S271501
Case No. B303451
Los Angeles Superior Court Case No. BC631077

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

LARRY QUISHENBERRY
Plaintiff and Appellant
vs.
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.

From the Court of Appeal of the State of California
Second Appellate District, Division 7, Case No. B303451

From the Superior Court for Los Angeles County, Case No. BC631077
Honorable Ralph Hofer, Judge
Department D
Phone: (818) 265-6413

RESPONDENT'S ANSWER TO PETITION FOR REVIEW

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS
(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).

WALRAVEN & WESTERFELD LLP

Dated: November 15, 2021

BY: _____
BRYAN S. WESTERFELD

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases

State Cases

Federal Statutes

State Statutes

State Rules

Federal Regulations

INTRODUCTION

Defendants and Respondents UnitedHealthcare, Inc. (incorrectly identified in the SAC as both "United Health Care, Inc." and "United Healthcare Insurance, Inc."), UnitedHealth Group Incorporated, UnitedHealthcare Services, Inc., and UHC of California (incorrectly identified in the SAC as "United Healthcare – California, Inc.," and "UHC-California, Inc.") (collectively "United" or "Respondents") hereby submit this brief in response to Plaintiff and Appellant Larry Quishenberry's ("Appellant") Petition for Review. Because Appellant has not shown that this matter necessitates Supreme Court review under Rule 8.500(b), United respectfully requests that this Court deny the Petition.

This matter involves Appellant's repeated, unsuccessful attempts to bring state-law causes of action for negligence and vicarious liability against a Medicare HMO, despite those causes of action being expressly and impliedly preempted by the federal Medicare Act as well as prohibited by California state law. Both the trial court and the Court of Appeal correctly held that all of Appellant's causes of action against United were preempted by the federal Medicare Act, 42 U.S.C. § 1395w-26(b)(3), and should be dismissed with prejudice. Under governing case law in the Second District, where this matter was commenced, common-law claims such as those Appellant has brought here, which would impose liability on Medicare Advantage organizations for failure to follow common-law standards of care, are both expressly and impliedly preempted by the Medicare Act. *See Roberts v. United Healthcare Services, Inc.*, 2 Cal. App. 5th 132, 148 (2d Dist. 2016). Because the Court of Appeal's opinion is consistent with established law and does not raise any novel issues

necessitating resolution by the Supreme Court, Respondents respectfully request that this Court deny the Petition for Review.

BACKGROUND

Appellant filed the original Complaint in this matter on August 19, 2016, as successor-in-interest to his father, Eugene Quishenberry. (Court of Appeal Opinion ("Opn.") at 3.) The gravamen of Appellant's complaint was that Defendants GEM Healthcare, LLC and Dr. Jae H. Lee failed to adequately treat Eugene and prematurely discharged him from a skilled nursing facility whereafter his health deteriorated and he later died. (*Id.*) Appellant sued GEM, Dr. Lee, Defendant Healthcare Partners ("HCP"), which provided physician services to Eugene, and United, which administered a Medicare Advantage ("MA") Health Maintenance Organization ("HMO") plan of which Eugene was a member. (*Id.* at 2.) After the trial court sustained United's and HCP's demurrers to the First Amended Complaint ("FAC") on the grounds that all of Appellant's causes of action were barred by the Knox-Keene Act, Cal. Health & Safety Code § 1371.25, and preempted by the Medicare Act, Appellant filed the Second Amended Complaint ("SAC"). (*Id.* at 3.) He alleged causes of action for negligence, elder abuse, bad faith, and wrongful death. (*Id.*) As to United, Appellant alleged that United delegated to HCP its responsibility to provide health care benefits and administrative protections owed to MA enrollees by contracting with HCP to provide physician services to the plan's enrollees. (*Id.* at 3-4.) United allegedly delegated to GEM, the operator of a skilled nursing facility where Eugene was housed, its responsibility to provide custodial care and administrative protections to plan enrollees. (*Id.* at 4.)

The SAC did not allege that any of the United Defendants actually provided medical care to Eugene. (*See id.* at 5-6.) Instead, it alleged that the United Defendants "ultimately delegated certain of their responsibilities to provide administrative protections and also health care benefits including custodial care, to their co-defendants, and to GEM." (*See id.* at 3-4.) In sum, the gravamen of Appellant's claims against the United Defendants has consistently remained that, as administrators of Eugene's Medicare Advantage ("MA") health plan, they had the duty to monitor and ensure the quality of care Eugene received from contracted providers such as GEM; in allegedly failing to monitor the quality of Eugene's care, the United Defendants are vicariously liable for harm caused by GEM's and Dr. Lee's allegedly substandard care. (*See id.* at 4-6.)

On October 25, 2019, after hearing oral arguments from all parties, the Superior Court sustained United's demurrer to the SAC, as well as a concurrently filed demurrer by Healthcare Partners, and dismissed all claims in the SAC as to United and Healthcare Partners without leave to amend. (*Id.* at 8.) Relying on *Roberts v. United Healthcare Services, Inc.* 2 Cal. App. 5th 132 (2016), the trial court found Appellant'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." (*Id.* at 8.) 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." (*Id.*) The trial court entered judgment in favor of HCP on December 3, 2019, and a judgment in favor of the United Defendants on December 6, 2019. (*Id.*) Appellant appealed.

THE COURT OF APPEAL'S RULING

On September 21, 2021, after considering briefing and oral argument from all parties, the Court of Appeal, Second Appellate District, Division Seven, issued an unpublished decision affirming the trial court's dismissal of the SAC with prejudice on the grounds that all of Appellant's claims were preempted by the Medicare Act. *(*Opn. at 12.) Specifically, the Court of Appeal held that Appellant's claims were both expressly and impliedly preempted, consistent with the holdings of *Roberts v. United Healthcare Services, Inc.*, 2 Cal. App. 5th 132, 148 (2d Dist. 2016) and *Yarick v. PacifiCare of California*, 179 Cal. App. 4th 1158 (2009). (*Id.*) It therefore affirmed the trial court's dismissal of the SAC with prejudice on the grounds of Medicare preemption. (*Id.* at 24.)

In analyzing the preemption issue, the Court of Appeal first examined the text of the Medicare Act's preemption provision as it was amended in 2003, which reads: "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." 2021 WL 4272048, at *5 (citing (Pub. L. No. 108-173, § 232 (Dec. 8, 2003) 117 Stat. 2066; 42 U.S.C. § 1395w-26(b)(3).) The Court noted that the 2003 amendment significantly expanded the breadth of the preemption language, which "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." *Id.* at *7 (quoting *Roberts*, 2 Cal. App. 5th at 143 (emphasis in original)).

Having noted the breadth of the preemption language, the Court of Appeal then examined the wide range of Medicare regulations that were

implicated by Appellant's state law claims. *Id.* at *5-6. Those 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,'" *id.* (quoting 42 C.F.R. § 422.4(a)(1)(i)); "standards governing provider 'selection and credentialing' for MA plans," *id.* (quoting 42 C.F.R. § 422.204); "requirements relating to 'an ongoing quality improvement program' for each MA plan," *id.* (quoting 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,'" *id.* (quoting 42 C.F.R. § 422.152(f)(3) (alteration in original)). The Court further noted that "[i]n 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.'" *Id.* (quoting 42 C.F.R. § 422.202(b)(3) (alterations in original)). Finally, the Court noted that Medicare regulations also govern a MA organization's provision of covered services and coverage determinations. *Id.*

Given the wide range of Medicare regulations touching upon everything from provision of services to coverage determinations to quality assurance, as well as the Congressional intent behind expanding the scope of the preemption clause, the Court determined that Appellant's state-law claims were expressly preempted. *Id.* at *5-6 ("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."). The Court noted that its decision was "consistent with the holdings by the courts that have broadly construed the Medicare Part C preemption clause." *Id.* at *7 (citing *Roberts*, 2 Cal. App. 5th at 138, 143; *Uhm v. Humana, Inc.*, 620 F.3d 1134, 1148-1153 (9th Cir. 2010); and *Morrison v. Health Plan of Nev., Inc.*, 130 Nev. 517, 523 (Nev. 2014)). The Court distinguished its holding with respect to express preemption from two other decisions that more narrowly construed the Medicare Part C preemption clause, *Cotton v. StarCare Medical Group*, 183 Cal. App. 4th 437, 450-451 (2010) (Fourth District, Division 3), and *Yarick*, 179 Cal. App. 4th at 1165 (Fifth District). The Court explained why the express preemption analysis in those decisions, rendered more than a decade earlier, was not consistent with current U.S. Supreme Court case law and not consistent with the Congressional intent of the preemption clause as discussed more recently in *Roberts*. *See id.* at *9. However, the Court did follow *Yarick* in holding that "[e]ven 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." *Id.* at *7 n. 11 (internal quotation marks, citations, and alterations omitted). As the Court noted, even though *Yarick* declined to find that the claims in that case were expressly preempted by Medicare, it held that they were *impliedly* preempted, reasoning that "[i]f 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." *Id.* (quoting *Yarick*, 179 Cal. App. 4th at 1167-68).

Because the Court held that Appellant's claims were both expressly and impliedly preempted by the Medicare Act and therefore properly dismissed with prejudice by the trial court, it declined to reach the issue of whether those claims were also barred by Cal. Health & Safety Code § 1371.25, and whether Appellant's state-law claims were sufficiently pled. *Id.* at *9, n.12.

STANDARD OF REVIEW

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

"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." *Id.*; *see also Aubry v. Tri-City Hosp. Dist.*, 2 Cal. 4th 962, 967 (1992) (judgment must be affirmed "if any one of the several grounds of demurrer is well taken"). "While the decision to sustain or overrule a demurrer is a legal ruling subject to de novo review on appeal, the granting of leave to amend involves an exercise of the trial court's discretion." *Lazar v. Hertz Corp.*, 69 Cal. App. 4th 1494, 1501 (1999). Thus, the appellate court reviews a decision denying leave to amend for an abuse of discretion. Cal. Code Civ.

Proc. § 472c(a); *Rosen v. St. Joseph Hosp. of Orange Cnty*., 193 Cal. App. 4th 453, 458 (2011).

LEGAL DISCUSSION

I. THERE IS NO NEED FOR REVIEW BECAUSE THE COURT OF APPEAL'S DECISION IS CONSISTENT WITH EXISTING AUTHORITY

Review of appellate court decisions by the Supreme Court is limited. This Court may order review of a Court of Appeal decision:

> (1) When necessary to secure uniformity of decision or to settle an important question of law;
>
> (2) When the Court of Appeal lacked jurisdiction;
>
> (3) When the Court of Appeal decision lacked the concurrence of sufficient qualified justices; or
>
> (4) For the purpose of transferring the matter to the Court of Appeal for such proceedings as the Supreme Court may order.

Cal. Rules of Court, rule 8.500(b); *see also People v. Davis*, 147 Cal. 346, 348 (1905) (Supreme Court's limited role is to "secure harmony and uniformity in the decisions [of the appellate courts], their conformity to the settled rules and principles of law, a uniform rule of decision throughout the state, a correct and uniform construction of the constitution, statutes, and charters, and, in some instances, a final decision by the court of last resort of some doubtful or disputed question of law").

"The District Courts of Appeal are established for the purpose of ascertaining and enforcing according to the rules of law the particular right of each case committed to their arbitrament." *People v. Groves*, 9 Cal. App. 2d 317, 322 (1935). "There is no abstract or inherent right in every citizen to take every case to the highest court." *Id.* Rehearing in the Supreme Court "is granted only when error appears upon the face of the

opinion of the appellate court, or when a doubtful and important question is presented [on the face of the opinion] upon which [the Supreme Court] desire[s] to hear further argument." *Burke v. Maze*, 10 Cal. App. 206 (1909) (order of Supreme Court denying transfer).

Appellant's Petition for Review does not satisfy any of the bases for Supreme Court review enumerated in Rule 8.500(b). The Court of Appeal's decision did not deviate from established authority nor does it present a "doubtful or disputed question of law." The Court of Appeal's decision simply followed the well-reasoned analysis set forth in *Roberts* as well as that of the Ninth Circuit in *Uhm* and applied that analysis to this case. (*See* Opn. at 21-23.) Although the Court of Appeal declined to follow the narrower preemption analysis set forth by the Fourth and Fifth Districts in *Cotton* and *Yarick* in 2010 and 2009, respectively, its decision to distinguish those cases from the instant case did not create the type of split of authority over an "important question of law" that would necessitate Supreme Court review. (*See id.*) *Roberts* has been the law of the Second District since 2016. The Court of Appeal in this case simply followed established precedent in rendering its decision.

Appellant does not even cite Rule 8.500 in 32 pages of briefing, let alone explain how that rule is satisfied in this case. (*See generally* Petition for Review.) He simply reargues the merits of his case, setting forth arguments that both the Court of Appeal and the trial court properly rejected. Appellant may not seek Supreme Court review simply to gain an extra shot at arguing the merits. *See Groves*, 9 Cal. App. 2d at 322. He must make a showing that Supreme Court review is necessary based on one of the four enumerated circumstances in Rule 8.500(b). He has not done so, and the Petition for Review should therefore be denied.

II. THE COURT OF APPEAL CORRECTLY HELD THAT APPELLANT'S STATE-LAW CLAIMS ARE PREEMPTED BY THE MEDICARE ACT

Appellant's Petition for Review is largely confined to arguing why the Court of Appeal's Medicare Preemption analysis is incorrect. (*See generally* Petition for Review.) Although the majority of those arguments are not relevant to whether or not this Court should review the case, *see* Rule 8.500(b), Respondent will address them here for the sake of clarity.

Common-law claims such as those Appellant attempted to assert in this action, are subject to Medicare standards and to Medicare preemption. As the Court of Appeal recognized, under the Medicare Act, preemption of state law can be express or implied. (Opn. at 9, 17 n.11); *Roberts*, 2 Cal. App. 5th at 142. "[E]xpress preemption arises when Congress 'define[s] explicitly the extent to which its enactments pre-empt state law.'" (Opn. at 9 (quoting *Parks v. MBNA America Bank, N.A.*, 54 Cal. 4th 376, 383 (2012)).) "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.'" (Opn. at 9 (quoting *Solus Industrial Innovations, LLC v. Superior Court*, 4 Cal. 5th 316, 331 (2018)).)

The current version of the Medicare Act's express preemption provision states: "The standards established under this part [42 U.S.C. § 1395w-21 *et seq*.] 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); *accord* 42 C.F.R. § 422.402. Courts have interpreted this provision broadly because to hold otherwise would frustrate the intent of Congress in requiring that the administrative process be the sole avenue for claims "arising under" the Medicare Act. *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000) (The "'channeling' of virtually all legal attacks" through CMS "assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying 'ripeness' and 'exhaustion' exceptions case by case."). Like the majority of courts to have considered the current preemption clause, the Court of Appeal made clear that express Medicare preemption applies to any state laws, whether they be based in statute, regulation or common law, in areas in which Medicare Part C regulations establish standards for MA plans. (*See* Opn. at 17-18); *accord Roberts*, 2 Cal. App. 5th at 143-44 (state laws are preempted "to the extent they touch upon areas regulated by Medicare Advantage standards").

Here, there is no question that Appellant's state statutory and common law claims against United "touch upon" areas regulated by Medicare Advantage standards. As the Court of Appeal correctly found, Appellant's state-law claims "are based on California law in an area in which Medicare Part C regulations have established standards for MA plans." (Opn. at 12.) The Centers for Medicare & Medicaid Services ("CMS")[1] requires that Medicare contractors maintain and adhere to

[1] CMS is a division of the Department of Health and Human Services and administers the Medicare Program. As part of its administration of the Medicare Program, CMS promulgates numerous rules and regulations with which Medicare contractors

utilization review and quality assurance programs, including ongoing evaluation and quality management. *See* 42 C.F.R. § 422.152; 42 C.F.R. § 422.202; 42 C.F.R. § 422.504. Importantly, MA organizations are expressly required to "[m]aintain a health information system that collects, analyzes, and integrates the data necessary to implement its quality improvement program," create and implement a "process for formal evaluation, at least annually, of the impact and effectiveness of its quality improvement program," and "correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms." *Id.* § 422.152(f)(1)-(3).[2] Medicare standards also govern benefit coverage, including post-hospital extended care services such as the type at issue in this case. *See* 42 C.F.R. § 422.101(b)(1-3); 42 U.S.C. § 1395d(a)(2)(A); (Opn. at 12 (explaining CMS regulations pertaining to benefit coverage)).

In the SAC, Appellant made several allegations pertaining to United's alleged duties to "provide Medicare's care and administrative protections to Eugene" (*see* Opn. at 4) – duties that stem from and are governed by the Medicare Act. For example, Appellant alleged that United had a duty to monitor and oversee the care being provided by GEM and Dr. Lee, but "[d]espite the said knowledge that GEM was not providing

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must comply in providing Medicare benefits to enrollees. *See generally* 42 C.F.R. §§ 401.101 *et seq.*

[2] Other CMS regulations relating to standards for MA organization selection and oversight of contracted providers abound. *See, e.g.*, 42 C.F.R. § 422.204(a) (requiring "written policies and procedures for the selection and evaluation of providers"); *id.* § 422.204(b) (requiring "credentialing that includes written application, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate"); *id.* § 422.4(a) (requiring CMS approval of provider network "to ensure that all applicable requirements are met, including access and availability, service area, and quality").

necessary skilled nursing care to its resident-patients," United allegedly "acquiesced to, encouraged, directed, aided and abetted 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." (Opn. at 5.)

The Court of Appeal examined these allegations and concluded that they were preempted. It reasoned as follows:

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

(Opn. at 15.) Appellant claims the Court of Appeal erred in "fail[ing] to discuss whether the claims asserted by Quishenberry were in conflict with federal standards." (Petition for Review at 21.) Nothing could be further from the truth. In fact, the Court of Appeal spent several paragraphs analyzing the various ways in which Appellant's claims conflicted with Medicare regulations. (*See* Opn. at 14-17.) The Court of Appeal's ruling on express preemption was not in error.

In addition to finding that Appellant's claims were expressly preempted, the Court of Appeal also held that Appellant's common-law claims were properly dismissed under the doctrine of implied preemption. (Opn. at 17 n.11.) The Court noted that "[e]ven 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.'" *Id.* (quoting *People ex rel. Harris v. Pac Anchor Trans., Inc.*, 59 Cal. 4th 772, 778 (2014) (alteration in original)). In doing so, the Court followed both *Roberts* and *Yarick*, which, despite narrowly construing the express preemption doctrine, still found that the plaintiff's claims in that case were impliedly preempted. *See Yarick*, 179 Cal. App. 4th at 1167-68 (holding that Medicare patient's state-law negligence claims were impliedly preempted by the Medicare Act because the Medicare Act established comprehensive standards for quality-of-care review, provision of sufficient and timely services, and duty to ensure adequate and timely care); *see also Cotton*, 183 Cal. App. 4th at 455 (upholding dismissal of plaintiff's constructive fraud claim based on failure to follow utilization review procedures because it conflicted with CMS regulations governing the contents of Medicare Advantage plans).

In the instant case, Appellant attempted to bring the same type of common-law claims held to be expressly preempted in *Roberts* and impliedly preempted in *Yarick*, and the Court of Appeal, properly following the analyses in both cases, found those claims to be both expressly and impliedly preempted. The Court of Appeal's ruling was correct and need not be disturbed. Appellant argues that the Court of Appeal's "finding of obstacle preemption is simply erroneous" because none of his claims "creates a conflict with or stands as an obstacle to the accomplishment of any federal objective." (Petition for Review at 9.) Appellant alleges, however, that United failed to adhere to common-law standards of care with respect to duties that Appellant acknowledges were required by the "Medicare Rules" – e.g., quality assurance and utilization review. (*See* Opn. at 15 n.9.) Those common-law standards stand as an obstacle to CMS's enforcement of its own broad standards and regulations relating to "Medicare rules" including quality assurance and utilization review. *See Roberts*, 2 Cal. App. 5th at 148-49. The Court of Appeal correctly held that Appellant's state-law causes of action were impliedly preempted by the Medicare Act, and were properly dismissed with prejudice.

III. APPELLANT'S VICARIOUS LIABILITY CLAIMS ARE ALSO BARRED BY CAL. HEALTH & SAFETY CODE § 1371.25

Although the Court of Appeal did not reach this issue, Appellant dedicates a section of the Petition for Review to rearguing the issue of whether § 1371.25 applies. This argument is improper and irrelevant to the Petition for Review, but even if this issue were properly before the Supreme Court, Appellant's take on the law is simply incorrect.

It is settled law in California that a health care service plan cannot be held liable for the acts or omissions of the health care providers who

delivered medical care to the plan's subscribers. *See* Cal. Health & Safety Code § 1371.25; *Watanabe v. Cal. Phys. Serv.*, 169 Cal. App. 4th 56, 63-64 (2008). Appellant admits that he is attempting to hold United vicariously liable for the allegedly wrongful actions of GEM, a contracted third-party provider. (*See* Petition for Review at 32 ("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.").) The trial court properly dismissed Appellant's claims against United under § 1371.25.

As an end run around § 1371.25, Appellant alleges that, because Eugene's health plan was a Medicare plan, under the most recent amendments to the Medicare Act's express preemption provision, § 1371.25 itself is preempted by the Medicare Act and therefore does not apply. (Petition for Review at 29-31.) This argument is nonsensical.

As discussed above, the Medicare Act expressly preempts "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); *accord* 42 C.F.R. § 422.402. Section 1371.25 is not a "state law or regulation" that creates any duties or causes of action that might interfere with Medicare regulations. It is simply a loss-apportionment statute. All § 1371.25 says is that a health care plan cannot be vicariously liable for the acts of its contracted providers; each entity is severally liable only for its own acts or omissions. No court has held that the Medicare Act preempts § 1371.25. And the one California court to have addressed the issue, albeit under a prior version of the Medicare Act's preemption provision, declined to find that § 1371.25 was preempted. *See Martin v. PacifiCare of Cal.*, 198 Cal. App. 4th 1390, 1410 (2011). There is therefore no basis to find that § 1371.25,

which does not create any independent legal claims or duties, is preempted by the Medicare Act.

Moreover, Appellant's contention that the Medicare Act preempts § 1371.25 but not his underlying common-law claims could not possibly hold true. The notion that a liability apportionment statute touches on or interferes with CMS's ability to regulate Medicare Advantage plans but underlying common-law theories based on conduct that is specifically regulated by CMS under the Medicare Act do not, defies common sense.

Finally, Appellant argues that "a Defendant can be vicariously liable for 'neglect' under the Elder Abuse Act" based on his interpretation of case law that does not address the issue of whether an insurance company can be vicariously liable for negligence by a medical provider. Appellant contends 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." (Petition for Review at 31.) The case law Appellant relies on in support of this argument, however, does not extend liability for elder abuse to insurance companies or even address whether an insurance company can be vicariously liable for a health care provider's neglect or abuse of an elder. *See Winn v. Pioneer Medical Group*, 63 Cal. 4th 148, 153 (2016) (action by children of deceased elderly patient against medical facility and doctors that treated patient and allegedly failed to provide adequate care). It cannot. *See* Cal. Health & Safety Code § 1371.25. Appellant's elder abuse claim was properly dismissed.

CONCLUSION

For all the foregoing reasons, Respondent respectfully requests that this Court deny Appellant's Petition for Review.

WALRAVEN & WESTERFELD LLP

Dated: November 15, 2021

BY: 

BRYAN S. WESTERFELD

Attorneys for Defendants/Respondents United Healthcare, Inc. (incorrectly identified as "United Health Care, Inc." and "United Healthcare Insurance, Inc."), UnitedHealth Group Incorporated, UnitedHealthcare Services, Inc., and UHC of California (incorrectly identified as "United Health Care—California" and "UHC—California")

CERTIFICATE OF WORD COUNT

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

The text of this brief consists of 5,634 words, as counted by the Microsoft Word word processing program used to generate this brief.

Dated: November 15, 2021

BRYAN S. WESTERFELD

PROOF OF SERVICE

STATE OF CALIFORNIA)
COUNTY OF ORANGE)

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 20 Enterprise, Suite 310, Aliso Viejo, California 92656. My electronic service address is jmr@walravenlaw.com.

On **November 15, 2021** I served the document described as **RESPONDENT'S ANSWER TO PETITION FOR REVIEW** on all interested parties by sending a true copy addressed to each through TrueFiling, the electronic filing portal of the California Supreme Court, pursuant to California Rules of Court, which will send notification of such filing to the email addresses denoted on the case's Electronic Service List.

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Hon. Ralph Hofer
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 **November 15, 2021** at Aliso Viejo, California.

JESSICA RIDLEY

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **QUISHENBERRY v. UNITEDHEALTHCARE**
Case Number: **S271501**
Lower Court Case Number: **B303451**

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/s/Sarah Walraven
Signature

Westerfeld, Bryan (218253)
Last Name, First Name (PNum)

Walraven & Westerfeld LLP
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