California Medical Association v. Aetna U.S. Healthcare

2002 Cal. LEXIS 2290 (Cal. Mar. 27, 2002) (unpublished decision)

Topics Covered: Payment Issues (for Physicians), Managed Care Payments

Outcome: Very Unfavorable

Issue

The issue in this case was whether, under a California statute, HMOs were required to pay physicians who had rendered services to the HMO's patients, after the bankruptcy of the Independent Practice Associations ("IPAs") with which those physicians had been under contract.

AMA Interest

The AMA supports fair and prompt compensation of physicians for the services they render.

Case Summary

In California, HMOs are licensed and regulated under the Knox-Keene Health Care Service Plan Act of 1975. California HMOs commonly contract with unlicensed and unregulated IPAs, which, in turn, contract with individual physicians. The HMOs reimburse the IPAs through capitated payments (i.e., set payments per patient); however, the IPAs usually pay the physicians on a fee for service basis. The contracts between the physicians and the IPAs typically state that the physicians must "look solely" to the intermediaries for payment. There is no direct contractual relationship (legally, "privity") between the HMOs and the individual physicians.

Several of the large IPAs with offices in California (and in other states, particularly Texas) went bankrupt. When this occurred, many physicians, who had already rendered services to the HMOs' patients, had only an unsecured claim in bankruptcy court for the money that the IPAs owed them. Unsecured creditors are generally the lowest priority of potential claimants in a bankruptcy case. Therefore, the physicians received little or nothing for their services from the bankrupt IPAs. They thus asked the HMOs to pay them for their services to the HMOs' patients.

In response to these requests, the HMOs contended that they had no privity with the physicians. Under the common law of contracts, any money the HMOs owed was to the bankruptcy estate.

Thus, the HMOs argued, the physicians, who had contracted with the defunct IPAs, bore the risk of their insolvency.

Section 1371 of the Knox-Keene Act, a prompt payment law, states that a managed care plan must pay uncontested claims within 30 or 45 working days (depending on the circumstances) of the plan's receipt of the claim. The last sentence of this section states as follows:

"The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services."

The California Medical Association (CMA) solicited California physicians with claims against bankrupt IPAs to assign those claims to it. As a result, CMA accumulated tens of millions of dollars of such claims. CMA sued several of the large California managed care organizations for recovery of this money. CMA contended that the HMOs, exercising their market power, had insisted that physicians contract with the IPAs, rather than the HMOs. At the same time, the HMOs knew that their capitation payments to the IPAs were so small that the IPAs stood a substantial risk of insolvency. The principal CMA legal theory was that Knox-Keene Act §1371 repealed the common law requirement of contractual privity and mandated that the managed care organizations pay CMA as the physicians' assignee.

The trial judge dismissed the CMA lawsuit based on the pleadings, and the Court of Appeal affirmed the dismissal. CMA asked the California Supreme Court to hear the case on a discretionary basis. However, on March 27, 2002, the California Supreme Court, with one justice dissenting, declined to hear the case.

Litigation Center Involvement

The Litigation Center filed a letter brief with the California Supreme Court, supporting the CMA request. The letter brief emphasized the importance of the case, both within California and the entire United States.

California Supreme Court letter brief