Palma Intercommunity Hospital and are the entities with the right to seek payment for the institutional portion of services provided at West Anaheim Medical Center, Huntington Beach Hospital, and La Palma Intercommunity Hospital.

4. Attached hereto as ~~Exhibit 1~~ is a true and correct copy of a notice which was sent by Action Collection Services, LLC to certain Kaiser members on or about May 1, 2008 for claims referred to Action Collection Services by West Anaheim Medical Center. Exhibit 1 includes two letters/notices, a letter/notice from Action Collection Services and a letter/notice from West Anaheim Medical Center. The second letter from West Anaheim Medical Center was sent by Action Collection Services on behalf of West Anaheim Medical Center. Similar letters/notices were sent as relates to claims from Huntington Beach Hospital and La Palma Intercommunity Hospital. That is, a letter/notice from Action Collection Services and a letter/notice from Huntington Beach Hospital/La Palma Intercommunity Hospital.

5. The notices referenced in ¶ 4 were sent to cause a settlement of the Kaiser Lawsuit and in serious contemplation of future lawsuits against Kaiser and/or the patients who received the emergency services at the hospitals and agreed to pay for the same as the notices included claims which are not involved in the Kaiser Lawsuit. The notices were part of an effort to encourage Kaiser enrollees to complain to Kaiser and/or to the DMHC about Kaiser's unreasonable claims settlement

1 practices with the expectation that such complaints would prompt settlement of the Kaiser Lawsuit  
2 and prompt Kaiser to reasonably reimburse the hospitals so future lawsuits would not be necessary.  
3 This is especially true in those cases where Kaiser denied the claims based on its contention that its  
4 members should not have sought emergent care or that the member was stable for transfer at some  
5 point during the stay.

6 6. The notices referenced in ¶ 4, like all demand letters that Defendants have sent to patients,  
7 were sent in an attempt to avoid litigation, which Defendants were seriously contemplating, in an  
8 effort to vindicate Defendants' right to payment for emergency services provided to the patients, for  
9 which the patients agreed to pay when they signed their admission form to the hospital.

10 7. Prior to the service of the DMHC's lawsuit in this matter on June 30, 2008, West Anaheim  
11 Medical Center, Huntington Beach Hospital, and La Palma Intercommunity Hospital had never  
12 received any written communications from the DMHC in which the DMHC claimed that balance  
13 billing by providers without a written contract was prohibited by Health & Safety Code § 1379(b).

14 I declare under penalty of perjury under the laws of the State of California that the foregoing  
15 is true and correct and that this declaration was executed on August 11, 2008 at Anaheim, California.

16 **SEE FACSIMILE**  
17 **SIGNATURE ATTACHED**

18 Virg Narbutas

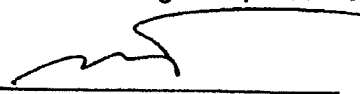
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16  
17   
18 Virg Narbutas

# **Exhibit C**

Plaintiff Kaiser Foundation Health Plan, Inc. (“Kaiser”) seeks a preliminary injunction to prohibit Defendants Prime Healthcare Services, Inc. *et al.* (“Prime”) from taking or initiating any collection efforts against Kaiser members. The court has read and considered the moving papers, opposition<sup>1</sup> and reply, and renders the following tentative decision.

#### **A. Statement of the Case**

Plaintiff Kaiser commenced this action on May 15, 2008, alleging claims for violation of B&P section 17200 (“UCL”), common law unfair competition, interference with contract and interference with prospective economic advantage.

The claims arise out of Defendants’ actions in attempting to collect disputed debts from Kaiser members. Defendants’ conduct is an attempt to gain leverage in separate lawsuits against Kaiser, which also concern the disputed bills.

On May 16, 2008, the court issue a temporary restraining order (“TRO”), enjoining Prime or its agents from pursuing further collection efforts against any Kaiser member.

#### **B. Applicable Law**

An injunction is a writ or order requiring a person to refrain from a particular act; it may be granted by the court in which the action is brought, or by a judge thereof; and when granted by a judge, it may be enforced as an order of the court. CCP §525. An injunction may be more completely defined as a writ or order commanding a person either to perform or to refrain from performing a particular act. *See Comfort v. Comfort* (1941) 17 Cal.2d 736, 741. *McDowell v. Watson* (1997) 59 Cal.App.4th 1155, 1160.<sup>2</sup> It is an equitable remedy available generally in the protection or to prevent the invasion of a legal right. *Meridian, Ltd. v. City And County of San Francisco, et al.* (1939) 13 Cal.2d 424.

The purpose of a preliminary injunction is to preserve the *status quo* pending final resolution upon a trial. *See Scaringe v. J.C.C. Enterprises, Inc.* (1988) 205 Cal.App.3d 1536.

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<sup>1</sup>The court did not read or consider Prime’s opposition brief, filed on June 2, 2008, for two reasons. First, in an obvious attempt to circumvent the page limitations of CRC 3.1113(d), the brief is printed in 11-point font. The minimum type size is 12-point. CRC 2.104. Second, much of the argument is based upon the depublished, and therefore uncitable, Prospect Medical Group v. Northridge Emergency Medical Group, in which the California Supreme Court has granted review. *See* CRC 8.1115. The court has considered Prime’s admissible evidence.

<sup>2</sup>The courts look to the substance of an injunction to determine whether it is prohibitory or mandatory. Agricultural Labor Relations Bd. v. Superior Court, (1983) 149 Cal.App.3d 709, 713. A mandatory injunction--one that mandates a party to affirmatively act, carries a heavy burden: “[t]he granting of a mandatory injunction pending trial is not permitted except in extreme cases where the right thereto is clearly established.” Teachers Ins. & Annuity Assoc. v. Furlotti, (1999) 70 Cal.App.4th 187, 1493.

Grothe v. Cortlandt Corp. (1992) 11 Cal.App.4th 1313, 1316; Major v. Miraverde Homeowners Assn. (1992) 7 Cal.App.4th 618, 623. The *status quo* has been defined to mean the last actual peaceable, uncontested status which preceded the pending controversy. Voorhies v. Greene (1983) 139 Cal.App.3d 989, 995, quoting United Railroads v. Superior Court (1916) 172 Cal. 80, 87. 14859 Moorpark Homeowner's Assn. v. VRT Corp. (1998) 63 Cal.App.4th 1396, 1402.

A preliminary injunction is issued after hearing on a noticed motion. The complaint normally must plead injunctive relief. CCP §526(a)(1)-(2).<sup>3</sup> Preliminary injunctive relief requires the use of competent evidence to create a sufficient factual showing on the grounds for relief. See e.g. Ancora-Citronelle Corp. v. Green, 41 Cal.App.3d 146, 150. Injunctive relief may be granted based on a verified complaint only if it contains sufficient evidentiary, not ultimate, facts. See CCP §527(a). For this reason, a pleading alone rarely suffices. Weil & Brown, California Procedure Before Trial, 9:579, 9(11)-21 (The Rutter Group 2007). The burden of proof is on the plaintiff as moving party. O'Connell v. Superior Court, (2006) 141 Cal.App.4th 1452, 1481.

A plaintiff seeking injunctive relief must show the absence of an adequate damages remedy at law. CCP §526(4); Thayer Plymouth Center, Inc. v. Chrysler Motors, (1967) 255 Cal.App.2d 300, 307; Department of Fish & Game v. Anderson-Cottonwood Irrigation Dist. (1992) 8 Cal.App.4th 1554, 1565. The idea "inadequacy of the legal remedy" or "inadequacy of damages" dates from the time of the early courts of chancery, the idea being that an injunction is an unusual or extraordinary equitable remedy which will not be granted if the remedy at law (usually damages) will adequately compensate the injured plaintiff. Department of Fish & Game v. Anderson-Cottonwood Irrigation Dist. (1992) 8 Cal.App.4th 1554, 1565.

In determining whether to issue a preliminary injunction, the trial court considers two factors: (1) the reasonable probability that the plaintiff will prevail on the merits at trial (CCP §526(a)(1)), and (2) a balancing of the "irreparable harm" that the plaintiff is likely to sustain if the injunction is denied as compared to the harm that the defendant is likely to suffer if the court grants a preliminary injunction. CCP §526(a)(2) 14859 Moorpark Homeowner's Assn. v. VRT Corp. (1998) 63 Cal.App.4th 1396, 1402; Pillsbury, Madison & Sutro v. Schectman (1997) 55 Cal.App.4th 1279, 1283 [Rev. Den. 10/1/97]; Davenport v. Blue Cross of California (1997) 52 Cal.App.4th 435, 446; Abrams v. St. Johns Hospital (1994) 25 Cal.App.4th 628, 636. Thus, a preliminary injunction may not issue without some showing of potential entitlement to such relief. Doe v. Wilson (1997) 57 Cal.App.4th 296, 304. The decision to grant a preliminary injunction generally lies within the sound discretion of the trial court and will not be disturbed on appeal absent an abuse of discretion. Thornton v. Carlson (1992) 4 Cal.App.4th 1249, 1255.

A preliminary injunction ordinarily cannot take effect unless and until the plaintiff provides an undertaking for damages which the enjoined defendant may sustain by reason of the injunction if the court finally decides that the plaintiff was not entitled to the injunction. See CCP §529(a); City of South San Francisco v. Cypress Lawn Cemetery Assn. (1992) 11 Cal.App.4th 916, 920.

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<sup>3</sup>However, a court may issue an injunction to maintain the *status quo* without a cause of action in the complaint. CCP §526(a)(3).

### C. Analysis<sup>4</sup>

This case concerns billing for emergency room services. Plaintiff Kaiser seeks an order enjoining all Defendants from engaging in unfair and unlawful intimidation tactics that target some six thousand Kaiser members.

#### 1. Governing Law

Kaiser is a health care service plan<sup>5</sup> regulated by The Knox-Keene Act, H&S §1340 *et seq.*, is a system of licensing and regulation under the jurisdiction of the Department of Managed Health Care (“DMHC”). Bell v. Blue Cross of California, (2005) 131 Cal.App.4th 211, 215. Both federal and state law require that emergency services be provided without questioning the patient’s ability to pay. *Id.*; §1317; 42 U.S.C. §1395dd(d).. Pursuant to the Knox-Keene Act, health care service plans such as Kaiser are compelled to reimburse emergency health care providers such as Prime for emergency services to the plan’s enrollees, even though the provider has no written contract with the plan and the services are not pre-approved. §1371.4; Ochs v. PacifiCare of California, (2004) 115 Cal.App.4th 782, 790.

If a provider believes that the health care plan has failed to pay the reasonable value of emergency room services, it may file a collection action against the plan. Bell, supra, 131 Cal.App.4th at 218. This action is based on an implied-in-law contract -- the provider has a statutory duty to provide stabilizing emergency room health care and the plan has a statutory duty to pay for emergency room services rendered to its enrollees. *Id.* The issues in such an action include whether the emergency services were actually performed (§1371.4(c)), and the reasonable and customary value of the emergency services rendered. Bell, supra 131 Cal.App.4th at 218.

Should the plan not pay the entire emergency services bill, the concept of balance billing

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<sup>4</sup>Kaiser asks the court to judicially notice the Notice of Removal to federal court of each of the Prime lawsuits. The request is granted. Ev. Code §452(d).

Prime asks the court to judicially notice various documents from the court file, which is unnecessary. In support of its opposition to the *ex parte* application for a TRO, Prime sought judicial notice of various documents from the Prime lawsuits, including the complaints and removal cover sheets, certain regulations of DMHC. These requests are granted. Ev. Code §452(b),(d).

Prime also sought judicial notice of a website article dated May 8, 2008, form collection letters, an Orange County Register news article, letters between counsel in this case, a depublished opinion in Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et al., a second Orange County Register article, and an *amicus curiae* brief filed with the Supreme Court by Kaiser’s counsel for another client in Prospect. Each of these matters is either not subject to judicial notice, are irrelevant, or both. The request is denied.

<sup>5</sup>The court has ruled on the parties’ evidentiary objections by placing “S” for “sustained” or “O” for “overruled” next to the original objection, sometimes with a comment, or by checking the appropriate box. Where an objection has been sustained, the court also has interlined the original evidence.

— the difference between a health care plan’s payment and the provider’s bill, excluding co-payments, coinsurance or deductibles -- comes into play. H&S section 1379(a) provides that every contract between a health care plan and a provider shall be in writing, and shall set forth that the member shall not be liable to the provider for any amount owed by the plan. In the event there is no written contract, the provider shall not collect or attempt to collect from the member any amount owed by the plan. H&S §1379(b).

Governor Schwarzenegger has signed an executive order directing DMHC to protect health plan members from balance billing. DMHC is pursuing that directive, and has a pending regulation that defines balance billing as an “unfair billing pattern.”

DMHC also has urged the Supreme Court in an *amicus* brief in the Prospect case that section 1379(b)’s prohibition against balance billing for unwritten contracts should apply to the Bell implied-in-law contract between a plan and a provider of emergency room services. This interpretation is based on the Knox-Keene Act intent to protect consumers over providers, and the plain language of section 1379 to prevent a provider from balance billing on all contracts between the provider and health plan, express or implied. DMHC disagreed with the appellate court that section 1379 requires a contract based on a meeting of the minds rather than one implied-in-law. Jacobs Decl., Ex. B, p.7-12. If the Supreme Court adopts DMHC’s interpretation, a provider would be prohibited from collecting from health plan enrollees where the plan owes for such services.

Finally, a provider is required to provide emergency room services only until the person is medically stabilized. The plan is not required to pay for post-stabilization care -- medically necessary care following medical stabilization — unless it has pre-authorized that care. *See* H&S §1371.4(j). The hospital provider is required by federal and state law to contact the plan before rendering such care to give it the opportunity to either authorize the care or arrange for transfer of the member to another hospital. H&S §1262.8; 42 CFR §422.113. A hospital required to contact a health care plan for authorization for post-stabilization services that does not do so provides such services at its own risk. It may not bill the plan and it may not bill the plan member either. H&S §1262.8(c).

## **2. Prime’s Litigation Tactic**

Prime has filed a collection action against Kaiser in five separate lawsuits, all of which have been removed by Kaiser to federal court (the “Prime lawsuits”). The Prime lawsuits seek over \$25 million for emergency room services provided to Kaiser members. Kaiser is defending the actions, claiming that Prime has a pattern of failing to notify Kaiser when its member is to receive post-stabilization services and of admitting patients to its hospitals through the emergency room for one-day admissions, all in an attempt to charge Kaiser.

In what seems a clearly abusive litigation tactic, on or about May 1, 2008 Prime sent a bill and a collection agency demand letter to thousands<sup>6</sup> of Kaiser members. The cover letter to the bill states that “Kaiser has failed to properly reimburse us for the care provided to you” and the “Hospital strongly disagrees with Kaiser’s unilateral determination but Kaiser leaves us no

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<sup>6</sup>Kaiser alleged that the number was 6,000, but its reply suggests that the number may be around 3,700.

choice but to seek payment from you even though we do not want to put you in the middle of our dispute with Kaiser.” See, e.g., Fuentes Decl., Ex. A.

The collection agency demand letter states that “the Hospital has exhausted its efforts in trying to collect the above referenced balance for emergency medical services rendered to you from Kaiser Permanente.” It threatens the members with collection activity over claims that already are the subject of the Prime lawsuit, including reporting the Kaiser member to a credit reporting bureau unless Kaiser pays the bills. It further suggests that the member contact Prime or Kaiser for assistance. See, e.g., Fuentes Decl. Ex. B.<sup>7</sup>

Most or all of these members had received no previous communication from the hospital. A number of the members are in the process of buying or refinancing homes, qualifying for car loans, or attempting to secure credit.

### **3. Kaiser's Lawsuit**

Kaiser's action concerns a UCL claim for unfair competition. It sent cease and desist letters to Prime to stop billing and sending demand letters to its members to no avail.

#### **a. Probability of Success**

Prime defended the TRO on the ground that the Kaiser members who received bills and collection letters for balance billing were patients whom it had a contractual right to bill. Prime had no right to bill the patients for post-stabilization services for which it did not receive Kaiser approval (H&S §1262.8(c)), and only has the right to bill for emergency services if DMHC is incorrect that H&S section 1379(b) prohibits a provider from collecting from health plan enrollees where the plan owes for such services.

Section 1379(b) may well have the meaning applied to it by DMHC. On its face, that section prohibits collection from a health plan member where there is an unwritten contract between the provider and the health plan. Bell states that such contract is implied-in-law. Prime's own lawsuit alleges an unwritten contract between it and Kaiser for these emergency room services. Therefore, Prime may be bound by its own allegation.

But the court need not interpret section 1379(b) and evaluate whether it requires a contract based on a meeting of the minds in order to determine that Kaiser has a probability of success on its UCL claim.

Section 17200, also known as the unfair competition law (UCL), provides that “unfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice[.]” Section 17200 is interpreted broadly and allows lawsuits based on the public's right to protection from fraud, deceit and other unlawful conduct, as well as actions aimed at anti-competitive business practices. See Hewlett v. Squaw Valley Ski Corp., (1997) 54 Cal.App.4th 499, 519. The law creates a streamlined procedure for the prevention of ongoing or threatened acts of unfair competition. Cortez v. Purolator Air Filtration Products Co., (2000) 23 Cal.4th 163, 173-74. The offense is one of strict liability for which causation and damages need not be shown. Bank of the West, (1992) 2 Cal.4th 1254, 1266-67. Injunctive relief and/or restitution are the authorized remedies for violations of section 17200. B&P Code §17203.

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<sup>7</sup>In addition, Prime has telephoned Kaiser members asking for payment.

The UCL governs anti-competitive business practices as well as injuries to consumers, and has as a major purpose the preservation of fair business competition. Barquis v. Merchants Collection Assn., (1972) 7 Cal.3d 94, 11. Section 17200 was once applicable only to unlawful business practices, requiring proof of a pattern or course of conduct, not just a single transaction. Poldolsky, et al. v. First HealthCare Corp., (1996) 50 Cal.App.4th 632, 653. However, the section was amended in 1992 to apply to any unlawful "act or practice," permitting invocation of the law based on a single instance of misconduct. Stop Youth Addiction, Inc. v. Lucky Stores, Inc., (1998) 17 Cal.4th 553, 570.

Section 17200 is written in the disjunctive, and establishes three varieties of unfair competition -- acts or practices that are unlawful, or unfair, or fraudulent. Cel-Tech Communications, inc. v. Los Angeles Cellular Telephone Co., (1999) 20 Cal.4th 163, 180. In general, the "unfairness" prong of section 17200 has been used to enjoin deceptive or sharp business practices. Klein v. Earth Elements, inc., (1997) 59 Cal.App.4th 965, 970. The test of whether a business practice is unfair involves an examination of the impact of the practice on the victim, balanced against the reasons, justifications, and motives of the alleged wrongdoer. Smith v. State Farm, 93 Cal.App.4th 700, 718. The "fraudulent" prong of section 17200 inquires simply "whether the public is likely to be deceived." This means that deception of some members of the public, or harm to the public interest, is likely. Watson laboratories, Inc. v. Rhone-Poulenc Rorer, (2001 C.D. Ca.) 178 F.Supp. 2d 1099, 1121. Unlike common law fraud, there is no requirement that anyone actually was deceived, relied upon the fraudulent practice, or sustained any damage. Poldolsky, et al. v. First HealthCare Corp., 50 Cal.App.4th at 653.<sup>8</sup>

Prime's bills and collection letters are both an unfair sharp practice and "fraudulent" in the sense that the public is likely to be misled.

It seems plain that Prime's purpose in sending the bills and demand letters to Kaiser members was not really to obtain payment from them, but rather to force Kaiser to settle the Prime lawsuits. Prime wanted the members to telephone Kaiser and pressure it to settle with Prime. Indeed, Prime's collection demand letter even provides Kaiser's telephone number for the member to call.

Prime's purpose has been achieved. Kaiser has, in fact, received the flood of calls from its members that Prime anticipated. This purpose — sending a collection letter to a third party in order to force an opposing litigant to settle a lawsuit — was at best a sharp practice and not one to be condoned.

In addition, the collection demand letter contains a false statement. It states "the Hospital has exhausted its efforts in trying to collect the above referenced balance for emergency medical services rendered to you from Kaiser Permanente." Of course, this statement is untrue. The Prime lawsuits are the means by Prime is seeking to obtain payment from Kaiser, and in no way

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<sup>8</sup> For the "unlawful" prong, section 17200 borrows violations of other laws, and makes them independently actionable. Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co., (1999) 20 Cal.4th 163, 180. Virtually any law -- federal, state or local -- can serve as a predicate for an unlawful conduct section 17200 claim (Stevens v. Superior Court, (1999) 75 Cal.App.4th 594, 602), including labor laws (Hernandez v. Stabach, (1983) 145 Cal.App.3d 309, 314-15) and vehicle laws. People v. James, (1981) 122 Cal.App.3d 25, 35-36.

has this avenue been exhausted. At the TRO hearing, Kaiser committed to pay any judgment resulting from the Prime lawsuits and the court has no evidence that Kaiser will actually be unable to pay. Therefore, Prime cannot credibly state that it has exhausted all efforts to collect from Kaiser, and the members receiving this letter were likely deceived by this statement.

The billing letter also falsely states that “Kaiser has failed to properly reimburse us for the care provided to you” and the “Hospital strongly disagrees with Kaiser’s unilateral determination but Kaiser leaves us no choice but to seek payment from you even though we do not want to put you in the middle of our dispute with Kaiser.” These statements, though not false, are misleading. Prime does have a choice other than putting the members in the middle of the dispute. It can collect from Kaiser in the Prime lawsuits.

The impact of these dunning collection letters on the members who received them, and the public interest in preventing this kind of *in terrorem* tactic, cannot be overstated. There simply is no legitimate reason to scare thousands of Kaiser members in an effort to collect from Kaiser.

All of this means that, whether or not Prime has the right to conduct balance billing of Kaiser members, it plainly has engaged in a sharp practice and has misled the public in the letters sent. Kaiser has shown a probability of success on its UCL claim for unfair and fraudulent business practice.<sup>9</sup>

#### **b. Irreparable Harm**

Each year, Kaiser receives thousands of claims from providers for emergency services rendered to its members. As part of its normal course of business, Kaiser pays for those services; when there is a dispute with the provider, Kaiser seeks to keep the member out of the dispute. Prime’s bill and collection efforts has put Kaiser’s members in the middle of the already pending Prime lawsuits.

There is no doubt that Kaiser is suffering irreparable harm. An important aspect of Kaiser’s business is to deliver service to members. When a member receives services from a non-contracted provider, the single most important aspect of the relationship between Kaiser and its members is confidence in Kaiser’s ability to service and protect the member with regard to bills for those emergency services. Prime’s collection threats have disrupted the relationship between Kaiser and its members.

Prime’s conduct also is causing, and will continue to cause, significant harm to large numbers of Kaiser members who have been targeted for the collection action. This harm includes emotional distress, as well as exposure to financial hardship and potential impairment of the members’ credit status.

The public interest must also be considered in balancing hardships. The public has a

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<sup>9</sup>Kaiser does not purport to challenge Prime’s right to collect, or attempt to collect, sums that are clearly the responsibility of Kaiser members - namely, co-pays, deductibles, co-insurance and non-emergent care rendered by Prime’s hospitals. Kaiser committed to pay any such claims through the date of hearing on preliminary injunction in order to obtain a TRO, but apparently wants that commitment to end.

strong interest in ensuring that health care plan members are not deceived or misled. It also has an interest in avoid the subjection of members to balance billing where it can be avoided, as evidenced by the Governor's executive order and DMHC's proposed regulation. *See Vo v. City of Garden Grove*, (2004) 115 Cal.App.4th 425, 435.

Prime's harm is difficult to quantify. Kaiser has committed on the record to pay whatever the judgment is in the Prime lawsuits. Since those lawsuits generally concern the very same bills at issue in Prime's collection effort, the principal harm Prime might suffer is a delay in receiving payment. Prime's cost of collecting these monies from members must be offset from any loss sustained from delayed payment.

This analysis assumes that the scope of the Prime lawsuits is co-extensive with the scope of the bills which Prime seeks to collect from Kaiser members. Prime's evidence suggests that they are not in one respect. Kaiser has refused to pay Prime for some services based on an assertion that the member owes them. Such claims would include co-payments and deductibles and co-insurance.<sup>10</sup> Kaiser acknowledges that co-payments, deductibles, and co-insurance are the member's responsibility. Reply at 1. While it committed to cover those claims to obtain the TRO, but now seeks to have any preliminary injunction narrowed so that they are not be included.

Any harm to Prime from a preliminary injunction can be avoided by permitting it to continue to collect from Kaiser members the portion of its bill (co-payments and deductibles) which Kaiser contends is solely the members responsibility.

The balance of hardships weighs strongly in favor of Kaiser, which has clearly established that both it and many of its members will suffer significant harm if the court does not issue the injunction. The public interest also weighs in favor of a preliminary injunction. The harm to Prime from a preliminary injunction is minimal, particularly if it is permitted to pursue those portions of the bills which Kaiser agrees are solely the member's responsibility.

#### **c. The Bond**

Conceptually, the bond should be the amount necessary to protect Prime in the event that it does not collect from Kaiser and ultimately is unable to collect from a member who would have paid during the pendency of this lawsuit. Neither party addresses the amount of bond in any evaluative manner. As a result, the court must arbitrarily set a bond. Given that the Prime lawsuits concern claims for \$25 million, it seems unlikely that the amount which would be unpaid by Kaiser and collectible from its members would exceed \$500,000. The bond is set at that amount.

#### **D. Conclusion**

The OSC re: preliminary injunction is granted conditioned on Kaiser posting a \$500,000 bond within five business days. The preliminary injunction shall preclude Prime from contacting Kaiser members during the pendency of this case for any collection purpose except for items owes solely by the member: co-payments, deductibles, and co-insurance

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<sup>10</sup>A fourth category -- "out-of-network services" — appears to be within the scope of the Prime lawsuits.

# **Exhibit D**

1 William A. Helvestine State Bar No. 058755  
Andrew J. Hefty State Bar No. 220450  
2 Jamie S. Platto State Bar No. 226723  
Carri Becker Maas State Bar No. 245816  
3 EPSTEIN BECKER & GREEN, P.C.  
One California Street, 26th Floor  
4 San Francisco, California 94111-5427  
Telephone: 415.398.3500  
5 Facsimile: 415.398.0955  
Emails: whelvestine@ebglaw.com;  
6 ahefty@ebglaw.com;  
jplatto@ebglaw.com;  
7 cmaas@ebglaw.com

8 David Jacobs State Bar No. 073545  
J. Susan Graham State Bar No. 128123  
9 EPSTEIN BECKER & GREEN, P.C.  
1925 Century Park East, Suite 500  
10 Los Angeles CA 90067  
Telephone: 310.556.8861  
11 Facsimile: 310.553.2165  
Emails: djacobs@ebglaw.com;  
12 sgraham@ebglaw.com

13 Attorneys for Plaintiff  
KAISER FOUNDATION HEALTH PLAN, INC.

14 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
15 **FOR THE COUNTY OF LOS ANGELES**  
16

17 KAISER FOUNDATION HEALTH PLAN,  
18 INC., a California nonprofit public benefit  
19 corporation,

20 Plaintiff,

21 v.

22 PRIME HEALTHCARE SERVICES, INC., a  
Delaware corporation; ACTION  
23 COLLECTION SERVICES, INC., a  
California limited liability company; PRIME  
24 HEALTHCARE SERVICES II, LLC, a  
Delaware limited liability company, doing  
25 business as Sherman Oaks Hospital;  
26 VERITAS HEALTH SERVICES, INC. a  
California corporation, doing business as  
27 Chino Valley Medical Center; PRIME  
28 HEALTHCARE SERVICES III, LLC, a

CASE NO: BC390969

**DECLARATIONS OF MEMBERS:**

1. CELINA E. FUENTES;
2. VICKI FUENTES;
3. WARREN HARDING;
4. VICTOR ORELLANA;
5. SARA PEZESHKPOUR;
6. LEILANI RAMIREZ;
7. KATHLEEN TROUT; and
8. JOSHUA ZITNIK

**IN SUPPORT OF MEMORANDUM OF  
POINTS AND AUTHORITIES IN SUPPORT  
OF PLAINTIFF'S EX PARTE  
APPLICATION FOR TEMPORARY  
RESTRAINING ORDER AND ORDER TO  
SHOW CAUSE RE PRELIMINARY  
INJUNCTION**

ORIGINAL FILED

MAY 16 2008

LOS ANGELES  
SUPERIOR COURT

1 Delaware limited liability company, doing  
2 business as Montclair Hospital Medical  
3 Center; DESERT VALLEY HOSPITAL,  
4 INC., a California corporation;  
5 DESERT VALLEY MEDICAL GROUP,  
6 INC., a California corporation;  
7 PRIME HEALTHCARE LA PALMA, LLC, a  
8 Delaware limited liability company, doing  
9 business as La Palma Intercommunity  
10 Hospital, PRIME HEALTHCARE  
11 HUNTINGTON BEACH, LLC, a Delaware  
12 limited liability company, doing business as  
13 Huntington Beach Hospital; PRIME  
14 HEALTHCARE ANAHEIM, LLC, a  
15 Delaware limited liability company, doing  
16 business as West Anaheim Medical Center;  
17 PRIME HEALTHCARE PARADISE  
18 VALLEY, LLC, a Delaware limited liability  
19 company, doing business as Paradise Valley  
20 Hospital; and Does 1-100, Inclusive,

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Defendants.

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**DECLARATION OF SARA PEZESHKPOUR**

I, Sara Pezeshkpour, declare as follows:

1. I am a current Kaiser member and I make this Declaration on personal knowledge and could and would competently testify to the facts set forth below if called upon to do so as witness.

2. Shortly after May 1, 2008, I received a bill from West Anaheim Medical Center and a demand notice from Action Collection Services. They were both dated May 1, 2008 and are attached hereto as Exhibits "A" and "B," respectively.

3. Both the bill and the demand notice claim that I owe \$28,207.33 for services rendered in December 2006. I do not owe that sum and was astonished and frightened to have received these letters as I cannot afford to pay this amount. I just graduated from UCLA Law School and am in the process of purchasing my first home. When I received the bill and the demand notice, I was extremely upset. One of my concerns that the hospital and collection agency would impair my credit and interfere with my ability to secure a loan for the purchase of my home. I have significant outstanding loans for my education, in the approximate amount of \$90,000. My credit, to date, has been excellent and I am very worried that West Anaheim Medical Center's collection actions will harm my credit rating.

4. I have been a member of Kaiser's health plans since approximately 1990. Prior to the collection activity of West Anaheim Medical Center and Action Collection Services, I had never experienced any problems with Kaiser's coverage of my medical care, including at West Anaheim Medical Center where I underwent a prior surgery in 2004.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 13 th day of May, 2008 at Los Angeles, California.

  
SARA PEZESHKPOUR

# EXHIBIT A

West Anaheim Medical Center  
FILE 1090 1801 W OLYMPIC  
PASADENA, CA 91199-1090

05/01/08

SARA PEZESHKPOUR  
[REDACTED]  
[REDACTED]

Patient Name: SARA PEZESHKPOUR  
Account Number: [REDACTED]  
Date of Service: 12/06/06  
Account Balance: \$ 28207.33

Dear SARA PEZESHKPOUR:

As you are aware, West Anaheim Medical Center (the "Hospital") provided emergency medical services to you on the dates referenced above. You presented to the emergency room for a medical condition that you reasonably believed needed immediate medical attention. Under the "Prudent Layperson Standard" and other state and federal regulations, you had the right to seek emergency medical services at the Hospital's emergency room, the Hospital had an obligation to provide those services necessary to stabilize your emergency medical condition, and your HMO, Kaiser, had a legal obligation to pay for the emergency medical services provided to you.

Under federal and state law ("EMTALA"), the Hospital was required not only to treat you in the emergency department but was also required to provide such care as ordered by the Board Certified physician who examined you with the necessary care to stabilize your emergency medical condition. This includes admitting you to the Hospital if such was necessary to stabilize your emergency medical condition as determined by a Board Certified Physician at the Hospital.

The Hospital has submitted a claim to Kaiser for the emergency medical services provide to you. Unfortunately, Kaiser has failed to properly reimburse us for the care provided to you. Kaiser's partial payment or total denial was based on its retrospective review of your medical chart and Kaiser has either determined that you did not have an emergency medical condition, that you were stable for transfer to a Kaiser facility miles away even though the physician examined you believed that you were not stable for transfer, or unilaterally determined its own reimbursement rates with no regards to the market based usual and customary rates uniformly charged by the hospitals.

The Hospital strongly disagrees with Kaiser's unilateral determination but Kaiser leaves us no choice but to seek payment from you even though we do not want to put you in the middle of our dispute with Kaiser. You may contact Kaiser Permanente at (800) 207-5084 or the Department of Managed Health Care ("DMHC") at (888) HMO-2219 for assistance. Otherwise the Hospital must pursue its collection efforts against you.

Please feel free to contact us at 714-229-4015 for any questions.

Sincerely,  
Business Office

## EXHIBIT B



**ACTION  
COLLECTION  
SERVICES.**

PO BOX 5139  
ANAHEIM, CA. 92814  
714-229-4092

05/01/08

SARA PEZESHKPOUR  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: SARA PEZESHKPOUR  
Account Number: \_\_\_\_\_  
Date of Service: 12/06/06  
Total charges: \$ 30807.33  
Account Balance: \$ 28207.33

Dear SARA PEZESHKPOUR:

This claim was referred to Action Collection Services by West Anaheim Medical Center (the "Hospital") for collection. The Hospital has exhausted its efforts in trying to collect the above referenced balance for emergency medical services rendered to you from Kaiser Permanente. For your reference, we are enclosing a copy of the letter sent by the Hospital to you outlining Kaiser's various tactics in denying fair and reasonable payments for the services.

As part of the collection efforts, if we fail to collect payment in this matter, we will report this account to the appropriate credit reporting bureaus thirty (30) days from the date of this letter. You may contact the Hospital, Kaiser Permanente at (800) 207-5084 or the Department of Managed Health Care at (888) HMO-2219 for assistance in this matter. Payment should be made to Action Collection Services or the Hospital.

Please feel free to contact us at 714-229-4092 for any questions

Sincerely,  
Business Office

# **Exhibit E**

1 William A. Helvestine State Bar No. 058755  
Andrew J. Hefty State Bar No. 220450  
2 Jamie S. Platto State Bar No. 226723  
Carri Becker Maas State Bar No. 245816  
3 EPSTEIN BECKER & GREEN, P.C.  
One California Street, 26th Floor  
4 San Francisco, California 94111-5427  
Telephone: 415.398.3500  
5 Facsimile: 415.398.0955  
Emails: whelvestine@ebglaw.com;  
6 ahefty@ebglaw.com;  
jplatto@ebglaw.com;  
7 cmaas@ebglaw.com

8 David Jacobs State Bar No. 073545  
J. Susan Graham State Bar No. 128123  
9 EPSTEIN BECKER & GREEN, P.C.  
1925 Century Park East, Suite 500  
10 Los Angeles CA 90067  
Telephone: 310.556.8861  
11 Facsimile: 310.553.2165  
Emails: djacobs@ebglaw.com;  
12 sgraham@ebglaw.com

13 Attorneys for Plaintiff  
KAISER FOUNDATION HEALTH PLAN, INC.

14 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
15 **FOR THE COUNTY OF LOS ANGELES**  
16

17 KAISER FOUNDATION HEALTH PLAN,  
18 INC., a California nonprofit public benefit  
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21 v.

22 PRIME HEALTHCARE SERVICES, INC., a  
Delaware corporation; ACTION  
23 COLLECTION SERVICES, INC., a  
California limited liability company; PRIME  
24 HEALTHCARE SERVICES II, LLC, a  
25 Delaware limited liability company, doing  
business as Sherman Oaks Hospital;  
26 VERITAS HEALTH SERVICES, INC. a  
California corporation, doing business as  
27 Chino Valley Medical Center; PRIME  
28 HEALTHCARE SERVICES III, LLC, a

CASE NO: BC390969

**DECLARATIONS OF MEMBERS:**

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4. VICTOR ORELLANA;
5. SARA PEZESHKPOUR;
6. LEILANI RAMIREZ;
7. KATHLEEN TROUT; and
8. JOSHUA ZITNIK

**IN SUPPORT OF MEMORANDUM OF  
POINTS AND AUTHORITIES IN SUPPORT  
OF PLAINTIFF'S EX PARTE  
APPLICATION FOR TEMPORARY  
RESTRAINING ORDER AND ORDER TO  
SHOW CAUSE RE PRELIMINARY  
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**ORIGINAL FILED**  
**MAY 16 2008**  
**LOS ANGELES  
SUPERIOR COURT**

1 Delaware limited liability company, doing  
2 business as Montclair Hospital Medical  
3 Center; DESERT VALLEY HOSPITAL,  
4 INC., a California corporation;  
5 DESERT VALLEY MEDICAL GROUP,  
6 INC., a California corporation;  
7 PRIME HEALTHCARE LA PALMA, LLC, a  
8 Delaware limited liability company, doing  
9 business as La Palma Intercommunity  
10 Hospital, PRIME HEALTHCARE  
11 HUNTINGTON BEACH, LLC, a Delaware  
12 limited liability company, doing business as  
13 Huntington Beach Hospital; PRIME  
14 HEALTHCARE ANAHEIM, LLC, a  
15 Delaware limited liability company, doing  
16 business as West Anaheim Medical Center;  
17 PRIME HEALTHCARE PARADISE  
18 VALLEY, LLC, a Delaware limited liability  
19 company, doing business as Paradise Valley  
20 Hospital; and Does 1-100, Inclusive,

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Defendants.



# EXHIBIT A

LA PALMA INTERCOMMUNITY HOSPITAL  
FILE 1080 1801 W OLYMPIC  
PASADENA, CA 91199-1080

05/01/08

CELINA FUENTES  
[REDACTED]  
[REDACTED]

Patient Name: CELINA FUENTES  
Account Number: [REDACTED]  
Date of Service: 03/24/07  
Account Balance: 5239.85

Dear CELINA FUENTES

As you are aware, La Palma Intercommunity Hos (the "Hospital") provided emergency medical services to you on the dates referenced above. You presented to the emergency room for a medical condition that you reasonably believed needed immediate medical attention. Under the "Prudent Lapperson Standard" and other state and federal regulations, you had the right to seek emergency medical services at the Hospital's emergency room, the Hospital had an obligation to provide those services necessary to stabilize your emergency medical condition, and your HMO, Kaiser, had a legal obligation to pay for the emergency medical services provided to you.

Under federal and state law ("EMTALA"), the Hospital was required not only to treat you in the emergency department but was also required to provide such care as ordered by the Board Certified physician who examined you with the necessary care to stabilize your emergency medical condition. This includes admitting you to the Hospital if such was necessary to stabilize your emergency medical condition as determined by a Board Certified Physician at the Hospital.

The Hospital has submitted a claim to Kaiser for the emergency medical services provide to you. Unfortunately, Kaiser has failed to properly reimburse us for the care provided to you. Kaiser's partial payment or total denial was based on its retrospective review of your medical chart and Kaiser has either determined that you did not have an emergency medical condition, that you were stable for transfer to a Kaiser facility miles away even though the physician examined you believed that you were not stable for transfer, or unilaterally determined its own reimbursement rates with no regards to the market based usual and customary rates uniformly charged by the hospitals.

The Hospital strongly disagrees with Kaiser's unilateral determination but Kaiser leaves us no choice but to seek payment from you even though we do not want to put you in the middle of our dispute with Kaiser. You may contact Kaiser Permanente at (800) 207-5084 or the Department of Managed Health Care ("DMHC") at (888) HMO-2219 for assistance. Otherwise the Hospital must pursue its collection efforts against you.

Please feel free to contact us at 714-229-4015 for any questions.

Sincerely,  
Business Office

## EXHIBIT B



**ACTION  
COLLECTION  
SERVICES.**

PO BOX 5139  
ANAHEIM, CA. 92814  
714-229-4092

05/01/08

CELINA FUENTES  
[REDACTED]  
[REDACTED]

Patient Name: CELINA FUENTES  
Account Number: [REDACTED]  
Date of Service: 03/24/07  
Total charges: \$ 11383.42  
Account Balance: 5239.85

Dear CELINA FUENTES

This claim was referred to Action Collection Services by La Palma Intercommunity Hos (the "Hospital") for collection. The Hospital has exhausted its efforts in trying to collect the above referenced balance for emergency medical services rendered to you from Kaiser Permanente. For your reference, we are enclosing a copy of the letter sent by the Hospital to you outlining Kaiser's various tactics in denying fair and reasonable payments for the services.

As part of the collection efforts, if we fail to collect payment in this matter, we will report this account to the appropriate credit reporting bureaus thirty (30) days from the date of this letter. You may contact the Hospital, Kaiser Permanente at (800) 207-5084 or the Department of Managed Health Care at (888) HMO-2219 for assistance in this matter. Payment should be made to Action Collection Services or the Hospital.

Please feel free to contact us at 714-229-4092 for any questions.

Sincerely,  
Collections Manager