

Case No. S271501
2nd Dist. No. B303451
Los Angeles Superior Court Case No. BC631077

**IN THE SUPREME COURT
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 Superior Court for Los Angeles County
Honorable Ralph Hofer, Judge
Department D
Phone: (818) 265-6413

APPELLANT'S REPLY BRIEF

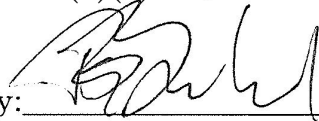
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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS
(Cal. Rules of Court, Rule 8.208)

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

Dated: May 9, 2022

By: 

RUSSELL S. BALISOK,
Attorneys for Appellant

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1. INTRODUCTION

The two issues to be considered in this case are whether Quishenberry's claims are subject to the Medicare Part C express preemption provision (42 U.S.C. §1395w-26(b)(3)) and whether his claims are impliedly preempted as an obstacle to the accomplishment and execution of the purposes and objectives of Congress. The Responsive Brief ("RB") in the main fails to address these two issues. Respondent's preoccupation with *McCall v. PacifiCare of California* (2001) 25 Cal. 4th 412 serves only to illustrate the point. In *McCall* this Court granted review to consider the limited issue whether state law claims arising out of its refusal to provide services fell within the exclusive review provisions of the Medicare Act requiring exhaustion of administrative remedies. *McCall* was not concerned with preemption.

Nonetheless, before considering considered the Respondent's preemption claims, Quishenberry would point out that his claims of negligence and Elder Abuse may be pleaded and proved without reference to Medicare rules concerning his father's eligibility for skilled nursing care. A claim of negligence may be generally alleged. The elements of a negligence claim are (a) defendant's legal duty of care; (b) a negligent act or omission in breach of that duty, (c) injury to the plaintiff as a result of the breach, and (d) damage to the plaintiff. 4 Witkin, California Procedure (6th edition) *Pleading* §581. Quishenberry can establish each of these elements as in any other case, by expert testimony related to the standard of care and or its breach. And,

as explained in Quishenberry’s opening brief, while negligence may be generally alleged, the elements of malice, fraud, oppression or recklessness must be specifically alleged and therefore, specific allegations of state of mind, motive or intent are required. in order to prove state of mind. 5 Witkin, California Procedure (6th ed) *Pleading* §707.

Pleading and proof of state of mind by reference to legal standards governing a defendant’s conduct, including federal standards expressed in Medicare Part C does not suggest that a plaintiff’s claim is one “arising under” the Medicare Act because the standing nor the substantive basis for the claim is the Medicare Act, nor is the claim inextricably intertwined with a claim for benefits. *McCall* at 417.

2. RESPONDENTS MAY NOT ESCAPE LIABILITY
BECAUSE THEIR INCENTIVE TO DENY CARE
WAS FINANCIAL

As Respondent contend, in creating HMOs, Congress has no doubt approved financial incentives to reduce the cost of medical care. The denial of reasonably necessary medical care is no doubt a foreseeable – if deplorable -- consequence of the creation of the financial incentives inherent in the capitated fee arrangements. Paying a flat fee to a provider who is then to arrange to pay for the provision of healthcare to assigned enrollees, whatever the cost of doing so, will without a doubt lead to healthcare decision making which promotes financial success at the expense of the reasonable healthcare needs of those

enrollees. Quishenberry was allegedly deprived of reasonable care including skilled nursing facility care so that he could recover from the effects of a broken hip, because of this financial incentive.

Respondent points to Congressional approval of financial incentives and argues that the denial of care based on those incentives is therefore likewise approved and therefore the denial is not actionable. This is simply perverse and ignores the duty imposed by Congress to provide care. Certainly, a financial incentive to limit the cost of care cannot serve as a foundation for the denial of care.

3. QUISHENBERRY'S CLAIMS ARE NOT EXPRESSLY PREEMPTED

Respondents cannot succeed on a claim of express preemption. As set forth in the opening brief the presumption against preemption required the Court to search for Congressional intent through the lens of that presumption. *Solus Indus. Innovations, LLC v. Superior Ct.* (2018) 4 Cal. 5th 316, 332. Even without this presumption, the provision at 42 U.S.C. §1395w-26(b)(3) *on its face plainly* preempts only state laws “with respect” to Medicare Advantage plans. This provision effectively preempts state laws which specifically refer to HMOs participating in Medicare. A more expansive interpretation of the preemption provision to include laws of general applicability such as Quishenberry’s common law claims and his Elder Abuse

claim, is not indicated by the plain language of the preemption provision.

At p. 31 of the Responsive Brief, the defendants suggest that the phrase “with respect to MA plans” limits the scope of the preemption provision to MA plans under Part C. But the plain meaning of the phrase is instead to limit the scope of preemption *to state laws* which refer to MA plans. This is consistent with the “last antecedent rule” which provides that qualifying words, phrases and clauses are to be applied to the words or phrases immediately preceding and are not to be construed as extending to or including others ore remote. *White v. County of Sacramento* (1982) 31 Cal. 3d 676, 680. And, interpreting the phrase to limit the scope of preemption to MA plans, instead of state laws, would render the “with respect to” language meaningless, since the preemption provision falls within Part C and applies only to Part C participants. The Court should give meaning to every word of a statute if possible and should avoid a construction making any word surplusage. *Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 22; *People v. Woodhead* (1987) 43 Cal. 3d 1002, 1010. Finally, Respondents’ interpretation of the preemption provision is, without reflection, nonsensical.

Because Quishenberry’s claims are based on common law and the Elder Abuse Act, a statute of general applicability, his claims are not expressly preempted.

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4. APPLICATION OF QUISHENBERRY'S COMMON
LAW CLAIMS AND HIS ELDER ABUSE CLAIM DO
NOT OBSTRUCT FEDERAL GOALS

Starting at p. 37 of their Brief, Respondents' point to the comprehensive federal regulations including regulations which require Respondents to monitor the care provided by contracted care providers. According to Respondents, the existence of these provisions is the basis for preemption, even preemption based on obstruction. Not so. As this Court explained:

In view of Bronco's repeated suggestions that we should be influenced in our assessment by the circumstance that the federal regulations at issue are part of a comprehensive scheme, in resolving these conflicting views concerning whether section 25241 stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress we bear in mind the high court's admonition in *Hillsborough County*, supra, 471 U.S. 707, 717, 105 S.Ct. 2371, 85 L.Ed.2d 714: "We are even more reluctant to infer pre-emption from the comprehensiveness of regulations than from the comprehensiveness of statutes. As a result of their specialized functions, agencies normally deal with problems in far more detail than does Congress. To infer pre-emption whenever an agency deals with a problem comprehensively is virtually tantamount to saying that whenever a federal agency decides to step

into a field, its regulations will be exclusive. Such a rule, of course, would be inconsistent with the federal-state balance embodied in our Supremacy Clause jurisprudence. See Jones [, supra], 430 U.S. [519] at 525. *Bronco Wine Co. v. Jolly* (as modified, Oct. 13, 2004) 33 Cal. 4th 943.

And, where the Congressional enactment plainly does not preempt, a federal agency's interpretation of that enactment to find that the statute does preempt, is entitled to little or no weight.

Congress was certainly aware of state common law when enacting the current provision of the preemption provision and was plainly content to allow state statutes which do not refer to HMOs to remain in effect. State laws other than state laws specifically targeting HMOs should not be seen as an obstacle to Congressional objectives. Turning to the federal regulations on which Respondents rely, none of them reserve to the federal agency the power to enforce those regulations. These regulations are clearly distinguishable from the marketing regulations examined in *Roberts v. United Healthcare* (2016) 2 Cal. App. 5th 132, which examined federal law requiring the federal agency to evaluate marketing materials and the adequacy of Medicare Advantage health plans. Federal regulations entrust the agency with reviewing and approving marketing materials. *Id.*, at 148. On this basis *Roberts* found that the plaintiff's complaint, based exclusively on allegations of the falseness of such marketing

materials, would pose an obstacle to the agency's determination of the adequacy of such marketing materials.

If the regulations relied upon by Respondents similarly reserved power to the federal agency to determine the adequacy of the MA plan's supervision or oversight of contract healthcare providers, then allowing state law claims such as Quishenberry's would likely fall within *Roberts* rule. But applicable federal regulations express no such provision reserving to the agency the power to make such determinations. Simply put, the existence of federal comprehensive regulations does not imply preemption. *Bronco Wine*, supra.

The court should therefore find Quishenberry's state law claims do not stand as an obstacle to federal goals. Instead, his state law claims are in harmony with federal regulations.

5. QUISHENBERRY'S CLAIMS ARE BASED ON TREATMENT DECISIONS, NOT BENEFITS DETERMINATIONS

Distinguishing a treatment decision, such as the decision to discharge Quishenberry's father from the skilled nursing facility, from a benefits determination is not always easy. Was the discharge due to a determination by a Respondent that he was not entitled under Medicare to further care in the skilled nursing facility? Or was the decision that he was no longer entitled to such benefits based on a medical determination that he was not benefitting from continued skilled care, such as physical therapy. As set forth in the Opening Brief and the Petition for Review,

skilled nursing care is only available under Medicare's if the patient is "attaining or maintaining" physical function. A medical determination that the patient is not "attaining or maintaining" physical function is a medical determination, but has the effect of terminating skilled nursing benefits.

Quishenberry's complaint alleges that such a medical determination was made not based on Quishenberry's progress but instead based on pressure to limit his skilled nursing care benefit. Proof of this claim does not require a trier of fact to invade the federal agency's requirements for eligibility for skilled nursing facility care. For this reason, too, application of state law to Quishenberry's claims in no way stand as an obstacle to any federal goal.

Given federal financial incentives to limit the cost of care, Respondents have wrongfully implied a federal financial incentive to deny care. There is no federal interest in the denial of reasonably necessary medical care. And federal regulations plainly lay out the scope of Respondents' duty to provide skilled nursing care. Respondents' alleged improper efforts to deny medical care to enrollees is a proper target for common law and for the Elder Abuse Act and the existence of federal descriptions of Medicare benefits cannot be seen as offended by such actions.

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6. CONCLUSION

For the foregoing reasons, it is respectfully submitted that neither the doctrines of express or implied preemption are defensive, and that the judgment of the trial court be reversed.

BALISOK & ASSOCIATES, INC.

BY: 

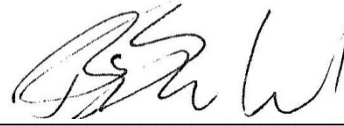
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CERTIFICATE OF WORD COUNT

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

The text of this brief consists of 1,830 words, as counted by the Microsoft Word word processing program used to generate this brief.

Dated: May 9, 2022



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Hon. Ralph Hofer
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Glendale, CA 91206

Trial Court

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Executed on **May 9, 2022** at Los Angeles, California.

/s/ Dorothy A. Droke

Dorothy A. Droke

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

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Case Number: **S271501**

Lower Court Case Number: **B303451**

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