# 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.



# REPLY 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
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# I.

# INTRODUCTION

In adopting the delegated model of health care (see Health and Safety Code section 1342)[1] and obligating emergency physicians to treat all patients regardless of ability to pay (section 1317), the Legislature carefully considered the competing economic and societal interests of patients, medical professionals and other providers, health plans and risk-bearing organizations. The statutes and regulations attempt to strike a balance between the desire for high quality care, including emergency care, and the need to deliver that care at the lowest possible cost. Risk-shifting arrangements like the ones at issue in this case are integral to that system, because they enable health plans and providers to control costs while also ensuring quality care.

As part of this complex regulatory framework, the Legislature has decreed that emergency physicians treat all patients regardless of ability to pay, including the uninsured and the indigent. In section 1371.4, however, the Legislature mandated certain financial protections for non-contracted emergency physicians who treat patients enrolled in health plans, by requiring that the health plans ***or*** their delegated IPAs reimburse the physicians the reasonable value of services. And, in the same statute, the Legislature expressly authorized health plans to delegate their reimbursement obligations to IPAs. Thus, the emergency physicians' treatment obligations, the health plans' reimbursement obligations,

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

and the health plans' right to delegate their reimbursement obligations to IPAs are inextricably intertwined by statutes and regulations.

There is no question that, here, the Health Plans delegated their obligations to La Vida pursuant to section 1371.4—that is, to an IPA the DMHC had listed as in sound financial health. In doing so, the Health Plans complied with all statutes and regulations pertaining to delegation arrangements. These facts dispose of plaintiffs' negligence claim because a duty of care in these circumstances would circumvent section 1371.4 and allow what the Legislature intended to foreclose—post-delegation liability on health plans after they lawfully carried out the risk-shifting essential to the legislatively adopted delegated model of health care.

The Legislature's intent to provide for clear-cut risk-shifting through delegation is established not just by section 1371.4's unambiguous language. That intent is reflected in other sources of statutory interpretation as well, such as the vetoed amendment of section 1371.4 that would have imposed exactly the kind of post-delegation liability plaintiffs urge here; the fact that the Legislature, through section 1375.8, restricted the delegation of responsibility for certain kinds of medical treatments despite expressly allowing delegation of emergency services in section 1371.4; and the fact that, five years after *California Emergency Physicians Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127, 1132 (*CEP*), the Legislature amended section 1371.4 to add "or its contracting medical providers," making it even more clear that the post-delegation reimbursement obligation falls only on IPAs. Just as plaintiffs' answer brief makes no attempt to justify negligence liability based on the text of

section 1371.4, it fails to come to terms with the host of other indicators of legislative intent to preclude post-delegation liability.

Plaintiffs' claims also fail because, in entering into delegation agreements with La Vida, the Health Plans had no duty to prevent financial harm to non-contracted emergency physicians like plaintiffs. The Health Plans did not intend to affect this undefined group of physicians, and they could not reasonably foresee that an IPA like La Vida, which was listed by the DMHC as financially sound, would collapse at some point in the distant future for myriad unknown and unknowable reasons, and that its collapse would injure plaintiffs specifically as non-contracted emergency physicians. Indeed, in their answer brief, plaintiffs make no attempt to demonstrate a duty of care under *Biakanja v. Irving* (1958) 49 Cal.2d 647 (*Biakanja*), completely failing to address any of the Health Plans' arguments as to the individual *Biakanja* factors.

To the contrary, plaintiffs largely avoid discussing section 1371.4 or *Biakanja*. Instead, plaintiffs candidly urge that health plans should be held liable for a delegated IPA's failure to pay non-contracted emergency physicians because such physicians are especially "vulnerable" and deserving of payment and, therefore, courts should carve out of the statutory scheme a special exception to ensure that they (out of all the participants in the managed care system) are guaranteed full compensation.

This Court should reject plaintiffs' request to rewrite the statutes and depart from the Court's prior precedents as to when a party owes a duty to protect others from financial harm. Enforcing the law as written also is consistent with public policy. Contrary to plaintiffs' claims, a post-delegation

negligence duty would interfere with the DMHC's efforts to rehabilitate financially troubled IPAs. Just as problematic, such a duty would undermine the legislative policy judgments reflected in the Knox-Keene Act and upset the balance of economic and societal interests the Legislature has sought to achieve.

The Court should reverse the judgment of the Court of Appeal and reinstate the trial court's judgment for the Health Plans.

## II.

## ARGUMENT

### A. The Relevant Statutes, Regulations, And Case Law All Point To One Legislative Intent—The Health Plans' Delegation Of Payment Responsibility Pursuant To Section 1371.4, Subdivision (e) Relieved Them Of Post-Delegation Liability

Plaintiffs' answer brief is a misfire on two levels. First, plaintiffs largely ignore section 1371.4—the dispositive statutory provision here—and the statutory framework regarding delegation arrangements in general. Second, plaintiffs offer no meaningful analysis of section 1317, neglecting the legislative intent behind that provision. Instead, plaintiffs focus on disparate statutes, regulations and cases that are irrelevant to the issues under review.

As demonstrated below, section 1317 reflects the Legislature's conscious imposition of some financial burden on emergency physicians. The Legislature took specific steps to ameliorate that burden, including requiring health plans to reimburse non-contracted emergency physicians for the reasonable value of services rendered to health plan enrollees.

Nevertheless, the Legislature also enacted section 1371.4, subdivision (e) expressly authorizing health plans to delegate that responsibility to IPAs. Nothing in the statutes or regulations contemplates post-delegation liability for health plans. Rather, all of the authorities confirm that when a health plan delegates its obligations to an IPA pursuant to section 1371.4, only the IPA remains liable. Thus, the relevant statutes, regulations, and case law foreclose a duty of care.

### 1. The Legislature Recognized That Emergency Physicians May Have To Bear A Financial Burden Because Of Section 1317, And Gave Health Plans The Right To Delegate To IPAs Their Reimbursement Obligations To Non-Contracted Emergency Physicians

As plaintiffs emphasize, section 1317 mandates that emergency physicians treat all patients regardless of ability to pay. Although plaintiffs insist the Legislature could not have intended for emergency physicians to provide uncompensated or undercompensated services, the Legislature was cognizant that section 1317 created an added financial burden on emergency physicians and that, on occasion, emergency physicians would have to provide uncompensated or undercompensated care. However, the Legislature decided to address those concerns through specific statutory provisions applicable to the treatment of uninsured and insured patients.

To begin, the legislative intent behind section 1317 is reflected in the note to section 1317—the uncodified portion of that statute. (*Carter v. California Dept. of Veterans Affairs* (2006) 38 Cal.4th 914, 925 ["An uncodified section is part of the statutory law."].) That note provides: "The Legislature finds and declares that the provision of emergency medical care is a vital public

service of great benefit to Californians. It is necessary for the protection of the health and safety of Californians that a comprehensive and high quality system of emergency medical services be provided." (Historical and Statutory Notes, West's Ann. Health & Saf. Code foll. § 1317.) The note reflects the Legislature's recognition of "the breadth of the uncompensated and undercompensated care problems facing California providers which serve large numbers of unsponsored persons." (*Ibid.*) The Legislature also understood that "physicians who provide emergency care to anyone in need, regardless of ability to pay, incur losses resulting from care of patients who have no third-party source of payment or for whom available payment is grossly inadequate to cover the costs of providing such care." (*Ibid.*)

Thus, contrary to what plaintiffs argue [ABOM 28], the Legislature was mindful that section 1317 means that emergency care providers may sometimes have to provide undercompensated or even completely uncompensated services to some patients. Nevertheless, the Legislature decided as a policy matter to impose the treatment obligation on emergency physicians.

To alleviate the financial burden of providing care to *uninsured* patients, the Legislature passed section 1797.98a. That provision established an Emergency Medical Services Fund to "provide limited funding to partially offset the losses [emergency] providers incur for treating unsponsored patients . . . ."

"Therefore, by enacting this legislation, the Legislature is providing a means of *partial* funding for these vital services." (*Ibid.*)[2]

While the emergency services fund partially offsets the cost of providing emergency services to *uninsured*, indigent persons, section 1371.4 provides for compensation when non-contracted emergency physicians render services to *insured* patients. (*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 220 (*Bell*) ["the health care plans' duty to reimburse arises out of the providers' duty to render services without regard to a patient's insurance status or ability to pay"].) The provisions requiring reimbursement of emergency physicians are section 1371.4's subdivisions (b) and (c). Lest there be any doubt that the reimbursement obligation rests on *either* the health plan or the IPA, the Legislature amended section 1371.4 in 2008 to add the phrase "or its contracting medical providers" in subdivisions (b) and (c). As amended, subdivision (b) provides that a "health care service plan, **or its contracting medical providers,** shall reimburse providers for emergency services and care provided to its enrollees . . . ." Symmetrically, subdivision (c), as amended, provides that "[p]ayment for emergency services and care may be denied only if the health care service plan, **or its contracting medical providers,** reasonably determines that the emergency services and care were never performed . . . ."

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[2] "The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code." (§ 1797.98a, subd. (c).) Government Code section 76000 sets forth the monetary penalties for violations of the Vehicle Code or local ordinances passed pursuant to the Vehicle Code. Section 1797.98a requires that each County establish and administer the emergency services funds and contains detailed provisions as to the method and amount of reimbursement for emergency services from the fund.

Accordingly, the 2008 amendment made it clear that the obligation to reimburse non-contracted emergency physicians does not rest solely or even principally with health plans.

Even more significantly, in the *same* statute stating the reimbursement obligation belongs to a health plan "or" its delegated IPA, the Legislature also expressly provided that a health plan "may delegate the responsibilities" to reimburse emergency physicians "to the plan's contracting medical providers." Section 1371.4 therefore leaves no ambiguity about the effect of a delegation—health plans do not retain any obligation to reimburse emergency care providers after a delegation.

Because of the mandates in subdivisions (b) and (c), and contrary to plaintiffs' characterization of themselves as a "vulnerable" group, non-contracted emergency physicians who treat health plan enrollees are almost always reimbursed for the reasonable value of their services by health plans or their delegated IPAs. And, they have legal recourse against a delegated IPA if the IPA fails to reimburse them. The situation involved in this lawsuit thus arises only in the extraordinary circumstance of an IPA's insolvency. But that type of extraordinary event does not shift the delegated reimbursement obligation back to the health plan.

Had the Legislature intended for health plans to retain post-delegation liability, it could have manifested that intent in a number of ways. It could have, for instance, used the word "and" instead of "or" in subdivisions (b) and (c) to signal that a health plan remains jointly liable with its contracting medical providers notwithstanding the health plans' right to delegate.

Alternatively, the Legislature could have included language in subdivision (e) to circumscribe the delegation, as it did for certain non-emergency services. In section 1375.8, for example, the Legislature mandated that, notwithstanding any contractual risk-shifting arrangement, health plans must retain the financial risk for a select list of medical services, including chemotherapy and adult vaccines. (§ 1375.8, subds. (a) & (b).) This list does *not* include emergency services. (*Id.*) Capitation fees paid under delegation contracts do not cover this list of excluded medical services 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).) The Legislature could have adopted a similar carve out for the financial risk associated with emergency services, but it did not. Instead, it expressly permitted the delegation of that financial risk. (*City of Ontario v. Superior Court* (1993) 12 Cal.App.4th 894, 902 [courts assume "the Legislature knew how to create an exception if it wished to do so"].)

The Knox-Keene Act's regulatory scheme likewise demonstrates the clear-cut nature of risk-shifting arrangements by defining "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] Plaintiffs do not explain how a provider's assumption of the "full risk for the cost of contracted services" can be reconciled with the

[3] All future references to regulations shall be to California Code of Regulations, title 28.

notion of post-delegation liability—that is, a health plan's retention of some of the risk of contracted services.

Other aspects of the Knox-Keene Act reinforce the cogency of this analysis. Just as the Legislature endeavored to partially alleviate the emergency physicians' financial burden in treating uninsured indigent patients, it also addressed the problem posed by a failing IPA. The Legislature, however, did not address that problem by creating some special fund, as it did with regard to uninsured indigent patients. Nor did the Legislature tackle that issue by diluting health plans' ability to effectuate risk-shifting through delegation, as it did with chemotherapy and adult vaccines.

Rather, the Legislature addressed the issue by empowering the DMHC with tools to safeguard IPAs' financial health. (See generally § 1341, subd. (a) [describing DMHC's broad regulatory and administrative powers regarding "the execution of the laws of this state relating to health care service plans *and the health care service plan business*"] (italics added); § 1341.9 [describing DMHC director's powers and broad jurisdiction].)[4] The Knox-Keene Act's implementing regulations accordingly include numerous mechanisms that enable the DMHC to monitor the financial integrity of IPAs and to restore the viability of financially troubled IPAs through corrective action plans. (§ 1375.4, subd. (b)(4); Regs. § 1300.75.4.8 subds. (a), (k) and (l) [detailing procedures for corrective action plans].)

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[4] The DMHC may sanction violations through license suspensions and revocations as well as various penalties. (§§ 1386, 1387, 1391, 1392.)

Section 1371.4's legislative history further demonstrates the Legislature's intent to foreclose post-delegation liability. The progenitor of section 1371.4 did not have a delegation provision. Subdivision (e) was added "as a concession to health care service [plans] to enable them to better manage their costs," and therefore "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 v. PacifiCare of California* (2004) 115 Cal.App.4th 782, 791 (*Ochs*).)

Additionally, in 2001, the Legislature attempted to amend section 1371.4 as plaintiffs are urging here—to ensure that health plans retain post-delegation liability if an IPA fails to pay. The Governor vetoed the bill because it "would adversely affect HMO patient care by . . . prohibiting delegated risk arrangements between [health plans] and physician groups based upon the type of service." (Governor's veto message to Senate on Sen. Bill No. 117 (Oct. 10, 2001); *CEP*, *supra*, 111 Cal.App.4th at p. 1132.) This reflects the Legislature's understanding that section 1371.4, as it existed in 2001 and as it exists today, forecloses post-delegation liability on health plans.

Section 1371.4's plain language, along with other available indicia of legislative intent, uniformly confirm that a health plan's obligation to reimburse non-contracted emergency physicians is delegable in the ordinary sense of that term. And "to say a duty is delegable is to say that there is no residual liability." (*Ochs, supra,* 115 Cal.App.4th at p. 790; accord *SeaBright Ins. Co. v. US Airways, Inc.* (2011) 52 Cal.4th 590, 603 [airline that delegated duty to repair and maintain conveyor belt to independent contractor had no residual liability].) As *CEP* recognized, a statutorily-permitted delegation of

reimbursement responsibility forecloses liability on the part of the delegating health plan under any theory. (*CEP, supra,* 111 Cal.App.4th at p. 1136.)

### 2. *Bell* And *Prospect* Have No Bearing On The Well-Established Principle That Statutorily-Permitted Delegation Forecloses Liability For The Delegating Health Plan

Plaintiffs argue that *CEP* is outdated and that *Bell* and *Prospect* have diminished its precedential value. (ABOM 37-41.) Plaintiffs do not argue that *Bell* or *Prospect* conflicts with *CEP*. Rather, they claim that *CEP* should be disapproved because *Bell* and *Prospect* changed "the compensation landscape for non-contracted emergency physicians . . . ." (ABOM 39.)

While *Bell* and *Prospect* clarified the compensation landscape for non-contracted emergency physicians, nothing about those clarifications affects the soundness of *CEP*'s holding or reasoning. In *Bell,* the class of non-contracted emergency service providers sued a health plan seeking reimbursement for the reasonable value of the emergency services provided to health plan enrollees. (*Bell*, *supra*, 131 Cal.App.4th at p. 214.) The court held the plaintiffs could sue for quantum meruit under an "implied-in-law right" for the reasonable value of their services. (*Id.* at pp. 215-221.)

*Bell* did not involve a delegation contract and does not suggest that emergency providers are entitled to reimbursement from health plans after a delegation. The only duty at issue in *Bell* was the health plan's duty. (*Bell*, *supra*, 131 Cal.App.4th at p. 220.) When a health plan delegates its reimbursement obligations, *Bell's* only import is that non-contracted emergency physicians can seek the reasonable value of their services *from the IPA*.

Developments subsequent to *CEP* and *Bell* reinforce the correctness of *CEP's* reasoning. As noted, section 1371.4, subdivisions (b) and (c) were amended in 2008—*after* both decisions—to add the "or its contracting medical providers" language, leaving no doubt that the reimbursement obligation belongs *either* to the health plan or the IPA when a delegation has occurred. In 2008, *CEP* had been published for five years. As this Court has held, "when the Legislature amends a statute without altering portions of the provision that have previously been judicially construed, the Legislature is presumed to have been aware of *and to have acquiesced in the previous judicial construction.* Accordingly, reenacted portions of the statute are given the same construction they received before the amendment." (*Marina Point, Ltd. v. Wolfson* (1982) 30 Cal.3d 721, 734 [italics added].)[5] The Legislature's amendments thus did not undermine, but instead strengthened *CEP's* holding.

Interpreting the applicable statutes and regulations, this Court held in *Prospect* that when a health care service plan pays less than the amount billed by an emergency care provider, the emergency care provider cannot bill the patient for the balance ("balance billing"). (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 502 (*Prospect*).)

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[5] Plaintiffs also argue the DMHC's amicus brief in *Bell* shows the DMHC believes the Knox-Keene Act does not bar post-delegation liability. (ABOM 19.) The DMHC's amicus brief in *Bell* is irrelevant here. The DMHC apparently took the position that a provider's action against a health plan for the reasonable value of services did not infringe upon the DMHC's jurisdiction. The DMHC took no position regarding the ramifications of a post-delegation negligence duty, as *Bell* did not involve such issues. Moreover, unlike in *Bell,* here post-delegation liability would infringe on the DMHC's jurisdiction. (See Section D, *infra*.)

That non-contracted emergency physicians cannot balance bill patients does not mean they can circumvent section 1371.4 and effectively "balance bill" health plans. Like *Bell, Prospect* did not involve delegation contracts and therefore did not undermine the holding of *CEP* in any way. To the contrary, *Prospect's* prohibition on balance billing seems to undermine plaintiffs' claim that non-contracted emergency physicians are entitled to the full value of their services in all circumstances.

Thus, neither *Bell* nor *Prospect* diminishes *CEP*'s holding or reasoning regarding the legal effect of a statutorily-compliant delegation of reimbursement responsibility. As demonstrated next, it is undisputed that the Health Plans delegated their obligations to La Vida in compliance with section 1371.4. As such, La Vida, and only La Vida, was obligated to reimburse plaintiffs the reasonable value of their services.

### 3. Because The Health Plans' Delegations Complied With Section 1371.4 And The Regulations Pertaining To Delegation Contracts, All Of Plaintiffs' Claims Fail

In their opening brief, the Health Plans noted that plaintiffs do not allege that the Health Plans failed to comply with section 1371.4 or any applicable regulation pertaining to delegations. (OBOM 19-20, 34-35.) Plaintiffs do not take issue with this argument in their answer brief. To the contrary, plaintiffs' summary of their allegations confirms that the delegations were authorized.

For example, consistent with their complaint [1AA38, 61], plaintiffs assert that the delegation contracts "allocated to La Vida the risk of loss if the

Health Plans' capitation payments were insufficient to cover the costs of the medical services rendered to enrollees," but that, if the capitation payments exceeded those costs, La Vida would have realized a profit. (ABOM 11-12.) Plaintiffs also do not disavow their allegation that La Vida was a risk-bearing organization "within the meaning of Cal. Health & Safety Code § 1375.4(g)." (1AA36.) And, to this day, plaintiffs do not dispute that the DMHC's website identified La Vida as meeting its financial grading criteria. Further, plaintiffs have never contended, and still do not contend, that the Health Plans failed to pay La Vida under the IPA contracts, or that they violated any statute or regulation in contracting with La Vida. (1AA43, 65-66.)

In addition to failing to allege any statutory or regulatory non-compliance at the time of the delegations, plaintiffs also do not claim the Health Plans violated any delegation-related statute or regulation *after* La Vida began experiencing financial problems. Plaintiffs do not dispute, and have never disputed, that La Vida was under a corrective action plan and that the Health Plans cooperated with the DMHC in that process. (4AA613-615; 2AA211-213.) Indeed, although plaintiffs insist the Health Plans should have unilaterally re-assumed payment responsibility from La Vida after it started experiencing problems, they have never alleged that the DMHC authorized the Health Plans to terminate their capitation payments to La Vida before May and June 2010, and they have never disputed that such terminations took place only after the DMHC directed the Health Plans to do so. (2AA264-301, 304-380.)

Thus, there is no question that the Health Plans' delegations were made *pursuant to* section 1371.4, subdivision (e)—both at the time of the initial delegations and thereafter. As such, under section 1371.4, subdivisions (b) and

(c)—only La Vida—the Health Plans' "contracting medical provider" had the obligation to reimburse plaintiffs.

## B. Plaintiffs' Authorities Do Not Support Post-Delegation Liability

Instead of addressing the dispositive statutory provisions regarding the questions under review, plaintiffs devote the majority of their brief to discussing statutes and regulations that are either irrelevant to post-delegation liability or that, when properly understood, support the Health Plans' position. Specifically, plaintiffs cite section 1371.25 and Regulations section 1300.71 for the proposition that the "Knox-Keene Act permits . . . a cause of action against the Health Plans for negligent delegation of the Health Plans' payment obligations . . . ." (ABOM 15.) However, nothing in these provisions alters the conclusion that a delegation pursuant to section 1371.4 bars post-delegation liability.

### 1. Section 1371.25 Provides No Basis For Post-Delegation Liability

Section 1371.25 precludes vicarious liability by providing that health plans, IPAs and providers "are each responsible for their own acts or omissions, and are not liable for the acts or omissions of" one another. Its second sentence states that "[a]ny provision to the contrary in a contract with providers is void and unenforceable." The third sentence—the one underlying plaintiffs' argument—states that "[n]othing in this section shall preclude a finding of liability on the part of a plan, any entity contracting with a plan, or a provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability."

Plaintiffs suggest this language somehow permits post-delegation liability on health plans because it "expressly allows common-law suits against health plans based on their own wrongful conduct." (ABOM 17.)

Section 1371.25 is not reasonably susceptible to plaintiffs' interpretation. Read in conjunction with the statute's first sentence, the third sentence does not permit post-delegation liability. It states that "[n]othing ***in this section*** shall ***preclude***" liability on the part of health plans, contracting entities or providers based on statutes, common law or equitable doctrines other than vicarious liability. It provides that, *if* some basis for direct liability exists for a health plan's own wrongful acts, section 1371.25's prohibition on vicarious liability does not preclude such liability. However, when a cause of action for direct liability is foreclosed by the Knox-Keene Act or some other principle of law, section 1371.25 does not ***create*** or ***revive*** such a claim.

Consistent with this analysis, the appellate decisions that have addressed section 1371.25 have held that when the Knox-Keene Act authorizes a delegation, post-delegation liability would impermissibly undermine section 1371.25's prohibition on vicarious liability. In *CEP,* the Court of Appeal rejected the emergency physician plaintiffs' argument that section 1371.25 permits a claim against health plans based on an implied contract theory notwithstanding section 1371.4, subdivision (e)'s authorization of delegations. The court observed that "section 1371.25 does not allow a common law cause of action that is contrary to a specific provision of the Knox-Keene Act." (*CEP, supra,* 111 Cal.App.4th at p. 1134.)

In *Watanabe v. California Physicians' Service* (2009) 169 Cal.App.4th 56 (*Watanabe*), the Court of Appeal extended this reasoning to bar liability of a health plan that had delegated utilization review to an IPA.[6] Although the health plan delegated review, it retained the power to override the IPA's decision through its appeal procedures. (*Id.* at pp. 59–60.) When the IPA allegedly unreasonably delayed and then denied necessary care, the plaintiff sued the plan.

The Court of Appeal held that section 1371.25 barred the plan's liability for the IPA's actions. (*Watanabe, supra*, 111 Cal.App.4th at pp. 63-64.) The court agreed with *CEP* in rejecting the argument that section 1371.25 allows liability notwithstanding the delegation of the review obligation, explaining that "it is common sense that an action" barred by section 1371.25's first sentence "is not resuscitated" by its third sentence. (*Id.* at p. 63.)

The Court of Appeal reached the same conclusion in *Martin v. PacifiCare of California* (2011) 198 Cal.App.4th 1390 (*Martin*). In that case, a health plan hired a provider to provide medical services to its subscribers and delegated utilization review to it. (*Id.* at pp. 1394-1395.) The plaintiffs alleged that the provider's delays in approving a treatment caused their family member's death and sought to hold the plan liable for the provider's actions. The court

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6 Utilization review is the process physicians use to determine whether a treatment is medically necessary and covered by the applicable health care service plan. Like the obligation to reimburse non-contracted emergency physicians, the Knox-Keene Act expressly permits delegation of utilization review. (§§ 1367 and 1367.01, subd. (a).)

rejected the argument that the plan could be held liable based on the doctrine that one who delegates a task can be held liable for injuries caused by its delegated agent. (*Id.* at p. 1405.) The court explained that this rule applies only to situations involving a nondelegable duty. The case before it, however, involved a "statutory scheme that expressly authorizes an insurer to delegate a duty to a third party while also barring [through section 1371.25] the insurer from liability for that party's acts or omissions." (*Ibid.*) This foreclosed plaintiffs' attempt to impose liability on the health plan.

The court also refused to rewrite the statutory scheme to achieve an outcome the plaintiffs argued would be more equitable. The court stated: "The Legislature enacted the statutory scheme authorizing [the health plan] to delegate its utilization review function and preventing [the health plan] from being held liable for [the IPA's] acts or omissions. It is not our role to question these statutes or the public policies underlying them." (*Martin*, *supra*, 198 Cal.App.4th at p. 1407.)

Here, plaintiffs are attempting to use section 1371.25 as a means to circumvent section 1371.4's authorization of delegation arrangements. As discussed more fully below, plaintiffs have largely abandoned their attempt to justify post-delegation liability based on negligence principles. Instead, they claim that non-contracted emergency physicians are in "a unique and often vulnerable position" and thus should be allowed to look to health plans for payment as a matter of fairness and public policy. (ABOM 1, 42-47.) This is the same kind of fallacious logic *CEP, Watanabe* and *Martin* rejected. As those courts recognized, a delegation pursuant to statute precludes liability for the acts and omissions of the delegated agent, and nothing in section 1371.25 changes

that result. Indeed, allowing post-delegation liability based on section 1371.25 would not only contravene section 1371.4, it would allow what amounts to imposition of vicarious liability on the Health Plans. Having barred vicarious liability with its first sentence, section 1371.25's third sentence does not create a backdoor through which a plaintiff can impose such liability under a different label.

### 2. Regulations Section 1300.71 Does Not Furnish Any Basis For Post-Delegation Liability

Plaintiffs next argue that post-delegation liability is contemplated by subdivision (e)(6) of Regulations section 1300.71. That regulation requires that "Contracts for Claims Payment" between a health plan and a claims processing organization or a capitated provider include a provision "authorizing the plan to assume responsibility for the processing and timely reimbursement of provider claims in the event that the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims . . . ." This regulation provides no foothold for post-delegation liability.

Section 1300.71 deals with the ministerial aspects of claims processing. The regulation is entitled "Claims Settlement Practices," and all of its provisions concern the "timely and accurate" reimbursement of claims. The regulation does not impose any obligation on a health plan to pay claims post delegation. Subdivision (e)(6) is no exception. That subdivision is entitled "Contracts for Claims Payment" and deals with contracts for "ministerial claims processing services . . . ." (Regs., § 1300.71, subd. (e).) It requires that a contract between a health plan and a "claims processing organization" or

"capitated provider" contain a provision "authorizing the plan to assume responsibility for *the processing and timely reimbursement of provider claims* in the event that the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims . . . ." (Regs. § 1300.71, subd. (e)(6) [italics added].)

Regulations section 1300.71 implements section 1371, which is entitled "[t]ime for reimbursement" of claims. Section 1371, which imposes claims processing timing and other requirements, provides: "The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations or other contracting entities *to pay claims for covered services.*"[7] By distinguishing between claims handling and the obligation to pay claims, this non-waiver provision presumes that health plans can delegate their *payment* obligations and makes clear that the plan's continuing obligation extends only to the ministerial aspect of claims handling.

The Court of Appeal has reached the same conclusion. In *Desert Healthcare District v. PacifiCare FHP, Inc.* (2001) 94 Cal.App.4th 781 (*Desert Healthcare*), a hospital sued a health plan after an IPA failed to pay due to bankruptcy. The hospital argued that under section 1371's non-waiver clause,

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[7] Subdivision (e)(8) of Regulations section 1300.71 is an identical non-waiver clause: "The plan's contract with a claims processing organization or a capitated provider shall not relieve the plan of its obligation to comply with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28." These provisions all concern claims processing.

health plans remain obligated to pay claims regardless of their capitation agreements. (*Id.* at p. 787.) The Court of Appeal rejected the argument, pointing out that section 1371's "nonwaiver clause presumes that plans can delegate their payment obligations; it provides that even when the payment obligation is delegated, the time limits and other procedural mechanisms still must be satisfied." The court further explained that, "[w]hen read as a whole, section 1371 . . . merely imposes certain procedural requirements on the processing of claims; it does not create a new, independent basis for liability. Again, the statute presumes that there is a legitimate contractual basis for liability, and merely creates a procedural framework for the satisfaction of those presumed contractual obligations." (*Id.* at pp. 788-789.)

Plaintiffs' reliance on Regulations section 1300.71 also fails because that regulation has nothing to do with reimbursement of claims submitted *by emergency care providers*. It applies broadly to all claims processing and "claims processing organizations" responsible for the ministerial task of processing payments. Regulations section 1300.71—concerning claims processing generally—cannot override section 1371.4, a specific statute authorizing delegation of reimbursement responsibility. (*Lake v. Reed* (1997) 16 Cal.4th 448, 464; *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864 [statutes supersede regulations]; see also *Desert Healthcare, supra,* 94 Cal.App.4th at p. 789 ["If section 1371 required plans to pay all claims regardless of their contractual arrangements, then capitation contracts . . . would be illusory."].)

In sum, nothing in Regulations section 1300.71 requires a health plan to re-assume the financial obligation to pay non-contracted emergency physicians.

## C. No Sound Basis Exists To Subject The Health Plans To A Duty To Protect Non-Contracted Emergency Physicians From Financial Harm

### 1. To The Extent This Case Implicates A Duty Of Care At All, The Only Duty At Issue Is An Economic One

On the question whether the Health Plans have a duty to protect non-contracted emergency physicians from financial harm, plaintiffs' brief has almost nothing to offer. Plaintiffs' primary argument—raised for the first time in this Court—is that the *Biakanja* financial harm analysis has no place here because the duty involved is not a "business duty," as "this case has real life and death implications for any California resident and/or visitor who may require emergency care." (ABOM 33-34.)

Plaintiffs' contention is difficult to fathom. Plaintiffs do not explain what kind of duty other than to prevent financial harm to non-contracted emergency physicians can be at issue. Further, both sides have litigated this as a "business duty" case both in the trial court and on appeal, and the Court of Appeal's conclusion that a duty exists here purports to be premised on *Biakanja*. For their part, although the Health Plans have always maintained that plaintiffs' claims fail by virtue of section 1371.4's authorization of delegation contracts, to the extent a duty of care analysis is appropriate, the nature of the duty is, and can only be, economic.

Plaintiffs' claim that the duty involved in this case will somehow affect the availability of care to emergency room patients also is wrong. Section 1317 obligates emergency physicians to treat emergency room patients regardless

of insurance or ability to pay. That will not change if this Court concludes, as it should, that the Health Plans owe no duty to plaintiffs.

### 2. Plaintiffs' Brief Reinforces The Conclusion That *Biakanja* Does Not Support A Duty Owed By The Health Plans To Plaintiffs To Prevent Economic Harm

Plaintiffs do not respond to the Health Plans' arguments regarding the individual *Biakanja* factors, commenting only that they agree with the Court of Appeal's analysis on this issue. (ABOM 34.) Plaintiffs then claim that, if this Court "is inclined to reverse the Court of Appeal based solely on the *Biakanja* factors," it should "defer a decision" until "the parties have developed a record." (ABOM 35.) Plaintiffs point specifically to the Health Plans' arguments regarding the ramifications of a duty of care as requiring factual investigation and discovery. (ABOM 35-36.)

But plaintiffs are mistaken that these arguments concern matters that are properly subject to discovery. Rather, these are legal arguments regarding the adverse consequences of a duty of care as that duty plays out in the real-world crucible of the managed care system.

Moreover, contrary to plaintiffs' claim, the duty issue is not in need of evidentiary development. The dispositive facts relevant to the *Biakanja* factors—as established by plaintiffs' allegations and the Health Plans' uncontroverted request for judicial notice—are undisputed, and they defeat any conclusion that a duty exists. Plaintiffs' attempt to sidestep the Health Plans' *Biakanja* arguments betrays the extent to which plaintiffs are using negligence

law to disguise what they are really after—the judicial creation of post-delegation liability.

As the Health Plans have demonstrated, none of the *Biakanja* factors supports a duty of care here. (OBOM 45-60.) Although plaintiffs offer no response to the Health Plans' arguments, certain factual assertions in plaintiffs' answer brief underscore the Health Plans' arguments regarding the most important factors—intent to affect the plaintiffs, foreseeability and causal connection. (*Biakanja*, *supra*, 49 Cal.2d at p. 650.)

First, plaintiffs offer no discussion of this Court's recent decision in *Beacon Residential Community Assn. v. Skidmore, Owings & Merrill LLP* (2014) 59 Cal.4th 568 (*Beacon*), which reaffirms that the defendant's transaction must have been intended to affect a "specific, foreseeable and well-defined class" of plaintiffs. (*Id.* at p. 584.) This is consistent with the Court's formulation in *Biakanja* that the "end and aim" of the transaction must have been to affect the plaintiff. (*Biakanja*, *supra*, 49 Cal.2d at p. 650.)

Plaintiffs put forth no reason to question the conclusion that the delegation contracts here fail this test. Indeed, plaintiffs go out of their way to emphasize that "[a]t all relevant times," they were "non-contracted providers with the Health Plans and with La Vida" and consequently "have no contract that they can enforce against either the Health Plans or their delegate IPA." (ABOM 12-13.) Plaintiffs do not dispute that the end and aim of the delegation contracts was risk-shifting. It was not to ensure payment to non-contracted physicians, since that obligation preexisted the delegation contracts.

Nor are plaintiffs a "foreseeable" or "well-defined" class. (*Beacon*, *supra*, 59 Cal.4th at p. 584.) Non-contracted emergency physicians are merely part of the general class of all creditors to whom an IPA may owe money. As such, they are not a "well-defined" or specifically foreseeable group.

Nothing about the intent-to-affect analysis changes post delegation, that is, when La Vida became subject to a corrective action plan. La Vida's undergoing a corrective action plan did not transform the delegation contracts such that the reimbursement of non-contracted emergency physicians became the contracts' end and aim. Rather, any impact the delegation transactions may have had on plaintiffs was always "collateral to the primary purpose of" those transactions. (*Summit Financial Holdings, Ltd. v. Continental Lawyers Title Co.* (2002) 27 Cal.4th 705, 715.)

Second, plaintiffs fail to rebut the Health Plans' arguments regarding foreseeability and causal connection. As they have pointed out, for the Health Plans to have foreseen plaintiffs' injury at the time the IPA contracts were signed, they would have had to foresee that La Vida would lose its primary funding source, become insolvent, and be unable to pay plaintiffs at some future point. The Health Plans also would have had to foresee that their delegation contracts would cause this result. But La Vida's financial health did not depend solely on its delegation arrangements. Indeed, as plaintiffs have alleged, its eventual failure was caused by its loss of funding. Framing the argument in the procedural context of this case, plaintiffs' complaint is devoid of allegations that the Health Plans could have foreseen that their delegation arrangements would lead to plaintiffs' bills going unpaid or underpaid years and years down the road.

Far from refuting these arguments, plaintiffs' brief only underscores the absence of foreseeability or a close causal connection. Plaintiffs state that "[u]ntil 2007, La Vida paid the Emergency Physicians for the services they rendered to the Health Plans' enrollees." (ABOM 13.) This admission defeats plaintiffs' contention that the Health Plans knew or should have known that their capitation payments were inadequate. If La Vida was paying plaintiffs until 2007, then the agreed-upon capitation fees in the delegation contracts were adequate, foreclosing any foreseeability or causal nexus. And, nowhere in their complaint do plaintiffs allege that the health plans reduced capitation payments. In fact, plaintiffs effectively concede that none of the Health Plans did so. (ABOM 15.)

Plaintiffs similarly assert that, after "La Vida's lender filed bankruptcy and withdrew $4 million from La Vida's account" in October 2009, "La Vida was unable to obtain replacement funding from other sources." (ABOM 14.) However, plaintiffs again fail to point to any allegation as to how the Health Plans reasonably could foresee that La Vida would not only lose its funding but would be unable to obtain another operating line of credit.

Again, as with *Biakanja*'s intent-to-affect factor, none of the dispositive facts with respect to foreseeability or causation changed after La Vida was placed under the corrective action plan. In fact, given that a corrective action plan was in place, as well as the success rate of such plans,[8] it was

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[8] According to DMHC estimates, available on its website, of 118 risk-bearing organizations that have in recent years undergone corrective action plans, 103 such organizations have emerged financially solvent. (See Department of

*Continued on next page.*

reasonable for the Health Plans to believe that La Vida would regain financial health.

Plaintiffs further claim it would be "unconstitutional" and against "public policy" to require them to provide uncompensated care. (ABOM 42-45.) Plaintiffs thus have largely abandoned any pretense of tethering their attempt to impose post-delegation liability to negligence law principles, demonstrating the extent to which their real grievance lies with section 1317's mandate.

As discussed more fully below, not only is there no statutory or common law basis for the duty plaintiffs would impose on health plans, such a duty would undermine the DMHC's role and disturb the balance of competing interests the Legislature achieved in the health care arena.

### D. Post-Delegation Liability Would Upset The Policy Balance The Legislature Has Sought To Achieve

Notably absent from plaintiffs' brief is any attempt to address the impact a duty of care owed to the emergency physicians would have on the managed care system as a whole. As demonstrated here, the negligence duty plaintiffs urge would undermine the balance of competing economic and societal

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*Continued from previous page.*

Managed Healthcare, *Minimum Solvency Criteria Discussion*, <https://www.dmhc.ca.gov/Portals/0/About the DMHC/FSSB/pdppsr.pdf> (as of March 18, 2015.)

interests the Legislature has sought to achieve through the statutory scheme governing managed care.

In enacting section 1317, the Legislature declared that "the provision of emergency medical care is a vital public service of great benefit to Californians" and is necessary to protect their health and safety. "Vital" and "great" suggest the Legislature has accorded preeminence to this consideration. The Legislature also has recognized that section 1317 imposes a financial burden on emergency physicians and has created a special fund to "partially" alleviate that burden. (Historical and Statutory Notes, West's Ann. Health & Saf. Code foll. § 1317.)

The Legislature also has taken into account the financial interests of other participants in the system and has emphasized the need to control costs. The Legislature's policy concerns and goals in this regard are stated in section 1342, namely: (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 delegated model of health care as reflected in the Knox-Keene Act is an attempt to balance all of these competing interests. (*Bell, supra,* 131 Cal.App.4th at p. 215; *Van de Kamp v. Gumbiner* (1990) 221 Cal.App.3d 1260, 1284 [Knox-Keene Act covers all aspects of health care system "including financial stability, organization, advertising and capability to provide health

services"].) Further, as the first item in section 1342 makes clear, risk-shifting arrangements are vital for ensuring the "best possible health care . . . at the lowest possible cost . . . ." (See also § 1342.6 [declaring legislative intent to promote risk-shifting arrangements].)

The statutory scheme is supported by a comprehensive and carefully calibrated regulatory framework that enables the DMHC to achieve the Legislature's stated goals. The DMHC exercises its functions through various methods—direct control and monitoring of health plans, indirect control and monitoring of IPAs through oversight of health plans, supervising corrective action plans to rehabilitate IPAs that fail financial solvency guidelines, and penalizing health plans or IPAs that violate regulations or the DMHC's directives.

This is not to say that the balance the Legislature has achieved is perfect in the sense that it fully accommodates all competing interests. Such compromises and trade-offs, however, are the essence of *legislative policy* judgments—judgments courts are not authorized or indeed equipped to second-guess. The Legislature has given supremacy to patient care—both emergency and non-emergency—through section 1317 and in its emphasis on continuity of care. And, the Legislature has imposed costs and burdens on emergency physicians, health plans, *and* IPAs.

Thus, on one hand, the Legislature has required emergency physicians to treat all patients, including uninsured and indigent patients, despite the fact that emergency physicians will sometimes be denied full compensation. But counterbalancing this burden, the Legislature has required health plans *or*

*IPAs* to reimburse non-contracted emergency physicians the reasonable value of services rendered to enrollees.

The Legislature also has embedded a cost-control component in the system by encouraging risk-shifting arrangements. The right to delegate, however, is not without cost to health plans either. The Legislature has stringently regulated the persons to whom health plans can delegate, the manner of delegations, and health plans' post-delegation regulatory obligations. As such, health plans must shoulder heavy regulatory burdens in their dealings with IPAs. The terms of their delegation contracts are subject to detailed requirements. And, following delegations, the regulations require health plans to assist the DMHC in its financial surveillance of IPAs. Yet, nothing in this intricate system of legislative policy trade-offs contemplates that health plans will continue to face liability for the financial failures of IPAs after a proper delegation.

An important aspect of the regulatory system is the corrective action plan. When an IPA fails financial solvency criteria and a corrective action plan goes into effect, the DMHC assumes control of the IPA's rehabilitation, including its risk-shifting arrangements with its contracting health plans. Health plans are required to cooperate with the DMHC in this process and may not transfer enrollees out of an IPA without DMHC approval. (Regs. § 1300.75.4.5, subd. (a)(2), (a)(6) & (a)(7).)

A post-delegation duty of care would place a health plan in an impossible position during the pendency of such a corrective action plan. A plan can either maintain the status quo with respect to the delegation contracts as DMHC regulations require, or unilaterally discontinue delegating new enrollees

and take back delegated enrollees. If a plan opts for the first course, it potentially faces negligence liability. If it opts for the second course, it risks undermining the corrective action plan because of capitation fee reductions and disciplinary action by the DMHC. No one disputes that the DMHC has jurisdiction over the mechanisms to rehabilitate financially troubled IPAs. Only the DMHC, therefore, should determine what a health plan can and should do when its delegated IPA comes under a corrective action plan. The specter of post-delegation negligence liability plaintiffs wish to impose thus conflicts with the DMHC's jurisdiction and undermines the goals of the regulatory scheme. (*Loeffler v. Target Corp.* (2014) 58 Cal.4th 1081, 1127 [when Legislature has empowered an administrative agency to determine the legality of practices arising within a comprehensive regulatory scheme, courts should not permit claims challenging conduct that falls within that agency's authority].)

Recognizing this dilemma, plaintiffs insist that when an IPA is placed under a corrective action plan, health plans must continue to pay that IPA its contracted fees and *also* pay *non-contracted* emergency physicians. According to plaintiffs, any other result would be unfair and unconstitutional to them. (ABOM 1, 45.) There is, however, no basis in statutory or common law for such an arbitrary and anomalous state of affairs. Non-contracted emergency physicians are not a special class that stands outside of the managed care statutory system and that is entitled to benefit at health plans' expense. The Legislature has already decided what burdens—financial and regulatory—health plans must carry. And it has decided what burdens emergency physicians must bear. *And* it has decided that "contracting medical providers" (IPAs) must reimburse non-contracted emergency physicians when a delegation has taken place.

This Court has repeatedly cautioned that courts must defer to the Legislature's judgment about how competing policy interests should be balanced. (See, e.g., *Coito v. Superior Court* (2012) 54 Cal.4th 480, 497; *Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 395–396.) Thus, courts do not ask whether a particular statute "ideally balances the competing concerns or represents the soundest public policy." (*Cassel v. Superior Court* (2011) 51 Cal.4th 113, 136.) Courts simply enforce the statute the Legislature has adopted.

These principles apply here. Imposing an additional financial burden on health plans to benefit non-contracted emergency physicians in preference to all other providers would disturb the balance of competing concerns the Legislature has struck. As this Court has warned, courts should not trespass the Legislature's domain in such matters.

## III.
## CONCLUSION

This Court should reverse the Court of Appeal judgment and reinstate the judgment of dismissal for the Health Plans.

DATED: March 23, 2015.

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**Certification of Word Count Pursuant To California Rules Of Court, Rule 8.520(c)**

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 Reply Brief on the Merits in this case.

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

4. According to the Word Count feature of Microsoft Word 2010, the Reply Brief on the Merits contains 8,377 words, including footnotes, but not including the table of contents, table of authorities, and this Certification.

5. Accordingly, the Reply Brief on the Merits complies with the requirement set forth in Rule 8.520(c), that a brief produced on a computer must not exceed 8,400 words, including footnotes.

I declare under penalty of perjury that the forgoing is true and correct and that this declaration is executed on March 23, 2015, 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 March 23, 2015, I served the following document(s) by the method indicated below:

## REPLY BRIEF ON THE MERITS

☐ 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 March 23, 2015, 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)**

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| Court of Appeal<br>Second Appellate District,<br>Division Three<br>300 South Spring Street<br>Second Floor, North Tower<br>Los Angeles, CA 90013-1213 | Case No. B238867 |
| Consumer Law Section<br>Los Angeles District Attorney<br>210 West Temple Street, Suite 1800<br>Los Angeles, CA 90012-3210<br>Tel: (213) 974-3512 | Served pursuant to Bus. & Prof. Code § 17209 and Cal. Rules of Court 8.29(a) and (b) |
| Appellate Coordinator<br>Office of the Attorney General<br>Consumer Law Section<br>300 South Spring Street<br>Los Angeles, CA 90013<br>Tel: (213) 897-2000 | Served pursuant to Bus. & Prof. Code § 17209 and Cal. Rules of Court 8.29(a) and (b) |