IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION FIVE

MEMORANDUM

TO: THE SUPREME COURT OF THE STATE OF CALIFORNIA

FROM: Brian Hoffstadt, Presiding Justice
Lamar Baker, Associate Justice
Carl Moor, Associate Justice

DATE: November 10, 2025

RE: Compliance with Rule 8.1120, California Rules of Court,
Prime Healthcare Centinela, LLC et al. v. United Healthcare Insurance Company, B334746, filed October 20, 2025

Attached hereto is a copy of the opinion in the above case, not certified for publication. Also attached are letters from: (1) the California Association of Health Plans (dated November 7, 2025), requesting publication of the opinion; (2) the California Hospital Association (dated November 9, 2025), opposing the request for publication; and (3) Appellant Prime Healthcare Centinela (dated November 10, 2025), opposing the request for publication. This court has denied the request for publication.

In this court's view, the opinion does not meet the criteria for publication set forth in California Rules of Court, rule 8.1105. This was our original view and, after reconsideration of the matter, it remains unchanged.

Pursuant to California Rules of Court, rule 8.1120, this court is referring this matter to the Supreme Court.

Attachments

cc: All parties

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

PRIME HEALTHCARE CENTINELA, LLC et al.,

Plaintiffs and Appellants,

v.

UNITED HEALTHCARE INSURANCE COMPANY,

Defendant and Respondent.

B334746

(Los Angeles County Super. Ct. No. 22STCV08452)

APPEAL from an order of the Superior Court of Los Angeles County, Lawrence P. Riff, Judge. Affirmed.

Buchalter, Damaris L. Medina, Devan J. McCarty, Robert M. Dato, Efrat M. Cogan and Karen N. George for Plaintiffs and Appellants.

Crowell & Moring, Nathaniel J. Wood, Marlee J. Godinho Santos; Gibson, Dunn & Crutcher, Kahn A. Scolnick, Matt A. Getz, and Allison R. Kawachi for Defendant and Respondent.

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Hospitals that "operate[] an emergency department" open "to the public" are obligated—under federal and state law—to provide emergency services to anyone who is "in danger of loss of life, or serious injury or illness." (Health & Saf. Code, § 1317, subd. (a); 42 U.S.C. § 1395dd(b).) The portion of the Health and Safety Code enacted as the Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340 et seq.) (the Knox-Keene Act) explicitly imposes a duty upon "health care service plan[s]," which are regulated by the Department of Managed Health Care (DMHC), to directly "reimburse" hospitals who are outside of the plans' contracted network for their provision of such services at their "reasonable and customary value." (*Id*., § 1371.4, subd. (b); Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3); *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215-216 (*Bell*).) Does a similar duty to directly reimburse out-of-network hospitals for the reasonable and customary value of any emergency services they provide exist for health insurance companies regulated by the Department of Insurance? We hold that it does not: The Insurance Code does not explicitly impose such a duty and the canons of statutory construction counsel against *inferring* such a duty from other provisions of the Insurance Code or their legislative history, by analogy to the Knox-Keene Act, or from the common law. Because the question whether insurance companies *should* have a duty to directly reimburse for such

services is one of public policy, it is a question for the Legislature and not this court. We must accordingly affirm the trial court's judgment dismissing the claims of several hospitals against an insurance company premised upon the existence of that duty.

FACTS AND PROCEDURAL BACKGROUND

I. Facts

Prime Healthcare (Prime) operates hospitals throughout Southern California, including in Chino Valley, Huntington Beach, Sherman Oaks, and Anaheim (collectively, the hospitals); each has an emergency department.[1] Since January 1, 2020, these hospitals have provided emergency services to patients who have health insurance with United Healthcare Insurance Company, Inc. (United) or who are members of the UHC of California, Inc. health insurance service plan (UHC), even though the hospitals are not part of United or UHC's network of providers. United and UHC have "ma[de] payments" to Prime "on a large number of claims," but in what Prime views as "inadequate amounts."

II. Procedural Background

A. *Complaint*

On March 9, 2022, Prime sued United and UHC for (1) quantum meruit, (2) open book account, and (3) violation of California's Unfair Competition Law (Bus. & Prof. Code, § 17200

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1 The corporate names of the five hospitals are (1) Prime Healthcare Centinela, LLC, dba Centinela Hospital Medical Center; (2) Veritas Health Services, Inc., dba Chino Valley Medical Center; (3) Prime Healthcare Huntington Beach, LLC, dba Huntington Beach Hospital; (4) Prime Healthcare Services – Sherman Oaks, LLC, dba Sherman Oaks Hospital; and (5) Prime Healthcare Anaheim, LLC, dba West Anaheim Medical Center.

et seq.) (UCL).[2] All of these claims are premised on United's and UHC's alleged failure to "pay the *reasonable* value of emergency medical services provided" by the hospitals. (Italics added.)

B. *United's demurrer*

United—but not UHC—demurred, arguing that it owed no duty to directly reimburse Prime the reasonable value of the emergency services its hospitals provided.[3] After fulsome briefing and two hearings, the trial court issued a 13-page order sustaining the demurrer without leave to amend. The court reasoned that the Insurance Code that regulates health insurance companies like United does not explicitly obligate insurers to directly reimburse the out-of-network providers of emergency services, and the court refused to infer such an obligation from the Insurance Code's obligation that insurers "cover emergency services" in their policies because "an insurer's statutory duty to provide insurance *coverage to insureds* does not necessarily imply a duty to *reimburse providers* the reasonable and customary value of the providers' services." (Italics in original.) The court also rejected Prime's proffered analogy to the Knox-Keene Act because the Insurance Code "lacks the express statutory duty to reimburse" providers that exists in the Knox-Keene Act. (Italics omitted.) Because no statute mandated direct

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2 Although Prime also asserted a separate claim for "services rendered," that claim is substantively duplicative of its equitable claim for quantum meruit. (See *Port Medical Wellness, Inc. v. Connecticut General Life Ins. Co.* (2018) 24 Cal.App.5th 153, 180.) We accordingly do not separately discuss it.

3 United also argued that the claims were barred by the doctrine of collateral estoppel, but the trial court rejected that argument and the parties do not renew it on appeal.

reimbursement at a reasonable rate, the fundamental premise of all of Prime's claims was absent and necessitated dismissal.[4]

C. *Appeal*

Following entry of an order dismissing United from the action, Prime filed this timely appeal.

DISCUSSION

All of Prime's claims against United have the same underlying premise—namely, that United has a duty to directly reimburse Prime for the "customary and reasonable" value of the emergency services that Prime's hospitals provided to United's insureds.[5] In reviewing the trial court's order dismissing these claims on demurrer, "'we accept the truth of material facts properly pleaded in the operative complaint, but not contentions, deductions, or conclusions of fact or law.'" (*Capito v. San Jose Healthcare System, LP* (2024) 17 Cal.5th 273, 280; *Ranger v.*

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4 In addition to finding that this overarching premise of Prime's complaint failed, the trial court also explained why each of Prime's claims failed as to certain required elements. Because our holding does not depend on the specific elements of each of Prime's claims, we need not discuss this further rationale by the trial court.

5 Although Prime's UCL claim was phrased in terms of United's conduct being "unfair" as well as "unlawful," and although those two prongs *can* be distinct (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 180), Prime did not treat them as distinct in its complaint, alleging that United's conduct was unfair because "it prevents the laws relating to services for emergency services and payment from protecting emergency providers and patients, as intended," which is alleged to have the effect of discouraging higher payments to those providers.

Alamitos Bay Yacht Club (2025) 17 Cal.5th 532, 538.) "Because this appeal was taken from a dismissal on demurrer, and involves questions of statutory interpretation, our review is de novo." (*Stone v. Alameda Health System* (2024) 16 Cal.5th 1040, 1052 (*Stone*).) Because Prime offers no argument that it should be entitled to amend its complaint, we focus solely on the viability of Prime's claims as alleged.

I. Pertinent Health Care Law

A health insurance company is obligated to pay the health care costs of its insured in accordance with the terms of the health insurance policy between them. (Ins. Code, §§ 10111, 106, subd. (b) [defining "health insurance" as a species of "disability insurance policy"].)[6] The insurance company often enters into contracts with providers of medical services, who become part of the insurance company's preferred "network" of providers and who can seek compensation for services rendered to insured patients from the insurance company at the agreed-upon, contractual rate. Sometimes, the insurance company and the provider of medical services are one and the same; in California, such a hybrid is officially called a "health care service plan" (Health & Saf. Code, § 1345, subd. (f)(1)) but is more "commonly known" as an HMO (health maintenance organization) (*Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.* (2016) 1 Cal.5th 994, 1000-1001, fn. 2 (*Centinela*); *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 501-502 (*Prospect*)). While health insurance companies and health care service plans perform similar functions, health insurance companies are regulated by

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6 All further statutory references are to the Insurance Code unless otherwise indicated.

the Insurance Code and overseen by the Department of Insurance (*Rea v. Blue Shield of California* (2014) 226 Cal.App.4th 1209, 1215), while health care service plans are regulated by the Knox-Keene Act and overseen by the DMHC (Health & Saf. Code, § 1341, subd. (a); *County of Santa Clara v. Superior Court* (2023) 14 Cal.5th 1034, 1041 (*Santa Clara*)).

Although insureds under a health insurance policy and enrollees in a health care service plan typically use the providers of medical services within the company's or plan's network (so-called "in-network providers"), this model "breaks down . . . in the case of emergency care" because, in such emergencies, a patient is likely to go "to the nearest hospital emergency room for treatment" regardless of whether it is an in-network or out-of-network provider. (*Prospect*, *supra*, 45 Cal.4th at p. 501.) Recognizing this reality, federal and state law obligate the providers of "emergency services"[7] to treat patients regardless of whether they are in- or out-of-network, regardless of their insurance status, and regardless of their ability to pay for medical services. (42 U.S.C. § 1395dd(b); Health & Saf. Code, § 1317, subds. (a) & (b); *Santa Clara*, *supra*, 14 Cal.5th at p. 1037.)

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7 "Emergency services and care" is defined as "medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility." (Health & Saf. Code, § 1317.1, subd. (a)(1).)

The Knox-Keene Act imposes a duty upon health care service plans to (1) cover "emergency services" provided by in-network and out-of-network providers as to plans that otherwise "cover[] hospital, medical or surgical expenses" (Health & Saf. Code, § 1371.4, subd. (a)), and (2) directly "reimburse [medical] providers for emergency services and care provided to its enrollees" "necessary to stabilize the enrollee's emergency medical condition" (*id.*, subd. (b); *Santa Clara*, *supra*, 14 Cal.5th at pp. 1037-1038). The Knox-Keene Act further delineates the scope of the duty to reimburse: If the emergency services provider is "in-network," the plan must directly pay the provider the "agreed upon" contractual rate (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(A)); if the emergency services provider is out-of-network, the plan must directly pay the provider the "reasonable and customary value for the [emergency] health care services rendered" (*id.*, subd. (a)(3)(B); *Santa Clara*, at p. 1042), and "reasonable and customary value" is defined by a nonexclusive list of factors (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B); *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1265, 1271). A provider may sue the plan in quantum meruit for any perceived shortfall (*Bell*, *supra*, 131 Cal.App.4th at pp. 213-215; *Prospect*, *supra*, 45 Cal.4th at p. 505), but may *not* pursue the plan's enrollee for the shortfall (which, in the vernacular, is called "balance billing" because the provider is seeking to recover from the enrollee the balance of the bill owed) (*Prospect*, at pp. 501-502, 507).[8]

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8 A plan may delegate its duty to reimburse providers under the Knox-Keene Act to an intermediary (§ 1371.4, subd. (e)), thereby absolving itself of liability unless it negligently selects or

The Insurance Code's provisions are different than the Knox-Keene Act's. Somewhat akin to the Knox-Keene Act, the Insurance Code explicitly imposes a duty upon health insurance companies whose policies "provide[] or cover[] any benefits with respect to services in an emergency department of a hospital [to] cover" those services without "prior authorization"; to do so regardless of whether the provider is in- or out-of-network; and if the provider is out-of-network, to do so at the same level of service and copayment as if it were in-network. (§ 10112.7, subd. (a).) But, unlike the Knox-Keene Act, the Insurance Code does not explicitly impose any duty upon insurance companies to directly reimburse providers of emergency services and the courts have not barred "balance billing" by providers to insureds.

II. Analysis

The question presented by Prime's appeal is whether health insurance companies have a duty, under the Insurance Code, to directly reimburse out-of-network providers for emergency services provided to company's insureds at the "reasonable and customary" value of those services. This is a question of statutory interpretation, and is accordingly guided by the pertinent canons: We start with the statute's text and, if it is clear, stop with the text (*Jarrow Formulas, Inc. v. LaMarche* (2003) 31 Cal.4th 728, 737); if the text is unclear, we may look to the statute's legislative history (*Stone*, *supra*, 16 Cal.5th at p. 1052).

Prime concedes that the Insurance Code nowhere explicitly imposes a duty upon health insurers to directly reimburse out-of-

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maintains that intermediary (*Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782, 787; *Centinela*, *supra*, 1 Cal.5th at pp. 1001-1002).

network providers for emergency services at the "reasonable and customary" value for those services. Prime nevertheless offers what boil down to five reasons why we should *infer* such a duty.

First, Prime argues that a duty arises from what it characterizes as "two inter-related mandates" of the Insurance Code—namely, (1) the mandate that "insurers must reimburse providers for all covered services," as Prime claims is set forth in section 10123.147, and (2) the mandate that "insurers must cover [out-of-network] emergency services," as set forth in section 10112.7. (Italics omitted.) "These two express mandates read together," Prime asserts syllogistically, "create the rule [that] insurers must reimburse [out-of-network] providers for non-contracted emergency services." (Emphasis omitted.)

We reject this argument because its two steps each rest on a misreading or an overreading of the provisions Prime cites.

To begin, section 10123.147 does not proclaim a substantive entitlement to reimbursement. Contrary to Prime's out-of-context quoting of section 10123.147, the statute actually states that "[e]very insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses . . . shall reimburse each complete claim" subject to timelines and procedures set forth in that statute. (§ 10123.147, subd. (a).) The Knox-Keene Act has parallel provisions that also lay out timelines and procedures for reimbursement. (Health & Saf. Code, §§ 1371.35, 1371.) If, as Prime contends, provisions detailing the timelines and procedures to be followed for reimbursement automatically create a substantive duty to directly reimburse out-of-network providers for *every service provided*, all of the provisions in the Knox-Keene Act and the Insurance Code explicitly imposing a duty of direct

reimbursement would be superfluous (§ 10120.35, subd. (b) [duty to "reimburse" for expenses related to preventing the spread of disease]; § 10126.66, subd. (d) [duty to "reimburse" ambulance provider]; Health & Saf. Code, § 1371.4, subd. (b) [duty to "reimburse providers"]; *id.*, § 1342.2, subd. (b) [duty to "reimburse" for COVID-19 diagnostic and screening testing]); we decline to nullify broad swaths of those Codes. Nor must we construe section 10123.147 to create such a substantive duty in order to give it purpose: As our Legislature has noted in a statement of intent accompanying section 10123.147, that section provides the procedural blueprint for *anyone* entitled to reimbursement, which would include the insured and in-network providers, to seek reimbursement for medical expenses. (Stats. 2005, ch. 723, § 1(b); *California Housing Finance Agency v. Elliott* (1976) 17 Cal.3d 575, 583 [legislative findings entitled to "great weight"].) Thus, the existence of section 10123.147 does not necessarily imply an entitlement *by out-of-network providers* to reimbursement. Put succinctly, the fact that section 10123.147 uses the word "reimburse" in its procedural context does not create a global substantive right to direct reimbursement for all expenses to everyone. Prime resists our analysis, citing cases decrying the use of the labels "procedural" and "substantive" being given dispositive weight (*Vaughn v. LJ Internat., Inc.* (2009) 174 Cal.App.4th 213, 220; *Evangelatos v. Superior Court* (1988) 44 Cal.3d 1188, 1238, fn. 2); but those cases frankly acknowledge that statutes that have the *effect* of being procedural rather than substantive are to be treated differently (*Evangelatos*, at p. 1238, fn. 2), and that is the statutory scheme here. (Accord, *California Medical Assn. v. Aetna U.S. Healthcare of California, Inc.* (2001) 94 Cal.App.4th 151, 163 [procedural

provision in Health and Safety Code section 1371 did not "impose an[y substantive] obligation on health plans"].)

Nor can we infer a duty to directly reimburse out-of-network providers from the duty to "cover" emergency services provided by such providers. Although, as noted above, section 10112.7 obligates a health insurance company to "cover" emergency services provided by an out-of-network provider if the policy already covers emergency services provided by an in-network provider, *covering those services* and *directly reimbursing the provider of those services* are not synonymous. To illustrate, the Knox-Keene Act imposes a duty to cover and a duty to directly reimburse a provider in separate statutory provisions in several instances, including with respect to the emergency services at issue here. (Compare Health & Saf. Code, § 1371.4. subd. (a) [duty to cover "emergency services"] with *id.*, subd. (b) [duty to "reimburse providers"]); compare *id.*, § 1342.2, subd. (a) [duty to "cover the costs for COVID-19 diagnostic and screening testing"] with *id.*, subd. (a)(4) [duty to "reimburse the provider"].) The Insurance Code also sets forth the two duties in separate statutes as to certain services. (Compare § 10110.7, subd. (b) [duty to "cover the costs for COVID-19 diagnostic and screening testing and [related] health care services"] with *id.*, subd. (b)(1) [duty to "reimburse the health care provider"].) If the duty to cover necessarily included the duty to directly reimburse providers, the provisions imposing the latter duty would be mere surplusage—and we are not to construe statutory provisions to be surplusage. (*Boghos v. Certain Underwriters at Lloyd's of London* (2005) 36 Cal.4th 495, 503.) Given our Legislature's practice of separately imposing the duty to cover services and the duty to directly reimburse providers, it contravenes legislative intent to

treat the duty to cover as including the duty to directly reimburse providers and to thereby impose a duty upon insurance companies to directly reimburse where the Legislature has chosen not to do so. (*Hoffman v. Young* (2022) 13 Cal.5th 1257, 1272 (*Hoffman*) [where "two statues relate to the same topic and have a similar purpose" but have "different terms," those differences should be given effect].)

Second, Prime contends that the legislative history underlying the Insurance Code obligates us to recognize a substantive duty by insurance companies to directly reimburse out-of-network providers the reasonable and customary value of any emergency services they provide.[9] Of course, the best and clearest expression of legislative intent is the language of the statutes themselves (*San Diegans for Open Government v. Public Facilities Financing Authority of City of San Diego* (2019) 8 Cal.5th 733, 740 ["'text of [a] statute [is] the best indictor of legislative intent'"]), and the provisions of the Insurance Code at issue here impose no such duty. Where, as here, the statutory text is silent and the reading urged by a party would significantly change the liability of insurance companies, our Legislature's intent to effect such a change must be plain and obvious in the legislative record because, as our Supreme Court has noted, our "'Legislature "does not . . . hide elephants in mouseholes."'" (*Jones v. Lodge at Torrey Pines Partnership* (2008) 42 Cal.4th 1158, 1171.)

We find no such clear evidence here. Prime cites a committee report analyzing the 1998 bill that added section

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9 Prime also cites legislative history underlying the Knox-Keene Act, but that has no bearing on what our Legislature intended in enacting portions of the *Insurance Code*.

10123.147 to the Code, but that report merely noted that the bill would "make[] various changes to the payment of emergency services and other provider claims." (Sen. Com. on Ins., Analysis of Assem. Bill No. 1560 (1997-1998 Reg. Sess.) as amended June 24, 1998, p. 1.) That description is wholly consistent with interpreting section 10123.147 as changing the procedures for reimbursement for claims that are otherwise covered by an insurance policy or the Insurance Code; it would be an obtuse way to announce a massive substantive expansion of the liability of health insurance companies. While that report also indicates that the bill "[p]rohibits a health plan or insurer from [] delaying *payment* of a claim from a physician or other provider to await the submission of a claim from a hospital" and "require[s] *payment* for portions of a claim not in dispute" (italics added), the report's reference to "payment[s]" addresses the timing and prerequisites of payments otherwise required; it does not purport to create or otherwise recognize a substantive, direct right of reimbursement running between an insurer and an out-of-network provider. Prime next cites a Senate committee's "background information worksheet" analyzing the effect of a 2005 amendment to section 10123.147, and asserts that it establishes "protections for health care providers regarding reimbursement by insurers." (Emphasis omitted.) Prime misses the gist of that worksheet, which actually explains that those protections are *procedural*: The worksheet notes that a complaint hotline would be established within the Department of Insurance, as one already existed within the DMHC as to health service plans, because a complaint process would "help[] to ensure that patients and providers will not be responsible for paying for services that should be paid under the terms of their

cont[r]act with a health insurance company." The worksheet nowhere suggests an intent to hold health insurance companies directly liable to providers. Prime lastly cites a letter from one interest group to the author of the 2005 amendment to section 10123.147, but what a constituent thinks about a bill has no bearing on what the Legislature was thinking.

Third, Prime asserts that we must construe the Insurance Code to impose a duty on insurance companies to directly reimburse out-of-network providers for emergency services because the Knox-Keene Act imposes such a duty on health care service plans and because, in Prime's view, the Insurance Code was "inten[ded] to mirror" and be in "parity" with the Knox-Keene Act. To be sure, the Insurance Code and the Knox-Keene Act both function as a mechanism for providing a form of health coverage (which is why health care service plans are deemed to be part of the insurance industry for purposes of federal preemption affecting state insurance laws). (See, e.g., *Coast Plaza Doctors Hospital v. Blue Cross of California* (2009) 173 Cal.App.4th 1179, 1187 [Knox-Keene Act is "specifically directed toward the insurance industry" for purposes of ERISA]; *Smith v. PacifiCare Behavioral Health of Cal., Inc.* (2001) 93 Cal.App.4th 139, 157-158 [health care service plans governed by Knox-Keene Act are "engaged in the business of insurance" for purposes of the McCarran-Ferguson Act].) But they are nevertheless "distinct regulatory regimes." (*Smith*, at pp. 158-159, italics omitted.) The Knox-Keene Act expressly declines to regulate entities regulated by the Department of Insurance unless those entities are "directly providing healthcare services" (Health & Saf. Code, § 1343, subd. (e)(1)) (and, here, United is not); and the Insurance Code expressly declines to regulate health care service plans (§

740, subd. (g); *Hailey v. California Physicians' Service* (2007) 158 Cal.App.4th 452, 469-470; *Williams v. California Physicians' Service* (1999) 72 Cal.App.4th 722, 729 (*Williams*).) Thus, the statutory provision in the Knox-Keene Act imposing a duty upon health care service plans to directly reimburse out-of-network providers for emergency services cannot be copied-and-pasted into the Insurance Code. To do so is to ignore the maxim, noted above, that statutes dealing with the same topic and with a similar purpose are not to be treated the same if the Legislature has employed different language. (*Hoffman*, *supra*, 13 Cal.5th at p. 1272.)

Prime resists this conclusion. It cites *Pesce v. Department of Alcoholic Beverage Control* (1958) 51 Cal.2d 310, urging that we must construe all Codes within California as a single Code, but this principle does not permit us to wipe away distinctions our Legislature has drawn merely because those distinctions happen to be in different Codes. More to the point, this principle has been rejected in several cases that refused to treat provisions in the Knox-Keene Act and the Insurance Code as interchangeable. (E.g., *Williams*, *supra*, 72 Cal.App.4th at p. 731; *Nieto v. Blue Shield of California Life & Health Ins. Co.* (2010) 181 Cal.App.4th 60, 84-85.) Prime also worries that rejecting its position leads to results inconsistent with *Santa Clara*, *supra*, 14 Cal.5th 1034; *Prospect*, *supra*, 45 Cal.4th 497; *Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.* (2021) 71 Cal.App.5th 323; *Bell*, *supra*, 131 Cal.App.4th 211; and *California Emergency Physician Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127, overruled on other grounds by *Centinela*, *supra*, 1 Cal.5th at p. 1014, fn. 10; but all of those cases arose under the Knox-Keene Act, and our

construction of the Insurance Code has no effect on the Knox-Keene Act.

Fourth, Prime argues that denying emergency service providers a right to sue health insurance companies for direct reimbursement at a reasonable and customary rate under the Insurance Code—while granting that right to health care service plans under the Knox-Keene Act—is bad public policy, is unfair under common-law notions of restitution, and borders on being confiscatory given that those providers *must* provide emergency services. For starters, it is not our place—as part of the judicial branch—to weigh in on the wisdom of public policy enacted by our Legislature. (*Los Angeles County Metropolitan Transportation Authority v. Alameda Produce Market, LLC* (2011) 52 Cal.4th 1100, 1112 ["policy argument[s]" are "'best directed to the Legislature'" as the courts' "'role . . . is to interpret the statute[s] [as they are written], not to establish policy'"]; *Vasquez v. State of California* (2008) 45 Cal.4th 243, 253 ["We may not rewrite the statute to confirm to an assumed intention that does not appear in its language"].) We may intervene only if the statute before us leads to absurd results or is unconstitutional. (*California School Employees Assn. v. Governing Board* (1994) 8 Cal.4th 333, 340; *Steen v. Appellate Division of Superior Court* (2014) 59 Cal.4th 1045, 1054; cf. *McMillin Albany LLC v. Superior Court* (2018) 4 Cal.5th 241, 249 [common law may be abrogated by statutes].) Neither ground exists here.

Prime asserts it faces an absurd and unconstitutional outcome because it would be without recourse if an insurance company paid just a "penny" for the emergency services its hospitals provided, as Prime would be unable to sue the insured

and, even if it could, that would lead to a multiplicity of lawsuits. Prime's assertion ignores that, during the "claims period" (as Prime calls it) at issue here, the Insurance Code did not bar Prime from seeking recourse against an insured; ignores that insureds during that "claims period" could simply assign to the providers their right to sue the insurance company, thereby avoiding a multiplicity of lawsuits (*Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693, 704); and ignores that concerns about too much litigation are a matter of policy for the Legislature.[10] Further, Prime is simply wrong that it faces any danger of receiving only a "penny" for its emergency services. That is because, during the "claims period" at issue in this lawsuit, federal law set a minimum amount that out-of-network providers must be paid for their emergency services—namely, the "greatest" of (1) the amount paid to in-network providers for the emergency services provided, (2) the amount "calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable amount)," or (3) the amount for those services under

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10 During the "claims period" at issue here, only the Knox-Keene Act barred recourse against insureds based on that Act's express, statutory duty of direct reimbursement. (*Prospect*, *supra*, 45 Cal.4th at pp. 508-509.)

As of January 1, 2022, Congress's No Suprises Act prohibits balance billing by insurers, as well. (42 U.S.C. § 300gg-131(a); 45 C.F.R. § 149.410(a).) At oral argument, Prime conceded (notwithstanding that its lawsuit was filed in March 2022, after the Act took effect), that "what's at issue here is the time period before" the No Surprises Act.

Medicare. (29 C.F.R. § 2590.715-2719A(b)(3)(i).)[11] Prime displays its true colors when, as its fallback position, it complains that out-of-network providers should not be limited to these amounts and, in fact, should be able to receive *more* than in-network providers. But it is *this* outcome that would lead to absurd results because it would disincentivize providers from joining an insurance company's network, would thereby eliminate the stability and certainty arising from having established contractual relationships with settled payment rates, and would result in a multiplicity of lawsuits aimed at settling the reasonable and customary rates. Thus, our Legislature's decision not to impose a duty upon insurance companies of direct reimbursement to out-of-network providers of emergency services is neither absurd nor confiscatory.

Fifth and finally, Prime contends that the collective force of its prior four arguments dictates a result in its favor. We disagree, as we find its arguments without merit whether viewed individually or collectively.

In light of our de novo analysis, we have no occasion to address Prime's further arguments attacking aspects of the trial court's reasoning (such as the court's analogy to Health and Safety Code section 1317.2a or its citation to the Legislature's

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11 The No Surprises Act sunsets this provision that established a substantive standard for minimum payment, and replaced it with a procedural mechanism requiring insurers and providers to engage in "open negotiation" followed by an arbitration to set the rate for reimbursement. (42 U.S.C. § 300gg-111; see *Texas Medical Assn. v. United States Dept. of Health & Human Services* (5th Cir. 2024) 110 F.4th 762, 767-769.) Again, Prime acknowledged at oral argument that these provisions do not apply to its lawsuit.

failure to enact a bill that would have created the right of direct reimbursement according to a specific formula). We also have no occasion to address arguments made by United that are not relevant to our analysis.

* * *

In the end, our task is a narrow one. Prime's arguments about the disparate treatment of health insurance companies and health care service plans when it comes to direct reimbursement for emergency services is not without persuasive force. But the branch that needs to be persuaded by these policy arguments is not us—it is the legislative branch.

DISPOSITION

The order is affirmed. United is entitled to costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS.

_____, P.J.
HOFFSTADT

We concur:

_____, J.
BAKER

_____, J.
MOOR

California Association of
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November 7, 2025

VIA TRUEFILING

The Honorable Presiding Justice Hoffstadt and Associate Justices
California Court of Appeal
Second Appellate District, Division 5
300 S. Spring St., 2d Fl., N. Tower
Los Angeles CA 90013

Re: Request for Publication of Opinion in *Prime Healthcare Centinela, LLC v. UnitedHealthcare Insurance Co.*, No. B334746 (Opinion Issued Oct. 20, 2025)

Dear Presiding Justice Hoffstadt and Associate Justices:

The California Association of Health Plans (CAHP) respectfully requests that this Court publish its October 20, 2025 opinion in *Prime Healthcare Centinela, LLC v. UnitedHealthcare Insurance Co.* (No. B334746). The Court's detailed opinion readily meets the standards for publication under California Rules of Court, rule 8.1105(c) and so warrants publication under rule 8.1120. Specifically, the opinion not only provides invaluable guidance for future cases involving similar claims against health insurers under the California Insurance Code relating to reimbursement for emergency services, but also cogently explains how courts should approach a broader set of issues involving proper construction of the Insurance Code alongside other statutory schemes. CAHP thus asks that this Court order the opinion published, or at a minimum that the Court transmit this request along with a recommendation for publication to the California Supreme Court. (Cal. Rules of Court, rule 8.1120(b).)

CAHP is a statewide trade association that represents an array of health insurers and care plans that together provide coverage to nearly 28 million Californians. CAHP represents the interests of health insurers subject to the California Insurance Code in addition to health care service plans subject to the distinct Knox-Keene Act framework. In general, CAHP is dedicated to ensuring a strong, sustainable environment in which its members can provide access to products that offer choice and flexibility to the Californians they serve. In that capacity, CAHP engages in advocacy and education efforts, promotes collaboration among the many stakeholders involved in providing high-quality and affordable health care, and observes and participates in litigation affecting those interests.

CAHP has reviewed this Court's opinion in *Prime Healthcare Centinela* and believes that it warrants publication under many of the factors set out in California Rules of Court, rule 8.1105(c). By enforcing the distinction between the Knox-Keene Act and Insurance Code frameworks in the context of claims seeking reimbursement for emergency care, the opinion

"[a]pplies an existing rule of law to a set of facts significantly different from those stated in published opinions." (Cal. Rules of Court, rule 8.1105(c)(2).) In so holding, the Court construes and clarifies many statutes across the Insurance Code that have never been squarely addressed in any published opinion. (*Id.*, rule 8.1105(c)(4).) The Court's opinion also "[a]ddresses . . . an apparent conflict in the law" (*id.*, rule 8.1105(c)(5)) by analyzing and rejecting the providers' argument that declining to impose a reimbursement obligation would depart from the prior decision in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211 (*Bell*). The opinion makes a significant contribution to the legal literature (Cal. Rules of Court, rule 8.1105(c)(7)) by setting out, in detail and with laudable precision, the complex interaction of multiple statutory frameworks. And at bottom, the opinion involves "a legal issue of continuing public interest" (Cal. Rules of Court, rule 8.1105(c)(6), by systematically addressing the nature of health insurers' coverage and reimbursement obligations in the frequently recurring context of emergency care.

Several features of the Court's opinion specifically warrant publication given the important and valuable role they could play in future litigation.

Reimbursement for emergency services. The central holding of the Court's opinion resolves a question that is likely to reemerge in a host of future cases. Providers, in this case and in others, have argued that insurers bear an obligation to reimburse them for the reasonable and customary value of emergency services provided to insureds. In so arguing, providers have invoked the reimbursement obligation under the Knox-Keene Act (Health & Saf. Code, § 1371.4, subd. (b); Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3); see *Bell*, *supra*, 131 Cal.App.4th at pp. 215–216), which is administered by the Department of Managed Health Care, and have argued that the Insurance Code should be read to impose a similar reimbursement obligation.

The opinion correctly rejects that argument, holding that the "Insurance Code does not explicitly impose such a duty and the canons of statutory construction counsel against *inferring* such a duty from other provisions of the Insurance Code or their legislative history." (Op. at p. 2.) Although the Court's opinion builds from longstanding principles of statutory construction and case law distinguishing between the Knox-Keene Act and Insurance Code frameworks, its holding on the asserted reimbursement requirement addressed an issue of first impression for the Court of Appeal. And without published authority, future litigants may raise the same mistaken argument the providers in this case raised. Those future disputes are likely to arise: as the opinion itself notes, emergency-care providers are "obligated" to provide care to people who need it, including people with policies governed by the Insurance Code. (*Id.* at pp. 2, 7–8.)

Limits of procedural statutes governing reimbursement. A key feature of the Court's analysis likewise warrants publication. The providers in this case urged the Court to impose a substantive reimbursement requirement based on statutes, principally Insurance Code section 10123.147, that "detail[] the timelines and procedures to be followed for reimbursement" when claims are made. (Op. at p. 10.) As the Court explains, that argument would improperly

render superfluous the host of distinct statutory provisions throughout the Insurance Code imposing affirmative duties to reimburse in specific circumstances. (*Id.* at pp. 10-11.) Publication of the Court's opinion would help ensure faithful adherence to the Legislature's carefully crafted scheme, including with respect to statutes that, though important, "have the effect of being procedural rather than substantive." (*Id.* at p. 11, italics omitted; see also *id.* at pp. 13-15 [detailing legislative history of section 10123.147 and again enforcing the limits of that procedural statute].)

Distinction between coverage and reimbursement. Another aspect of the opinion likely to prove important in future litigation is the Court's explanation of the difference between statutes that require *coverage* of certain services and those that require *reimbursement* for such services. (Op. at p. 12.) As the Court detailed, although providers have argued that a duty to cover necessarily gives rise to a related duty to reimburse, the Legislature has consistently treated those duties differently. (*Id.* at pp. 12-13.) Eliding that distinction, as the Court explains, would "contravene[] legislative intent." (*Id.* at p. 12.)

Policy arguments and federal protections. The opinion also capably addresses, and rejects, the providers' arguments "that denying emergency services providers a right to sue health insurance companies for direct reimbursement at a reasonable and customary rate … is bad public policy, is unfair under common-law notions of restitution, and borders on being confiscatory." (Op. at p. 17.) The opinion explains, as a matter of fact, why there is nothing "absurd" or "unconstitutional" about the Legislature's differential design of the Knox-Keene Act and Insurance Code. (*Id.* at pp. 17-18.) In doing so, the opinion helpfully details the independent role that federal law has played and continues to play in ensuring that providers receive meaningful compensation for emergency services. (*Id.* at pp. 18-19.) That analysis is spot-on and valuable for future cases—and is particularly valuable given the Court of Appeal's puzzling, drive-by suggestion in *Bell* that construing the Knox-Keene Act's reimbursement obligation to require anything other than "reasonable" reimbursement could produce a "confiscatory" and thus unconstitutional scheme. (*Bell*, *supra*, 131 Cal.App.4th at p. 220.)

Reinforcing the Knox-Keene Act/Insurance Code divide. This case is illustrative of a broader conflict taking place all across California courts. For decades, the Legislature has maintained "distinct regulatory regimes" for health insurers and health care service plans in the Insurance Code and Knox-Keene Act (respectively). (Op. at p. 15.) Courts have previously recognized that these frameworks are distinct and that specific rules from one ought not be ported over to the other, at least without statutory language indicating that that was the Legislature's design. (See *id.* at pp. 15-16.) But it is clear that litigants are not getting the message. In fact, the providers' claim here was entirely inconsistent with previous decisions announcing that principle—revealing just how useful it can be for published opinions to apply generally recognized principles in novel context. (See Cal. Rules of Court, rule 8.1105(c)(2).)

Channeling attention to the Legislature. Finally, the Court's opinion recognizes that whatever "persuasive force" the providers' policy arguments in favor of requiring direct reimbursement may be, "the branch that needs to be persuaded" is "the legislative branch," not the judiciary. (Op. at p. 20.) That is a commendable application of core separation-of-powers principles that alone warrants publication. And if there *were* legitimate policy concerns worthy of legislative attention, then publication of the opinion would send a stronger signal to the coordinate branches.

In short, the opinion ticks all the boxes for publication: it is comprehensive in its treatment and analysis of issues that are likely to recur and provides valuable guidance to providers and insurers alike, not to mention patients and insureds. This Court should order the opinion published, or recommend that the California Supreme Court do so.

Respectfully submitted,

Charles Bacchi
President and Chief Executive Officer

cc: Served by TrueFiling

PROOF OF SERVICE

I, Anete Millers, declare as follows:

I am employed in Sacramento County, Sacramento, California. I am over the age of 18 years and not a party to this action. My business address is California Association of Health Plans, 1415 L Street, Suite 850, Sacramento, California 95814. On **November 7, 2025**, I served the within: **REQUEST FOR PUBLICATION** on the interested parties in this action addressed as follows:

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☒	**(BY ELECTRONIC SERVICE)** Based on a court order or an agreement of the parties to accept service by e-mail or electronic transmission via the Court's Electronic Filing System (EFS) operated by TrueFiling.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on **November 7, 2025**, at Sacramento, California.

Anete Millers

STATE OF CALIFORNIA California Court of Appeal, Second Appellate District	***PROOF OF SERVICE*** **STATE OF CALIFORNIA** California Court of Appeal, Second Appellate District

Case Name: **Prime Healthcare Centinela, LLC et al. v. United Healthcare Insurance Company, et al.**
Case Number: **B334746**
Lower Court Case Number: **22STCV08452**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

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

11/7/2025

Date

/s/Anete Millers

Signature

Millers, Anete (Other)

Last Name, First Name (PNum)

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November 9, 2025

Honorable Brian M. Hoffstadt, Presiding Justice
Honorable Lamar W. Baker, Associate Justice
Honorable Carl H. Moor, Associate Justice
Court of Appeal
Second Appellate District, Division Five
300 S. Spring Street
Los Angeles, California

Re: B334746
Prime Healthcare Centinela, LLC v. United Healthcare Insurance Company
Opposition to Request for Publication

Honorable Justices:

The **CALIFORNIA HOSPITAL ASSOCIATION** respectfully **opposes** the request by the California Association of Health Plans (CAHP) that this Court order the publication of its opinion filed October 20, 2025.

Introduction

Key authorities support direct actions against health insurers by out-of-network hospitals seeking quantum meruit (reasonable value) for emergency services provided to insured patients: (1) subdivision (d) of Health and Safety Code section 1317; and (2) caselaw recognizing common-law actions for quantum meruit.

But those authorities—found outside the Insurance Code—are not addressed in the Court's opinion. An appellate court "may affirm the sustaining of a demurrer only if the complaint fails to state a cause of action under any possible legal theory." (*Sheehan v. San Francisco 49ers, Ltd.* (2009) 45 Cal.4th 992, 998; *Fox v. Ethicon Endo–Surgery, Inc.* (2005) 35 Cal.4th 797, 810.) The opinion should not be published, thereby setting precedent that bars actions against health insurers by out-of-network hospitals and physicians providing emergency services, without exploring each plausible "possible legal theory" to support such an action.

Under the circumstances, the California Hospital Association respectfully requests that the Court maintain its designation of the opinion as unpublished.

Key authorities not discussed in the opinion support direct actions by medical providers against health insurers to recover the reasonable value of emergency services

1. Health and Safety Code section 1317, subdivision (d), implies that providers may pursue health insurers

Health and Safety Code section 1317 requires hospitals that maintain and operate emergency departments to provide emergency services and care to anyone who presents in need:

> Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

(*Id.*, subd. (a); *County of Santa Clara v. Superior Court* (2023) 14 Cal.5th 1034, 1037 (*County of Santa Clara*).)

Once emergency services have been provided, the patient or another responsible person must execute an agreement to pay. (Health & Saf. Code, § 1317, subd. (d).) But if a patient has **insurance**, subdivision (d) of section 1317 provides that the patient may instead supply the hospital with "insurance … information":

> Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. However, **the patient** or his or her legally responsible relative or guardian **shall execute an agreement to pay** therefor ***or otherwise supply insurance*** or credit ***information*** promptly after the services are rendered.

(Health & Saf. Code, § 1317, subd. (d), emphasis added.)

In *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 506, the Supreme Court cited subdivision (d) of section 1317 as one of the grounds for its holding that providers are barred from "balance billing" patients enrolled in health care service plans.

> Other provisions point in the same direction. Section 1317, subdivision (d), which requires emergency room doctors to render emergency care without questioning a patient's ability to pay, also provides that "the patient or his or her legally responsible relative or guardian shall execute an agreement to pay [for the services] or o*therwise supply insurance* or credit *information* promptly after the services are rendered." (Italics added.) This provision implies that once patients who are members of an HMO provide insurance information, they have satisfied their obligation towards the doctors.

(*Id.* at p. 506, emphasis in Supreme Ct. opn.)

The Legislature did not prescribe an idle act; a patient supplies "insurance … information" to the hospital so it can **pursue** the insurer for payment. Thus, following the Supreme Court's interpretation, once a patient supplies valid insurance information, the provider of emergency services has recourse against the insurer instead of the patient. The Supreme Court's citation of additional grounds for its holding, that balance billing is barred, does not permit a court to deny or invalidate the Supreme Court's reliance on section 1317, subdivision (d).

By its terms, section 1317, subdivision (d), applies as much to health "insurance" as it does to enrollment in a health plan. But this Court's opinion assumes that hospitals may "balance bill" patients with health insurance; citing *Prospect*, it suggests that only the Knox–Keene Health Care Service Plan Act of 1975 (Knox–Keene Act) (Health & Saf. Code, § 1340 et seq.), which governs health care service plans, bars balance billing. (See opn. pp. 8–9, 18 & fn. 10.) But as shown, *Prospect* also cited section 1317, subdivision (d), which is **not** part of the Knox–Keene Act.

When holding health plans liable for the reasonable value of emergency services, *Bell* cited section 1317, subdivision (d) (in addition to Health & Saf. Code, § 1371.4) and explained that imposing a duty on medical providers to provide emergency services carries with it a right to reasonable compensation.

> [T]he health care plans' duty to reimburse arises out of the providers' duty to render services …. [¶] … Blue Cross's interpretation would mean the emergency care providers could be reimbursed at a confiscatory rate that, aside from being unconscionable, would be unconstitutional. (*Cooley v. Superior Court* (2002) 29 Cal.4th 228, 252 […] [a statute should be interpreted to avoid constitutional difficulties]; *Cunningham v. Superior Court* (1986) 177 Cal.App.3d 336, 348 […] [a professional cannot be forced to give away a portion of his livelihood]; *California Gillnetters Assn. v. Department of Fish & Game* (1995) 39 Cal.App.4th 1145, 1156 […].)

> In short, the statute must be read to require reasonable reimbursement.

(*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215 & fn. 4, 220 (*Bell*) [construing "reimbursement" in § 1371.4].)

2. Caselaw recognizes a common-law action for quantum meruit

Courts have recognized common-law actions by providers of emergency services to recover quantum meruit from responsible parties. The adoption of express provisions in the Knox–Keene Act for reimbursement has not done away with common-law rights of action against health care service plans governed by the Knox–Keene Act or against health insurers outside the Knox–Keene Act. (See *Presbyterian Camp & Conference Centers, Inc. v. Superior Court* (2021) 12 Cal.5th 493, 503 ["'As a general rule, "[u]nless expressly provided, statutes should not be interpreted to alter the common law, and should be construed to avoid conflict with common law rules"'"].)

In *Bell*, the court held that a physician who provided emergency services could pursue a **common-law** claim for **quantum meruit** against a patient's health care service plan. (*Bell*, *supra*, 131 Cal.App.4th at pp. 215–218.) The court cited the Restatement (First) of Restitution (1937) section 114, which recognizes liability where, in an emergency, the plaintiff has performed the defendant's duty to take care of a third person:

> We reject Blue Cross's contention that Dr. Bell has no implied-in-law right to recover for the reasonable value of his services. "He who takes the benefit must bear the burden" (Civ. Code, § 3521), and he who has "**performed the duty of another** by supplying a third person with necessaries, although acting **without the other's knowledge or consent**, is entitled to **restitution** from the other therefore if [¶] (a) he acted unofficiously and with intent to charge therefor, and [¶] (b) the things or services supplied were immediately necessary to prevent serious bodily harm to or suffering by such person." (Rest., Restitution, § 114 (1937), ….) Dr. Bell's quantum meruit claim is sufficient for pleading purposes and thus is not subject to demurrer.

(*Id.* at p. 221, emphasis added.)

The common-law quantum-meruit doctrine cited in *Bell* entitles an out-of-network provider of emergency services to recover reasonable value from a health insurer as well as a health plan. By issuing an insurance policy that covers emergency services, a health insurer undertakes a duty to its insured to provide for emergency services.[1]

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[1] The first comment to Restatement section 114 states that it includes "not only the situations where the other is under a duty imposed by law to support a third person … but also where the other has undertaken such a duty by contract with the third person or with others." (Rest., Restitution, § 114, com. a.)

continued

A hospital does not act "officiously" when an insured patient presents at the hospital's emergency department for emergency services; in fact, the hospital **must** provide emergency services. (Health & Saf. Code, § 1317.) And, by definition, the context involves an emergency.

In *County of Santa Clara*, when discussing medical providers' right to sue for quantum meruit, the Supreme Court, too, cited section 114 of the Restatement (First) of Restitution. (*County of Santa Clara*, *supra*, 14 Cal.5th at p. 1050.) And like the court in *Bell*, the Supreme Court cited caselaw that hospitals have a right to bring "common law and other statutory causes of action"—"such as an action for quantum meruit, …." (*County of Santa Clara*, *supra*, 14 Cal.5th at p. 1044, fn. 4; *Bell supra*, 131 Cal.App.4th at pp. 216–217.)[2]

Further, the Insurance Code requires that health insurance policies cover emergency services. (Ins. Code, § 10112.27, subd. (a)(1) [both pre-and post-Jan. 1, 2026, versions] [individual and small-group policies, eff. Jan. 1, 2017]; *id.*, § 10112.281, subd. (b)(6) [large-group policies, eff. July 1, 2022].)

[2] A provider's common-law right of action to recover quantum meruit does not depend on the regulatory provision adopted under the Knox–Keene Act requiring prompt payment of "reasonable and customary value …." (See Cal. Code Regs., title 28, § 1300.71, subds. (a)(3)(B), (g).) Both *County of Santa Clara* and *Bell* cited *Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693, 706, which predated the adoption of section 1300.71 in 2003.

Thus, caselaw supports a common-law action by a provider of emergency services to recover quantum meruit from a health insurer that insured the patient with coverage for emergency services.

Interest of the California Hospital Association

The California Hospital Association, representing more than 400 hospitals throughout California, advocates for better, more accessible health care for all Californians. CHA ensures that hospitals will continue to be able to provide exceptional care to patients and comprehensive health services to communities. Established in 1935, CHA provides information, resources, and perspective to state and federal policy makers to inform decisions that affect 40 million Californians.

CHA is a nonprofit, member-driven organization, led by a 40-plus member Board of Trustees composed of the leaders of California's hospitals and health systems. (https://calhospital.org/.)

The California Hospital Association has a particular interest in preserving the ability of California hospitals to provide emergency services, including their right to recover from health insurers for emergency services provided to insured patients.

Conclusion

For these reasons, the California Hospital Association respectfully requests that this Court **deny** the request to publish the opinion filed by this Court on October 20, 2025, in *Prime Healthcare Centinela, LLC v. United Healthcare Insurance Company* (B334746).

Respectfully,

King & Spalding LLP

by 
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Counsel for the
California Hospital Association

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Proof of Service

Prime Healthcare Centinela, LLC v. United Healthcare Insurance Company
Court of Appeal No. B334746 (Div. 5)
Los Angeles County Superior Court No. 22STCV08452

I am a citizen of the United States, over 18 years of age, and not a party to the within action. My primary business address is: King & Spalding LLP, 633 W. 5th Street, Suite 1600, Los Angeles, California 90071

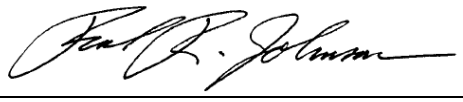
On the date set forth below, I am serving the foregoing **Opposition to Request for Publication** by causing true copies to be distributed as follows—

To all parties:

ELECTRONIC SERVICE THROUGH TRUEFILING: This document is being submitted for filing through the Supreme Court's TrueFiling service, with designation that an electronic copy be served through a link provided by email from TrueFiling to the attorneys who are registered with TrueFiling for this proceeding.

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

Executed on November 9, 2025.



Paul R. Johnson

STATE OF CALIFORNIA
California Court of Appeal, Second Appellate District

PROOF OF SERVICE

STATE OF CALIFORNIA
California Court of Appeal, Second Appellate District

Case Name: **Prime Healthcare Centinela, LLC et al. v. United Healthcare Insurance Company, et al.**
Case Number: **B334746**
Lower Court Case Number: **22STCV08452**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **pjohnson@kslaw.com**

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

11/9/2025

Date

/s/Paul Johnson

Signature

Johnson, Paul (115817)

Last Name, First Name (PNum)

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November 10, 2025

The Honorable Presiding Justice Hoffstadt and Associate Justices
California Court of Appeal
Second Appellate District, Division Five
Via TrueFiling

Re: Opposition to Request by California Association of Health Plans for Publication of Opinion in *Prime Healthcare Centinela LLC v. United Healthcare Insurance Co.*, No. B334746 (Issued October 20, 2025)

Dear Presiding Justice Hoffstadt and Associate Justices:

Appellant Prime Healthcare Centinela, LLC ("Centinela Hospital") opposes the request of California Association of Health Plans (CAHP) to publish this court's opinion in *Prime Healthcare Centinela, LLC v. United Healthcare Insurance Co*. (No. B334746.)

CAHP addresses only a few of the standards relevant to whether an opinion should be published under California Rules of Court, rule 8.1105; Centinela Hospital will likewise limit its discussion. The opinion does not meet the standards to be certified for publication and should remain unpublished.

United Healthcare urged that the trial court's ruling on demurrer be affirmed based on arguments that the case does not establish a new rule of law, and by the court's analysis, does not apply existing rules to a different set of facts. And, United Healthcare's arguments were endorsed by this court in its affirmance.

To the extent any facts are material, they are these: United Healthcare took the position that Centinela Hospital had no recourse against United Healthcare because its patients could be balance billed during the pre-2022 claims period at issue, thereby avoiding the constitutional question of whether any reimbursement rates were confiscatory. (Typed opn. at pp. 17-18) As the opinion notes, the federal No Surprises Act[1] was enacted as of January 1, 2022, and therefore governs all claims since that time. (*Ibid.*) As a result, the opinion does not address an issue of

[1] See 42 U.S.C. § 300gg-131(a); 45 C.F.R. § 149.410(a) [prohibiting balance billing to patients]; see also typed opn. at fn. 10 [recognizing same].)

current significance, and publication is more likely to confuse the issues than clarify them.

The opinion further recognized this circumstance when it elected not to address a number of arguments raised by the parties, stating that its task was a narrow one. This court's decision not to publish ther opinion was appropriate and should stand.

Respectfuly submitted,

BUCHALTER, A Professional Corporation

By

RMD:rm

cc: See proof of service

PROOF OF SERVICE

Prime Healthcare Centinela, et al., United Healthcare, et al.
Appeal No. B334746

I am employed in the County of Orange, State of California. I am over the age of 18 and not a party to the within action. My business address is at BUCHALTER, A Professional Corporation, 18400 Von Karman Avenue, Suite 800, Irvine, CA 92612.

On the date set forth below, I served the foregoing document described as:

LETTER OPPOSING PUBLICATION

on all other parties and/or their attorney(s) of record to this action by ☒ electronically serving ☐ faxing and/or ☐ placing a true copy thereof in a sealed envelope as follows:

Jennifer S. Romano Nathanial J. Wood Marlee Santos CROWELL & MORING LLP 515 South Flower Street, 40th Fl. Los Angeles, CA 90071	*Attorneys for:* United Healthcare Insurance Company and UHC of California Email: nwood@crowell.com Email: msantos@crowell.com Email: jromano@crowell.com
Matt Aidan Getz Kahn A. Scolnick Allison Roy Kawachi GIBSON, DUNN & CRUTCHER, LLP 333 South Grand Ave., Suite 5400 Los Angeles, CA 90071	*Attorneys for:* United Healthcare Insurance Company Email: mgetz@gibsondunn.com kscolnick@gibsondunn.com akawachi@gibsondunn.com

☐ **BY MAIL** I am readily familiar with the business' practice for collection and processing of correspondence for mailing with the United States Postal Service. The address(es) shown above is(are) the same as shown on the envelope. The envelope was placed for deposit in the United States Postal Service at Buchalter in Irvine, California on November 10, 2025. The envelope was sealed and placed for collection and mailing with first-class prepaid postage on this date following ordinary business practices.

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the cause; otherwise at that party's place of residence.

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☑ **BY ELECTRONIC SERVICE** On November 10, 2025, via electronic transmission to TrueFiling e-service via the Internet as a scanned image of the document.

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.

Executed on November 10, 2025, at Irvine, California.

Raquel Moreno

/s/ *Raquel Moreno*
(Signature)

STATE OF CALIFORNIA California Court of Appeal, Second Appellate District	***PROOF OF SERVICE*** **STATE OF CALIFORNIA** California Court of Appeal, Second Appellate District

Case Name: **Prime Healthcare Centinela, LLC et al. v. United Healthcare Insurance Company, et al.**
Case Number: **B334746**
Lower Court Case Number: **22STCV08452**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **rdato@buchalter.com**

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

11/10/2025

Date

/s/Rachel Moreno

Signature

Dato, Robert (110408)

Last Name, First Name (PNum)

Buchalter

Law Firm