SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

CALIFORNIA HOSPITAL ASSOCIATION, Plaintiff, v. BLUE CROSS OF CALIFORNIA dba ANTHEM BLUE CROSS, and DOES 1-100, inclusive, Defendants.	LASC Case No: 24STCV10193 COURT'S RULING AND ORDER RE: 1) DEFENDANT ANTHEM BLUE CROSS'S DEMURRER TO COMPLAINT; AND 2) MOTION TO STRIKE Hearing Date: February 21, 2025 Complaint Filed: April 23, 2024

I.

BACKGROUND

In this litigation, Plaintiff California Hospital Association ("CHA") has sued Defendant Blue Cross of California dba Anthem Blue Cross ("Anthem") over its alleged policy of failing to arrange for and authorize post-acute care.[1] Plaintiff CHA alleges that "[e]very day, Anthem

[1] Complaint, ¶1.

causes patients across California to languish in hospitals when they are ready for post-acute care. These patients are stranded in a hospital by Anthem without being able to receive post-acute care because Anthem refuses to arrange for and authorize that post-acute care: a specific skilled nursing facility ("SNF"), inpatient rehabilitation facility ("IRF"), behavioral health unit facility ("BHU"), long term care facility ("LTAC"), acute rehabilitation unit ("ARU") or home health care service ("Home Health")."[2]

CHA alleges that when Anthem fails to arrange for and authorize post-acute care, patients are forced to remain in the hospital needing additional acute care, and hospitals are forced to continue providing that care.[3] Per the complaint, California law requires Anthem to arrange for and authorize post-acute care for its members, and to not cease authorizing ongoing hospital acute care until Anthem has communicated with the member's treating provider and agreed upon a plan for alternative care.[4] CHA alleges that Anthem routinely fails to follow these laws.[5]

CHA alleges that when a patient is ready for post-acute care and Anthem fails to perform its obligations to make that care happen as required by law, the patient is not just inconvenienced: the patient is put in danger of long-term harm.[6] Different types of post-acute care are crucial to the patient's swift recovery; however, CHA alleges, a patient Anthem leaves in a hospital ends up not timely receiving post-acute care, thereby prolonging the patient's recovery time and sometimes even limiting the patient's ability to reach the optimal medical and

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[2] Complaint, ¶1.

[3] Complaint, ¶1.

[4] Complaint, ¶2.

[5] *Id.*

[6] Complaint, ¶3.

functional outcome.[7] Anthem's failure to arrange for post-acute services for these patients also allegedly harms other patients who need, but cannot access, hospital beds for acute care occupied by patients for whom Anthem should have authorized and arranged post-acute care, which would have allowed those patients to be discharged from the hospital.[8]

CHA alleges that Anthem simultaneously denies payment to the hospitals for the continued acute care the hospitals are forced to provide to these patients, thereby injuring not only the patients but also the hospitals.[9] Therefore, CHA alleges, California hospitals are forced to incur substantial unreimbursed expenses due to Anthem's failure to timely arrange for and authorize post-acute care.[10]

Anthem allegedly causes these problems by failing to arrange for and authorize the timely transfer of its members from hospitals to such post-acute facilities, failing to timely arrange for and authorize medically necessary Home Health services so that the patients can be discharged home, failing to locate available post-acute facilities that are willing and able to accept Anthem members who require post-acute care, failing to ensure that ongoing acute care is not discontinued until an appropriate treatment plan has been arranged in accordance with the medical determinations of the patient's treating provider, and otherwise failing to manage the care of its members who require post-acute care.[11] CHA alleges that these are all things that Anthem is legally obligated to do.[12]

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[7] *Id.*

[8] Complaint, ¶4.

[9] Complaint, ¶5.

[10] *Id.*

[11] Complaint, ¶6.

[12] *Id.*

Instead of complying with its legal obligations (arising under the Knox-Keene Act - Health & Safety Code §§1340, et seq., including §§1367.03(a)),[13] CHA alleges, Anthem foists onto hospital personnel Anthem's responsibility to perform these managed care tasks that California law requires of Anthem.[14] Anthem also allegedly fails to authorize or pay the hospitals for the ongoing additional acute care services the patients require when Anthem fails to arrange for post-acute care.[15]

Based on these allegations and the other allegations set forth in the Complaint, the CHA has alleged a single claim for violation of the California Unfair Competition Law ("UCL") (Bus. & Prof. Code §§17200, et seq.). Plaintiff seeks restitution, injunctive relief, and attorneys' fees.

Defendant CHA has demurred to the Complaint under CCP §430.10(a), and alternatively, seeks an order striking the prayer for restitution, injunctive relief, and attorneys' fees. For the reasons discussed *infra,* the demurrer is sustained, without leave to amend. The motion to strike is moot.

II.

REQUEST FOR JUDICIAL NOTICE

Plaintiff CHA requests judicial notice of the following exhibits:

Exhibit A: Statutes 1999, Chapter 539, Senate Bill No. 59;

Exhibit B: Proposed statutory amendments faxed by the California Association of Health Plans (CAHP) on December 22, 1999, titled "CAHP Clean-Up Amendments to SB 59 (Perata)," located in the "Author's File" of Senator Don Perata within the legislative-history materials submitted as Exhibit G (bookmarked under Exhibit A at "18. Author's File"), at consecutively numbered pages 614–619;

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[13] Complaint, ¶¶18-27.

[14] Complaint, ¶7.

[15] *Id.*

Exhibit C: Memorandum faxed by the Consumer Attorneys of California on February 15, 2000, titled "UR COMMENTS ON CAHP CLEAN-UP AMENDMENTS TO SB 59," located in the "Author's File" of Senator Don Perata within the legislative-history materials submitted as Exhibit G (bookmarked under Exhibit A at "18. Author's File"), at consecutively numbered pages 610–613;

Exhibit D: Statutes 2000, Chapter 1067, Senate Bill No. 2094 ;

Exhibit E: Screen capture of the Board of Directors page of the California Association of Health Plan's website from November 2000;

Exhibit F: Screen capture of the Member Health Plans of the Association page from the California Association of Health Plan's website from November 2000; and

Exhibit G: Declaration of Anna Maria Bereczky-Anderson of Legislative Intent Service, Inc., with attached compilation of legislative-history materials regarding Senate Bill No. 59, Chapter 539 (Statutes 1999).

Plaintiff's request for judicial notice is granted as to Exhibits A, D and G pursuant to Evidence Code §452(a).

The request is denied as to Exhibits B and C. *See People v. Patterson* (1999) 72 Cal.App.4th 438, 444 (declining to take judicial notice of letters written by interested parties to influence legislators, where those views were not communicated to the legislature as a whole).

The request is granted as to Exhibits E and F pursuant to Evidence Code §452(h). The Court's judicial notice of Exhibits E and F is limited to the existence of these pages and the Court does not judicially notice the truth of the matters set forth within these exhibits.

III.

PLAINTIFF'S OBJECTION TO NEW ARGUMENTS ON REPLY

Plaintiff has filed an objection to what it submits are new arguments raised by Defendant Anthem for the first time on reply – to wit:

1) that legislative history—the deletion of "deemed … authorization" language in paragraph (6) of Health and Safety Code section 1367.01, subdivision (h)—somehow shows that health plans are not subject to the requirement in paragraph (3) that "care shall not be discontinued";

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2) that the Legislature established a "safe harbor" for its practices, foreclosing liability under the Unfair Competition Law (UCL) (Bus. & Prof. Code, § 17200 et seq.); and

3) that the Department of Managed Health Care (DMHC) should consider under the doctrine of primary jurisdiction three (3) hypotheticals.

The objection is overruled. The Court has considered the arguments in ruling on the demurrer and motion to strike.

IV.

DEMURRER

Defendant Anthem has demurred to the sole cause of action alleged in the Complaint for violation of the California Unfair Competition Law ("UCL"), on several grounds. The Court takes the arguments in turn.

a. Failure to plead an unlawful practice

Defendant Anthem demurs to Plaintiffs' UCL claim, insofar as it premised on Anthem's alleged unfair or unlawful conduct.

"Unlike other states' Acts, the UCL permits a cause of action to be brought if a practice violates some other law. In effect, the 'unlawful' prong of §17200 makes a violation of the underlying law a *per se* violation of §17200." California Practice Guide, Bus. & Prof. C. §17200 Practice, ¶3:53 (The Rutter Group 2024) (referencing *Kasky v. Nike, Inc.* (2002) 27 Cal.4th 939, 950; *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 180; and *Farmers Ins. Exch. v. Sup.Ct.* (1992) 2 Cal.4th 377, 383). Significantly, §17200 allows a remedy even if the underlying statute confers no private right of action. *Stop Youth Addiction, Inc. v. Lucky Stores, Inc.* (1998) 17 Cal.4th 553, 561-567; *Committee on Children's Television, Inc. v. General Foods Corp.* (1983) 35 Cal.3d 197, 210-211; *California Med. Ass'n. v. Aetna U.S. Healthcare of Cal., Inc.* (2001) 94 Cal.App.4th 151, 169.

The UCL "unlawful" claim here is premised on violations of the Knox-Keene Act (codified at Health and Safety ("H&S Code") §§1342, et seq.). H&S Code §§1342 (a) and (b) provide:

> It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:
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> (a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.
>
> (b) Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace. See H&S Code §§1342(a), (b).

At ¶30, Plaintiff alleges:

> The Knox–Keene Act provides that Anthem cannot discontinue ongoing hospital acute care for a patient until the health plan has both notified the treating provider of its decision and a care plan has been agreed upon for the patient. Specifically, the statute requires:
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> "In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements: …
>
> (3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. **In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient**."
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> (Health & Saf. Code, § 1367.01, subd. (h)(3) (emphasis added).) This law precludes Anthem from unilaterally discontinuing authorization for ongoing acute care before there is an agreement between Anthem and the treating provider for post-acute care. But Anthem ignores this legal obligation.[16]

However, Plaintiff alleges, "Anthem consistently fails to arrange for post-acute care for

[16] Complaint, ¶30 (bold added by Plaintiff).

its members in several ways, yet simultaneously discontinues authorization and payment for the ongoing hospital care the hospital is forced to provide while the patient remains there. This causes both the patients and the hospital to suffer."[17] Anthem's alleged failures include:

> A. Anthem discontinues ongoing hospital acute care before it and the treating provider have agreed upon a care plan that is appropriate for the medical needs of the patient, including specifically identifying and approving where the patient will be going to receive post-acute care.
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> B. Anthem fails to identify, arrange for, and/or authorize a specific available post-acute facility that is available to accept the patient and that Anthem approves for that patient.
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> C. Anthem does not timely respond—or respond at all—to requests for authorization for post-acute care for its members and otherwise prolongs the concurrent review process.
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> D. For patients who require medically necessary Home Health upon discharge, Anthem fails to authorize and arrange for a Home Health agency to provide such Home Health to its members.[18]

According to Defendant Anthem, though, §1367.01(h)(3) prohibits *providers* (which, Anthem argues, are CHA's client hospitals) "from discontinuing care while a health plan completes its review of a request for authorization of covered health services."[19] Anthem argues that this is a "practical requirement to protect the patient: when a health plan, like Anthem, conducts concurrent review of the medical necessity of health care services, *the provider* must continue providing care until the health plan notifies the provider of the health plan's concurrent review decision. If the health plan, through concurrent review, concludes that the requested level of care is no longer authorized, *the provider* must continue providing care until 'a care plan has been agreed upon by the treating provider that is appropriate for the needs of that patient.'"[20]

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[17] Complaint, ¶31.

[18] Complaint, ¶31.

[19] Demurrer at 6:18-20.

[20] Demurrer at 6:20-7:4 (emphasis supplied by Defendant).

The issue for the Court to resolve is the breadth of §1367.01(h)(3). Does the statute apply equally to health plans, like Defendant Anthem and health care providers (such as the CHA's clients)? In other words, does §1367.01(h)(3) impose the obligation on health care service plans CHA argues it does, or does this obligation extend only to the provider (as opposed to the health care service plan)?

As Plaintiff argues, Anthem, as a health care service plan, is required to comply with the Knox-Keene Act. The Knox-Keene Act establishes a comprehensive system of licensing and regulation for health care service plans in California, which is overseen by the Department of Managed Health Care ("DMHC"). A health care service plan "shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. A plan shall establish and maintain networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard."[21] Additionally, a health care service plan "shall ensure that all plan and provider processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with this section."[22]

Any licensed health care service plan "shall ensure it has sufficient numbers of network providers to maintain compliance with the standards established by this section."[23] Any licensed health care service plan is required to "arrange for the provision of covered services from

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[21] Complaint, ¶19 (citing H&S Code §1367.03(a)(1)).

[22] Complaint, ¶20 (citing H&S Code §1367.03(a)(2)).

[23] Complaint, ¶21 (citing H&S Code §1367.03(a)(7)).

providers outside the plan's network if unavailable within the network if medically necessary for the enrollee's condition."[24]

Under the Knox-Keene Act, health care service plans must provide enrollees with access to quality health care services and protect and promote the interests of enrollees. *Rea v. Blue Shield of California* (2014) 226 Cal.App.4th 1209. Health care service plans are required to be licensed by the DMHC and must comply with various regulatory standards, including ensuring the financial stability of the system, *providing continuity of care*, and transferring the financial risk of health care from patients to providers. *Allied Anesthesia Medical Group, Inc.* (2022) 80 Cal.App.5th 794, 804.

Additionally, health care service plans must ensure that all processes necessary to obtain covered health care services are completed in a timely manner appropriate for the enrollee's condition and in compliance with the Knox-Keene Act. See 28 CCR §1300.67.2.2. The Act also requires plans to provide basic health care services, which include physician services, hospital inpatient services, diagnostic laboratory services, home health services, and preventive health services. *Rea v. Blue Shield of California, supra,* 226 Cal.App.4th 1209, 1215.

The Court finds section 1367.01(h)(3) applies to health plans like Anthem. This is so, given: 1) the policy promoting the importance of providing accessible and continuous health care services to enrollees, and 2) the express legislative intent "to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan" and "[e]nsuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care[.]" See H&S Code §1342 and

[24] Complaint, ¶22 (citing H&S Code §1367.03(a)(7)(C)).

subsection (g). Additionally, §1367.01(h) makes clear that "[i]n determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity", the section imposes the requirements under subsections 1-6 on "a health care service plan subject to this section[.]" H&S Code §1367.01(h).

The allegation in the Complaint is that Defendant Anthem, as a health care services plan, is not abiding by its obligation, with respect to "case[s] of *concurrent review*", as alleged at ¶30 (emphasis added). In such cases, the statute makes clear that "care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision *and* a care plan *has been agreed upon* by the treating provider that is appropriate for the medical needs of that patient." While a health plan may ultimately not be responsible for providing those services in dispute, the Court emphasizes that the litigation is at the pleading stage. The extent of any alleged UCL violation(s), premised on alleged underlying Knox-Keene Act violations (as alleged at ¶31, ¶34 [the specific examples of Patients One through Four], and elsewhere in the Complaint), is a factual determination.

At the pleading stage, the Court finds that Plaintiff CHA has stated an underlying basis for a UCL "unlawful" violation, premised on the requirements of the Knox-Keene Act.

b. Failure to plead an unfair practice

Defendant Anthem also argues Plaintiff CHA has failed to plead an unfair practice. In *Camacho v. Automobile Club of Southern California* (2006) 142 Cal.App.4th 1394, 1403, the Court applied the following test for an "unfair" UCL claim by a consumer: (1) the consumer injury must be substantial; (2) the injury must not be outweighed by any countervailing benefits to consumers or competition; and (3) it must be an injury that consumers themselves could not reasonably have avoided. *See also Klein v. Chevron U.S.A., Inc.* (2012) 202 Cal.App.4th 1342,

1376 (citing *Camacho*).

Other courts have determined that the definition of "unfair" under the UCL is uncertain. *Durell v. Sharp Healthcare* (2010) 183 Cal.App.4th 1350, 1364. However, the *Durell* court adopted the following definition of "unfair" in the context of UCL, non-competitor actions: "'[t]o show a business practice is unfair, the plaintiff must show the conduct 'threatens an incipient violation of an antitrust law, or violates the policy or spirit of one of those laws because its effects are comparable to or the same as a violation of the law, or otherwise significantly threatens or harms competition.'" *Durell,* 183 Cal.App.4th at 1366 (citing *Byars v. SCME Mortgage Bankers, Inc.* (2003) 109 Cal.App.4th 1134, 1147. *See also Scripps Clinic v. Superior Court* (2003) 108 Cal.App.4th 917, 940 ("'where a claim an unfair act or practice is predicated on public policy, we read *Cel-Tech* to require that the public policy which is a predicate to the action must be "tethered" to specific constitutional, statutory or regulatory provisions'") (citing *Gregory v. Albertson's, Inc.* (2002) 104 Cal.App.4th 845, 854).

However, the Second District has consistently followed the *Camacho* definition for consumer claims. *See Rubenstein v. The Gap, Inc.* (2017) 14 Cal.App.5th 870, 880; *Klein, supra; Davis v. Ford Motor Credit Co.* (2009) 179 Cal.App.4th 581, 584, 594-597; *Daugherty v. American Honda Motor Co., Inc.* (2006) 144 Cal.App.4th 824, 838-839.

The "unfair" standard is intentionally broad, allowing courts maximum discretion to prohibit new schemes to defraud. California Practice Guide, Bus. & Prof. Code §17200 Practice, ¶3:113 (The Rutter Group 2024) (citing *Motors, Inc. v. Times Mirror Co.* (1980) 102 Cal.App.3d 735, 740 and *Bank of the West v. Sup. Ct.* (1992) 2 Cal.4th 1254, 1266-1267).

According to Defendant Anthem, Plaintiff CHA cannot, as a matter of law, allege an "unfair" UCL claim because Anthem is neither a "consumer" nor a "competitor" of CHA. Two unpublished federal cases suggest one must be a "consumer" or a "competitor" to state a UCL

unfair violation (*Ctr. for Neuro Skills v. Blue Cross of Cal.*, No. 1:13-CV-00743-LJO-JLT, 2013 WL 56709889 at *26-27 (E.D. Cal. Oct. 15, 2013) and *Almasi v. Equilon Enters.*, LLC (N.D. Cal. Sept. 10, 2012) No. 5:10-cv-03458 EJD, 2012 WL 3945528 at *26-27). Additionally, in *Linear Technology Corp. v. Applied Materials, Inc.* (2007) 152 Cal.App.4th 115, 135, the Court of Appeal affirmed the trial court's dismissal of a UCL "unfair" claim on grounds the alleged victims were "neither competitors, nor powerless, unwary consumers".

However, in *California Medical Ass'n. v. Aetna Health of California, Inc.* (2023) 14 Cal.5th 1075, the California Supreme Court reversed the Court of Appeal's affirming a trial court's ruling that the plaintiff did not have standing to bring its UCL claim. While the case deals in large part with the concept of organizational and association standing under the UCL (concepts more thoroughly discussed below), the case significantly let stand the plaintiff's UCL claims in full. The plaintiff in the *CMA* case was neither a consumer, nor a direct competitor of Aetna Health; the CMA (a professional association representing California physicians) is akin to the CHA here (an association representing more than 400 hospitals throughout California – see Complaint, ¶10). Therefore, despite the fact that Plaintiff CHA has not alleged it is a consumer or a competitor with Defendant Anthem, it may still allege a UCL "unfair" claim. Ultimately, there is no definitive limitation under California law to whether one must actually be a consumer or a competitor to allege a UCL "unfair" claim. Since the Court must, at the pleading stage, allow a claim to survive if it states a cause of action under "any" theory (see *Quelimane Co. v. Stewart Title Guaranty Co.*, *supra,* 19 Cal.4th at 38), the demurrer to the UCL "unfair" claim on this ground is not well-taken.

c. Injunctive relief

Next, Defendant Anthem demurs to the prayer for injunctive relief. The prayer seeks an

injunction enjoining Anthem from:

> A. Denying or discontinuing authorization or payment for ongoing hospital acute care through discharge without first reaching an agreement with the provider on the plan for post-acute care;
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> B. For patients who require care in a post-acute facility, denying or discontinuing authorization or payment for ongoing hospital acute care through discharge, unless and until Anthem has arranged for the transfer of the member to a specific post-acute facility and has authorized the post-acute facility to take the patient; [and]
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> C. For patients who require Home Health services, denying or discontinuing authorization or payment for ongoing hospital acute care through discharge, unless and until Anthem has arranged for and authorized the Home Health care services[.][25]

"Section 17203 makes injunctive relief 'the primary form of relief available under the UCL,' while restitution is merely 'ancillary.'" *Clayworth v. Pfizer, Inc.* (2010) 49 Cal.4th 758, 790 (citing *In re Tobacco II Cases* (2009) 46 Cal.4th 298, 319)). "Nothing in the statute's language conditions a court's authority to order injunctive relief on the need in a given case to also order restitution. Accordingly, the right to seek injunctive relief under section 17200 is not dependent on the right to seek restitution; the two are *wholly independent remedies*." *Clayworth v. Pfizer, Inc.*, 49 Cal.4th at 790 (emphasis added).

Defendant Anthem argues that injunctive relief is not appropriate because the purported "discharge failures" CHA describes in the Complaint are fact-dependent disputes for which monetary relief is adequate. These are "manufactured injuries," according to Defendant Anthem, and that "CHA seeks a preemptive determination that the ongoing acute care *its client hospitals* provide is medically necessary as a matter of law, regardless of the clinical facts."[26]

While an injunction may be granted "[w]hen pecuniary compensation would not afford adequate relief" (see CCP §526(a)(4)), it is not at all clear at this time that this is, in fact, the

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[25] Complaint, ¶41.

[26] Demurrer at 10:12-14.

case. Defendant would have the opportunity, following discovery, to raise this argument in opposing any sought injunction (or at trial). Presently, though, the Court again emphasizes this litigation is only at the pleading stage. Whether the Court can, or should, issue an injunction under the UCL (as set forth at ¶41 of the Complaint) cannot be resolved at this time.

d. Standing

Defendant Anthem argues that Plaintiff CHA has not, and cannot, allege UCL standing.

In *California Medical Assn. v. Aetna Health of California, Inc., supra,* 14 Cal.5th 1075, the California Supreme Court addressed the concept of standing and the "injury in fact" requirement, as it relates to whether an organization can satisfy these requirements "by diverting its own resources to combat allegedly unfair competition." *California Medical Assn. v. Aetna Health of California, Inc.,* 14 Cal.5th at 1082. The Court stated:

> We hold that the UCL's standing requirements are satisfied when an organization, in furtherance of a bona fide, preexisting mission, incurs costs to respond to perceived unfair competition that threatens that mission, so long as those expenditures are independent of costs incurred in UCL litigation or preparations for such litigation. When an organization has incurred such expenditures, it has "suffered injury in fact" and "lost money or property as a result of the unfair competition." (§ 17204.) *California Medical Assn.,* 14 Cal.5th at 1082.

In so holding, the California Supreme Court determined that "[t]his is not a case of an organization attempting to manufacture standing and insert itself into a dispute in which it had no natural stake. While voluntary in one sense — CMA, like many other organizations, is free to set its own budgetary priorities — its decision to expend resources on working to counter the perceived threat in Aetna's policy followed from that policy in a sufficiently direct and uninterrupted causal chain." *California Medical Assn.* at 1100.

With respect to UCL standing, Plaintiff CHA alleges in applicable part as follows:

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> 15. CHA has standing to bring this action under the UCL for the reasons stated in *California Medical Assn. v. Aetna Health of California Inc.* (2023) 14 Cal.5th 1075, 1082: "[T]he UCL's standing requirements are satisfied when an organization, in furtherance of a bona fide, preexisting mission, incurs costs to respond to perceived unfair competition that threatens that mission, so long as those expenditures are independent of costs incurred in UCL litigation or preparations for such litigation. When an organization has incurred such expenditures, it has 'suffered injury in fact' and 'lost money or property as a result of the unfair competition.'"
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> 16. CHA's pre-existing mission includes more accessible health care for all Californians and representing the interests of California member hospitals in that endeavor. CHA's mission has been frustrated by Anthem's unlawful and unfair conduct described in this lawsuit. CHA has incurred expenditures of staff time, as well as expenditures of money, investigating Anthem's conduct and its impact on hospitals and the delivery of health care in California, learning from CHA's members about Anthem's conduct and its impact, and educating CHA's members about Anthem's conduct and its impact.
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> 17. These efforts by CHA include, without limit, conducting a comprehensive survey in 2023 to better understand how discharge failures by health plans, including Anthem, regarding post-acute care play out in California. This survey gathered data from three settings: emergency departments, general acute care hospitals, and inpatient acute psychiatric hospitals. The survey asked respondents to provide information about the extent of patient discharge failures, contributing factors to these failures, and the impact of these failures on patients and the hospitals....[27]

At the pleading stage, the Court finds these allegations are sufficient to meet the standard enunciated in *California Medical Association*. Plaintiff CHA has alleged that it has incurred costs with respect to conducting the survey, incurring expenditures of staff time, expenditures investigating Anthem's conduct and impact on hospitals and the delivery of health care of California. Such expenditures, at the pleading stage, would qualify as those "independent of costs incurred in UCL litigation or preparations for such litigation" under *California Medical Association*.

Additionally, whether CHA's response to Anthem's alleged practices was foreseeable or not (as discussed in *CMA*) presents a factual issue which cannot be resolved on demurrer. In any event, the Court determines Plaintiff CHA has alleged a foreseeable economic injury stemming

[27] Complaint, ¶¶15-17.

from Defendant Anthem's practices.

For these reasons, the Court finds that Plaintiff has adequately pled standing under the UCL, consistent with *California Medical Association.*

e. Abstention

Defendant Anthem argues that, in any event, the Court should equitably abstain from hearing this case. Under California law, the doctrine of equitable abstention allows a court to abstain from adjudicating a suit that seeks equitable remedies under certain conditions. These conditions include:

> 1. When granting the requested relief would require a trial court to assume the functions of an administrative agency or interfere with the functions of an administrative agency (see *Hambrick v. Healthcare Partners Medical Group, Inc.* (2015) 238 Cal.App.4th 124; *Shuts v. Covenant Holdco LLC* (2012) 208 Cal.App.4th 609);
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> 2. When the lawsuit involves determining complex economic policy, which is best handled by the Legislature or an administrative agency (*Hambrick, supra,* 238 Cal.App.4th 124; *Klein v. Chevron USA, Inc.* (2012) 202 Cal.App.4th 1342); and
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> 3. When granting injunctive relief would be unnecessarily burdensome for the trial court to monitor and enforce, given the availability of more effective means of redress. *Klein, supra,* 202 Cal.App.4th 1342; *People ex rel. Elliott v. Kaiser Foundation Health Plan, Inc.* (2024) 105 Cal.App.4th 1114.

Additionally, judicial abstention is generally appropriate only if there is an alternative means of resolving the issues raised in the action. *People ex rel. Elliott, supra,* 105 Cal.App.4th at 1114; *Olson v. Hornbrook Community Services District* (2021) 68 Cal.App.5th 260. This doctrine is often applied in cases involving the UCL where the relief sought would drag a court of equity into an area of complex economic policy. *Shamsian v. Department of Conservation* (2006) 136 Cal.App.4th 621; *Feitelberg v. Credit Suisse First Boston, LLC* (2005) 134 Cal.App.4th 997.

In this case, Anthem argues equitable abstention is appropriate because "CHA is asking the Court to encroach on authority that the California legislature entrusted to the DMHC" and

that there are "ample alternative means to address this issue, including through DMHC enforcement actions and pursuant to contract-based dispute provisions in Anthem's contracts with hospitals."[28]

First, Anthem argues that CHA is effectively seeking a mandatory injunction that would usurp the DMHC's rulemaking and enforcement authority over complex policy issues. Turning again to the allegations of the Complaint, Plaintiff alleges at ¶36:

> Anthem has engaged in unlawful and unfair business acts and practices by failing to comply with the Knox–Keene Act provisions and regulations cited above. This harms California hospitals as well as other patients by (a) forcing the hospitals to use inpatient acute beds for patients who could and should be moved by Anthem to post-acute care; (b) preventing hospitals from admitting other patients who require acute care services during times of hospital space constraints; and (c) failing to pay hospitals for the additional acute care that Anthem forced the patients to need.[29]

The sought injunction seeks to "prohibit[] Anthem from continuing to engage in the wrongful actions listed above, including, but not limited to:

> A. Discontinuing authorization or payment for ongoing hospital acute care through discharge without first reaching an agreement with the treating provider (i.e., the hospital and physician) on the plan for post-acute care;
>
> B. For patients who require care in a post-acute facility, discontinuing authorization or payment for ongoing hospital acute care through discharge, unless and until Anthem has arranged for the transfer of the member to a specific post-acute facility and has authorized the post-acute facility to take the patient;
>
> C. For patients who require Home Health services, discontinuing authorization or payment for ongoing hospital acute care through discharge, unless and until Anthem has arranged for and authorized the Home Health care services.[30]

The question becomes whether the Complaint satisfies any of the three conditions referenced above: 1) whether the relief here would require the Court to assume the functions of an administrative agency (in this case, DMHC) or interfere with DMHC's functions; 2) whether

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[28] Demurrer at 15:13-16.

[29] Complaint,¶36.

[30] Complaint,¶39.

this lawsuit involves determining complex economic policy, which is best handled by the Legislature or DMHC; or 3) whether granting Plaintiff's injunction here would be unnecessarily burdensome for this Court to monitor and enforce, given the availability of more effective means of redress.

Here, the Court finds that the requested relief, as framed by the allegations of the Complaint, would require the Court to assume the DMHC's functions or, at best, to interfere with those functions. The Court would be required to assess whether, in a given circumstance or set of circumstances, Anthem violated the Knox-Keene Act by failing to arrange for and authorize care at a specific post-acute facility (or Home Health care services). Such determinations are within the purview of DMHC's authority.

Under H&S Code §1341(c), the director of the DMHC is "responsible for the performance all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws described in subdivision (a)." H&S Code §1341(c).

H&S Code §1341(a), in turn, creates the DMHC, which "has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees." See H&S Code §1341(a).

DMHC also has authority over the myriad other provisions cited in the Complaint. For example, the Complaint alleges a litany of Anthem's legal obligations "to arrange for and authorize care for its members under California law," including:

1) the requirement that a health care service plan "shall provide or arrange for the

provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. A plan shall establish and maintain networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard." (Health & Saf. Code § 1367.03, subd. (a)(1).)

2) the requirement that the plan "shall ensure that all plan and provider processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with this section." (Health & Saf. Code § 1367.03, subd. (a)(2).)

3) the requirement that the plan "shall ensure it has sufficient numbers of network providers to maintain compliance with the standards established by this section." (Health & Saf. Code, § 1367.03, subd. (a)(7).)

4) the requirement that the plan must "arrange for the provision of covered services from providers outside the plan's network if unavailable within the network if medically necessary for the enrollee's condition." (Health & Safety Code § 1367.03(a)(7)(C).).

5) the requirement that the plan provide "basic health care services" which include Home Health services. (See Health & Saf. Code, § 1367, subd. (i).)

6) the requirement that the plan provide essential health benefits which include skilled nursing facility services, durable medical equipment, and rehabilitative services, such as physical, occupational and speech therapy. (See Cal. Code Regs., title 22, § 1300.67.005(d)(10).)

7) the requirement that the plan ensure that "[a]ll services shall be readily available at reasonable times to each enrollee consistent with good professional practice." (Health & Saf. Code, § 1367, subd. (e)(1).)

8) the requirement that the plan "shall have the organizational and administrative capacity to provide services to subscribers and enrollees." (Health & Saf. Code, § 1367, subd. (g).)

9) the requirement that the plan "operating in a network service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring an enrollee to, or, in the case of a preferred provider network, by assisting an enrollee to locate available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs." (Health & Saf. Code, § 1367.03, subd. (a)(7)(B).)[31]

The allegations of the Complaint, for all intents and purposes, reflect Plaintiff's view that Defendant Anthem has abdicated these responsibilities. The regulation of such responsibilities,

[31] Complaint,¶¶19-27.

again, are within the purview of DMHC's authority. Indeed, H&S Code §1367.01(h)(6) specifically provides that "[i]f the director [of the DMHC[32]] determines that a health care service plan has failed to meet any of the timeframes in this section, *or has failed to meet any other requirement of this section*, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397." H&S Code §1367.01(h)(6).

This Court would be required to assess compliance with the above provisions and, relatedly, whether the equitable relief provided for under the UCL is appropriate. Importantly, "courts cannot assume general regulatory powers over health maintenance organizations through the guise of enforcing Business and Professions Code section 17200." *Alvarado v. Selma Convalescent Hospital* (2007) 153 Cal.App.4th 1292, 1299. The concern expressed by the *Alvarado* court is present through the instant litigation.

The Court is not persuaded by Plaintiff's argument that abstention is not appropriate here because "'resolution of the issues involves solely the judicial function of resolving questions of law based on facts before the court.'"[33] The allegations of the Complaint would not involve solely the Court's question of resolving questions of law based on facts before the Court. As discussed above, the Court would be required to assume DMHC's general regulatory power over health care service plans. The relief sought would also require the Court to determine complex economic policy with respect to the Complaint's allegations. Finally, the Court determines that granting the injunction prayed for here would be unnecessarily burdensome for this Court to

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[32] H&S Code §1341(b) identifies the chief officer of the DMHC as the "Director" of the DMHC, who "shall be appointed by the Governor and shall hold office at the pleasure of the Governor." H&S Code §1341(b).

[33] Opposition at 19:11-13 (citing *People ex rel. Elliott v. Kaiser Foundation Health Plan* (2024) 105 Cal.App.5th 1114, 1132 and *Hambrick v. Healthcare Partners etc.* (2015) 238 Cal.App.4th 124, 152).

monitor and enforce, given the availability of more effective means of redress before DMHC itself.

People ex rel. Elliott, supra, 105 Cal.App.4th 1114 is factually distinguishable from the instant litigation. There, the Court of Appeal reversed the trial court's order abstaining from adjudicating the UCL claim of the plaintiff (People of the State of California, acting by and through the San Diego City Attorney) against Defendant Kaiser Foundation Health Plan. The plaintiff in *People ex rel. Elliott* alleged that Kaiser "had failed to maintain and update accurate PDs [provider directories for defendant's health plans], setting forth information regarding a health plan's providers" as required by H&S Code §1367.27. *People ex rel. Elliott*, 105 Cal.App.4th at 1120.

In reversing the trial court's order granting summary judgment on equitable abstention grounds, the Court of Appeal analyzed each of the three considerations referenced above proffered by the defendant for equitable abstention.

As to the first factor, the Court of Appeal rejected the defendant's argument that only the DMHC had the regulatory power to enforce §1367.27's "clear requirements for PD accuracy"; such authority, the Court of Appeal concluded, was complementary to a UCL cause of action. *People ex rel. Elliott* at 1134. Additionally, the Court of Appeal concluded that enforcing §1367.27's PD accuracy requirements would not assume, or interfere with, the regulatory functions of DMHC. *Id.*

With respect to the second factor of the analysis, the Court of Appeal addressed H&S Code §1367.27, and concluded the statute imposed "clear requirements for PD accuracy." *People ex rel. Elliott* at 1137. The Court emphasized that "in simply adjudicating the People's UCL cause of action based on Kaiser's alleged violation of those clear statutory requirements, the court would not be making *any* economic or other policy determinations. It would merely be

enforcing the policy judgments already made by the Legislature." *Id.* Thus, the Court of Appeal concluded, the "complex economic policy" factor did not rationally support the trial court's decision to abstain. *Id.*

Finally, as to the third factor, the Court of Appeal concluded that the plaintiff's sought remedy "simply requests an injunction and, in so doing, does not request any ongoing monitoring of Kaiser's future conduct." *People ex rel. Elliott* at 1137. The Court of Appeal, in reasoning that this factor of the analysis was not satisfied, stated that "the trial court would have the ability to fashion an injunction that, for example, simply prohibits future violations by Kaiser of section 1367.27's PD accuracy requirements, which could be identified by reference to specific subdivisions of section 1367.27." *Id.* at 1138.

Unlike *People ex rel. Elliott,* this is not a case of an alleged straightforward violation of an underlying provision of the Health and Safety Code, with established parameters. Again, the Court determines that the Complaint and prayed injunction would require this Court to essentially usurp the functions of DMHC, drag the Court into an area of complex economic policy, and would be unnecessarily burdensome for the Court.

For all of these reasons, equitable abstention is appropriate, and the demurrer based on this ground is sustained, without leave to amend. The Court is not persuaded by Plaintiff's argument that any amendment would eliminate any of the three conditions for equitable abstention discussed above.[34]

[34] At the Court's hearing, counsel for Plaintiff, for the first time, submitted a document (initially dating from March 31, 2006, with its last revision on September 9, 2015) entitled "State-Specific Addendum for California." Counsel did not provide this document to Defendant in advance of the hearing, and counsel has not provided an adequate explanation for why this document was not submitted as part of the Plaintiff's briefing opposing the demurrer and motion to strike. Therefore, the Court has exercised its discretion and not considered this document in issuing its ruling. *See Jack v. Ring LLC* (2023) 91 Cal.App.5th 1186, 1210; CCP §1005(b). Defendant formally objected at the hearing to the Court considering the document, and that objection is sustained.

V.

RULING AND ORDER

For the foregoing reasons, the demurrer is sustained, without leave to amend, on grounds of equitable abstention. The motion to strike is moot.

Defendant Anthem Blue Cross shall submit a proposed judgment forthwith. Plaintiff shall have ten (10) days to object to the form of said judgment.

Dated: February 27, 2025

KENNETH R. FREEMAN

Kenneth Freeman
Judge of the Superior Court