No. S218497

In the Supreme Court of the State of California

CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES, ET AL.,

Plaintiffs and Appellants,

vs.

HEALTH NET OF CALIFORNIA, INC., ET AL.,

Defendants and Respondents.

SUPREME COURT
FILED

OCT 16 2014

Frank A. McGuire Clerk

Deputy

OPENING BRIEF ON THE MERITS

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

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)

---

*Margaret M. Grignon (SBN 76621)
Kurt C. Petersen (SBN 83941)
Kenneth N. Smersfelt (SBN 166764)
Zareh A. Jaltorossian (SBN 205347)
Reed Smith LLP
355 S. Grand Avenue, Suite 2900
Los Angeles, CA 90071
Telephone: 213.457.8000
Facsimile: 213.457.8080

Attorneys for Defendant, Respondent, and Petitioner *Blue Cross of California dba Anthem Blue Cross*

William A. Helvestine (SBN 58755)
Crowell & Moring LLP
275 Battery Street, 23rd Floor
San Francisco, CA 94111
Telephone: 415.986.2800
Facsimile: 415.986.2827

Attorneys for Defendant, Respondent and Petitioner *Health Net of California Inc.*

(Additional Counsel on Next Page)

ADDITIONAL COUNSEL

Jennifer S. Romano (SBN 195953)
Crowell & Moring LLP
515 S. Flower St., 40th Floor
Los Angeles, CA 90071
Telephone: 213.622.4750
Facsimile: 213.622.2690
Attorneys for Defendant, Respondent, and Petitioner UHC of California f/k/a Pacificare of California

Gregory N. Pimstone (SBN 150203)
Joanna S. McCallum (SBN 187093)
Jeffrey J. Maurer (SBN 190183)
Manatt, Phelps & Phillips, LLP
11355 W. Olympic Blvd.
Los Angeles, CA 90064
Telephone: 310.312.4000
Facsimile: 310.312.4224
Attorneys for Defendant, Respondent, and Petitioner *California Physicians' Service dba Blue Shield of California*

Don A. Hernandez (SBN 125119)
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, Respondent, and Petitioner *SCAN Health Plan*

Richard J. Doren (SBN 124666)
Heather L. Richardson (SBN 246517)
Gibson, Dunn & Crutcher
333 S. Grand Ave., 50th Floor
Los Angeles, CA 90071
Telephone: 213.229.7664
Facsimile: 213.229.6664
Attorneys for Defendant, Respondent, and Petitioner *Aetna Health of California*

William P. Donovan, Jr. (SBN 155881)
Cooley LLP
1333 Second Street, Suite 400
Santa Monica, CA 90401-4100
Telephone: 310.883.6435
Facsimile: 310.883.6500
Attorneys for Defendant, Respondent, and Petitioner *Cigna HealthCare of California, Inc.*

TABLE OF CONTENTS

Page

I. QUESTIONS PRESENTED 1

II. INTRODUCTION 1

III. STATUTORY AND REGULATORY BACKGROUND 6

A. The Legislature Has Specifically Approved Risk-Shifting Agreements Between Health Plans And IPAs 6

B. The Legislature Also Has Specifically Approved Delegation Of Payment Responsibilities For Emergency Services To IPAs 10

C. Risk-Shifting Contracts Between Health Plans And IPAs Are Subject To Detailed Statutory Requirements 11

D. The Legislature Has Charged The DMHC With Monitoring The Financial Stability Of IPAs Through Its Regulatory Oversight Of Health Plans 13

E. The Legislature Has Charged The DMHC With Implementing A Specific Process To Rehabilitate Financially Troubled IPAs 16

F. A Health Plan May Not Unilaterally Terminate Or Modify Its Contract With An IPA That Is Subject To A Corrective Action Plan 17

TABLE OF CONTENTS

CONTINUED)

Page

IV. FACTUAL AND PROCEDURAL BACKGROUND 19

A. Pursuant To Health And Safety Code Section 1371.4, Subdivision (e), The Health Plans' Delegate To IPA La Vida Their Responsibilities To Reimburse Emergency Service Providers For Care Provided To The Plans' Enrollees 19

B. Subsequently, La Vida Experiences Financial Difficulty, Is Placed Under A Corrective Action Plan, And Ultimately Becomes Insolvent 20

V. LEGAL DISCUSSION 22

A. Section 1371.4, Subdivision (e) Authorizes The Health Plans To Delegate Their Obligation To Reimburse Plaintiffs For Emergency Services Rendered To The Health Plans' Enrollees 22

1. The Use Of "Delegate" In Section 1371.4, Subdivision (e) Establishes The Legislature's Intent That Health Plans Not Retain Any Post-Delegation Liability To Non-Contracted Emergency Care Providers 22

a. The Clear Statutory Language In The Context Of The Entire Knox-Keene Act Establishes An Intent That Health Plans Not Retain Any Post-Delegation Liability 23

TABLE OF CONTENTS

CONTINUED)

Page

b. The DMHC's Implementing Regulations Support The Statute's Usual And Ordinary Meaning 27

c. The Statute's Usual And Ordinary Meaning Is Consistent With The Common Law.................. 28

d. The Statute's Legislative History Supports Its Clear Meaning 31

2. The Health Plans' Delegations To La Vida In Accordance With The Requirements Of The Statutory/Regulatory Scheme Mean The Health Plans No Longer Retain Responsibility To Reimburse Plaintiffs For Services They Provided To The Health Plans' Enrollees 34

B. Common Law Negligence Principles Cannot Override The Statutory Preclusion Of Liability.. 35

C. A Health Plan Owes No Duty To Protect Emergency Medical Providers From Financial Harm Caused By The Insolvency Of An IPA To Whom The Health Plan Has Properly Delegated Payment Responsibility Pursuant To Section 1371.4, Subdivision (e) 43

TABLE OF CONTENTS

CONTINUED)

Page

1. The Health Plans Did Not Enter Into Contracts With La Vida Intending To Affect Plaintiffs 45

2. The Connection Between The Risk-Shifting Contracts And Plaintiffs' Injury Is Remote 51

3. The Health Plans Could Not Reasonably Have Foreseen Plaintiffs' Injury 55

4. The Health Plans' Conduct Is Not Morally Culpable 57

5. Imposing A Duty Of Care Would Not Further Any Policy To Prevent Future Harm 59

VI. CONCLUSION 60

CERTIFICATION OF WORD COUNT 64

TABLE OF AUTHORITIES

Cases

Adams v. City of Fremont
(1998) 68 Cal.App.4th 243 57

Adelman v. Associated Intern. Ins. Co.
(2001) 90 Cal.App.4th 352 60

Beacon Residential Community Assn. v. Skidmore, Owings & Merrill LLP
(2014) 59 Cal.4th 568.......... *passim*

Bell v. Blue Cross of California
(2005) 131 Cal.App.4th 211 6

Biakanja v. Irving
(1958) 49 Cal.2d 647 .... *passim*

Bily v. Arthur Young & Co.
(1992) 3 Cal.4th 370 .... *passim*

Blair v. Pitchess
(1971) 5 Cal.3d 258 35

California Assn. of Health Facilities v. Department of Health Services
(1997) 16 Cal.4th 284.......... 11, 28

California Emergency Physicians Medical Group v. PacifiCare of California
(2003) 111 Cal.App.4th 1127 .... *passim*

California Medical Assn., Inc. v. Aetna U.S. Healthcare of California, Inc.
(2001) 94 Cal.App.4th 151 .... 7, 8

Campbell v. Ford Motor Co.
(2012) 206 Cal.App.4th 15 57

Christensen v. Superior Court
(1991) 54 Cal.3d 868 48

City of Alhambra v. County of Los Angeles
(2012) 55 Cal.4th 707.......... 22

City of Ontario v. Superior Court
(1993) 12 Cal.App.4th 894 25

Coalition of Concerned Communities, Inc. v. City of Los Angeles
(2004) 34 Cal.4th 733.......... 24

TABLE OF AUTHORITIES

CONTINUED)

Page

Desert Healthcare Dist. v. Pacificare FHP, Inc.
(2001) 94 Cal.App.4th 781 .... 9, 13

Dutton v. City of Pacifica
(1995) 35 Cal.App.4th 1171 58

Esberg v. Union Oil Co.
(2002) 28 Cal.4th 262 23

Freedom Newspapers, Inc. v. Orange County Employees Retirement System
(1993) 6 Cal.4th 821 33

Gentry v. eBay, Inc.
(2002) 99 Cal.App.4th 816 36

Goodman v. Kennedy
(1976) 18 Cal.3d 335 .... 45, 47, 49

Goodman v. Zimmerman
(1994) 25 Cal.App.4th 1667 28

Harris v. Capital Growth Investors XIV
(1991) 52 Cal.3d 1142 59

Harshbarger v. City of Colton
(1988) 197 Cal.App.3d 1335 36

In re Gilbert R.
(2012) 211 Cal.App.4th 514 31

In re Jorge M.
(2000) 23 Cal.4th 866 38

Irvine Co. v. California Employment Commission
(1946) 27 Cal.2d 570 33

J'Aire Corp. v. Gregory
(1979) 24 Cal.3d 799 48

Kelly v. Methodist Hospital of Southern Cal.
(2000) 22 Cal.4th 1108 25

Loeffler v. Target Corp.
(2014) 58 Cal.4th 1081 40

Los Angeles Unified School Dist. v. Garcia
(2013) 58 Cal.4th 175 22

TABLE OF AUTHORITIES

CONTINUED)

Page

McCollum v. CBS, Inc.
(1988) 202 Cal.App.3d 989 58

Ochs v. PacifiCare of California
(2004) 115 Cal.App.4th 782 .... *passim*

People v. Zikorus
(1983) 150 Cal.App.3d 324 29

Prospect Medical Group, Inc. v. Northridge Emergency Medical Group
(2009) 45 Cal.4th 497 24

Quelimane Co. v. Stewart Title Guaranty Co.
(1998) 19 Cal.4th 26 .... *passim*

Rojas v. Superior Court
(2004) 33 Cal.4th 407 25

Rosenbaum v. Security Pacific Corp.
(1996) 43 Cal.App.4th 1084 58

Savient Pharmaceuticals, Inc. v. Department of Health Services
(2007) 146 Cal.App.4th 1457 30

Scott v. Chevron, U.S.A.
(1992) 5 Cal.App.4th 510 58

SeaBright Ins. Co. v. US Airways, Inc.
(2011) 52 Cal.4th 590 29

Seeley v. Seymour
(1987) 190 Cal.App.3d 844 24

Soukup v. Law Offices of Herbert Hafif
(2006) 39 Cal.4th 260 31

Summit Financial Holdings, Ltd. v. Continental Lawyers Title Co.
(2002) 27 Cal.4th 705 .... 46, 47, 48

Tverberg v. Fillner Construction, Inc.
(2010) 49 Cal.4th 518 29

Ultramares Cor. v. Touche
(1931) 255 N.Y. 170 50

TABLE OF AUTHORITIES

CONTINUED)

Page

Van de Kamp v. Gumbiner
(1990) 221 Cal.App.3d 1260 6

Watanabe v. California Physicians' Service
(2008) 169 Cal.App.4th 56 11

Williams v. State Farm Fire and Casualty Co.
(1990) 216 Cal.App.3d 1540 36

Yamaha Corp. of America v. State Bd. of Equalization
(1998) 19 Cal.4th 1 27

Statutes

42 U.S.C.
§ 1395dd *et seq.* 42
§ 1395dd(b) 10
§ 1395dd(h) 10

Health & Safety Code
§ 1317, subd. (a) 10
§ 1317, subd. (b) 10
§ 1317.6, subd. (g) 42
§ 1341 13
§ 1341, subd. (c) 15
§ 1341.9 .... 13, 15
§ 1342, subd. (d) 2, 8, 9, 41
§ 1342, subd. (e) 9
§ 1342, subd. (f) 9, 39, 40
§ 1342, subd. (g) 9, 18, 41
§ 1342.6 .... 7, 41

TABLE OF AUTHORITIES

CONTINUED)

Page

§ 1348.6 7
§ 1348.6, subd. (b) 8
§ 1371 32
§ 1371.4 5
§ 1371.4, subd. (b) 2, 10
§ 1371.4, subd. (e) .... *passim*
§ 1371.25 11
§ 1371.35 32
§ 1371.37 32
§ 1375.4 .... 12, 14
§ 1375.4, subd. (a) 11, 14
§ 1375.4, subd. (b) 14
§ 1375.4, subd. (b)(1)(A) 15
§ 1375.4, subds. (b)(1)(A)(i)-(iv) 12
§ 1375.4, subd. (b)(4) 16, 17
§ 1375.4, subd. (c) 14, 18
§ 1375.4, subd. (g) 7, 19
§ 1375.5 12
§ 1375.5, subd. (g) 8
§ 1375.6 12
§ 1375.8 24
§ 1375.8, subd. (a) 25
§ 1375.8, subd. (a)(1) 25
§ 1375.8, subd. (b) 25
§ 1386 18
§ 1387 18
§ 1390 18
§ 1391 18
§ 1392 18

TABLE OF AUTHORITIES

CONTINUED)

Page

Regulations

California Code of Regulations
§ 1300.71, subd. (e) 28
§ 1300.71, subd. (e)(6) 27
§ 1300.75.4.1 14
§ 1300.75.4.2 .... 13, 14
§ 1300.75.4.2, subd. (b) 14
§ 1300.75.4.3 14
§ 1300.75.4.3, subd. (a) 21
§ 1300.75.4.3, subd. (e) 15
§ 1300.75.4.5, subd. (a)(4) 18
§ 1300.75.4.5, subd. (a)(5) 15
§ 1300.75.4.5, subd. (a)(6) 18
§ 1300.75.4.5, subd. (e) 18
§ 1300.75.4.5, subd.(d) 18
§ 1300.75.4.7 .... 13, 14, 15
§ 1300.75.4.8 .... 13, 15, 16
§ 1300.75.4.8, subd. (a) 16
§ 1300.75.4.8, subd. (c) 17
§ 1300.75.4.8, subd. (j) 17
§ 1300.75.4.8, subd. (k) 16
§ 1300.75.4.8, subd. (l) 17
§ 1300.75.4.8, subds. (a)(1)-(7) 16
§ 1300.75.4.8, subds. (e)-(f) 17
§ 1300.75.4.8, subds. (g)-(i) 17
§ 1300.76, subds. (b)(3)(A) 9, 27
§ 1300.76, subds. (b)(3)(B) 9, 27
§ 1300.76, subd. (f) 27

TABLE OF AUTHORITIES

CONTINUED)

Page

Other Authorities

Barron's Law Dict. (2d ed. 1984) 23

Dept. of Health Services, Enrolled Bill Rep. on Sen. Bill No. 1832 (1993–1994 Reg. Sess.), Sept. 9, 1994 31

Department of Managed HealthCare, *RBO & Capitated Providers*, <http://www.hmohelp.ca.gov/providers/rbo/rbo_cap.aspx> (as of Oct. 15, 2014); 9

Governor's veto message to Senate on Sen. Bill No. 117 (Oct. 10, 2001) 32

Sen. Bill No. 117 (2000–2001 Reg. Sess.) § 2, subd. (f) 32

I.

QUESTIONS PRESENTED

1. Does the delegation by a health care service plan (health plan) to an independent physicians association (IPA) under Health and Safety Code section 1371.4, subdivision (e) of the health plan's responsibility to reimburse emergency medical service providers for emergency care provided to the health plan's enrollees relieve the health plan of the ultimate obligation to pay for emergency medical care provided to its enrollees by non-contracting emergency medical service providers, if the IPA becomes insolvent and is unable to pay?

2. Does a health plan have a duty to emergency medical service providers to protect them from financial harm resulting from the insolvency of an IPA which is otherwise financially responsible for the emergency medical care provided to its enrollees?

II.

INTRODUCTION

In order to improve the quality of health care and control its cost, the California Legislature encourages health care service plans to enter into contracts with independent physicians associations (known as "IPAs" or risk-bearing organizations) to accept responsibility for managing the care of health plan enrollees

in exchange for monthly payments. As part of these managed care contracts, health plans are statutorily authorized to delegate to IPAs the obligation to pay non-contracted emergency physicians. In this case, defendant Health Plans entered into managed care contracts with and delegated their payment obligations to IPA La Vida in accordance with the comprehensive statutory and regulatory scheme adopted by the Legislature and the Department of Managed Health Care ("DMHC"). When La Vida subsequently began to experience financial problems, became insolvent, and could not meet the payment obligations it had assumed, plaintiff emergency physicians sued the Health Plans, asserting a common-law tort duty. Plaintiffs did not allege that the Health Plans violated any statutes, regulations, or directives of the DMHC in connection with their managed care contracts or the delegation of payment obligations. Under these circumstances, the Health Plans retained no obligation to pay plaintiffs for three reasons.

First, the California Legislature has specifically adopted the delegated model of health care services in the Knox-Keene Act. The purpose of this delegation model is to lower health care costs for patients "by transferring the financial risk of health care from patients to providers." (Health & Saf. Code § 1342, subd. (d).)[1] Subdivision (b) of section 1371.4, part of the Act's integrated

[1] All statutory references are to the Health and Safety Code unless otherwise noted.

managed care system, requires a health plan or its IPA to pay non-contracted emergency physicians for services rendered to the plan's enrollees. Subdivision (e), however, expressly permits health plans to "delegate" to IPAs their statutory responsibilities to reimburse non-contracted emergency physicians.

Through these managed care contracts, the financial risk of providing medical services (including emergency services) to health plan enrollees is shifted away from health plans and their enrollees and placed instead on IPAs, which retain all obligations to pay the providers. This model controls costs and improves quality of care by putting doctors closer to their patients both in terms of making medical decisions and managing the financial aspects of health care delivery, while also protecting the financial viability of providers and health plans.

Under the Legislature's comprehensive and integrated statutory scheme, overseen and enforced by the DMHC, once a health plan delegates its statutory obligation to reimburse emergency physicians to an IPA in accordance with the statutory scheme established in section 1371.4 and DMHC regulations, the health plan no longer retains residual liability to emergency physicians if the delegated IPA fails to pay. This is the only conclusion that comports with the fundamental purposes underlying the delegated model of health care the Legislature has adopted. Because the Health Plans delegated their payment obligations to La Vida in

accordance with the requirements of the statute and the regulations, the Health Plans have no statutory obligation to pay plaintiffs.

Second, the common-law duty that plaintiffs alleged and the Court of Appeal imposed cannot exist in the context of this highly regulated scheme, which establishes the parameters of any payment obligations health plans owe to providers. The Legislature and the DMHC carefully set the rules applicable to the health plan/IPA/emergency provider relationship, including when and how payment responsibilities may be delegated. Those rules not only address financial solvency concerns, but also include the requirement for plans to cooperate with corrective action plans established by the DMHC so as to minimize the risks of IPA failures, which would be detrimental to enrollees and providers. Where the Legislature has set forth ground rules governing proper delegation that carefully balance the interest of plans, their enrollees, IPAs, and individual providers, those statutory prescriptions must govern health plan conduct and liability. These statutory and regulatory provisions are the sole source of any health plan obligation to non-contracted emergency physicians, foreclosing the imposition of additional and inconsistent duties claimed to arise by virtue of a common-law tort duty.

Here, at the time the Health Plans entered into the managed care contracts with La Vida and delegated their payment responsibilities, La Vida was on the DMHC's list of financially solvent IPAs, and there are no allegations that the contracts violated

any statutory or regulatory requirements. Once La Vida's financial problems began to surface, the DMHC stepped in and imposed a mandatory corrective action plan with which the Health Plans were required to cooperate to restore the struggling IPA to solvency. Because the Health Plans delegated their payment obligations to La Vida pursuant to section 1371.4, subdivision (e), the Health Plans did not retain any obligation to reimburse plaintiffs for the reasonable value of their services to the Health Plans' enrollees. And, because section 1371.4, subdivision (e) expressly authorizes the delegation arrangements the Health Plans entered into, it precludes imposition of a duty of care arising from so-called "negligent delegations" where a plan delegated its obligations in accordance with the statute.

Third, not only is a common-law tort duty foreclosed by this comprehensive statutory and regulatory scheme, the *Biakanja* factors this Court has articulated to guide the analysis of whether a tort duty should be recognized in circumstances where no duty between the parties would otherwise exist are not met here.

In sum, a proper delegation under section 1371.4, which complies with the statutory and regulatory scheme, relieves a health plan of the ultimate obligation to pay emergency providers if the IPA later becomes insolvent and is unable to pay. And, the statutory and regulatory scheme establishes the duties owed by a health plan to emergency providers when the health plan delegates its payment obligation to an IPA. A health plan does not owe

emergency providers an additional and inconsistent tort duty to protect the providers from financial harm resulting from the insolvency of an IPA to whom the payment obligation has been properly delegated. The Court should reverse the judgment of the Court of Appeal and order plaintiffs' complaint to be dismissed.

III.
STATUTORY AND REGULATORY BACKGROUND

To address the issues in this appeal, it is necessary to describe the statutory and regulatory scheme governing managed health care in California. As will be shown, the Legislature has adopted a delegated model of managed health care and has charged the DMHC with monitoring the financial well-being of the participants in the system.

A. The Legislature Has Specifically Approved Risk-Shifting Agreements Between Health Plans And IPAs

"The Knox-Keene Act [the 'Act'] is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care." (*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215.) "All aspects of the regulation of health plans are covered [by the comprehensive system], including financial stability, organization, advertising and capability to provide health services." (*Van de Kamp v. Gumbiner*

(1990) 221 Cal.App.3d 1260, 1284.) The Health Plans are health care service plans licensed by the DMHC and subject to the Act.

California law authorizes health plans to provide health care services through a delegated model. (§ 1342.6 [declaring legislative intent "to promote various types of contracts between public or private payers of health care coverage, and institutional or professional providers of health care services"].) Under this model, a health plan contracts with medical professionals who accept responsibility for the financial risks and burdens of the care for the assigned enrollees in return for agreed-upon payments. (See *California Medical Assn., Inc. v. Aetna U.S. Healthcare of California, Inc.* (2001) 94 Cal.App.4th 151, 162 (*California Medical*).)

The flexibility the delegation model offers in terms of sharing of financial risk with providers is the key feature that distinguishes health care service plans licensed under the Act from health insurers licensed under the Insurance Code. Risk-shifting arrangements thus are the cornerstone of the delegated model. (See § 1342.6.) The Legislature has specifically approved risk-shifting arrangements, including capitation agreements with "risk-bearing organizations."[2] (§ 1375.4, subd. (g).) Section 1348.6 expressly

---

[2] Under the Act, an IPA is a risk-bearing organization ("RBO"), defined as "a professional medical corporation, other form of corporation controlled by physicians and surgeons . . . or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not

Continued on next page.

permits capitation payments, or shared-risk arrangements. (§ 1348.6, subd. (b).) The Legislature has recognized that, without this shift, the risk of rising health care costs would be borne by plans, and derivatively by their subscribers, whose rates are established based on the health costs experienced by the subscriber pool. (§ 1342, subd. (d).)

"Similarly, administrative regulations contemplate the contractual shifting of financial risk from health plans to other risk-bearing entities." (*California Medical*, *supra*, 94 Cal.App.4th at p. 162.) For example, 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 of contracted services without regard to the type, value or frequency of services provided." (Cal. Code Regs., tit. 28, § 1300.76, subd. (f).)[3] Consistent with this structure, services paid on a capitated basis are

---

Continued from previous page.

include an individual or a health care service plan, and that does all of the following: (A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees. (B) Receives compensation for those services on any capitated or fixed periodic payment basis. (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." (§ 1375.5, subd. (g).)

[3] All citations to Title 28 of the California Code of Regulations are henceforth abbreviated as "Regs."

excluded when calculating a health plan's required tangible net equity or reserve. (Regs. § 1300.76, subd. (b)(3)(A) & (B).)

In a capitation arrangement, in exchange for receiving a set fee per enrollee from a health plan, the IPA assumes full responsibility for the costs of a specified set of health care services for the health plan's enrollees, allowing the plan to keep premiums predictable and affordable. (See, e.g., *Desert Healthcare Dist. v. Pacificare FHP, Inc.* (2001) 94 Cal.App.4th 781, 785 (*Desert Healthcare*); *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782, 787, 790-793 (*Ochs*).)

This model is designed to realize the legislative goals set forth in section 1342: (1) ensuring 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"; (2) promoting "effective representation of the interests of" enrollees; (3) protecting the "financial stability" of the managed care system; and (4) providing patients with continuity of care. (§ 1342, subds. (d), (e), (f), and (g).)

The DMHC's website reflects a list of IPAs that are financially solvent and that meet the DMHC's financial grading criteria. La Vida was on that list when it entered into risk-shifting contracts with the Health Plans. (Department of Managed HealthCare, *RBO & Capitated Providers*, <http://www.hmohelp.ca.gov/providers/rbo/rbo_cap.aspx> (as of Oct. 15, 2014); Opn. 12, fn. 16.)

B. The Legislature Also Has Specifically Approved Delegation Of Payment Responsibilities For Emergency Services To IPAs

Under state and federal law, emergency care "shall be provided to any person requesting the services or care" at any hospital with appropriate facilities and qualified personnel. (§ 1317, subd. (a); 42 U.S.C. § 1395dd(b).) Such services are to be provided without regard to the patient's "insurance status, economic status [or] ability to pay" and without first questioning the patient as to insurance or ability to pay. (§ 1317, subd. (b); 42 U.S.C. § 1395dd(h).)

Section 1371.4 of the Act governs health plan reimbursement of providers for emergency services. Subdivision (b) requires health plans or their IPAs to pay for emergency care rendered to the health plans' enrollees regardless of whether the emergency care provider is under contract with the plan: "A health care service plan, *or its contracting medical providers*, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in the stabilization of the enrollee . . . . As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition." (§ 1371.4, subd. (b), italics added.)

Although the Legislature imposed an obligation on health plans to reimburse emergency care providers, it also authorized health plans to delegate that obligation. Thus, subdivision (e) of section 1371.4 expressly permits health plans to delegate payment responsibilities for emergency services to IPAs: "A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers." (§ 1371.4, subd. (e).)[4]

C. Risk-Shifting Contracts Between Health Plans And IPAs Are Subject To Detailed Statutory Requirements

The Act establishes detailed standards and requirements for capitation and risk-shifting agreements between health plans and IPAs. Section 1375.4 contains a series of detailed provisions regarding an IPA's "administrative and financial capacity" that must be included in "[e]very contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state . . . ." (§ 1375.4, subd. (a).) Specifically, the contract must include requirements that: (1) the risk-bearing organization furnish financial information to the health plan and

---

[4] The transfer of liability embodied in subdivision (e) is echoed in the Legislature's rejection of vicarious liability for health plans and IPAs. (§ 1371.25; *Watanabe v. California Physicians' Service* (2008) 169 Cal.App.4th 56, 64.) One who delegates its obligations is not vicariously liable for the acts or omissions of the delagatee. (See generally *California Assn. of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284, 296-297.)

meet any other financial requirements that assist the health plan in maintaining the financial viability of its arrangements for the provision of health care services; (2) the health plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract; and (3) the health plan timely pay the risk-bearing organization.

Section 1375.5 provides that an IPA contract shall not require the IPA "to be at financial risk for the provision of health care services, unless the provision has first been negotiated and agreed to between the health care service plan and the risk-bearing organization." It further provides that "[t]his section shall not prevent a risk-bearing organization from accepting the financial risk pursuant to a contract that meets the requirements of Section 1375.4." (§ 1375.5.) Section 1375.6 provides that no IPA contract shall require a provider to accept rates or methods of payment for services from the IPA "unless the provision has been first negotiated and agreed to between the health care service plan and the risk-bearing organization." (§ 1375.6.)

Section 1375.4 empowers the DMHC to adopt regulations to implement its provisions regarding the contents of IPA contracts, including a "process for reviewing or grading risk-bearing organizations based on" various criteria relating to their financial viability, specifically their liabilities, net equity and working capital. (§ 1375.4, subds. (b)(1)(A)(i)-(iv).)

The DMHC's implementing regulations impose *further* requirements for "[e]very contract involving a risk arrangement between a plan" and an IPA. (Regs. § 1300.75.4.7.) These regulations require that the contract permit the DMHC to "[o]btain and evaluate supplemental financial information pertaining to the" IPA in certain circumstances, including if the IPA fails to satisfy financial grading criteria or "experiences an event that materially alters its ability" to meet that criteria. (*Ibid.*) The regulations also require that the contracts obligate both the health plan and the IPA to cooperate with the DMHC's processes for rehabilitating a financially troubled IPA. (Regs. § 1300.75.4.8.)

D. The Legislature Has Charged The DMHC With Monitoring The Financial Stability Of IPAs Through Its Regulatory Oversight Of Health Plans

Under the Act, the DMHC's "charge" is over the "execution of the laws . . . relating to health care service plans and the health care service plan business . . . ." (§§ 1341, 1341.9 [enumerating powers of DMHC's Director].) "[T]he Legislature attempted to avoid the direct approach" of regulating IPAs "by indirectly reaching contracting entities through the health care service plans that" contract with them. (*Desert Healthcare*, *supra*, 94 Cal.App.4th at p. 791.) The DMHC monitors IPAs generally through two methods.

Oversight Of IPA Contracts: The DMHC is required to "periodically evaluate contracts between health care service plans

and risk-bearing organizations to determine if any audit, evaluation or enforcement actions should be undertaken by the department." (§ 1375.4, subd. (c).) Consistent with this statutory charge, the regulations require that IPA contracts contain provisions obligating IPAs to comply with the DMHC's review and audit process and permitting the DMHC to obtain and evaluate IPAs' financial information. (Regs. §§ 1300.75.4.2, 1300.75.4.7.)

The statutes and regulations also contain numerous other requirements regarding the contents of contracts between health plans and IPAs that are designed to facilitate DMHC oversight. (§ 1375.4; Regs. § 1300.75.4.7.) The regulations require that such contracts obligate IPAs and health plans to furnish financial information to one another. (Regs. § 1300.75.4.1.) In turn, health plans must periodically provide to the DMHC financial information regarding their operations as well as the finances of their contracting IPAs. (Regs. § 1300.75.4.3.) Indeed, the statutes are designed to ensure that health plans inform the DMHC if an IPA is not timely paying claims. (§ 1375.4, subds. (a) & (b).)

Review Of Financial Information: Section 1375.4 and the DMHC's regulations require IPAs to report quarterly financial information to the DMHC and to health plans. (§ 1375.4, subds. (a) & (b); Regs. § 1300.75.4.2, subd. (b).) These oversight requirements also include the timeframes within which IPAs must pay claims, the reserves they must maintain for incurred but unreported claims, requirements regarding positive tangible net equity, and level of working capital. (§ 1375.4, subd. (b); Regs.

§ 1300.75.4.2.) The statute and regulations also require the DMHC to review or grade IPAs based on these financial benchmarks. (§ 1375.4, subd. (b)(1)(A); Regs. § 1300.75.4.7.)

As noted, the regulations similarly require IPAs to comply with the DMHC's review process and allow the DMHC to obtain and evaluate supplemental financial information when necessary. (Regs. § 1300.75.4.7.) On its website, the DMHC explains that the purpose of these regulations is to "enable[] the DMHC to closely monitor the financial solvency of RBOs in order to keep this important component of the managed care system strong." (4AA571.)

Further, the regulations mandate that IPA contracts "ensure that the plan notifies the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that any of its contracting organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency." (Regs. § 1300.75.4.3, subd. (e); see also Regs. § 1300.75.4.5, subd. (a)(5).) And, the regulations require that the IPA contracts obligate the IPAs to comply with the corrective action process—the process designed to rehabilitate financially troubled IPAs discussed in more detail in Section E below. (Regs. § 1300.75.4.8.)

This regime gives the DMHC wide-ranging powers to enforce the financial solvency regulations applicable to IPAs. (§§ 1341, subd. (c), 1341.9.)

E. The Legislature Has Charged The DMHC With Implementing A Specific Process To Rehabilitate Financially Troubled IPAs

The Legislature also has created a process for corrective action plans to enable the DMHC to rehabilitate IPAs that fall below the financial benchmarks. (§ 1375.4, subd. (b)(4); Regs. § 1300.75.4.8; see also 4AA613-615.) The regulations require that when an IPA reports a grading deficiency or when the DMHC determines an IPA may lack financial capacity to meet its contractual obligations, the IPA must submit a corrective action proposal to the DMHC and its contracting health plans. (Regs. §§ 1300.75.4.8, subds. (a) & (k).)[5]

The IPA's proposal must identify the grading criteria it failed to meet, identify all plans with which it has contracts, describe the actions it has taken or will take to correct any deficiency such that it is "acceptable to the [DMHC]," describe the timeframe for completing the corrective action plan, and provide a schedule for submitting progress reports to the DMHC and health plans, among other things. (Regs. § 1300.75.4.8, subds. (a)(1)-(7).)

---

[5] A health plan and the IPA must mutually agree to a corrective action plan, but if they fail to do so, "the director [of the DMHC] shall determine the corrective action plan." (§ 1375.4, subd. (b)(4); Regs. § 1300.75.4.8, subd. (k).)

After the IPA's corrective action proposal is submitted, health plans may submit objections and recommendations for revisions to the proposal and the IPA may submit a revised proposal. (Regs. § 1300.75.4.8, subd. (c).) Health plans may then submit additional objections and recommendations to the IPA's revised corrective action proposal, and the DMHC must schedule a meeting with the IPA and health plans to resolve differences. (Regs. § 1300.75.4.8, subds. (e)-(f).) After this conference, the IPA must submit a final proposal to the DMHC, which has the final authority to approve, reject or modify the proposal. (Regs. § 1300.75.4.8, subds. (g)-(i); § 1375.4, subd. (b)(4).)

When a final plan is in place, the IPA must provide periodic progress reports to the DMHC and health plans. (Regs. § 1300.75.4.8, subd. (l).) The final corrective action plan remains in effect until the IPA demonstrates compliance with its requirements, or the plan expires based on its terms. (Regs. § 1300.75.4.8, subd. (j).) As described, the DMHC is deeply involved in the development and implementation of corrective action plans and has complete oversight over IPAs that fall below the financial benchmarks.

F. A Health Plan May Not Unilaterally Terminate Or Modify Its Contract With An IPA That Is Subject To A Corrective Action Plan

The regulations also severely limit a health plan's ability to terminate or modify an IPA contract and thereby defeat the

rehabilitative goal of the corrective action process. Health plans are expressly required to cooperate with the corrective action plan process. (Regs. § 1300.75.4.5, subds. (a)(4) & (d).)

For example, the regulations prohibit a health plan from effectuating a block transfer of its enrollees from an IPA that is working under a corrective action plan, without permission from the DMHC. (Regs. § 1300.75.4.5, subd. (a)(6).) The DMHC may "disapprove, postpone or suspend the plan's proposed transfer of enrollees if the department reasonably determines . . . [t]hat the proposed reassignment of enrollees will likely cause the [IPA's] failure . . . ." (*Ibid.*) The DMHC justified this interference with a health plan's contractual right to terminate the IPA contract on the ground that a *"single health plan cannot be allowed to disrupt the rehabilitation and corrective action plan process without Department approval."* (2AA574; see § 1342, subd. (g) [legislative intent is to ensure continuity of care].)

Finally, the DMHC has authority to address a health plan's violations of the corrective action plan process. A plan's failure to comply with that process "shall constitute grounds for disciplinary action." (§ 1375.4, subd. (c).) The DMHC may sanction violations by health plans through license suspensions and revocations, civil penalties, equitable relief, criminal fines, imprisonment, and cease and desist orders, among other things. (§§ 1386, 1387, 1390, 1391, 1392; Regs. § 1300.75.4.5, subd. (e).)

IV.

FACTUAL AND PROCEDURAL BACKGROUND

A. Pursuant To Health And Safety Code Section 1371.4, Subdivision (e), The Health Plans Delegate To IPA La Vida Their Responsibilities To Reimburse Emergency Service Providers For Care Provided To The Plans' Enrollees

Sometime prior to 2007, the Health Plans entered into contracts with La Vida for medical services to be provided to the Health Plans' enrollees in exchange for compensation on a capitated basis. (1AA38, 61.) As the complaint alleges, under these contracts, "La Vida accepted financial responsibility for covered health care services provided to Plan Enrollees, and bore the risk of loss if the capitation payments from the Health Plans failed to cover its reimbursement costs to providers such as Plaintiffs, while gaining a profit if the capitation payments exceeded those costs." (1AA38, 61.)

Plaintiffs have never disputed that, at the time of the delegations, La Vida was listed on the DMHC's website as an approved IPA, that is, as an IPA that was in compliance with the DMHC's financial grading criteria. In fact, the complaint alleges that La Vida was a risk-bearing organization "within the meaning of Cal. Health & Safety Code § 1375.4(g)." (1AA36.) Further, plaintiffs have never contended that the Health Plans failed to pay

La Vida under the IPA contracts, or that they violated any statute or regulation in entering into the IPA contracts with La Vida. (Opn. 10-11; 1AA43, 64-65.)

B. Subsequently, La Vida Experiences Financial Difficulty, Is Placed Under A Corrective Action Plan, And Ultimately Becomes Insolvent

The complaint alleges plaintiffs provided emergency services to Health Plan enrollees and sought reimbursement from La Vida. Beginning in 2007, La Vida allegedly failed to pay plaintiffs, in whole or in part, for services they rendered to the Health Plans' enrollees. (Opn. 10; 1AA38, 41, 64.) Also, allegedly beginning in 2007 and "continuing through each quarter thereafter, La Vida failed to comply with multiple financial solvency requirements, including Department of Managed Health Care Standards for maintaining sufficient working capital, tangible net equity and cash to pay provider claims. La Vida also fell short with respect to timely payment of provider claims." (1AA41.) By failing to meet certain financial requirements, including timely payment of claims, "positive tangible net equity, positive working capital and the requisite cash-to-claims ratio," La Vida allegedly violated certain regulations. (1AA43.)

In 2008, the DMHC placed La Vida under a corrective action plan. (Opn. 13; 4AA613-615.) Specifically, on February 14, 2008, 45 days after the end of the fourth quarter of 2007 when

La Vida allegedly began experiencing financial problems [1AA41], La Vida reported its failure to meet financial grading criteria (as required by section 1300.75.4.3, subdivision (a) of the regulations) and simultaneously submitted a proposed corrective action plan to the DMHC. (2AA211.) The DMHC then directed La Vida to "continue to work collaboratively with contracted health plans to ensure compliance with all financial solvency standards and requirements pursuant to Section 1300.75.4.2." (*Ibid.*) All of La Vida's contracting health plans were copied on this letter. (2AA212-213.) The Health Plans also were directly involved in the corrective action process, cooperating with the DMHC by providing comments on La Vida's proposed plan. (2AA259.) Plaintiffs have never contended that the Health Plans failed to cooperate with the DMHC regarding the corrective action plan or that the Health Plans violated any statute or regulation relevant to the corrective action plan process.

In October 2009, La Vida's lender filed bankruptcy and withdrew $4 million from La Vida's account. (1AA42.) "Around May and June 2010, *years* after La Vida first began openly demonstrating financial instability, the Health Plans finally discontinued their capitation payments to La Vida and terminated the Delegation Contracts. Shortly thereafter, La Vida closed its doors, laid off nearly every employee, turned off telephone and effectively went out of business." (*Ibid.*) Although plaintiffs do not allege the circumstances surrounding the Health Plans' termination of the capitation payments, they have never alleged that the DMHC

authorized the Health Plans to terminate the payments before May and June 2010, and they have never disputed that the terminations took place only after the DMHC directed the Health Plans to do so. (See 2AA269-301, 304-380.)

V.

LEGAL DISCUSSION

A. Section 1371.4, Subdivision (e) Authorized The Health Plans To Delegate Their Obligation To Reimburse Plaintiffs For Emergency Services Rendered To The Health Plans' Enrollees

1. The Use Of "Delegate" In Section 1371.4, Subdivision (e) Establishes The Legislature's Intent That Health Plans Not Retain Any Post-Delegation Liability To Non-Contracted Emergency Care Providers

When interpreting a statute, a court's task "'is to determine the intent of the enacting body so that the law may receive the interpretation that best effectuates that intent.'" (*Los Angeles Unified School Dist. v. Garcia* (2013) 58 Cal.4th 175, 186, quoting *City of Alhambra v. County of Los Angeles* (2012) 55 Cal.4th 707, 718-719.)

a. The Clear Statutory Language In The Context Of The Entire Knox-Keene Act Establishes An Intent That Health Plans Not Retain Any Post-Delegation Liability

The statute's language is the most reliable indicator of legislative intent. Courts give the words in a statute "their usual and ordinary meaning . . . ." (*Esberg v. Union Oil Co.* (2002) 28 Cal.4th 262, 268.) When statutory language is clear, "there is no need for construction and courts should not indulge in it." (*Ibid.*, internal quotation marks omitted.)

This principle of statutory construction compels the conclusion that a health plan's delegation of reimbursement responsibility in accordance with the requirements of section 1371.4, subdivision (e) precludes post-delegation liability for emergency care provided to the health plan's enrollees if the IPA is unable to pay. Subdivision (e) states that health plans "may delegate the responsibilities enumerated in this section"—including specifically the responsibility to reimburse emergency care providers—"to the plan's contracting medical providers." (§ 1371.4, subd. (e).) "Delegate" has a usual and ordinary meaning. A "'delegation' is commonly understood to mean the 'transfer of authority by one person to another, which may infer a general power to act for another's benefit or which may assign a debt to another.'" (*Ochs*, *supra*, 115 Cal.App.4th at pp. 789-790, quoting Barron's Law Dict. (2d ed. 1984), p. 124.) "[W]hen the

thing to be delegated is a legal *duty* of one party to another, the characterization of that duty as nondelegable is a shorthand way of saying that a party could not escape liability altogether by delegating this duty to someone else. Conversely, to say a duty is delegable is to say that there is no residual liability." (*Ochs*, *supra*, 115 Cal.App.4th at p. 790, citing *Seeley v. Seymour* (1987) 190 Cal.App.3d 844, 863.)

Other provisions of the Act support the ordinary meaning of the word "delegate." (*Coalition of Concerned Communities, Inc. v. City of Los Angeles* (2004) 34 Cal.4th 733, 737 ["We do not examine [statutory] language in isolation, but in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the various parts of the enactment."]; *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 506-507 [construing Health and Safety Code provision in context of other provisions in Knox-Keene Act].)

In particular, the Legislature has specified certain services for which financial risk may *not* be delegated. Emergency services are not among them. In section 1375.8, for example, the Legislature mandated that, notwithstanding any contractual risk-shifting arrangement, health plans retain the financial risk for certain medical treatments and procedures (e.g., chemotherapy, adult vaccines etc.) not including emergency services. Under this provision, the cost for such services must be reimbursed on a fee-for-service basis as mutually agreed to by health plans and IPAs,

unless an IPA expressly assumes the financial risk for the cost of such treatments. (§ 1375.8, subds. (a) & (b).) These medical services are not covered by the capitation fees because, in the Legislature's judgment, "the financial risk of these items is better retained by the health care service plan than by [the IPA]." (*Id.* at subd. (a)(1).) When the Legislature intended for health plans to retain financial risk notwithstanding a risk-shifting arrangement, it expressed that intent explicitly. (*City of Ontario v. Superior Court* (1993) 12 Cal.App.4th 894, 902 ["We must assume that the Legislature knew how to create an exception if it wished to do so[.]"].) But the Legislature did not mention emergency services in the list of services excluded from capitation arrangements. Therefore, it must be concluded that, for those medical services, the IPA assumes full financial risk. (*Rojas v. Superior Court* (2004) 33 Cal.4th 407, 424 [when the Legislature has excluded certain items from statutory coverage, courts "may not imply additional exemptions"]; *Kelly v. Methodist Hospital of Southern Cal.* (2000) 22 Cal.4th 1108, 1121 [Legislature's elimination of only certain exemptions indicates intent to maintain the other exemptions].)

The statute's usual ordinary meaning, therefore, in the context of the entire Act, is that, after delegating payment obligations to an IPA in accordance with section 1371.4, subdivision (e), a health plan does not retain any reimbursement obligation to non-contracting emergency care providers, even if the IPA is unable to pay.

Here, the Health Plans delegated their payment obligations to La Vida in accordance with subdivision (e). Plaintiffs specifically allege that La Vida was "a risk-bearing organization *within the meaning of Cal. Health & Safety Code §1375.4(g)* and [is] subject to the provisions of the Knox-Keene Act pursuant to their contract with the Health Plans." (1AA36, italics added.) Plaintiffs do not allege that La Vida was in financial difficulty at the time of the IPA contracts. In fact, plaintiffs have never disputed that, at the time the Health Plans entered into contracts with La Vida, La Vida appeared on the DMHC's list of IPAs that were in a compliance with financial grading criteria. Plaintiffs' complaint alleges typical risk-shifting arrangements, namely, ones pursuant to which "La Vida accepted financial responsibility for covered health care services provided to Plan Enrollees, and bore the risk of loss if the capitation payments from the Health Plans failed to cover its reimbursement costs to providers such as Plaintiffs, while gaining a profit if the capitation payments exceeded those costs." (1AA38, 61.)

As such, once the Health Plans delegated payment responsibility to La Vida pursuant to section 1371.4, subdivision (e), they did not retain any liability for La Vida's failure to pay emergency physicians like plaintiffs.

b. The DMHC's Implementing Regulations Support The Statute's Usual And Ordinary Meaning

The Act's implementing regulations reinforce the plain meaning of "delegation." As quasi-legislative acts within the DMHC's authority, those regulations are accorded the same weight as the provisions of the Act itself. (*Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 10-11 ["quasi-legislative rules have the dignity of statutes"].)

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 of contracted services without regard to the type, value or frequency of services provided." (Regs. § 1300.76, subd. (f), italics added.) In addition, the regulations provide that services paid on a capitated basis are excluded when calculating a health plan's required tangible net equity. (*Id.* at subds. (b)(3)(A) & (B).) This regulation allows health plans to remove from their reserves payment obligations that have been delegated. Thus, under the regulations, delegation of payment responsibility to an IPA results in the IPA's assumption of the full risk of providing services and a corresponding elimination of financial risk on the part of the delegating health plan.[6]

---

[6] Section 1300.71, subdivision (e)(6) of the regulations is not inconsistent with this conclusion. Subdivision (e)(6) provides that

Continued on next page.

Accordingly, the regulations confirm the usual and ordinary meaning of the statutory language.

c. The Statute's Usual And Ordinary Meaning Is Consistent With The Common Law

"Unless expressly provided, statutes should not be interpreted to alter the common law, and should be construed to avoid conflict with common law rules. A statute will be construed in light of common law decisions, unless its language clearly and unequivocally discloses an intention to depart from, alter, or abrogate the common-law rule concerning the particular subject matter . . . ." (*California Assn. of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284, 297, quoting *Goodman v. Zimmerman* (1994) 25 Cal.App.4th 1667, 1676 (internal quotation

---

Continued from previous page.

an IPA contract shall include a provision "authorizing the plan to assume responsibility for *the processing and timely reimbursement* of provider claims," if the IPA fails to do so (italics added). Contrary to the Court of Appeal's opinion, that regulation does not require that health plans re-assume the obligation to reimburse providers after a delegation. The entirety of subdivision (e) concerns prompt claims processing. (Regs. § 1300.71, subd. (e).) Given the specific legislative authorization of delegation in section 1371.4, subdivision (e), it is extremely implausible that the DMHC would have buried such an inconsistent *risk-re-shifting* provision in a regulation dealing with claims *processing*. Moreover, this subdivision only requires a contractual provision allowing a health plan the option to re-assume processing and timely reimbursement of claims if an IPA fails to do so. It does not impose a duty to re-assume payment obligation.

marks and citation omitted).) Accordingly, "[t]here is a presumption that a statute does not, by implication, repeal the common law." (*People v. Zikorus* (1983) 150 Cal.App.3d 324, 330.)

The usual and ordinary meaning of "delegate" is consistent with the common law: an authorized delegation to a third party of an obligation owed to another relieves the delegating party of any liability for breach of the duty. (See *SeaBright Ins. Co. v. US Airways, Inc.* (2011) 52 Cal.4th 590, 603 [where defendant airline owed a duty to provide a safe workplace to employees of independent contractor hired to maintain and repair conveyor belts at airport, and defendant delegated that duty to the independent contractor, defendant was not liable to the independent contractor's employee in negligence arising from violations of safety regulations]; *Tverberg v. Fillner Construction, Inc.* (2010) 49 Cal.4th 518, 528-529 [delegation of duty for task not involving peculiar risk precludes liability on part of delegating party].)

In *California Emergency Physicians Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127 (*Emergency Physicians*), the Court of Appeal applied these principles in rejecting liability in circumstances identical to this case. There, the defendant health plan had delegated its responsibility to reimburse emergency physicians to an IPA. 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. (*Id.* at p. 1130.) The court held that the term "delegate" in section 1371.4,

subdivision (e) precluded health plans' post-delegation liability to emergency care providers under any theory, including negligence. (*Id.* at p. 1132.)

The court reasoned that this result comports not only with the statute's ordinary meaning but also the historical construction of that term as reflected in the common law decisions. "The term 'delegate' has a specific meaning for licensees like health care service plans, which is expressed in the context of the 'well-established rule of *nondelegable* duty of licensees: 'Under that rule, a licensee remains liable for the acts of its agents and employees. [Citation.] 'The rule of nondelegable duties for licensees is of common law derivation. The essential justification for this rule is one of ensuring accountability of licensees so as to safeguard the public welfare.' [Citation.] Because a licensee like [the defendant health plan] remains liable for a *nondelegable* duty, when the Legislature used the term 'delegate' in subdivision (e), it must have intended that the obligations of section 1371.4 are *delegable* duties; that is, duties for which the health care service plan does not retain liability." (*Emergency Physicians*, *supra*, 111 Cal.App.4th at p. 1132.) Thus, "by using the term 'delegate,' the Legislature clearly and unequivocally disclosed an intention to depart from the common law rule that licensees are liable for the acts of their agents." (*Ibid.*; see also *Savient Pharmaceuticals, Inc. v. Department of Health Services* (2007) 146 Cal.App.4th 1457, 1465-1468 [because agency's contractual delegation of statutory duties to corporation in administration of AIDS drug assistance

program was authorized by statute and did not exceed scope of permissible delegation, plaintiff pharmaceutical company was not entitled to nullify delegation contract].)

d. The Statute's Legislative History Supports Its Clear Meaning

Section 1371.4's legislative history reinforces the Health Plans' position as to subdivision (e)'s clear meaning. (*Soukup v. Law Offices of Herbert Hafif* (2006) 39 Cal.4th 260, 279 [even though recourse to extrinsic material is unnecessary when a statute is clear, courts may consult it for material that buttresses their construction of the statute]; *In re Gilbert R.* (2012) 211 Cal.App.4th 514, 519 [same].)

Section 1371.4 was enacted in 1994 to require health plans to pay for emergency services by non-contracting physicians. An Analysis of Senate Bill No. 1832, the progenitor of section 1371.4, warned that the bill "would shift decision making authority regarding the provision of services to emergency providers, which would significantly reduce the ability of the health plans to manage overall care and costs." (Dept. of Health Services, Enrolled Bill Rep. on Sen. Bill No. 1832 (1993–1994 Reg. Sess.), Sept. 9, 1994, p. 6.) Subdivision (e) was added to reduce opposition from health plans. (*Emergency Physicians*, *supra*, 111 Cal.App.4th at p. 1132.) "Because the delegation provision of section 1371.4, subdivision (e) was enacted as a concession to health care service providers to enable them to better manage their costs, construing the subdivision

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.)

Another aspect of the legislative history bolsters this conclusion. In 2001, the Legislature passed Senate Bill No. 117. This bill would have amended subdivision (e) to add a new provision requiring health care service plans to pay emergency service providers if the IPA did not. (*Ochs*, *supra*, 115 Cal.App.4th at p. 791, citing Sen. Bill No. 117 (2000–2001 Reg. Sess.) § 2, subd. (f).)[7] However, the Governor vetoed the bill and it did not become law. In his veto message, the Governor stated in part: "SB 117 would adversely affect HMO patient care by . . . prohibiting delegated risk arrangements between HMOs and physician groups based upon the type of service." (Governor's veto message to Senate on Sen. Bill No. 117 (Oct. 10, 2001); *Emergency Physicians*, *supra*, 111 Cal.App.4th at p. 1132.) Thus, the Governor vetoed the bill precisely because he understood that, by requiring health care service plans to pay emergency service providers if an IPA did not,

---

[7] The amendment stated: "If a medical group or independent practice association has accepted the responsibility for payment of emergency services and care and fails to comply with the payment requirements of Sections 1371, 1371.35, and 1371.37, the provider may submit the complete claim to the health care service plan. The health care service plan shall pay the complete claim on a fee-for-service basis within 45 days of the provider's submission of the completed claim to the plan . . . ."

the amendment would essentially prohibit delegated risk arrangements.

"The Legislature's adoption of subsequent, amending legislation that is ultimately vetoed may be considered as evidence of the Legislative's understanding of the unamended, existing statute." (*Freedom Newspapers, Inc. v. Orange County Employees Retirement System* (1993) 6 Cal.4th 821, 832; *Irvine Co. v. California Employment Commission* (1946) 27 Cal.2d 570, 578 [veto of proposed amendment evidenced legislative intent as to meaning of existing statute].) "The 2001 legislation reflects 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." (*Emergency Physicians*, *supra*, 111 Cal.App.4th at p. 1133.)

Section 1371.4's legislative history therefore confirms that the Legislature intended the proper delegation of payment responsibilities to completely foreclose all post-delegation liability on the part of health plans, regardless of the IPA's ability to pay. Imposing post-delegation liability on health plans would be inconsistent with the Legislature's intent to permit health plans to delegate their statutory duty to IPAs. It also would effectively transform health plans' delegable statutory duty into a non-delegable one.

2. The Health Plans' Delegations To La Vida In Accordance With The Requirements Of The Statutory/Regulatory Scheme Mean The Health Plans No Longer Retain Responsibility To Reimburse Plaintiffs For Services They Provided To The Health Plans' Enrollees

The ordinary meaning of "delegate," the Act's implementing regulations, the case law regarding delegable and non-delegable duties, and section 1371.4's legislative history all point to the same conclusion—when the Health Plans delegated their statutory duties to reimburse emergency medical providers to La Vida pursuant to section 1371.4, subdivision (e), they did not retain any obligation to reimburse such providers if La Vida failed to pay.

The purpose of an IPA contract is to provide for the shifting of risk from a health plan to a risk-bearing organization in order to provide the best medical care at the lowest cost. This is accomplished by utilizing a capitation arrangement in which the IPA assumes the full risk for the cost of contracted services and the health plan does not retain any residual liability. Where a health plan has delegated its duties pursuant to section 1371.4, subdivision (e), to impose post-delegation negligence liability on the health plan would be completely inconsistent with the notion of the IPA assuming the full risk.

The Legislature knew that, under subdivision (e), health plans retained no residual liability for emergency services rendered to their enrollees by non-contracting emergency providers. Post-delegation retention of liability by health plans was the very purpose of the amendment that was passed in 2001 and that the Governor vetoed. Imposing liability in these circumstances would effectively rewrite subdivision (e) to conform it to the failed 2001 amendment. But, a "court cannot . . ., in the exercise of its power to interpret, rewrite the statute." (*Blair v. Pitchess* (1971) 5 Cal.3d 258, 282, internal quotation marks omitted.)

In sum, the Health Plans delegated their reimbursement obligations to La Vida as authorized by section 1371.4, subdivision (e). Accordingly, La Vida's failure to reimburse plaintiffs does not afford any basis to re-impose that obligation on the Health Plans and thereby shift back to them the same cost risk the Legislature has permitted them to delegate in order to manage health care costs.

B. Common Law Negligence Principles Cannot Override The Statutory Preclusion Of Liability

Plaintiffs' theory of liability is one of "negligent delegation." Plaintiffs maintain, and the Court of Appeal agreed, that even though section 1371.4, subdivision (e) expressly authorizes health plans to delegate their statutory obligation to reimburse emergency physicians, and even if the health plans' delegations were

made pursuant to that statutory authorization, health plans may nevertheless be held liable for delegating their payment obligations "negligently" under the factors for determining a duty of care set forth in *Biakanja*. This view is erroneous.

When a statute permits certain conduct, no liability for that conduct can attach under *any* legal theory. (*Emergency Physicians*, *supra*, 111 Cal.App.4th at p. 1133; *Gentry v. eBay, Inc.* (2002) 99 Cal.App.4th 816, 833-834 (*Gentry*).) Courts have applied this rule to bar a variety of tort claims, including negligence. (See *Gentry*, *supra*, 99 Cal.App.4th at p. 831 [negligence claim was barred because "substance of appellants' allegations reveal they ultimately seek to hold [defendant] responsible for conduct falling within the reach of" statute permitting such conduct]; *Harshbarger v. City of Colton* (1988) 197 Cal.App.3d 1335, 1341-1348 [because statute immunized public entities from liability for misrepresentations arising from commercial transactions between plaintiffs and public entities, plaintiff could not maintain claims for fraud or negligent hiring based on city employees' faulty inspection of construction]; *Williams v. State Farm Fire and Casualty Co.* (1990) 216 Cal.App.3d 1540, 1549 [rejecting liability for breach of the implied covenant of good faith and fair dealing based on insurer's cancellation of policy because statute permitted cancellation].)

These authorities prevent a plaintiff from pleading around a statutory bar to liability simply by opting not to allege a direct violation of the statute and instead relabeling the claim as one

for negligence or some other tort. *Emergency Physicians* applied this principle to bar a negligence claim, among others, based on a health plan's allegedly improper delegation of payment responsibilities to an IPA. In that case, 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. (*Emergency Physicians*, *supra*, 111 Cal.App.4th at p. 1130.)

As *Emergency Physicians* recognized, section 1371.4, subdivision (e) forecloses the imposition of a negligence duty on a health plan. (*Emergency Physicians*, *supra*, 111 Cal.App.4th at p. 1136.) "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-Keene Act." (*Ibid.*)

In these circumstances, to impose liability on the Health Plans would circumvent the statutory preclusion of liability and frustrate the Legislature's intent to allow delegation. Simply put, when a delegation of a statutory duty is in accordance with statutory and regulatory requirements, the law does not recognize the notion of a "negligent delegation." Conversely, if a delegation is not in compliance with such requirements, that is, when a party improperly purports to delegate a non-delegable duty or delegates it to an unauthorized individual, that party faces liability not because it

delegated its duty "negligently," but because its delegation was ineffectual such that the duty remained with that party in the first place. A party either may legally delegate a particular duty or it may not. Because the Health Plans had the statutory right to delegate their duty to reimburse emergency physicians, and because they did so in accordance with the requirements of the statutory scheme, they did not, after their delegation, become subject to a *tort* duty to perform the very same statutory duty they had delegated (reimburse emergency physicians).[8]

A negligence duty runs counter not only to section 1371.4, subdivision (e)'s specific authorization of delegation of responsibilities to reimburse emergency care providers, it also contravenes the fundamental purpose of the entire Act. (*In re Jorge M.* (2000) 23 Cal.4th 866, 880 [statutes should be interpreted in a manner "to further the legislative intent"].) As explained, the purpose behind the Act was to ensure "the financial stability" of the health care system "by means of proper regulatory procedures."

---

8 For these reasons, *Ochs'* recognition of a negligent delegation cause of action was in error. *Ochs* followed the reasoning of *Emergency Physicians* in holding that the quantum meruit claim in that case was properly dismissed because such a claim "would frustrate the law" and "thwart the Legislature's intent . . . when the law expressly permits such delegations." (*Ochs*, supra, 115 Cal.App.4th at p. 794.) But *Ochs* failed to consistently apply this reasoning to the negligence claim, failing to recognize that allowing a negligent delegation claim would thwart the Legislature's intent in the same manner as allowing a quantum meruit claim. Thus, *Ochs* represents a departure from the weight of precedent and is inconsistent with its own reasoning.

(§ 1342, subd. (f).) The financial solvency of health plans and IPAs is a primary focus of that system. In that regard, the Legislature has adopted detailed procedures for monitoring the financial solvency of health plans and IPAs and dealing with financially troubled IPAs. It has charged the DMHC with the task of monitoring the financial solvency of IPAs and rehabilitating financially troubled IPAs through corrective action plans. The cornerstone of that process is the preservation of the status quo by maintaining an IPA's capitation arrangements in order to give that IPA an opportunity to re-establish compliance with the DMHC's financial grading criteria. The regulations do not contemplate that an individual health plan will act unilaterally when an IPA is undergoing a corrective action plan. Rather, the action a health plan may take when an IPA experiences financial problems is subject to strict DMHC oversight and control.

Contrary to this clear legislative and regulatory mandate, the Court of Appeal held that health plans are required, post delegation, to re-assume responsibility for paying emergency physicians in the event the IPA fails to do so. 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." (Opn. 40, fn. 36.) The Court of Appeal's suggested dismantling of the IPA's delegated responsibility is not only impractical, it also is incompatible with the Legislature's intent.

If a health plan is required to re-assume payment obligations that it had delegated to an IPA and paid for in the capitated payment to the IPA, that reassumed payment obligation will have an impact on the plan's capitation payments to the IPA going forward. The health plan cannot continue to make the same monthly payments to an IPA where the health plan has been required to re-assume a substantial part of the financial liability that had factored into the calculation of the capitation rate in the first place. This reduction in monthly revenue may exacerbate an IPA's financial stress, and some IPAs that might have emerged intact from a corrective action plan may fail because of the decrease in capitation payments. An IPA's demise would have severe repercussions not only for that IPA but also other stakeholders in the system. A defunct IPA, for instance, would no longer be able to reimburse any of its contracted physicians. Of course, anything that can undermine the financial viability of a financially troubled IPA also would interfere with the DMHC's efforts to rehabilitate that IPA through a corrective action plan. (*Loeffler v. Target Corp.* (2014) 58 Cal.4th 1081, 1123–1124, 1130 [rejecting claim because it "could displace the [administrative agency] and the procedures currently established by the Legislature" regarding enforcement of tax laws].) In sum, any post-delegation duty on the part of health plans would conflict with the Legislature's goal to ensure "the financial stability" of the health care system "by means of proper regulatory procedures" overseen by the DMHC. (§ 1342, subd. (f).)

Such a post-delegation duty also would undermine the manageability and predictability of health care costs and 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 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"].)

There are still other challenges that the Court of Appeal's judicially prescribed fix fails to take into account. These include the difficulty a health plan would face in determining when to step in to re-assume payment obligations, especially since an IPA can be on "marginal" status for years and still satisfy its financial obligations. Moreover, the kind of duty the Court of Appeal has fashioned also can have a de-incentivizing effect on the IPA, causing it to discourage enrollees from seeking emergency care.

The Court of Appeal premised its holding on the fact that the Legislature has mandated that emergency care providers treat patients regardless of insurance or ability to pay—a duty not imposed on other health care providers. According to the Court of Appeal, because of this special statutory burden, if an IPA fails to reimburse emergency care providers, "the resulting loss should be borne by" the health plans. (Opn. 4.) The court stated: "The burden of providing services to the poor cannot be accomplished at the expense of one particular group of people." (Opn. 33.) Yet, the court's opinion does precisely that—it requires health plans to bear that burden even though they have already paid for those services in the form of capitation payments made pursuant to IPA contracts. Accordingly, in balancing the economic interests of the various groups involved, the Court of Appeal engaged in a legislative function and it did so in a manner contrary to the express legislative intent.

Section 1317 and the Emergency Medical Treatment and Labor Act (42 U.S.C. § 1395dd *et seq.*), its federal counterpart, were intended for a different purpose. These statutes placed this burden on emergency physicians as a condition of their holding themselves out as emergency service providers. (See, e.g., § 1317.6, subd. (g) [hospital violating section 1317 may have its emergency services permits revoked or suspended].) It was these statutes that compelled plaintiffs to provide services "regardless of insurance or ability to pay." However a court may view the Legislature's wisdom in requiring emergency physicians to provide

uncompensated care, it does not justify disregarding the clear and explicit recognition of a health care service plan's delegation of financial responsibility under section 1371.4, subdivision (e).

What is particularly troubling is that the Court of Appeal carried out its own re-balancing of the competing economic interests when the Legislature already has taken those divergent interests into account in formulating this statutory scheme. Although the Legislature required emergency care providers to treat all patients regardless of ability to pay and required health plans to reimburse such providers, it also allowed health plans to delegate their statutory duty as part of the *larger* economic policy determination embodied in the Act—to allow risk-shifting arrangements in order to lower managed care costs overall. Imposing a negligence duty in these circumstances improperly *re*-distributes risk and strikes a *new* economic balance that threatens the equilibrium that the Legislature sought to achieve and that is reflected in the statutory scheme.

C. A Health Plan Owes No Duty To Protect Emergency Medical Providers From Financial Harm Caused By The Insolvency Of An IPA To Whom The Health Plan Has Properly Delegated Payment Responsibility Pursuant To Section 1371.4, Subdivision (e)

"Recognition of a duty to manage business affairs so as to prevent purely economic loss to third parties in their financial

transactions is the exception, not the rule, in negligence law." *Quelimane Co. v. Stewart Title Guaranty Co.* (1998) 19 Cal.4th 26, 58 (*Quelimane*).) "In the business arena it would be unprecedented to impose a duty on one actor to operate its business in a manner that would ensure the financial success of transactions between third parties. With rare exceptions, a business entity has no duty to prevent financial loss to others with whom it deals directly. A fortiori, it has no greater duty to prevent financial losses to third parties who may be affected by its operations." (*Ibid.*) Thus, there is no "duty to avoid business decisions that may affect the financial interests of third parties, or to use due care in deciding whether to enter into contractual relations with another." (*Ibid.*)

This Court has recognized an exception to this general rule in certain narrow circumstances, namely, where benefit to the plaintiff is the end and aim of the contractual transaction at issue and there is a close and foreseeable connection between the defendant's conduct and the plaintiff's injury. In *Biakanja v. Irving* (1958) 49 Cal.2d 647 (*Biakanja*), this Court expressed this general rule in terms of several factors, "among which are the extent to which the transaction was intended to affect the plaintiff, the foreseeability of harm to him, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, and the policy of preventing future harm." (*Biakanja, supra,* 49 Cal.2d at p. 650.)

Here, the Court of Appeal concluded that, under *Biakanja*, health plans owe a duty to emergency care providers to protect them from financial harm resulting from an IPA's insolvency. This conclusion is incorrect. First, as demonstrated above, a delegation in accordance with section 1371.4, subdivision (e) precludes liability under all theories, including negligence. Second, *Biakanja* militates against imposition of a duty in this case.

1. The Health Plans Did Not Enter Into Contracts With La Vida Intending To Affect Plaintiffs

To satisfy the first *Biakanja* factor, the end and aim of the business transaction at issue must have been to affect the plaintiff or a determinate, "specific, foreseeable and well-defined class" of plaintiffs. (*Beacon Residential Community Assn. v. Skidmore, Owings & Merrill LLP* (2014) 59 Cal.4th 568, 584.)

In *Goodman v. Kennedy* (1976) 18 Cal.3d 335 (*Goodman*), this Court held that shareholders could not maintain a negligence claim against the attorney for officers of a corporation, even though the attorney misadvised the officers that certain stock could be issued to the shareholders as dividends and sold to third parties without jeopardizing the stocks' exemption status under securities laws. The plaintiff shareholders alleged that the stocks depreciated in value due to the loss of the exemption. (*Id.* at pp. 340-341.) Addressing the "intent to affect" *Biakanja* factor, the Court explained that "plaintiffs were not persons upon whom defendant's clients had any wish or obligation to confer a benefit in

the transaction. Plaintiffs' only relationship to the proposed transaction was that of parties with whom defendant's clients might negotiate a bargain at arm's length." (*Id.* at p. 344.) The Court thus concluded that this factor weighed against a duty of care.

This Court rejected a negligence claim under similar circumstances in *Summit Financial Holdings, Ltd. v. Continental Lawyers Title Co.* (2002) 27 Cal.4th 705 (*Summit*). In that case, the defendant, a title company, was instructed by the parties to the escrow to pay a note by issuing a check to a certain party. The defendant did so despite knowing that the rights to the note had been assigned to the plaintiff. (*Id.* at p. 708.) This Court held that the first *Biakanja* factor was not satisfied because the transaction was "not intended to affect or benefit" the plaintiff. (*Id.* at p. 715.) The Court explained that the escrow company was hired to assist in closing a loan transaction, not to confer some benefit on the plaintiff. Thus, "any impact that transaction may have had on [the plaintiff] was collateral to the primary purpose of the escrow." (*Ibid.*)

Although this Court reached a different result in *Beacon,* its formulation of the first *Biakanja* factor was consistent with *Goodman* and *Summit.* In *Beacon*, this Court held that architectural firms owed a duty of care to condominium homeowners who alleged that homes were negligently designed and as a result became uninhabitable during high temperatures. The Court concluded that the first *Biakanja* factor was satisfied because the "defendants engaged in work on the Project with the knowledge

that the finished construction would be sold as condominiums and used as residences." (*Beacon*, *supra*, 59 Cal.4th at pp. 583-584.)

The Court distinguished that case from *Bily v. Arthur Young & Co.* (1992) 3 Cal.4th 370 (*Bily*), where the Court concluded that an auditor that had examined a corporation's books prior to a public offering owed no duty of care to its client's investors who invested in the corporation in reliance on the auditor's opinions. The Court explained that the architects occupied a different position because, unlike in *Bily*, there "was no uncertainty . . . as to 'the existence, let alone the nature or scope, of the third party transaction that resulted in the claim.'" (*Beacon*, *supra*, 59 Cal.4th at p. 584, quoting *Bily*, *supra*, 3 Cal.4th at p. 400.) Rather, the "[d]efendants' work on the Project 'was intended to affect the plaintiff,' and 'the "end and aim" of the transaction was to provide' safe and habitable residences for future homeowners, a specific, foreseeable, and well-defined class." (*Ibid.*, quoting *Biakanja, supra*, 49 Cal.2d at p. 650.) There was thus no "'spectre of vast numbers of suits and limitless financial exposure.'" (*Ibid.*, quoting *Bily, supra*, 3 Cal.4th at p. 400.) "Instead, defendants 'clearly intended to undertake the responsibility of influencing particular business transactions [i.e., condominium purchases] involving third persons [i.e., prospective homeowners] . . . .'" (*Ibid.*, quoting *Bily, supra*, 3 Cal.4th at p. 408; accord *Christensen v. Superior Court* (1991) 54 Cal.3d 868, 891 [close relatives of deceased whose remains were mishandled by defendant mortuary could maintain a negligence claim against the

defendant because "a benefit to the plaintiff[s] was the purpose of the contract and the damage was foreseeable"]; *J'Aire Corp. v. Gregory* (1979) 24 Cal.3d 799, 804-805 [contractor who undertook construction work pursuant to contract with owner of premises had a duty to lessee not to unreasonably delay construction because the purpose of the contract was to benefit the lessee by renovating the premises in which it maintained its business].)

Here, the first *Biakanja* factor strongly disfavors a duty of care. The "end and aim" of the IPA contracts was not to provide some benefit to non-contracted emergency physicians, or indeed to any physicians. Specifically, the Health Plans did not enter into the contracts in order to ensure that non-contracted emergency physicians were reimbursed the reasonable value of their services. The Health Plans were already under a statutory duty to reimburse plaintiffs. The contracts therefore were not needed, and were not intended, to ensure that emergency physicians or any other health service provider was reimbursed for the value of services.

The end and aim of the IPA contracts was entirely different. As noted above, IPA contracts are arrangements pursuant to which health plans pay IPAs a capitated fee per enrollee in return for the IPAs' assumption of risk for the cost of providing care to that enrollee. The Act permits these arrangements for the specific purpose of distributing risk by shifting the cost of medical services to IPAs. The overarching goal of this system is to provide the best medical care at the lowest cost. The Health Plans contracted with La Vida in order to accomplish the risk/cost shifting encouraged by

the Act. As in *Summit*, the effect of the arrangements upon emergency care providers "was collateral to [their] primary purpose" of cost management of medical care through risk shifting. (*Summit*, *supra*, 27 Cal.4th at p. 715.) To the extent reimbursement of any physician group was a consideration at all, it "'was only a collateral consideration of the transaction.'" (*Goodman*, *supra*, 18 Cal.3d at p. 344, quoting *Biakanja*, *supra*, 49 Cal.2d at p. 650.)

Moreover, because the Health Plans/La Vida contracts were not limited to emergency care providers, the Health Plans could not have intended to affect a "specific, foreseeable, and well-defined class" comprised solely of non-contracted emergency physicians. (*Beacon*, *supra*, 59 Cal.4th at p. 584.) When a health plan contracts with an IPA, that contract covers all health care services rendered for the health plan's enrollees. Indeed, Plaintiffs allege that the Health Plans "delegate[d] their duties" to La Vida for *all* covered health care services. Thus, the IPA contract shifts the costs of reimbursement for all providers that deal with an IPA, not just a particular set of physicians like non-contracted emergency care physicians. And, the contract shifts the costs for all medical services (with the exception of certain ones that cannot be delegated by statute, as discussed above, or as otherwise agreed). Consequently, recognizing a duty of care in these circumstances presents the prospect of "'liability in an indeterminate amount for an indeterminate time to an indeterminate class.'" (*Bily*, *supra*, 3 Cal.4th at p. 385, quoting *Ultramares Corp. v. Touche* (1931) 255 N.Y. 170, 179, 174 N.E. 441, 444.)

This analysis does not change *after* a delegation, that is, when a health plan becomes aware that an IPA is no longer in compliance with the DMHC's financial grading criteria. An IPA's development of financial problems does not somehow create a duty on a health plan to protect non-contracted emergency physicians from financial harm where no such duty existed at the time of the delegation. The fact that an IPA begins experiencing financial problems does not transform a risk-shifting arrangement into a transaction whose end and aim is to benefit non-contracted emergency physicians. An IPA can experience financial problems because of a myriad of causal factors (see infra 54-55, 57). Thus, notice to a health plan that a delegated IPA is no longer in compliance with the DMHC's financial grading criteria does not constitute notice that those problems are due to that health plan's particular contractual arrangement. Nor do an IPA's financial problems put a health plan on notice of a determinate and well-defined class of plaintiffs that could be affected by the health plan's particular contract with the IPA. As noted, an IPA contract does not distinguish among different providers. Accordingly, the first *Biakanja* factor cannot be satisfied simply because an IPA develops financial problems after it enters into a capitation arrangement with a health plan.

2. The Connection Between The Risk-Shifting Contracts And Plaintiffs' Injury Is Remote

In *Bily*, this Court concluded that the connection between the auditor's actions and the plaintiffs' harm was remote because it was "attenuated by unrelated business factors that underlie investment and credit decisions . . . ." (*Bily, supra,* 3 Cal.4th at p. 402.) The Court explained that "[i]nvestment and credit decisions are by their nature complex and multifaceted. Although an audit report might play a role in such decisions, reasonable and prudent investors and lenders will dig far deeper in their 'due diligence' investigations than the surface level of an auditor's opinion. And, particularly in financially large transactions, the ultimate decision to lend or invest is often based on numerous business factors that have little to do with the audit report." (*Id.* at pp. 401-402.)

Similarly, in *Quelimane,* this Court refused to recognize a duty of care in circumstances where there was no close connection between the alleged negligent conduct and the plaintiffs' injury. In that case, the plaintiffs, who purchased tax-defaulted properties intending to resell them at a profit, asserted a negligence claim against a title insurance company because of its refusal to issue title insurance on tax-defaulted properties. The plaintiffs alleged they were injured because the defendant's refusal to issue title insurance lowered the value of the properties and reduced the plaintiffs' profits. This Court held that the defendant's conduct was too

remote from the injury to support a duty of care. (*Quelimane*, *supra*, 19 Cal.4th at p. 58.) The Court explained that "unavailability of title insurance is simply one factor in the market price of tax-defaulted property," and thus the "relationship between the [plaintiff] seller's lost profit, if any, and defendant's conduct is tenuous at best." (*Ibid.;* cf. *Beacon*, *supra*, 59 Cal.4th at p. 583 [finding a close connection between the architects' negligence and condominium owners' injury because architects "played a lead role not only in designing the Project but also in implementing the Project design"].)

Here, the connection between the IPA contracts and plaintiffs' injury—not receiving the reasonable value of their services for treatment rendered to the Health Plans' enrollees—is even more attenuated than the connection between the auditor's opinion and the investment losses in *Bily* or the refusal to issue title insurance and the plaintiffs' lost profits in *Quelimane*. Plaintiffs allege that La Vida began to show signs of financial problems in 2007, after it had entered into contracts with the Health Plans. Plaintiffs also allege that it was not until 2009 that La Vida lost funding from its lender, precipitating its collapse. During the period La Vida was in financial difficulty, it was undergoing a corrective action plan under the DMHC's supervision. Thus, according to plaintiffs' own allegations, La Vida did not begin to experience financial problems until after the contracts were entered into and did not become incapable of meeting its obligations until several years after it began experiencing financial problems. Moreover, La Vida

became insolvent only after its lender went into bankruptcy *and* the corrective action plan did not succeed in rehabilitating its finances.

Bily warned against deriving a tort duty by adopting a "revisionist view" of events, one that ignores all of the variables that could have contributed to the plaintiffs' injury and assigns undue causal weight to the defendant's alleged actions. (*Bily, supra,* 3 Cal.4th at p. 401.) The Court pointed out that when the investors' losses in that case were viewed realistically in the context of the myriad causal factors involved, what emerged was "something less than a 'close connection'" required for a tort duty. (*Ibid.*)

The same is true here. Although plaintiffs' complaint alleges a timeline of causal events leading to their injury, it assigns dispositive weight to the IPA contracts. Not only does this approach ignore the numerous other, and more proximate, causes of plaintiffs' injury, it also improperly distorts the causal picture by lumping all of the contracts together. A tort duty cannot be imposed on a particular defendant because of the conduct of the *other* defendants. Plaintiffs must establish a close connection between *each* defendant's contract and plaintiffs' injury, not between all of the contracts and their injury.

When the question is properly framed, it becomes even clearer that there is no close connection between each defendant's contract and plaintiffs' injury. Like the reasons for the failure of the investments in *Bily*, the reasons for La Vida's failure and plaintiffs'

ultimate injury were "complex and multifaceted." (*Bily*, *supra*, 3 Cal.4th at p. 400.) Those reasons included not only La Vida's access to credit and the failure of the corrective action plan, but also La Vida's financial management, the total number of enrollees it serviced under its contracts with all of its contracting health plans, the medical needs of its enrollees at any given time, the number of doctors (both contracted and non-contracted) submitting claims to La Vida, the amount of those claims, and a myriad other financial and economic factors on both a micro (La Vida-specific) and macro (relating to the health care industry and the economy in general) level. Just as the unavailability of title insurance in *Quelimane* was but "one factor in the market price of" the properties and the plaintiffs' resulting injury [*Quelimane*, *supra*, 19 Cal.4th at p. 58], here, each Health Plan's particular contract was at most but one—and probably minor—factor in La Vida's financial problems and plaintiffs' ultimate inability to obtain reimbursement. According to plaintiffs' own allegations, their injury was years in the making, and it was brought about by a number of factors external to the IPA contracts. Given this complex chain of causal events, the relationship between plaintiffs' injury and any particular arrangement is "tenuous at best." (*Quelimane*, *supra*, 19 Cal.4th at p. 58.)[9]

---

[9] Clearly, this nexus analysis does not change when the focus is placed on post-delegation events for the simple reason that the causal picture remains unaltered. In other words, the causal connection

Continued on next page.

3. The Health Plans Could Not Reasonably Have Foreseen Plaintiffs' Injury

This Court in *Bily* took pains to point out that because foreseeability, like light, can be "endless" and "travel[] indefinitely in a vacuum," it is "but one factor to be considered in the imposition of negligence liability." (*Bily, supra,* 3 Cal.4th at p. 398, internal quotation marks omitted.) The Court explained that policy factors play a more important role in the duty analysis, whose goal is to avoid "virtually unlimited responsibility for intangible injury." (*Ibid.*)

As explained above, recognizing a duty of care here would threaten to impose limitless liability on health plans to an indeterminate group of plaintiffs. Moreover, that liability exposure would be antithetical to the statutory scheme, whose purpose is to allow the shifting of health care costs through risk-shifting contracts. Although these considerations should preclude a duty as a matter of policy, the reality is that the absence of causal and temporal

---

Continued from previous page.

between an IPA contract and plaintiffs' injury is no "closer" after a delegation than it is at the time of the delegation, since the IPA's post-delegation financial problems could have been caused by any number of complicated and interrelated factors apart from the capitation payments from one particular health plan.

proximity between the contracts and plaintiffs' injury also defeats an inference of reasonable foreseeability.

In order for the Health Plans to have foreseen plaintiffs' injury at the time the IPA contracts were entered into, *each* Health Plan would have had to foresee that La Vida would encounter financial difficulties at some point in the future. But such foresight is beyond human capacity. When a health plan enters into an IPA contract, it cannot foresee how its particular capitation arrangement will impact the financial condition of that IPA or whether that IPA will remain financially viable in the future. An IPA's financial condition does not depend on its arrangement with one particular health plan. It depends on a host of factors, including that IPA's arrangements with other health plans, its operating costs, its management, the total number of enrollees it services, the health care needs of its enrollees at any particular time, its access to capital markets, its credit worthiness which affects the interest rate it can negotiate on loans, the number of contracted doctors in its network, the number of doctors, contracted and non-contracted, who present claims for payment, the timing of the claims, the turnaround time for paying claims, the amount of the claims, and the cost of medical services in general. In addition to having no basis to predict an IPA's financial viability, a health plan also cannot judge how an IPA's possible financial difficulties will affect that IPA's relationships with the medical providers to whom the IPA is indebted, the number of physicians, or the amount of outstanding claims.

Further, the foreseeability of injury did not become greater after the contracts were entered into, that is, when the Health Plans became aware that La Vida was experiencing financial problems. The relevant inquiry is whether each Health Plan should have foreseen that plaintiffs might be injured because of *its* contract. But a particular Health Plan's awareness that La Vida was undergoing financial problems would not give that Health Plan reason to believe that those financial problems were caused by *that* Health Plan's capitation arrangement. Moreover, since the entire purpose of a corrective action plan is to rehabilitate a financially troubled IPA, the Health Plans could not reasonably have foreseen the eventual failure of that corrective action plan and La Vida's ultimate collapse, much less that those events would lead to the non-payment of non-contracted emergency physicians' bills.

4. The Health Plans' Conduct Is Not Morally Culpable

Moral culpability for purposes of imposing a duty of care requires some unlawful conduct or conduct amounting to bad faith. "[T]he moral blame that attends ordinary negligence is generally not sufficient"; something more, such as bad faith, unlawful conduct, or reckless indifference, is required. (See *Adams v. City of Fremont* (1998) 68 Cal.App.4th 243, 270; *Campbell v. Ford Motor Co.* (2012) 206 Cal.App.4th 15, 32 [when considering whether to impose a duty of care, "courts require a higher degree of moral culpability" than what is involved in ordinary negligence]; cf. *Biakanja*, *supra*, 49 Cal.2d at p. 651 [defendant notary was

deserving of moral blame because, by preparing a will, he had engaged in the unauthorized practice of law].) Thus, courts have required a higher degree of moral culpability such as where the defendant intended or planned the harmful result [*McCollum v. CBS, Inc.* (1988) 202 Cal.App.3d 989, 1005], had actual or constructive knowledge of the harmful consequences of their behavior [*Rosenbaum v. Security Pacific Corp.* (1996) 43 Cal.App.4th 1084, 1098; *Beacon*, *supra*, 59 Cal.4th at p. 586], acted in bad faith or with a reckless indifference to the results of their conduct [*Dutton v. City of Pacifica* (1995) 35 Cal.App.4th 1171, 1176], or engaged in inherently harmful acts [*Scott v. Chevron, U.S.A.* (1992) 5 Cal.App.4th 510, 517].

Here, plaintiffs' allegations do not furnish any basis to infer moral culpability on the part of any of the Health Plans. The Health Plans were permitted by law to delegate their payment obligations to La Vida. Indeed, the underlying purpose of the Act is to encourage such risk-shifting arrangements in order to provide the best medical care at the lowest cost. Plaintiffs do not allege that any of the Health Plans engaged in inherently harmful acts or that any of them had actual or constructive knowledge that La Vida would fail years later and that that failure would result in the non-payment or underpayment of non-contracted emergency physicians.

The Health Plans' awareness after the risk-shifting arrangements were entered into that La Vida was having financial problems does not support an inference of moral culpability.

Because a financially troubled IPA is automatically subjected to a corrective action plan, a health plan cannot be blamed for trusting in and cooperating in that process (as the statutory and regulatory scheme required it to do, or be penalized). Contrary to the Court of Appeal opinion [Opn. 32-33], a health plan is not morally culpable for failing to pay emergency physicians when the IPA fails to do so, because the health plan has already paid the IPA for that service and under the statutory and regulatory scheme does not retain any reimbursement obligation.

5. Imposing A Duty Of Care Would Not Further Any Policy To Prevent Future Harm

The policy of preventing future harm also does not support the recognition of a duty of care. The comprehensive system of statutes and regulations as well as DMHC oversight designed to ensure the financial health of IPAs like La Vida demonstrates that the Legislature has entrusted the DMHC with the task of preventing future harm to all participants in the health care system. As this Court explained in *Bily*, courts should not "'engage in complex economic regulation under the guise of judicial decisionmaking.'" (*Bily*, *supra*, 3 Cal.4th at p. 406, quoting *Harris v. Capital Growth Investors XIV* (1991) 52 Cal.3d 1142, 1168 & fn. 15.)

This is especially true when imposing a duty of care could have adverse economic consequences. (*Bily*, *supra*, 3 Cal.4th

at pp. 404-405 [rejecting duty of care on auditors because, *inter alia,* it could result in "an increase in the cost and decrease in the availability of audits"]; *Adelman v. Associated Intern. Ins. Co.* (2001) 90 Cal.App.4th 352, 367 [policy of future harm factor weighed against imposing a duty of care because imposing such a duty would have "serious adverse consequences"].) As explained above, imposition of a negligence-based duty on health plans could undermine the DMHC's efforts to rehabilitate struggling IPAs through the corrective action plan process with a corresponding economic ripple effect on other participants in the health care system. When it comes to risk-shifting arrangements in the health care field, future harm is best prevented by allowing the Legislature to handle the "complex economic decisionmaking" this Court has warned courts to avoid. In this way, the underlying legislative goal to provide health plan enrollees the best medical care at the lowest cost may be attained.

VI.
CONCLUSION

For all of these reasons, the Court should reverse the judgment of the Court of Appeal and order plaintiffs' complaint dismissed.

DATED: October 15, 2014.

REED SMITH LLP

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

DATED: October 15, 2014.

CROWELL & MORING, LLP

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

DATED: October 15, 2014.

By ____________________________
Jennifer Salzman Romano
Attorneys for *UHC of California f/k/a Pacificare of California*

DATED: October 15, 2014.

REED SMITH LLP

By ______________________________

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

DATED: October 15, 2014.

CROWELL & MORING, LLP

By

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

DATED: October 15, 2014.

By ______________________________

Jennifer Salzman Romano
Attorneys for *UHC of California f/k/a Pacificare of California*

DATED: October 15, 2014.

REED SMITH LLP

By ______________________________

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

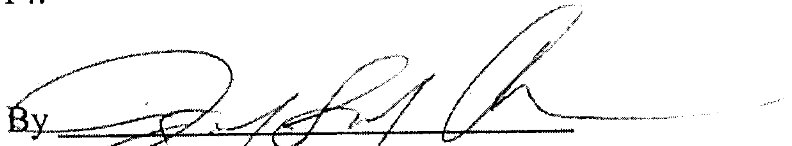
DATED: October 15, 2014.

CROWELL & MORING, LLP

By ______________________________

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

DATED: October 15, 2014.

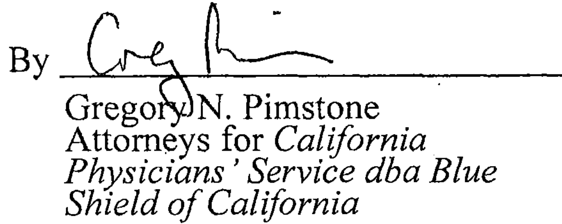


By ______________________________

Jennifer Salzman Romano
Attorneys for *UHC of California f/k/a Pacificare of California*

DATED: October 15, 2014.

MANATT, PHELPS & PHILLIPS, LLP

By 

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

DATED: October 15, 2014.

COOLEY LLP

By ______________________________

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

DATED: October 15, 2014.

GIBSON, DUNN & CRUTCHER LLP

By ______________________________

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

DATED: October 15, 2014.

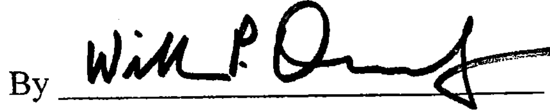
MANATT, PHELPS & PHILLIPS, LLP

By ______________________________

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

DATED: October 15, 2014.

COOLEY LLP

By 

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

DATED: October 15, 2014.

GIBSON, DUNN & CRUTCHER LLP

By ______________________________

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

DATED: October 15, 2014.

MANATT, PHELPS & PHILLIPS, LLP

By ______________________________

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

DATED: October 15, 2014.

COOLEY LLP

By ______________________________

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

DATED: October 15, 2014.

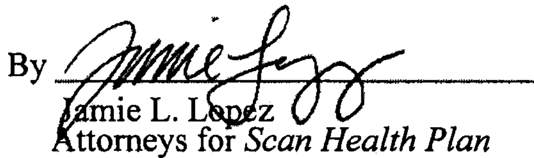
GIBSON, DUNN & CRUTCHER LLP

By

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

DATED: October 15, 2014.

GONZALEZ SAGGIO & HARLAN LLP

By 

Jamie L. Lopez
Attorneys for *Scan Health Plan*

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

I, Margaret M. Grignon, 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 Opening Brief on the Merits in this case.

3. The brief was produced on a computer, using the word processing program Microsoft Word 2003.

4. According to the Word Count feature of Microsoft Word 2003, the Opening Brief on the Merits contains 13,956 words, including footnotes, but not including the table of contents, table of authorities, and this Certification.

5. Accordingly, the Opening Brief on the Merits complies with the requirement set forth in Rule 8.504(d)(1), that a brief produced on a computer must not exceed 14,000 words, including footnotes.

I declare under penalty of perjury that the forgoing is true and correct and that this declaration is executed on October 15, 2014, at Los Angeles, California.

Margaret M. Grignon

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 October 15, 2014, I served the following document(s) by the method indicated below:

OPENING BRIEF ON THE MERITS
FILED CONCURRENTLY WITH
MOTION FOR JUDICIAL NOTICE

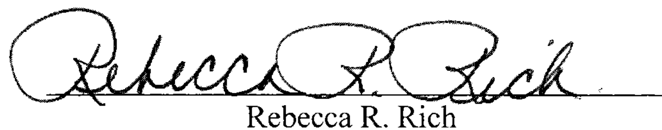
☐ by transmitting via facsimile on this date from fax number +1 213 457 8080 the document(s) listed above to the fax number(s) set forth below. The transmission was completed before 5:00 PM and was reported complete and without error. The transmission report was properly issued by the transmitting fax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

☒ 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. 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 E-MAIL] by transmitting via email to the parties indicated at the email addresses listed below:

☐ (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 October 15, 2014, at Los Angeles, California.



Rebecca R. Rich

Centinela Freeman Emergency Medical Associates. V. Health Net of California, Inc., et al.
Supreme Court Case No. S218497
Court of Appeal, Second Appellate District, Division Three, Case No. B238867
(Los Angeles Superior Court Case No. BC415203)

SERVICE LIST

Andrew H. Selesnick, Esq. Jason O. Cheuk, Esq. 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, Sherman Oaks Emergency Medical Associates; Valley Presbyterian Emergency Medical Associates* and *Westside Emergency Medical Associates*
Robin James, Esq. Michelman & Robinson, LLP 1 Post Street, Suite 2500 San Francisco, CA 94104 Tel: (415) 882-8772 Fax: (415) 882-1570 rjames@mrllp.com	Attorneys for Plaintiffs and Appellants, *Centinela Freeman Emergency Medical Associates, Sherman Oaks Emergency Medical Associates; Valley Presbyterian Emergency Medical Associates* and *Westside Emergency Medical Associates*
William A. Helvestine, Esq. Ethan P. Schulman, Esq. Crowell & Moring LLP 275 Battery Street, 23rd Fl. San Francisco, CA 94111 Tel: (415) 986-2800 Fax: (415) 986-2827 whelvestine@crowell.com eschulman@crowell.com Damian D. Capozzola, Esq. Crowell & Moring 515 South Flower Street, 40th Fl. Los Angeles, CA 90071 Tel: (213) 622-4750 Fax: (213) 622-2690 dcapozzola@crowell.com 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 *Health Net of California, Inc.* ***Via Email*** Attorneys for Defendant and Respondent *Health Net of California, Inc.* ***Via Email*** Attorneys for Defendant and Respondent *UHC of California, f/k/a Pacificare of California* ***Via Email***

Richard J. Doren, 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 and Respondent *Aetna Health of California, Inc.* ***Via Email***
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* ***Via Email***
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.* ***Via Email***
Don A. Hernandez Jamie L. Lopez 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* ***Via Email***
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, 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 Tel: (213) 897-2000	Served pursuant to Bus. & Prof. Code § 17209 and Cal. Rules of Court 8.29(a) and (b)