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Supreme Court of California
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No. S271501

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

LARRY QUISHENBERRY,

Plaintiff and Appellant,

v.

UNITED HEALTH CARE, INC., UNITED HEALTH GROUP, INC., UNITED HEALTH CARE - CALIFORNIA, UHC - CALIFORNIA, UNITED HEALTHCARE INSURANCE, INC., UNITED HEALTHCARE SERVICES, INC., HEALTHCARE PARTNERS AFFILIATES MEDICAL GROUP, AND HEALTHCARE PARTNERS MEDICAL GROUP,

Defendants and Respondents.

DEFENDANTS AND RESPONDENTS' CONSOLIDATED ANSWER TO AMICUS CURIAE BRIEFS

After a Decision by the Court of Appeal
Second Appellate District, Division Seven, Case No. B303451
Los Angeles County Superior Court Case No. BC631077
The Hon. Ralph Hofer, Judge Presiding

GIBSON, DUNN & CRUTCHER LLP
*KAHN A. SCOLNICK (228686), kscolnick@gibsondunn.com
HEATHER L. RICHARDSON (246517), hrichardson@gibsondunn.com
JENNAFER M. TRYCK (291088), jtryck@gibsondunn.com
PATRICK J. FUSTER (326789), pfuster@gibsondunn.com
333 South Grand Avenue
Los Angeles, CA 90071-3197
Telephone: 213.229.7000
Facsimile: 213.229.7520

(*Additional counsel listed on following page*)

Attorneys for Defendants and Respondents UnitedHealthcare, Inc. (incorrectly identified as United Health Care, Inc. and United Healthcare Insurance, Inc.), UnitedHealth Group, Inc., UnitedHealthcare Services, Inc., and UHC of California (incorrectly identified as United Health Care – California and UHC – California), Healthcare Partners Affiliates Medical Group, and Healthcare Partners Medical Group

WALRAVEN & WESTERFELD LLP
BRYAN S. WESTERFELD (218253)
bwesterfeld@walravenlaw.com
JESSICA B. HARDY (246377)
jbh@walravenlaw.com
20 Enterprise, Suite 310
Aliso Viejo, CA 92656-7107
Telephone: 949.215.1990
Facsimile: 949.215.1999

Attorneys for Defendants and Respondents UnitedHealthcare, Inc., United Health Group, Inc., UnitedHealthcare Services, Inc. and UHC of California

CARROLL, KELLY, TROTTER & FRANZEN
MICHAEL J. TROTTER (139034)
mjtrotter@cktflaw.com
BRENDA M. LIGORSKY (169707)
bligorsky@cktflaw.com
DAVID P. PRUETT (155849)
dpruett@cktfmlaw.com
111 W. Ocean Blvd., 14th Floor
P.O. Box 22636
Long Beach, CA 90801-5636
Telephone: 562.432.5855
Facsimile: 562.432.8785

Attorneys for Defendants and Respondents Health Care Partners Affiliates Medical Group and Healthcare Partners Medical Group

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INTRODUCTION

Respondents' interpretation of the Medicare Part C preemption statute, 42 U.S.C. § 1395w-26(b)(3), ensures the uniform administration of Medicare Advantage plans (MA plans) according to federal standards prescribed by Congress and the Centers for Medicare and Medicaid Services. All the amici have not only coalesced around Respondents' interpretation—they have *rejected* Plaintiff Larry Quishenberry's contrary interpretation.

Three of the amici—the Chamber of Commerce of the United States of America, the Civil Justice Association of California, and (speaking with one voice) the California Medical Association, California Dental Association, and California Hospital Association—argue in favor of express preemption. The Attorney General stops short of taking a position on the disposition of this case, but he agrees with Respondents that preemption turns on whether federal standards govern the area addressed by the state-law claims.

Quishenberry's claims are preempted under the test advocated by all amici. Together, Congress and CMS have spelled out detailed rules governing available benefits, benefit determination review, and provider oversight. These rules supersede the state-law duties alleged by Quishenberry, which seek to force Respondents to guarantee alleged benefits under his father's MA plans and to intervene in treatment decisions by healthcare providers.

Amici also line up in opposition to Quishenberry's four arguments why state law nonetheless can regulate core subjects of Medicare. They agree that no presumption against preemption applies to express provisions like section 1395w-26(b)(3). And they reject Quishenberry's three proposed carveouts for parallel state laws, generally applicable state laws, and common-law duties. If this Court likewise rejects these proposals, Quishenberry is left with no argument for why federal standards do not supersede his claims.

The Chamber of Commerce, the Civil Justice Association of California, and the California Medical Association et al. supply important context on the objectives of national uniformity that spurred Congress to expand the scope of Medicare Part C preemption in 2003. Having given a narrower preemption model a try, Congress intentionally shifted to a provision that sweeps broadly, subject only to enumerated exceptions for state licensing and solvency laws (which Quishenberry does not try to invoke here). That decision was consistent with other congressional efforts to eliminate patchwork state regulation of vital federal programs.

The Attorney General expresses concern that the Medicare Part C preemption provision could *theoretically* interfere with state priorities to protect MA plan enrollees. But the statute, properly interpreted, leaves a wide berth for state enforcement of health and safety regulations against healthcare providers. When it comes to the administration of MA plans, however, the federal interests in uniform application of Part C standards are

at their zenith. Congress reinforced the primacy of federal law on such subjects by first allowing and then foreclosing a model of duplicative state regulation. This policy choice should not worry the Attorney General, but if it does, it was still Congress's choice to make.

At any rate, this Court need not map out the frontiers of section 1395w-26(b)(3) in this case. Recall, again, why Quishenberry has called Respondents into court: to respond to allegations that they structured and administered an MA plan in a manner that created incentives for a treating physician to deny Medicare benefits to his father. Whatever cases might arise on the fringes, Quishenberry's claims inhabit the heartland of Medicare Part C preemption. They threaten crucial federal interests in the uniform administration of benefits, the capitation model adopted by Congress, and the exclusive review provisions of Medicare. That is why the claims would be impliedly preempted even without an express preemption provision. Amici's arguments confirm that all roads here lead to preemption.

ARGUMENT

I. All amici interpret the Medicare Part C preemption statute in a manner that preempts Quishenberry's claims.

This case concerns the proper interpretation of Medicare Part C's preemption 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." (42 U.S.C. § 1395w-26(b)(3).) Respondents have advanced an interpretation that honors the text and gives effect to Congress's decision to expand the statute in 2003. (See Ans. Br. at 30–33.) Small wonder, then, that all the amici agree with this interpretation in the main. (See Arg. Pt. I.A.)

This consensus includes the Attorney General, whose interpretation of section 1395-26(b)(3) largely tracks Respondents' Answer Brief. But the Attorney General declines to carry his arguments forward to their inevitable conclusion; he instead elects not to express a view on the proper disposition of this appeal. Still, the Attorney General identifies a few theoretical concerns about potential preemption in contexts as far flung as enrollment fraud and the Medi-Cal program. This case, however, lies at the core of Medicare preemption. An affirmance here portends none of the adverse consequences that trouble the Attorney General. And Respondents' interpretation in fact contains limiting principles that should ease his concerns.

A. Section 1395w-26(b)(3) preempts state laws that regulate the same subject matter as Medicare Part C standards.

The Medicare Part C preemption statute has four key textual components: "[1] The standards established under this part [2] shall supersede [3] any State law or regulation (other than State licensing laws or State laws relating to plan solvency) [4] with respect to MA plans which are offered by MA organizations under this part." (42 U.S.C. § 1395w-26(b)(3); see

Ans. Br. at 30–31.) Respondents have explained that these phrases operate in tandem to ensure that "Part C standards 'displace' state laws 'that regulate the same subject matter' as applied to MA plans." (Ans. Br. at 31–32, quoting *Pharm. Care Mgmt. Assn. v. Wehbi* (8th Cir. 2021) 18 F.4th 956, 971.)

Amici all advance materially identical interpretations of section 1395w-26(b)(3). (See AG Br. at 23–24; Chamber Br. at 14–15; CJAC Br. at 13; see also CMA Br. at 9 [agreeing with Respondents' interpretation and not further addressing issue].) If amici's view of the preemptive reach of Medicare Part C seems "very broad," it is because Congress meant it to be so. (*Morrison v. Health Plan of Nev., Inc.* (Nev. 2014) 328 P.3d 1165, 1168.) The conference report explained that "the MA program is a federal program operated under Federal rules," which means that "[s]tate laws, do not, and should not apply" except with respect to licensing and solvency. (H.R.Conf.Rep. No. 108-391, 1st Sess., p. 557 (2003).) The language Congress chose thus serves "to protect the purely federal nature of Medicare Advantage plans." (*First Medical Health Plan, Inc. v. Vega-Ramos* (1st Cir. 2007) 479 F.3d 46, 52.) Now, CMS has principal (and often exclusive) authority to administer this federal program. (See Ans. Br. at 19–20.)

Amici also underscore that Congress did not draft the Medicare Part C preemption provision "on a blank slate." (CJAC Br. at 16.) Instead, it borrowed "strikingly similar language" from the Employee Retirement Income Security Act. (*Ibid.*; see AG Br. at 30.) The latter "*supersede[s]* any and all State laws

insofar as they may now or hereafter *relate to* any employee benefit plan." (29 U.S.C. § 1144(a), italics added.) As the Civil Justice Association of California points out, the resemblance between this ERISA provision and section 1395w-26(b)(3) bolsters Respondents' interpretation. (See CJAC Br. at 17–18; see also Ans. Br. at 34–35, 40–41, 48, 50–51, 57.)

The interpretive principles advocated by amici make short work of this case. Quishenberry claims that Respondents violated state law in the way they allegedly structured and administered the MA plan in which his father, Eugene, enrolled. Specifically, he alleges that Respondents made capitated payments to healthcare providers that created an incentive to limit care and failed to intervene to stop his father's discharge from a skilled nursing facility despite an alleged Medicare entitlement to more days of care. (See Op. Br. at 9.) But Part C standards establish capitated payments and govern what benefits are covered by Respondents' MA plan, how and where coverage determinations (including skilled nursing facility discharges) are reviewed, and how Respondents engage in oversight of providers, as depicted in the chart below. (See also Ans. Br. at 36–44.)

The Attorney General avoids expressly taking sides on the proper disposition of the case. (AG Br. at 10.) But the conclusion that Medicare expressly preempts Quishenberry's claims is a fait accompli if the Court adopts the Attorney General's proffered test: Courts should "determine whether the state law duties to be enforced are already prescribed by specific federal standards" through a "careful comparison of the substance of state-law

claims and related allegations with CMS's detailed federal standards for private Medicare plans." (*Id.* at 25.) That is precisely how Respondents interpret the statute. (Ans. Br. at 29–32.) And this shared understanding makes this case an easy one:

Quishenberry's allegations	**Medicare Part C standards**
Respondents were obligated "to provide, at a minimum, those health care benefits and administrative protections to which Eugene was due *under Medicare*." (1AA28–29 [SAC ¶¶ 6, 9], italics added.)	MA plans must provide the benefits covered by Parts A and B of Medicare. (42 U.S.C. § 1395w-22(a)(1).) MA plans cannot cover *other* benefits unless approved by the Secretary of Health and Human Services. (§ 1395w-22(a)(3).)
"Those health care benefits . . . included custodial care within skilled nursing facilities such as GEM"—allegedly, "another period of 76 days" at this skilled nursing facility. (1AA28, 1AA33 [SAC ¶¶ 7, 26].)	Medicare covers skilled nursing care only under limited circumstances. (42 U.S.C. § 1395d(a)(2)(A); 42 C.F.R. §§ 409.30–409.36; see *Rapport v. Leavitt* (W.D.N.Y. 2008) 564 F.Supp.2d 186, 193–194.)

Quishenberry's allegations	**Medicare Part C standards**
On orders of the treating physician, Dr. Lee, "and pursuant to the business practice of [Respondents], GEM [a separate defendant] furnished Eugene with a false statement that he was no longer qualified *under Medicare* for further inpatient care at GEM." (1AA33 [SAC ¶ 26], italics added.)	An enrollee who disagrees with a discharge decision must "proceed through the MA organization's internal benefits determination process" and the Medicare review scheme. (*Aylward v. SelectHealth, Inc.* (9th Cir. 2022) 35 F.4th 673, 678, citing 42 U.S.C. § 1395w-22(g)(1); see 42 C.F.R. §§ 422.566, 422.626.) If the enrollee exhausts those administrative remedies, he can then obtain judicial review in federal court. (42 U.S.C. § 1395w-22(g)(5).)

Quishenberry's allegations	**Medicare Part C standards**
Respondents "were by contract *and by federal law* in a position to control the conduct of Lee and GEM in their provision of care to Eugene." (1AA35 [SAC ¶¶ 40], italics added.)	MA organizations must engage in oversight of provider networks (42 C.F.R. §§ 422.200–422.224), create an "ongoing quality improvement program" for monitoring provider performance (§ 422.152(a)), and establish "meaningful procedures for timely hearing and resolving grievances" (§ 422.564(a)).

Quishenberry's allegations	**Medicare Part C standards**
"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*," Respondents "failed to take any action, and allowed Lee and GEM's discharge [of] Eugene to home." (1AA35 [SAC ¶ 41], italics added.)	Having channeled disputes into these formalized processes, Medicare forbids administrators receiving capitated payments from interfering with a provider's advice about "medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice." (42 U.S.C. § 1395w-22(j)(3); see 42 C.F.R. § 422.206(a)(1)(i).)

Quishenberry's claims traverse ground covered many times over by Part C standards, as already outlined in Respondents' Answer Brief. (Ans. Br. at 36–44; see also Chamber Br. at 14–15; CJAC Br. at 13–15.) That being so, the Attorney General's suggestion that "the parties' briefing and decision below make broad, bright-line statements" (AG Br. at 11) rings hollow. The Attorney General himself observes that Part C standards govern "beneficiary protections such as minimum benefits," "grievance

and appeal procedures," and "many more" "comprehensive regulations detailing MA plans' federal obligations." (*Id.* at 24.) Indeed, many are listed in the chart above and discussed at length by the Court of Appeal. (Opn. at 12–17.)

The Attorney General doesn't suggest that the Court of Appeal's conclusions here would fail his test. He even quotes the holding below that 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.'" (AG Br. at 33, quoting Opn. at 6.) State regulation of this core Medicare issue should satisfy preemption under any possible reading of the statute. (See, e.g., CJAC Br. at 15–16.)

The decision under review aligns with precedent addressing the question too. As the Chamber points out, "[m]ultiple other federal and state courts have interpreted Part C's express preemption clause the same way as the Court of Appeal below." (Chamber Br. at 18 [collecting cases].) These decisions, each persuasive on their own, provide additional force in the aggregate. If one value animates federal preemption above all others, it's the importance of a "clear and uniform" nationwide rule. (*Id.* at 20.) This Court is thus in a position to mop up the *only* two outlier appellate decisions on express preemption that the parties and amici have been able to identify—both earlier opinions from the Court of Appeal. (See CJAC Br. at 23–26; see also *Cotton v. StarCare Medical Grp., Inc.* (2010) 183 Cal.App.4th 437; *Yarick v. PacifiCare of Cal.* (2009) 179 Cal.App.4th 1158.)

The Attorney General's other criticism is, respectfully, not in tune with the decision below. He contends the Court of Appeal "fail[ed] to differentiate in its preemption analysis" between the MA organization (UnitedHealthcare) and its delegated administrator (Healthcare Partners). (AG Br. at 26.) Quishenberry never makes this argument in this Court—and for good reason. The Court of Appeal addressed this very question, holding that the claims against all entities "would be derivative of the liability of the MA plan provider." (Opn. at 14, fn. 8, citing *Do Sung Uhm v. Humana, Inc.* (9th Cir. 2010) 620 F.3d 1134, 1157–1158.) This decision was correct because downstream entities "are largely subject to the same requirements" as MA organizations when they administer MA plans, which was the only hook for bringing any of the entities into this case. (*Escarcega v. Verdugo Vista Operating Co.* (C.D.Cal., Apr. 8, 2020) 2020 WL 1703181, at *12; see 42 C.F.R. §§ 422.2, 422.504(i); see also Ans. Br. at 41, fn. 1.) The Attorney General resists this statement but provides no reason to doubt that Quishenberry's claims target federal obligations possessed by all of Respondents here. (AG Br. at 26–27.) If the issue is as difficult as the Attorney General suggests, however, that is all the more reason not to resurrect an unbriefed (and therefore waived) issue.

B. Amici unite in rejecting Quishenberry's carveouts from the scope of section 1395w-26(b)(3).

While amici embrace Respondents' interpretation—albeit with varying levels of enthusiasm—none agrees with Quishenberry's four counterarguments for a narrower reading of section 1395w-26(b)(3).

1. No presumption against preemption applies to section 1395w-26(b)(3).

Quishenberry's interpretation of section 1395w-26(b)(3) ends up worlds away from everyone else's because he starts from a presumption against preemption. (Op. Br. at 6; Reply Br. at 7.) But the U.S. Supreme Court already settled this question against Quishenberry. (See Ans. Br. at 33–36.) When, as here, "the statute contains an express pre-emption clause," courts "do not invoke any presumption against pre-emption but instead focus on the plain wording of the clause." (*Puerto Rico v. Franklin Cal. Tax-Free Tr.* (2016) 579 U.S. 115, 125.)

Amici recognize that the presumption of preemption no longer can apply to an express provision. (See, e.g., CJAC Br. at 20–23.) For example, the Chamber explains that, "when Congress *deliberately* intended to preempt state law," "an analysis of whether that clause preempts state law begins and ends with the statutory text." (Chamber Br. at 13, original italics.) The Attorney General too acknowledges that no presumption against preemption cabins the scope of section 1395w-26(b)(3) and advocates only that the presumption apply to implied preemption. (See AG Br. at 35.)

2. Section 1395w-26(b)(3) preempts state law that parallels federal standards.

Quishenberry also contends that section 1395w-26(b)(3) preserves claims that "parallel federal requirements." (Op. Br. at 10.) This contention cannot be reconciled with the statutory text (which preempts "*any* State law or regulation") or statutory history. (Ans. Br. at 45–48.) The Ninth Circuit recently put it well: "There is no basis for concluding that a state law duty that parallels, enforces, or supplements an express federal MA standard on the subject is *not* one 'with respect to MA plans.'" (*Aylward*, 35 F.4th at 681, original italics, analogizing to ERISA with citation to *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 47–48.)

On this point, all amici agree. (See, e.g., Chamber Br. at 15, fn. 1.) For example, the Attorney General notes that the 2003 amendments "broadened the scope of MA preemption to supersede even state laws or regulations not in direct conflict with federal law." (AG Br. at 23.) The statute now, he continues, makes "duplicative state claims preempted." (*Id.* at 37.) The result, as the Civil Justice Association of California explains, is an even "'*stronger* preemption provision.'" (CJAC Br. at 12, original italics.)

3. Section 1395w-26(b)(3) preempts generally applicable state law.

Quishenberry next argues that generally applicable state laws cannot be "with respect to MA plans" because they do not specifically "refer" to MA plans. (See Op. Br. at 7, 9; Reply Br. at

7–8.) This argument misunderstands the function of "with respect to," contradicts *Riegel v. Medtronic, Inc.* (2008) 552 U.S. 312, and effectively negates the preemption provision (because Quishenberry identifies no state laws that apply only to MA plans). (See Ans. Br. at 48–53.)

All amici disagree with Quishenberry on this issue as well. The Chamber correctly identifies *Riegel* as the controlling precedent here. (See Chamber Br. at 16–17.) And the Attorney General collects examples of generally applicable laws that were properly superseded by Part C standards. (See AG Br. at 25–26.)

For the first time in his Reply Brief, Quishenberry concocted the notion that the last antecedent canon limits Medicare Part C preemption to state laws that "refer to MA plans," as opposed to preempting state law only as applied to MA plans. (Reply Br. at 8.) The Chamber exposes the many flaws in this argument.

To start, the last antecedent canon applies only to "'statutes that include a *list* of terms or phrases followed by a limiting clause.'" (Chamber Br. at 17, original italics, quoting *Lockhart v. United States* (2016) 577 U.S. 347, 351.) But the statute here contains only a single phrase followed by a modifier. A (partially paraphrased) refresher: Part C standards "supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans." (42 U.S.C. § 1395w-26(b)(3).) So "with respect to" naturally qualifies the unified phrase "supersedes any state law or regulation." The adverbial phrase "with respect to MA plans"

tells the reader the extent to which the subject (Part C standards) supersedes the object (any state law or regulation), namely, as to MA plans offered under Part C, but no further. (See Ans. Br. at 48–49.)

Moreover, Quishenberry has "misapplied" the last antecedent canon "by attaching the modifier to something *more* than the last thing before it." (*Cyan, Inc. v. Beaver County Employees Retirement Fund* (2018) 138 S.Ct. 1061, 1077, original italics.) The last antecedent in the supposed list is "regulation"—or perhaps the parenthetical phrase "(other than State licensing laws or State laws relating to plan solvency)"—not "state law or regulation." (See Chamber Br. at 17, fn. 3; contra Reply Br. at 8.) So the consequence of applying the canon would be that section 1395w-26(b)(3) generally preempts *all state laws*, period—but for *state regulations*, they would be preempted only when they are "with respect" to MA plans. (See *Facebook, Inc. v. Duguid* (2021) 141 S.Ct. 1163, 1176.) That reading is nonsensical because the modifier follows a "single, integrated" phrase. (*Jama v. ICE* (2005) 543 U.S. 335, 344, fn. 4.)

In the end, the last antecedent canon does not move the ball forward for Quishenberry in any respect. It makes no difference whether "with respect to" modifies the entire phrase "supersede any state law or regulation," or only the phrase "any state law or regulation." When a plaintiff seeks to enforce generally applicable state law against the administration of an MA plan, that state-law duty is "with respect" to the MA plan. (See Chamber Br. at 18, citing *Uhm*, 620 F.3d at 1150, fn. 25.)

That again is the holding of *Riegel*. (552 U.S. at 328; see Ans. Br. at 49–50.)

The Attorney General emphasizes a different interpretive tool—subsequent agency interpretations. (AG Br. at 29.) In one, CMS stated that "State health and safety standards, or generally applicable standards, that do not involve regulation of an MA plan are not preempted." (Establishment of Medicare Advantage Program, 70 Fed.Reg. 4665 (Jan. 28, 2005).) In another, CMS interpreted the Part D preemption provision—which incorporates the Part C provision (42 U.S.C. § 1395w-112(g))—to "operate[] only when CMS actually creates standards in the area regulated. To the extent [CMS] do[es] not create *any standards whatsoever in a particular area*, [CMS] do[es] not believe preemption would be warranted." (Medicare Prescription Drug Benefit, 70 Fed.Reg. 4319–4320 (Jan. 28, 2005), italics added.)

This is another example of Respondents and the Attorney General singing from the same hymnal, just in different keys. The reason why many "'State health and safety standards'" avoid preemption (AG Br. at 29) is that Medicare, by and large, does not regulate the practice of medicine or provision of medical services (see 42 U.S.C. § 1395; Ans. Br. at 41). As always, the question is whether Part C standards address the area purportedly regulated by state law—not whether state law specifically refers to MA plans. (Ans. Br. at 48–53.) And here, only an outright preemption exception for generally applicable laws could save Quishenberry's claims, because he never denies

that Medicare Part C standards address the state-law duties he seeks to impose on Respondents. (See, e.g., Op. Br. at 10.)

4. Section 1395w-26(b)(3) does not exempt common-law duties from preemption.

Quishenberry finally argues that section 1395w-26(b)(3) preempts only positive enactments (such as statutes and regulations), but not common-law duties. (See Op. Br. at 7.) This exclusion rests on a misreading of *Sprietsma v. Mercury Marine* (2002) 537 U.S. 51 (which turned on a saving provision for common-law actions), upends the structure of Medicare Part C, and disregards CMS guidance. (See Ans. Br. at 53–61.)

Tellingly, none of the amici argues that Congress drew a bright-line distinction between positive enactments and common-law duties. The statute makes clear that "'that common law claims can fall within the ambit of Part C's preemption provision.'" (Chamber Br. at 16; see *Aylward*, 35 F.4th at 681.) In fact, "case-by-case jury determinations of 'negligence'" are likely to be "even more disruptive" than the enforcement of state statutes and regulations. (CJAC Br. at 19; see *Riegel*, 552 U.S. at 324; see also Ans. Br. at 59.)

Put in the Attorney General's terms, positive-enactments-versus-common-law simply is not "the central question." (AG Br. at 34.) His only caveat is "the fact that specific state common law claims *may* be preempted does not mean that Congress intended to displace *all* state law claims as applied to MA plans." (*Ibid.*, original italics.) True enough, preemption depends on the existence of Part C standards that address the conduct at issue in

the case. (See, e.g., *New York City Health & Hospitals Corp. v. WellCare of New York, Inc.* (S.D.N.Y. 2011) 801 F.Supp.2d 126, 140–141 [prospective establishment of Part C standards for payments to non-contracted providers does not expressly preempt "claims predating the recent CMS pronouncements"].) In this case, though, the common-law claims cut deep into areas regulated by such standards. (See ante, at 14–17.)

C. The Attorney General's concerns about the scope of express preemption are misplaced.

While Respondents and the Attorney General agree on much about the law, the Attorney General also weighs in on the effect of federal preemption on his enforcement priorities. This case implicates no such priority. But the theoretical potential for conflict down the line in other cases leads him to urge against a broad interpretation of section 1395w-26(b)(3). This objection is not only premature, but also unwarranted. Even when granted the appropriate breadth to account for its text, history, and purpose, section 1395w-26(b)(3) appears unlikely to preempt the state priorities identified in the Attorney General's brief.

The Attorney General raises several concerns about state-law protections enjoyed by patients in healthcare facilities. (AG Br. at 16–17.) He worries about the preemption of state antidiscrimination rules for "the provision of medical services." (*Id.* at 16.) He suggests that Medicare might preempt consumer protection and false advertising laws governing skilled nursing facilities. (*Id.* at 17.) And he raises alarms about prosecutions

against nursing home providers for patient abuse or neglect. (*Id.* at 19.)

The Attorney General has nothing to fear. Medicare Part C does not displace the California Department of Public Health's role as "'the primary enforcer of standards of care in the long-term health care facilities of this state,'" for CMS does not directly regulate the operation of such facilities. (AG Br. at 18, quoting *California Assn. of Health Facilities v. Dept. of Health Servs.* (1997) 16 Cal.4th 284, 305, fn. 7.)

Nor does section 1395w-26(b)(3) cast any doubt on the ability of the Attorney General to "bring[] both administrative and trial proceedings against state-licensed physicians and other health-related licensees." (AG Br. at 18.) While Medicare governs the administration of MA plans, it does not regulate the standards by which healthcare professionals engage in the practice of medicine for MA enrollees. (42 U.S.C. § 1395; see Ans. Br. at 41.) To be sure, such claims against healthcare providers might "cause[] some disuniformity in plan administration." (*Rutledge v. Pharm. Care Mgmt. Assn.*, 141 S.Ct. 474, 480.) All healthcare regulation does to some degree. (See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (1995) 514 U.S. 645, 660–661.) But as the Attorney General notes by analogy to ERISA, the preemption provision typically does not spring into effect based on mere "fiscal impact" on MA plan. (AG Br. at 31.)

This appeal, of course, does not present claims against the treating physician or skilled nursing facility for how they

provided care to Eugene. (See also Ans. Br. at 35.) Quishenberry did bring claims against the skilled nursing facility and treating physician. Maybe, as the California Medical Association et al. explains, he brought the *wrong* claims against the doctor by eschewing professional negligence. (CMA Br. at 29–31.) But putting that aside, Quishenberry also reached well beyond the doctor and nursing facility to plan administrators—Respondents here—thereby transforming this case into a vehicle to impose duplicative and even inconsistent *legal* obligations on MA plans. (See *id.* at 11–12.) The ERISA model advocated by the Attorney General establishes preemption when, as here, a plaintiff brings claims against administrators of MA plans for denying Medicare benefits and failing to intervene outside the prescribed Medicare procedures for oversight and review of provider decisions. (See *Aetna Health Inc. v. Davila* (2004) 542 U.S. 200, 213–215.)

The Attorney General also describes investigations under the Elder Abuse Act into insurance brokers who fraudulently enrolled individuals into MA plans. (AG Br. at 15.) While Part C standards do touch on brokers selling MA plans, they appear to require only that brokers procure state licenses and undergo training by MA organizations. (See 42 C.F.R. § 422.2274(b).) The Attorney General goes on to speculate that an MA organization that assisted a broker in fraudulent conduct could be held liable under state law as well. (AG Br. at 15.) That poses a more difficult question because CMS has promulgated rules for MA organizations to engage in oversight of brokers. (See 42 C.F.R. § 422.2274(c); see also *Becerra v. Empire Health Foundation, for*

Valley Hospital Medical Ctr. (2022) 142 S.Ct. 2354, 2364 [MA organization "may not distribute advertising materials to eligible beneficiaries unless materials are first cleared by HHS"].) Should such a case arise, the preemption analysis would require an examination whether these (and other) provisions govern the same subject as the state-law claims—the sort of examination undertaken above and in the Answer Brief with respect to the claims *in this case*. (See ante, at 14–17; Ans. Br. at 36–44.)

Two of the Attorney General's examples actually involve the application of state law to MA organizations. But far from suggesting that a cautionary impulse should indiscriminately restrain preemption, both reinforce the importance of devoting careful attention to the statutory text and the specific regulatory scheme.

First, the Department of Managed Health Care licenses MA plans and assesses their finances. (See AG Br. at 18.) As well it should, for such activities have a clear mandate under Medicare Part C. Section 1395w-26(b)(3) carves out two exceptions from its preemptive sweep: "State licensing laws or State laws relating to plan solvency." On licensing and solvency, Congress expected States to work hand in hand with the federal government. (See Ans. Br. at 44–45.)

Second, the Department of Health Care Services negotiates with MA organizations to offer MA plans to people eligible for both Medicare and Medicaid benefits (so-called dual eligibles). (See AG Br. at 19.) These MA plans, however, likely are not "offered by MA organizations *under this part*" (that is, Part C) for

purposes of preemption. (42 U.S.C. § 1395w-26(b)(3), italics added.) The First Circuit has addressed this very situation, ruling that the statute does not preempt state-law requirements imposed on MA organizations who wish to offer MA plans to dual eligibles through the Medicaid program operated by the State (or, as there, Puerto Rico) rather than through Medicare Part C. (*First Medical Health Plan*, 479 F.3d at 51–52; see Ans. Br. at 53.) In fact, the example given by the current Attorney General—an article reporting on former Attorney General Harris's announcement of a *Medi-Cal* settlement against an MA plan—underscores this critical distinction between the federal Medicare Part C program and state Medicaid programs. (AG Br. at 20, fn. 4; cf. *id.* at 30, fn. 4 [expressing uncertainty about this distinction].)

The State appears to be following the law—a welcome sign that the textual limits on preemption identified by Respondents have been administrable in practice for government officials. Still, if any federal standards *do* displace authority sought by the Attorney General to regulate parties involved in the Medicare Part C program, that is an expected and appropriate consequence of preemption. The Supremacy Clause makes federal law "the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." (U.S. CONST., art. VI, cl. 2.) The Constitution thus leaves "no doubt that Congress may withdraw specified powers from the States by enacting a statute

containing an express preemption provision." (*Arizona v. United States* (2012) 567 U.S. 387, 399.)

Preemption entails a "congressionally designed interplay between state and federal regulation." (*Northwest Central Pipeline Corp. v. State Corp. Com. of Kan.* (1989) 489 U.S. 493, 518; see, e.g., *Gobeille v. Liberty Mut. Ins. Co.* (2016) 577 U.S. 312, 325.) Attuned to state interests, Congress first experimented with a narrow approach of preempting only inconsistent laws and laws that invaded four specified categories of Part C regulations. (See Balanced Budget Act of 1997, Pub.L. No. 105-33, § 4001 (Aug. 5, 1997), 111 Stat. 251, 319.) But unsatisfactory results under the 1997 law soon brought Congress to the view that that "[s]tate laws, do not, and should not apply"—excepting only licensing and solvency laws—because "the MA program is a federal program operated under Federal rules." (H.R.Conf.Rep. No. 108-391, at 557; see Ans. Br. at 51–52.) Now, just as Congress intended, CMS occupies pole position, using its "agency expertise" to outline and enforce the obligations of MA plans and their administrators. (CJAC Br. at 10; see, e.g., 42 C.F.R. §§ 422.504(i), 422.510, 422.752(a).)

Congress had good reason to opt for this broader preemption regime. Available benefits, benefit determination review, and provider oversight are all core territory regulated by Part C standards. (See Ans. Br. at 19–20, 36–44.) Section 1395w-26(b)(3) guarantees up front that participating administrators will not face "duplicative compliance costs"—potentially "multiplied fifty-fold by distinct state requirements"—

that could “stifle innovation, drive up prices for consumers, and constrain the job-creating powers of American businesses.” (Chamber Br. at 19; see CJAC Br. at 10–11.) Like other federal preemption provisions, the statute eliminates the risk that MA plans will fall prey to a “‘patchwork scheme of regulation.’” (Chamber Br. at 19, quoting *Fort Halifax Packing Co. v. Coyne* (1987) 482 U.S. 1, 11 [ERISA].) No longer can duplicative state regulation—whether parallel, inconsistent, or supplemental—fracture national uniformity in the administration of MA plans. (See *Aylward*, 35 F.4th at 681.)

That congressional decision may—or perhaps may not—frustrate some of the Attorney General’s objectives. Happily, this case presents none of the difficulties that trouble the Attorney General. In truth, his only wish appears to be that this Court “refrain from an overbroad ruling” in Respondents’ favor. (AG Br. at 34; see *id.* at 10.) However broad the reasoning, the disposition should be an affirmance on express preemption.

II. Even if the claims are not expressly preempted, they are impliedly preempted as an obstacle to the purposes and objectives of the Medicare Act.

If section 1395w-26(b)(3) does not expressly preempt the claims in this case, Medicare Part C impliedly preempts them. Respondents have identified three federal interests obstructed by Quishenberry’s claims.

First, they threaten the uniform administration of Medicare benefits. (Ans. Br. at 63–65.) Quishenberry seeks a determination of the skilled nursing benefit allowable under

Eugene's MA plan—a decision that can be made only through federal channels. At times, he also appears to assert a right to "custodial care." (1AA28–29, 1AA34 [SAC ¶¶ 7, 35].) But Medicare does not cover custodial care. (42 U.S.C. § 1395y(a)(9); see also CMA Br. at 26–28 [plan administrators do not provide custodial care in state-law sense either].) Either way, his claims pose an obstacle to the uniform administration of MA plans. (See *Egelhoff v. Egelhoff* (2001) 532 U.S. 141, 148.)

Second, the claims are "a thinly-veiled attack" on the capitation model embodied in Medicare Part C. (CMA Br. at 21; see Ans. Br. at 65–68.) MA organizations receive "a fixed per enrollee per month amount" in exchange for stepping into the shoes of the federal government to cover the benefits in Parts A and B of Medicare. (42 C.F.R. § 422.350(b); see 42 U.S.C. § 1395w-23.) Participating providers also receive a capitated rate for providing healthcare services to enrollees. (§ 1395w-25(b)(4).) As the Supreme Court has observed, "[t]he flat-rate payment system thus gives hospitals an incentive to provide efficient levels of medical service." (*Empire Health Foundation*, 142 S.Ct. at 2359.)

Quishenberry, however, alleges that capitated payment encourage healthcare providers "to identify and exploit opportunities to reduce the cost of care to enrollee." (1AA31 [SAC ¶ 16]; see, e.g., 1AA36 [SAC ¶ 43].) This frontal assault on the capitation model is misguided and ultimately irrelevant because *Congress* chose this manner of structuring Part C. (Chamber Br. at 21; see Ans. Br. at 65–66.) In doing so, Congress also forbade

capitated entities from interfering with healthcare decisions—something Quishenberry argues state law *required* Respondents to do. (*Id.* at 66–67.)

The Attorney General may misapprehend Respondents' argument about the prohibition on capitated entities interfering with healthcare decisions. He contends that the "fact that federal Medicare rules cannot mandate particular medical practice standards is entirely consistent with state oversight agencies' responsibilities to establish such standards." (AG Br. at 37.) This language seems to refer to 42 U.S.C. § 1395, which makes clear that the CMS does not "exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." (See also Ans. Br. at 35.) To clarify, if section 1395 is what the Attorney General labels "Medicare's federal non-interference law," he is talking about a different provision than Respondents. (See *id.* at 66–67.) Quishenberry's state-law claim is that Respondents should have intervened in the treating decision, which conflicts with the rule that entities receiving capitated payments under Part C cannot interfere in medical decisions of healthcare providers. (42 U.S.C. § 1395w-22(j)(3); 42 C.F.R. §§ 422.206, 422.208(c)(1), 422.504(a)(6); see *Yarick*, 179 Cal.App.4th at 1164.)

Third, the claims undermine Medicare's exclusive-review provisions. (See Ans. Br. at 68–71.) Eugene could have sought review of his discharge through Medicare procedures up to federal court. (See *id.* at 38–41; see also 42 C.F.R. § 422.626.) And the organization determination that he was not entitled to

additional benefits under Medicare is "binding on all parties unless" that determination is "reconsidered" or "reopened and revised." (§ 422.576; see *Global Rescue Jets, LLC v. Kaiser Foundation Health Plan, Inc.* (9th Cir. 2022) 30 F.4th 905, 919.) In light of this review scheme, Quishenberry "cannot, consistent with federal law, forgo this review procedure and substitute a state court's or jury's judgments for those of the federal decisionmakers that Congress selected to review Part C coverage determinations." (Chamber Br. at 21.)

The Attorney General pushes back on implied preemption across the board—but his rationale for doing so is telling. Although he scrupulously refuses to take a position on the proper application of section 1395w-26(b)(3), he also argues that this Court need not worry about "state juries revisiting Medicare coverage determination; a state court undoing MA capitated payment models; or beneficiaries deliberately waiting until federal administrative remedies were unavailable in order to seek damages in state court," because "these scenarios may be governed by express federal laws and regulations (making duplicative state claims preempted)." (AG Br. at 37.) The Attorney General thus appears to argue against implied preemption by suggesting (but not coming right out and saying) that the claims here are expressly preempted. At the end of the day, Respondents could not agree more that "[c]ourts need not resort to an implied preemption doctrine in order to avoid adjudicating" expressly preempted state-law claims. (*Ibid.*; see also Chamber Br. at 21.)

The Attorney General also suggests that another limitation on state-law claims—administrative exhaustion of claims "arising under" the Medicare Act—leaves less work for preemption to do. (AG Br. at 21–22, 37.) That is true in some sense because unexhausted claims must be dismissed without regard to preemption. But the overall thrust of the argument is ahistorical. Congress broadened preemption to clear up "some confusion in recent court cases" giving unduly narrow effect to administrative exhaustion and the earlier version of the preemption statute. (H.R.Conf.Rep. No. 108-391, at 557; see Ans. Br. at 51–52; see also, e.g., *McCall v. PacifiCare of Cal., Inc.* (2001) 25 Cal.4th 412.) As the law now stands, express and implied preemption are vital backstops for state-law claims that address or obstruct conduct governed Part C standards, whether or not such claims technically "arise under" Medicare. (See, e.g., *Aylward*, 35 F.4th at 679–682.)

CONCLUSION

The Court should affirm the judgment of the Court of Appeal. If this Court is inclined to reverse on preemption grounds, it should remand for the Court of Appeal to consider Respondents' alternative grounds for affirmance. (Opn. at 24, fn. 12; see, e.g., *Yamaha Corp. of Am. v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 15.)

DATED: July 15, 2022

Respectfully submitted,

GIBSON, DUNN & CRUTCHER LLP

By:
Kahn A. Scolnick

Attorneys for Defendants and Respondents
United Health Care, Inc., United Health Group, Inc., United Health Care - California, UHC - California, United Healthcare Insurance, Inc., United Healthcare Services, Inc., Healthcare Partners Affiliates Medical Group, and Healthcare Partners Medical Group

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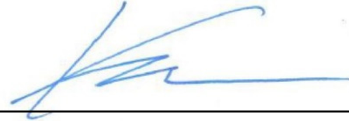

Kahn A. Scolnick

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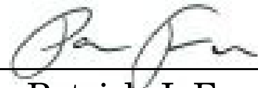

Patrick J. Fuster

Appellant's Counsel	**Method of Service**
Russell S. Balisok (65116) BALISOK & ASSOCIATES, INC. 330 N. Brand Blvd., Ste. 702 Glendale, CA 91203 Telephone: 818.550.7890	Electronic service
Amici Curiae's Counsel	
Anna Rich (230195) Deputy Attorney General 1515 Clay St., 20th Floor P.O. Box 70550 Oakland, CA 94612-0550 Telephone: 510.879.0296	Electronic service
Cassidy C. Davenport (259340) COLE PEDROZA LLP 2295 Huntington Dr. San Marino, CA 91108 Telephone: 626.431.2787	Electronic service
Fred J. Hiestand (44241) General Counsel—Civil Justice Assoc. of California 3418 Third Ave., Ste. 1 Sacramento, CA 95817 Telephone: 916.448.5100	Electronic service
Ethan P. Davis (294683) KING & SPALDING LLP 50 California St., Ste. 94111 San Francisco, CA 94111 Telephone: 415.318.1200	Electronic service

Court of Appeal

Second Appellate District Division Seven Ronald Reagan State Building 300 S. Spring St. 2nd Floor, North Tower Los Angeles, CA 90013 Telephone: 213.830.7000	Electronic Service

Trial Court

Hon. Ralph Hofer Judge Presiding Los Angeles County Superior Court 600 East Broadway Glendale, CA 91206 Telephone: 818.265.6400	Mail service

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Bryan Westerfeld Walraven & Westerfeld LLP 218253	bwesterfeld@walravenlaw.com	e-Serve	7/15/2022 4:44:05 PM
Dorothy Droke Balisok & Associates, Inc.	rebecca@stopelderabuse.org	e-Serve	7/15/2022 4:44:05 PM
Jessica Ridley Walraven & Westerfeld LLP	jmr@walravenlaw.com	e-Serve	7/15/2022 4:44:05 PM
Ethan Davis KING & SPALDING LLP 294683	edavis@kslaw.com	e-Serve	7/15/2022 4:44:05 PM
Sarah Walraven Walraven & Westerfeld LLP	skw@walravenlaw.com	e-Serve	7/15/2022 4:44:05 PM
Curtis Cole Cole Pedroza LLP 52288	curtiscole@colepedroza.com	e-Serve	7/15/2022 4:44:05 PM
Cassidy Davenport Cole Pedroza LLP 259340	cassidydavenport@colepedroza.com	e-Serve	7/15/2022 4:44:05 PM
Jennafer Tryck Gibson Dunn & Crutcher, LLP	jtryck@gibsondunn.com	e-Serve	7/15/2022 4:44:05 PM

Lorraine Orduno Carroll, Kelly, Trotter & Franzen	alorduno@cktfmlaw.com	e-Serve	7/15/2022 4:44:05 PM
David Pruett Carroll, Kelly, Trotter, Franzen, McKenna & Peabody 155849	dpruett@cktfmlaw.com	e-Serve	7/15/2022 4:44:05 PM
Heather Richardson Gibson Dunn & Crutcher LLP 246517	hrichardson@gibsondunn.com	e-Serve	7/15/2022 4:44:05 PM
Russell Balisok Balisok & Associates, Inc. 65116	balisok@stopelderabuse.org	e-Serve	7/15/2022 4:44:05 PM
Brenda Ligorsky Carroll, Kelly, Trotter, Franzen & McKenna	bligorsky@cktfmlaw.com	e-Serve	7/15/2022 4:44:05 PM
Freddi Lindsey Cole Pedroza LLP	flindsey@colepedroza.com	e-Serve	7/15/2022 4:44:05 PM
Fred Hiestand Attorney at Law 44241	fred@fjh-law.com	e-Serve	7/15/2022 4:44:05 PM

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Fuster, Patrick (326789)

Last Name, First Name (PNum)

Gibson, Dunn & Crutcher LLP

Law Firm