4th Civil No. E026961

STATE OF CALIFORNIA

COURT OF APPEAL

FOURTH APPELLATE DISTRICT

DIVISION TWO

DESERT HEALTHCARE DISTRICT,

Plaintiff and Respondent,

vs.

PACIFICARE, FHP, INC.,

Defendant and Appellant,

Appeal from the Riverside County Superior Court
Honorable Douglas Miller, Judge
Riverside Superior Court Case No. INC 0011734

RESPONDENT'S BRIEF

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INTRODUCTION

Plaintiff hospital is an unsecured creditor of a bankrupt medical group, Desert Physicians Association ("DPA"). Barred from suing DPA, with whom it had a contract, the hospital sued defendant PacifiCare, FHP, Inc., a health care service plan, with whom plaintiff had no contractual relationship. But plaintiff's gambit has not succeeded. After three attempts, it has failed to find a legal basis for holding PacifiCare liable for the debts of DPA; and, despite pleading a kitchen sink of contract, tort and statutory claims, its second amended complaint was dismissed without leave to amend.

Plaintiff admits that it is common practice for health care plans to contract with medical groups and independent practice associations ("IPAs") to provide treatment to enrollees, and for such entities then to subcontract with third party providers. (CT 414; AOB 2.) That common practice was followed here: PacifiCare entered into a contract ("Plan Contract") with DPA to pay it capitation, and DPA separately entered into a contract ("Hospital Contract") with plaintiff to provide hospital services. (CT 416.) As plaintiff concedes, PacifiCare paid capitation to DPA as required by the Plan Contract. (CT 417, 418.) So how can PacifiCare be forced to pay *again* – and to an entity with whom it had no contract?

It can't. On appeal, plaintiff has abandoned all its contract claims. This is not surprising: Plaintiff never managed to allege any kind of contractual relationship between it and PacifiCare; it never attached the written contracts it alleged and never pleaded their terms. Plaintiff's case now reduces to two theories – (1) the Knox-Keene Health Care Services

Act (Health & Saf. Code, § 1340 et seq.) imposes an obligation on PacifiCare to pay the debts of its contracting IPAs, which can be enforced by an action for damages; and (2) if the statute doesn't impose it, courts may do so under tort and unfair competition law.

Plaintiff is wrong on both counts. As the trial court held, a plan is not "a financial guarantor of the contractual obligations of the plan's contracting medical providers" and has no duty "to ensure the[ir] financial stability." (CT 360, 410, 485.)

Plaintiff chiefly relies on section 1371 as amended in 1996 in asserting that PacifiCare must pay plaintiff what DPA owes it under the Hospital Contract.[1] All plaintiff's claims are bottomed on that section; indeed, it is expressly incorporated into each cause of action. But all to no avail: Section 1371 does not provide a basis for compelling PacifiCare to assume DPA's contractual promises to plaintiff.

So says the plain language of section 1371. Section 1371 establishes deadlines by which a plan must reimburse claims or give notice that it is contesting them. That's all it does. It does not create liability where none already exists. It contains not a whisper of an intent to compel plans to assume the obligations of their subcontractors to providers with whom the plans have no contract.

So says section 1371's legislative history. The 1996 amendment to section 1371 was intended to close a loophole: section 1371's reimbursement deadlines applied to plans, but arguably not to entities to whom plans had "delegat[ed] payment responsibilities." (CT 23-24, 92-

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1/ Unless otherwise specified, all statutory citations are to the Health & Safety Code.

93.) The Legislature drafted section 1371 to extend the statute's existing time deadlines to subcontractors. That's all that was intended. As a key Senate analysis stated, the amendment simply meant that "medical groups and IPAs will be required to meet the existing law on reimbursement requirement of 30 to 45 days." (CT 98.)

So says the Department of Corporations. In the very context presented here, the bankruptcy of an IPA, the Department of Corporations ("DOC"), the agency charged with enforcing Knox-Keene, rejected the very construction of section 1371 advanced by plaintiff. (CT 19.) The DOC definitively ruled that section 1371's legislative history "is devoid of any suggestion that the legislation was intended to create a liability for the payment of provider claims for which the plans were not otherwise liable, and for which the providers had negotiated compensation terms with another entity." (CT 25.)

Moreover, plaintiff is not entitled to sue to enforce section 1371 even were it able to allege a statutory violation. The Legislature has vested that right exclusively in an agency, first the DOC, and now the Department of Managed Care ("DMC"). (§§ 1341, 1346; *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, 1299 [power to enforce Knox-Keene "entrusted exclusively" to DOC].) Nor may plaintiff enforce section 1371 through "back doors": Courts may not assume regulatory power by enforcing the Act under the guise of determining duties of care in tort or unlawful practices under the Unfair Competition Law (Bus. & Prof. Code, § 17200 et seq.). Yet, all plaintiff's claims take the court deep into the regulatory thicket of Knox-Keene. That is not permitted.

Plaintiff's tort claims fail in any event: The law does not require plans to protect providers from financial loss from their own contracts with IPAs. Here, plaintiff seeks to found a tort claim on the fact that PacifiCare honored its contract with DPA by paying it capitation (CT 417-419), but there is no such thing as a duty to breach a contract. Plaintiff's unfair competition claim also fails. It is premised on the notion that PacifiCare's capitation arrangements with DPA are illegal, unfair and fraudulent. But Knox-Keene expressly sanctions those arrangements, as part of its goal of shifting risk to providers, and thus as a matter of law they cannot violate the Unfair Competition Law.

Plaintiff doesn't like Knox-Keene. It candidly admits that it wants the right "to seek payment for covered services from the patient or from PacifiCare as a condition of providing services to its insureds." (AOB 10.) But that's exactly what Knox-Keene was enacted to prevent. Accordingly, plaintiff's fight is with the Legislature, not with PacifiCare. The judgment must be affirmed.

STATEMENT OF THE CASE.

A. Plaintiff's Factual Allegations.

Defendant PacifiCare, FHP, Inc., a health care service plan licensed under Knox-Keene, entered into contracts with enrollees to purchase health care services. (CT 412.) It then in turn entered into written agreements with medical groups, independent practice associations or other contracting entities "to be responsible for managing or arranging for medical services"

in return for capitation payments. (CT 1-2, 414.) This is common practice in California. (CT 414.)

In this case, the subcontractor was DPA, with whom PacifiCare contracted to arrange for such services for PacifiCare's enrollees. (CT 416.) DPA in turn contracted with plaintiff to provide services to PacifiCare's enrollees; plaintiff performed services, but DPA failed to pay plaintiff. (CT 416.) DPA filed for bankruptcy (CT 417); its obligation to pay plaintiff has been extinguished through the bankruptcy proceedings (CT 3).

PacifiCare paid DPA what was owed under their contract. (CT 417.)

B. Plaintiff's Legal Contentions.

1. The original complaint, PacifiCare's demurrer, and the court ruling.

Plaintiff sued PacifiCare "for breach of written contract." (CT 1.) It alleged a contract between PacifiCare and DPA (CT 2), but did not plead its terms or attach it to the complaint. It did not allege a contract between plaintiff and PacifiCare. Despite pleading a "breach of contract," plaintiff in fact sought to enforce an alleged statutory right, asserting that though DPA's obligations "have been extinguished through bankruptcy proceedings," PacifiCare's "obligation" to pay plaintiff for its services "remains intact by operation of Health & Safety Code § 1371." (CT 3.) This is confirmed by plaintiff's opposition to PacifiCare's demurrer to the complaint. (CT 340.)

The trial court sustained PacifiCare's demurrer with leave to amend. The court held that section 1371 "does not impose a duty upon the health

plans to be a financial guarantor of the contractual obligations of the plan[']s contracting medical providers." (CT 360.)

2. The first amended complaint, PacifiCare's demurrer, and the court ruling.

Plaintiff filed a first amended complaint "for breach of written contract" that essentially repeated the allegations of its original complaint, adding an allegation that plaintiff was a third-party beneficiary of contracts between PacifiCare and its enrollees. (ACT 1-3.)[2] Plaintiff did not plead the terms of any "written contract" in or attach any contract to its first amended complaint. Plaintiff again alleged that though DPA's obligations "have been extinguished through bankruptcy proceedings," PacifiCare's "obligation" to pay plaintiff for its services "remains intact by operation of Health and Safety Code § 1371." (ACT 3.)

The trial court sustained the demurrer *without* leave to amend to the extent plaintiff sought to recover under section 1371 and with leave to amend to the extent it sought to recover on a third-party-beneficiary theory. (CT 410.)

3. The second amended complaint, PacifiCare's demurrer, the court ruling and judgment.

Plaintiff pleaded ten causes of action in its second amended complaint: (1) For statutory violation of section 1371; (2) For negligence; (3) For negligence per se based on section 1371; (4) For negligence based

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2/ "ACT" refers to the Augmented Clerk's Transcript filed concurrently with this brief.

on a special relationship; (5) For violation of Business and Professions Code section 17200 et seq.; (6) For breach of express contract; (7) For breach of implied contract; (8) For breach of third party beneficiary contract between PacifiCare and DPA; (9) For breach of third party beneficiary contract between PacifiCare and enrollees; (10) For declaratory relief regarding section 1371. (CT 417-424.)

All plaintiff's causes of action were grounded in section 1371, which plaintiff quoted verbatim and incorporated by reference in every claim. (CT 414-415, 417-424.) Plaintiff alleged, for the first time, that PacifiCare had a duty to plaintiff to ensure that DPA was financially able to pay plaintiff (CT 418-419), knew or should have known that DPA was unable to do so (CT 417), and breached that duty by paying capitation to DPA rather than paying plaintiff (CT 417-419). Plaintiff also alleged that PacifiCare violated Business and Professions Code section 17200 by requiring waivers from plaintiff and "insist[ing] that the Hospital look only to the intermediary for payment for services rendered to [plan] enrollees." (CT 420.)

PacifiCare demurred to the complaint, and the trial court sustained the demurrer as to each cause of action *without leave to amend.* As to the causes of action (first, third, sixth, seventh and tenth) that were "based in whole or in part" on section 1371, the court found that the statute "did not impose a duty on health care service plans to guarantee or maintain ultimate financial responsibility for the obligations of the plans' contracting medical providers." (CT 485.) As to the causes of action (second, third and fourth) "based on negligence theories," the court found that plaintiff failed to allege "sufficient facts to establish a duty of health care service plans to ensure the

financial stability of contracting medical providers" and that section 1371 provides no "basis for the imposition of such a duty." (CT 485.)

As to the fifth cause of action based on Business and Professions Code section 17200, the court found that (a) plaintiff alleged no facts "establishing any conduct by PacifiCare that is unlawful, unfair or fraudulent within the meaning of" that section; (b) its cause of action "essentially seeks to regulate the provisions of health care service plan agreements, a task which has been entrusted exclusively to the California Department of Corporations"; and (3) "the contractual arrangement at issue have [*sic*] been expressly allowed by the California Legislature and approved by the Department of Corporations." (CT 485.) Lastly, as to the sixth through ninth causes of action based on "breach of contract theories," the court found (a) no express contract – because plaintiff failed to allege the existence of any contract with PacifiCare, any terms that contractually bind PacifiCare or any terms it breached; (b) no implied contract – because plaintiff failed to allege any conduct creating a contractual obligation or the terms PacifiCare allegedly breached; and (c) no third party beneficiary contract – because plaintiff failed to allege that any contracts were made expressly for its benefit. (CT 485-486.)

Based on its ruling, the court entered judgment in favor of PacifiCare. (CT 488.)

ARGUMENT

I. PLAINTIFF HAS NOT ALLEGED AND CANNOT ALLEGE A VALID STATUTORY CLAIM AGAINST PACIFICARE UNDER THE KNOX-KEENE ACT.

A. The Statutory Scheme Governing Health Care Plans.

The Legislature enacted Knox-Keene to promote the delivery of health and medical care to plan enrollees by "[h]elping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers" and by "[e]nsuring the financial stability [of plans] by proper regulatory procedures." (§ 1342, subds. (d) and (f).)

The transfer of risk to providers is chiefly accomplished through the payment of "capitation," a system under which a medical group or provider receives a set amount per enrollee per month instead of a separate fee for each service performed. "Plans often enter into capitated payment arrangements with subcontracting entities, whereby the subcontracting entities receive capitated payments from the plans in exchange for the subcontracting entities arranging for the provision of health care to the plans' enrollees" under separate contracts with providers. (CT 25.) The "manner and rate of reimbursement [to providers] is based on the terms" of these separate contracts, to which plans are not parties. (CT 25.) Knox-Keene pervasively recognizes such subcontractor arrangements (§§ 1348.6, 1363.5, 1364.1, 1367.01, 1371, 1371.4, subd. (e), 1375.4-1375.6; Cal.Code

Regs., tit. 28, §§ 1300.70, subd. (b)(2)(H), 1300.76, subd. (f)),[3] and explicitly encourages them as mechanisms to shift financial risk and further "the public's interest in obtaining quality health care services in the most efficient and cost-effective manner" (§§ 1342, subd. (d), 1342.6, 1371.25).

Except where Knox-Keene explicitly states otherwise, the transfer of risk is absolute. Thus, plans are required to maintain reserves based on annual health care expenditures, "except those paid on a capitated basis." (§ 1300.76, subd. (a)(3)(A) and (B).)

B. Section 1371 Does Not Require Health Care Plans To Assume The Contractual Obligations Of Their Medical Groups And IPAs.

Section 1371 has been at the core of plaintiff's efforts to find a way to force PacifiCare to hold plaintiff harmless from the consequences of DPA's bankruptcy. For example, though pleaded as suits for breach of contract, the gravamen of plaintiff's first two complaints was in fact the assertion that though DPA's obligations "have been extinguished through bankruptcy proceedings," PacifiCare's "obligation" to pay plaintiff for its services "remains intact by operation of Health & Safety Code § 1371." (CT 3, ACT 3.) In its second amended complaint, plaintiff pleads claims for violation of section 1371, for negligence per se based on section 1371 and for a declaration as to the effect of section 1371; moreover, the statute is quoted verbatim and expressly incorporated by reference in each

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3/ Unless otherwise stated, all administrative citations are to Title 28 of the California Code of Regulations. Title 28 was previously part of Title 10 until its renumbering in December 2000. (Register 2000, No. 51.)

succeeding cause of action. (CT 415-424.) There is a reason – all plaintiff's claims are so thinly pleaded that they vanish without recourse to section 1371.

But section 1371 can't help plaintiff. In dismissing plaintiff's second amended complaint, the trial court found "as a matter of law that Health and Safety Code section 1371 does not impose a duty on health care service plans to guarantee or maintain ultimate financial responsibility for the obligations of the plans' contracting medical providers." (CT 485.)

On appeal, plaintiff argues, somewhat inconsistently, that its case "is grounded in the 1996 amendment" to section 1371 and that the amendment "merely served to clarify existing law." (AOB 13.) But, contrary to plaintiff's assertions (AOB 13-14, 15-16), neither the original text of section 1371 nor the 1996 amendment, imposes "ultimate responsibility" on health care plans to pay providers for covered services when those providers separately contracted with a plan's medical groups. Plaintiff's position is contrary to the statute's plain language, its legislative history, its interpretation by the DOC, the overall scheme of Knox-Keene and, finally, the common sense of the matter. At bottom, plaintiff demands that PacifiCare assume responsibility for DPA's debts even though it admits that PacifiCare has *already made timely payment* of capitation to DPA and plaintiff by contract *agreed to look to the capitated medical group for payment.* (CT 417, 419, 420; AOB 16.) Less compelling circumstances for wrenching Knox-Keene out of shape to rescue plaintiff from the consequences of its contract with DPA are hardly imaginable.

1. By its plain language, section 1371 does no more than establish time deadlines for reimbursing claims; it does not create a new source of health care plan liability.

Courts "interpret statutory language according to its usual and ordinary import, keeping in mind the apparent purpose of the statute. [Citation.] When no ambiguity appears, we give statutory terms their plain meaning. [Citation.]" (*Kraus v. Trinity Management Services, Inc.* (2000) 23 Cal.4th 116, 140, internal quotes omitted.) The words of a statute "generally provide the most reliable indicator of legislative intent. [Citation.] If there is no ambiguity in the language, we presume the Legislature meant what it said and the plain meaning of the statute governs." (*Diamond Multimedia Systems, Inc. v. Superior Court* (1999) 19 Cal.4th 1036, 1047, internal quotes omitted.)

Section 1371 could not be clearer or more straightforward. It mandates that plans must "reimburse claims . . . as soon as practical" and establishes end dates by which the plan must either pay a claim or notify the claimant that it is contesting the claim. As the DOC itself noted, before section 1371 was enacted, "the law did not specify a time period during which a claim must be paid. Thus, the Legislature clearly intended for section 1371 to implement *a time period* for the payment of claims." (CT 23, emphasis added). And that's all the statute does.

The statute does not address at all the circumstances that give rise to a plan's liability to a provider. In contrast, when the Legislature mandates payment to a provider, it says so in clear language. Section 1371.4, subdivision (b), for example, expressly provides that "[a] health care

service plan shall reimburse providers for emergency services and care provided to its enrollees." Nothing like that appears in section 1371.

But plaintiff insists that the 1996 amendment shows that the Legislature specifically intended to make plans the ultimate guarantors for the contract promises that their subcontractors make to providers. (AOB 13-16.) Plaintiff relies on the amendment in its complaints and quotes it in its opening brief, but yet the statute merely states:

> 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.

(Emphasis added.)

By its terms, the amendment enforces compliance with "this section," i.e. with the existing mandate of section 1371 that plans reimburse claims within the statutory deadlines. The amendment merely clarifies that those deadlines continue to apply when a plan delegates the payment of claims to its subcontractors; and, by providing that "[t]he obligation of the plan to comply with this section shall not be deemed to be waived," the amendment requires the plan to enforce its subcontractors' compliance.

Plaintiff offers three arguments in response. First, it insists that "the plain wording" of section 1371 shows that plans are ultimately responsible to pay the debts of subcontractors who defaulted on their contractual obligations to providers. (AOB 13-16.) But plaintiff never shows where in the statute this "plain wording" can be found. Indeed, it admits that the phrase "ultimately responsible" – which plaintiff treats as part of section 1371 (AOB 13, 15) – is in fact from a press release issued by the

governor's office when he signed the 1996 amendment into law. (AOB 15-16.)[4]

Second, plaintiff argues that section 1371 must be read as if it were written to impose on plans "the ultimate responsibility for payment for covered services [rendered under contracts between subcontractors and providers] because there can be no obligation on the part of health care service plans to make payments within the time periods specified in § 1371 if [they] had no duty, in the first place, to make such payments." (CT 13-14.) Plaintiff's premise is correct, its conclusion dead wrong. Of course, "there can be no obligation" on a plan to make payments it doesn't owe. That's PacifiCare's exact point here: It has no contractual liability to plaintiff, and section 1371 creates none. But under plaintiff's cockeyed logic, because section 1371 requires plans to pay what they *do* owe within specific deadlines, and subcontractors to pay claims *they* owe within those same deadlines, the statute must therefore require plans to assume what they do *not* owe – their IPAs' independent contractual liability to providers.

That's nonsense.

Third, plaintiff relies on the legislative history the 1996 amendment to section 1371. (AOB 15-20.) That also gets it nowhere. If the plain language of the amendment were not enough to demolish plaintiff's

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4/ Far from supporting plaintiff's position, the press release underscores that the 1996 amendment, by mentioning medical groups and the like, does not do anything more than ensure that plans cannot skirt the obligation to pay claims promptly by delegating the payment function to subcontractors. Thus, the press release provides that "[t]his bill will clarify existing law to ensure that HMOs . . . are ultimately responsible for the prompt payment of claims *even though they contract out this function* to medical groups, independent practice associations or other contracting entities." (CT 276, emphasis added, quoted at AOB 16.)

position, the statute's legislative history finishes the job; as we show below, the Legislature was crystal clear that its intent in amending section 1371 was only to ensure that the statutory time periods applied not only when plans but also when subcontractors reimbursed claims.

2. The legislative history of the 1996 amendment unmistakenly shows that the Legislature never intended to make plans responsible for the contractual debts of their contracting medical groups.

"A first principle of statutory construction is that the intent of the Legislature is paramount. (Code Civ. Proc., § 1859.) The court's role in construing a statute is to ascertain the intent of the Legislature so as to effectuate the purpose of the law and, in doing so the court looks first to the words of the statute. [Citation.] If the language is ambiguous, we may look to the history and background of the statute to ascertain legislative intent." (*Kraus v. Trinity Management Services, Inc.*, *supra*, 23 Cal.4th at p. 129, internal quotes omitted.)

Plaintiff all but ignores the pertinent legislative history of SB 1478, the bill that became the 1996 amendment to section 1371. Instead, inexplicably, it spends most of its time (AOB 16-19) discussing an earlier version of SB 1478 that dealt with a subject (financial incentive arrangements) that has nothing to do with the issue in this case and that was deleted in the Assembly. (CT 92.) Plaintiff itself admits that the earlier bill was "an entirely different bill" than the one that amended section 1371. (AOB 19.) Here's the story that plaintiff fails to tell. Originally, section

1371 did not mention subcontractors. The version of SB 1478 that became the 1996 amendment to section 1371 was proposed by the California Medical Association ("CMA") for one purpose only – to ensure that section 1371's claim-reimbursement deadlines, which *explicitly* applied to health care plans, also were made explicitly applicable to plan subcontractors. (CT 23, 92-93, 97, 98, 99, 192, 193 [SB 1478's purpose "is to ensure that medical groups and independent practice associations pay claims in the same time frame as health care service plans"], 229.) Accordingly, the first draft of SB 1478 (after its earlier "financial incentive" content had been deleted) made subcontractors *directly subject* to section 1371's statutory deadlines: Everywhere section 1371 used the term "health care service plan," SB 1478 added the words "medical group, independent practice association, or their contracting entities." (CT 71-73.)

The DOC objected to that approach for fear that it implied that the agency had jurisdiction over subcontractors. (CT 23-24, 194, 231.) Instead, the DOC proposed a "less burdensome alternative":

> Rather than adding medical groups, independent practice associations, or contracting entities to the provisions of the Knox-Keene Act relating to prompt payment, the prompt payment provisions can be amended to simply provide that the obligation of the health care service plan to comply with these provisions shall not be deemed to be waived when the health care service plan contracts with a medical group, independent practice association, or similar contracting entity.

(CT 194-195.)

The DOC proposal was adopted. (CT 74.) But the original legislative objective of subjecting subcontractors to the statute's prompt payment deadlines remained unchanged. One piece of legislative analysis

in particular makes this clear: First, a Senate Committee paraphrased the bill in its final form:

> This bill would provide that the obligation of health care plans and HMOs to comply with current law, reimbursement requirement of 30 and 45 days, shall not be waived when they delegate payment of claims to a medical group or an IPA.

(CT 98.)

This alone is proof that the bill's only intention was to ensure that the statute's reimbursement deadlines were not sidestepped when a plan used subcontractors to pay claims. Then, the Committee drove the point home:

> *Put in another way*, medical groups and IPAs will be required to meet the existing law on reimbursement requirement of 30 to 45 days.

(CT 98, emphasis added.)

There is not a shred of evidence in the legislative history that anyone, including the CMA, intended the bill to foist liability on plans for the debts of their contracting medical groups – and, significantly, plaintiff cites none.

3. The DOC has completely rejected plaintiff's interpretation of section 1371.

Under Knox-Keene, an administrative agency is given responsibility for the administration and enforcement of the Act, including the authority to adopt rules and regulations to carry out its provisions and to give "interpretive opinions" as to their meaning; until recently, that agency was the DOC. (Former §§ 1341, 1344.) "An agency's expertise with regard to a statute or regulation it is charged with enforcing entitles its interpretation

of the statute or regulation to be given great weight unless it is clearly erroneous or unauthorized." (*Rick's Electric, Inc. v. Occupational Safety & Health Appeals Bd.* (2000) 80 Cal.App.4th 1023, 1033-1034.)

The DOC definitively interpreted section 1371 in relation to the exact issue before this Court. The CMA petitioned the DOC to adopt a regulation under section 1371 that made "[h]ealth plans . . . liable for payment to providers rendering covered services to enrollees, notwithstanding any contractual provisions to the contrary." (CT 21.) The CMA had in mind the very situation faced by plaintiff – a subcontractor bankruptcy causing non-payment of providers who rendered services to plan enrollees. (CT 20-21, 29.)

The DOC refused to adopt the proposed regulation on the ground that neither the plain language of section 1371 nor its legislative history imposed on plans "a liability for the payment of provider claims for which the plans were not otherwise liable, and for which the providers had negotiated compensation terms with another entity." (CT 21, 25.) The DOC determined that:

(1) The "plain meaning of Section 1371 does not require a plan to assume liability for the payment of a claim where no such liability otherwise exists" because "[t]he statute merely sets forth an obligation to process and pay claims in 30 working days" (CT 26);

(2) When originally enacted, the only purpose of section 1371 was "to specify in the law a time period during which a claim must be paid" (CT 23);

(3) The 1996 amendment "had one effect"– to clarify that "plans remained obligated to meet the statutory time period for the payment of claims paid by subcontractors" (CT 23); and

(4) The CMA, who had sponsored the 1996 amendment, itself understood that it merely closed a "loophole" in the statute "where contracting entities were not obligated to ensure that providers were paid within 30 working days" (CT 23).

Most significantly, the DOC found that if section 1371 were construed to foist liability on plans for their subcontractors contract debt, it "would discourage plans from subcontracting with IPAs and medical groups and thereby undermine providers' efforts to form networks." (CT 27.) In other words, the agency charged with enforcing the statute ruled that making plans guarantors for the obligations of their subcontractors would undermine the statutory scheme. If nothing else, that is a fatal objection to plaintiff's lawsuit.

4. Plaintiff's interpretation of section 1371 would compel PacifiCare (and health care plans generally) to pay twice for the same services.

Plaintiff's proposed construction of section 1371 – indeed, its entire case – is grounded in the notion that health care plans can and must be made to pay for the same services twice. Here, plaintiff admits that PacifiCare already paid DPA under the Plan Contract. (CT 417, 418.) That is how capitation is supposed to work. Interpreting section 1371 to compel the kind of double payment plaintiff demands would undermine Knox-Keene's overall statutory scheme. The Legislature intended to encourage

subcontracting and capitation arrangements (see §§ 1342, subd. (d), 1342.6), but making plans responsible for the financial obligations of their subcontractors would clearly discourage that kind of risk transference. That was the precise conclusion of the DOC. (CT 27.)

Moreover, exposing plans to double liability flies in the face of the Legislature's goal of protecting plans from insolvency. (See§ 1375.1 (a)(1) [plans must have "[a] fiscally sound operation and adequate provision against the risk of insolvency"].) The Assembly sponsor of the bill that became section 1371 gave voice to this concern, noting that "since a health care service plan is a high-cost, low-profit business, insolvency can occur in a much shorter period of time than in other types of business." (Assemblyman John T. Knox, letter to Governor Edmund G. Brown, Jr., Sept. 11, 1975, quoted in *Van de Kamp v. Gumbiner* (1990) 221 Cal.App.3d 1260, 1274.) He then singled out a chief reason for plan insolvency: "Plans which have failed in the past have invariably entered into unworkable contracts with providers." (*Ibid.*)

What plaintiff is asking for in this case is an open invitation to plan insolvency – requiring plans who paid capitation to subcontractors additionally to guarantee the subcontractors' contracts with providers, contracts whose terms the plans had no say in negotiating.

C. Section 1371.25 Explicitly Bars Courts From Making Plans Responsible For The Obligations Of Their Subcontractors.

Section 1371.25 provides, in pertinent part, that "[a] plan, any entity contracting with a plan, and providers are each responsible for their

own acts or omissions, *and are not liable for the acts or omissions of, or the costs of defending, others.* Any provision to the contrary in a contract with providers is void and unenforceable." (Emphasis added.)

Could anything be clearer? Under Knox-Keene, PacifiCare cannot even enter into an agreement that makes it responsible for a subcontractor's "acts or omissions" to a provider. Plainly, a court cannot impose such liability on PacifiCare. DPA alone is responsible for its alleged breach of its contractual obligations to plaintiff.

D. No Other Provision Of Knox-Keene Imposes Liability On PacifiCare For DPA's Debts.

Plaintiff's pervasive reliance on section 1371 throughout this litigation betrays its inability to find any other Knox-Keene provision that even arguably requires plans to assume their subcontractors' contractual obligations to providers. The absence of such a requirement anywhere in the statutory scheme is not surprising. As the DOC recognized, "[t]he Legislature has historically permitted the market to dictate the compensation arrangements between plans and providers, including arrangements involving subcontracting entities" and has not evidenced any intent to "require plans to cover any loss that a provider may incur from a business arrangement involving the provision of health care." (CT 27.) And, as we've seen, section 1371.25 affirmatively precludes any such requirement.

Faced with this reality, plaintiff tries a different approach. It argues that the Plan Contract – the capitation arrangement between PacifiCare and DPA – is illegal under section 1349, which makes it unlawful for a plan to

operate without a license unless it "is exempted by the provisions of Section 1343 or a rule adopted thereunder." (AOB 4, 11-12.) The argument is absurd: Section 1349 only applies to plans, not to medical groups or IPAs, and plaintiff concedes that PacifiCare is licensed. (AOB 4.) Moreover, far from pleading that the Plan Contract was illegal, plaintiff pleaded itself a third party beneficiary of the agreement and sought to enforce it. (CT 422.)

Plaintiff acknowledges that risk-sharing agreements like the capitation agreement between PacifiCare and DPA "are not prohibited" by Knox-Keene, but insists that "the Act does require that risk-sharing agreements whereby *full risk* i[s] transferred, must be entered into between two entities licensed under the Act." (AOB 11, emphasis in original.) Tellingly, plaintiff cites no Knox-Keene provision (or any kind of authority, for that matter) to support that statement. Indeed, plaintiff fails to explain what it means for a plan to transfer "full risk" to a subcontractor. It sounds suspiciously like the ordinary capitation situation where a plan subcontracts with a medical group and takes no responsibility for the medical group's contractual obligations to providers. And that's not illegal: Knox-Keene doesn't bar such agreements – indeed, encourages them – and section 1371 (as we've seen) doesn't rewrite them to require plans to pay the contractual obligations of their IPAs.

Plaintiff also cites section 1345, subdivision (f)(1), which defines a "health care service plan" as "[a]ny person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." (AOB 3.) Plaintiff does not explicitly use that section to make

an argument; it simply notes that PacifiCare was licensed as a health care plan, and DPA was not. (AOB 3-4.) So what? Section 1345, subdivision (f)(1) doesn't create a subcontractor licensing requirement. Is plaintiff's point that the Legislature intended to use a definition of a "health care service plan" to enact a requirement that medical groups and IPAs must be licensed before plans may enter into capitation agreements with them? Surely not. If the term "health care service plan" were construed to refer not just to the plan but to its contracting entities, the entire statutory scheme would be thrown off-balance. Certainly, it would not have been necessary for the Legislature to have amended section 1371 in 1996 to extend its statutory deadlines to IPAs if they were already part of the definition of a health care plan.

For the same reasons, section 1343 can't help plaintiff. Subdivision (b) of section 1343 allows the DOC to grant exemptions "from this chapter" if in the public interest and not detrimental to enrollees or persons regulated "under this chapter." Citing that language, plaintiff argues that PacifiCare cannot establish at the demurrer stage "that the intermediary (DPA) to whom it alleges it transferred its risk was granted a limited license or license exemption by the DOC." (AOB 12.) This is a phony issue. First, at the demurrer stage, a defendant is not expected to allege or establish anything. It is the plaintiff who must allege facts to state a cognizable claim. But plaintiff here has not alleged or established that DPA failed to comply with any supposed licensing requirement. The complaint is simply silent on the subject. Second, section 1343, by its terms, doesn't apply to medical groups and IPAs. It allows exemptions to be granted "from this chapter" and expressly provides that "[t]his chapter" applies to "health care

service plans" as defined in section 1345, subdivision (f)(1). (§ 1343, subd. (a).) And, as explained above, that definition does not and cannot include IPAs.

E. Even If Section 1371 Imposed A Duty On Plans To Assume Their Contracting Entities Contractual Obligations To Providers, That Duty Could Not Be Enforced By A Civil Action.

Plaintiff's first cause of action directly seeks to enforce section 1371. (CT 417-418.) In at least two additional claims, plaintiff explicitly pleads a violation of section 1371 and effectively seeks to enforce the statute: the third cause of action for negligence per se is based on violation of section 1371 (CT 418-419) and the tenth cause of action for a declaration as to "whether defendants' [*sic*] failure to pay the Hospital violates" section 1371 and as to the statute's "validity and enforceability . . . as applied to the factual situation set forth herein" (CT 424). In fact, all plaintiff's claims, however labeled, are grounded in the allegation that section 1371 makes plans responsible for paying providers what the plan's subcontractors owe them under contracts to which the plans were not parties; section 1371 is quoted in full and its alleged effect is pleaded in the general allegations and then incorporated by reference in every succeeding cause of action.

But section 1371 cannot be enforced by way of a private action for damages or restitution. The Legislature has vested the right to enforce Knox-Keene exclusively in an agency, first the DOC, and now, the DMC. (Former and current §§ 1341, 1346, 1386, 1387, 1391, 1392, 1393.5, 1394;

Samura v. Kaiser Foundation Health Plan, Inc., supra, 17 Cal.App.4th at p. 1299 [power to enforce Knox-Keene "entrusted exclusively" to DOC]).

1. Knox-Keene is a self-contained scheme to comprehensively regulate and promote health care plans and enforce their compliance with the Act.

Former section 1341 provided that "[r]esponsibility for the administration and enforcement of this chapter is vested in the Commissioner of Corporations." Current section 1341 places the DMC in "charge of the execution of the laws of this state relating to health care service plans and the health care service plan business" and makes the DMC director "responsible for the performance of all duties, *the exercise of all powers and jurisdiction*, and the assumption and discharge of all responsibilities vested by law in the department." (§ 1341, subds. (a) and (c), emphasis added.)

Section 1346, subdivision (a) (current and former) mandates that the pertinent agency head (formerly, the Commissioner; now, the Director) "*shall* administer and *enforce* the provisions of this chapter." (Emphasis added.) The Legislature explicitly empowered the agency head to "[s]tudy, investigate, research, and analyze matters affecting the interests of plans, subscribers, enrollees, and the public" and to "[h]old public hearings, subpoena witnesses, take testimony, compel the production of books, papers, documents, and other evidence." (§1346, subds. (d), (e).)

The Legislature also gave the agency head disciplinary powers; for example, the power to suspend or revoke a plan's license or to "assess administrative penalties" against the plan by way of "a civil action brought

in the name of the people of the State of California." (§§ 1386, 1387.) Such "disciplinary action" may be taken, among other reasons, if a plan engages "in any conduct which constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code." (§ 1386, subd. (b)(7).) Where a plan violates the Act, the Commissioner (or Director) may issue a cease and desist order or seek injunctive or other equitable relief. (§§ 1391, 1392.) The agency head is explicitly authorized to bring an action for civil penalties for violation of the licensing provisions of section 1349. (§§ 1393.5, 1394.)

2. There is no private right of action to enforce Knox-Keene.

The Act itself shows that the Legislature never intended statutory violations to give rise to a private right of action. To begin with, there is no private right of action provided for in Knox-Keene. Moreover, the structure of the Act shows that none was intended:

> the extensive statutory scheme outlined in the Act [shows] that the Legislature intended to occupy completely the field of health service plans. The duty to regulate health plans and protect the public interest is completely vested in the Commissioner and Department of Corporations. . . . Any intrusion into this regulatory function *by seeking remedies in other venues and supplanting that authority* must be viewed with caution.

(*Schmidt v. Foundation Health* (1995) 35 Cal.App.4th 1702, 1713-1714.)

In addition, the Legislature has given the DOC and its successor agency an arsenal of sanctions to impose for violation of the Knox-Keene Act: license suspension, revocation, civil penalties, equitable relief, cease and desist orders. (See, e.g., §§1386, 1387, 1391, 1392.) That, too, evinces

a legislative intent to preclude a private right of action to enforce Knox-Keene. (See *Estate of Starkweather* (1998) 64 Cal.App.4th 580, 588 ["(w)here a statute creates a new right and provides a remedy, that remedy is exclusive"].)

For these and other reasons, courts have refused to supplant the DOC's authority. For example, in *Samura v. Kaiser Foundation Health Plan, Inc., supra*, the court reversed a judgment entered against a plan under Business and Professions Code section 17200, holding that the trial court "improperly sought to enforce compliance" with Knox-Keene. (17 Cal.App.4th at pp. 1301-1302.) The court cited section 1397, which provides for judicial review "if the Department of Corporations fails to discharge its responsibilities under the Knox-Keene Act," but ruled that "courts cannot assume general regulatory powers over health maintenance organizations through the guise of enforcing" civil claims. (*Ibid.*) Even the Attorney General cannot sue a health care plan, since under Knox-Keene "[a]ll of the statutory authority once granted to the Attorney General has been stripped away and is now expressly vested in the [DOC]." (*Van de Kamp v. Gumbiner, supra*, 221 Cal.App.3d at p. 1284.)

Plaintiff has failed to cite any legislative history that shows that the Legislature intended to allow private litigants to sue to enforce the Act. That's fatal: "[W]hen neither the language nor the history of a statute indicates an intent to create a new private right to sue, a party contending for judicial recognition of such a right bears a heavy, perhaps insurmountable, burden of persuasion." (*Crusader Ins. Co. v. Scottsdale Ins. Co.* (1997) 54 Cal.App.4th 121, 133 [affirming dismissal of suit

alleging violation of regulatory statute because nothing in the legislative history suggests a legislative intent to create a private right to sue].)

So here – there is no provision in the Act allowing private damages lawsuits; there is no legislative history showing an intention to allow private suits; on the contrary, the Act and its history demonstrate an intent to vest exclusive jurisdiction in the DOC. Therefore, even if Knox-Keene made PacifiCare responsible for DPA's debts – and the statute does nothing of the kind – plaintiff is limited to the administrative remedies under the Act. It cannot sue civilly to enforce the Act, or to recover damages for its violation.

II. PLAINTIFF HAS NOT ALLEGED AND CANNOT ALLEGE VALID NEGLIGENCE CLAIMS: PACIFICARE OWED PLAINTIFF NO DUTY TO PROTECT IT FROM DPA'S INSOLVENCY OR TO PAY IT WHAT PACIFICARE WAS CONTRACTUALLY BOUND TO PAY TO DPA.

In its second amended complaint, plaintiff alleged, for the first time, that PacifiCare had a duty to plaintiff to ensure that DPA was financially able to pay plaintiff (CT 418-419), knew or should have known that DPA was unable to do so (CT 417), and breached that duty by paying capitation to DPA rather than paying plaintiff (CT 417-419). In dismissing all plaintiff's negligence claims, the trial court found "as a matter of law that Plaintiff has not alleged sufficient facts to establish a duty of health care service plans to ensure the financial stability of contracting medical

providers" and that "[s]ection 1371 does not provide a basis for the imposition of such a duty." (CT 485.)

In the opening brief, plaintiff argues that its complaint did allege sufficient facts to "form the basis of a meritorious negligence claim"; and, at any rate, that "it should have been afforded at least an opportunity to amend the claims and include additional facts." (AOB 6.) And, while it no longer even mentions section 1371 as a source of a duty of care in negligence, plaintiff asserts, for the first time on appeal, that a regulatory provision, section 1300.70, subdivision (b)(2)(H), imposes duties on licensed health care plans for the benefit of medical providers; specifically, that a plan must ensure that subcontractors are able to pay medical providers with whom they contract. (AOB 8.)

Plaintiff is wrong on every count. It admits "that generally a person owes no duty to control the conduct of another." (AOB 7.) But, plaintiff argues, "exceptions are recognized where a special relationship exists between the Defendant and the active wrongdoer or a statute imposes such a duty." (AOB 7.) So what? Neither condition is met here. First, California recognizes "special relationships" only in the context of one party assuming responsibility for the *physical* well-being of another. Plaintiff cites no case – and none exists – in which a court has imposed affirmative duties on a third party to protect one business entity from the *financial* consequences of its contract with another.

This case shows why. Plaintiff's case reduces to the allegation that PacifiCare breached an affirmative duty to plaintiff when it paid capitation to DPA, as it was required to do under the Plan Contract, rather than paying plaintiff what DPA owed plaintiff under the Hospital Contract. (CT 417-

419.) In other words, according to plaintiff, PacifiCare had a duty to breach its contract with DPA. Not surprisingly, plaintiff cites no support for *that* proposition.

Nor does "a statute impose[] such a duty." We've seen that section 1371 only requires plans and their subcontractors to pay claims within specified statutory deadlines. It does not require plans to stand surety for their contracting medical groups or to ensure their financial stability before paying them. And if section 1300.70, subdivision (b)(2)(H) imposes a duty on plans, that duty runs to the plan's enrollees, not to third party providers.

Finally, any such tort duty would directly conflict with Knox-Keene by undermining the capitation arrangements that the statute seeks to encourage and trespassing on the exclusive regulatory preserve of the DOC.

A. Contrary To Plaintiff's Contentions, A Defendant Has No Common Law Duty To Protect A Plaintiff From Financial Harm Due To A Third Party's Conduct.

As a general rule, a person owes no duty to control the conduct of another, "nor to warn those endangered by such conduct." (*Tarasoff v. Regents of University of California* (1976) 17 Cal.3d 425, 435.) There is a limited exception to this rule: The law will impose a duty "in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct." (*Id.* at p. 435.)

The exception only applies (or, put another way, a special relationship will only be found) in cases where the relationship between the defendant and either the victim or perpetrator is one of dependence and

where inaction threatens a person's physical well-being. Thus, psychotherapists had a duty to warn a victim and her parents that a mental outpatient had threatened to kill her. (*Ibid.*) Common carriers and innkeepers have special relationships with their passengers and guests "'to protect them against unreasonable risk of physical harm.'" (*Peterson v. Superior Court* (1995) 10 Cal.4th 1185, 1206.) A police officer had a special relationship to a stranded motorist who was injured by a passing motorist because of the officer's inaction. (*Mann v. State of California* (1977) 70 Cal.App.3d 773, 779-781, superseded by Gov. Code, § 820.25.)[5]

But no special relationship exists where the threat posed by a third party is only to a plaintiff's *financial* well-being, let alone where the injured party (here, a hospital) and the alleged tortfeasor (here, an IPA) were sophisticated business entities who were in no way dependent on the defendant health plan. We have found no case imposing an affirmative duty on a defendant to control or to warn another about a third person's conduct in those circumstances. Nor has plaintiff.[6]

5/ Though dependency and potential physical harm are necessary conditions, even they are not always sufficient, to impose an affirmative duty to protect a person from third party negligence. Thus, in *Nally v. Grace Community Church* (1988) 47 Cal.3d 278, the court refused to find a special relationship between a suicidal individual and religious counselors who knew of her prior suicides, because "[m]ere foreseeability of the harm or knowledge of the danger is insufficient to create a legally cognizable special relationship giving rise to a legal duty to prevent harm." (*Id.* at pp. 294, 297.)

6/ None of plaintiff's cases validates its negligence claims. As we've seen, *Tarasoff* (cited AOB 7-8) found a special relationship where psychotherapists knew that a mental patient under their care had threatened to kill plaintiffs' daughter. Clearly, a far cry from the present case. *Rowland v. Christian* (1968) 69 Cal.2d 108 (cited AOB 7) did not involve the issue of when a person has a duty to control or warn another of the

Specifically, plaintiff argues that PacifiCare was negligent in contracting with DPA in the first place and then in failing "to monitor the performance or financial stability of DPA after the contract was signed." (AOB 8.) Our Supreme Court has rejected strikingly similar tort claims in *Nipper v. California Auto. Assigned Risk Plan* (1977) 19 Cal.3d 35. There, an automobile accident victim sued a state assigned risk insurance plan ("CAARP"), alleging that it owed a common law duty to the motoring public to take affirmative steps to ensure that incompetent drivers are denied insurance and thereby inhibited to drive. (*Id.* at p. 46.) The Supreme Court rejected this reasoning and affirmed the trial court's decision to dismiss the case on demurrer. The court held:

> Plaintiff has cited no authority, and we are aware of none, which suggests that an insurer (or other person to whom an application for insurance is tendered) either stands in a special relationship with the applicant or his potential victims, or alternatively owes any affirmative duty of inquiry or disclosure regarding the applicant.

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conduct of a third person. Plaintiff cites *Rowland* for its description of the factors a court must consult in determining whether a duty of care exists. But in *Tarasoff*, the Supreme Court makes clear that those general factors are trumped by the specific common-law rule that governs the present case: "[W]hen the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person or to the potential victim." (17 Cal.3d at p. 435.)

J'Aire Corp. v. Gregory (1979) 24 Cal.3d 799 (cited at AOB 9) also did not involve the issue of whether a defendant had a duty to warn another of a third party's conduct; rather, the issue there was the defendant's own negligent failure to timely complete construction. At any rate, plaintiff only cites the case for the general principle that a duty of care may be based on contract, statute, or the surrounding circumstances of the parties' relationship. (*Id.* at p. 803, cited at AOB 9.) But, again, the common law rule that there is no duty to control a third party absent a special relationship takes precedence over that kind of general language.

(*Id.* at p. 47.)

The court also refused to find a duty of care in the fact that CAARP was "statutorily authorized" or of a "'quasi-public' nature." (*Ibid.*) "[T]hat fact alone," the court stated, "is an insufficient basis upon which to predicate a common law duty to the motoring public in general, or to plaintiff in particular." (*Ibid.*)

So, in the present case, PacifiCare has no special relationship with IPAs with whom it contracts or with providers with whom the IPAs contract. And the fact that PacifiCare has certain statutory duties to its enrollees is also "an insufficient basis upon which to predicate a common law duty" to third party providers who contract with PacifiCare's contracting medical groups or IPAs.

The case law confirms the common sense of the matter: A court may not impose an affirmative duty on a health plan to safeguard and protect a large hospital from the financial consequences of a contract it freely entered into with the plan's IPA. This is particularly so where, as here, such a duty would force a plan to pay twice for the same services, threatening its solvency and undermining the statutory purpose of encouraging capitation and the transfer of risk. (Cf. *Nally v. Grace Community Church*, *supra*, 47 Cal.3d at p. 297 [no affirmative duty on religious counselors to refer clients to psychiatrists because that "may stifle all gratuitous or religious counseling"].)

B. Contrary To Plaintiff's Contentions, A Health Care Plan Has No Statutory Duty To Protect The Financial Health Of A Provider Who Contracts With The Plan's Contracting Medical Group Or IPA.

We have shown above that section 1371 imposes no duty on health plans to investigate and guarantee the solvency of their contracting IPAs. Accordingly, that section cannot be the basis of a duty in tort to providers who contract with those groups. (See *Shin v. Kong* (2000) 80 Cal.App.4th 498, 504-505; *Nipper v. California Auto. Assigned Risk Plan, supra*, 19 Cal.3d at pp. 40-46.) Since section 1371 was not designed to prevent the conduct that plaintiff complains of, i.e, since the statute creates no duty that PacifiCare violated, it clearly cannot support the presumption of negligence available under Evidence Code, section 669, subdivision (a). (See *Victor v. Hedges* (1999) 77 Cal.App.4th 229, 235-236.)

On appeal, plaintiff appears to abandon section 1371 as the statutory basis for creating a duty of care running from PacifiCare to plaintiff hospital. Plaintiff does not mention section 1371 in the section of its brief entitled "The Negligence Claims" (AOB 6-9) and it does not mention its negligence claims or discuss the issue of duty of care in the section of its brief dealing with section 1371 (AOB 13-20). Instead, it cites for the first time on appeal one isolated subpart of an administrative regulation, section 1300.70, subdivision (b)(2)(H). (AOB 8.) That subpart provides that "[a] plan that has capitation or risk-sharing contracts must . . . [e]nsure that each contracting provider has the administrative and financial capacity to meet its contractual obligations."

But, as the rest of section 1300.70 shows, that obligation runs to and is intended only for the benefit of enrollees. Far from imposing duties on plans for the benefit of third party providers that have freely entered into their own contracts with IPAs, section 1300.70 is transparently about each plan's "responsibility for reviewing the overall quality of care delivered to plan enrollees." (§ 1300.70, subd. (b)(2)(G).)[7] Therefore, plaintiff hospital may not state a negligence claim based on an alleged breach of duty owed to enrollees. (See *Hoff v. Vacaville Unified School Dist.* (1998) 19 Cal.4th 925, 938-939.)

Why would section 1300.70 turn plans into guarantors of their subcontractors' contractual promises to providers? The resulting effect on plans – which would invariably find themselves paying twice for the same services – would undermine "the overall quality of care delivered to plan enrollees" that section 1300.70 is intended to ensure.

7/ For example, the regulation enforces statutory section 1370, which requires plans to establish procedures "for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs." In addition, the regulation's "intent and regulatory purpose" is the maintenance of quality assurance in the delivery of health care to enrollees. (§ 1300.70, subd. (a)(1).) Thus, each plan's quality assurance program shall be designed to ensure that "a level of care which meets professionally recognized standards of practice is being delivered to all enrollees." (*Id.*, subd. (b)(1)(A).) The very subdivision plaintiff quotes also provides that plans "[h]ave a mechanism to detect and correct under-service by an at-risk [contracting] provider (as determined by its patient mix) including possible under utilization of specialist services and preventive health care services." (*Id.*, subd. (b)(2)(H).) The focus there is clearly on the relationship between the plan's IPAs and enrollees, not the relationship between the IPAs and the third party providers with whom they contract.

C. Contrary To Its Contentions, Plaintiff Is Not Automatically Entitled To Leave To Amend To Replead Its Negligence Claims. It Must Show What New Facts It Would Plead Were It Granted Leave To File A Third Amended Complaint – And That Plaintiff Has Not Done.

Plaintiff insists that since its "negligence based claims" are "new to the Second Amended Complaint," "it should have been afforded at least an opportunity to amend the claims and include additional facts." (AOB 6.) But plaintiff has never set out those supposed "additional facts" – not to the trial court, not on appeal. That's fatal.

"A trial court does not abuse its discretion when it sustains a demurrer without leave to amend if . . . the facts and the nature of the claims are clear and no liability exists." (*Cantu v. Resolution Trust Corp.* (1992) 4 Cal.App.4th 857, 890.) As we've shown, that's this case. But even were plaintiff's claims not foreclosed as a matter of law, it still must plead something more than the facts pleaded in its dismissed complaint in order to demand leave to amend as a matter of course: "[T]he burden falls squarely on [a plaintiff] to show what facts he could plead to state a cause of action if allowed the opportunity to replead. [Citation.] To meet this burden, a plaintiff must submit a proposed amended complaint or, on appeal, enumerate the facts and demonstrate how those facts establish a cause of action. [Citations.] Absent such a showing, the appellate court cannot assess whether or not the trial court abused its discretion by denying leave to amend." (*Ibid.*)

Plaintiff did not file a proposed amended complaint when it opposed the demurrer below and it has not set out any new facts in its opening brief.

Plaintiff is not entitled to plead again simply because its negligence claims were "new" to its third complaint, when it has so cavalierly failed to show what new facts it could possibly allege that would make a difference.

III. PLAINTIFF HAS NOT ALLEGED AND CANNOT ALLEGE A VALID CLAIM AGAINST PACIFICARE UNDER THE UNFAIR COMPETITION LAW.

Plaintiff challenges the trial court's dismissal of its claim for unfair competition under Business and Professions Code section 17200 et seq., the Unfair Competition Law ("UCL"). (AOB 9-13.) Plaintiff pleaded an unfair competition claim for the first time in its Second Amended Complaint based on the allegation that "Defendant health plan have [*sic*] required waivers from the Hospital and insisted that the Hospital look only to the intermediary for payment for services rendered to [plan] enrollees." (CT 420.) Plaintiff further alleged that requiring such waivers "and failing to pay for services for which the Defendant received premiums, and the Plaintiff provided to the Defendant's enrollees, constitutes an unfair business practice" under section 17200. (CT 420.)

The trial court dismissed this cause of action without leave to amend, finding it invalid for three independent reasons:

- Plaintiff failed to allege "facts establishing any conduct by PacifiCare that is unlawful, unfair or fraudulent within the meaning of" section 17200. (CT 485.)
- The section 17200 cause of action "essentially seeks to regulate the provisions of health care service plan agreements, a task which

has been entrusted exclusively to the Department of Corporations." (CT 485.)

- The "contractual arrangement[s] at issue have been expressly allowed by the California Legislature and approved by the Department of Corporations." (CT 485.)

The trial court was correct on every ground. PacifiCare has no obligation to pay plaintiff what DPA owes it under a contract to which PacifiCare was not a party. As we've shown, PacifiCare has no duty to do so under Knox-Keene or the law of negligence. As we show below, PacifiCare has no contract duty to plaintiff, and on appeal plaintiff has abandoned its contract claims. Section 17200 is plaintiff's last hope for finding a way to make PacifiCare pay plaintiff its business loss, now by way of an award of restitution under the UCL. Section 17200 stretches far – but not that far.

The California Supreme Court and lower appellate courts have repeatedly recognized that section 17200 does not, notwithstanding its broad scope, "give the courts a general license to review the fairness of contracts" (*Samura v. Kaiser Foundation Health Plan, Inc.*, *supra*, 17 Cal.App.4th at p. 1299, fn.6), or allow them to "engage in complex economic regulation under the guise of judicial decisionmaking" (*Harris v. Capital Growth Investors XIV* (1991) 52 Cal.3d 1142, 1168). Nor may courts declare a practice "unlawful" or "unfair" under the UCL, where the state has itself specifically declared the practice to be lawful. (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 182 ["If the Legislature has permitted certain conduct or considered a situation and concluded no action should lie, courts may not

override that determination"].) Yet, these are precisely the transgressions plaintiff urges this court to commit.

Indeed, plaintiff's section 17200 claim is nothing short of a declaration of war on Knox-Keene. Thus, plaintiff argues in the opening brief that it "is an unfair and fraudulent business practice" for PacifiCare to require providers "to waive their rights to seek payment for covered services from the patient or from PacifiCare as a condition of providing services to its insureds" and that "[b]y mandating that the health care provider assume PacifiCare's risk," though it "collects the premiums, PacifiCare is unfairly, and fraudulently attempting to relinquish its responsibly [*sic*] to its enrollees and subscribers by transferring the very risk it collects premiums to cover." (AOB 10.)

Unfair and fraudulent for a health care plan to enter capitation arrangements that protect *patients and plans* from exactly the kind of direct charges that plaintiff would like to use here? Not according to the Legislature. Not according to the DOC. Plaintiff's complaint is with them, and with Knox-Keene, not with a defendant who has just been following the rules.

A. Plaintiff Has Not Alleged And Cannot Allege Any Unlawful Practices By PacifiCare.

Contrary to plaintiff's contentions, it is not illegal for a health care plan to enter into capitation arrangements with medical groups and IPAs that then contract with providers who have no direct contractual relationship with the plan. As we've shown, that is specifically what Knox-Keene contemplates as a vehicle for transferring risk from patients to

providers. As we've also shown, PacifiCare has no common law duty to pay plaintiff for services it rendered to plan enrollees under a contract with DPA; the imposition of such a duty would discourage the kind of capitation arrangements encouraged by Knox-Keene.

It follows that a plan does nothing illegal if it requires providers who contract with its IPAs "to waive their rights to seek payment for covered services from the patient or [the plan] as a condition of providing services to its insureds." (AOB 10.) That is the effect of capitation arrangements in any event. Plaintiff cites no statute that makes it illegal for a health plan to require waivers that make providers look for payment to the IPAs with whom they contract, or otherwise to refuse to pay providers for losses sustained if the IPAs become insolvent. As we've shown, section 1371 plainly does nothing of the kind.[8]

8/ In its Second Amended Complaint (CT 415), plaintiff cited Civil Code section 3513, one of the codified maxims of jurisprudence, which allows a person to "waive the advantage of a law intended solely for his benefit," but provides that "a law established for a public reason cannot be contravened by a private agreement." However, the statute is not cited in plaintiff's opening brief and plaintiff makes no argument based on its terms. That means any argument based on the statute has been waived. (See *Badie v. Bank of America* (1998) 67 Cal.App.4th 779, 784-785 ["[T]he briefs do not even so much as cite to the [statutes on which the complaint is based], much less discuss their provisions or their application to the evidence presented at trial and to the causes of action framed under them. When an appellant fails to raise a point, or asserts it but fails to support it with reasoned argument and citations to authority, we treat the point as waived"].)

In fact, section 3513 is completely irrelevant to this case. The statute only comes into play if a party's case depends on a private agreement that purports to contravene a law established for a public reason. But that's not this case. First, plaintiff never managed to allege below any "private agreement" between PacifiCare and itself, and, as shown hereafter, has now abandoned all its contract claims on appeal. (See pp.47-48, *post.*) Second, no law prevents a plan from requiring a provider to waive any right

Plaintiff concedes that "risk-sharing agreements themselves are not prohibited by the Knox-Keene Act"; but, it argues, if the plan transfers "*full risk*," then the agreement is illegal unless the plan's contracting IPA is licensed under the Act. (AOB 11.) And plaintiff insists PacifiCare "did not establish that the risk-sharing agreement which it entered into with its chosen intermediary *complied* with the Knox-Keene Act requirements for such full risk agreements." (AOB 11.)

Plaintiff has things backwards. At the demurrer stage, it is plaintiff who has to "establish" facts in the sense of pleading sufficient facts to state a claim or at least asserting the facts it would plead if it were given a fourth chance to plead claims against PacifiCare. But plaintiff hasn't done that. Plaintiff never pleaded this theory of illegality in any of its complaints. Now, on appeal, plaintiff studiously fails to show *what* "Knox-Keene Act requirements" for "full risk agreements" the Plan Contract did not comply with. We have shown elsewhere (pp. 21-24, ante) that the two Knox-Keene provisions plaintiff does cite (§§ 1343, subd. (b) and 1349) only require that health care plans are licensed, and plaintiff concedes that PacifiCare is licensed under the Act. (AOB 4.)

In sum, it is untenable to assert, as plaintiff does, that a practice which furthers the explicit goal of a statutory scheme – to require providers to bear the risk of payment; to protect the solvency of plans – and is specifically approved by a government agency (here, the DOC), may nonetheless be deemed "illegal." As previously noted, it is not surprising that California courts have uniformly held that where, as here, a challenged

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it might have to sue the plan or its enrollees for monies owed to the provider by a subcontractor. Hence, section 3513 is inapplicable.

practice is specifically authorized by the state, the practice cannot, as a matter of law, be deemed to be "illegal" under the UCL. (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.*, *supra*, 20 Cal.4th at p. 183; *Lazar v. Hertz Corp.* (1999) 69 Cal.App.4th 1494, 1505-1506 [where Civil Code section 1936 authorizes rental car companies to set limitation on age of renter, no UCL claim can be brought based upon purported unlawfulness of practice]; *Hobby Industry Association of America, Inc. v. Younger* (1980) 101 Cal.App.3d 358, 370.)

B. Plaintiff Has Not Alleged And Cannot Allege Any Unfair Practices By PacifiCare.

As we've seen, plaintiff doesn't like capitation. It argues that "a business policy" that requires it to accept a plan's risk "with no 'sharing' of the policy premium" under circumstances that will require it "to provide medical services which are PacifiCare's obligation to 'cover,' free of charge, is both unfair and deceptive." (AOB 12.) Plaintiff is wrong.

PacifiCare's so-called "business policy" is not unfair because "[a] business practice cannot be unfair if it is permitted by law." (*Lazar v. Hertz Corp.*, *supra*, 69 Cal.App.4th at p. 1505.) In *Schnall v. Hertz Corp.* (2000) 78 Cal.App.4th 1144, for example, the trial court sustained without leave to amend a demurrer to a UCL claim premised upon an alleged "unfair" practice, and the appellate court affirmed, on the ground that the practice in question was specifically authorized by statute, and hence could not constitute an "unfair" practice under section 17200. (78 Cal.App.4th at p. 1160 ["where the allegedly unfair business practice has been authorized

by the Legislature, no factual or equitable inquiry need be made, as the court can decide the matter *entirely on the law,*" emphasis added].)

Similarly here, as a matter of law, the practices in question cannot be deemed "unfair" under section 17200 because, as noted above, they are expressly authorized by and in furtherance of the Knox-Keene Act and approved by the Department of Corporations.

In addition, plaintiff is not an unwary "consumer" but a large hospital who freely entered into an agreement with DPA to further its business interests. Plaintiff knew it had no right to demand payment from PacifiCare, an entity with whom it had no contractual relationship. Even when it was pursuing its contract claims – now abandoned – plaintiff never alleged that it only contracted with DPA on the assumption that PacifiCare was standing behind DPA's contractual obligations, or that any such promise was contained in the Hospital Contract, plaintiff's contract with DPA.

In *South Bay Chevrolet v. General Motors Acceptance Corp.* (1999) 72 Cal.App.4th 861, a car dealership brought an action against a lender on behalf of itself and the general public asserting that the lender used an improper method to calculate interest and did so without specific contractual authorization and disclosure. Plaintiff asserted that the practice was "unfair" under the UCL. However, the Court of Appeal held the practice could not be deemed "unfair" under section 17200 because "South Bay entered into the disputed loan agreements knowing, understanding, agreeing and expecting that GMAC would use the 365/360 method to calculate interest." (72 Cal.App.4th at p. 887.) Similarly here, plaintiff has never alleged that it entered into the Hospital Contract without full

knowledge that PacifiCare was not a party and had not agreed to any kind of guaranty of the obligations of DPA to PacifiCare. Far from it: Plaintiff now pleads that it was forced to look only to DPA for payment, and still plaintiff entered the contract.

Finally, if anything in this scenario is "unfair," it is plaintiff's contention that a health care plan should bear all risk of loss from the insolvency of its contracting IPAs and that a provider hospital should bear no risk of loss at all. Worse yet, plaintiff's case rests on the notion that PacifiCare should be compelled to suffer a double loss – losing what it paid to DPA, and then having to pay plaintiff what DPA owed it. To make PacifiCare pay twice, would be unfair to it, and even more to the enrollees who depend on its solvency.

C. Plaintiff Has Not Alleged And Cannot Allege Any Fraudulent Practices By PacifiCare.

"The 'fraud' contemplated by section 17200's third prong bears little resemblance to common law fraud or deception. The test is whether the public is likely to be deceived." (*South Bay Chevrolet v. General Motors Acceptance Corp.*, *supra*, 72 Cal.App.4th at p. 888, internal quotes omitted.) Below, plaintiff alleged no facts showing fraud of any variety. On appeal, plaintiff argues that "those members who are covered under a PacifiCare policy . . . would be mislead [*sic*] and deceived if they were assured by PacifiCare that their covered medical needs would be provided for by PacifiCare, when in fact PacifiCare mandated that the physicians and hospitals, who were actually providing the covered services do so at their own risk of never being paid." (AOB 12.)

The argument is a red herring. Significantly, plaintiff has not alleged or argued that any PacifiCare enrollee has been denied services because of DPA's bankruptcy. Nor could it: PacifiCare's obligations to its enrollees are unaffected by a subcontractor bankruptcy; either the plan uses a different subcontractor (usually, plans have more than one) or it pays providers on a fee-for-service basis. Neither the general public nor enrollees are defrauded or harmed by a policy that ensures that the each contracting party bear its own loss.

That's the view of the DOC – which rejected this very argument in refusing CMA's efforts to make plans pay physician losses due to the FHP bankruptcy. If faced with an insolvency, the DOC stated, its "primary obligation is to ensure the health and safety of plan enrollees." (CT 27.) Thus, "even more critical and pressing than assisting providers in obtaining compensation for health care services, the Department must ensure that insolvency does not disrupt access and continuity of care for plan enrollees." (CT 27-28.) To prevent such a disruption, the DOC recognized that it had to protect the solvency of plans – because each has a continuing obligation to "provide all medically necessary health care . . . regardless of the duties it has delegated to subcontractors." (CT 28.) On the other hand, if providers who contracted with a bankrupt subcontractor were not left to bear the loss of that insolvency, but the loss was foisted on health care plans instead, that would prejudice enrollees. Hence, the DOCs refusal to countenance such an argument.

In sum, plaintiff did not, and indeed could not, allege a valid claim under Business and Professions Code section 17200. Thus, the demurrer was properly sustained without leave to amend and the claim dismissed.

D. Plaintiff May Not Use Section 17200 To Supplant Agency Jurisdiction To Administer And Enforce Knox-Keene.

We have shown above that plaintiff may not civilly enforce the regulatory provisions of Knox-Keene, either directly or under the guise of suing for common law damages or restitution under Business and Professions Code section 17200. (See pp. 24-28, ante.) Thus, in *Samura v. Kaiser Foundation Health Plan, Inc., supra*, the court reversed a judgment entered against a plan under the section 17200, holding that "courts cannot assume general regulatory powers over health maintenance organizations through the guise of enforcing . . . section 17200." (17 Cal.App.4th at pp. 1301-1302.) And in *Schmidt v. Foundation Health, supra*, 35 Cal.App.4th 1702, the court affirmed the trial court's order sustaining demurrers to plaintiff's civil complaint challenging the legality of a regulation enacted under Knox-Keene.

That is precisely what plaintiff is doing in the present case – challenging Knox-Keene's acceptance of capitation arrangements to transfer risk to providers and claiming to be acting on the basis of a public interest. But *Schmidt* held that "[t]he duty to regulate health plans and protect the public interest is completely vested in the Commissioner and Department of Corporations." (*Id.* at p. 1714.)

IV. PLAINTIFF HAS ABANDONED ITS CONTRACT CLAIMS BY FAILING TO ARGUE THEM ON APPEAL.

Plaintiff's Second Amended Complaint pleaded breaches by PacifiCare of an express contract, an implied contract, a third party beneficiary contract between PacifiCare and DPA, and a third party beneficiary contract between PacifiCare and enrollees. In its prior complaints, plaintiff alleged a written contract between itself and PacifiCare and pleaded itself a third party beneficiary of the Plan Contract between PacifiCare and DPA. Plaintiff argued the sufficiency of those claims in its points and authorities below, complete with case law citations. (CT 399, 471-472.) However, it has argued none of those points in its opening brief on appeal. "A point not presented in a party's opening brief is deemed to have been abandoned or waived." (*Humes v. MarGil Ventures, Inc.* (1985) 174 Cal.App.3d 486, 493; accord *McGettigan v. BART*, 57 Cal.App.4th 1011, 1016 n.4 (1997) (on appeal from the sustaining of a demurrer without leave to amend, claims are deemed "abandoned for lack of argument that the trial court erred in dismissing them").) The absence of argument and citation to authority in an appellate brief permits courts to treat issues and claims as waived. (*Interinsurance Exchange v. Collins* (1994) 30 Cal.App.4th 1445, 1448.)[9]

9/ Plaintiff never pleaded a sufficient contract claim. It alleged a written contract between itself and PacifiCare, but never attached it to its complaints or alleged its terms. That renders the claim insufficient as a matter of law. (See *Harris v. Rudin, Richman & Appel* (1999) 74 Cal.App.4th 299, 307.) It pleaded breach of an implied contract, without specifying whether the contract was implied in fact or in law. Either way,

CONCLUSION

For all the foregoing reasons, PacifiCare requests that the court affirm the judgment.

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Respectfully submitted,

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the claim failed. If the former, plaintiff failed to allege the conduct that gave rise to the implied contract; if the latter, plaintiff itself disproved any assertion that PacifiCare had been unjustly enriched, because plaintiff admitted that it was obliged to perform its services under its contract with DPA and PacifiCare made capitation payments to DPA to cover such services. (See e.g. *Major-Blakeney Corp. v. Jenkins* (1953) 121 Cal.App.2d 325, 340-41; *Truestone, Inc. v. Simi West Industrial Park II* (1984) 163 Cal.App.3d 715, 724 ["subcontractor, who has no direct contractual relationship with the property owner, may generally not recover on an unjust enrichment theory for benefits conferred on the property"].) Lastly, plaintiff pleaded itself a third party beneficiary of PacifiCare's contracts with respectively its enrollees and DPA, but plaintiff may not enforce such contracts unless they were expressly made for its benefit and that fact appears on the face of each contract. (See *Bancomer, S. A. v. Superior Court* (1996) 44 Cal.App.4th 1450, 1458-1459.) But plaintiff twice chose not to plead those essential allegations. (CT 410, 486.)