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Supreme Court of California
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IN THE
SUPREME COURT
OF THE STATE OF CALIFORNIA

LARRY QUISHENBERRY
Appellant

v.

UNITED HEALTHCARE, INC., et al.
Respondents

Review of an Unpublished Opinion by the Court of Appeal,
Second Appellate District, Division Seven, Case No. B303451,
Los Angeles Superior Court Case No. BC631077

PETITION FOR REVIEW

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CERTIFICATE OF INTERESTED ENTITIES
(Cal. Rules of Court, Rule 8.208)

There are no interested entities or persons to list in this certificate. Cal. Rules of Court, Rule 8.208(d)(3).

Dated: October 26, 2021

RUSSELL S. BALISOK,
Counsel for Appellant

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ISSUES PRESENTED

1. Whether any of the claims asserted by Plaintiff are *expressly* preempted by Medicare's Preemption Provision at 42 USC §1395w-26(b)(3)?

2. Whether any of the claims asserted by Plaintiff are *impliedly* preempted as conflicting with, or obstructing federal law?

3. Whether Health & Safety Code §1371.25, which generally prohibits vicarious liability for managed care entities, is *expressly* preempted when applied to Medicare Managed Care Organizations such as the Respondents?

4. Whether *Winn v. Pioneer Medical Group* (2016) 63 Cal.4th 148, precludes application of common law principles, including vicarious liability, in cases of neglect based on the Elder Abuse Act?

INTRODUCTION

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). (Pub.L. No. 108–173 (Dec. 8, 2003) 117 Stat. 2066.). The MMA amended section 1395w–26(b)(3) by replacing the prior limited preemption provision with the current broader provision:

> The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) *with respect to MA plans* which are offered by MA organizations under this part." (emphasis added.)

(This subsection is referred to as the Medicare Preemption Provision).

This Petition is mainly concerned with the meaning of this provision and its application to Quishenberry's claims which are based on common law and on the Elder Abuse Act (Welf. & Inst. Code §15657), a statute of general applicability.

The scope of the Medicare Preemption Provision: A Split of Authority

A split of authority exists among California Courts regarding the scope of this Medicare Preemption Provision. In *Cotton v. StarCare Medical Group, Inc.* (2010) 183 Cal. App. 4th 437, the court generally held that the Medicare Preemption Provision did not expressly preempt most of plaintiff's state

common law claims against Medicare Advantage Organizations (MAO). Although a dispute exists with respect to which of the United Healthcare entities and HealthCare Partners are MAOs, this section assumes that Respondents are correct, and that each qualifies as such.

However, in *Roberts v. United Healthcare Services, Inc.* (2016) 2 Cal. App. 5th 132, the court disagreed with *Cotton* and explained that the Medicare Preemption Provision expressly preempted all state law claims including claims based on common law. This holding applies wherever federal standards exist. For example, where federal standards exist pertaining to HMO marketing materials, any claim pertaining to marketing materials is expressly preempted. Or where federal standards exist pertaining to the Medicare benefit covering skilled nursing facility care, an action claiming that a patient was prematurely discharged from a nursing home would be expressly preempted.

In addition, *Roberts* found obstacle preemption of the plaintiff's claims based on United Healthcare's false marketing materials.

Quishenberry contends that the Medicare Preemption Provision only expressly preempts positive laws aimed specifically at HMOs. Quishenberry further contends that unless his claims are in conflict with federal standards, or stand as an obstacle to a federal objective, his claims are not impliedly (ore expressly) preempted. See *Riegel v. Medtronic* (2008) 552 U.S. 312, 330 (state laws are preempted only to the extent they are

different from or in addition to the requirements imposed by federal law).

The Appellate Court's finding of obstacle preemption is simply erroneous. Quishenberry contends that neither application of his common law claims, nor application of the Elder Abuse Act, creates a conflict with or stands as an obstacle to the accomplishment of any federal objective.

As for Health & Safety Code §1371.25 applying the plain language of the Medicare Preemption Provision, section 1371.25 is a state law aimed at HMOs. Therefore it is a state law "*with respect"* to an HMO including Medicare Advantage Organizations and expressly preempted by the Medicare Preemption Provision.

Martin v. PacifiCare of California (2011) 198 Cal. App. 4th 1390 found the previous version of the Medicare Preemption Provision did not require preemption of section 1371.25, and explicitly failed to reach the question whether the current Medicare Preemption Provision would have preempted 1371.25. *Martin* at 1410-1411.

Finally, in *Winn v. Pioneer Medical Group* (2016) 63 Cal.4th 148 this Court held that liability for neglect (Welf. & Inst. Code §15610.57) under the Elder Abuse Act required significant responsibility for attending to an elder's basic needs and that a physician who treated a patient sporadically at an outpatient clinic did not have the "care or custody" required for "neglect." *Winn* did not decide whether vicarious liability may exist for the conduct of a defendant who did have "care or custody."

Quishenberry contends that since the Elder Abuse Act does not expressly provide that common law principles, including vicarious liability principles, do not apply, under established case law, a defendant could be held vicariously liable for another defendant's neglect. *California Association of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284, 297, citing *Goodman v. Zimmerman* (1994) 25 Cal. App. 4th 1667.

BACKGROUND

Larry Quishenberry's father Eugene enrolled in a Medicare health plan offered by United Healthcare, Inc., United Health Group, Inc., United Healthcare Services, Inc., and or UHC of California. As alleged it is unclear from the Evidence of Coverage document issued to Eugene which of these United Healthcare entities became obligated to provide healthcare to Eugene. One of these United Healthcare entities contracted with defendant Health Care Partners Medical Group and Healthcare Partners LLC to provide medical care, including care in hospitals, nursing facilities and physician care. Defendant Dr. Lee was employed by one of the Healthcare Partners entities to provide physician care to Eugene.

Larry's complaint alleged that Eugene was initially hospitalized for treatment of a broken femur, and then discharged to Defendant Gem HealthCare, LLC's (GEM) skilled nursing facility, under the care of Defendant Dr. Lee. Larry settled with GEM.

Larry alleged that GEM and Dr. Lee were negligent in providing care and as a result Eugene developed severe pressure sores on his feet. See 22 Cal. Code Regs. §72315(f). These pressure sores were painful and made it difficult for Eugene to participate in physical therapy and he never regained the ability to walk. He was discharged from the nursing home to his residence, where he ultimately but prematurely passed away.

Larry's complaint alleged that each of the United Healthcare Defendants and Healthcare Partners were, as delegors, vicariously liable for the negligence of GEM and Dr. Lee. In addition, Larry alleged that these defendants were directly liable under the special relationship doctrine. In addition, Larry alleged that GEM and Dr. Lee had committed Elder Abuse and that United Healthcare and Healthcare Partners were vicariously liable for these defendants' elder abuse.

In addition to these claims on behalf of Eugene, Larry stated his own wrongful death claims, based on the same theories asserted on behalf of Eugene.

The trial court sustained Defendants' demurrers which asserted that Larry's claims were preempted and that Health & Safety Code §1371.25 barred liability. The trial court dismissed Larry's action against the United Healthcare Defendants and Healthcare Partners.

LEGAL DISCUSSION

1. THE MEDICARE PREEMPTION PROVISION ON ITS FACE ONLY EXPRESSLY PREEMPTS STATE STATUTES AND REGULATIONS AIMED AT, OR DESIGNED TO REGULATE, HMOS

"'[E]xpress preemption arises when Congress "define[s] explicitly the extent to which its enactments pre-empt state law."' *Parks v. MBNA America Bank, N.A.* (2012) 54 Cal.4th 376, 383. Consideration of issues arising from the Supremacy Clause starts with the assumption that the historic police powers of the States are not to be superseded unless that is the clear and manifest purpose of Congress. *Cipollone v. Liggett* Group, Inc. (1992) 505 U.S. 504, 516.

Preemption of State law requires the courts "in the first instance [to] focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent." *CSX Trans. Inc. v. Easterwood* (1993) 507 U.S. 658, 664. The court may find preemption only where it is the clear and manifest purpose of Congress. *Rice v. Santa Fe Elevator Corp*. (1947) 331 U.S. 218, 230.

To recall, the preemption provision states:

> The standards established under this part shall supersede *any State law or regulation* (other than State licensing laws or State laws relating to plan solvency) *with respect to* MA plans which are offered

by MA organizations under this part. (emphasis added.)

The phrase "standards established under this part" refers to regulatory standards adopted by the regulatory agency. The phrase, "State law or regulation . . . with respect to MA plans" effectively means state laws directed at any HMO plan, not just Medicare plans. In California, State laws with respect to HMOs would include provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Health & Safety Code §§1340, et seq.) which expresses California's law licensing and regulating HMOs.

Quishenberry recognizes that the analysis in *Do Sung Uhm v. Humana* (9th cir. 2010) 620 F.3d 1134 (*Uhm*) suggests that in order to be expressly preempted, a state law must be in conflict with federal law. This finding should be limited to the facts in *Uhm* because conflict pertains to implied preemption, not express preemption. The state laws examined by *Uhm* were statutory consumer protection laws which apply generally, i.e., are not aimed at HMOs, and state common law. But state statutes and regulations specifically aimed at HMOs, including Medicare financed HMO plans, appear to be expressly preempted, i.e., whether or not they conflict with federal law. That is the plain meaning of the Medicare Preemption Provision.

On the face of the Medicare Preemption Provision, common law claims would not be preempted because they do not apply specifically to HMOs. The same conclusion applies to statutes of general applicability, such as California's Elder Abuse Act. This narrower scope of the Medicare Preemption Provision, as

discerned from the plain meaning of the provision, is the best evidence of "the clear and manifest purpose of Congress." *Parks, supra.*

In adhering to *Roberts,* the Court of Appeal based its finding of express preemption merely on the existence of relevant standards established for Medicare Advantage plans. Opinion, p. 12. At p. 15, the Court of Appeal concluded Quishenberry's action "require[s] a determination of the amount of allowable Medicare benefits for skilled nursing care, an area regulated by standards established by CMS; this Quishenberry's claims are [expressly] preempted."

Even if was true that Quishenberry's action required a determination of the amount of allowable Medicare benefits for skilled nursing care, the Court of Appeal's conclusion that this action is expressly preempted is unsupportable. And, as will be explained there is no conflict or obstacle preemption because Quishenberry's action neither conflicts with, nor stands as an obstacle. In other words, except for state laws directed at HMOs, such as the Knox-Keene Act (Health & Safety Code §1340, et seq.) no state laws are expressly preempted, or at the very least, as explained in *Uhm* there must be a finding of conflict.

Roberts v. United Healthcare, etc. (2016) 2 Cal. App. 5th 132 was relied upon by the Court of Appeal but reading *Roberts* carefully, the plaintiff's action, like the plaintiffs in *Uhm* was premised on allegedly false marketing materials. *Uhm* explained:

> To recall, the Uhms' consumer protection act claims allege that Humana violated the consumer

protection statutes of various states in which Humana operates by "systematically represent[ing] ... that prescription drug coverage would begin January 1, 2006 for those Class members who enrolled by December 31, 2005, when in fact [Humana] knew, or should have known, that Defendants would not be providing prescription drug coverage" beginning on that date. According to the Uhms' complaint, these misrepresentations were both written and oral: written in the Humana Prescription Drug Plan Enrollment Form and orally stated by Humana's employees in the course of marketing the plan. We hold that the Uhms' claims are preempted by the extensive CMS regulations governing PDP marketing materials.

The Act provides that CMS must approve all PDP marketing materials before they are made available to Medicare beneficiaries. See 42 U.S.C. § 1395w–101(b)(1)(B)(vi) (incorporating id. § 1395w–21(h)). The Act requires that each Part D sponsor "shall conform to fair marketing standards," id. *1151 § 1395w–21(h)(4), and that CMS "shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation," id. § 1395w–21(h)(2). In 2005, CMS promulgated detailed regulations governing

how Part D sponsors market their plans. See 42 C.F.R. § 423.50(a)–(f) (2005).26 Under those regulations, Part D sponsors were not to "distribute any marketing materials ... or enrollment forms, or make such materials or forms available to Part D eligible individuals" unless they had been CMS-approved. Id. § 423.50(a)(1).27 Moreover, under both the 2005 version of these provisions and their most recent amendment in 2008, CMS is required to screen marketing materials or enrollment forms to ensure they are not "materially inaccurate or misleading" and do not "otherwise make material misrepresentations." Id. § 423.50(d)(4) (redesignated as id. § 423.2264(d) (2008)). CMS must also ensure that all marketing materials and enrollment forms provide adequate descriptions of all rules, an explanation of the grievance and appeals process, and "[a]ny other information necessary to enable beneficiaries to make an informed decision about enrollment." Id. § 423.50(d)(1) (redesignated as id. § 423.2264(a) (2008)).

Uhm at 1134, 1150–51 further explained:

> Any court attempting to evaluate a claim based on that statute must determine whether the particular action in question is "[d]eceptive." To do so, the court must determine whether "the defendant made misrepresentations or omissions that were likely to

mislead a reasonable consumer in the plaintiff's circumstances ... and that as a result the plaintiff suffered injury." Solomon v. Bell Atl. Corp., 9 A.D.3d 49, 777 N.Y.S.2d 50, 52 (2004). *Yet, under the Act, CMS is charged with reviewing marketing materials and determining whether they are "materially inaccurate or misleading or otherwise make[ ] a material misrepresentation*." 42 U.S.C. § 1395w–21(h)(2). If the materials are misleading, CMS is instructed to disapprove them or later require their correction. Id.

Thus, allowing a suit to proceed based on a state statute such as New York's consumer protection law risks the possibility that materials CMS has deemed not misleading—and therefore allowed to be distributed—will later be determined "likely to mislead" by a state court. In other words, application of these state laws could potentially undermine the Act's standards as to what constitutes non-misleading marketing.[fn] That is precisely the situation that both the current version of the Act's preemption provision as well as its previous incarnations contemplated and sought to avoid. * * * Because the reach of the 2003 provision is at least as broad as that of the 2000 version, it follows that state causes of action *inconsistent with* the CMS's role in reviewing and approving marketing materials

distributed by Part D sponsors are preempted. (emphasis added.) *Uhm* at 1152–53. (emphasis added.)

Roberts as well as the Court of Appeal opinion in this case ignored *Uhm's* stated requirement that the state cause of action be inconsistent with federal law, and broadly found preemption based on the mere existence of federal standards. Doing so also completely ignores the provision's "with respect to" language. And *Roberts* too broadly applies *Uhm's* ruling re federal standards pertaining to false marketing materials to claims touching on other federal standards.

As noted by the Court of Appeal, federal standards applicable to Quishenberry's claims include federal approval of the network of providers, for provider selection and credentialing, requirements for an ongoing quality improvement plan, and a requirement that the plan must correct all problems that come to its attention through internal surveillance, complaint or otherwise. There is also a requirement that the MA organization consult with physicians who provide services under the MA plan regarding the organization's medical policy, quality improvement programs and medical management procedures and ensure the physicians' decisions with respect to utilization management, enrollee education, coverage of services and other areas are consistent with guidelines. Opinion, at p. 13. Other federal standards are discussed. Ultimately, the Court of Appeal found that Quishenberry's claims touched on existing federal standards: Quishenberry's claims "require a determination of the amount of

allowable Medicare benefits for skilled nursing care, an area regulated by standards established by CMS; thus Quishenberry's claims are preempted."

There are likewise several flaws in the Court of Appeal's analysis of the preemption claim. First, Quishenberry's claims include the claim that his premature discharge was not medically appropriate. This claim stands wholly apart from any standard established by the federal government for the operation of HMO plans. And this claim stands wholly apart and distinct from, or at most only incidentally related to, any analysis of how many days Quishenberry was entitled to under Medicare. See 42 USC §3295 ("Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.")

Second, even if Quishenberry's only claim was that he was denied the full benefit of 100 days in skilled nursing facility care, the only issues are medical issues, i.e., whether conditions existed which qualified Eugene to receive skilled nursing care. His medical condition is the only matter in controversy because his entitlement to further skilled nursing facility care is clearly defined in the federal standards on which the Court of Appeal in part relied. Therefore even in this instance, Quishenberry's claim

is only incidentally related to a federal standard. Quoting from the Court of Appeal Opinion:

> To receive coverage, "the beneficiary must (1) require skilled nursing or rehabilitative services, (2) on a daily basis, (3) the services must be furnished for a condition for which the beneficiary received inpatient services, *for a condition which arose while the beneficiary was receiving care in an SNF* [skilled nursing facility] for a condition for which the beneficiary was hospitalized, or, for MA beneficiaries whose plans waive the 3 day hospital stay requirement, for a condition for which a physician has determined that direct admission to an SNF was medically appropriate without a prior hospital stay, and (4) the services must be such that as a practical matter they can only be provided at an SNF on an inpatient basis." (*United HealthCare Ins. Co. v. Sebelius* (D. Minn. 2011) 774 F.Supp.2d 1014, 1019, citing 42 C.F.R. § 409.31.) (emphasis added.) Opinion, at p. 14.

In this case the condition which arose was the pressure sores on his feet which made his participation in physical therapy difficult or impossible. In addition, allegations pertaining to federal requirements for skilled nursing facility benefits are mainly relevant to show Defendants' knowledge of their responsibility to enrollees such as Quishenberry, and their conscious disregard of those requirements. In other words, allegations pertaining to

Quishenberry's federal benefit would accordingly go not to establish negligence for the early discharge which was medically inappropriate given his pressure sores and his inability to walk, but instead – given Quishenberry's allegations of willful misconduct or recklessness -- to establish a basis for his allegations of malice or oppression. Civil Code §3294. For this reason, too, Quishenberry's claims are only incidentally related to federal standards.

The second flaw in the Court of Appeal opinion is its failure to discuss whether the claims asserted by Quishenberry were in conflict with federal standards. While *Uhm* explained that such a conflict was necessary for a claim to be preempted, the Court of Appeal followed *Roberts v. United Healthcare, supra,* which simply held that the existence of federal standards pertaining to a claim was all that was required to establish express preemption. In doing so, the Court of Appeal disagreed with *Cotton v. Starcare*, supra and *Yarick v. PacifiCare* (2009) 179 Ca. App. 4th 1158.

To recall, in *Uhm* the court declined to determine the precise degree to which the 2003 amendment to the preemption provision expanded the preemption provision beyond state laws and regulations inconsistent with enumerated federal standards. *Uhm* at 1150. But the plain language of the preemption provision enacted in 2003 clearly restricts the scope of the preemption provision to state law or regulation *with respect to a Medicare plan*. Since no state law appears to apply specifically *to a Medicare plan*, the natural reading of the preemption provision

would be to include any state law or regulation which applies *to any HMO*, whether or not a Medicare plan. As stated, this includes California's statutes and regulations designed to regulate HMO. Health & Safety Code §1340, et seq.

To give full sweep to the Medicare Preemption Provision, *Uhm* explained that state law claims which conflict with federal standards are *expressly preempted*. It follows that *Roberts'* reliance on *Uhm* is misplaced.

Two rules of statutory construction dictate that only state laws and regulations applicable to HMOs, and not those common laws or statutes of general applicability such as the Elder Abuse Act, are expressly preempted. And, while *Uhm* found express preemption for state laws which conflict with federal standards, there appears to be no sound basis for engrafting conflict principles into the analysis of express preemption.

First, is the rule that in construing statutes, meaning should be given to each word or phrase if possible. "It is axiomatic that the goal of statutory construction is to ascertain and effectuate the intent of the Legislature. In approaching this task, we must first look at the plain and commonsense meaning of the statute because it is generally the most reliable indicator of legislative intent and purpose. If there is no ambiguity or uncertainty in the language, the Legislature is presumed to have meant what it said, and we need not resort to legislative history to determine the statute's true meaning." *People v. Cochran* (2002) 28 Cal.4th 396, 400–401. See also *People v. Sylvester* (1997) 58 Cal. App. 4th 1493, 1496 (separate items in a statute

should be given meaning with reference to the whole, and each word or phrase in the statute should be interpreted to give meaning to every word and phase in the statute to accomplish a result consistent with the legislative purpose.)

Expressly preempting State efforts to regulate HMOs, by law or regulation is plainly intended from the statute which applies to laws or regulations *with respect* to HMOs. Nothing else is plainly intended and the language of the statute does not apply to statutes of general applicability, or to common law, neither of which exists with respect to HMOs. Nonetheless, preemptive intent may also be inferred if the scope of the statute indicates that Congress intended federal law to occupy the legislative field, or if there is an actual conflict between state and federal law. *Altria Group, Inc. v. Good* (2008) 555 U.S. 70-76-77. (Claims based on common law, which conflict with federal standards, as by applying different requirements or additional requirements, may be impliedly preempted.)

In *Roberts, supra,* the court evaluated the decision in *Cotton v. Starcare, supra. Cotton* determined that the words "law or regulation" had an established meaning which included statutes and regulations. Citing *Yarick v. PacifiCare of California* (2009) 179 Cal. App. 4th 1158, 1166-1167, *Cotton* explained the statute's use of the term "standards" and the phrases "law or regulation" and "with respect to MA plans" reflects Congress intended to preempt only state enactments including regulations, but not the common law. *Cotton* also found that the federal proposed rule implementing the Medicare

Advantage Act, agreed, noting "tort law, and often contract law, generally are developed based on case law precedents established by courts, rather than statutes enacted by legislators or regulations and concluded "Congress intended to preempt only the latter type of State standards." 69 Fed. Reg. 46914 (Aug. 3, 2004). A revision of the proposed rule implementing Congressional intent made no substantive change: "All State standards, including those established through case law, are preempted to the extent that they specifically would regulate Medicare Advantage plans, with exceptions of State licensing and solvency laws." 70 Fed. Reg. 4665 (Jan. 28, 2005).

Since it is difficult, if not impossible, to conceive of common law specifically regulating anything, particularly a federal Medicare plan, common law claims would not be expressly preempted by the Medicare Preemption provision. Given the analysis in *Yarick* and *Cotton* Quishenberry concludes that preemption of his common and Elder Abuse claims are not the clear and manifest intent of Congress. *Cipollone, supra.*

The remaining question is whether Quishenberry's action conflicts with federal standards, or as the Court of Appeal found, whether the laws on which Quishenberry relies stand an as obstacle to the accomplishment of a federal objective.

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2. QUISHENBERRY'S ACTION DOES NOT CONFLICT WITH FEDERAL STANDARDS

Although the Court of Appeal focused on obstacle preemption, Quishenberry will also briefly discuss conflict preemption.

Concededly, there are federal standards which govern the relationship between Medicare Advantage Organizations and contract providers of healthcare. But conflict preemption requires that compliance with both federal and state laws is an impossibility. *Parks, supra* at 383. No suggestion has been made by Respondents (nor by the Court of Appeal) that compliance with both the common law as applied in this case and with federal law would be impossible. In fact, Quishenberry's action might, in effect, require the defendants to comply with federal standards, particularly those establishing member rights to skilled nursing facility benefits.

Quishenberry alleged that GEM and Dr. Lee failed to properly treat Eugene's pressure sores and he was unable to walk without assistance. Although Eugene was entitled to up to 100 days of care at GEM's nursing facility with daily physical therapy and care for his pressure sores, following Dr. Lee's instruction and pursuant to the business practice of the Defendants, GEM furnished Eugene with a false statement that he was no longer qualified for further inpatient care at GEM. Court of Appeal Opinion (hereinafter "Opinion"), p. 4.

Despite knowledge that GEM was not providing necessary skilled nursing care to its resident-patients the Defendants

acquiesced to, encouraged, directed, aided and abetted Dr. Lee's action to discharge Eugene under circumstances where acceptable medical practice and Medicare rules required that Eugene remain at GEM for more intense attention to his healthcare needs.

In addition, in Plaintiff's cause of action based on the special relationship doctrine, Larry asserted that Lee was an agent of Healthcare Partners and both were agents of the United Healthcare entities. Opinion, pp. 4-5. Larry further alleged that both the Healthcare Partners and the United Healthcare entities were in a position by contract and by federal law to control the conduct of Dr. Lee and Gem. They knew GEM and Dr. Lee would formulate their treatment plan for Eugene so as to arrange for his early discharge from GEM to home and actually knew that this treatment plan would be harmful to Eugene. They failed to intervene, based on a motivation to increase profit by reducing the cost of providing care to enrollees including Eugene in nursing facility settings.

Larry's Elder Abuse claim alleged that all defendants had responsibility for the care and treatment of Eugene. Opinion, p. 6.

It is submitted that it is not impossible for defendants to comply with their common law duties to Eugene in this action, while at the same time complying with their responsibilities under federal standards.

3. NEITHER THE COMMON LAW NOR THE ELDER ABUSE ACT STAND AS AN OBSTACLE TO THE ACCOMPLISHMENT OF A FEDERAL OBJECTIVE

Obstacle preemption occurs when state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Parks*, at 383.)

For the reasons stated above in relation to conflict preemption, allowing Quishenberry's action to proceed presents no obstacle to the accomplishment of a federal objective. In both *Uhm* and *Roberts* the plaintiff's allegation was that the defendants had issued false marketing materials. In those cases, federal standards reserved to the federal agency the power to determine the truthfulness of marketing materials, and also to monitor plan compliance to determine whether the plan's ongoing practices continued to comply with their marketing materials. *Uhm* at 1150-1152. *Roberts* at 144. While the result in *Uhm* and *Roberts* are no doubt correct, given the federal standards reserving to the federal government the power to determine the truthfulness of marketing materials, no such sweeping reservation is to be found in the federal standards which apply to Quishenberry's claims.

Under *Uhm*, a conflict results in *express* preemption under the Medicare Preemption Provision. But it doesn't seem to matter in this case whether such conflicting state laws are expressly preempted, or impliedly preempted, because there is no conflict.

The common laws on which Quishenberry's claims based are not in conflict with federal law. The same is true of Quishenberry's claim under the generally applicable Elder Abuse Act. And although the court of Appeal found that the common law on which Quishenberry relied for his allegations of misconduct constituted an *obstacle* to the accomplishment of a federal objective, there is no basis for that conclusion and no explanation from the Court of Appeal, other than the bare existence of federal standards. Therefore, the Court of Appeal erred in holding Larry's claims to be preempted.

With respect to express preemption, *Roberts* explained that the task of the court is reduced to simply identifying the domain expressly preempted (citing *Quesada v. Herb Thyme Farms, Inc.* (2015) 62 Cal. 4th 298, 308). *Robert's* test for express preemption comes up short of the mark given the plain language of the Medicare Preemption Provision and it denies HMO members enrolled in Medicare plans any avenue to seek redress for the wide variety of HMO schemes to increase profit by withholding care which they are bound to provide. *Roberts* found that the plain language of the Medicare Preemption Provision "plainly spells out Congress's intent that the standards governing Medicare Advantage plans will displace '*any* State law or regulation' except for State laws regarding licensing or plan solvency. (italics supplied.) *Roberts* identified federal standards governing marketing materials and the adequacy of the provider network because they were the basis for the Plaintiff's claims.

On this basis *Roberts* found those claims expressly preempted. *Roberts* at 143.

Summarizing, *Roberts* correctly found that the plaintiff's claims based on false marketing materials to be preempted, but in doing so it ignored the plain meaning of the Medicare Preemption provision and misstated the law.

For these reasons it is respectfully submitted that Quishenberry's claim of medical mismanagement of his pressure sores, as well as his claim that he was denied benefits to which he was entitled are not expressly or impliedly preempted.

4. HEALTH & SAFETY CODE §1371.25, AS A STATE LAW SPECIFICALLY AIMED AT HMOs, IS EXPRESSLY PREEMPTED

One of Quishenberry's claims is based on the Special Relationship doctrine. Another of his claims are that defendants knew of and encouraged the misconduct of GEM and Dr. Lee in compelling the premature discharge of Eugene. These claims suggest the defendants' direct liability and do not depend on the application of vicarious liability principles. Others of Larry's claim are plainly dependent on the application of vicarious liability principles.

Health & Safety Code §1371.25 is part of the Knox-Keene Health Care Service Plan Act, which encompasses California's regulation of HMOs. Defendants raised §1371.25 as defensive and the trial court agreed. The Court of Appeal did not reach the question whether §1371.25 was preempted because it erroneously

found that each of Plaintiff's claims were preempted. Assuming that this Court finds that one or more of Quishenberry's claims are not preempted, applying the same laws applicable to preemption claims, he asserts that §1371.25 is expressly preempted.

Applying the plain language of the Medicare Preemption Provision, section 1371.25 is a state law aimed at HMOs and therefore a state law "with respect" to an HMO including Medicare Advantage Organizations and expressly preempted by the Medicare Preemption Provision. Section 1371.25 affects the relationship between HMOs and its delegees. But federal standards established by the federal agency include those pertaining to the HMO's relationship with providers. See 42 C.F.R. §422.200; 202-224.

Section 1371.25 provides:

> *A plan, any entity contracting with a plan, and providers are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others.* Any provision to the contrary in a contract with providers is void and unenforceable. Nothing 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. (emphasis added.)

Martin v. PacifiCare of California (2011) 198 Cal. App. 4th 1390 found a previous version of the Medicare Preemption Provision did not require preemption of section 1371.25, and explicitly failed to reach the question whether the current Medicare Preemption Provision would have preempted 1371.25. *Martin* at 1410-1411.

But is now clear that statutes and regulations specifically applicable to HMOs are preempted when applied to Medicare plans.

5. A DEFENDANT CAN BE VICARIOUSLY LIABLE FOR "NEGLECT" UNDER THE ELDER ABUSE ACT

Winn v. Pioneer Medical Group (2016) 63 Cal.4th 148, held that in order to be liable for "neglect" (Welf. & Inst. Code §15610.57), a defendant must have a robust care-giving relationship with the patient. A question seemingly not decided in *Winn* is whether a defendant who did not have care or custody can be vicariously liable for the conduct of another who did have care or custody. Here, it is alleged in part, that GEM and Dr. Lee had care or custody and committed neglect, and that the United Healthcare and Health Care Partners Medical Group defendants, as delegors of their duty to provide medical care, are vicariously liable for that neglect.

This Court has already decided that common law principles will apply to statutory claims, unless contrary intent is stated in the statute. *California Association of Health Facilities v.*

Department of Health Services (1997) 16 Cal.4th 284, 297, citing *Goodman v. Zimmerman* (1994) 25 Cal. App. 4th 1667. To repeat, the Elder Abuse Act, starting at Welf. & Inst. Code §15600, makes no provision with respect to the application of common law. In fact §15657, which provides for actions for neglect, provides:

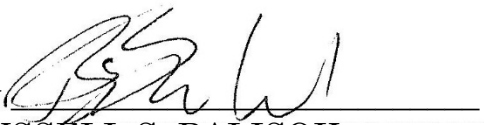
> Where it is proven by clear and convincing evidence that a defendant is liable for physical abuse as defined in Section 15610.63, neglect as defined in Section 15610.57, or abandonment as defined in Section 15610.05, and that the defendant has been guilty of recklessness, oppression, fraud, or malice in the commission of this abuse, the following shall apply, *in addition to all other remedies otherwise provided by law*: (emphasis added.)

It is submitted that Health Care Partners and the United Healthcare Defendants can be held vicariously liable for the neglect of Eugene by Lee and GEM

6. CONCLUSION

For the foregoing reasons, Petitioner requests that this Court grant review.

Respectfully submitted
BALISOK & ASSOCIATES, INC.

By: 
RUSSELL S. BALISOK,
Attorneys for Appellant
Larry Quishenberry

CERTIFICATE OF WORD COUNT

(Cal. Rules of Court, Rule 8.204(c)(1))

The text of this brief consists of 5,832 words, as counted by the Microsoft Office Word, word processing program used to generate this brief.

Dated: October 26, 2021

RUSSELL S. BALISOK,
Counsel for Appellant

PROOF OF SERVICE

STATE OF CALIFORNIA)
COUNTY OF LOS ANGELES)

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 330 North Brand Boulevard, Suite 702, Glendale, California 91203.

On **October 27, 2021** I served the document described as **PETITION FOR REVIEW** on all interested parties by sending a true copy addressed to each through TrueFiling, the electronic filing portal of the California Court of Appeal, pursuant to Local Rules, which will send notification of such filing to the email addresses denoted on the case's Electronic Service List.

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Court of Appeal 2nd Appellate District, Division 7 300 S. Spring St. Second Floor, North Tower Los Angeles, CA 90013	

As the below recipients are not able to be served electronically via TrueFiling, I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed below and placed the envelope(s) for collection and mailing, following our firm's ordinary business practices. I am readily familiar with this firm's practice for collecting and processing correspondence for mailing. On the same day the correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with post-age fully prepaid.

Hon. Ralph Hofer, Dept. D
Glendale Courthouse
600 E. Broadway
Glendale, CA 91206

Trial Court

[X] **(STATE)** I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on **October 27, 2021** at Los Angeles, California.

/s/ Dorothy A. Droke

Dorothy A. Droke

Filed 9/21/21 Quishenberry v. UnitedHealthcare CA2/7

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

California Rules of Court, rule 8.1115(a), prohibits courts and parties from citing or relying on opinions not certified for publication or ordered published, except as specified by rule 8.1115(b). This opinion has not been certified for publication or ordered published for purposes of rule 8.1115.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

LARRY QUISHENBERRY, Plaintiff and Appellant, v. UNITEDHEALTHCARE, INC. et al., Defendants and Respondents.	B303451 (Los Angeles County Super. Ct. No. BC631077)

APPEAL from judgments of the Superior Court of Los Angeles County, Ralph Hofer, Judge. Affirmed.

Balisok & Associates and Russell S. Balisok for Plaintiff and Appellant.

Walraven & Westerfeld, Bryan S. Westerfeld and Jessica B. Hardy for Defendants and Respondents UnitedHealthcare, Inc., UnitedHealth Group Incorporated, UnitedHealthcare Services, Inc., and UHC of California.

Carroll, Kelly, Trotter & Franzen, Michael J. Trotter, Brenda M. Ligorsky, and David P. Pruett for Defendants and Respondents Health Care Partners Medical Group and Healthcare Partners LLC.

Larry Quishenberry appeals from judgments of dismissal entered after the trial court sustained the demurrers of defendants UnitedHealthcare, Inc., UnitedHealth Group Incorporated, UnitedHealthcare Services, Inc., and UHC of California (collectively, the UnitedHealthcare entities) and Health Care Partners Medical Group and Healthcare Partners LLC (collectively, Healthcare Partners) without leave to amend. Quishenberry alleged his father, Eugene Quishenberry,[1] was prematurely discharged from a skilled nursing facility operated by GEM HealthCare, LLC (GEM), and Eugene died after his health deteriorated. Quishenberry sued GEM; Dr. Jae H. Lee, the doctor who provided Eugene's care at the GEM facility; the UnitedHealthcare entities, which provided a Medicare Advantage (MA) Health Maintenance Organization plan to Eugene; and Healthcare Partners, which provided physician services to Eugene, including the services of Dr. Lee. Quishenberry asserted causes of action for negligence, elder abuse, bad faith, and wrongful death.[2]

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[1] To avoid confusion, we refer to Eugene Quishenberry by his first name.

[2] Quishenberry describes his first and second causes of action as claims for "[n]egligence and [r]ecklessness—elder abuse." We refer to these claims as negligence claims for simplicity.

On appeal, Quishenberry contends the trial court erred in ruling the Medicare Part C preemption clause (42 U.S.C. §1395w-26(b)(3)) barred his causes of action. Quishenberry also challenges the trial court's determination Health & Safety Code section 1371.25 barred his claims against the UnitedHealthcare entities because the claims were based on the UnitedHealthcare entities' vicarious liability for the acts of GEM and Dr. Lee. Because Quishenberry's claims are preempted, we affirm.

FACTUAL AND PROCEDURAL BACKGROUND

A. *The Lawsuit*

Quishenberry filed this action on August 19, 2016 individually and as a successor in interest to Eugene. After the trial court sustained demurrers to the first amended complaint, Quishenberry filed a second amended complaint (complaint) alleging claims for negligence, elder abuse, bad faith,[3] and wrongful death. The complaint alleged Eugene, who was born on October 12, 1929, was enrolled in an MA plan offered by one or more of the UnitedHealthcare entities.[4] The relationships among the UnitedHealthcare entities were "complex and not fully known or understood by" Quishenberry. The complaint alleged the UnitedHealthcare entities delegated to HealthCare Partners their responsibility to provide certain health care benefits

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[3] Quishenberry does not on appeal challenge dismissal of this claim.

[4] The second amended complaint incorrectly identified UnitedHealthcare, Inc. as United Health Care, Inc. and United Healthcare Insurance, Inc., and UHC of California as United Healthcare-California, Inc. and UHC-California, Inc.

(physician services) and administrative protections owed to MA plan enrollees by contracting with Healthcare Partners to provide physician services for the plan's enrollees. The UnitedHealthcare entities delegated to GEM,[5] which operated a skilled nursing facility in Pasadena, their responsibility to provide custodial care and administrative protections to plan enrollees.

In approximately November 2014, then-85-year-old Eugene broke his hip and was hospitalized at Huntington Hospital, which had a contract with the UnitedHealthcare entities to provide hospital services for enrollees. Eugene was later transferred to GEM's skilled nursing facility under the care of Dr. Lee, a medical doctor allegedly employed by Healthcare Partners. The complaint alleged that during Eugene's stay at GEM's skilled nursing facility, he developed severe pressure sores on his feet because of GEM's neglect. Neither Dr. Lee or GEM's nursing staff properly treated the sores, which made it difficult and painful for Eugene to walk without assistance.

Eugene was at GEM's skilled nursing facility for 24 days, from November 4 through 28, 2014. According to the complaint, Eugene was entitled under Medicare to an additional 76 days of care at GEM's skilled nursing facility with daily physical therapy and care for his pressure sores. "Nevertheless, following [Dr.] Lee's direction, and pursuant to the business practice of [Healthcare Partners] and the UnitedHealthcare entities, GEM furnished Eugene with a false statement that he was no longer qualified under Medicare for further inpatient care at GEM. [¶] Eugene was transferred to his home, where, without adequate nursing care and physical therapy and as a proximate cause of

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[5] In 2016 Quishenberry settled with GEM.

Dr. Lee's treatment decisions, Eugene's health declined, he experienced pain and suffering, and died."[6]

The complaint alleged as to the negligence cause of action, "Despite the said knowledge that GEM was not providing necessary skilled nursing care to its resident-patients . . . , the [UnitedHealthcare] entities, GEM and [Healthcare Partners] acquiesced to, encouraged, directed, aided and abetted [Dr.] Lee's action to discharge Eugene under circumstances where acceptable medical practice and Medicare rules required that Eugene remain at GEM for more intense attention to his health care needs." Further, the UnitedHealthcare entities, Healthcare Partners, and Dr. Lee acted recklessly and willfully because they "knew or should have known that they created the peril that enrollee patients including Eugene would be at risk of injury" and "consciously disregarded the peril and the probability of injury to resident-patients, including Eugene."

The complaint alleged a separate negligence cause of action against the UnitedHealthcare entities and Healthcare Partners based on the special relationship doctrine. The complaint asserted Dr. Lee was an agent of Healthcare Partners, and both Healthcare Partners and GEM were agents of the

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[6] Although the complaint alleged Eugene died on August 24, 2014, Eugene's death certificate, which was attached to Quishenberry's successor-in-interest affidavit, shows Eugene died on August 24, 2015. Healthcare Partners argues that Eugene therefore lived for 269 days after his discharge from GEM's nursing facility, questioning whether Eugene's death could have been caused by his premature discharge. But whether Quishenberry would be able to prove at trial that Eugene's death was caused by his allegedly premature discharge from GEM is not before us in this appeal.

UnitedHealthcare entities. The complaint alleged, "Both [Healthcare Partners] and the United Healthcare entities were by contract and by federal law in a position to control the conduct of [Dr.] Lee and GEM in their provision of care to Eugene . . . . [¶] Both [Healthcare Partners] and the United Healthcare entities actually knew that GEM and Lee would formulate their treatment plan for Eugene so as to arrange for his early discharge from GEM to home, and actually knew that this treatment plan would be harmful to Eugene. Instead of intervening to control GEM and Lee's treatment decision making, as by ensuring that GEM and Lee knew that further care and treatment at GEM was a covered benefit under Eugene's Medicare plan, each said defendant failed to take any action, and allowed Dr. Lee and GEM's discharge of Eugene to home." The complaint added, "[Healthcare Partners] and the United Healthcare entities were motivated by their need to increase profit by reducing the cost of providing care to enrollees including Eugene in a skilled nursing facility setting."

For the elder abuse cause of action, the complaint alleged all defendants "had responsibility for the custodial care and custodial treatment of Eugene" because of their agreement with the Center for Medicare and Medicaid Services (CMS).[7] The complaint alleged Healthcare Partners and the UnitedHealthcare entities "were and are legally responsible for the physical care

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[7] The Centers for Medicare & Medicaid Services is part of the United States Department of Health and Human Services and contracts with MA plan providers. (<https://www.cms.gov/About-CMS/About-CMS> [as of Sept. 21, 2021], archived at <https://perma.cc/M49Y-2889>; *Uhm v. Humana, Inc.* (9th Cir. 2010) 620 F.3d 1134, 1138.)

and custody of enrollees including Eugene under Welfare & Institutions Code section 15610.57."

Finally, the complaint asserted a wrongful death cause of action against all defendants for Quishenberry's loss of consortium.

B. *Defendants' Demurrers*

On April 19, 2019 the UnitedHealthcare entities demurred to the second amended complaint. They argued Quishenberry's state law claims were preempted by the Medicare Act's preemption clause (42 U.S.C. § 1395w-26(b)(3); Medicare Part C preemption clause). Further, Quishenberry's claims were based on vicarious liability for the acts of GEM and Dr. Lee, and thus the claims were barred under section 1371.25 of the Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340 et seq.; Knox-Keene Act). The UnitedHealthcare entities asserted Health & Safety Code section 1371.25 was not preempted by the Medicare Act, and if it was, Quishenberry's claims would also be preempted. In addition, Quishenberry failed to state viable claims for elder abuse and wrongful death.

Healthcare Partners and Dr. Lee also demurred, likewise asserting the Medicare Act preempted Quishenberry's claims. In addition, they asserted Quishenberry failed to exhaust his administrative remedies available under the Medicare Act before seeking judicial review. They also contended Quishenberry's claims for negligence and elder abuse were disguised challenges to the financial arrangements among the defendants, which were authorized under the Knox-Keene Act. Moreover, Dr. Lee could not be held liable for elder abuse because he was not in a custodial or caretaking relationship with Eugene.

C. *The Trial Court's Ruling and Judgment*

After a hearing, on October 25, 2019 the trial court sustained the demurrers filed by the UnitedHealthcare entities and Healthcare Partners without leave to amend, but overruled Dr. Lee's demurrer. Relying on *Roberts v. United Healthcare Services, Inc.* (2016) 2 Cal.App.5th 132 (*Roberts*), the court found Quishenberry's causes of action against the UnitedHealthcare entities and Healthcare Partners were preempted by the Medicare Act because the allegations involved defendants' "failure to administer properly the health care plan." In addition, the claims against the UnitedHealthcare entities were "barred by Health & Safety Code section 1371.25 which provides that a healthcare service plan is not vicariously liable for acts or omissions of the actual health care services providers."

The trial court entered a judgment in favor of Healthcare Partners on December 3, 2019, and a judgment in favor of the UnitedHealthcare entities on December 6, 2019. Quishenberry timely appealed both judgments.

DISCUSSION

A. *Standard of Review*

"'In reviewing an order sustaining a demurrer, we examine the operative complaint de novo to determine whether it alleges facts sufficient to state a cause of action under any legal theory.' [Citation.] '"'We treat the demurrer as admitting all material facts properly pleaded, but not contentions, deductions or conclusions of fact or law. . . . We also consider matters which may be judicially noticed." . . . Further, we give the complaint a reasonable interpretation, reading it as a whole and its parts in their context."'" (*Mathews v. Becerra* (2019) 8 Cal.5th 756, 768;

accord, *Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.* (2016) 1 Cal.5th 994, 1010.) "A judgment of dismissal after a demurrer has been sustained without leave to amend will be affirmed if proper on any grounds stated in the demurrer, whether or not the court acted on that ground." (*Carman v. Alvord* (1982) 31 Cal.3d 318, 324; accord, *Ko v. Maxim Healthcare Services, Inc.* (2020) 58 Cal.App.5th 1144, 1150.)

B. *Preemption Principles*

"'"The supremacy clause of the United States Constitution establishes a constitutional choice-of-law rule, makes federal law paramount, and vests Congress with the power to preempt state law." [Citations.] Similarly, federal agencies, acting pursuant to authorization from Congress, can issue regulations that override state requirements. [Citations.] Preemption is foremost a question of congressional intent: did Congress, expressly or implicitly, seek to displace state law?'" (*Solus Industrial Innovations, LLC v. Superior Court* (2018) 4 Cal.5th 316, 331 (*Solus*); accord, *Quesada v. Herb Thyme Farms, Inc.* (2015) 62 Cal.4th 298, 307-308 (*Quesada*).)

"'Congress may expressly preempt state law through an explicit preemption clause, or courts may imply preemption under the field, conflict, or obstacle preemption doctrines.'" (*Solus, supra*, 4 Cal.5th at p. 332; accord, *Quesada, supra*, 62 Cal.4th at p. 308.) "'[E]xpress preemption arises when Congress "define[s] explicitly the extent to which its enactments pre-empt state law."' (*Parks v. MBNA America Bank, N.A.* (2012) 54 Cal.4th 376, 383; accord, *Viva! Internat. Voice for Animals v. Adidas Promotional Retail Operations, Inc.* (2007) 41 Cal.4th 929, 936.) "Implied preemption, for its part, may be found '(i) when it

is clear that Congress intended, by comprehensive legislation, to *occupy the entire field* of regulation, leaving no room for the states to supplement federal law [citation]; (ii) when compliance with both federal and state regulations is an *impossibility* [citation]; or (iii) when state law "stands as an *obstacle* to the accomplishment and execution of the full purposes and objectives of Congress."'" (*Solus*, at p. 332; accord, *Parks*, at p. 383.)

"We 'conduct[] the search for congressional intent through the lens of a presumption against preemption. [Citations.] The presumption is founded on "respect for the States as 'independent sovereigns in our federal system"'; that respect requires courts "to assume that 'Congress does not cavalierly pre-empt state-law causes of action."'" (*Solus, supra*, 4 Cal.5th at p. 332; accord, *Quesada, supra*, 62 Cal.4th at pp. 312-313.) "A rebuttal of the presumption requires a demonstration that preemption was the '"clear and manifest purpose of Congress."'" (*Quesada*, at p. 313; accord, *Roberts, supra*, 2 Cal.App.5th at p. 142.) The party asserting preemption has the burden of overcoming the presumption against preemption and demonstrating preemption applies. (*Quesada*, at p. 308; *Jankey v. Lee* (2012) 55 Cal.4th 1038, 1048.) "Where, as here, preemption turns on questions of law such as the meaning of a preemption clause or the ascertainment of congressional intent, our review is de novo." (*Roberts*, at p. 142; accord, *People v. Superior Court (Cal Cartage Transportation Express, LLC)* (2020) 57 Cal.App.5th 619, 627; see *Farm Raised Salmon Cases* (2008) 42 Cal.4th 1077, 1089, fn. 10 ["federal preemption presents a pure question of law"].)

C. *The Medicare Act and Part C Preemption*

The Medicare Act (42 U.S.C. § 1395 et seq.; Medicare Act) "established a federally subsidized health insurance program

that is administered by the Secretary of Health and Human Services (the Secretary) . . . . Part A of Medicare, 42 United States Code section 1395c et seq., covers the cost of hospitalization and related expenses that are 'reasonable and necessary' for the diagnosis or treatment of illness or injury . . . . Part B of Medicare (42 U.S.C. § 1395j et seq.) establishes a voluntary supplementary medical insurance program for Medicare-eligible individuals and certain other persons over age 65, covering specified medical services, devices, and equipment." (*McCall v. PaciCare of Cal., Inc.* (2001) 25 Cal.4th 412, 416; accord, *Roberts, supra*, 2 Cal.App.5th pp. 139-140.)

Under Part C of the Act, added in 1997 (42 U.S.C. §§ 1395w-21 to 1395w-28), "Medicare beneficiaries can sign up for a privately administered health care plan—originally called a "Medicare+Choice" plan, but later renamed a "Medicare Advantage" plan—that provides all of the Part A and B benefits as well as additional benefits. [Citations.] If a beneficiary elects to participate in such a plan, the government pays the plan's administrator a flat, monthly fee to provide all Medicare benefits for that beneficiary. Because Part C limits the government's responsibility to adjust the monthly fee, the private health plan—rather than the government—ends up 'assum[ing] the risk associated with insuring' the beneficiary." (*Roberts, supra*, 2 Cal.App.5th p. 140; accord, *Martin v. PacifiCare of California, supra*, 198 Cal.App.4th at p. 1394; *Yarick v. PacifiCare of California* (2009) 179 Cal.App.4th 1158, 1163 (*Yarick*).)

When it was first enacted in 1997, Part C contained a preemption clause that provided, "(A) In general.—The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph

(B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards. [¶] (B) Standards specifically superseded.—State standards relating to the following are superseded under this paragraph: [¶] (i) Benefit requirements. [¶] (ii) Requirements relating to inclusion or treatment of providers. [¶] Coverage determinations (including related appeals and grievance processes)." (Pub.L. No. 105-33, § 1856(b)(3) (Aug. 5, 1997) 111 Stat. 251.)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (2003 Medicare Modernization Act) amended the Medicare Part C preemption clause to contain the current language: "Relation to state laws.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part." (Pub.L. No. 108-173, § 232 (Dec. 8, 2003) 117 Stat. 2066; 42 U.S.C. § 1395w-26(b)(3).)

D. *Quishenberry's Claims Are Expressly Preempted by the Medicare Part C Preemption Clause*

Quishenberry's negligence, elder abuse, and wrongful death causes of action are based on California law in an area in which Medicare Part C regulations have established standards for MA plans. Under part 422 of title 42 of the Code of Federal Regulations, the Secretary through CMS has "establishe[d] standards and set[] forth the requirements, limitations, and procedures for Medicare services furnished, or paid for, by Medicare Advantage organizations through Medicare Advantage plans." (42 C.F.R. § 422.1(b).) The regulations include CMS's approval of the network of MA providers "to ensure that all

applicable requirements are met, including access and availability, service area, and quality." (42 C.F.R. § 422.4(a)(1)(i)).) CMS also sets standards governing provider "selection and credentialing" for MA plans (42 C.F.R. § 422.204); requirements relating to "an ongoing quality improvement program" for each MA plan (42 C.F.R. § 422.152(a)); and the requirement that "[f]or each plan, the organization must correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms" (42 C.F.R. § 422.152(f)(3)). In addition, the MA organization must consult with physicians who provide services under the MA plan regarding the MA organization's "medical policy, quality improvement programs and medical management procedures" and ensure the physicians' "[d]ecisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines." (42 C.F.R. § 422.202(b)(3)).

CMS has also promulgated regulations requiring MA organizations to provide services "covered by Part A and Part B (if the enrollee is entitled to benefits under both parts)" and to comply with "CMS's national coverage determinations," "[g]eneral coverage guidelines," and "[w]ritten coverage decisions of local Medicare contractors with jurisdiction for claims in the area in which services are covered under the MA plan." (42 C.F.R. § 422.101 (b)(1-3).) Under Part A, Medicare benefits include coverage of "post-hospital extended care services for up to 100 days during any spell of illness." (42 U.S.C. § 1395d(a)(2)(A).) The regulations require an MA organization to provide coverage of posthospital extended care services at a skilled nursing facility if an enrollee "[has] been an inpatient in a qualifying hospital for at least three (3) consecutive calendar

days, not including the day of the discharge, and must have been discharged in or after the month he or she became eligible for Medicare." (*Rapport v. Leavitt* (W.D.N.Y. 2008) 564 F.Supp.2d 186, 188-189, citing 42 C.F.R. § 409.30(a).)

To receive coverage, "the beneficiary must (1) require skilled nursing or rehabilitative services, (2) on a daily basis, (3) the services must be furnished for a condition for which the beneficiary received inpatient services, for a condition which arose while the beneficiary was receiving care in an SNF [skilled nursing facility] for a condition for which the beneficiary was hospitalized, or, for MA beneficiaries whose plans waive the 3 day hospital stay requirement, for a condition for which a physician has determined that direct admission to an SNF was medically appropriate without a prior hospital stay, and (4) the services must be such that as a practical matter they can only be provided at an SNF on an inpatient basis." (*United HealthCare Ins. Co. v. Sebelius* (D. Minn. 2011) 774 F.Supp.2d 1014, 1019, citing 42 C.F.R. § 409.31.)

Quishenberry's common law negligence and statutory elder abuse and wrongful death claims against the UnitedHealthcare entities[8] and Healthcare Partners are based on the premature

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[8] Quishenberry argues that because the complaint alleged it is "uncertain[]" which of the UnitedHealthcare entities contracted with CMS to provide an MA plan to Eugene, none of the entities qualifies as an MA organization. But Quishenberry's claims are premised on the provision of an MA plan to Eugene, and therefore, only the UnitedHealthcare entity that provided the MA plan would be directly liable. Any liability of the related UnitedHealthcare entities would be derivative of the liability of the MA plan provider, and thus preempted to the same extent the claims against the MA organization are preempted. (See *Uhm v.*

discharge of Eugene from GEM without adequately treating his pressure sores or providing sufficient physical therapy. The complaint alleged Eugene stayed for 24 days at GEM's skilled nursing facility, but under Medicare Eugene was entitled to an additional 76 days of stay to receive daily physical therapy and care for his pressure sores. Further, "[d]espite the said knowledge that GEM was not providing necessary skilled nursing care to its resident-patients," Healthcare Partners and the UnitedHealthcare entities "acquiesced to, encouraged, directed, aided and abetted [Dr.] Lee's action to discharge Eugene under circumstances where acceptable medical practice and Medicare rules required that Eugene remain at GEM for more intense attention to his health care needs." These allegations require a determination of the amount of allowable Medicare benefits for skilled nursing care, an area regulated by standards established by CMS; thus, Quishenberry's claims are preempted. (See 42 C.F.R. § 422.101 [MA plan must provide services covered by Parts A and B]; 42 C.F.R. §§ 409.30 & 409.31 [setting eligibility requirements for skilled nursing facility benefits].)[9]

Humana, Inc., supra, 620 F.3d at pp. 1157-1158 [claims against parent company of MA plan provider were preempted because the liability of the parent was "entirely derivative of its relationship with the [MA plan provider]"].)

[9] The complaint also alleged GEM nursing staff and Dr. Lee did not properly treat Eugene's pressure sores. The UnitedHealthcare entities argue these allegations concern the UnitedHealthcare entities' oversight of GEM and Dr. Lee, which is subject to CMS's requirement that MA organizations "operate a quality assurance and performance improvement program" (42 C.F.R. § 422.504(a)(5)), maintain an "ongoing quality improvement program," and "correct all problems that come to its

Quishenberry contends his claims against Healthcare Partners are not preempted because only an MA organization is entitled to the benefit of the Medicare Part C preemption clause, and it is undisputed Healthcare Partners is not an MA organization. But the allegations concerning Eugene's eligibility for posthospital extended care services at a skilled nursing facility are governed by the CMS standards regardless of whether the claims are asserted against an MA organization. For example, 42 Code of Federal Regulations 409.30 sets standards for the provision of posthospital skilled nursing facility care, without any reference to MA organizations.[10] Although the Medicare Part C preemption provision applies to preempt state laws "with respect to MA plans which are offered by MA organizations under this part" (42 U.S.C. § 1395w-26(b)(3)), Healthcare Partners's liability arises from the decision to

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attention through internal surveillance, complaints, or other mechanisms" (42 C.F.R. § 422.152(f)(3)). The UnitedHealthcare entities are correct that to the extent the complaint alleged they failed to provide sufficient oversight of the care provided by GEM and Dr. Lee, Quishenberry's claims would be preempted. As to Healthcare Partners, the complaint alleged Dr. "Lee was employed by [Healthcare Partners] . . . to provide physician services to enrollees including Eugene," but Quishenberry did not argue in the trial court in opposition to Healthcare Partners' demurrer, nor does he argue on appeal, that his claims against Healthcare Partners are based on its vicarious liability as Dr. Lee's employer.

[10] Under 42 Code of Federal Regulations section 409.30, posthospital skilled nursing facility care "is covered only if the beneficiary meets the requirements of this section and only for days when he or she needs and receives care of the level described in § 409.31."

discharge Eugene based on a determination Eugene was not eligible for additional Medicare benefits under the MA plan offered by UnitedHealthcare entities (an MA organization).[11]

Our conclusion that preemption applies to Quishenberry's causes of action against the UnitedHealthcare entities and against Healthcare Partners is consistent with the holdings by the courts that have broadly construed the Medicare Part C preemption clause. (See *Roberts*, *supra*, 2 Cal.App.5th at pp. 138, 143 [MA standards governing the content of an MA plan's marketing materials and adequacy of its network expressly

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[11] Even if express preemption did not apply, Quishenberry's claims would be barred by implied preemption based on the doctrine of "obstacle preemption" because his state law claims would "stand[] as an obstacle to the full accomplishment and execution of congressional objectives." (*People ex rel. Harris v. Pac Anchor Transportation, Inc.* (2014) 59 Cal.4th 772, 778; accord, *Solus, supra*, 4 Cal.5th at p. 332.) Allowing Quishenberry to bring state law claims against Healthcare Partners based on the premature discharge of Eugene from GEM's skilled nursing facility would undermine CMS's ability to regulate Medicare benefits coverage, including eligibility requirements for skilled nursing facility care. (See *Roberts, supra*, 2 Cal.5th at p. 149 ["[C]laims based on misrepresentations in United Healthcare's marketing materials and based on the adequacy of its plan are impliedly preempted by the Act."]; *Yarick, supra*, 179 Cal.App.4th at pp. 1167-1168 ["If state common law judgments were permitted to impose damages on the basis of these federally approved contracts and quality assurance programs, the federal authorities would lose control of the regulatory authority that is at the very core of Medicare generally and the MA program specifically."].)

preempted state law claims for unfair competition, misleading advertising, constructive fraud, and financial elder abuse under Medicare Part C preemption clause]; *Uhm v. Humana, Inc., supra*, 620 F.3d 1134, 1148-1153 (*Uhm*) [under Medicare Part C preemption clause, expressly incorporated into Medicare Part D, CMS regulations governing Part D prescription drug plan's marketing materials preempted state law fraud and consumer protection act claims]; *Morrison v. Health Plan of Nev., Inc.* (Nev. 2014) 130 Nev. 517, 523 [328 P.3d 1165, 1169] [CMS regulations governing provider selection and quality improvement program preempted state common law negligence claim alleging MA organization negligently directed plaintiff to clinic and failed to investigate clinic's unsafe medical practices].)

As our colleagues in Division Two of this district explained in *Roberts, supra*, 2 Cal.App.5th at page 143, "[T]he plain language of section 1395w-26(b)(3) plainly spells out Congress's intent that the standards governing Medicare Advantage plans will displace '*any* State law or regulation' except for State laws regarding licensing or plan solvency." Further, the legislative history of the 2003 Medicare Modernization Act—in replacing the prior preemption clause that only superseded "state standards" in four discrete areas and other "[s]tate laws or regulations" inconsistent with the Part C standards with the current language preempting "any [s]tate law or regulation"—shows Congress's clear intent to broaden the scope of the preemption clause. (*Roberts*, at p. 143.)

As the Conference Report accompanying the 2003 House bill explained, "Medicare law currently preempts state law or regulation from applying to M+C plans to the extent they are inconsistent with federal requirements imposed on M+C plans, and specifically, relating to benefit requirements, the inclusion or

treatment of providers, and coverage determinations (including related appeals and grievance processes). . . . [¶] . . . Federal standards established by this legislation would supersede any state law or regulation (other than state licensure laws and state laws relating to plan solvency) with respect to MA plans offered by MA organizations." (H.R. Rep. No. 108-391, 1st Sess., pp. 1, 556 (2003).) The report added, "The conference agreement clarifies that the MA program is a federal program operated under Federal rules. State laws do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency. There has been some confusion in recent court cases." (*Id.* at p. 557; see *Roberts, supra*, 2 Cal.App.5th at p. 143.)

Moreover, in its proposed rule for the MA program, CMS stated, "Congressional intent is now unambiguous in prohibiting States from exercising authority over MA plans in any area other than State licensing laws and State laws relating to plan solvency." (69 Fed.Reg. 46866, 46880 (Aug. 3, 2004).) CMS added, "In 2003, section 232(a) of the [2003 Medicare Modernization Act] . . . broadened Federal preemption of State standards to broadly apply preemption to all State law or regulation (other than State licensing laws or State laws relating to plan solvency)." (69 Fed.Reg. at p. 46926.) The 2003 Medicare Modernization Act "revision relieves uncertainty of which State laws are preempted by 'preempting the field' of State laws other than State laws on licensing and solvency." (*Id.* at p. 46927.)

In its final rule, CMS noted that prior to enactment of the 2003 Medicare Modernization Act, "[t]he presumption was that a State law was not preempted if it did not conflict with an M+C requirement, and did not fall into one of the four specified categories where preemption was presumed . . . . [¶] We concluded that the [2003 Medicare Modernization Act] reversed

this presumption and provided that State laws are presumed to be preempted unless they relate to licensure or solvency. We also referenced the Congress' intent that the MA program, as a Federal program, operate under Federal rules, and referred to the Conference Report as making clear the Congress' intent to broaden the scope of preemption." (70 Fed.Reg. 4194, 4319 (Jan. 28, 2005).)

Quishenberry also contends the Medicare Part C preemption clause does not preempt his state common law claims because the clause's "language usually is interpreted to preempt only 'positive state enactments,' that is, laws and administrative regulations, but not the common law." (*Yarick, supra*, 179 Cal.App.4th 1158, 1165-1166, citing *Sprietsma v. Mercury Marine* (2002) 537 U.S. 51, 63 (*Sprietsma*); accord, *Cotton v. StarCare Medical Group* (2010) 183 Cal.App.4th 437, 450-451 (*Cotton*) ["The statute's use of the term 'standards' and the phrases 'law or regulation' and 'with respect to MA plans' reflects Congress intended 'to preempt only "positive state enactments," that is, laws and administrative regulations, but not the common law.'"].) Quishenberry's contention is not persuasive.

In *Yarick*, the Fifth Appellate District rejected the defendant MA organization's argument the Medicare Part C preemption clause expressly preempted the plaintiff's claims for negligence, elder abuse, and wrongful death arising from the allegedly premature discharge of decedent from a health care facility to the extent the claims were based on common law duties independent of standards under the Knox-Keene Act, but the court found the common law claims were impliedly preempted under the Medicare Act. (*Yarick*, *supra*, 179 Cal.App.4th at p. 1161, 1166-1168.) In *Cotton*, 183 Cal.App.4th at pages 450 to 451, the Fourth Appellate District read the Medicare Part C

preemption provision even more narrowly than *Yarick*, concluding the plaintiff's claims for negligence, elder abuse, and wrongful death were not preempted because the Medicare Part C preemption clause only superseded state laws or regulation "with respect to" MA plans, that is, state laws or regulations that targeted MA plans. (*Id*. at pp. 452-453.)

We agree with our colleagues in *Roberts*, *supra*, 2 Cal.App.5th at pages 145 to 147 and decline to follow *Cotton* and *Yarick*. As the court in *Roberts* explained, *Cotton* and *Yarick* are inconsistent with *Riegel v. Medtronic, Inc.* (2008) 552 U.S. 312, 315, 324, in which the Supreme Court held the preemption clause in the Medical Device Amendments of 1976 (21 U.S.C. § 360k), which preempted "state 'requirements,' reached 'common-law duties' as well as duties created by positive law." (*Roberts, supra*, at 2 Cal.App.5th at p. 145, quoting *Riegel*, at p. 324.) The court in *Roberts* explained *Riegel* rejected "*Cotton's* holding that Part C's preemption clause only reaches laws specifically targeting Medicare Advantage plans" by concluding the Medical Device Amendments of 1976's preemption clause that reached "'requirements . . . with respect to'" medical devices did not mean "that the state laws preempted by that clause 'must apply *only* to the relevant device, or only to medical devices and not to all products and all actions in general.'" (*Roberts*, at pp. 146-147, quoting *Riegel, supra*, 552 U.S. at pp. 327-328.)

We also agree with *Roberts* that *Sprietsma, supra*, 537 U.S. at page 51, relied on by *Cotton* and *Yarick*, is not controlling as to the determination of the scope of Medicare Part C preemption. (*Roberts, supra*, 2 Cal.App.5th at pp. 145-146.) In *Sprietsma*, the Supreme Court held the language of the express preemption clause in the Federal Boat Safety Act of 1971, which provided that "a State . . . may not establish, continue in effect, or enforce

a law or regulation establishing a recreational vehicle or associated equipment performance or other safety standard," did not preempt common law claims. (*Sprietsma*, at pp. 58, 63-64.) The court in *Roberts* explained, "*Sprietsma* held that the clause reached only positive state enactments and grounded its holding on three points: (1) '[T]he article "a" before "law or regulation" implies a discreteness—which is embodied in statutes and regulations—that is not present in the common law' (*Sprietsma*, at p. 63); (2) the word 'law' in 'law or regulation' 'might . . . be interpreted to include regulations, which would render the express reference to "regulation" . . . superfluous' (*ibid.*); and (3) the existence of the savings clause, which exists to '"save"' '"some significant number of common-law liability cases"' (*ibid.*, quoting *Geier v. American Honda Motor Co.* (2000) 529 U.S. 861, 868)." (*Roberts*, at pp. 145-146.)

Roberts distinguished *Sprietsma* as to all three bases for its holding: "[*Sprietsma's*] first and third rationales are wholly inapplicable to Part C. Part C's preemption clause refers to 'any State law or regulation'—not 'a State law or regulation'; because '"the word 'any' has an expansive meaning, that is, 'one or some indiscriminately of whatever kind'" [citations], '[t]he use of "any" negates the "discreteness" that the Court identified in *Sprietsma*' . . . . Part C also has no clause saving common law actions. The closest the Act comes is section 1395, which reserves to state law only the 'supervision or control' (1) 'over the practice of medicine or the manner in which medical services are provided,' (2) 'over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services,' or (3) 'over the administration or operation of any such institution.' (42 U.S.C. § 1395.) Even if we assume that Part C's later-enacted express preemption clause did not supersede this reservation

clause . . . , the reservation clause does not purport to preserve common law actions dealing with the same subjects otherwise covered by Part C's standards—and hence does not override Part C's preemption clause." (*Roberts, supra*, 2 Cal.App.5th at p. 146.)

As to the second concern—"that the word 'regulation' 'might' be superfluous if the word 'law' were read broadly to reach *all* positive and common law enactments"—the court in *Roberts* concluded this was "too thin a reed upon which to leave all common law actions intact when doing so, as noted above, would disrupt the efficacy of the Center's preapproval of marketing materials and plan coverage." (*Roberts, supra*, 2 Cal.App.5th at p. 146.) We agree with *Roberts's* reasoning that the "canon of statutory construction that counsels against construing words as surplusage," albeit "a guide for ascertaining legislative intent," "is not a command," and "[w]here . . . that canon leads to a result at odds with the otherwise clearly expressed legislative intent, the canon necessarily yields to that intent." (*Roberts*, at p. 146; accord, *Uhm, supra*, 620 F.3d at p. 1154 ["[G]iven the tentative nature of *Sprietsma's* superfluity point—using the word 'might'—as well as the key differences we have identified between the [Federal Boat Safety Act] and the [2003 Medicare Modernization] Act, we hold that *Sprietsma* does not control here."].) Although we generally construe words in a statue to avoid surplusage, this canon of construction must yield to the plain language of the Medicare Part C preemption clause and its legislative history that clearly state Congress's intent that Medicare Part C's

standards preempt "any" state law or regulation (except for state licensing or plan-solvency laws) with respect to MA plans.[12]

DISPOSITION

The judgments are affirmed.

FEUER, J.

We concur:

PERLUSS, P. J.

SEGAL, J.

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[12] Because the Medicare Part C preemption clause preempts Quishenberry's state common law and statutory claims, the trial court did not err in sustaining the demurrers filed by the United HealthCare entities and Healthcare Partners without leave to amend. Further, we do no reach whether Quishenberry failed to exhaust his administrative remedies under the Medicare Act; whether Quishenberry's claims were barred under Health & Safety Code section 1371.25 of the Knox-Keene Act; and whether Quishenberry stated viable claims for elder abuse and wrongful death.