CENTINELA FREEMAN EMERGENCY MED. ASSOCS. v. HEALTH NET OF CALIFORNIA, INC.

S218497
Supreme Court of California
May 13, 2014

Reporter: 2014 CA S. Ct. Briefs LEXIS 443
CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES, ET AL., Plaintiffs and Appellants, vs. HEALTH NET OF CALIFORNIA, INC., ET AL., Defendants and Respondents.

Type: Petition for Appeal

Prior History: After An Opinion By The Court Of Appeal Second Appellate District, Division Three, No. B238867. Appeal From A Judgment Of Dismissal Following Demurrer. Los Angeles County Superior Court, Case No. BC415203. Honorable John Shepard Wiley.

Counsel

[*1] *Margaret M. Grignon (SBN 76621), Kurt C. Petersen (SBN 83941), Kenneth N. Smersfelt (SBN 166764), Zareh A. Jaltorossian (SBN 205347), Reed Smith LLP, Los Angeles, CA, Attorneys for Defendant and Respondent Blue Cross of California dba Anthem Blue Cross.

William A. Helvestine (SBN 58755), CROWELL & MORING, LLP, San Francisco, CA, Attorneys for Defendant and Respondent Health Net of California Inc.

Jennifer S. Romano (SBN 195953), Crowell & Moring LLP, Los Angeles, CA, Attorneys for Defendant and Respondent Pacificare of California dba Secure Horizons Health Plan of America.

Gregory N. Pimstone (SBN 150203), Joanna S. McCallum (SBN 187093), Jeffrey J. Maurer (SBN 190183), Manatt, Phelps & Phillips, LLP, Los Angeles, CA, Attorneys for Defendant and Respondent California Physicians' Service dba Blue Shield of California.

Don A. Hernandez (SBN 125119), Jamie L. Lopez (SBN 260721), Gonzalez Saggio & Harlan LLP, Pasadena, CA, Attorneys for Defendant and Respondent SCAN Health Plan.

Richard J. Doren (SBN 124666), Heather L. Richardson (SBN 246517), Gibson, Dunn & Crutcher, Los Angeles, CA, Attorneys for Defendant and Respondent Aetna Health of California.

William **[*2]** P. Donovan, Jr. (SBN 155881), Cooley LLP, Santa Monica, CA, Attorneys for Defendant and Respondent Cigna HealthCare of California, Inc.

Title

Petition For Review

Text

Service on the Attorney General and the Los Angeles District Attorney Required by Bus. & Prof. Code § 17209 and Cal. Rules of Court, rule 8.29(a) and (b)

I.

INTRODUCTION

This petition presents an important issue affecting the health care industry and as to which the published Court of Appeal authorities have been in sharp conflict for a decade: whether a health care service plan owes a tort duty to

reimburse non-contracted emergency physicians for services rendered to the plan's enrollees, when the plan has delegated its payment responsibilities to an independent physicians association, pursuant to statute, and the independent physicians association becomes financially insolvent. Although the Court of Appeal held that such a duty existed, it acknowledged:

> In addressing this question, we are not writing on a clean slate. Two courts have addressed the question directly, reaching contradictory results. (Compare *California Emergency Physicians Medical Group v. PacifiCare of California (2003) 111 Cal.App.4th 1127, 1135-1136* **[*3]** (*CEP*) [finding no negligence cause of action] with *Ochs v. PacifiCare of California (2004) 115 Cal.App.4th 782, 796-797* (*Ochs*) [finding such a cause of action exists].)

(Opn. 17, attached hereto as Ex. A.)

This Court should grant review to resolve the conflict and provide clarity on a question that has wide-ranging implications for the California health care industry, including health plans, emergency and other physicians, and, most importantly, the health plan members that industry serves.

The Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code § 1340 *et seq*. (the ″Act″) is a comprehensive statutory and regulatory scheme that is designed to ensure quality health care at low cost through a system of managed care and-a key component-*delegated risk*. Under that system, patients transfer the risk of health care costs to health care service plans, which may further transfer the risk to health care providers. The Act provides for the regulation of all entities in this delegated model to ensure their financial stability.

To these ends, Health and Safety Code section 1371.4 [1] requires that health care service plans reimburse **[*4]** emergency care providers for services rendered to the plan's enrollees, even when the emergency care providers have no contracts with the health plan. It also provides, however, that health plans may delegate their reimbursement responsibilities to the plan's contracting medical providers, known as risk bearing organizations (″RBO″) or independent physicians associations (″IPA″). Under the Act's implementing regulations, the Department of Managed Health Care (″DMHC″) must monitor the financial solvency of health plans and IPAs and implement processes to rehabilitate financially troubled IPAs. The statute requires health plans to cooperate with the DMHC's rehabilitation processes.

In this case, plaintiffs are emergency room physicians who allegedly provided emergency services to enrollees of the Health Plans' delegated IPA, La Vida Medical Group, Inc., and with whom plaintiffs had no contracts. Plaintiffs allege that La Vida failed **[*5]** to reimburse them when it became insolvent several years after the delegation. Plaintiffs sued the Health Plans, alleging that they negligently delegated their reimbursement responsibilities to La Vida. Plaintiffs claim the Health Plans knew or should have known that La Vida would be unable, in the future, to meet its financial obligations to plaintiffs.

In a published decision, Division Three of the Second Appellate District held that neither section 1371.4's express authorization of delegation arrangements nor the comprehensive statutory scheme regulating the managed care system precludes imposing negligence liability on health plans arising from such delegations. Applying the factors in *Biakanja v. Irving (1958) 49 Cal.2d 647* (*Biakanja*) for evaluating the existence of a tort duty involving economic relationships, the Court of Appeal concluded that the Health Plans could have a tort duty to plaintiffs if they knew or should have foreseen that the delegated IPA would not pay non-contracted emergency physicians. The Court of Appeal further held that a health plan's duty is a continuing one, such that, when a health plan discovers that a contracted IPA is unable **[*6]** to meet its obligations, it must re-assume the obligation to reimburse non-contracted emergency physicians. In reaching these conclusions, the Court of Appeal expressly disagreed with *California Emergency Physicians Medical Group v. PacifiCare of California (2003) 111 Cal.App.4th 1127, 1131-1132* (*CEP*), a 2003 decision from Division One of the Fourth Appellate District, which held that a negligence claim in identical circumstances was barred as a matter of law by section 1371.4 and further held that *Biakanja* does not support a duty of care in such circumstances.

This case thus presents two clear grounds for review. First, the Court of Appeal's decision conflicts with *CEP* on two issues: (1) whether section 1371.4's express authorization for a health plan to delegate its reimbursement obligations

---

[1] All unspecified statutory references are to the Health and Safety Code.

bars tort causes of action premised on allegedly improper or negligent delegations; and (2) whether *Biakanja* supports injecting a judicially created tort duty into this carefully calibrated statutory and regulatory scheme.

Second, the Court of Appeal's decision conflicts with the statutory scheme governing the managed care system, closely overseen by the DMHC. **[*7]** A tort duty is not compatible with section 1371.4's express and unqualified authorization of delegation of the health plan's reimbursement obligations. Nor is it consistent with the purpose that statute serves in the delegated model of health care the Legislature has adopted. That model is anchored on the notion that contracted IPAs, not health plans, retain post-delegation risk to reimburse providers.

The Court of Appeal's rewrite of the statute is stark because it implements a profound change in the Act that the Legislature proposed and *failed to enact* in 2001. The Legislature passed Senate Bill No. 117 in 2001 to add a new provision requiring health care service plans to pay emergency service providers if a contracting medical provider did not do so, but the Governor vetoed the bill. (*Ochs v. PacifiCare of California (2004) 115 Cal.App.4th 782, 791* (*Ochs*), citing Sen. Bill No. 117 (2000-2001 Reg. Sess.) § 2, subd. (f).) This demonstrates that the Legislature interpreted the current version of subdivision (e) as *not* requiring health plans to re-assume payment obligations delegated to an IPA. The Court of Appeal's opinion therefore judicially enacts **[*8]** a new law that the Legislature expressly tried, but failed, to pass.

A tort duty also undermines the specific procedure established in the regulations to rehabilitate a failing IPA. When an IPA fails the financial grading criteria in the regulations, the health plans and the IPA are required by statute to cooperate with the DMHC to implement a ″corrective action plan.″ The purpose of this mechanism is to ensure the stability of the managed care system and continuity of care for patients. If health plans are required to re-assume an IPA's reimbursement obligations, this would require an adjustment in the IPA's capitation payments, which would hurt the IPA's cash flow and exacerbate its financial condition, decreasing the likelihood that the corrective action plan will succeed in rehabilitating that IPA. An IPA's collapse would not only undermine the DMHC's efforts, it also would have severe consequences for the IPA's contracted emergency and nonemergency physicians as well as enrollees by disrupting the quality and continuity of care.

The Court of Appeal's holding also is at odds with the comprehensive statutory system governing health plans and IPAs as well as the DMHC's role in **[*9]** administering that system. Whether a health plan may re-assume reimbursement responsibilities when a contracted IPA is undergoing a corrective action plan is an issue the regulations place within the purview of the DMHC. To inject a judicially created tort duty into this comprehensive scheme could disturb the risk spreading balance the Legislature struck when it expressly approved the delegation of reimbursement responsibilities, authorized the DMHC to administer that system, and established the corrective action processes. Such complex economic policy choices should be left to the Legislature, and the courts should abstain from creating new tort duties in this arena.

Finally, regardless of which of the currently conflicting court of appeal decisions is correct, all participants in the health care industry have a pressing need for this Court to settle the question so they can order their affairs accordingly. The contractual delegation of risk is a core feature of the Knox-Keene statutory system, and a wide variety of contractual relationships are established based on assumptions of which risks are borne by which entities. The holding here-that a risk delegation that was fully authorized **[*10]** by statute at the time of contracting may be disturbed based on retrospectively applied negligence principles-injects uncertainty and unpredictability into a regime that demands both. This Court should settle the rules so all participants may follow them.

II.

ISSUES PRESENTED

(1) Whether a health care service plan's delegation of its reimbursement obligations to an independent physicians association in accordance with Health and Safety Code section 1371.4 precludes imposition of tort liability on the health care service plan to reimburse non-contracted emergency physicians based on such delegation?

(2) Where a health care service plan delegated its reimbursement responsibilities to a financially solvent independent physicians association pursuant to section 1371.4, and the independent physicians association later becomes insolvent and fails to pay non-contracted emergency physicians for services rendered to health care service plan enrollees, may the health care service plan be liable in negligence to the non-contracted emergency physicians?

III.

PROCEDURAL BACKGROUND

A. Background Regarding The Governing Law

"All aspects of the regulation **[*11]** of health plans are covered" by the Knox-Keene Act, "including financial stability, organization, advertising and capability to provide health services." (*Van de Kamp v. Gumbiner (1990) 221 Cal.App.3d 1260, 1269;* see § 1340.) Among the Act's goals are "[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 "[e]nsuring the financial stability" of health plans "by means of proper regulatory procedures." (§ 1342, subds. (d) &(f).)

1. The Legislature Has Specifically Approved Risk-Shifting Arrangements

Through the Act, the Legislature has adopted the delegated model of health care, approving risk-shifting arrangements between health plans and IPAs. (*California Medical Assn., Inc. v. Aetna U.S. Healthcare of California, Inc. (2001) 94 Cal.App.4th 151, 162.)*[2] "Similarly, administrative regulations contemplate the contractual shifting of financial risk from health plans to other risk-bearing entities." (*Ibid.*) Section 1348.6 expressly permits "capitation payments, or shared-risk arrangements." (§ 1348.6, subd. (b).) **[*12]**

A health plan thus may contract with an IPA to delegate reimbursement obligations. (§ 1375.4, subd. (g)(1).) [3] The IPA is a group of physicians that contracts with a health plan to provide services for the plan's enrollees on a "capitated" basis, that is, a fixed payment per enrollee. (*Ibid.*) The IPA is responsible for processing and paying claims for services physicians render to enrollees. **[*13]** (*Id.* at subd. (g)(1)(C).) The DMHC's website has a list of IPAs that are financially solvent and that meet the DMHC's financial grading criteria. La Vida was on that list when the Health Plans entered into their delegation contracts with it. (Dept. of Managed Healthcare, Healthcare Providers Information regarding Risk Bearing Organizations (May 13, 2010), http://www.hmohelp.ca.gov/providers/rbo/rbo_cap.aspx; Opn. 12.)
[*14]

2. The Legislature Has Charged The DMHC With Monitoring The Financial Stability Of IPAs And Implementing The Process To Rehabilitate Financially Troubled IPAs

IPAs are subject to financial condition requirements. (§ 1375.1, subds. (b)(1) & (b)(3) [in determining whether a health plan is financially sound, the DMHC considers the "financial soundness of the plan's arrangements for health care services" and its agreements with providers].) The Act imposes specific requirements on any contract between a health plan and an IPA, including a contractual provision requiring the IPA to provide regular financial information to the health plan to "assist the [health plan] in maintaining the financial viability of its arrangements for the provision of health care services . . . ." (§ 1375.4, subd. (a)(1).)

There are financial criteria every IPA must meet on a regular basis. (§ 1375.4, subd. (b)(1)(A).) Should the IPA fail those requirements, the IPA and the health plans with which it contracts must agree to a "corrective action plan," approved by the DMHC, designed to bring the IPA back into compliance and restore its financial health. (*Id.* at

---

[2] Respondents Health Net of California, Inc., Blue Cross of California dba Anthem Blue Cross, PacifiCare of California, California Physicians' Service dba Blue Shield of California, Cigna HealthCare of California, Inc., Aetna Health of California, Inc., and SCAN Health Plan, are health care service plans within the meaning of section 1345, subd. (f)(1). In this brief, respondents are referred to as "Health Plans" for convenience. Although a "health maintenance organization" (HMO) technically is a type of health care service plan, the Court of Appeal's opinion uses "HMO" generically to refer to the Health Plans.

[3] A "risk-bearing organization" is "a professional medical corporation" or an "organized group of physicians" that provides health care services and that: "(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees. [P] (B) Receives compensation for those services on any capitated or fixed periodic payment basis. [1] (C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization." (§ 1375.4, subd. (g)(1)(A)-(C).) An IPA is a type of risk bearing organization.

subd. (b)(4).) Specifically, when **[*15]** an IPA has reported any deficiencies in meeting the financial grading criteria, it ″shall simultaneously submit a self-initiated″ corrective action proposal. (Cal. Code Regs., tit. 28, § 1300.75.4.8, subd. (a).) At that point, the DMHC assumes control of the IPA's rehabilitation, including its risk-shifting arrangements with its contracting health plans. Health plans are required to cooperate with the DMHC with respect to corrective action plans. Health plans are further required to take ″appropriate action(s) . . . *following the Department's written notification to*″ a health plan that an IPA has failed with respect to its duties to report financial information, to cooperate with the DMHC, or to comply with a corrective action plan. (Cal. Code Regs., tit. 28, § 1300.75.4.5, subd. (a)(2), italics added.) ″[A]ppropriate action shall include . . . a prohibition on the assignment or addition of any additional enrollees to the risk arrangement with that organization[,] without the prior written approval of the″ DMHC. (*Id*. at subd. (a)(3).) The regulations also prohibit health plans from transferring existing enrollees out of an IPA that is subject to a corrective action plan **[*16]** without DMHC approval. (See *id*. at subds. (a)(6) & (a)(7).)

3. The Legislature Has Specifically Approved Delegation Of Payment Responsibilities For Emergency Services

Section 1371.4 governs health plans' obligations with respect to emergency services and care. Subdivision (b) requires a health plan ″or its contracting medical providers″ to pay for emergency care rendered to their enrollees regardless of whether the emergency care provider is under contract with the plan. (§ 1371.4, subd. (b).) Section 1371.4 expressly permits health plans to delegate payment responsibilities for emergency services and care to IPAs. (*Id*. at subd. (e).)

B. The Allegations Of Plaintiffs' Complaints[4] **[*17]**

Plaintiffs allege that they provided emergency services to La Vida enrollees and sought reimbursement from La Vida. Beginning in 2007, La Vida allegedly failed to pay plaintiffs for those services. (Opn. 10; 1 AA 41, 64.) Plaintiffs do not allege that La Vida was not listed on the DMHC's list of financially solvent IPAs at the time of the initial delegations, that the Health Plans failed to pay La Vida under the capitation agreements with La Vida, or that the Health Plans violated any statute or regulation in entering into the delegation contracts with La Vida. (Opn. 10-11; 1 AA 43, 64-65.)

Plaintiffs allege that, at the time the Health Plans delegated their responsibilities to La Vida and throughout the duration of those contracts, the Health Plans knew or should have known that La Vida would be unable to meet its obligations in the future. (Opn. 10.) Plaintiffs do not allege that La Vida operated in violation of the statutorily required corrective action plan when it began experiencing financial problems. Nor do they allege that the DMHC had requested or authorized a re-assumption of payment responsibilities by the Health Plans. Plaintiffs allege that after La Vida's lender filed **[*18]** bankruptcy in October 2009 and withdrew $ 4 million from La Vida's account, La Vida failed. (PFR 8; 1 AA 42.)

Plaintiffs allege causes of action for negligence, unfair competition, quantum meruit, open book account, and services rendered. (Opn. 11.)

The trial court sustained the Health Plans' demurrers without leave to amend and entered judgment for the Health Plans. (Opn. 14-15.) Plaintiffs appealed. (Opn. 15.)

IV.

REVIEW IS NECESSARY TO SECURE UNIFORMITY IN THE CASE LAW AND DECIDE AN IMPORTANT ISSUE

A. Review Is Warranted To Resolve The Conflict In The Court Of Appeal's Decisions

The Court of Appeal acknowledged the inconsistent approaches taken by *CEP* and *Ochs* to the question whether a health plan may be liable in negligence despite complying with section 1371.4. (Opn. 17.) The Court of Appeal followed *Ochs* and disagreed with *CEP*. (*Ibid* **[*29]** .)

---

[4] The factual and procedural information recited in subsections B, C and D is taken largely from the Court of Appeal's opinion. To the extent certain facts are not contained in the Court of Appeal's opinion, they were brought to the Court of Appeal's attention in the Health Plans' petition for rehearing (″PFR″). (See Cal. Rules of Court, rule 8.500(c)(2).)

In *Ochs*, the plaintiffs, emergency services providers, claimed the defendant health plans were liable for services the plaintiffs rendered to the health plans' enrollees because the delegated IPA became bankrupt. (*Ochs, supra, 115 Cal.App.4th at p. 788.)* The trial court sustained the health plans' demurrer without leave to amend as to all causes of action, including negligence. (*Ibid.*) The Court of Appeal agreed that the complaint did not allege sufficient facts to show the existence of a duty of care. (*Id. at p. 794.)* However, the court held that the plaintiffs should have been given leave to amend because they had offered to plead that the health plans ″knew or should have known that [the IPA] was insolvent based on [their] audits of that entity″ at the time they initially contracted with the IPA. (*Id. at p. 796.)*

Following *Ochs*, the Court of Appeal here concluded that because plaintiffs allege that the Health Plans knew or should have known that La Vida would be unable to meet its financial obligations at the time of the delegation contracts, they have stated a cause of action for negligent delegation. (Opn. **[*30]** 35-36.)

The Court of Appeal thus disagreed with and rejected *CEP*. The Court of Appeal's decision conflicts with *CEP* in two important respects. The first conflict concerns the issue whether section 1371.4's authorization of delegation arrangements is, in and of itself, preclusive of a negligence duty. In *CEP*, as here, a group of emergency physicians sued a health plan for payment for emergency services provided to the plan's enrollees after the IPA became insolvent. The plaintiffs alleged statutory violations, negligence, violation of the UCL, and quantum meruit. (*CEP, supra, 111 Cal.App.4th at p. 1130.)*

The Court of Appeal in *CEP* affirmed the judgment of dismissal. It noted that the legislative history of section 1371.4 reflected the ″Legislature's understanding that under section 1371.4 subdivision (e), health care service plans that delegate their responsibilities under section 1371.4 to contracting medical providers are not responsible to pay emergency services providers when the contracting medical providers fail to pay.″ (*CEP, supra, 111 Cal.App.4th at p. 1133.)* Addressing the negligence claim against the backdrop of **[*31]** the statute and legislative history, the court concluded that section 1371.4 forecloses a duty of care whether or not the plaintiffs ″could satisfy some of the *Biakanja* factors . . . .″ (*Id. at p. 1136.)* The court explained: ″The Legislature has approved risk-sharing plans, such as capitation, and has allowed health care service plans to delegate payment responsibility to contracting medical providers. Finding a duty in this situation is directly contrary to section 1371.4, subdivision (e) of the Knox-KeeneAct.″ (*Ibid.*)

Here, the Court of Appeal questioned whether *CEP* was suggesting that section 1371.4 ″barred a negligence action as a matter of law, as opposed to simply concluding that policy reasons would outweigh any *Biakanja* factors that would favor finding a duty.″ (Opn. 23, fn. 25.) The Court of Appeal rejected the proposition that section 1371.4 provides a ″safe-harbor″ or ″immunity″ from negligence liability, and it did not view *CEP* as standing for any such proposition. (Opn. 36, fn. 33.)

Whether *CEP* intended to suggest that a negligence duty is precluded because of ″policy reasons″ or because section 1371.4 provides a ″safe harbor″ **[*32]** or ″immunity,″ however, is immaterial and does not avoid the conflict between *CEP* and the Court of Appeal's decision on this issue. What matters is *CEP's* recognition that a negligence duty cannot be imposed *in light of* that statutory authorization. Whether the legal bar is characterized as arising from ″policy,″ a ″safe harbor″ or ″immunity″ does not alter the source of that bar-section 1371.4's authorization of delegation contracts. There is, therefore, an intractable conflict on this point between *CEP* and the Court of Appeal's decision.

The second point of conflict between the Court of Appeal's decision and *CEP* concerns *Biakanja*. As the Court of Appeal noted, *CEP* concluded that the plaintiffs in that case could not satisfy the first *Biakanja* factor because the most they could show was that the health plan's contract with the IPA ″was intended to affect any emergency services provider whom [the IPA] had an obligation to pay.″ (*CEP, supra, 111 Cal.App.4th at p. 1136.)* In this regard, *CEP* followed *Desert Healthcare Dist. v. Pacificare FHP, Inc. (2001) 94 Cal.App.4th 781, 791-792* (*Desert Healthcare*), where **[*33]** the Court of Appeal rejected a hospital's contention that the health plan had a special duty to insure the financial stability of its contracting medical provider. (*CEP, supra, 111 Cal.App.4th at pp. 1135-1136.)Desert Healthcare* concluded that the plaintiff could not satisfy the first *Biakanja* factor based on allegations that the transaction was intended to affect a class of third parties as opposed to the plaintiff in particular. (*Desert Healthcare, supra,*

94 Cal.App.4th at p. 792.)[6]*Desert Healthcare* applied well-settled law requiring a specific intent to affect the Plaintiff, as opposed to a class of Plaintiffs. (*Ibid*.; see, e.g., *Giacometti v. Aulla, LLC, 187 Cal.App.4th 1133, 1138* [first Biakanja factor is satisfied only if the ″transaction was to affect″ the third party]; accord *Worldvision Enterprises, Inc. v. American Broadcasting Companies, Inc. (1983) 142 Cal.App.3d 589, 597-598;Keru Investments, Inc. v. Cube Co. (1998) 63 Cal.App.4th 1412, 1418;Grey stone Homes, Inc. v. Midtec, Inc. (2008) 168 Cal.App.4th 1194, 1231.)*

[*34]

The Court of Appeal in this case followed *Ochs* in concluding that the first *Biakanja* factor can be satisfied so long as the transaction was intended to affect a class of persons. The Court of Appeal acknowledged that the ″standard formulation″ of the first *Biakanja* factor is ″a duty to be owed to the plaintiff specifically, rather than a class to which the plaintiff belongs[.]″ (Opn. 30.) It held, however, that the standard formulation does not apply here. (*Ibid*.) The Court of Appeal reached this conclusion despite the fact that plaintiffs had no contracts with La Vida or the Health Plans, and based on the rationale that the Health Plans have a statutory duty to reimburse emergency physicians. (*Ibid*.) This aspect of the Court of Appeal's holding thus not only is in direct conflict with *CEP*, it goes against the prevailing weight of authority.

This Court should grant review to resolve the conflicts in the case law created by the Court of Appeal's decisions.

B. A Negligence Duty Undermines The Effective Operation And Goals Of The Managed Care System

The imposition of a negligence duty on health plans also conflicts with the comprehensive statutory **[*35]** and regulatory scheme the Legislature has established in connection with its adoption of the delegated model of health care.

1. The Court Of Appeal's Holding Cannot Be Reconciled With Section 1371.4 And Contravenes The Fundamental Purpose Of Capitation Contracts

A negligence duty is incompatible with the language of the statute authorizing delegation contracts. Section 1371.4 expressly permits delegation of payment responsibilities ″to the plan's contracting medical providers.″ (§ 1371.4, subd. (e).) The plain meaning of this statute is that ″health care service plans that delegate their responsibilities under section 1371.4 to contracting medical providers are not responsible to pay emergency services providers when the contracting medical providers fail to pay.″ (*CEP, supra, 111 Cal.App.4th at p. 1133.)*

Subdivision (e) therefore precludes not only causes of action for direct violation of that statute, it bars delegation-based liability under *any* legal theory. (*CEP, supra, 111 Cal.App.4th at p. 1133.)* A plaintiff may not plead around a statutory bar to liability by labeling a claim as one for negligence or some other tort rather **[*36]** than one for direct violation of the statute. (See, e.g., *Gentry v. Ebay, Inc. (2002) 99 Cal.App.4th 816, 833-834* [negligence claim was barred because it sought to hold the defendant liable for conduct falling under a statute permitting such conduct].)

This rule has particular force here in light of the undisputed fact that La Vida was on the DMHC's list of financially solvent IPAs at the time of the delegation contracts. Plaintiffs have never alleged that La Vida did not meet the DMHC's financial grading criteria at the time it entered into the delegation contracts with the Health Plans. Nor have plaintiffs alleged that the Health Plans' delegations-both at the time of the initial delegations and thereafter-failed to comply with section 1371.4, any of the implementing regulations, or the DMHC's directives. To impose a negligence duty in the absence of any claim that a health plan's delegation failed to comply with any aspect of a comprehensive and detailed statutory and regulatory scheme runs counter to that scheme and the Legislature's intent.

Section 1371.4's legislative history supports the conclusion that the Legislature did not intend health plans to retain **[*37]** any post-delegation payment obligation in the event of an IPA's failure to reimburse providers. The Analyses of Senate Bill No. 1832, the progenitor of section 1371.4, stated that the bill requiring health plans to pay for emergency services provided by noncontracted physicians ″'would shift decision making authority regarding

---

[6] *CEP* did not address the other *Biakanja* factors. (See Ott v. Alfa-Laval Agri, Inc. (1995) 31 Cal.App.4th 1439, 1455-1456 [failure to establish the first factor ″precludes a finding of 'special relationship.'″].)

the provision of services to emergency providers, which would significantly reduce the ability of the health plans to manage overall care and costs.'" (*Ochs, supra, 115 Cal.App.4th at p. 790,* quoting Dept. of Health Services, Enrolled Bill Rep. on Sen. Bill No. 1832 (1993-1994 Reg. Sess.), Sept. 9, 1994, p. 6.) Subdivision (e) was thereafter added to the bill to reduce the opposition of several health plans. (*CEP, supra, 111 Cal.App.4th at p. 1132.)* Thus, even *Ochs* recognized that "construing . . . subdivision [(e)] to allow a complete delegation of responsibility for emergency payments, with no residual liability for those payments, is consistent with its legislative purpose." (*Ochs, supra, 115 Cal.App.4th at p. 791.)*

This conclusion is bolstered by the Legislature's failed attempt to enact **[*38]** into law Senate Bill No. 117 in 2001. This bill, which was passed by the Legislature but subsequently vetoed by the Governor, would have amended subdivision (e) to add a new provision requiring health care service plans to pay emergency service providers if a contracting medical provider did not. (*Ochs, supra, 115 Cal.App.4th at p. 791,* citing Sen. Bill No. 117 (2000-2001 Reg. Sess.) § 2, subd. (f).) Thus, the Legislature interpreted the current version of subdivision (e) as not requiring health plans to re-assume payment obligations delegated to an IPA. The Court of Appeal's holding here achieves exactly the same result that the failed legislation would have achieved.

The Court of Appeal's holding also contravenes the basic purpose of the risk shifting arrangements the Legislature has specifically approved in adopting the delegated model of health care. The entire point of the delegated model of health care and of capitation agreements is to have clear-cut risk-*shifting* arrangements. Indeed, the regulations define capitation as a "fixed per member per month payment or percentage of premium payment *wherein the provider assumes the full risk* for the cost **[*39]** of contracted services without regard to the type, value or frequency of services provided." (28 Cal. Code Regs. § 1300.76, subd. (f), italics added.) This arrangement enables the health plan to keep premiums predictable and affordable. (§ 1342.)

Holding health plans liable when an IPA the DMHC has recognized as financially solvent fails to pay providers contradicts the very essence of capitation arrangements, shifting the post-delegation risk back to the health plan. The Legislature has made clear that the basic purpose of capitation agreements is that only IPAs retain post-delegation risk. (*Desert Healthcare, supra, 94 Cal.App.4th at p. 789* [requiring health plans to retain post-delegation risk would "effectively destroy[] capitation contracts"]; *CEP, supra, 111 Cal.App.4th at p. 1137* [post-delegation liability on health plans would "thwart the Legislature's determination that the benefits to the public of allowing health care service plans to delegate risk to contracting medical providers outweigh the cost to emergency service providers"].) The imposition of a negligence duty arising from such delegations effectively re-distributes **[*40]** post-delegation risk, amounting to an end run around section 1371.4 and the underlying purpose of the entire delegated model of managed care.

In sum, a delegation-based negligence duty conflicts with the text of section 1371.4, its legislative history, and the Legislature's expressed purpose for permitting delegation contracts.

2. The Court Of Appeal's Holding Subverts The Goals Of The Knox-Keene Act

The Court of Appeal's decision also threatens to undermine the Legislature's goal to rehabilitate financially troubled IPAs through corrective action plans. The cornerstone of that process is the maintenance of the status quo regarding the IPA's capitation arrangements. If health plans are faced with the potential for negligence liability in the event an IPA becomes financially insolvent, they might unwind delegation contracts, thus contributing to the IPA's financial problems and interfering with the DMHC's efforts to rehabilitate that IPA.

The Court of Appeal states that it is not suggesting that the Health Plans have "a duty to 'de-delegate' the IPA in its entirety." (Opn. 40, fn. 36.) The Court of Appeal suggests, instead, that the Health Plans are required to re-assume "'responsibility **[*41]** for the processing and timely reimbursement of provider claims in the event that the [IPA] fails to timely and accurately reimburse its claims.'" (*Ibid*., quoting Cal. Code Regs., tit. 28, § 1300.71, subd. (e)(6).) According to the Court of Appeal, in such a situation, the health plan would have responsibility to reimburse non-contracted emergency physicians while the delegated "IPA would continue to . . . provide all non-emergency services to its enrollees." (*Ibid*.)

The approach the Court of Appeal has mandated, however, does not avoid the problem. A health plan that re-assumes payment obligations from an IPA will have to adjust its capitation payments to that IPA accordingly. The Court of

Appeal ignores the potential impact this would have on the IPA's financial stability. For instance, some IPAs that might have emerged intact from a corrective action plan may go under because of the decrease in capitation payments. This conflicts with the Legislature's goal to ensure ″the financial stability″ of the health care system ″by means of proper regulatory procedures.″ (§ 1342, subd. (f).)

Moreover, an IPA's demise would have severe repercussions for other stakeholders in the **[*42]** system. A defunct IPA, for instance, would no longer be able to reimburse its contracted physicians, including contracted emergency physicians. The Court of Appeal expresses a willingness to tolerate placement of the financial burden on contracted emergency physicians on the theory that these doctors had the ability to protect themselves by contract. Thus, reasons the Court of Appeal, it is only fair to have a special rule ensuring that *only* non-contracted emergency physicians obtain reimbursement from health plans in the event of an IPA's inability to pay. But by elevating the emergency physicians' interests above the interests of contracted physicians of all specialties, the Court of Appeal creates a perverse economic incentive for emergency physicians to avoid contracted arrangements and penalizes those doctors who have entered into such arrangements. This runs counter to the Legislature's avowed purpose to ″promote various types of contracts between public or private payers of health care coverage, and institutional or professional providers of health care services.″ (§ 1342.6.)

Such a system also would undermine the manageability and predictability of health care costs and **[*43]** prove detrimental to the economic efficiency of the health care system. (See § 1342.6 [″It is the intent of the Legislature to ensure that the citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible.″]; § 1342, subd. (d) [purpose of Knox-Keene Act is to ″ensure the best possible health care for the public at the lowest possible cost″].)

The IPA's enrollees also would be affected. A failing IPA's enrollees would need to be transferred to another IPA, compromising the quality and continuity of their care as well as the efficient delivery of services. This would further erode the underlying goals of the managed health care system. (§ 1342, subd. (g) [expressing Legislature's intent that medical services be ″rendered in a manner providing continuity of care″].)

3. The Court Of Appeal's Holding Is Incompatible With The Comprehensive Statutory System The Legislature Has Established For Health Care

The Act and its implementing regulations represent a statutory system that comprehensively regulates the health care industry. The financial solvency of health plans and IPAs is a primary focus of that system. In **[*44]** that regard, the Legislature has instituted detailed regulations for dealing with financially troubled IPAs, and it has charged the DMHC with the task of rehabilitating such IPAs through the specific and detailed procedure of corrective action plans. The regulations do not contemplate that health plans will take unilateral actions such as re-assuming reimbursement responsibilities when an IPA is undergoing a corrective action plan. Rather, what action health plans may take when an IPA experiences financial problems is subject to strict DMHC oversight and control.

Just this term, in Loeffler v. Target Corp. (May 1, 2014, S173972) Cal.4th [2014 WL 1714947] (*Loeffler*), this Court re-affirmed the principle that when the Legislature has established a comprehensive statutory and regulatory regime over a particular field and empowered an administrative agency to determine the legality of practices arising within it, a plaintiff may not maintain a claim premised upon conduct that falls within the authority of that agency. Thus, this Court held that the trial court in that case had properly dismissed the plaintiffs' causes of action for violation **[*45]** of the UCL and the Consumer Legal Remedies Act (CLRA) (Civ. Code, § 1750 *et seq*.) against a retailer because those claims challenged a practice regarding collection of sales taxes that fell within the Board of Equalization's jurisdiction. (Loeffler, supra, 2014 WL 1714947 at p. *25.)

In reaching this conclusion, the Court relied on its well-settled jurisprudence that a UCL claim may not be used to circumvent a statutory safe-harbor immunizing certain conduct from liability. Although this Court did not specifically hold that the tax statutes at issue in *Loeffler* provided a safe-harbor, it concluded that the plaintiffs' claims nevertheless were barred because ″the statutory scheme″ provided ″the exclusive means for resolving disputes″ of the type underlying the plaintiffs' causes of action. (Loeffler, supra, 2014 WL 1714947 at p. *27.) This Court pointed out that the ″taxability question″ the plaintiffs' claims implicated lay at the ″center of the Board's function and authority″ as defined in an ″exceedingly comprehensive and complex″ statutory system, a system in which the permissibility of certain types of practices is ″debatable. **[*46]** ″ (*Id*. at p. *28.) To allow the plaintiffs to maintain UCL and CLRA

claims in the face of this statutory scheme ″could displace the Board and the procedures established by the Legislature, thereby undermining the orderly administration of the tax laws.″ (*Id*. at p. *31.)

Loeffler's rationale applies here. This case, too, involves a comprehensive statutory and regulatory system and challenges conduct implicating the functions and authority of the agency charged with administering that system. And, as in *Loeffler*, here a health plan's re-assumption of reimbursement obligations from a financially troubled IPA is ″debatable,″ in that its permissibility will depend on the circumstances of each case.

The Court of Appeal rejected the Health Plans' argument that the doctrine of judicial abstention applies on the ground that abstention applies to equitable claims, and negligence is a legal claim. (Opn. 42.) As *Loeffler* recognized, however, whether a comprehensive statutory scheme precludes a particular claim does not turn on technical doctrinal distinctions. It turns on whether the maintenance of that claim is fundamentally incompatible with the statutory and regulatory **[*47]** system. The Court of Appeal's *categorical* mandate that health plans re-assume reimbursement obligations from an IPA subject to a corrective action plan could displace the DMHC and the corrective action plan procedures, thus undermining the DMHC's orderly administration of the Act.

The Court of Appeal also overlooked the potential impact of affording preference to non-contracted emergency physicians over other stakeholders in the system that the DMHC is charged with overseeing. Whether and under what circumstances health plans should re-assume payment responsibility from a financially troubled IPA is a decision the DMHC should make in consultation with the health plans and the particular IPA, taking into account the unique circumstances of each case and the competing interests of the health plans and the IPA as well as the IPA's enrollees. Indeed, the Legislature has imposed on emergency physicians the financial burden of treating patients that will have no ability to pay for those services, such as indigent, uninsured individuals. In light of this legislatively imposed financial burden, emergency physicians presumably factor in the known risk of nonpayment by adjusting their charges **[*48]** to paying patients. The Court of Appeal's view that health plans are somehow forcing emergency physicians to work for ″free″ fails to take into account this basic economic reality. By imposing a negligence duty on health plans, the Court of Appeal has effectively readjusted the risk calculus in contravention of the Legislature's original balancing.

Contrary to the Court of Appeal's statement that it was not involving itself ″in complex issues of economic or health care policy″ [Opn. 42], the Court of Appeal has done precisely that. If the risk shifting calculus is to be altered, especially in as drastic a manner as the Court of Appeal has done, the Legislature should be the one to do it.

V.

CONCLUSION

The Court of Appeal's decision perpetuates and exacerbates a conflict in the appellate courts' decisions and contravenes the language and purposes of the Knox-Keene Act with respect to legislatively-approved risk-shifting arrangements. For both of these reasons, this Court should grant review.

DATED: May 12, 2014.

REED SMITH LLP

By /s/ Margaret M. Grignon
Margaret M. Grignon
Attorneys for *Blue Cross of California dba Anthem Blue Cross*

DATED: May 12, 2014.

CROWELL **[*49]** & MORING, LLP

By: /s/ William Albert Helvestine
William Albert Helvestine
Attorneys for *Health Net of California Inc*.

DATED: May 12, 2014.

Jennifer Salzman Romano
Attorneys for *Pacificare of California dba Secure Horizons Health Plan of America*

DATED: May 12, 2014.

MANATT, PHELPS & PHILLIPS, LLP

Gregory N. Pimstone
Attorneys for *California Physicians' Service dba Blue Shield of California*

DATED: May 11, 2014.

CROWELL & MORING, LLP

William Albert Helvestine
Attorneys for *Health Net of California Inc*.

DATED: May 11, 2014.

By: /s/ Jennifer Salzman Romano
Jennifer Salzman Romano
Attorneys for *Pacificare of California dba Secure Horizons Health Plan of America*

DATED: May 11, 2014.

MANATT, PHELPS & PHILLIPS, LLP

Gregory N. Pimstone
Attorneys for *California Physicians' Service dba Blue Shield of California*

DATED: May 12, 2014.

CROWELL & MORING, LLP

William Albert Helvestine
Attorneys for *Health Net of California Inc*.

DATED: May 12, 2014.

Jennifer Salzman Romano
Attorneys for *Pacificare of California dba Secure Horizons Health Plan of America*

DATED: May 12, 2014.

MANATT, **[*50]** PHELPS & PHILLIPS, LLP

By: /s/ Gregory N. Pimstone
Gregory N. Pimstone
Attorneys for *California Physicians' Service dba Blue Shield of California*

DATED: May 12, 2014.

COOLEY LLP

By: /s/ William P. Donovan, Jr.
William P. Donovan, Jr.

Attorneys for *Cigna HealthCare of California, Inc*.

DATED: May 12, 2014.

GIBSON, DUNN & CRUTCHER LLP

Heather L. Richardson
Attorneys for *Aetna Health of California, Inc*.

DATED: May 12, 2014.

GONZALEZ SAGGIO & HARLAN LLP

Jamie L. Lopez
Attorneys for *Scan Health Plan*

DATED: May 12, 2014.

COOLEY LLP

William P. Donovan, Jr.
Attorneys for *Cigna HealthCare of California, Inc*.

DATED: May 12, 2014.

GIBSON, DUNN & CRUTCHER LLP

By: /s/ Heather L. Richardson
Heather L. Richardson
Attorneys for *Aetna Health of California, Inc*.

DATED: May 12, 2014.

GONZALEZ SAGGIO & HARLAN LLP

Jamie L. Lopez
Attorneys for *Scan Health Plan*

DATED: May 12, 2014.

COOLEY LLP

William P. Donovan, Jr.
Attorneys for *Cigna HealthCare of California, Inc*.

DATED: May 12, 2014.

GIBSON, DUNN & CRUTCHER LLP

Heather L. Richardson
Attorneys for *Aetna Health* **[*51]** *of California, Inc*.

DATED: May 12, 2014.

GONZALEZ SAGGIO & HARLAN LLP

By: /s/ Jamie L. Lopez
Jamie L. Lopez

Attorneys for *Scan Health Plan*

Certification Of Word Count Pursuant To California Rules Of Court, Rule 8.504(d)(1)

I, Zareh A. Jaltorossian, declare and state as follows:

1. The facts set forth herein below are personally known to me, and I have first-hand knowledge thereof. If called upon to do so, I could and would testify competently thereto under oath.

2. I am one of the appellate attorneys principally responsible for the preparation of the Petition for Review in this case.

3. The Petition for Review was produced on a computer, using the word processing program Microsoft Word 2010.

4. According to the Word Count feature of Microsoft Word 2010, the Petition for Review contains 8,390 words, including footnotes, but not including the table of contents, table of authorities, and this Certification.

5. Accordingly, the Petition for Review complies with the requirement set forth in Cal. Rules of Court, rule 8.504(d)(1), that a brief produced on a computer must not exceed 8,400 words, including footnotes.

I declare under penalty of perjury that **[*52]** the forgoing is true and correct and that this declaration is executed on May 12, 2014, at Los Angeles, California.

/s/ Zareh A. Jaltorossian
Zareh A. Jaltorossian

PROOF OF SERVICE

I am a resident of the State of California, over the age of eighteen years, and not a party to the within action. My business address is REED SMITH LLP, 355 South Grant Avenue, Suite 2900, Los Angeles, CA 90071-1514. On May 12, 2014, I served the following document(s) by the method indicated below:

PETITION FOR REVIEW

[] by transmitting via facsimile on this date from fax number +1 213 457 8080 the document(s) listed above to the fax number(s) set forth below. The transmission was completed before 5:00 PM and was reported complete and without error. The transmission report was properly issued by the transmitting fax machine. The transmitting fax machine complies with Cal.R.Ct 2003(3).

[X] by placing the document(s) listed above in a sealed envelope with postage thereon fully prepaid, in the United States mail at Los Angeles, California addressed as set forth below. I am readily familiar with the firm's practice of collection and processing of correspondence for mailing. **[*53]** Under that practice, it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if the postal cancellation date or postage meter date is more than one day after the date of deposit for mailing in this Declaration.

[] (BY ELECTRONIC MAIL OR ELECTRONIC TRANSMISSION) Based on a court order and agreement of the parties to accept service by e-mail or electronic transmission, I provided the documents listed above electronically to the Lexis Nexis website and thereon to those parties on the Service List maintained by that website by submitting an electronic version of the documents to Lexis Nexis. If the documents are provided to Lexis Nexis by 5:00 p.m., then the documents will be deemed served on the date that it was provided to Lexis Nexis.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed on May 12, 2014, at Los Angeles, California.

/s/ Rebecca R. Rich
Rebecca R. Rich

SERVICE LIST

Andrew H. Selesnick, Esq.
Jason O. Cheuk, Esq. **[*54]** Michelman & Robinson, LLP
15760 Ventura Blvd., 5th Floor
Encino, CA 91436
Tel: (818) 783-5530
Fax: (818) 783-5506
aselesnick@mrllp.com
jcheuk@mrllp.com

Attorneys for Plaintiffs and Appellants, *Centinela Freeman Emergency Medical Associates, Centinela Radiology Medical Group; Sheran Oaks Energency edical Association; Valley Presbyterian Emergency Medical Association* and *Westside Energency Medical Association*

William A. Helvestine, Esq.
Crowell & Moring LLP
275 Battery Street, 23rd Fl.
San Francisco, CA 94111
Tel: (415) 986-2800
Fax: (415) 986-2827
whelvestine@crowell.com

Attorneys for Defendants and Respondents *Health Net of California, Inc*.

Jennifer S. Romano, Esq.
Crowell & Moring
515 South Flower Street, 40th Fl.
Los Angeles, CA 90071
Tel: (213) 622-4750
Fax: (213) 622-2690
jromano@crowell.com

Attorneys for Defendant and Respondent *Pacificare of California DBA Secure Horizons Health Plan of America*

Kirk A. Patrick, Esq.
Heather L. Richardson, Esq.
Gibson, Dunn & Crutcher LLP
333 S. Grand Avenue
Los Angeles, CA 90071-3197
Tel: (213) 229-7000
Fax: (213) 229-7520
kpatrick@gibsondunn.com

Attorneys for Defendant **[*55]** and Respondent *Aetna Health of California, Inc*.

Gregory N. Pimstone, Esq.
Joanna S. McCallum, Esq.
Jeffrey J. Maurer, Esq.
Manatt, Phelps & Phillips LLP
11355 West Olympic Blvd.
Los Angeles, CA 90064
Tel: (310) 312-4132
Fax: (310) 312-4224
jmaurer@manatt.com

Attorneys for Defendant and Respondent *California Physicians' Service dba Blue Shield of California*

William P. Donovan, Jr., Esq.
Matthew D. Caplan, Esq.
Cooley LLP
1333 2nd Street, Suite 400
Santa Monica, CA 90401
Tel: (310) 883.6400
Fax: (310) 883-6500
wdonovan@cooley.com
mcaplan@cooley.com

Attorneys for Defendant and Respondent *Cigna Healthcare of California, Inc*.

Jamie L. Lopez (SBN 260721)
Gonzalez Saggio & Harlan LLP
2 N. Lake Avenue, Suite 930
Pasadena, CA 91101
Telephone: 626.440.0022
Facsimile: 626.628.1725

Attorneys for Defendant and Respondent *SCAN Health Plan*

Astrid G. Meghrigian
715 Scott Street
San Francisco, CA 94117

Attorney for Amicus Curiae for Appellant *California Chapter of the American College of Emergency Physicians*

Long Xuan Do
Francisco Javier Silva
Michelle Rubalcava
California Medical Association
1201 J. Street, **[*56]** Suite 200
Sacramento, CA 95814

Attorneys for Amici Curiae *California Medical Association, California Hospital Association, California Orthopaedic Association, California Radiological Society, and California Society of Pathologists*

John M. LeBlanc
Sandra I. Weishart
Barger & Wolen LLP
633 West Fifth Street, 47th Floor
Los Angeles, CA 90071
Telephone: 213.680.2800

Attorneys for Amicus Curiae *California Association of Health Plans*

Honorable John S. Wiley, Jr.
Los Angeles Superior Court
Central Civil West, Dept. 311
600 S. Commonwealth Avenue
Los Angeles, CA 90005

Case No. BC449056

Court of Appeal
Second Appellate District, Division Three

300 South Spring Street
Second Floor, North Tower
Los Angeles, CA 90013-1213

Case No. B238867

Consumer Law Section
Los Angeles District Attorney
210 West Temple Street, Suite 1800
Los Angeles, CA 90012-3210
Tel: 213.974.3512

Served pursuant to Bus. & Prof. Code § 17209 and Cal. Rules of Court 8.29(a) and (b)

Appellate Coordinator
Office of the Attorney General
Consumer Law Section
300 South Spring Street
Los Angeles, CA 90013
Telephone: 213.897.2000

Served pursuant **[*57]** to Bus. & Prof. Code § 17209 and Cal. Rules of Court 8.29(a) and (b)

[SEE EXHIBIT A IN ORIGINAL]