# Health Care Law Legislation and Litigation Update for 2015: California Health Law Continues to Evolve at a Rapid Pace

Carol Scott, H. Thomas Watson, and David D. Johnson

Carol D. Scott J.D., M.P.H. is a health care law partner with the law firm of Hinshaw & Culbertson, LLP, in its Los Angeles, California office. Her practice focuses on advising various types of health care providers and related entities on regulatory, transactional, fraud and abuse, reimbursement, compliance, privacy and security, and business issues. She is the Co-Chair of the State Bar Legislation Subcommittee.

H. Thomas Watson is a partner at Horvitz & Levy LLP. He is a California State Bar Certified Appellate Specialist and chairs the State Bar's Health Law Committee. He has authored numerous articles on health law and damages issues, and is a frequent lecturer on these topics.

David D. Johnson is a health law attorney in the San Francisco office of Crowell & Moring, LLP. He focuses on health care litigation and regulatory counseling. Mr. Johnson graduated from the University of Texas at Austin School of Law. Prior to law school, he worked as a C.P.A.

## I. Introduction

The Legislature enacted over 130 significant new health care laws in 2015. The bills that generated the most news addressed individual rights. The most controversial was Assembly Bill X2-15 (2015-2016 Reg. Sess.), the End of Life Option Act, which for the first time permits physicians to provide terminally ill patients with drugs to aid in their death. Similarly controversial was Senate Bill 277 (2015-2016 Reg. Sess.), which phases out the "personal belief" exemption for vaccinations of school-aged children. Other consumer-oriented bills tighten the regulations on medical marijuana, require disclosures by pregnancy counseling centers, and change the rules for when a sperm/ova donor will be deemed the parent of a child conceived through assisted reproduction.

While the major reforms to California's health care coverage system of recent years have been largely completed, the Legislature enacted several bills in 2015 that expanded access to health care. These included Senate Bill 4 (2015-2016 Reg. Sess.) and Senate Bill 75 (2015-2016 Reg. Sess.), which extended full-scope Medi-Cal benefits to children under the age of 19 who are unable to prove that they have satisfactory immigration status; Senate Bill 337 (2015-2016 Reg. Sess.), which provides physicians with more flexible alternatives for reviewing the records of physician assistants; and Assembly Bill 848 (2015-2016 Reg. Sess.), which expands the ability of alcohol and drug treatment centers to provide medical services. Other bills tweaked insurance coverage, such as by limiting cost-sharing for drugs.

The California Supreme Court filed only one health care opinion last year, *State Department of Public Health v. Superior Court*.[1] This decision recognizes a limited exception to patient confidentiality for citations issued by the Department of Public Health to providers under the Long-Term Care Act. The court of appeal, however, published many significant health law decisions, which addressed professional and medical staff matters, billing, medical coverage, premium taxes, tort liability, MICRA, workers' compensation medical review, and other issues.

## II. Significant Legislation

### *A. Consumer/Public Health*

#### *1. Vaccinations*

In June 2015, Governor Brown signed Senate Bill 277, one of the strictest school vaccination laws in the United States. Starting July 1, 2016, all children enrolled in public or private schools, day care, and nursery

schools must be vaccinated against a variety of diseases, regardless of religious or other personal beliefs. Children with special medical conditions, such as immune system deficiencies and medical allergies, may be exempt if they have a doctor's statement. Senate Bill 277 provides that children who do not qualify for a medical exemption and who are not vaccinated must be home-schooled or enroll in an independent study program off school grounds. Only children with serious health issues are allowed to opt out of the mandatory vaccinations—with one exception. If a parent filed a personal belief statement on or before December 31, 2015, the child can attend school until the child reaches the next "grade span" (e.g., graduation from grade school to middle school).[2]

### 2. *End of Life*

In October 2015, the Governor signed another piece of controversial landmark legislation, Assembly Bill X2-15, the California End of Life Option Act ("ELOA"), which allows a terminally ill patient to request that a physician prescribe a lethal drug to aid the patient in ending his or her life. ELOA includes the following criteria: (i) two doctors must examine the patient and determine that the patient has six (6) months or less to live; (ii) the patient must make a written request and two oral requests at least fifteen (15) days apart; (iii) the patient must provide informed consent; (iv) the patient must be mentally capable of making decisions about his or her own health; and (v) the drug must be self-administered by the patient. Compliance with ELOA is voluntary. Health care providers are immune from liability for refusing to comply with a patient's request. Conversely, physicians who do comply with a patient's request have professional, civil, and criminal immunity.[3] With the passage of ELOA, California is the fifth state to allow medically-assisted death. [4]

### 3. *Mental Health and Involuntary Holds*

Under pre-existing law, a peace officer or other authorized individual may, upon probable cause, involuntarily detain an individual for an initial 72-hour mental health evaluation, if they determine that the individual, as a result of a mental disorder, is a danger to self or others, or is gravely disabled. This is known as a "5150 hold."[5] When determining if probable cause exists, the officer may consider information about the historical course of the person's mental disorder, if relevant. Some law enforcement authorities, however, have interpreted the law as requiring a finding of imminent danger before a hold is warranted.[6] Assembly Bill 1194 (2015-2016 Reg. Sess.) provides that probable cause for a 5150 hold is not limited to whether there is a danger of imminent harm, and that the factors stated in Welfare and Institutions Code section 5150.05, such as the historical course of the individual's mental health disorder, are what should be considered in determining whether a 5150 hold is proper.[7]

### 4. *Medical Marijuana*

Senate Bill 643, Assembly Bill 243 and Assembly Bill 266 (2015-2016 Reg. Sess.), collectively known as the Medical Marijuana Regulation and Safety Act ("MMRA"), establish a comprehensive new licensing and regulatory regime for medical marijuana. Under MMRA, cultivators will be required to obtain licenses from the California Department of Food and Agriculture, and transporters, testing labs, dispensaries, and others in the distribution chain will be required to obtain licenses from the California Department of Consumer Affairs. Licensees also will be required to comply with new standards controlling cultivation, advertising, packaging, transporting, distributing, and dispensing medical marijuana. MMRA further provides for the termination of the existing model of marijuana cooperatives and collectives one year after this new licensing program has been established.[8]

MMRA also includes new requirements designed to curb physician over-prescription of medical marijuana. Under MMRA, only the patient's attending physician can recommend medical marijuana. MMRA also requires that the Medical Board of California prioritize its investigative and prosecutorial resources to identify and discipline physicians who repeatedly recommend excessive medical marijuana to patients, recommend marijuana to patients without a good faith examination, prescribe over the Internet, or fail to keep proper records. MMRA also prohibits a physician who recommends medical marijuana from having an interest in another medical marijuana enterprise, or from accepting, soliciting, or offering any form of remuneration to or from a facility licensed under MMRA.[9]

### 5. *Pregnancy Counseling Centers*

Assembly Bill 775 (2015-2016 Reg. Sess.), the Reproductive Freedom, Accountability, Comprehensive

Care, and Transparency Act ("RFACTA"), requires certain pregnancy counseling centers to provide clients with information about state-funded family planning services. Under RFACTA, licensed facilities whose primary purpose is providing family planning or pregnancy-related services, and who meet specified criteria, are now required to provide their clients with a notice stating:

> California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care and abortion for all eligible women. To determine whether you qualify, contact the county social services office at [insert telephone number].

Unlicensed facilities are required to provide a different notice, indicating that the facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services.[10]

#### 6. *Assisted Reproduction*

Assembly Bill 960 (2015-2016 Reg. Sess.) clarifies the rules regarding parentage for assisted reproduction. Prior law treated a man who donated sperm through a physician or sperm bank, and whose sperm was used by a woman other than the donor's wife, as if he were not the child's natural father. This rule did not apply where sperm was not donated through a physician or sperm bank. Under Assembly Bill 960, a donor who uses a physician or sperm bank still will not be treated as the natural father, unless the parties agree to the contrary in writing prior to the conception. But a man who donates without the assistance of a physician or sperm bank will be treated as the natural father, unless the donor and woman have a written or qualifying oral agreement to the contrary prior to conception. Assembly Bill 960 also provides that a woman who provides ova for use in assisted reproduction will not be considered a parent unless a court finds satisfactory evidence that the ova donor and the woman intended the ova donor to be a parent.[11]

### B. *Physician Assistants*

Several bills loosened regulations on physician assistants. Senate Bill 337 (2015-2016 Reg. Sess.) provides alternative methods of record review for physicians who supervise physician assistants. Under prior law, a licensed physician was required to review, countersign, and date at least five percent of the medical records for patients treated by a physician assistant within 30 days of treatment, and to select for review those cases that by diagnosis, problem, treatment, or procedure represent, in the physician's judgment, the most significant risk to the patient. Under Senate Bill 337, the supervising physician can select one or more methods of record review, including conducting a "medical records review meeting" on a monthly basis for at least 10 months of the year in which the physician and assistant jointly review at least 10 patient records.

Prior law prohibited a physician assistant from administering, providing, or issuing a drug order to a patient for schedule II through schedule V controlled substances without advance approval by a supervising physician unless the physician assistant had completed a specified education course. Senate Bill 337 changes the law to provide that a physician assistant can issue a drug order for a schedule II drug as long as the order is reviewed, countersigned, and dated by a supervising physician and surgeon within seven days, and the drug order is issued pursuant to the physician's written protocols.[12]

### C. *Health Care Facilities*

A number of bills altered regulations for health care facilities. In the past, alcoholism and drug abuse treatment facilities could not offer most medical services to patients. Assembly Bill 848 (2015-2016 Reg. Sess.) authorizes medical providers to perform limited medical services at such facilities, including obtaining medical histories, monitoring resident health status, performing certain tests, providing medical recovery or treatment services, overseeing patient self-administered medications, and treating substance abuse disorders. Physicians and other health care providers are still prohibited from offering general primary medical care at these facilities.[13]

Assembly Bill 389 (2015-2016 Reg. Sess.) follows national trends that have increased translation requirements for patients with limited English proficiency. Assembly Bill 389 provides that beginning July 1, 2016, all general acute care hospitals must post a language assistance policy on their website in English and up to five other commonly spoken languages, and that the policy must be updated every January. The hospitals must also post a notice of the availability of interpreters. The bill further requires the California Department of Public

Health to post each hospital's interpreter services policies on its website. In the past, general acute care hospitals were required to have language assistance policies, but there were no website posting or notice requirements.[14]

Senate Bill 396 (2015-2016 Reg. Sess.) provides that all physicians and other practitioners who are granted clinical privileges in accredited outpatient settings and surgicenters must be peer-reviewed at least every two years. The peer review must be conducted by licensees qualified by education and experience to perform the same type of (or similar) procedures. The peer review findings must be reported to the licensee's governing body, which is to determine whether the licensee is appropriately credentialed. Senate Bill 396 also provides that the accreditation agency and the Medical Board may make unannounced inspections (with 60 days' notice) of accredited outpatient settings.[15]

Assembly Bill 1177 (2015-2016 Reg. Sess.) deals with licensing requirements for primary care clinics. By regulation, primary care clinics were required to maintain a written transfer agreement with one or more nearby hospitals as appropriate to meet medical emergencies. A clinic could, however, request a waiver of this requirement, unless the clinic provided abortion or birthing services.[16] The end result was that hospitals could prevent primary care clinics that provided abortions from being licensed by refusing to enter into a transfer agreement. Assembly Bill 1177 (2015-2016 Reg. Sess.) provides that a licensed primary care clinic that does not offer alternative birth center services is not required to enter into a written transfer agreement as a condition of licensure.[17]

### *D. Pharmacy*

Assembly Bill 1073 (2015-2016 Reg. Sess.) added new requirements for California pharmacists to include translated instructions on prescription labels or in a supplemental document. Under the new law, upon patient request, such instructions must be provided in Korean, Russian, Spanish, Chinese, and Japanese, as well as in English.[18]

Senate Bill 671 (2015-2016 Reg. Sess.) expands the scope of practice for pharmacists by giving pharmacists the freedom to select alternative biological products in place of the drug prescribed by the provider as long as: (1) the alternative product is "interchangeable," as defined in the statute; (2) the cost of the product is the same or less than the prescribed item; and (3) the provider does not indicate "do not substitute" on the prescription. The bill also requires the California State Board of Pharmacy to maintain on its website a list of biological products determined by the federal Food and Drug Administration to be interchangeable.[19]

### *E. Health Care Coverage*

Assembly Bill 248 (2015-2016 Reg. Sess.) addresses what is popularly known as "skinny" coverage. Under the Affordable Care Act ("ACA"), also known as Obamacare, employees may be eligible for subsidies to help them purchase coverage on state exchanges, unless they are covered under an employer-sponsored health plan.[20] Some employers, however, provide "skinny" coverage that covers only a small portion of a member's health costs. Assembly Bill 248 attempts to ensure that such employees do not lose access to robust coverage by requiring that all non-grandfathered large group coverage sold in California must meet a sixty percent minimum value requirement—i.e., must provide the same actuarial value as a bronze level exchange policy.[21]

Assembly Bill 339 (2015-2016 Reg. Sess.) caps co-insurance and deductibles for prescription drugs for certain non-grandfathered health care plans. The law provides that beginning on January 1, 2017, co-payments and co-insurance for certain outpatient prescription drugs that constitute essential health benefits may not exceed $250 for a 30-day supply; except for bronze-level plans, which may charge $500 for a 30-day supply. Deductibles for outpatient drugs for individual and small-group plans may not exceed $500 ($1,000 for bronze plans). Drugs still may be classified into tiers, with different cost-sharing among tiers; however, grouping into tiers must be based on "clinically indicated, reasonable medical management practices." Assembly Bill 339 also directs the Department of Managed Health Care ("DMHC") and the Department of Insurance to create a standard formulary template that plans must post on their websites, listing the drugs covered, information on cost-sharing, each medication's tier, and other relevant information to permit cost comparisons.[22]

Assembly Bill 1305 (2015-2016 Reg. Sess.) attempts to equalize deductibles between individual and family health plans by providing that an individual within a family will only be required to satisfy the same deductible required for individual coverage for the same product.

Senate Bill 137 addresses complaints by health plan members that it is becoming difficult to locate health care providers, and that the information they receive is out of date. The bill requires plans to publish online directories of provider information, starting July 1, 2016. The bill also instructs the DMHC to create a standardized template for the directories. Plan directories must comply with the template by July 1, 2017. Some of the information—such as provider availability to accept new patients—must be updated weekly.

#### *F. Medi-Cal*

With Senate Bill 75 and Senate Bill 4 (2015-2016 Reg. Sess.), the Legislature expanded full-scope Medi-Cal coverage to undocumented immigrant children under 19 years of age, even if those children do not have "satisfactory immigration status." Previously, such individuals were eligible only for "limited-scope" benefits such as pregnancy-related services and emergency care. The bill directs the Department of Health Care Services ("DHCS") to enroll such children in Medi-Cal managed care health plans to the extent possible. This expansion will take effect as soon as DHCS is able to implement it, but no sooner than May 1, 2016.[23]

## III. Litigation update

### *A. California Supreme Court Decisions*

The California Supreme Court published one health law decision in 2015, *State Department of Public Health v. Superior Court*,[24] in which it recognized a limited exception to patient confidentiality for the Department of Public Health ("DPH") under the Long-Term Care Health, Safety, and Security Act of 1973 (the "LTCHSS Act").

Under the LTCHSS Act, the DPH has authority to cite long-term care facilities that violate statutes or regulations.[25] In 2011, the Center for Investigative Reporting ("CIR") asked the DPH for copies of its citations to aid CIR's investigation into the abuse of mentally ill and developmentally disabled individuals in state-owned facilities. The LTCHSS Act states that citations are public records, but that names of patients must be redacted. The DPH produced the citations with more extensive redactions than the LTCHSS Act prescribed, contending that heavier redactions were required by Welfare and Institutions Code ("WIC") section 5328, which prohibits the release of all confidential "information and records obtained in the course of providing services" to mentally ill and developmentally disabled individuals.

The CIR sought a writ of mandate ordering disclosure of the redacted material. The trial court found that the LTCHSS Act and WIC section 5328 were irreconcilable, and ruled that the LTCHSS Act controlled because it was more recent and specific. The Court of Appeal reversed, holding that because both statutory schemes were designed to protect the same vulnerable population, they could be harmonized in a way that permitted the DPH's extensive redactions.

The California Supreme Court granted review and reversed the court of appeal. The Supreme Court agreed with the trial court that the newer LTCHSS Act cannot be reconciled with WIC section 5328. The Court found the LTCHSS Act to be the more specific statute, since it specified the information that must be included in public DPH citations, and construed the LTCHSS Act as a limited exception to WIC section 5328's general rule of patient confidentiality. Thus, DPH citations issued under the LTCHSS Act are public records that must be disclosed, subject only to the specific redactions mandated by the LTCHSS Act.

### *B. California Court of Appeal Decisions*

The California Court of Appeal published numerous opinions in 2015 on health law issues. The following were some of the more significant decisions:

#### *1. Medical staff*

The court of appeal published several decisions addressing health care providers' potential liability as employers to both employees and patients.

- DeCambre v. Rady Children's Hospital-San Diego, 235 Cal. App. 4th 1 (2015): An anti-SLAPP motion can defeat an action based on statements made during the course of a "peer review" process, but cannot defeat harassment or emotional distress claims arising from conduct occurring independent of peer review during the course of a doctor's employment.
- Whitlow v. Rideout Mem'l Hosp., 237 Cal. App. 4th 631 (2015): Whether a physician is a hospital's ostensible agent usually presents a triable issue of fact regarding whether a sick or injured patient was capable of understanding signage and forms, and therefore is seldom capable of summary adjudication.

- Sternberg v. Cal. State Bd. of Pharmacy, 239 Cal. App. 4th 1159 (2015): Under Business and Professions Code section 4081, a pharmacist-in-charge need not have actual knowledge of a recordkeeping violation to be subject to discipline. The statute imposes strict liability and incentivizes pharmacists-in-charge to take "necessary precautions" to adequately supervise and maintain the inventory of controlled substances.

- Nosal-Tabor v. Sharp Chula Vista Med. Ctr., 239 Cal. App. 4th 1224 (2015): A hospital may be liable for wrongful termination in violation of public policy for discharging a nurse who refused to perform cardiac stress testing pursuant to hospital procedures that failed to comply with mandatory state guidelines.

- Mobile Med. Servs. for Physicians and Advanced Practice Nurses, Inc. v. Rajaram, 241 Cal. App. 4th 164 (2015): A nursing service's lawsuit against the director of rehabilitation facilities, based on the director's statements to the California Nursing Board that triggered disciplinary proceedings against the nursing service, is subject to an anti-SLAPP motion.

### 2. *Medical Billing*

The court of appeal published one medical billing decision, which gave deference to a hospital's billing practices.

- Nolte v. Cedars Sinai Med. Ctr., 236 Cal. App. 4th 1401 (2015): A hospital does not engage in unfair business practices by charging patients published facility fees that were not explicitly listed on the admission forms signed by the patients.

### 3. *Medical Confidentiality*

Though courts continue to emphasize the importance of medical confidentiality, the court of appeal determined that some statutory damages are limited.

- Lemaire v. Covenant Care Cal., LLC, 234 Cal. App. 4th 860 (2015): Though patients have a private right of action under Health and Safety Code section 1430 to enforce medical records regulations, that statute authorizes a damage award of only $500 per action (in addition to attorney fees), regardless of the number of infractions.

### 4. *Medical Coverage*

The court of appeal protected Medi-Cal beneficiaries and addressed the classification of several major health care providers in several published opinions last year.

- Aguilera v. Loma Linda Univ. Med. Ctr., 235 Cal. App. 4th 821 (2015): The California Department of Health Services must prove the reasonably probable amount of future medical expenses it will actually pay when asserting a lien against a Medi-Cal beneficiary's settlement with a third party who is liable for medical expense damages.

- Hambrick v. Healthcare Partners Med. Grp., 238 Cal. App. 4th 124 (2015): The Department of Managed Health Care is the appropriate entity to determine whether a medical group is a "health care service plan" under the Knox-Keene Act based on the level of risk it assumed.

- Marquez v. Dep't of Health Care Servs., 240 Cal. App. 4th 87 (2015): Medi-Cal beneficiaries are not entitled to notice or hearing regarding "other health coverage" coding changes by the Department of Health Care Services that result in only a delay, not a denial, of benefits.

- Myers v. State Bd. of Equalization, 240 Cal. App. 4th 722 (2015): Even though they are regulated by the California Department of Managed Health Care rather than the Department of Insurance, Blue Cross and Blue Shield may be required to pay insurer premium taxes, instead of corporate franchise taxes, because the extent to which they undertake to indemnify others for contingent medical expenses may make them insurers for tax purposes.

### 5. *Medical Tort Liability*

In 2015, appellate courts refused to immunize health care providers from tort liability despite tenuous causation evidence. The courts did, however, show some lenience towards health care defendants with respect to the standard of proof in medical malpractice actions.

- Harb v. City of Bakersfield, 233 Cal. App. 4th 606 (2015): When a plaintiff sues health care providers for aggravating an injury, the providers may not seek to reduce their potential liability by attributing fault to the plaintiff for negligently causing the injury.

- Uriell v. Regents of the Univ. of Cal., 234 Cal. App. 4th 735 (2015): California's standard jury instruction on substantial factor causation (CACI No. 430) is adequate for use in medical malpractice actions, and does not have to be tailored to couch causation in medical terms.

- Keys v. Alta Bates Summit Med. Ctr., 235 Cal. App. 4th 484 (2015): A court of appeal affirmed an award of negligent infliction of emotional distress damages to relatives who witnessed inadequate resuscitation efforts in a surgical recovery room.

- Lattimore v. Dickey, 239 Cal. App. 4th 959 (2015): A doctor certified in family and emergency medicine was found qualified to testify about the standards of care applicable to a general surgeon and a gastroenterologist who were treating the plaintiff's decedent for internal bleeding because, liberally construed, his qualifications adequately demonstrated his skill and experience in treating such patients.

### 6. *MICRA (Medical Injury Compensation Reform Act)*

The court of appeal rejected a constitutional challenge to MICRA's damages cap, and held that MICRA's limitation period may be tolled by other statutes.

- Blevin v. Coastal Surgical Instit., 232 Cal. App. 4th 1321 (2015): MICRA's one-year limitations period may be tolled by Insurance Code section 11583 when a party making an advance payment as an accommodation to an injured person who is not represented by counsel fails to provide the payment recipient with written notice of the statute of limitations applicable to the conduct causing the injury.

- Chan v. Curran, 237 Cal. App. 4th 601 (2015): MICRA's $250,000 cap on noneconomic damages does not violate a plaintiff's constitutional rights to equal protection, due process, or trial by jury.

### 7. *Medical Review in Workers' Compensation*

California's workers' compensation scheme for resolving medical treatment disputes survived a constitutional challenge.

- Stevens v. Workers' Compensation Appeals Bd., 241 Cal. App. 4th 1074 (2015): The independent medical review ("IMR") process used in California's workers' compensation scheme to resolve challenges to the denial of claims is constitutional, and the Workers' Compensation Appeals Board has jurisdiction to review an IMR determination regarding whether treatment is statutorily authorized.

### 8. *Procedural Issues*

The court answered several procedural questions regarding claims against health care providers.

- Sela v. Med. Bd. of Cal., 237 Cal. App. 4th 221 (2015): A trial court's affirmance of the California Medical Board's denial of a physician's petition seeking early termination of probationary restrictions on his medical license was a non-appealable decision that was reviewable solely by a petition seeking writ relief.

- UFCW & Emp'rs Benefit Trust v. Sutter Health, 241 Cal. App. 4th 909 (2015): An arbitration clause in a contract between Blue Shield and certain providers did not bind a third-party ERISA plan whose beneficiaries accessed those providers.

- AIDS Healthcare Found. v. State Dep't of Health Care Servs., 241 Cal. App. 4th 1327 (2015): When parties agree to resolve disputes through the administrative process provided by Health and Safety Code section 100171, they must exhaust their administrative remedies before seeking judicial review.

## IV. Conclusion

While the restructuring of California's health coverage system in the wake of the Affordable Care Act has been largely completed, California health care law continues its quick pace of evolution. Given the constant technological developments and the current controversies surrounding many elements of the system, we can expect the pace of change to continue in the coming year.

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1 60 Cal. 4th 940 (2015).

2 CAL. HEALTH & SAFETY CODE §§ 120325, 120380, 120400 et seq.

3 *Id.* § 443 et seq.

4 Washington, Oregon, and Vermont have such statutes; Montana has a Supreme Court ruling permitting assisted suicide, but has not enacted legislation.

5 Based on CAL. WELF. & INST. CODE § 5150.

6 Based on cases such as *People v. Triplett*, 144 Cal. App. 3d 283 (1982).

7 Modifying CAL. WELF. & INST. CODE § 5150.

8 Assemb. B. 243, 2015-2016 Reg. Sess. (adding CAL. BUS. & PROF. CODE art. 6 (§§ 19331-33), 14 (§§ 19350-52), 17 (§ 19360), and amending provisions of the CAL. FISH AND GAME CODE, CAL. HEALTH AND SAFETY CODE, and CAL. WATER CODE); Assemb. B. 266, 2015-2016 Reg. Sess. (amending CAL. BUS. & PROF. CODE §§ 27, 101; adding CAL. BUS. & PROF. CODE §§ 205.1, 19300-19355; and amending/adding provisions in the CAL. GOV'T CODE, CAL. HEALTH AND SAFETY CODE, CAL. LAB. CODE, and CAL. REV. & TAX. CODE).

9 S.B. 643, 2015-2016 Reg. Sess. (amending/adding provisions of the CAL. HEALTH AND SAFETY CODE and CAL. BUS. & PROF. CODE).

10 Adding CAL. HEALTH AND SAFETY CODE art. 2.6 (§§ 123470-73).

11 Amending CAL. FAM. CODE §§ 7613, 7613.5.

12 Amending CAL. BUS. & PROF. CODE §§ 3501, 3502, 3502.1.

13 Amending CAL. HEALTH & SAFETY CODE §§ 11834.03, 11834.36, and adding §§ 11834.025, 11834.026.

14 Amending CAL. HEALTH & SAFETY CODE § 1259.

15 Amending CAL. BUS. & PROF. CODE § 805.5, CAL. GOV'T CODE § 12529.7; CAL. HEALTH & SAFETY CODE §§ 1248.15, 1248.35.

16 *See* CAL. CODE REGS. tit. 22, § 75047.

17 Adding and repealing CAL. HEALTH & SAFETY CODE § 1201.2.

18 Adding/amending CAL. BUS. & PROF. CODE §§ 4076, 4076.6, 4199.

19 Adding CAL. BUS. & PROF. CODE § 4073.5.

20 *See* ACA § 1401(c)(2)(C)(iii).

21 Adding CAL. HEALTH & SAFETY CODE § 1367.010; CAL. INS. CODE § 10112.9.

22 Amending/adding CAL. HEALTH & SAFETY CODE §§ 1367.205, 1367.41, 1342.71; CAL. INS. CODE §§ 10123.192, 10123.201, 10123.193.

23 Amending CAL. WELF. & INST. CODE §§ 14007.7, 14007.8.

24 60 Cal. 4th 940 (2015).

25 CAL. HEALTH & SAFETY CODE § 1417 et seq.