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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

ROBERT J. COHEN, Plaintiff and Appellant, v. HEALTH NET OF CALIFORNIA, INC., et al., Defendants and Respondents.	G033868 (Super. Ct. No. 02CC13219) O P I N I O N

Appeal from a judgment of the Superior Court of Orange County, Clay M. Smith, Judge. Affirmed. Request for judicial notice. Granted.

Richard L. Spix for Plaintiff and Appellant.

Musick, Peeler & Garrett, Michael F. Klein, Cheryl A. Orr and Peter T. Haven for Defendant and Respondent Health Net of California, Inc.

Law Offices of Norman A. Filer, Norman A. Filer and Gene A. McKenzie, Jr., for Defendant and Respondent Los Alamitos Medical Center, Inc.

* * *

INTRODUCTION

Robert J. Cohen sued Health Net of California, Inc. (Health Net), and Los Alamitos Medical Center, Inc. (Los Alamitos). Cohen's son Jeremy had been provided emergency medical services on three occasions at Los Alamitos by California EM-1 Medical Services (CA Em-1), an emergency physicians group. Cohen received a series of billing statements totaling $744 and dunning notices from CA Em-1 or its collection agent.

Cohen, a member of Health Net's HMO through his employee benefit plan, had paid the applicable copayments and was not responsible for paying the bills. After Cohen filed this lawsuit, CA Em-1 submitted the bills to Health Net, which paid them. Cohen made the applicable copayments, paid nothing else, and no longer is a Health Net member.

Cohen asserted a variety of causes of action and theories against Health Net and Los Alamitos, including fraud, unfair business practices under the California unfair competition law (UCL), intentional infliction of emotional distress, insurance bad faith, and negligence. Cohen also sued CA Em-1 and its billing service, but they are not parties to this appeal. The trial court, granting Health Net's and Los Alamitos's motions for summary judgment, concluded Cohen's claims were preempted by the Employee Retirement Income Security Act of 1974 (ERISA), were subject to the exclusive regulatory powers of the California Department of Managed Health Care (DMHC), or had no merit under the undisputed facts.

We affirm. Under United States Supreme Court decisions, ERISA preempts Cohen's claims against Health Net, and Cohen cannot state a claim under ERISA. If or to the extent ERISA does not preempt Cohen's claims against Health Net based upon alleged violations of the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), those claims either are subject to the exclusive regulatory powers

of the DMHC or have no merit under the undisputed facts. Cohen's claim against Los Alamitos has no merit under the theory advanced on appeal—that Los Alamitos somehow converted his property and/or contractual interest in his Health Net HMO policy. Finally, under Proposition 64, Cohen lacks standing to prosecute his UCL claim because he suffered no actual loss of money or property as a result of the challenged conduct.

FACTS

Health Net is a federally qualified HMO which provides health care service plans. Health Net itself does not provide medical care, but arranges medical services for its members through contracts with third parties, such as hospitals and intermediary physicians groups (IPA's).

Health Net entered into a provider services agreement with Allied Physicians of California (Allied) to serve as an IPA. The provider services agreement between Health Net and Allied states that Allied "agrees that in no event, including, but not limited to, non-payment by [Health Net] . . . shall [Allied] bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members" other than for applicable copayments and noncovered services. In 2000 and 2001, Long Beach IPA, a subsidiary of Allied, provided medical care to Health Net members pursuant to the provider services agreement between Health Net and Allied.

Health Net contracted with Los Alamitos to provide hospital and emergency room services to Health Net members. The contract between Los Alamitos and Health Net states: "In no event . . . shall any Member be liable for any sums owed by HEALTH NET, and neither [Los Alamitos] nor any health care provider rendering services to Members pursuant to this Agreement shall bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any

action or have any other recourse against a Member or other person acting on a Member's behalf. [Los Alamitos] may only bill HEALTH NET Members directly for applicable deductibles or co-insurance amounts and for any non-covered services."

Los Alamitos in turn contracted with CA EM-1 to provide Los Alamitos with emergency room physicians. The contract between Los Alamitos and CA Em-1 states the CA Em-1 physicians "shall act at all times under this Agreement as independent contractors." The contract also states CA EM-1 "shall separately bill patients for professional services rendered" and requires CA Em-1 to accept as payment in full for its physicians' services the amount agreed upon by Health Net and Los Alamitos.

Cohen's employer, the Legal Aid Society of Orange County, purchased health insurance benefits for its ERISA plan through an entity known as PacAdvantage, which offers benefits through Health Net and other HMO's and medical service providers. Under the Legal Aid Society's ERISA plan, each employee may select any health insurance plan PacAdvantage offered. Effective January 1, 2001, Cohen became enrolled in Health Net's HMO through the Legal Aid Society's ERISA plan and selected Allied as his group IPA. At that time, Health Net members selecting Allied were assigned to Long Beach IPA for medical care. Both the Legal Aid Society and Cohen contributed to purchasing his health insurance benefits under the Health Net plan offered by PacAdvantage.

PacAdvantage's preenrollment public marketing matrix of services handbook and Health Net's evidence of coverage (EOC), as well as PacAdvantage's health benefits employee handbook state the member is only responsible for a $50 copayment for nonadmitted emergency medical care, including both facilities and professional services. Cohen relied upon those documents in deciding to enroll in Health Net's HMO.

Cohen's son Jeremy received treatment at the Los Alamitos emergency room on March 15, June 7, and November 13, 2001. These treatments were covered under Cohen's Health Net HMO plan, and on each occasion, Cohen or his wife made the applicable $50 copayment.

Paragraph 8 of Los Alamitos's conditions of services (COS) states, in part: "I further understand that I am responsible to the hospital and physician(s) for all reasonable charges incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the hospital, I understand that I will be responsible for collection of expenses as well as reasonable attorney's fees and court costs if a suit is instituted." When Jeremy received emergency room treatment on March 15, 2001, a friend signed the COS form. On June 7 and November 13, 2001, Cohen's wife signed the COS form. Aftercare instructions provided by Los Alamitos stated, "[i]n addition to the hospital bill, you will receive bills for professional services of the . . . emergency department physician."

CA Em-1 or its billing agent sent balance bills for the emergency medical services provided Jeremy Cohen to Long Beach IPA, the medical provider group to which Health Net had assigned Cohen. CA Em-1 initially did not send the bills to Health Net. Long Beach IPA did not pay the bills. Long Beach IPA filed for bankruptcy protection and listed CA Em-1 as an unsecured creditor.

From June 2001 through September 2002, Cohen received some 13 billing statements from CA Em-1 or its collection agent for the balance due on the emergency medical services Jeremy received at Los Alamitos. The three outstanding balances were, respectively, $149, $369, and $226, for a total of $744. The initial billing statements asserted: "Your insurance carrier has not paid this claim. Please contact your insurance company today to ensure their timely payment to us. . . . This is not a request for payment." But later, the statements asserted the insurance carrier had not paid the bill and Cohen was responsible for payment, demanded payment from him, and threatened to

damage his credit if he did not pay. Cohen also received at least one telephone call at night from a collection agent telling Cohen he had to "'settle them up.'" A statement dated September 30, 2002—after Cohen filed this lawsuit—stated: "Your insurance has not paid this balance in full and it is now seriously past due[.] You are responsible for payment. Call your insurance plan for assistance."

After Jeremy Cohen's emergency medical treatment at Los Alamitos in November 2001, Cohen learned from his family physician that Long Beach IPA was not paying its bills. Cohen contacted Health Net and asked to be changed to a different provider group. When Health Net refused, Cohen complained to the DMHC. The DMHC intervened, and Health Net agreed to change Cohen's group IPA. In speaking with a Health Net representative, Cohen mentioned the bills he had been receiving from CA Em-1. The Health Net representative told Cohen the bills he had received from CA Em-1 were due to a billing error and he could ignore them.

Cohen soon thereafter received a telephone call from a DMHC representative asking him if his problem with Health Net had been resolved. Cohen said it had. Cohen continued, however, to receive dunning statements from CA Em-1 or its collection agent.

Cohen contacted CA Em-1 on July 3, 2002 and stated he had made the requisite copayments for Jeremy's three emergency room visits and was not financially responsible for the balance billings. CA Em-1 told Cohen in response he was liable for the full cost of services and if he did not pay the bills his credit would be adversely affected.

Cohen filed this lawsuit in August 2002. About two weeks later, Cohen contacted CA Em-1's billing service about the bills he had been receiving. On August 29, 2002, CA Em-1's billing service sent Heath Net a bill for $226. Health Net paid the bill by October 21, 2002. On February 27 and March 4, 2003, the billing service sent

Health Net bills for, respectively, $369 and $149. Health Net paid those bills by March 20, 2003. The accounts have been deemed fully paid and collection efforts have ceased.

In oral argument on appeal, Cohen's counsel asserted an account report printed by CA Em-1's billing service established that as early as December 1, 2001 Health Net had been sent a bill for the services rendered Jeremy Cohen. The document (submitted by Health Net in support of its motion for summary judgment) reflects that on December 1, 2001, an "on-demand form" had been printed for Health Net. The account report does not establish the form or any other kind of billing was arguably sent to Health Net on or about that date. Rather, the account report confirms that, as explained above, on August 29, 2002, CA Em-1's billing service billed Health Net $226 and that Health Net paid that amount in October 2002.

PROCEEDINGS IN THE TRIAL COURT

I. *COHEN'S COMPLAINT AND THEORIES OF RECOVERY*

The verified second amended complaint (the complaint) asserted eight causes of action: (1) fraud (against Health Net and Los Alamitos); (2) unfair business practices under the UCL, Business and Professions Code section 17200 et seq. (against Health Net and Los Alamitos); (3) declaratory and injunctive relief (against Health Net and Los Alamitos); (4) intentional infliction of emotional distress (against Health Net and Los Alamitos); (5) breach of contract (against Health Net); (6) insurance bad faith (against Health Net); (7) unfair collection practices (not asserted against Health Net or Los Alamitos); and (8) negligence per se (against Health Net and Los Alamitos). The complaint named CA EM-1, its collection agency (NCO Financial Systems, Inc.), and/or one of its emergency room physicians as defendants to the second, third, fourth, seventh, and eighth causes of action. Those three defendants are not parties to this appeal.

Cohen has pursued the complaint under several theories. First, Cohen asserts that Health Net misrepresented in its advertisements and policies the insured would be liable only for a specified copayment when treated at in-network hospitals and that Los Alamitos misrepresented Health Net members would only be billed and obligated to pay for the copayment specified by Health Net. Those misrepresentations, Cohen alleges, violate Health and Safety Code section 1360, which prohibits a health plan from using any untrue or misleading advertisements or solicitations, or from using any evidence of coverage which is "deceptive."

Second, Cohen asserts Health Net capitation policies "failed . . . to assure the administrative and financial integrity of its IPAs for profits," rendering the IPA's unable to pay the providers' bills. Third, Cohen asserts Health Net engages in systematic delay of paying its providers' bills, thereby requiring its members to pay in full for covered claims, and "jeopardiz[ing] the health care delivery system."

Fourth, Cohen asserts Los Alamitos "attempts to insulate itself and its assigns from non-payment by Health Net through terms contained in its [COS] forms, still in use." Cohen contends the COS forms are unlawful, unfair, or misleading because they purport to make the patient/Health Net member fully liable for the entire cost of treatment. Fifth, Cohen asserts Los Alamitos, when contracting with CA Em-1 "did not pass on any prohibition against billing members. . . . [but] assigned its duty to supervise its E[mergency] R[oom] to defendant CA EM-1 . . . by contract which expressly contradicts the terms of [Health Net's] . . . EOC." Finally, Cohen argues in his opening brief that Los Alamitos "coercively converted" his property and/or contractual interest in the liability limits of his Health Net HMO plan by balance billing Health Net members as though no limitation existed.

The result of those various practices, Cohen asserts, is that Health Net providers cannot receive payments from IPA's because Health Net's capitation policies render the IPA's insolvent. As a result, Cohen contends, the providers wrongfully

"'balance bill[]'" Health Net members for covered claims. "Such billings are inherently coercive," Cohen contends, "because the care can involve the need to assure continuing treatment, credit reporting can affect loan costs to members, patients can be unwilling to disappoint their trusted doctors, and consumers would rather pay than litigate." Cohen contends that Health Net, by subjecting its insureds to such balance billing, converts its HMO prepaid plan into a fee-for-service plan in violation of Health and Safety Code section 1379.

II. *DEMURRER AND SUMMARY JUDGMENT RULINGS*

The trial court sustained, without leave to amend, Health Net's demurrer to the sixth and eighth causes of action and Los Alamitos's demurrer to the first and eighth causes of action. Cohen later moved for summary adjudication or judgment on the second cause of action under the UCL. Health Net and Los Alamitos moved for summary judgment.

The trial court denied Cohen's motion and granted summary judgment in favor of Health Net and Los Alamitos. The trial court concluded: (1) ERISA preempted Cohen's claims; (2) no reasonable trier of fact could find the existence of the elements of a claim for fraud; (3) "no reasonable trier of fact could find the existence of an existing unfair business practice on the part of Health Net requiring the fashioning of an equitable remedy under Business and Professions Code [section] 17200"; (4) the relief Cohen sought under the second cause of action "would essentially require this Court to step into the shoes of California's Department of Managed Health Care and begin regulating HMOs and their contractual agreements with health care providers—something which this Court cannot do"; (5) no reasonable trier of fact would find the existence of a dispute requiring declaratory relief or otherwise justifying the imposition of equitable relief; (6) no reasonable trier of fact could find the existence of extreme or outrageous conduct by Health Net sufficient to sustain a claim for infliction of emotional distress; and (7) no

reasonable trier of fact could find the existence of a breach of contract by Health Net or any damages resulting from a breach.

Cohen timely appealed from the judgments entered on March 5 and 22, 2004. We review summary judgment de novo, "considering all of the evidence the parties offered in connection with the motion (except that which the court properly excluded) and the uncontradicted inferences the evidence reasonably supports." (*Merrill v. Navegar, Inc.* (2001) 26 Cal.4th 465, 476.)

ANALYSIS

I. *ERISA PREEMPTS COHEN'S CLAIMS AGAINST HEALTH NET.*

Health Net contends, and the trial court concluded, all Cohen's claims against Health Net are related to an employee benefit plan and therefore are preempted by ERISA, 29 United States Code section 1001 et seq. ERISA preemption does not apply to Los Alamitos because it is not the employer, the beneficiary under the employee benefit plan, the benefit plan itself, or the benefit plan fiduciary. (*Benitez v. North Coast Women's Care Medical Group, Inc.* (2003) 106 Cal.App.4th 978, 990.)

A. *The ERISA Preemption Provisions*

Congress enacted ERISA to "protect . . . the interests of participants in employee benefit plans and their beneficiaries" by establishing a substantive and comprehensive regulatory scheme for employee benefit plans and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts." (29 U.S.C. § 1001(b); see *Aetna Health Inc. v. Davila* (2004) 542 U.S. 200, __ [124 S.Ct. 2488, 2495] (*Davila*).) To this end, ERISA includes an expansive preemption "intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'" (*Davila, supra,* 542 U.S. at p. __ [124 S.Ct. at p. 2495].)

ERISA preemption has three provisions. The first provision states ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." (29 U.S.C. § 1144(a).) The second provision—the so-called "saver clause"—states, "[e]xcept as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." (*Id.*, § 1144(b)(2)(A); see *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 45 (*Pilot Life*).) The third provision—the so-called "deemer clause"—states, "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." (29 U.S.C. § 1144(b)(2)(B); see *Pilot Life, supra,* 481 U.S. at p. 45.)

The three preemption provisions operate as follows: If a state law "relate[s] to . . . employee benefit plan[s]," it is preempted. (29 U.S.C. § 1144(a).) The saver clause excepts from the preemption clause those laws that "regulate[] insurance." (*Id.*, § 1144(b)(2)(A).) The deemer clause clarifies that an employee benefit plan cannot be deemed to be an insurance company or insurer subject to state laws purporting to regulate insurance. (*Id.*, § 1144(b)(2)(B); see *Pilot Life, supra,* 481 U.S. at p. 45.)

B. *Application of the ERISA Preemption Provisions to Cohen's Claims Against Health Net*

1. The Relate To Clause

Under the first ERISA preemption provision, Cohen's claims relate to an employee benefit plan. The term "relate to" is given "'its broad common-sense meaning'" so that a state law "'"relate[s] to"'" an employee benefit plan "'"in the normal sense of the phrase, if it has a connection with or reference to such a plan."'" (*Pilot Life, supra,* 481 U.S. at p. 47.) Put another way, a state law cause of action "that duplicates,

supplements, or supplants the ERISA civil enforcement remedy" is preempted. (*Davila, supra,* 542 U.S. at p. __ [124 S.Ct. at p. 2495].)

Cohen concedes his Health Net HMO plan is part of an employee benefit plan governed by ERISA. "ERISA's comprehensive regulation of employee welfare and pension benefit plans extends to those that provide 'medical, surgical, or hospital care or benefits' for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.'" (*New York Blue Cross v. Travelers Ins.* (1995) 514 U.S. 645, 650-651.) Cohen's claims against Health Net, though parsed into various causes of action, are that he was denied the benefit of his prepaid Health Net HMO plan and was wrongfully subjected to balance billing in violation of the terms and representations of that plan.

Such claims are covered by ERISA. In *Davila, supra,* 542 U.S. __ [124 S.Ct. 2488], two persons sued their respective HMO's in state court for refusing to cover certain medical expenses, allegedly in violation of a duty imposed by state law. (*Id.* at __ p. __ [124 S.Ct. at pp. 2492-2493].) The Supreme Court held the claims were completely preempted by ERISA. (*Id.* at p. __ [124 S.Ct. at p. 2492].) The court analyzed the complaints and determined the claims were based upon denials of coverage promised under the terms of ERISA-regulated employee benefit plans, and "interpretation of the terms of respondents' benefit plans forms an essential part of their [state law] claim." (*Id.* at p. __ [124 S.Ct. at p. 2498].)

Similarly here, Cohen's claims amount to an assertion of wrongful denial of benefits under the terms of his ERISA-regulated Health Net HMO plan and the wrongful conversion of his plan from a prepaid to a fee-for-service plan. These claims require interpretation of plan terms and seek injunctive relief. Cohen's claims duplicate ERISA's civil enforcement remedy, under which Cohen could have sued "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." (29 U.S.C. § 1132(a)(1)(B).) ERISA's equitable remedies include restitution of ill-gotten gain

(*Mertens v. Hewitt Associates* (1993) 508 U.S. 248, 260), the only monetary relief available to Cohen under his UCL cause of action (*Kraus v. Trinity Management Services, Inc.* (2000) 23 Cal.4th 116, 126-127).

2. The Saver Clause

The second ERISA preemption provision, the saver clause, applies to state laws specifically directed to the insurance industry and which "substantially affect the risk pooling arrangement between the insurer and the insured." (*Kentucky Assn. of Health Plans, Inc. v. Miller* (2003) 538 U.S. 329, 342.) Such laws are not preempted by ERISA.

Cohen's Health Net plan is an HMO plan, and within the UCL claim Cohen asserted violations of the Knox-Keene Act, Health and Safety Code section 1340 et seq., including violations of sections 1360, 1371.35, and 1379. Several cases have held the Knox-Keene Act does not constitute a state law regulating insurance excepted from ERISA, to the extent the Knox-Keene Act seeks to regulate employee benefit plans as part of its health care service legislation. (*Hewlett-Packard Co. v. Barnes* (9th Cir. 1978) 571 F.2d 502, 505, cert. den. (1978) 439 U.S. 831; see also *Kayes v. Pacific Lumber Co.* (9th Cir. 1995) 51 F.3d 1449, 1456; *Drummond v. McDonald Corp.* (1985) 167 Cal.App.3d 428, 432-433.)

We need not resolve the issue whether ERISA preempts the Knox-Keene Act as applied to Cohen's HMO plan.[1] As explained below in part III, Cohen's claims

[1] The Knox-Keene Act falls within the saver clause if the state law is "specifically directed toward entities engaged in insurance" and "substantially affect[s] the risk pooling arrangement between the insurer and the insured." (*Kentucky Assn. of Health Plans, Inc. v. Miller, supra,* 538 U.S. at p. 342.) The Knox-Keene Act is specifically directed to HMO's and other health care service plans (see Health & Saf. Code, § 1342), and its comprehensive regulations substantially affect the risk-pooling and risk-shifting arrangements between health care plans and their contracting entities (e.g., *id.*, §§ 1374.5, 1375.4, 1375.5, 1375.6, 1376, 1377, 1378, 1379; see also *California Medical Assn. v. Aetna U.S. Healthcare of California, Inc.* (2001) 94 Cal.App.4th 151, 162-163).

based on violations of the Knox-Keene Act either fall within the exclusive regulatory powers of the DMHC or are without merit under the undisputed facts.

Cohen's insurance bad faith claim does not come within the saver clause and therefore is subject to ERISA preemption. California's bad faith law is not a law specifically directed to the insurance industry, but developed from the common law doctrine finding an implied covenant of good faith and fair dealing in every contract. (*Pilot Life, supra*, 481 U.S. 41, 50-51 [claim under Mississippi bad faith law preempted by ERISA]; *Jabour v. CIGNA Healthcare of California, Inc.* (C.D.Cal. 2001) 162 F.Supp.2d 1119, 1127-1128 [California bad faith claim is not specifically directed toward insurance industry but is a product of general principles of tort and contract law]; see also 1 Witkin, Summary of Cal. Law (9th ed. 1987) Contracts, § 749.)

3. The Deemer Clause

Finally, under the deemer clause, the third ERISA preemption provision, Cohen's employee benefit plan is not deemed to be an insurance contract subject to California's laws regulating insurance. We therefore conclude Cohen's individual claims against Health Net are completely preempted by ERISA, except, arguably, for those claims based upon violations of the Knox-Keene Act, an issue we need not reach.

II. *COHEN CANNOT STATE A CLAIM UNDER ERISA.*

Cohen argues, as he did in opposing Health Net's motion for summary judgment, that ERISA preemption does not necessarily result in dismissal of his case and that the trial court should have recast his complaint as asserting ERISA claims. State courts have concurrent jurisdiction with federal courts over ERISA-based claims. (29 U.S.C. § 1132(e)(1).)

ERISA preemption does not entitle the defendant to dismissal of the plaintiff's claims when there is a possibility the complaint states a valid ERISA claim. (*Singh v. Prudential Health Care Plan, Inc.* (4th Cir. 2003) 335 F.3d 278, 292; *Andrews-*

Clarke v. Lucent Technologies, Inc. (D.Mass. 2001) 157 F.Supp.2d 93, 106.) The preempted state law claim should be recharacterized as a claim arising under federal law and assessed on the merits under federal law. (*Singh v. Prudential Health Care Plan, Inc., supra,* 335 F.3d at p. 292; see also *Commercial Life Ins. Co. v. Superior Court* (1988) 47 Cal.3d 473, 484-485 [ERISA preempted plaintiff's private cause of action under Insurance Code section 790.03, but plaintiff permitted to amend complaint to state claim for ERISA remedies].)

ERISA permits a participant or beneficiary to bring a civil action (1) "to recover benefits due to him under the terms of his plan," (2) "to enforce his rights under the terms of the plan," or (3) "to clarify his rights to future benefits under the terms of the plan." (29 U.S.C. § 1132(a)(1)(B).) "This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to 'enforce his rights' under the plan, or to clarify any of his rights to future benefits." (*Davila*, *supra*, 542 U.S. at p. __ [124 S.Ct. at p. 2496].)

"Any dispute over the precise terms of the plan is resolved by a court under a *de novo* review standard, unless the terms of the plan 'giv[e] the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" (*Davila*, *supra*, 542 U.S. at p. __ [124 S.Ct. at p. 2496].)

What benefits promised Cohen by Health Net under the terms of the HMO plan did Health Net fail to provide him? We cannot identify any. As part of his employee benefit plan, Cohen opted for a prepaid HMO plan, and that is what he received. Cohen's son Jeremy received emergency medical services at a hospital contracted to provide services to Health Net HMO members. Cohen paid only the applicable copayments for those emergency services.

Cohen contends he can state an ERISA claim because Health Net's actions amounted to a denial of his claims without notice to him with an explanation of benefits and grievance procedures, as required by Code of Federal Regulations, title 29, part 2560.503-1(e) and Health and Safety Code section 1371.35, subdivision (a). Health Net did not deny any claim. There was no evidence CA Em-1 submitted to Health Net the bills for services rendered Jeremy Cohen until after Cohen filed this lawsuit. As explained above, the account report printed by CA Em-1's billing service reflects only that an "on-demand form" had been printed for Health Net on December 1, 2001 and does not establish the form or any other kind of billing was sent to Health Net on that date. When ultimately presented with CA Em-1's bills, Health Net paid them. Cohen might have a complaint about CA Em-1's billing practices, but CA Em-1 is not part of Health Net, has no contractual relationship with it, and is not its agent. Health Net did not guarantee its members would not be subject to billing errors by service providers.

Cohen expressed his displeasure with Health Net by switching to a different health care plan. A declaration under ERISA to clarify his rights to future benefits under the terms of the Health Net HMO plan is therefore unnecessary.

III. *COHEN CANNOT OBTAIN RELIEF FOR ALLEGED VIOLATIONS OF THE KNOX-KEENE ACT.*

Cohen cannot recover for violations of the Knox-Keene Act, even assuming such claims are not preempted by ERISA, because his claims under the Knox-Keene Act either fall within the DMHC's exclusive regulatory powers or have no merit.

The Knox-Keene Act creates a distinct statutory enforcement scheme regulating HMO's. (*Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, 1299 (*Samura*).) "Business and Professions Code sections 17203 and 17200 do not confer on [plaintiff] a general power to enforce the act. This power has

been entrusted exclusively to the Department of Corporations,[2] preempting even the common law powers of the Attorney General. [Citations.] Among other things, the Department of Corporations has exclusive power to regulate the provisions of health service agreements of health maintenance organizations and the content of the required disclosure form and evidence of coverage pamphlets. [Citation.]" (*Ibid*.)

Cohen may not seek to enforce provisions of the Knox-Keene Act that govern the DMHC in the exercise of its regulatory powers. (*Samura, supra,* 17 Cal.App.4th at p. 1301.) The distinction between the Knox-Keene Act provisions defining unlawful acts (which may be enjoined) and those "having a purely regulatory import" (*Samura, supra,* at p. 1302) is significant: "[T]he courts cannot assume general regulatory powers over health maintenance organizations through the guise of enforcing Business and Professions Code section 17200." (*Id.* at pp. 1301-1302.)

Cohen contends Health Net violated Health and Safety Code sections 1360, 1371.35, 1379 and the corresponding regulations, California Code of Regulations, title 28, sections 1300.70, subdivision (b)(2)(H) and 1300.71.4, subdivision (a).

Health and Safety Code section 1360 prohibits untrue, misleading, or deceptive statements in advertising or soliciting participation in a health care service plan. Cohen contends Health Net violated section 1360 by representing in its preenrollment public marketing matrix and EOC that the plan member would receive a prepaid health plan and would be responsible only for a $50 copayment for emergency services. Although section 1360 defines an unlawful act and may be privately enforced (*Samura, supra,* 17 Cal.App.4th at p. 1300), the DMHC has the exclusive power to regulate the content of plan disclosure forms, materials containing information regarding benefits, and the terms of plan contracts (Health & Saf. Code, § 1361; see also *Samura,*

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[2] In July 2000, the Department of Corporations transferred its regulatory authority under the Knox-Keene Act to the DMHC. (*California Medical Assn. v. Aetna U.S. Healthcare of California, Inc., supra,* 94 Cal.App.4th at p. 162, fn. 12.)

supra, 17 Cal.App.4th at p. 1299). Further, the preenrollment matrix of services was issued by PacAdvantage, not Health Net. Cohen's claim of misrepresentation is therefore subject to the DMHC's exclusive regulatory power.

In addition, Cohen failed to submit evidence in the trial court showing Health Net made any untrue, misleading, or deceptive representations. Cohen paid only the applicable copayments for his son's emergency services and identified no situation where he was required to pay more than the applicable copayment for medical services under his Health Net HMO plan. CA Em-1 perhaps engaged in wrongful conduct by balance billing Cohen for services provided his son, but Cohen conceded Health Net made no guarantee he would not be subject to a provider's billing errors.

Health and Safety Code section 1379, subdivision (a) provides that "[e]very contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan." Even assuming section 1379 is not purely of regulatory import, we conclude Cohen failed to submit evidence establishing Health Net violated it. The contract between Health Net and Los Alamitos satisfies section 1379 by stating: "In no event . . . shall any Member be liable for any sums owed by HEALTH NET, and neither [Los Alamitos] nor any health care provider rendering services to Members pursuant to this Agreement shall bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any other recourse against a Member or other person acting on a Member's behalf." The provider services agreement between Health Net and Allied contains a similar provision stating Allied "agrees that in no event, including, but not limited to, non-payment by [Health Net] . . . shall [Allied] bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members" other than for the applicable copayments and for noncovered services.

Health and Safety Code section 1371.35 places limits on the time in which a health care service plan must pay claims. Section 1371.35, subdivision (a) provides, in part, "[a] health care service plan . . . shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is [an HMO], 45 working days after receipt of the complete claim by the health care service plan." If the health care service plan does not contest or deny the claim, and fails to timely pay the amount of the claim, the plan must pay the claimant a fee.[3] (*Id*., § 1371.35, subd. (b).)

Health and Safety Code section 1371.35 is of purely regulatory import.[4] If section 1371.35 created a private right of action, that right would only belong to a claimant. Cohen is not a claimant; he submitted no claim under section 1371.35 to Health Net. CA Em-1 ultimately submitted bills to Health Net for the emergency medical services provided Jeremy Cohen, and Health Net appears to have paid those bills within the statutory time frame. Cohen failed to controvert evidence establishing Health Net did not violate section 1371.35.

Finally, Cohen asserts violations of California Code of Regulations, title 28, sections 1300.70 and 1300.71.4. Section 1300.70, subdivision (b)(2)(H) provides a health care service plan that has capitation must "[e]nsure that each contracting provider has the administrative and financial capacity to meet its contractual obligations."

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[3] Health and Safety Code section 1371.35 does not apply to capitated payments. (*Id*., § 1371.35, subd. (i).) Health Net paid Long Beach IPA a monthly capitation payment for routine medical care, but agreed to reimburse Long Beach IPA in full for emergency room services provided Health Net members.

[4] In support of his motion for summary adjudication, Cohen submitted a letter to Health Net from the DMHC levying fines against Health Net for failure to pay claims from emergency care providers within the statutory time frame. The letter supports the conclusion that Health and Safety Code section 1371.35 is of purely regulatory import and the DMHC has exclusive power to enforce its requirements.

Section 1300.70 sets forth the Health Care Service Plan Quality Assurance Program and requires health care service plans to adopt quality assurance programs. The DMHC assesses these programs. (*Id*., § 1300.70, subd. (a)(4).) Section 1300.71.4, subdivision (a) provides that a health care service plan must pay for an enrollee's "immediate medically necessary health care services." These regulations have a purely regulatory import and their enforcement is the exclusive province of the DMHC.

Cohen argues *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782 (*Ochs*) supports his claims against Health Net for violations of the Knox-Keene Act. The plaintiff in *Ochs*, a provider of emergency room services akin to CA Em-1, sued PacifiCare of California, a health care service plan under the Knox-Keene Act, for violations of Health and Safety Code section 1371.4 for PacifiCare's failure to pay for emergency services the plaintiff provided PacifiCare's enrollees. (*Ochs, supra,* at pp. 787-788.) PacifiCare contracted with an IPA—Family Health Network (FHN)—to provide health care services to PacifiCare enrollees who chose FHN as their group medical provider. (*Ibid*.) The plaintiff did not have a contract with PacifiCare or FHN. (*Id.* at p. 788.) The plaintiff provided emergency services to PacifiCare enrollees covered by FHN and submitted the bills to FHN. (*Ibid.*) When FHN declared bankruptcy and was unable to pay the bills, the plaintiff sought payment directly from PacifiCare, which declined payment on the ground it was not financially responsible for services delegated to FHN. (*Ibid*.)

The plaintiff contended PacifiCare, by failing to pay the submitted charges, violated Health and Safety Code section 1371.4, subdivision (b), requiring a health care service plan to reimburse providers for emergency services to the plan enrollees until the care results in the patient's stabilization. (*Ochs*, *supra,* 115 Cal.App.4th at p. 789.) But PacifiCare delegated responsibility to reimburse emergency care providers to FHN under subdivision (e) of Health and Safety Code section 1371.4, and, as a result, was not obligated to reimburse the plaintiff for emergency services provided PacifiCare members,

notwithstanding FHN's bankruptcy. (*Ochs, supra,* at p. 789.*)* The Court of Appeal concluded, "a health care service plan is not statutorily obligated to pay for emergency services when it has delegated its payment responsibilities to a contracting medical provider that becomes insolvent and is unable to pay." (*Id*. at p. 787.) The plan might be liable to pay for emergency services when it has acted negligently in delegating its payment responsibilities. (*Ibid*.)

Cohen has no claim for negligent delegation, as suggested in *Ochs,* because Health Net did not delegate the obligation to reimburse professional emergency services to Allied or Los Alamitos. Rather, Health Net conceded its provider services agreement with Allied required Health Net to pay for professional emergency room services provided to Health Net members and their beneficiaries at Los Alamitos. When CA EM-1 ultimately sent the bills to Health Net, it paid them.

IV. *SUMMARY JUDGMENT WAS CORRECTLY GRANTED AGAINST COHEN ON HIS INDIVIDUAL CLAIMS AGAINST LOS ALAMITOS.*

Cohen sued Los Alamitos for fraud, unfair business practices under the UCL, declaratory and injunctive relief, intentional infliction of emotional distress, and negligence per se. Cohen's claims against Los Alamitos are not subject to ERISA preemption.

Cohen, in support of his non-UCL claims, argues Los Alamitos "coercively converted" his property and/or contractual interest in the liability limits of his Health Net HMO plan by balance billing him and other Health Net members as though no limitation existed.[5] Los Alamitos's billing practices, Cohen contends, violate both Health and

[5] As the bases for Cohen's UCL and False Advertising Act claims against Los Alamitos, Cohen asserts: (1) Los Alamitos's COS forms purport to make the patient/Health Net member fully liable for the entire cost of treatment and therefore violate Health and Safety Code section 1379; and (2) Los Alamitos, when contracting with CA EM-1, "did not pass on any prohibition against billing members. . . . [but] assigned its duty to supervise its E[mergency] R[oom] to defendant CA EM-1 . . . by contract which

Safety Code section 1379 and Los Alamitos's contract with Health Net, which permits Los Alamitos to bill Health Net members only for the applicable deductible or copayment or for noncovered services.

Los Alamitos did not as a matter of law convert any property or contract right created by Cohen's Health Net policy or deprive Cohen of his prepaid health plan benefits. Jeremy Cohen received emergency medical services from CA Em-1 physicians at Los Alamitos, and Los Alamitos never billed Cohen for those emergency services. CA Em-1, the emergency physicians group that treated Jeremy Cohen, sent Cohen the challenged billing statements. Cohen did not pay Los Alamitos anything other than the applicable copayments required by his Health Net HMO plan.

V. *COHEN LACKS STANDING TO PROSECUTE HIS UNFAIR COMPETITION LAW CLAIMS.*

Cohen, in addition to his personal claims, seeks relief on behalf of the general public pursuant to the UCL, Business and Professions Code section 17200 et seq. The UCL permits injunction and restitution remedies for "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising." (Bus. & Prof. Code, § 17200; see also *id.*, § 17203 [injunction and restitution remedies]; *Kraus v. Trinity Management Services, Inc.*, *supra,* 23 Cal.4th at pp. 126-127 [restitution is the only monetary relief available under the UCL].)

In November 2004, after Cohen filed this lawsuit, the voters of the State of California passed Proposition 64, repealing that portion of Business and Professions Code section 17204 permitting "any person acting for the interests of . . . the general public" to bring an action under the UCL. (Former Bus. & Prof. Code, § 17204.) We invited the parties to submit supplemental briefing on the issues whether Proposition 64 should be

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expressly contradicts the terms of [Health Net's] . . . EOC." We conclude in part V Cohen lacks standing to assert a claim under the UCL and the False Advertising Act.

applied in this case and what impact, if any, application of Proposition 64 has on Cohen's standing and claims. We have considered the parties' supplemental briefs directed to those issues.[6]

Proposition 64 modified Business and Professions Code sections 17204 and 17535 to permit the filing of an action for injunctive relief under the UCL or False Advertising Act only by certain public prosecutors or "any person who has suffered injury in fact and has lost money or property as a result of such unfair competition." (Bus. & Prof. Code, §§ 17204, 17535.) Proposition 64 modified sections 17203 and 17535 to authorize persons other than public prosecutors to pursue representative claims or relief on behalf of others only if the claimant meets the standing requirements of sections 17204 and 17535 and complies with the requirements for a class action under Code of Civil Procedure section 382. (Bus. & Prof. Code, §§ 17203, 17535.)

In *Frey v. Trans Union Corp.* (2005) 127 Cal.App.4th 986, 998, we joined those courts holding the amendments to the UCL and False Advertising Act enacted by Proposition 64 are to be applied to pending cases. (See *Lytwyn v. Fry's Electronics, Inc.* (2005) 126 Cal.App.4th 1455; *Benson v. Kwikset Corp.* (2005) 126 Cal.App.4th 887, 897-898; *Branick v. Downey Savings & Loan Assn.* (2005) 126 Cal.App.4th 828.)

Because Proposition 64 applies to pending cases, Cohen must have suffered an injury in fact and lost money or property as a result of the alleged unfair competition to have standing to prosecute this lawsuit. Health Net paid the bills from CA Em-1, Cohen no longer is a Health Net HMO member, and he paid nothing to Los Alamitos or CA Em-1 for his son's emergency medical treatments at Los Alamitos other than the applicable copayments. Cohen concedes he "contests the rulings on the [UCL] Cause of

[6] The request for judicial notice submitted with Health Net's supplemental brief is granted.

Action only in his representative capacity 'on behalf of the general public[,'] and not in his individual capacity."

Cohen contends he meets the standing requirements imposed by Proposition 64 because he paid premiums for a prepaid HMO insurance plan but did not receive one in return. He argues "respondents converted 3% of appellant's premiums from a *co*-payment health insurance policy, into a **'***down* payment' for emergency medical care while his son was on the gurney." Cohen received exactly what he paid premiums for: a prepaid HMO plan. He paid only the applicable copayments for his son's emergency medical treatment. Cohen also argues the dunning statements and telephone calls he received about the CA Em-1 bills resulted in injury. But, after Proposition 64, only a person who has suffered injury in fact *and* has lost money or property as a result of the alleged unfair competition has standing under the UCL.

Cohen does not seek leave to amend to substitute a plaintiff with standing or to allege class allegations. To the contrary, he asserted in his supplemental brief on Proposition 64 that "[n]o remand is needed for additional pleadings." We therefore affirm judgment on the UCL and False Advertising Act claims without leave to amend.

VI. *THE TRIAL COURT'S DISCOVERY RULINGS ARE AFFIRMED BECAUSE COHEN LACKED STANDING UNDER PROPOSITION 64 TO PROSECUTE A UCL CLAIM ON THE PUBLIC'S BEHALF.*

Cohen argues the trial court abused its discretion in denying him discovery on behalf of the general public.[7] Since we have concluded Cohen lacks standing under

[7] Cohen apparently challenges these orders: (1) order entered March 25, 2003, denying Cohen's motion to compel further answers to special interrogatories against Health Net; (2) order entered April 1, 2003, denying Cohen's motion to compel further responses to requests for production of documents against Los Alamitos; (3) order entered December 5, 2003, granting Los Alamitos's motion to quash 44 deposition subpoenas directed to other hospitals; and (4) order entered November 21, 2003, granting Health Net's motion for a protective order relieving it from answering 81 requests for admission regarding Health Net's capitation payments to its IPA's.

Proposition 64 to prosecute a UCL claim on the public's behalf, the trial court's discovery orders were not an abuse of discretion.

DISPOSITION

The judgment is affirmed. Respondents to recover costs incurred in this appeal.

FYBEL, J.

WE CONCUR:

RYLAARSDAM, ACTING P. J.

MOORE, J.

CERTIFIED FOR PARTIAL PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

ROBERT J. COHEN, Plaintiff and Appellant, v. HEALTH NET OF CALIFORNIA, INC., et al., Defendants and Respondents.	G033868 (Super. Ct. No. 02CC13219) ORDER MODIFYING OPINION, GRANTING REQUEST FOR PARTIAL PUBLICATION, DENYING PETITION FOR REHEARING; CHANGE IN JUDGMENT

It is ordered that the opinion filed herein on April 27, 2005, be modified as follows:

1. On page 1, in the first editorial paragraph beginning "Appeal from a judgment," delete the second sentence reading "Affirmed" and replace it with the following two sentences: "Award of discovery sanctions reversed. Otherwise affirmed in full."

2. On page 25, after the paragraph beginning "Cohen argues the trial court," under part VI, that continues from page 24, and before the section entitled "Disposition," insert two new paragraphs that read as follows:

> We agree with Cohen the issue of discovery sanctions is not moot. The trial court imposed sanctions of $2,050 against Cohen and his counsel on the ground they did not act with substantial justification in opposing Health Net's motion for a protective order as to requests for admission propounded by Cohen. In granting

Health Net's motion and imposing sanctions, the trial court stated the discovery was "outside the scope of permissible discovery in this case." The requests for admission arguably were relevant to Cohen's representative claims, which at that time Cohen had standing to pursue. Because Cohen acted with substantial justification in opposing Health Net's motion for a protective order, we believe the trial court abused its discretion in imposing sanctions.

Accordingly, the trial court's award of discovery sanctions in the amount of $2,050 against Cohen and his counsel is reversed.

3. On page 25, under the section entitled "Disposition," delete the first sentence reading "The judgment is affirmed" and replace it with the following two sentences: "The order awarding discovery sanctions in the amount of $2,050 against Cohen and his counsel is reversed. In all other respects, the judgment is affirmed."

Respondent Health Net of California, Inc., has requested that our opinion, filed April 27, 2005, be certified for partial publication. Pursuant to rules 976(b) and 976.1 of the California Rules of Court, the request for partial publication is granted. The opinion filed April 27, 2005, as modified herein, is ordered published in the Official Reports, except for parts IV, V, and VI of the section entitled "Analysis."

The petition for rehearing is DENIED.

This modification changes the judgment.

FYBEL, J.

WE CONCUR:

RYLAARSDAM, ACTING P. J.

MOORE, J.