No. S 142209
(Court of Appeal Nos. B172737, B172817)
(Los Angeles County Super. Ct. Nos. BC 300850, SC076909)

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

PROSPECT HEALTH SOURCE MEDICAL GROUP, ET AL.
***Plaintiff and Appellant*,**
v.

NORTHRIDGE EMERGENCY MEDICAL GROUP,
***Defendants and Respondents*.**

After Decision By the Court of Appeal,
Second Appellate District, Division Three

AMICI CURIAE BRIEF IN SUPPORT OF DEFENDANTS AND RESPONDENTS

Astrid G. Meghrigian, SBN 120896
Email: astridmeg@yahoo.com
715 Scott Street
San Francisco, CA 94117
Telephone: 415/350-3966

Attorneys for Amici Curiae
American College of Emergency Physicians and the California Chapter of the American College of Emergency Physicians, and California Chapter, American Academy of Emergency Medicine

TABLE OF CONTENTS

I. INTRODUCTION 1

II. THE PROVISION OF EMERGENCY MEDICAL CARE INVOLVES UNIQUE DIFFICULTIES 7

III. THE UNDERLYING PURPOSE OF EMTALA WAS TO SHIFT PARTIAL RESPONSIBILITY FOR THE PROVISION AND PAYMENT OF EMERGENCY MEDICAL SERVICES TO THE UNINSURED TO THE PRIVATE SECTOR 9

IV. THE ECONOMICS OF AN EMERGENCY DEPARTMENT'S PRACTICE CANNOT BE GENERALIZED 11

- A. The Uninsured 14
- B. Medicaid 15
- C. Medicare 16

V. LEGISLATIVE AND REGULATORY EFFORTS ENSURING HEALTH PLAN ACCOUNTABILITY TO EMERGENCY PHYSICIANS SHOULD NOT BE CIRCUMVENTED AGAIN 20

VI. BECAUSE OF THE VITAL PUBLIC NEED FOR AND FISCAL BURDENS IMPOSED UPON PROVIDERS OF EMERGENCY CARE AND SERVICES, THE KNOX-KEENE ACT IMPOSES AN OBLIGATION UPON HEALTH PLANS TO REIMBURSE THOSE PROVIDERS THEIR CONTRACTED RATE, OR IF NOT CONTRACTED, THEIR USUAL AND CUSTOMARY CHARGE........ 24

VII. CALIFORNIA'S CONSTITUTION REQUIRES THAT EMERGENCY PHYSICIANS RECEIVE ADEQUATE COMPENSATION TO COVER THEIR LOSSES FOR SERVING THE INDIGENT 28

VIII. CALIFORNIA'S EMERGENCY DEPARTMENTS ARE ALREADY OPERATING AT CAPACITY AND RISK JEOPARDIZING QUALITY OF CARE........ 29

IX. CONCLUSION 36

TABLE OF AUTHORITIES

Federal Statutes

42 U.S.C. §1395dd 3

Federal Cases

Fed. Power Comm'n v. Hope Natural Gas Co. (1944)
320 U.S. 591, 601 29

Wallis v. Princess Cruises, Inc. (9th Cir. 2002)
306 F.3d 827 26

California Statutes

Health & Safety Code §1317 .... 3, 4, 10, 24

Health & Safety Code §1367 .... 4, 20, 27

Health & Safety Code §1371 .... 20, 22, 23

Health & Safety Code §1371.35 23

Health & Safety Code §1371.4 .... passim

Welfare & Institutions Code §17000 10

California Regulations

28 C.C.R. §1300.51 20

28 C.C.R. §1300.67 20

28 C.C.R. §1300.71 .... 5, 23

California Cases

Bell v. Blue Cross of California (2005)
131 Cal.App.4th 211 ....5, 25, 26, 28

California Association of Nursing Homes v. Williams (1970)
4 Cal.App.3d 800...28

California Emergency Physicians Medical Group v. PacificCare (2003)
111 Cal.App.4th 1127 25

Cunningham v. Superior Court of Ventura (1986)
177 Cal.App.3d 336, 222 Cal.Rptr. 854...28

Gould v. W.C.A.B. (1992)
4 Cal.App.4th 1059 ....6, 26

Ochs v. PacificCare of California (2004)
115 Cal.App.4th 782 25

Soldinger v. Northwest Airlines, Inc. (1996)
51 Cal.App.4th 345 26

Spear v. California State Auto Association (1992)
2 Cal.4th 1035 26

The Housing Authority v. Dockweiler (1939)
14 Cal.2d 437 29

Other Authorities

A System in Continued Crisis: CMA's Annual ER Losses Report,
Sept. 20, 2004...34

American College of Emergency Physicians, *Ethics and Emergency Medicine*, available on ACEP's website, http://www.acep.org..........9

Ann S. O'Malley, et al., *Rising Pressure: Hospital Emergency Departments as Barometers of the Health Care System*,
Centers for Studying Health System Change,
Issue Brief No. 101 (Nov. 18, 2005)..32

Bamezai, et al., *The Cost of an Emergency Department Visit and Its Relationship to Emergency Department Volume*, Ann.Emerg.Med. 45:5 (May 2005) 30

Brewster, et al., *Emergency Room Diversions: A Symptom of Hospitals Under Stress*, Center for Studying Health Systems Change, (May 20, 2001) No. 38 31

Bruce Siegel, *The Emergency Department: Rethinking the Safety Net for the Safety Net*, Health Affairs, (March 24, 2004) W4-146 32

Burt, et al., *Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States 2003-04*, Advance Data from Vital and Health Statistics, United States Department of Health and Human Services, Center for Disease Control and Prevention, No. 376, September 27, 2006 .... 1, 15, 30

California Emergency Departments, Do They Contribute to Hospital Profitability? July 2003, California Health Care Foundation 12

Carol K. Kane, Ph.D., *The Impact of EMTALA on Physician Practices* 14

Cunningham, *What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities*, (July 18, 2006) Health Affairs 32

Gallery, Ph.D., et al., *A Study of Occupational Stress and Depression Among Emergency Physicians*, Ann.Emerg.Med., (January 1992:21:58-64) 8

Gary P. Young, M.D., et al., *Managed Care Gatekeeping, Emergency Medicine Coding, and Insurance Reimbursement Outcomes for 980 Emergency Department Visits from Four States Nationwide* (January 2002) Ann.Emerg.Med. 39:1 21

Gresenz, et al., *Disputes Over Coverage of Emergency Department Services: A Study of Two Health Maintenance Organizations*, Ann.Emerg.Med. 2004, February; 43(2); 155-62 22

Himmelstein, et al., *Patient Transfers: Medical Practices as Social Triage,* 74 Am.J.Pub.Health, 494, 495 (1984) 9

Hospital-Based Emergency Care—At the Breaking Point; Institute of Medicine, National Academies Press (2006) 1, 7, 14, 18

Kapur, et al., *Managing Care: Utilization Review in Action at Two Capitated Medical Groups*, Health Affairs (2003), W3-275-282....22

Kellermann, M.D., Ph.D., *Crisis in the Emergency Department,* N.Eng.J. Med., 355:13, Sept. 28, 2006 34

Lambe, M.D., et al., *Trends in the Use and Capacity of California's Emergency Departments, 1990-1999*, Ann.Emerg.Med. (April 2002, 39:4)..33

Lambe, M.D., et al., *Waiting Time in California's Emergency Departments*, Ann.Emerg.Med. (January 2003, 41:4)..33

Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.Law&Pol'y 695 (2006) 3, 10

Mohanty, M.D., M.P.H., et al., *Predictors of On-Call Specialists Response Times in California Emergency Departments*, Acad.Emerg.Med., Vol. 13, No. 5 (2006) 8

On-Call Physicians at Emergency Departments: Problems and Potential Solutions, January 2005, California Health Care Foundation...........7

Rudkin, M.D., et al., *The State of ED On-Call Coverage in California*, American Journal of Emergency Medicine, Vol. 22, Nov. 7.............8

Stretched Thin: Growing Gap in California's Emergency Room Backup System, California Senate Office of Research, (May 2003)...............8

Sun, et al., *Effect of Hospital Closures and Hospitals Characteristics on Emergency Department Ambulance Diversion, Los Angeles County, 1998-2004*, Ann.Emerg.Med. (April 2006, 47:4) 33

Where Do Patients Go? Low Medi-Cal Rates—Separating the Neediest from Health Care, California Medical Association 16

I. INTRODUCTION

As Respondents have shown in their Answer Brief, the Legislature has never sanctioned the relief sought by Appellants, particularly given the complexity of the factors involved and the clear public policy supporting the financial viability of the emergency medical system. Indeed, the Legislature could never have intended what Appellants seek in light of the devastating consequences that would result if Appellants' request is granted.

Overcrowding, underfunding, outdated equipment, and no readiness to handle a major medical disaster (such as an epidemic or earthquake) sounds like the description of emergency departments in an underdeveloped country. But these are just some of the frightening conditions affecting emergency care throughout the United States, according to separate reports recently issued by the Institute of Medicine and the U.S. Centers for Disease Control and Prevention.[1] Emergency physicians who toil in this overburdened and cash-strapped environment treat patients of all kinds, regardless of income, ethnic background, disability, or any other difference, experiencing everything from life-threatening conditions to less serious ailments such as lacerations and ear infections. And they do all this without first asking whether they will be paid.

This case involves a critical question—are physicians who provide emergency medical care to patients who have paid premiums for coverage of those

[1] *See Hospital-Based Emergency Care—At the Breaking Point*; Institute of Medicine, National Academies Press (2006) (hereinafter "IOM Report"); *see also* Burt, Ed.D., et al., *Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States*, *2003-04*, Advanced Data from Vital Health Statistics, U.S. Department of Health and Human Services, Center for Disease Control and Prevention, No. 376, Sept. 27, 2006 (hereinafter "CDC Report").

In the event this Court would like to review any of the articles cited herein, Amici will happily supply them upon request.

services going to be paid fairly for those services, or are they going to be forced to chase billion dollar health plans for payment of whatever portion of their reasonable charges these physicians can afford to fight for? As the testimony demonstrated from a recent regulatory hearing concerning this issue,[2] health plans make lowball payments, apparently as part of their business model to make even more money. For example, one emergency physician provided a graphic illustration of how he was shortchanged his reasonable fee:

> I was practicing at one of our emergency departments late one afternoon, and a 50-year old guy came in with chest pain, and he died.
>
> And he died for a little bit; I brought him back and I resuscitated him; spent 45 minutes at his bedside doing chest compressions, shocked him a few times, brought the family back to help pray for him. Had five nurses shut the ER down to bring this guy back, and did. And he walked out of the emergency department or walked out of the hospital seven or eight days later; thankful clearly, and I was very happy.
>
> And the insurance company paid me $128.50. And I thought that was a little bit unreasonable since my electrician billed me more just to put a hot box in the backyard.[3]

Similar stories of payment horror surfaced throughout the day. For example, defending himself against the "egregious behavior" emergency physicians are wrongly accused of, another emergency physician explained:

> I've never had a patient present me with a bill for, you know, they'll see total charges, $275. And then it will say that this insurance plan, whom they pay

---

[2] Amici bring the testimony from the Department of Managed Health Care (DMHC) regulatory hearing to this Court's attention merely to explain how unfairly emergency physicians are being treated by plans. The fact that the DMHC is conducting regulatory hearings as to whether Health & Safety Code §1371.39 (as opposed to Section 1379) should prohibit billing patients is absolutely irrelevant to the issue before this Court.

[3] *See* Transcript, Department of Managed Health Care Public Hearing, September 13, 2006, p. 296.

> $600 a month for to provide insurance coverage for their family, paid me $58 to spend an hour with the patient in the emergency department and potentially save their life.

(*Id.* at 143. *See also* Testimony on p. 174 wherein an emergency physician was paid a mere $40 for treating a complex hand laceration.)

By law, hospitals that maintain an emergency department must provide emergency medical services to all those that need them, regardless of the ability to pay. (Health & Safety Code §1317; 42 U.S.C. §1395dd) Pursuant to the Emergency Medical Treatment and Active Labor Act, and corresponding California law (hereinafter collectively referred to "EMTALA" unless separately referenced), hospitals that maintain emergency departments must assure the assessment and stabilization of emergency medical conditions for patients. As is discussed in more detail below, the precipitating concerns warranting the imposition of this enormous responsibility were twofold: (1) the recognition that it was vital for the public health that emergency services be available to every member of the public, as there were reports of emergent patients, mostly indigent, suffering harm as a result of delay in reaching public hospitals, and (2) the fact that state and local governments were no longer willing to absorb the costs of providing emergency care to these patients, and the de-facto political decision to shift these costs, in part, to the private sector. Thus, the passage of EMTALA was more of a stopgap measure to protect both indigent patients and the public fisc without requiring an overhaul of the medical system.[4]

From a financial standpoint, private health plans may be the greatest beneficiaries of EMTALA. Not only did the law save them from potential extinction, but unfortunately, and contrary to what was intended, the law gave

---

[4] *See* Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.Law&Pol'y 695 (2006).

plans an escape valve, enabling them to avoid their own obligations under the law to contract with and/or pay emergency physicians appropriately. Put another way, plans no longer needed as a practical matter to assure accessibility through adequate contracted networks of emergency service providers because the law requires emergency physicians—to provide emergency care to plan enrollees, no matter how low or unfair plan contractual/payment practices are. EMTALA provides no method of compensating emergency medical providers for any of the free care they render in compliance with the statute's terms. California's Legislature, on the other hand, recognized that emergency medical care providers cannot absorb the costs of providing under- or uncompensated care and still remain financially viable.[5] For that reason, it enacted a number of measures specific to Knox-Keene plans, and their agents, such as the Appellant in this case. For example, these entities are required to assure their enrollees have accessible emergency services in their communities. *See* Health & Safety Code §1367 and other authorities discussed below. Emergency departments, therefore, must be open and available in each of the plan's service areas for there to be compliance under the Knox-Keene Act. To assure accessibility, plans are bound to comply with a host of contractual and payment protections so that emergency physicians are paid timely and appropriately and thus, can function. *See*, for example, Health & Safety Code §§1367, 1371.4. These laws recognize the social imperative that these physicians be reasonably compensated, so that they will be there when the public needs them.

---

[5] *See* historical derivation to Health & Safety Code §1317, stating in part: "The breadth of the uncompensated and under-compensated care problems facing California providers, which, if allowed to continue, could force many physicians to reduce the quality and availability of emergency medical services, to the detriment of Californians."

Unfortunately, California's Legislature has been forced to amend these laws virtually every year to remedy health plan tactics reducing the coverage of and payment for emergency medical services. After trying to remediate plan misconduct on a piecemeal basis, the Legislature created a "catchall" in 2000 with the passage of AB 1455 (Stats 2000, ch. 827). This legislation provided heightened penalties to be imposed on plans for "unfair payment practices," later defined in regulations adopted in 2003 as, among other things, the failure to pay non-contracted physicians providing emergency medical care reasonably. *See* 28 C.C.R. §1300.71.

In response, the plans devised yet another scheme to shortchange non-contracting emergency physicians, but this time under the guise of "patient protection," by arguing that these physicians should be precluded from billing patients when the plan underpaid them.

No one disputes that the law requires that non-contracting physicians providing emergency medical services are entitled to be paid the reasonable value of their services. *See Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211. A determination of "reasonableness" of fees, however, cannot be mechanized, and this is particularly true in the context of emergency departments given the wide variation of patients and communities they serve. No "one size" fits them all, and what is "reasonable" in the context of a particular emergency department must be decided on a case-by-case basis.

Rather than pay the emergency physician's charge as the law requires and is typically the case in any service setting, plans automatically discount these physicians' bills according to their own preset fee schedules reflecting what they are willing to dole out.[6] Their preset fee schedules are based on unknown and

---

[6] Thus, the Appellants in this case below sought a declaration that it is "reasonable" in each and every case to pay at levels paid by the Medicare

unsupportable factors and imposed without regard to whether the charge was, in fact, reasonable in light of the circumstances of the case, i.e., the skill and tasks involved, and the economics of the practice in which the care was provided.[7] To make matters worse, the plans not only make lowball payments, but also now take the position that physicians should be precluded from looking to patients for payment for the remainder of the reasonable value of the bill (as common law authorizes and the Knox-Keene Act does not prohibit)[8] to "protect patients."[9] But protecting patients means paying fairly so that patients can access the care they need, as the law unequivocally demands, not disregarding the physicians' attestations of reasonableness.

California's health care system cannot afford the type of relief sought in this case. Apart from being illegal under the Knox-Keene Act, as well as unconstitutional, from a real world perspective, precluding emergency physicians from obtaining reasonable payments[10] would dramatically reduce access to emergency medical care for everyone by forcing the closure of even more

---

program—a level that the federal government itself has admitted is insufficient to cover a physician's costs. *See* discussion below.

[7] *See Gould v. W.C.A.B.* (1992) 4 Cal.App.4th 1059.

[8] Amici Curiae fully incorporate the compelling argument on this point provided by the Defendants and Respondents in this case.

[9] Patients sometimes complain to plans about the receipt of these bills. At this point in time, when patients complain, the plans typically pay the billed charge. Thus, a ban on "balance billing" insulates a plan not only from patient complaints, but also the legal and financial responsibility to pay for emergency care appropriately.

[10] Technically, physicians could sue health plans for the balance of their bills, but the small amounts involved for each claim do not warrant the hiring of a lawyer and going to court. Thus, as a practical matter, a ban on billing patients would be tantamount to requiring that physicians be underpaid.

emergency departments and increasing the overcrowding in all those emergency departments that are able to survive, decreasing the quality of care for all.

II. THE PROVISION OF EMERGENCY MEDICAL CARE INVOLVES UNIQUE DIFFICULTIES

The responsibility for appropriate payment for emergency care must be considered in the context of the services that emergency physicians perform, the environment in which they operate, the liability to which they are exposed, and the sacrifices they make to fulfill this vital public need to our communities. As was recently described by the Institute of Medicine:

> Emergency care is delivered in an inherently challenging environment, often requiring providers to make quick life and death decisions based on minimal information. Many who go into [the] emergency care profession enjoy the challenging work and the high pressure environment, and take satisfaction in providing care to patients in urgent need. But providers on the front lines of emergency care increasingly express frustration with the deteriorating state of emergency care and the health care safety net. They experience the imbalance between demand and capacity . . . on a daily basis, and find themselves spending an increasing proportion of their time in tasks such as getting patients admitted to crowded inpatient units; finding specialists willing to come during the middle of the night; and finding psychiatric centers, skilled nursing facilities, or specialists who are willing to accept referrals. They also face a rigid regulatory environment that can make it difficult to address the patient's needs in the most efficient, effective, and patient-centered manner.

(*IOM Report*, *supra* at 163.)

Unfortunately, one problem in the emergency physician's world just leads to another. For example, finding an appropriate specialist to care for patients requiring more complex treatment is a major hurdle that emergency physicians face every day, a particularly acute problem in California. *See,* for example*, On-Call Physicians at Emergency Departments: Problems and Potential Solutions*, January 2005, California Health Care Foundation (fewer specialists are taking

call, and the major reason cited for this phenomena is inadequate reimbursement); *see also Stretched Thin: Growing Gap in California's Emergency Room Backup System,* California Senate Office of Research, (May 2003) (stating, "Problems with access to emergency on-call services…are adversely impacting the quality of patient care...and are primarily the result of problems with reimbursement."); *see also* Rudkin, M.D., et al., *The State of ED On-Call Coverage in California*, American Journal of Emergency Medicine, Vol. 22, (Nov. 7, 2004) ("The on-call situation in California has reached crisis proportions"). Unfortunately, this limited availability of on-call specialists only contributes to yet another hardship imposed on the emergency physicians—overcrowding. *See* Mohanty, M.D., M.P.H., et al., *Predictors of On-Call Specialists Response Times in California Emergency Departments*, Acad.Emerg.Med., Vol. 13, No. 5 (2006).

Further, given the fact that these emergency departments must be available 24 hours a day, 7 days a week, emergency physicians have erratic work schedules, wreaking havoc on their family and social life, and therefore, emotional health. Given the exigencies that emergency physicians face day in and day out, it is little wonder that the stress and depression that their jobs create result in them leaving the specialty of emergency medicine in numbers that could very well be greater than the number that will replace them through residency training.[11]

Even apart from the clinical and regulatory demands of this practice, these professionals face violence at unacceptable levels. In a February 15th, 2005 survey report issued by the American College of Emergency Physicians, a majority of respondents reported experiencing at least one violent act over the previous twelve-month period. Of the emergency physicians who reported

---

[11] *See* Gallery, Ph.D., et al., *A Study of Occupational Stress and Depression Among Emergency Physicians*, Ann.Emerg.Med., (January 1992:21:58-64).

experiencing physical assaults, 89% came from the patient, 9% came from a family member, and 2% from a friend of the patient. Drugs and alcohol appeared to be the major factor in the most violent acts. *See* www.ACEP.org.

Notwithstanding the personal hardships these emergency physicians endure, and the fact that they rely for their livelihoods upon payment for the services they provide, emergency physicians believe that access to emergency medical care is a fundamental right and must not be denied based on the ability to pay. The Principles of Ethics for Emergency Physicians, as adopted by the American College of Emergency Physicians, provide in part:

> Because it is an essential part of health care, access to emergency care is a fundamental individual right and should be available to all who seek it. All impediments to access to emergency care should be removed. Denial of emergency care or delay in providing emergency services on the basis of race, religion, gender, ethnic background, social status, type of illness or injury, or ability to pay is unethical.[12]

III. THE UNDERLYING PURPOSE OF EMTALA WAS TO SHIFT PARTIAL RESPONSIBILITY FOR THE PROVISION AND PAYMENT OF EMERGENCY MEDICAL SERVICES TO THE UNINSURED TO THE PRIVATE SECTOR

While emergency physicians have long held as a core value the belief that emergency care should be provided to all those in need, regardless of their insurance status or ability to pay, Congress enacted EMTALA in 1986 in response to reports of private hospitals transferring patients to public hospitals when those patients either had no insurance or were government-insured through Medicare or Medicaid.[13] Significantly, prior to EMTALA's enactment, there were numerous

---

[12] *See* American College of Emergency Physicians, *Ethics and Emergency Medicine*, available on ACEP's website, http://www.acep.org.

[13] *See* Himmelstein, et al., *Patient Transfers: Medical Practices as Social Triage,* 74 Am.J.Pub.Health, 494, 495 (1984).

laws ensuring that the indigent received life-saving medical services. Thus, while these patients were turned away from private hospitals, they received care—they were redirected to public hospitals or otherwise showed up there for treatment.

First and foremost, many states such as California already imposed a responsibility to provide health care services to the indigent. *See*, for example, Welfare & Institutions Code §17000 (enacted in 1937), providing an unequivocal mandate upon counties to "relieve and support all indigent persons, including those incapacitated by age, disease or accident." Further, many states, such as California, had already imposed upon hospitals a statutory duty to treat patients without regard for their ability to pay. Indeed, California's EMTALA analog, in its most nascent form, Health & Safety Code §1317, predated EMTALA by a full ten years.

Prior to EMTALA's passage, providing care to the uninsured was financially feasible, given the flexible reimbursement system that existed at the time. Significant changes in financing preceding the enactment of EMTALA, however, resulted in an increase in patient transfers to public hospitals.[14] Hospitals and physicians were no longer able to shift the fees for the uninsured to others, particularly given Medicare's new reimbursement system which, due to budgetary cost constraints, capped charges for emergency care notwithstanding the true costs of that care, and medical inflation generally. *See id.* 706-708. At the same time, the number of uninsured in the United States had sharply and steadily increased. (*Id*. at 698.)

Because of preexisting state laws mandating the provision of care to the poor, the cost of care for the indigent largely came from state and local coffers.

---

[14] *See* Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.Law&Pol'y 695 (2006).

Congress, when debating EMTALA, was "arguably aware of this issue" and the fact that these costs need to be shifted in part to the private sector until a broader health reform package could be enacted. As was recently summarized, Congress was:

> aware that EMTALA was merely a stopgap measure, a way of insuring that the growing millions of uninsured and publicly insured Americans were able to obtain care in a genuine medical emergency without requiring a complete overhaul of the American system of health insurance and finance. [Footnote omitted.] **As such, EMTALA not only helped guarantee that the uninsured and the publicly insured could receive care in an emergency, but also the cost of providing such care was borne by both private and public sectors.** (Emphasis added.)

(*Id.* at 715-716.)

With the passage of EMTALA, the provision of emergency medical care to the uninsured now became a cost of doing business not only for health care providers, but also for both public and private payors. Thus, even the Medicare program, universally known to be unable to pay for the true costs of care in light of its budgetary constraints, adjusted the emergency medicine "practice expense" portion of the equation for its fee schedule because of its "concern that emergency medicine physicians could spend a significantly higher portion of time than other physicians providing uncompensated care to patients." (67 Federal Register 251:79972 12/31/02.)

IV. THE ECONOMICS OF AN EMERGENCY DEPARTMENT'S PRACTICE CANNOT BE GENERALIZED

While it is impossible to predict with precision exactly how much money emergency departments lose as a result of their legal and ethical mandates to

provide care to the poor,[15] the literature is uncontroverted that the amount is real, substantial, and certain to ensure their demise if appropriate funding is not forthcoming. The California Health Care Foundation recently estimated that emergency departments lose an average of $84 on each patient treated and discharged on an outpatient basis.[16] Unlike institutional providers, emergency physicians generally do not have other business units or other sources of revenue (such as ambulatory care centers) to sustain high levels of un- or under-compensated care costs.

The amount a particular emergency department loses, of course, is dependent upon its profile of patient and payment characteristics. No two emergency departments are alike. As the CDC recently stated:

> EDs varied widely in terms of their profile of patient and payment characteristics, diagnostic and treatment services, and case disposition.

(CDC, *supra* at 7.)

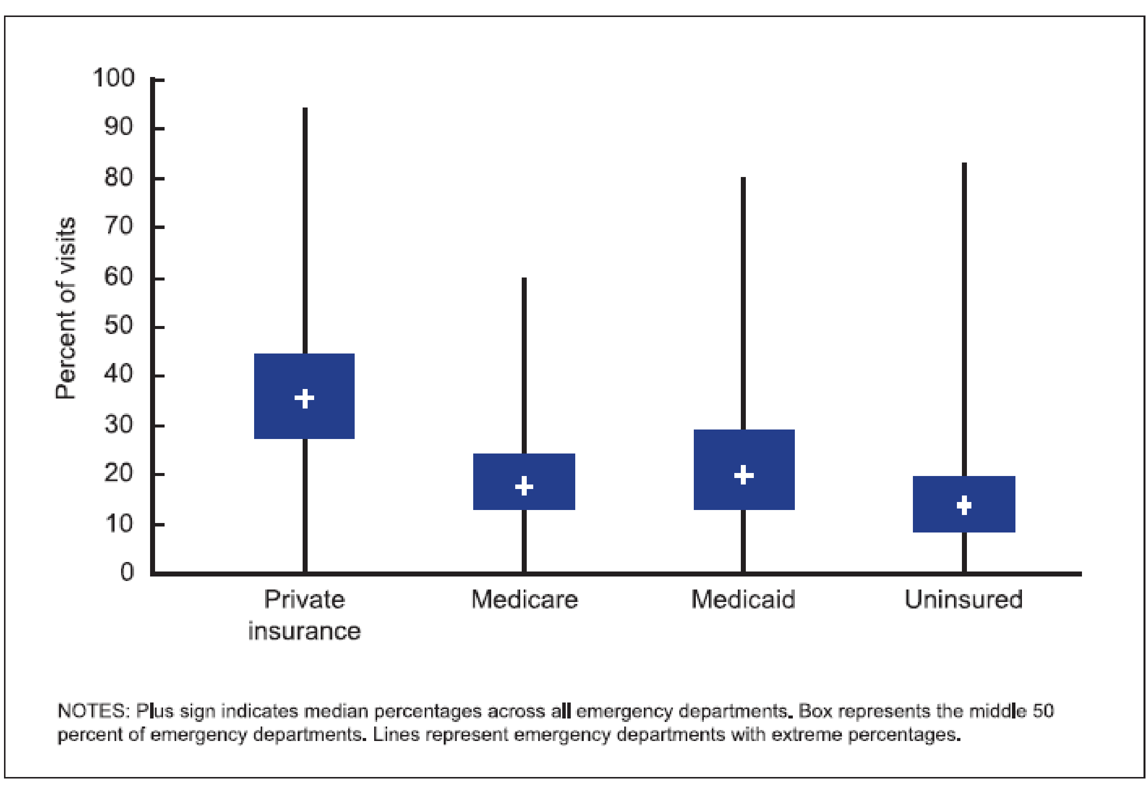
The CDC report then provided a table graphically demonstrating the differences between emergency departments, depending on whether they are in metropolitan areas or not and depending upon who they treated. This Table 7 follows this brief. As can be seen, there is no uniformity as to the patients' ages, severity of illness, diagnosis, and other factors.

---

[15] Currently, Duke University is under contract with the Agency for Health Care Research and Quality to prepare a paper concerning the costs and benefits of EMTALA. According to the June 2006 draft, after considering government regulatory costs, indirect (costs such as mortality loses and the external costs of the uninsured), and social welfare costs, EMTALA results in expected costs of $4.4 billion and expected benefits of $2.1 billion. A copy of this draft can currently be found at www.hpolicy.duke.edu/cyberexchange/regulate/chsr/pdfs/f1-emtala.pdf.

[16] *See California Emergency Departments, Do They Contribute to Hospital Profitability?* July 2003, California Health Care Foundation.

Nor is there any uniformity as to the source of payment for patients treated at emergency departments. Depending upon where an emergency department is located, the payor mix differs. This can be easily seen through data accumulated by the Centers for Disease Control.

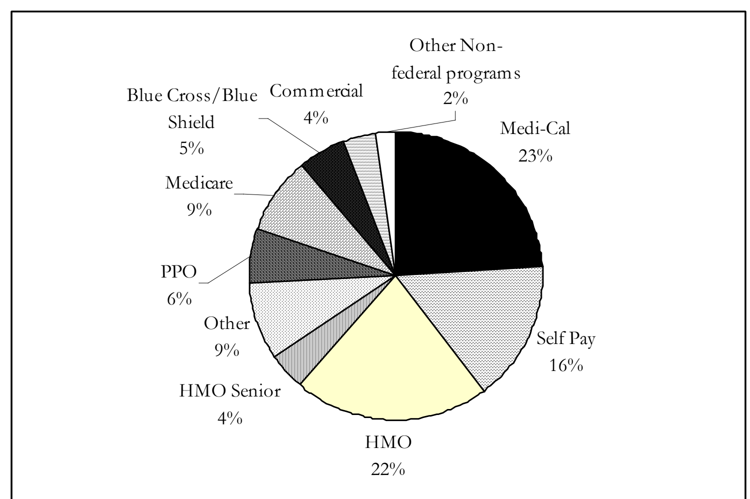


Box plots of emergency departments on caseload percentages for expected sources of payment: United States, 2003-04. CDC Advance Data No. 376, September 27, 2006.

Given the high percentages of publicly funded and uninsured patients, however, it is quite clear that reimbursement by private payors to emergency physicians must be sufficient to cover these losses to ensure their survival.

On its face, the payor mix of patients admitted to California's emergency departments is insufficient to ensure their financial viability without substantial cost shifting to private payors. According to data prepared by California's Office of Statewide Health Planning and Development, California emergency department

encounters by payors for the period January to June 2005 can be summarized as follows:



Significantly, this 16% figure of self-pay (uninsured) is even higher than the nationwide average of uninsured visiting emergency departments, which approximates 14%.[17] But again these percentages do not apply equally to all emergency departments.

A. The Uninsured

Emergency physicians are not in a position to control and limit their uncompensated care burden and their losses are substantial. The American Medical Association has estimated that emergency physicians incur an average level of bad debt attributable to EMTALA equal to $138,300 per physician, per year.[18] Bad debt includes only services for which payment was expected but not made. Thus, this figure does not include charity care nor does it include the

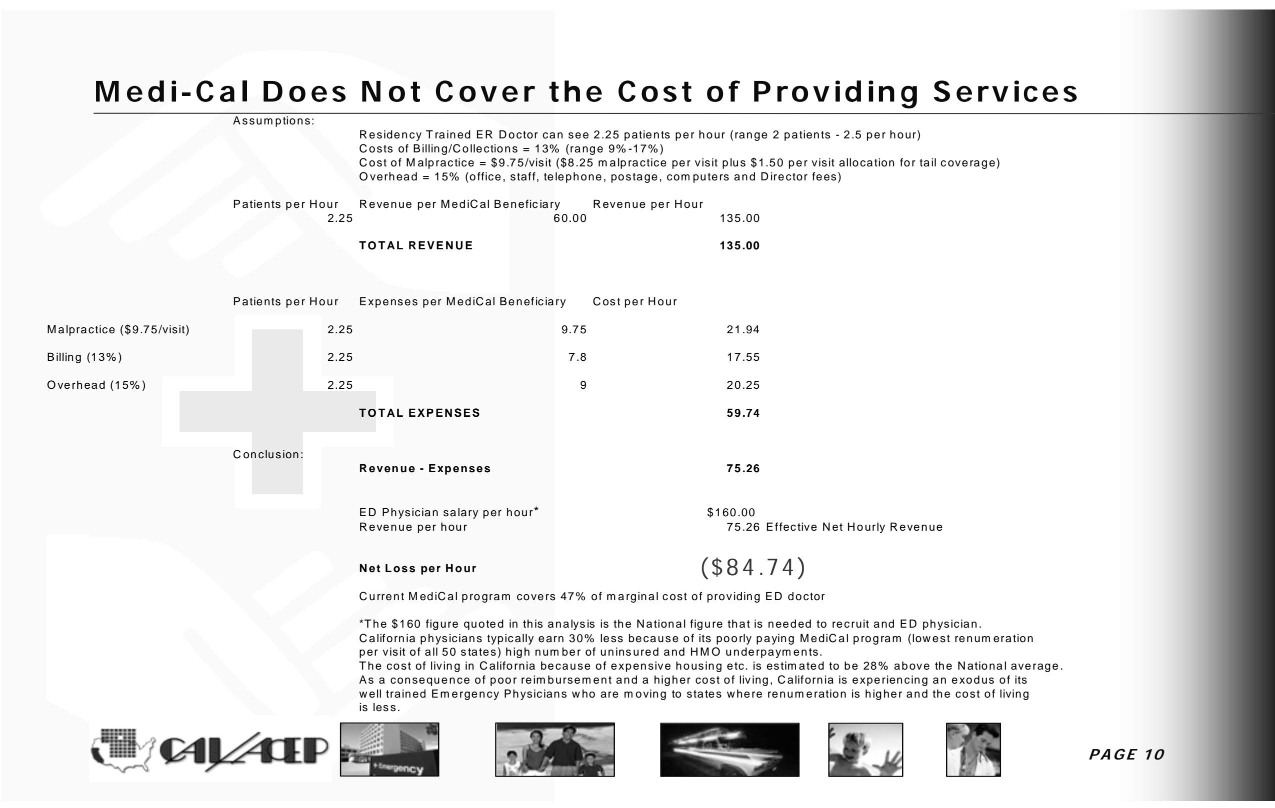
[17] *See IOM Report, supra,* at 41. Also, the California number of uninsured could be even higher than 16%, depending upon what reporting patients believed the term "other" to mean.

[18] *See* Carol K. Kane, Ph.D., *The Impact of EMTALA on Physician Practices.*

difference between a physician's usual fee and discounted rates paid by Medicare, Medicaid, and private payors. This figure is not surprising given the fact that collected charges for self-paid patients are under 20% for physicians. *See* Burt, et al., *Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States 2003-04*, Advance Data from Vital and Health Statistics, United States Department of Health and Human Services, Center for Disease Control and Prevention, No. 376, September 27, 2006.

B. Medicaid

Nor does California's Medicaid program, Medi-Cal, cover the cost of providing emergency services. Indeed, consider the following chart provided by CAL-ACEP during a regulatory hearing on an issue related to the one presented in this case.



Medi-Cal Does Not Cover the Cost of Providing Services

Assumptions:

Residency Trained ER Doctor can see 2.25 patients per hour (range 2 patients - 2.5 per hour)
Costs of Billing/Collections = 13% (range 9%-17%)
Cost of Malpractice = $9.75/visit ($8.25 malpractice per visit plus $1.50 per visit allocation for tail coverage)
Overhead = 15% (office, staff, telephone, postage, computers and Director fees)

	Patients per Hour	Revenue per MediCal Beneficiary	Revenue per Hour
	2.25	60.00	135.00
		TOTAL REVENUE	**135.00**

	Patients per Hour	Expenses per MediCal Beneficiary	Cost per Hour
Malpractice ($9.75/visit)	2.25	9.75	21.94
Billing (13%)	2.25	7.8	17.55
Overhead (15%)	2.25	9	20.25
		TOTAL EXPENSES	**59.74**

Conclusion:

Revenue - Expenses	**75.26**	
ED Physician salary per hour*	$160.00	
Revenue per hour	75.26	Effective Net Hourly Revenue
Net Loss per Hour	($84.74)	

Current MediCal program covers 47% of marginal cost of providing ED doctor

*The $160 figure quoted in this analysis is the National figure that is needed to recruit and ED physician.
California physicians typically earn 30% less because of its poorly paying MediCal program (lowest renumeration per visit of all 50 states) high number of uninsured and HMO underpayments.
The cost of living in California because of expensive housing etc. is estimated to be 28% above the National average.
As a consequence of poor reimbursement and a higher cost of living, California is experiencing an exodus of its well trained Emergency Physicians who are moving to states where renumeration is higher and the cost of living is less.

The Medi-Cal program is woefully underfunded. The Kaiser Family Foundation has determined that California ranked last in the country on spending per Medicaid beneficiary. *See* www.kff.org. In fact, California spends slightly more than $2500 per beneficiary per year, compared to the national average of over $4000. Largely due to low reimbursement, physician participation in Medi-Cal is lower than in any other state. *See Where Do Patients Go? Low Medi-Cal Rates—Separating the Neediest from Health Care*, California Medical Association. As a result, more than half of Medi-Cal patients report difficulty in finding a physician. When they are unable to find one, many of these patients seek preventive and other non-urgent care in a hospital emergency department, exacerbating the overcrowded problem even further. Indeed, Medi-Cal enrollees accounted for 27% of ED visits in California, yet the average monthly case load is less than 15% of the total population. (*Id.* at p. 4.)

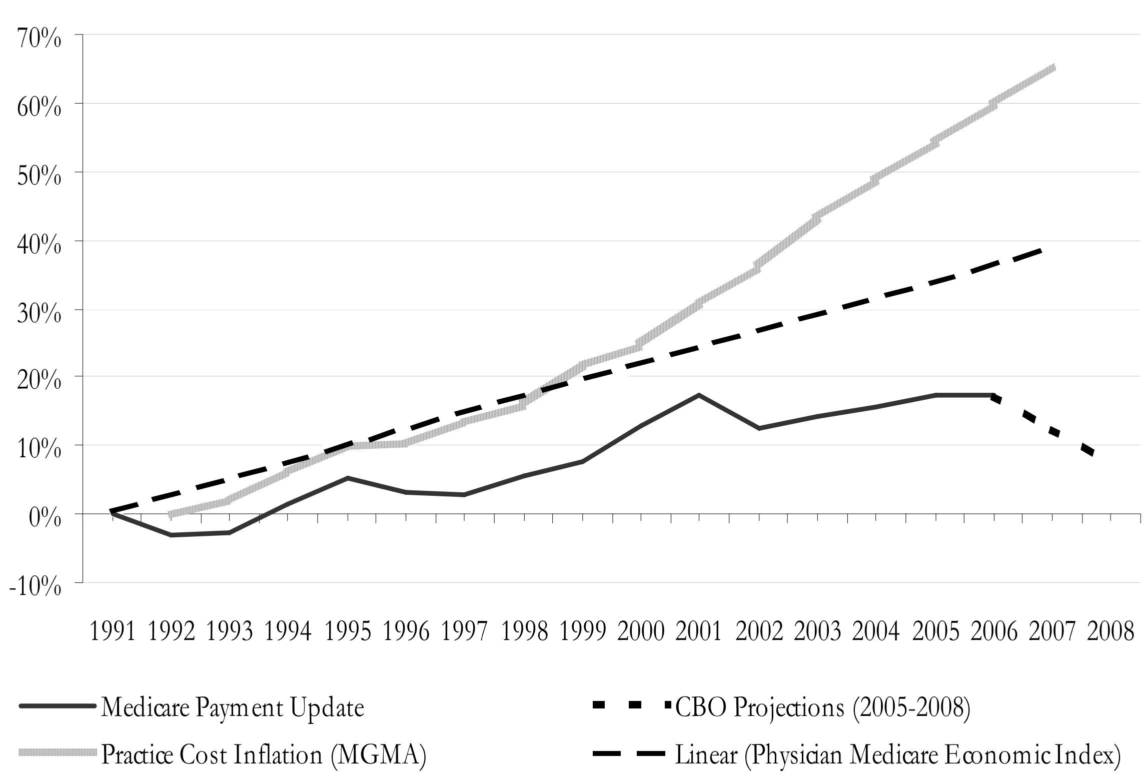
C. Medicare

Like the Medi-Cal program, the Medicare program does not provide sufficient compensation to maintain the financial viability of physicians, since it is publicly funded and subject to budgetary considerations. For example, with respect to Medicare, adjustments to achieve a balanced budget are incorporated when developing the fee schedule. The net effect of the budget balancing mechanism is to widen the gap between the cost of practicing medicine and reimbursement. Notably, even the Centers for Medicare and Medicaid Services (CMS) acknowledged in its July 29, 2006 CMS proposed rule (i.e., Federal Register, Vol. 71, No. 125) that the Medicare fee schedule recognized only two-thirds of a physician's direct expenses.

The Medicare Payment Advisory Commission (MedPAC) estimated in 2004 that the resulting underpayment for physician services (in the aggregate) was

20% below the reimbursement needed just to keep up with its estimate of inflation (assuming no other systemic issues existed). To the extent physician practice costs have increased at a steeper rate as the Medical Group Management Association has concluded, the deficiency is substantially greater. A comparison of the actual Medicare physician payment update from 1991, the Medical-Economic Index updated by the Office of the Actuary, and the MGMA practice cost inflation estimates provides a graphic representation of the reasons Medicare cannot be used as an appropriate measure of the reasonableness of fees non-contracted physicians charge private patients:

Cumulative Change in MEI and Medicare Physician Payment Update



Certainly, since the rates paid by these programs that are so low that patients cannot even access care, these rates cannot be considered "reasonable" under any "reasonable" construction of that term. And, notwithstanding the fact that in each of these scenarios, a physician's costs are simply not covered, private payors are not keeping their end of the bargain. In fact, according to the recent IOM Report, average reimbursement rates declined 8 percentage points over a mere two-year period.[19] This finding is consistent with a study recently released by the Center for Studying Health System Change, demonstrating that between 1995 and 2003, average physician net income from the practice of medicine declined about 7% after adjusting for inflation. *See Losing Ground: Physician Income, 1995-2003*, Tracking Report No. 15 (June 2006), Center for Studying Health System Change. The report notes that flat or declining fees from both public and private payors are the major factor underlying the declining incomes for physicians, and that even though private insurers are not subject to budgetary constraints as is the Medicare program, the trend for "private insurer payments to physicians has lagged even more." (*Id.* at pp. 4-5.) This downward trend in incomes is likely an important reason for growing physician unwillingness to undertake charity care, *id.*, a phenomenon in and of itself which will cause even further strain on the emergency system.

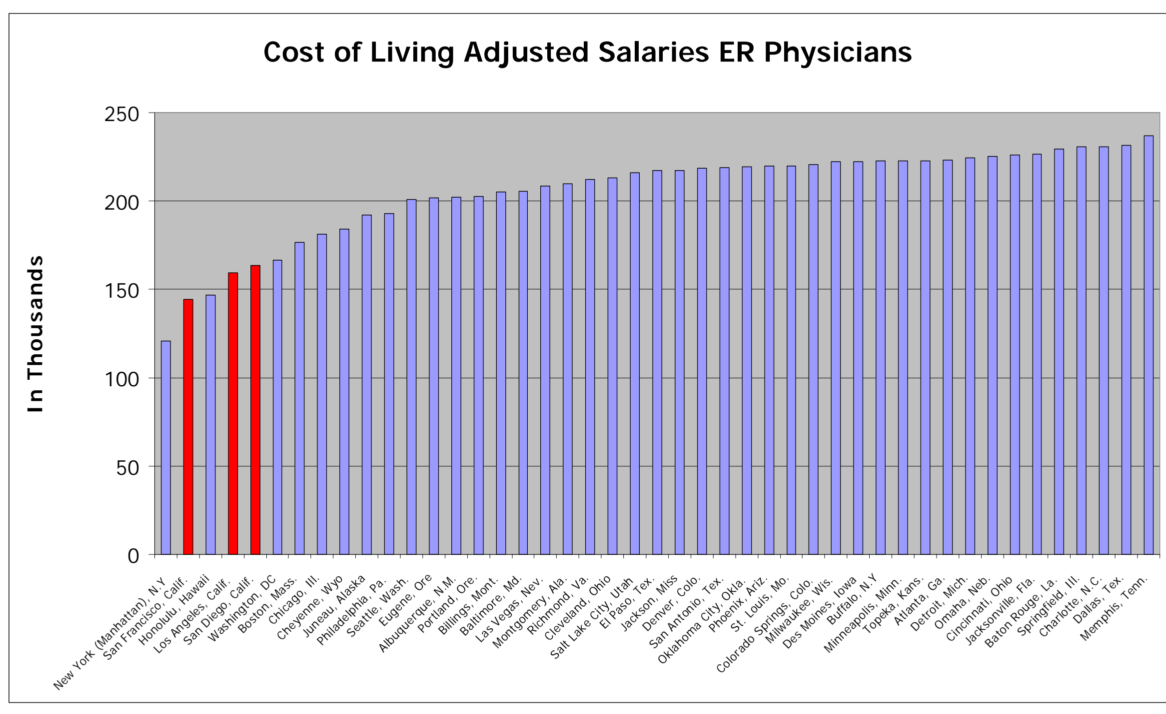
Finally, because of the underfunding of emergency medical services in California,[20] it appears that the incomes of emergency physicians are at the very

---

[19] *See IOM Report, supra,* p. 43.

[20] The relatively low income earned by California's emergency physicians, as well as these physicians' testimony before the DMHC hearings, belies the payers' unwarranted protestations that emergency medicine charges are anything but reasonable.

low end of the scale when compared to what their colleagues earn in other states, even though the cost of living in California is amongst the highest in the nation.



Sources:

1. ACCRA Cost of Living Index; Second Quarter 2004-First Quarter 2005, the Council for Community and Economic Research, www.coli.org.
2. Certified Compensation Professionals' Survey; updated August 2006, www.salary.com.

Emergency physicians cannot continue to survive in this state indefinitely without adequate payment. This failure to adequately fund emergency medicine has occurred notwithstanding the plethora of laws specifically designed to assure its financial stability.

V. LEGISLATIVE AND REGULATORY EFFORTS ENSURING HEALTH PLAN ACCOUNTABILITY TO EMERGENCY PHYSICIANS SHOULD NOT BE CIRCUMVENTED AGAIN

The Knox-Keene Act imposes the direct duty upon health plans to ensure access to emergency medical services. *See* Health & Safety Code §1367; *see also* 28 C.C.R. §1300.67, stating in part:

> Emergency health care services . . . shall be available and accessible to enrollees on a 24-hour a day, seven days a week basis within the health care service plan area.

The law is specific in its mandate as it requires that in the case of a full service plan, all Knox-Keene enrollees have a residence or workplace within thirty minutes or fifteen miles of a contracting or plan-operated hospital which has the capacity to serve the entire dependent enrollee population based on normal utilization, and if separate from the hospital, a contracting or plan-operated provider of all emergency health care services. *See* 28 C.C.R. §1300.51.

There are a host of Knox-Keene laws promoting enrollee access, at least two of which are relevant here—(1) regulations requiring that there be a complete network of contracting or plan-employed physicians (28 C.C.R. §1300.51) in the network, and (2) fair and prompt payment requirements to ensure a stable environment for patients to access care. *See,* for example, Health & Safety Code §1371 (prompt payment).

Plans must not rely upon emergency physician EMTALA obligations to provide emergency care and services as an alternative to fulfilling their obligation to have an adequate network of contracted providers, including emergency care providers, and to pay them adequately. To the contrary, because of the vital need for, and fiscal burdens imposed upon providers of emergency medical care and services, the Knox-Keene Act mandates that plans "shall reimburse providers for emergency services and care" at the amount it contracted for with the physician, or

in the absence of a contract, the physician's usual, customary and reasonable charge. (Health & Safety Code §1371.4.)

Unfortunately, despite numerous legislative efforts to hold health plans accountable to pay critically important emergency care claims, health plans have tirelessly found ways to circumvent the law. The phenomenon of managed care non-accountability to emergency physicians is documented in both the literature and in legislation.

For example, based on a study conducted on emergency departments in twelve academic community hospitals in four states, including California, almost two-thirds of all emergency department claims were initially denied, and reimbursed claims were uniformly downcoded (paid at a lesser level than billed for). *See* Gary P. Young, M.D., et al., *Managed Care Gatekeeping, Emergency Medicine Coding, and Insurance Reimbursement Outcomes for 980 Emergency Department Visits from Four States Nationwide* (January 2002) Ann.Emerg.Med. 39:1. On appeal, reimbursement was often reinstated or increased, although billing services only appealed half of the emergency department visits. (*Id.*) These results are astounding. Given the critical function they serve, and the scarce resources that are afforded to them to provide these services, emergency physicians cannot absorb these losses, nor can they be expected to take on the added administrative burden of fighting the health plans for fair payment for each and every service provided to a health plan's enrollees.

Unfortunately, legislative efforts to address the problem of health plans not paying appropriately for emergency services have been futile, notwithstanding strong enforcement of the mandate to keep emergency services available 24/7. If anything, payment problems increased significantly with the delegation of financial responsibility for emergency services to capitated IPAs and medical groups (many of whom are members of the California Association of Physician

Groups—another amicus before this Court). These groups are essentially unlicensed agents of the health plans who themselves are trying to make a living in the face of health plan economic pressure.

Elaborating on the protections set forth in Health & Safety Code §1371 (requiring prompt payment), California's Legislature adopted numerous provisions to correct health plan circumventions of law. When doing so, the Legislature recognized the importance of payment to emergency departments for their continued survival. Consider the following chronology:

- **1986**—Enactment of EMTALA. This obligation was then misused by plans to eliminate effectively their responsibility to reimburse and cover emergency services properly;

- **1994**—Due to health plans denying emergency services altogether and/or not paying emergency physicians appropriately, the Legislature enacted Health & Safety Code §1371.4, mandating that plans reimburse non-contracting physicians for emergency services and for the care resulting in stabilization, and that coverage be provided under the "prudent layperson" standard. Significantly, even this provision had little effect, as a study of two capitated medical groups in California found that one of the most frequently denied services was emergency care, almost universally on the grounds that the visit was not deemed an emergency according to the "prudent layperson standard."[21] A follow-up study found that patients who had the wherewithal to appeal prevailed in over 90% of appeals involving emergency care.[22]

- **1998**—Due to further reimbursement problems, the Legislature amended Section 1371.4 to clarify that the payment mandate included all physicians providing emergency services, not just those that had no contract with the health plan. *See* Stats. 1998, ch. 1015,

---

[21] *See* Kapur, et al., *Managing Care: Utilization Review in Action at Two Capitated Medical Groups*, Health Affairs (2003), W3-275-282.

[22] *See* Gresenz, et al., *Disputes Over Coverage of Emergency Department Services: A Study of Two Health Maintenance Organizations*, Ann.Emerg.Med. 2004, February; 43(2); 155-62.

Section 2 (AB 682). Further, in response to plan denial due to lack of prior authorization, that same year the Legislature amended Section 1371.4 **again** to clarify that so long as California and federal law requires that emergency services be provided without first questioning the patient's ability to pay, a health care service plan may not require a provider to obtain authorization prior to the provision of emergency services. Ch. 1016, Stats. 1998, Section 2 (AB 677).

The Legislature also added Health & Safety Code §1371.35 to deal specifically with the problem of health plans failing to make and/or making payments late to emergency care providers. Among other things, this provision increased the penalty for late payments from those currently set forth in Health & Safety Code §1371 and demanded that health plans provide more specific information when denying or contesting a claim in full or in part.

- **1999**—Shortly thereafter, some health plans and their subcontractors denied reimbursement for psychiatric evaluation. In response, the Legislature amended the definitional portion of California's emergency transfer law, Health & Safety Code §1371, to clarify that emergency services and care also means those additional screening, examination and evaluative services needed to determine if a psychiatric emergency medical condition exists.

- **2000**—Because reimbursement problems were still plaguing providers throughout the state, the Legislature enhanced Section 1371.35, providing for even greater penalties for late payments. The Legislature also directed the Department of Managed Health Care to punish health plans for "unfair payment practices."

- **2003**—The Department of Managed Health Care finally issued its regulations defining "unfair payment practices" and specifically defining an unfair payment practice as the failure to reimburse non-contracted physicians providing emergency care the reasonable value of their services. *See* 28 C.C.R. §1300.71.

It is inconceivable that all these laws were passed to ensure the financial survival of providers of emergency services only to have health plans escape their reach by simply using their computers to automatically reduce a physician's bill with no provision for determining whether that payment was reasonable in light of

the services rendered or the emergency physician's practice--and then seek to avoid pressure from their enrollees to fulfill their contractual obligations by precluding these physicians from looking to patients to pay the remainder of the reasonable fee.

VI. BECAUSE OF THE VITAL PUBLIC NEED FOR AND FISCAL BURDENS IMPOSED UPON PROVIDERS OF EMERGENCY CARE AND SERVICES, THE KNOX-KEENE ACT IMPOSES AN OBLIGATION UPON HEALTH PLANS TO REIMBURSE THOSE PROVIDERS THEIR CONTRACTED RATE, OR IF NOT CONTRACTED, THEIR USUAL AND CUSTOMARY CHARGE

The fact that the Legislature never authorized the type of relief Appellants seek in this case is further borne out by the constitutional and statutory issues that arise given the complexities of determining what constitutes a "reasonable" fee.

Patients enrolled in health plans are entitled to have emergency medical services reimbursed and/or paid for by their health plans. To ensure that patients receive prompt, medically necessary life-saving services, the law guarantees that patients receive such services without the need for prior authorization and assures that payment will be made for such services, regardless of whether the facility or the physician was a contracting provider. *See* Health & Safety Code §§1317, 1371.4.

As is discussed briefly above, the Legislature's overriding concern about the financial stability of the emergency system resulted in the enactment of Health & Safety Code §1371.4. That provision, stating in part that "a health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in a stabilization of the enrollee," represents a reflection of the Knox-Keene Act's core purpose to ensure that providers that care for enrollees get paid so that they can keep their doors open and provide medically necessary and often life-saving health care. This has been recognized already by

at least three courts. (*Bell v. Blue Cross* (2005) 131 Cal.App.4th 211 (non-contracting physicians have right to reasonable amounts under Knox-Keene Act, not amounts unilaterally determined by plans); *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782 summarizing the provision as follows:

> Section 1371.4 is the portion of the Knox-Keene Act governing compensation for emergency care services. Subdivision (b) of that statute requires health care service plans to pay for emergency care rendered to their enrollees regardless of whether the emergency care provider is under contract with the plan. (*Id*. at 789.)

See also California Emergency Physicians Medical Group v. PacificCare (2003) 111 Cal.App.4th 1127 (stating "we agree with Emergency Physicians and *Amicus Curiae* California Medical Association that health care service plans have a mandatory duty to pay for emergency medical services under section 1371.4(b).")

Because of the Legislature's preeminent concern about the financial stability of the emergency system, Health & Safety Code §1371.4 does not allow health plans to unilaterally and automatically discount a provider's fees, nor does it provide that health plans are the exclusive source of recovery for the physician providing emergency services. It requires that the health plan reimburse providers of emergency services and care.

Health & Safety Code §1371.4(b) provides, in part:

> A health care service plan **shall** reimburse providers for emergency services and care provided to its enrollees, until the care results in a stabilization of the enrollee . . .

Significantly, as recently reaffirmed by *Bell,* common law principles require that the payment obligation to a non-contracted physician only extends to require the payment of the reasonable value of the services rendered. However, a

determination of "reasonableness"[23] in the context of an emergency department setting in particular, cannot be reduced to a mechanical application, but must be analyzed on a case-by-case basis utilizing separate, but related , factors including:

(i) The provider's training, qualifications, and length of time in practice;

(ii) The nature of the services provided;

(iii) The fees usually charged by the provider;

(iv) Prevailing provider rates charged in the geographic area in which the services were rendered;

(v) Other circumstances of the economics of the medical provider's practice that are relevant; and

(vi) Any unusual circumstances in the case.

See Gould v. W.C.A.B. (1992) 4 Cal.App.4th 1059. Thus, the *Bell* court properly remanded that case to the trial court to adjudicate whether the billed charges at issue were reasonable based on the facts of the case.

Unfortunately, emergency physicians do not get paid their reasonable fee, notwithstanding Health & Safety Code Section 1371.4 . If the Legislature were to provide a specific enforcement mechanism for each claim, then it would have to address the widespread disparities of emergency departments, the types of and severity of illnesses and conditions suffered by the patients they treat, and the economics of their practices, i.e., their payor mix, including the amount of uncompensated care provided and the special characteristics of the communities

---

[23] Of necessity, a finding of reasonableness in any context depends on the facts of a particular case. Thus, what constitutes a "reasonable" time with respect to waivers of the right to arbitration, "reasonable" suspicion, "reasonable" notice, and a "reasonable" accommodation are questions of fact to be determined on a case-by-case basis. *See Spear v. California State Auto Association* (1992) 2 Cal.4th 1035, 1043; *Wallis v. Princess Cruises, Inc.* (9th Cir. 2002) 306 F.3d 827; *Soldinger v. Northwest Airlines, Inc.* (1996) 51 Cal.App.4th 345.

they serve. Under these circumstances, the non-contracting emergency physician's charge must be presumed to be reasonable,[24] and not be automatically and unilaterally reduced. Any other result would deprive these physicians of their constitutional right to equal protection (as discussed below), and their common law right to have their fees judged on a case-by-case basis. Further, such a conclusion would actually (1) discourage plans from meeting their statutory obligations to have an adequate network of contracting physicians and pay for covered services, *see* Health & Safety Code §§1345, 1367, 1371.4, and (2) encourage plans to rely on the EMTALA obligations of physicians and hospitals to provide emergency care.[25]

This does not mean that the health plans have no ability to later contest amounts paid that they believe were unreasonable. The lower court expressly recognized the availability of court remedies, and they are available to plans where they believe they have overpaid for services. Any other conclusion raises serious constitutional questions.

---

[24] Indeed, given the low income levels of emergency physicians in California when viewed against their colleagues in other states, see Footnote 18, *supra*, these physicians' charges must generally be reasonable as a matter of economics. Further, it should be noted that market forces, in addition to the factors outlined in the Amicus Curiae brief of the California Medical Association, serve as another check on emergency physician fees to assure their reasonableness. Despite significant fraud and abuse considerations, hospitals typically require that they review their emergency medical group's fees to ensure they are reflective of a fair market in order to promote themselves in the community. While Amici have significant concerns with both the legality and fairness of this practice, it nonetheless constitutes another oversight mechanism.

[25] Again, taking a plan to court each time it pays is not a viable option. First, there are literally hundreds of different payors in California. With a ban on billing the patient for the remainder of the fee, there will be potentially millions of claims and hundreds of thousands of disputes and underpaid claims to resolve—making the "option" not only "unrealistic" but also unfair.

VII. CALIFORNIA'S CONSTITUTION REQUIRES THAT EMERGENCY PHYSICIANS RECEIVE ADEQUATE COMPENSATION TO COVER THEIR LOSSES FOR SERVING THE INDIGENT

As emergency services are mandated pursuant to federal law, mandating that all physicians providing emergency services accept health plan rates for all plan enrollees becomes a legal compulsion which could invoke a "constitutional right" as violative of the equal protection clause. *See Bell*, *supra* (allowing plans to unilaterally set rates "aside from being unconscionable, would be unconstitutional"). *See also California Association of Nursing Homes v. Williams* (1970) 4 Cal.App.3d 800 (noting constitutional problems of requiring nursing homes to accept Medi-Cal rates if they were required to treat all Medi-Cal patients).

At issue in this case are physicians providing critical emergency care services, to everyone, rich or poor, whether insured or not. It is essential that these physicians receive adequate compensation for their services and that health plans be accountable to assure the stability of the emergency system in this state. This obligation rests with plans as a matter of public policy, and as a matter of law. *See* discussion above of Health & Safety Code §1371.4.

Letting health plans unilaterally decide whether and how much these physicians should be paid is also a violation of California's Equal Protection Clause. This result is confirmed by *Cunningham v. Superior Court of Ventura* (1986) 177 Cal.App.3d 336, 222 Cal.Rptr. 854. In that case, an attorney was ordered by the Superior Court to represent an indigent defendant in a paternity action, even though that attorney's practice was limited to personal injury matters, and he had never handled a paternity case. The court held that the order violated the Equal Protection Clause, as the forced appointment of the attorney without adequate compensation unfairly singled out attorneys to donate their services to

the poor. Applying the rational relationship (as opposed to strict scrutiny) test, the court reasoned as follows:

> It is a legitimate state function to assist the poor (*The Housing Authority v. Dockweiler* (1939) 14 Cal.2d 437, 450 [94 P.2d 794]), but, under the Constitution, this goal cannot be accomplished at the expense of one particular group of people. It is a denial of equal protection when the government seeks to charge the cost of operation of a state function, conducted for the benefit of the public, to a particular class of persons.
>
> To charge the cost of operation of state functions conducted for public benefit to one class of society is arbitrary, and violates the basic constitutional guarantee of equal protection. (Citation omitted.)

(*Id*. at 348.)

Physicians who are required to provide emergency medical care without adequate compensation to cover their losses are effectively forced to give away a portion of their livelihood, whereas other professionals, and even some other physicians, are not so impacted. Under these circumstances, the relief sought also constitutes a violation of California's Equal Protection Clause. Further, as physicians would not receive a fair return that permits them to operate successfully and maintain financial integrity, serious implications arise under the Fifth Amendment to the U.S. Constitution. *See Fed. Power Comm'n v. Hope Natural Gas Co.* 320 U.S. 591, 601 (1944).

VIII. CALIFORNIA'S EMERGENCY DEPARTMENTS ARE ALREADY OPERATING AT CAPACITY AND RISK JEOPARDIZING QUALITY OF CARE

The health plans' failure to properly reimburse for emergency medical services has already substantially contributed to the unraveling of California's emergency medical system. Emergency rooms nationwide are becoming stretched as patient visits increase while the number of emergency facilities declines. Indeed, the Institute of Medicine, a branch of the National Academy of Sciences

that serves as an independent government advisory group, convened a committee in 2003 to study the nation's emergency medical services. Among its findings:

- Across the country, ambulances were turned away from emergency rooms over 500,000 times in just one year (2003) because of overcrowding;
- Patients in many areas wait hours or even days for a hospital bed;
- Emergency rooms took in 114 million patients in 2003, a 26% increase over the past decade, yet during the same ten year period, the United States lost 703 hospitals and 425 emergency departments.[26]

These findings are consistent with those recently released by the U.S. Centers for Disease Control and Prevention, finding that:

- Nearly two-thirds of hospital emergency departments in the United States face overcrowding;
- The annual number of visits to an emergency department rose by 18% in the ten years from 1994, but that the number of hospitals operating 24 hours a day decreased by 12% over the same period of time;
- Between 1995 and 2003, the average caseload among emergency departments rose by 78%.[27]

---

[26] Significantly, more patients going to an emergency department does not translate into profits, as the marginal costs of an emergency department visit are higher than expected. *See* Bamezai, et al., *The Cost of an Emergency Department Visit and Its Relationship to Emergency Department Volume*, Ann.Emerg.Med. 45:5 (May 2005).

[27] *See* Burt, Ed.D., et al., *Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States 2003-04*, Advance Data from Vital and Health Statistics, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, No. 376, September 27, 2006.

Unfortunately, the advent and expansion of managed care has not stopped the growing swell of visits to the emergency department, even though the concept of managed care was intended to prevent this result. As was aptly stated by Derlet, M.D. and Richards, M.D., *Overcrowding in the Nation's Emergency Departments: Complex Causes and Disturbing Effects*, Ann.Emerg.Med., (2000) 39, No. 6, 551-561:

> Depending on the area of the country, managed care may affect ED (Emergency Department) crowding in very significant ways. In the early 1990s, many predicted that managed care would decrease ED visits because patients would be appropriately "managed" and therefore, seldom need ED care. Paradoxically, the volume of patients in EDs located in some heavily penetrated managed care areas have increased. Some patients complain of difficulty in accessing their personal managed care physicians because they are often booked for weeks at a time. In one case at our hospital, a patient with severe asthma was told by her managed care organization (MCO) not to go to the ED but to see her primary care physician, and an appointment was made for one week. Five days later, she presented to the ED in respiratory distress, was intubated, and was admitted to the ICU for status asthmaticus.

See also Brewster, et al., *Emergency Room Diversions: A Symptom of Hospitals Under Stress*, Center for Studying Health Systems Change, (May 20, 2001) No. 38, (stating "It also appears that HMO enrollees are turning to emergency rooms for less serious medical problems because they are unable to get timely access to primary care physicians (PCPs).")

In California, specifically, many people are increasingly turning to emergency departments for which they should have received treatment elsewhere. No longer does the emergency department act as a safety net for the more routine care primarily for the uninsured. With health plans' enrollees facing access

problems throughout the state,[28] emergency departments are increasingly providing care to the insured—those who have paid for full health care coverage but have nowhere else to go. *See,* for example, Cunningham, *What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities*, (July 18, 2006) Health Affairs; *see also* Bruce Siegel, *The Emergency Department: Rethinking the Safety Net for the Safety Net*, Health Affairs, (March 24, 2004) W4-146. *See also* Ann S. O'Malley, et al., *Rising Pressure: Hospital Emergency Departments as Barometers of the Health Care System*, Centers for Studying Health System Change, Issue Brief No. 101 (Nov. 18, 2005) (diminishing access to primary care resulting in increased usage of emergency departments). This problem is particularly acute in California. *See Overuse of Emergency Departments Among Insured Californians,* California Healthcare Foundation (2006).

And this increase in emergency department use has nothing to do with the "prudent layperson" mandate for coverage set forth in Health & Safety Code §1371.4, despite the HMOs' protestations to the contrary during the legislative debate over its enactment. *See* Hsia, et al., *Do Mandates Requiring Insurers to Pay for Emergency Care Influence the Use of the Emergency Department?,* Health Affairs (July/August 2006).

At the same time, the patients going to California's emergency departments appear to be sicker. Based on a study of California emergency department visits from 1990-1999, the authors concluded that critical (not including urgent or non-urgent) visits per emergency department increased by 59%. See Lambe, M.D., et al., *Trends in the Use and Capacity of California's Emergency Departments,*

---

[28] For example, in 2004, the Department of Managed Health Care reported in its Annual Report (the most recent one available) that nearly 42% of its urgent complaints were related to access/referral issues.

1990-1999, Ann.Emerg.Med. (April 2002, 39:4). During this time period, the severity of patient illness or injury intensified. (*Id.*) This increase poses particular hardships in California since during this time period, the number of emergency departments decreased by 12%. (*Id.*)

California patients, like those cited in the *IOM Report*, wait for excessive periods of time before they are seen, assuming they are even allowed entry into an emergency department. *See,* for example, Lambe, M.D., et al., *Waiting Time in California's Emergency Departments*, Ann.Emerg.Med. (January 2003, 41:4) (most patients waited approximately an hour for care, though 42% waited longer than 60 minutes); *see also* Lambe, M.D., et al., *Trends in the Use and Capacity of California's Emergency Departments, 1990-1999*, Ann.Emerg.Med. (April 2002, 39:4) (increases in visits per ED, beds per ED, and the proportion of patients categorized as critical helps explain the perception that capacity is inadequate to meet growing demand).

Further, many emergency departments in California have become so overcrowded that they must divert ambulances to other hospitals that are presumably less crowded, and therefore delay potentially life-saving treatments, and/or risk jeopardizing patient care. "Diversion" is the polite shorthand for "no vacancy, go take a ride and search for somewhere willing to take you." Unfortunately, ambulance diversion has been associated with "impaired patient care, including increased transportation times, discontinuity of inpatient care, delays in reperfusion therapy in patients with acute myocardial infarction, and mortality in severely injured trauma patients." *See* Sun, et al., *Effect of Hospital Closures and Hospitals Characteristics on Emergency Department Ambulance Diversion, Los Angeles County, 1998-2004*, Ann.Emerg.Med. (April 2006, 47:4), (finding an increasing number of diversion hours in Los Angeles from a mean of 57 hours in 1998 to 190 hours in 2004). Indeed, it is ironic that those were the

very problems being experienced by the uninsured and indigent that caused EMTALA to be enacted to begin with.

Now "diversion" affects everyone. As was recently reported by the New England Journal of Medicine:

> Diversion may provide a brief respite for a beleaguered staff, but it prolongs ambulance transport times and disrupts established patterns of care. It can also create ripple effects that can compromise access to care throughout a city. Because crowding is rarely limited to a single hospital, one facility's decision to divert ambulances can prompt others to follow suit. When that happens, a city may experience a health care equivalent of a "rolling blackout." Everyone's access to care is effected—the insured and uninsured alike.[29]

Unfortunately, as the demand for emergency department services has risen, the number of emergency departments has declined quite dramatically. Due to financial difficulties, more than 65 emergency departments have closed in little more than a decade. *See*, *A System in Continued Crisis: CMA's Annual ER Losses Report,* Sept. 20, 2004, www.cmanet.org. These closures resulted from the widespread financial difficulties experienced by emergency departments throughout California. These losses create such a financial strain on some hospitals that the viability of the entire facility is threatened. As the report demonstrates, in the fiscal 2002, losses from uncompensated care at these hospital emergency departments totaled $635 million—an 18% increase from the year before. Under these circumstances, it is little wonder that the recently issued National Report Card on the State of Emergency Medicine rated California a "C" with respect to access to emergency care, and was rated last among all states with

---

[29] *See* Kellermann, M.D., Ph.D., *Crisis in the Emergency Department,* N.Eng.J.Med., 355:13, Sept. 28, 2006.

the District of Columbia for its number of emergency departments per 1 million people (51st).[30]

The relief sought in this case would only create even further underfunding of the system as a whole, causing more closures and, moreover, reducing the availability of qualified emergency physicians. CAL/ACEP recently surveyed 1800 emergency physicians in California, including residents in training in emergency medicine, directors of emergency departments, and emergency department staff physicians, in order to assess the potential impact of proposed regulations banning billing enrollees on patient access to qualified emergency physician services.[31] Based on this survey, it is apparent that providing the relief Appellants seek in this case could undermine staffing for many of California's emergency departments.[32] The survey assessed responses based on best-case and worst-case scenarios. The worst-case scenario was predicated on the loss of an average of $66,800 per year in income for full time emergency physicians, based on the difference between payment at 110% of Medicare rates (one of the safe harbor standards for initial payment suggested by the DMHC), and payment at current rates from an extrapolation of average receipts on Knox-Keene claims

---

[30] *The National Report Card on the State of Emergency Medicine,* The American College of Emergency Physicians (January 2006).

[31] The survey results are reported at www.calacep.org; click on Lifeline October 2006.

[32] These survey results are consistent with the testimony of emergency medicine residents at the DMHC hearing who uniformly explained that they cannot afford to stay in California if a ban on billing were to take effect. *See*, for example, DMHC transcript, *supra*, at pp. 87-88, This is particularly troubling given testimony that California has already witnessed "physicians with excellent training and skill sets leave California for other states in practice situations where their compensation will range as much as 150 to 200 percent of current California compensation levels." (*Id.* at 93.)

from several ER groups from around the State, both contracted and non-contracted. Thirty five percent of the physicians (635) responded to the survey, and of the currently practicing emergency physicians, more than half indicated they would consider retiring early, switching careers, or leaving California to practice elsewhere, in the worst-case scenario. Thirty-three of the fifty-four residents currently planning on remaining in California to practice emergency medicine would also leave the State in this scenario. Even a very conservative extrapolation of the results of this survey to the 3000+ emergency physicians in California indicates such a dramatic loss of professional resources, that a ban on billing patients would result in the closure of more than a third of all the EDs in California.

IX. CONCLUSION

For the foregoing reasons, Amici Curiae urges that the lower court's opinion be affirmed.

Dated: December 20, 2006 ASTRID G. MEGHRIGIAN

By: ______________________________
Astrid G. Meghrigian
Attorney for Amici Curiae

Table 6. Percent distribution of emergency departments and corresponding standard errors, by utilization estimates, according to metropolitan status: United States, 2003–04

Characteristic	Total		Metropolitan area		Not metropolitan area	
	Percent distribution	Standard error	Percent distribution	Standard error	Percent distribution	Standard error
All emergency departments	100.0	. . .	100.0	. . .	100.0	. . .
Daily visit volume						
Less than 30	32.2	3.3	11.0	3.1	66.9	6.4
30–49	18.0	2.6	15.5	2.9	22.1	5.6
50–99	24.6	2.2	33.5	2.9	10.3	2.8
100–199	19.5	1.6	31.1	2.6	*0.7	0.6
200 or more	5.5	0.9	8.9	1.4	*0.0	. . .
Patient characteristics						
Percent under 18 years:						
Less than 10	6.3	0.8	9.8	1.2	*0.5	0.5
10–19	21.5	2.2	25.6	2.7	14.8	3.9
20–29	45.3	2.8	35.5	2.5	61.2	5.1
30–49	18.1	2.4	18.4	2.9	17.6	4.0
50 or more	8.9	1.5	10.7	1.9	*5.9	2.7
Percent 65 years and over:						
Less than 5	6.2	1.2	10.0	1.8	*0.0	. . .
5–14	33.8	2.5	41.9	2.7	20.6	3.8
15–24	35.4	2.9	31.1	2.8	42.4	5.2
25–34	13.8	2.1	10.3	1.7	19.6	4.7
35 or more	10.8	1.8	6.8	1.5	17.5	3.9
Percent Medicare:						
Less than 5	4.8	1.1	7.7	1.7	*0.0	. . .
5–14	28.0	2.6	35.4	2.9	15.9	4.1
15–24	36.4	2.5	40.4	2.7	30.0	4.8
25–34	17.6	2.7	6.9	1.4	34.8	5.8
35 or more	13.3	1.7	9.6	1.4	19.3	3.7
Percent Medicaid:						
Less than 10	16.1	2.0	19.2	2.1	*11.1	3.6
10–19	28.5	2.8	30.8	3.2	24.6	5.4
20–29	27.7	2.6	22.4	2.2	36.3	5.5
30–49	17.3	2.2	17.7	2.4	16.5	4.2
50 or more	10.5	1.5	9.8	1.7	11.6	3.1
Percent private insurance:						
Less than 10	4.8	1.0	4.0	0.7	6.1	2.5
10–19	5.7	1.1	6.6	1.2	4.2	1.9
20–29	21.5	2.2	18.0	2.2	27.2	4.7
30–49	45.2	2.5	43.6	2.5	47.9	5.2
50 or more	22.8	2.0	27.8	2.6	14.6	3.5
Percent uninsured:						
Less than 5	16.0	2.4	14.5	2.0	18.5	5.4
5–14	38.4	3.0	32.4	2.5	48.1	6.4
15–24	27.1	2.7	30.8	3.0	21.1	5.1
25–34	10.4	1.6	11.5	1.7	*8.7	3.5
35 or more	8.2	1.3	11.0	1.6	*3.7	2.1
Patient acuity						
Percent arriving by ambulance:						
Under 10	37.6	2.8	36.5	3.1	39.5	5.6
10–14	45.7	3.1	43.0	2.9	50.0	6.0
15–29	2.9	0.6	4.4	0.9	*0.4	0.3
30 or more	13.8	2.1	16.1	2.2	*10.2	3.9
Percent emergent and urgent:						
Under 20	21.8	2.6	22.4	2.8	20.8	4.7
20–34	12.9	1.9	14.0	1.9	*11.0	3.7
35–49	14.2	1.7	15.3	2.3	12.3	2.6
50–64	13.0	1.8	12.4	1.8	14.1	3.9
65 or more	38.1	2.9	35.8	3.2	41.9	5.8

See footnotes at end of table.

Table 6. Percent distribution of emergency departments and corresponding standard errors, by utilization estimates, according to metropolitan status: United States, 2003–04—Con.

Characteristic	Total		Metropolitan area		Not metropolitan area	
	Percent distribution	Standard error	Percent distribution	Standard error	Percent distribution	Standard error
Services provided						
Average number of diagnostic services per 100 visits:						
Less than 200	18.7	2.5	14.8	2.2	25.2	5.6
200–299	24.9	2.2	24.0	2.4	26.4	4.0
300–399	27.4	2.5	23.0	2.2	34.4	5.5
400 or more	29.0	2.7	38.2	3.1	*14.1	4.5
Average number of therapeutic services per 100 visits:						
Less than 40	27.8	2.5	19.4	2.7	41.5	5.0
40–59	34.2	3.0	33.0	2.6	36.1	6.7
60–69	15.4	2.2	19.0	2.4	*9.6	4.1
70 or more	22.6	2.1	28.6	2.5	12.9	3.1
Percent using physician assistants or nurse practitioners:						
0	57.3	3.5	51.6	2.9	66.5	7.7
1–9	15.2	2.0	18.0	2.4	10.5	3.2
10–19	9.0	1.4	11.7	1.6	*4.7	2.4
20 or more	18.5	3.1	18.7	2.1	18.3	7.4
Percent not seeing a physician:						
0	18.0	2.4	14.4	2.1	23.8	5.2
1–2	18.4	2.2	18.2	2.1	18.7	4.6
3–19	37.9	2.7	44.4	2.7	27.3	5.2
20 or more	25.8	3.3	23.0	2.3	30.2	7.5
Disposition						
Percent admitted:						
Less than 5	24.0	2.6	23.2	3.0	25.4	5.2
5–9	11.3	1.9	11.5	2.0	*11.1	3.8
10–14	18.9	2.4	17.4	2.0	21.3	5.2
15–19	19.3	2.4	17.2	2.2	22.6	5.2
20 or more	25.5	2.0	30.8	2.4	19.5	4.1
Percent transferred:						
Less than 1	28.9	2.5	38.4	2.9	*13.4	4.1
1–2	19.8	2.0	20.7	2.1	18.3	4.1
3–9	32.9	3.0	23.8	2.5	47.6	6.0
10 or more	18.5	1.8	17.0	2.1	20.8	3.5
Percent left before being seen:						
Less than 1	57.9	2.8	50.4	3.5	70.0	5.1
1–2	25.9	2.3	27.6	2.9	23.2	3.9
3–4	9.0	1.6	11.0	1.9	*5.9	3.4
5 or more	7.2	1.3	11.0	2.0	*0.9	0.7
Throughput measures						
Average waiting time:						
Less than 15 minutes	17.6	2.2	9.0	2.0	31.7	4.6
15–29 minutes	29.8	3.1	19.2	2.7	46.9	5.4
30–44 minutes	24.7	2.4	29.3	2.8	17.3	4.2
45–59 minutes	14.9	1.9	22.2	2.7	*3.0	1.7
60 minutes or more	13.0	1.4	20.3	2.1	*1.2	0.8
Average treatment time in minutes:						
Less than 60 minutes	8.2	2.7	*4.8	1.8	13.7	6.3
60–89 minutes	21.9	2.1	15.4	2.2	32.6	4.6
90–119 minutes	29.1	3.1	27.4	2.7	31.8	6.8
120–179 minutes	29.2	2.6	35.6	2.9	19.0	4.6
180 minutes or more	11.6	1.3	16.9	2.0	3.0	0.7
Average total visit duration:						
Less than 2 hours	31.8	3.5	17.5	3.4	54.9	6.8
2 hours	39.8	3.0	41.2	2.8	37.5	6.8
3 hours	18.2	1.8	26.0	2.5	*5.7	2.8
4 hours or more	10.2	1.2	15.3	1.9	*1.9	1.2

See footnotes at end of table.

Table 6. Percent distribution of emergency departments and corresponding standard errors, by utilization estimates, according to metropolitan status: United States, 2003–04—Con.

Characteristic	Total		Metropolitan area		Not metropolitan area	
	Percent distribution	Standard error	Percent distribution	Standard error	Percent distribution	Standard error
Throughput measures—Con.						
Average waiting time for urgent cases[1]:						
Less than 15 minutes	27.3	2.9	16.5	3.0	44.6	5.4
15–29 minutes	25.1	2.8	20.0	2.4	33.3	5.9
30–44 minutes	27.3	2.4	31.8	2.7	20.1	3.9
45–59 minutes	12.5	1.5	18.9	2.3	*2.0	1.1
60 minutes or more	7.9	1.0	12.8	1.6	*0.1	0.0

. . . Category not applicable.
* Figure does not meet standard of reliability or precision.
0.0 Quantity more than zero but less than 0.05.
[1]Urgent cases are defined as those that must be seen within 15–60 minutes.

Certification Under Section 14 of the California Rules of Court

I, Astrid G. Meghrigian, am an attorney at law licensed to practice before all courts of the State of California. I hereby certify that the word counting feature on the computer word processing program with which this brief was written indicates that the actual text of this brief, excluding the cover page and addresses of counsel, the Table of Authorities, the Table of Contents, this certification, and the Proof of Service, is 8,531 words.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my knowledge and that this Declaration was executed on December 20, 2006 in San Francisco, California.

____

Astrid G. Meghrigian