63 Cal.4th 148
Supreme Court of California

Kathleen A. **WINN**, et. al, Plaintiffs and Appellants,

v.

PIONEER MEDICAL GROUP, INC., et. al, Defendants and Respondents.

No. S211793.
May 19, 2016.

Synopsis

Background: Deceased patient's children brought action against physicians for elder abuse. The Superior Court, Los Angeles County, No. BC455808, Joanne B. O'Donnell, J., sustained demurrer without leave to amend. Patient's children appealed. The Court of Appeal reversed and remanded. Physicians petitioned for review. The Supreme Court granted review, superseding the opinion of the Court of Appeal.

Holdings: The Supreme Court, Cuéllar, J., held that:
1 a claim of neglect under the Elder Abuse Act requires significant responsibility for attending to one or more of those basic needs of the elder or dependent adult that an able-bodied and fully competent adult would ordinarily be capable of managing without assistance, disapproving *Mack v. Soung*, 80 Cal.App.4th 966, 95 Cal.Rptr.2d 830, and
2 physicians who treated patient at outpatient clinics did not have "care or custody" required for "neglect" of patient under Elder Abuse Act.

Reversed and remanded.

Opinion, 157 Cal.Rptr.3d 124, superseded.

West Headnotes (13)

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Opinion

CUÉLLAR, J.

*152 **1013 The Elder Abuse and Dependent Adult Civil Protection Act affords certain protections to elders and dependent adults. Section 15657 of the Welfare and Institutions Code provides heightened remedies to a plaintiff who can prove "by clear and convincing evidence that a defendant is liable for physical abuse as defined in Section 15610.63, or neglect as defined in Section 15610.57," and who can demonstrate that the defendant acted with "recklessness, oppression, fraud, or malice in the commission of [this] abuse." Section 15610.57, in turn, defines "neglect" in relevant part as " [t]he negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise." (Welf. & Inst.Code § 15610.57, subd. (a)(1).)

We granted review to determine whether the definition of neglect under the Elder Abuse and Dependent Adult Civil Protection Act (Welf. & Inst.Code § 15600 et seq.; the Elder Abuse Act or Act) [1] applies when a health care provider—delivering care on an outpatient basis—fails to refer an elder patient to a specialist. What we conclude is that the Act does not apply unless the defendant health care provider had a substantial caretaking or custodial relationship, involving ongoing responsibility for one or more basic needs, with the elder patient. It is the nature of the elder or dependent adult's relationship with the defendant—not the defendant's professional standing—that makes the defendant potentially liable for neglect. Because defendants did not have a caretaking or custodial relationship with the decedent, we find that plaintiffs cannot adequately allege neglect under the Elder Abuse Act.

I. BACKGROUND

This case involves the Court of Appeal's reversal of a trial court order sustaining defendants' demurrer. In considering whether that demurrer should have been sustained, we treat the demurrer as an ***450 admission by defendants of all material facts properly pled in plaintiffs' first amended complaint—but not logical inferences, contentions, or conclusions of fact or law. (*Evans v. City of Berkeley* (2006) 38 Cal.4th 1, 6, 40 Cal.Rptr.3d 205, 129 P.3d 394.)

Plaintiffs Kathleen A. **Winn** and Karen Bredahl allege the following facts. They are the daughters and surviving heirs of Elizabeth M. Cox. As early as *153 November 2000, Mrs. Cox sought medical care on an outpatient basis at the facilities of **Pioneer** Medical Group, Inc. (**Pioneer**) and received treatment from Dr. Csepanyi, a medical doctor working at **Pioneer** and another named defendant. In 2004, Dr. Lowe, a podiatrist and one of the named defendants in this case, treated Mrs. Cox for "painful onychomycosis," a condition **1014 that may limit mobility and impair peripheral circulation. Dr. Lowe recorded pulses that reflected impaired vascular flow in the lower legs, and sent a copy of his report to Dr. Csepanyi.

In January and February 2007, Mrs. Cox's lower extremity vascular symptoms worsened, and in February 2007, Dr. Csepanyi diagnosed Mrs. Cox with peripheral vascular disease. In December 2007, Dr. Lowe evaluated Mrs. Cox and found a reduced pulse in her extremities. He advised her to return for a follow-up visit in two months, but did not refer her to a vascular specialist. In February 2008, Dr. Lowe found an abscess and cellulitic changes, both of which are consistent with tissue damage resulting from vascular insufficiency. Dr. Lowe drained the infection, prescribed medication, and recommended another follow-up appointment, but again did not refer Mrs. Cox to a specialist.

When Dr. Csepanyi examined Mrs. Cox in July 2008, he found that she still suffered from peripheral vascular disease. He saw her a month later but did not perform a vascular examination. After suffering a laceration on her right foot in December 2008, Mrs. Cox sought treatment from Dr. Lee—another podiatrist at **Pioneer**—who prescribed antibiotics and instructed Mrs. Cox to return for follow-up treatment in January 2009. Mrs. Cox returned to Dr. Lee in January 2009, but the wound had not healed and Mrs. Cox saw Dr. Csepanyi later that month. She noted the wound was painful and Dr. Csepanyi recommended medication and foot soaks. The following

month, Dr. Csepanyi diagnosed cellulitis of the toes, cyanosis, and a toe abscess, all of which point to cellular deterioration and tissue destruction from peripheral vascular ischemia.

Mrs. Cox saw Dr. Lowe four times in February and March 2009. Dr. Lowe noted that Mrs. Cox suffered from chronic nondecubitus ulcer of the toes, caused by vascular compromise. He recommended topical cream and a special shoe, but did not refer Mrs. Cox to a specialist. During two visits, Dr. Lowe reported that he could not feel a pulse in Mrs. Cox's feet. On March 18, 2009, Mrs. Cox saw Dr. Csepanyi. Dr. Csepanyi noted that Mrs. Cox had suffered abnormal weight loss, but also failed to refer Mrs. Cox to a specialist.

The following day, Mrs. Cox was admitted to a hospital with symptoms consistent with ischemia and gangrene. She suffered from sepsis, or blood *154 poisoning, which caused her foot to appear black, and doctors unsuccessfully attempted a revascularization procedure. In April of that year doctors amputated Mrs. Cox's right leg below the knee and in June doctors performed an above-the-knee amputation. In January 2010 Mrs. Cox was hospitalized for blood poisoning. She died several days later.

Plaintiffs filed a complaint alleging medical malpractice against defendants on ***451 March 19, 2010. Later, on February 23, 2011, plaintiffs filed a complaint for elder abuse, alleging that defendants consciously failed "to make a vascular referral." The trial court sustained defendants' demurrer based on plaintiffs' failure to sufficiently allege more than "mere negligence" and the "provision of inadequate care." In their first amended complaint, plaintiffs alleged again the conduct highlighted above.

Defendants again demurred. They also sought and obtained judicial notice of the March 2010 complaint plaintiffs had filed alleging medical malpractice. The trial court sustained defendants' demurrer to the first amended complaint without leave to amend. It concluded that plaintiffs had not offered facts sufficient to show that defendants had recklessly denied the needed care to Mrs. Cox, as would be necessary to show a violation of the Elder Abuse Act. Instead, the trial court concluded, plaintiffs' allegations again showed only professional negligence and "incompetence." Absent malice, oppression, or fraud, the trial court determined, plaintiffs could not support a claim of neglect under the Act. The court ordered the complaint dismissed and plaintiffs appealed.

The Court of Appeal then reversed the trial court in a split opinion. It held that the Elder Abuse Act does not require the existence of a custodial relationship in order for the plaintiff to establish a cause of action for **1015 neglect.[2] The court also rejected defendants' contention that the trial court should determine, as a matter of law, whether defendants' conduct constituted professional negligence rather than neglect. The Court of Appeal distinguished two of our opinions interpreting the Act—*Delaney v. Baker* (1999) 20 Cal.4th 23, 82 Cal.Rptr.2d 610, 971 P.2d 986 (*Delaney*) and *Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, 11 Cal.Rptr.3d 222, 86 P.3d 290 (*Covenant Care*)—and found that sections 15657, 15610.57, and 15657.2 did not impose any special relationship requirement.

Citing *Mack v. Soung* (2000) 80 Cal.App.4th 966, 95 Cal.Rptr.2d 830 (*Mack*), the Court of Appeal concluded that the "statutory language simply does not support defendants' contention that only 'care custodians' are liable *155 for elder abuse." And besides, the majority concluded, defendants here were in fact "care custodians." The majority likewise rejected defendants' claim that *Delaney* and *Covenant Care* suggested the Act's inapplicability to health care providers who have no custodial obligations, but instead "merely provide care." In dissent, Presiding Justice Bigelow criticized the majority as blurring the lines between Elder Abuse Act neglect and professional negligence. The dissent read *Delaney* as "reject[ing] the theory that a cause of action could be based on professional negligence within the meaning of section 15657.2 and also constitute reckless neglect within the meaning of section 15657," and it focused on language in both *Delaney* and *Covenant Care* defining "neglect" as the

failure to *provide* medical care. Examining the statutory language and the cases most on point, the dissent concluded that the "gravamen of plaintiffs' claim is one of professional negligence, not elder abuse."

We granted review to consider whether a claim of neglect under the Elder Abuse Act requires a caretaking or custodial relationship—where a person has assumed significant ***452** responsibility for attending to one or more of those basic needs of the elder or dependent adult that an able-bodied and fully competent adult would ordinarily be capable of managing without assistance. Taking account of the statutory text, structure, and legislative history of the Elder Abuse Act, we conclude that it does.

II. DISCUSSION

When legislators enacted the Elder Abuse Act, they enhanced the potential sanctions for neglect of elders or certain dependent adults. They did so by establishing heightened remedies—allowing not only for a plaintiff's recovery of attorney fees and costs, but also exemption from the damages limitations otherwise imposed by Code of Civil Procedure section 377.34. Unlike other actions brought by a decedent's personal representative or successor in interest, claims under the Act allow for the recovery of damages for predeath pain, suffering, and disfigurement. (Welf. & Inst.Code § 15657.) The question before us turns on the availability of these very remedies—a question that, in turn, depends on the presence of neglect under the Act, as defined in section 15610.57.

1 2 3 Our analysis begins with the text of this provision, as the statutory language is typically the best indication of the Legislature's purpose. (*Larkin v. Workers' Comp. Appeals Bd.* (2015) 62 Cal.4th 152, 157–158, 194 Cal.Rptr.3d 80, 358 P.3d 552; see *Fitch v. Select Products Co.* (2005) 36 Cal.4th 812, 818, 31 Cal.Rptr.3d 591, 115 P.3d 1233; *Baker v. Workers' Comp. Appeals Bd.* (2011) 52 Cal.4th 434, 442, 129 Cal.Rptr.3d 133, 257 P.3d 738.) We consider the ordinary meaning of the statutory language, its relationship to the text of related provisions, terms used elsewhere in the ***156** statute, and the overarching structure of the statutory scheme. (*Larkin, supra,* 62 Cal.4th at pp. 157–158, 194 Cal.Rptr.3d 80, 358 P.3d 552; *California Teachers Assn. v. San Diego Community College Dist.* (1981) 28 Cal.3d 692, 698, 170 Cal.Rptr. 817, 621 P.2d 856; *Lonicki v. Sutter Health Central* (2008) 43 Cal.4th 201, 209, 74 Cal.Rptr.3d 570, 180 P.3d 321; see also ***1016** *Clean Air Constituency v. State Air Resources Bd.* (1974) 11 Cal.3d 801, 814, 114 Cal.Rptr. 577, 523 P.2d 617; *People v. Rogers* (1971) 5 Cal.3d 129, 142, 95 Cal.Rptr. 601, 486 P.2d 129 (conc. & dis. opn. of Mosk, J.) [in construing a statute, we do not look at each term as if "in a vacuum," but rather gather "the intent of the Legislature ... from the statute taken as a whole"].) When the language of a statutory provision remains opaque after we consider its text, the statute's structure, and related statutory provisions, we may take account of extrinsic sources—such as legislative history—to assist us in discerning the Legislature's purpose. (*Holland v. Assessment Appeals Bd. No. 1* (2014) 58 Cal.4th 482, 490, 167 Cal.Rptr.3d 74, 316 P.3d 1188.)

The Elder Abuse Act's heightened remedies are available only in limited circumstances. A plaintiff must prove, by clear and convincing evidence, that a defendant is liable for either physical abuse under section 15610.63 or neglect under section 15610.57, and that the defendant committed the abuse with "recklessness, oppression, fraud, or malice." (§ 15657.) Section 15610.57, in turn, provides two definitions of neglect. First, "[t]he negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise." (§ 15610.57, subd. (a)(1).) Second, "[t]he negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise." (*Id.*, subd. (a)(2).) Because plaintiffs allege neglect arising in the ***453** context of medical care and not self-care, we deal only with section 15610.57's first definition of neglect.

Complementing these two definitions is the statute's explicitly nonexhaustive list of "neglect" examples. These include failures "to assist in personal hygiene" or to provide "food, clothing, or shelter" (§ 15610.57, subd. (b)(1)); "to provide medical care for

physical and mental health needs" (*id.*, subd. (b)(2)); "to protect from health and safety hazards" (*id.*, subd. (b)(3)); and "to prevent malnutrition or dehydration" (*id.*, subd. (b)(4)).

What these provisions show is that neither section 15610.57, subdivision (a)(1) nor other relevant portions of the statute flatly preclude the statute's applicability to outpatient medical treatment. Instead, the statute simply refers explicitly to "any person having the care or custody of an elder." (§ 15610.57, subd. (a)(1).) As defendants contend, "care" and "custody" may sometimes be used as synonyms, (see Oxford Engl. Dict. Online (2016) < http://oed.com> ***157** [as of May 19, 2016] [defining "care" as "[c]harge" or "oversight with a view to protection, preservation, or guidance," and defining "custody" as "[s]afe keeping, protection, defence; *charge, care,* guardianship" italics added]), and defendants would construe "care" and "custody" as identical and synonymous. Plaintiffs' interpretation, in contrast, would construe "any person having the care or custody of" as "any person having *either* the care *or* the custody of" an elder or dependent adult.

To rebut this interpretation, defendants emphasize two textual elements of section 15610.57. First, they note the Legislature's decision to use the definite article "the" before "care or custody." From defendants' perspective, this definite article, used with the modifier "having," suggests that the Legislature sought to signal a distinction as to the relationship between someone who has been charged with "having" "the care" of an elder or dependent adult and someone who merely provides care to a recipient. As defendants see it, had the Legislature not meant to signal a custodial relationship, it could have drafted section 15610.57 to apply to "any person caring for an elder or a dependent adult." Second, defendants argue that the Legislature's failure to use a definite article before the word "custody" suggests that we should read "care" and "custody" as "identical or synonymous." Plaintiffs, in turn, argue that the "or" in "care or custody" is an "*inclusive disjunctive conjunction*—that is, a conjunction that denotes separation or alternatives, while also allowing that both alternatives may be true."

4 These dueling textual and grammatical arguments may tell us something about the statute's scope, but neither interpretation fully answers a question implicit in the statute's use of the terms "having the care or custody": what kind of caretaking or custodial relationship is required to justify the conclusion that an individual or organization may ****1017** be subjected to the Act's heightened remedies? Indeed, while defendants' interpretation is not categorically excluded by the statutory language, it not especially persuasive on its face, nor does the argument that the words "care" and "custody" should be read together as synonyms—even if it were availing—offer much insight into what those terms mean in the context of section 15610.57. The parties' dispute about whether "care or custody" should be taken individually or together does, however, highlight the fact that the text of section 15610.57, subdivision (a)(1) standing alone does not fully elucidate the scope of the relationship that the statute evokes by using these terms.

*****454** The content of section 15610.57, subdivision (b) nonetheless proves particularly instructive. Neglect includes the "[f]ailure to assist in personal hygiene, or in the provision of food, clothing, or shelter." (***158** § 15610.57, subd. (b)(1).) It also includes the "[f]ailure to protect from health and safety hazards" (*id.*, subd. (b)(3)), and the "[f]ailure to prevent malnutrition or dehydration" (*id.*, subd. (b)(4)). These examples add some context elucidating the statute's meaning—context that supports inferences about the sort of conduct the Legislature sought to address from individuals "having the care or custody" of an elder. What they each seem to contemplate is the existence of a robust caretaking or custodial relationship—that is, a relationship where a certain party has assumed a significant measure of responsibility for attending to one or more of an elder's basic needs that an able-bodied and fully competent adult would ordinarily be capable of managing without assistance.

5 6 One would not normally expect an able-bodied and fully competent adult to depend on another for "assist[ance] with personal hygiene" or "protect [ion] from health and safety hazards," any more than one would expect a party with only

circumscribed, intermittent, or episodic engagement to be among those who "have ... care or custody" of someone who may be particularly vulnerable. (§ 15610.57, subd. (b)(1), (3).). An individual might assume the responsibility for attending to an elder's basic needs in a variety of contexts and locations, including beyond the confines of a residential care facility. Certain in-home health care relationships, for example, may satisfy the caretaking or custodial relationship requirement set forth under the Act. Ultimately, the focus of the statutory language is on the nature and substance of the relationship between an individual and an elder or a dependent adult. This focus supports the conclusion that the distinctive relationship contemplated by the Act entails more than casual or limited interactions.

7 The remaining example of neglect—the "[f]ailure to provide medical care for physical and mental health needs" (§ 15610.57, subd. (b)(2))—fits the pattern. As with the other examples of neglect, the failure to provide medical care assumes that the defendant is in a position to deprive an elder or a dependent adult of medical care. Section 15610.57, subdivision (b)(2)'s use of the word "provide" also suggests a care provider's assumption of a substantial caretaking or custodial role, as it speaks to a determination made by one with control over an elder whether to *initiate* medical care at all. Read in tandem, section 15610.57, subdivisions (a)(1) and (b)(2) support a straightforward conclusion: whether a determination that medical care should be provided is made by a health care provider or not, it is the defendant's relationship with an elder or a dependent adult—not the defendant's professional standing or expertise—that makes the defendant potentially liable for neglect.

8 ***159** Section 15610.57, subdivision (b) is a case in point. By invoking failure to provide food or clothing, or neglect in providing mental health care, its provisions convey the broad range of conduct encompassed by the Elder Abuse Act's definition of neglect. What those examples nonetheless also suggest is that the statute was not meant to encompass every course of behavior that fits either legal or colloquial definitions of neglect. In construing statutes, we bear in mind that the scope of certain terms may sometimes be elucidated by related provisions. (See, e.g., *Kraus v. Trinity Management Services, Inc.* (2000) 23 Cal.4th 116, 141, 96 Cal.Rptr.2d 485, 999 P.2d 718 ["[I]f the Legislature ***455** intends a general word to be **1018** used in its unrestricted sense, it does not also offer as examples peculiar things or classes of things since those descriptions then would be surplusage."]; see also *Internat. Federation of Prof. & Technical Engineers, Local 21, AFL–CIO v. Superior Court* (2007) 42 Cal.4th 319, 341–342, 64 Cal.Rptr.3d 693, 165 P.3d 488 [applying the principle of *ejusdem generis* to ascertain Legislature's intended purpose where a general term was followed by a nonexhaustive list of specific examples].) The examples of neglect in subdivision (b), though nonexhaustive, are nonetheless related terms that shed light on the type of conduct the Legislature sought to forestall—and on the conditions that could place an individual or organization in a position to commit "neglect" in the first place.

9 Contrast the examples from section 15610.57, subdivision (b)—and the underlying concept of neglect they imply—with the sort of conduct triggering more conventional tort liability. A doctor's failure to prescribe the right medicine, or refer a patient to a specialist may give rise to tort liability even in the absence of a caretaking or custodial relationship. (See Code Civ. Proc., § 364 [defining professional negligence as the "negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death"]; see also *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 143–145, 151, 211 Cal.Rptr. 368, 695 P.2d 665 [affirming medical malpractice judgment where defendants misdiagnosed plaintiff]; *Evans v. Ohanesian* (1974) 39 Cal.App.3d 121, 129, 112 Cal.Rptr. 236 [failure to refer to specialist].) What seems beyond doubt is that the Legislature enacted a scheme distinguishing between—and decidedly not lumping together—claims of professional negligence and neglect. (See § 15657.2 ["Notwithstanding this article, any cause of action for injury or damage against a health care provider ... based on the health care provider's alleged professional negligence, shall be governed by those laws which specifically apply to those professional negligence causes of action"]; see also *Covenant Care, supra,* 32 Cal.4th at p. 785, 11

Cal.Rptr.3d 222, 86 P.3d 290.) The Act seems premised on the idea that certain situations place elders and dependent adults at heightened risk of harm, and heightened remedies relative to conventional tort remedies are *160 appropriate as a consequence. (See *Delaney, supra,* 20 Cal.4th at pp. 36–37, 82 Cal.Rptr.2d 610, 971 P.2d 986.) Blurring the distinction between neglect under the Act and conduct actionable under ordinary tort remedies—even in the absence of a care or custody relationship—risks undermining the Act's central premise. Accordingly, plaintiffs alleging professional negligence may seek certain tort remedies, though not the heightened remedies available under the Elder Abuse Act. (See, e.g., Code Civ. Proc. § 377.34 [generally limiting recovery of predeath pain and suffering damages].)

10 Aside from neglect situations, the only other circumstances where those heightened remedies are available under the Act must involve "physical abuse" as defined in section 15610.63. (See § 15676.) This, too, is consistent with the distinction between neglect and other forms of negligent conduct. Though the Act sets forth a rather broad definition of " 'abuse of an elder,' " including physical abuse, neglect, financial abuse, isolation, abandonment, and the deprivation by a care custodian of certain goods or services (§ 15610.07), section 15657 is explicitly limited to physical abuse and neglect. This qualification on the types of conduct that trigger heightened remedies supports the conclusion ***456 that the Legislature explicitly targeted heightened remedies to protect particularly vulnerable and reliant elders and dependent adults. Indeed, the limited availability of heightened remedies is indicative of a determination that individuals responsible for attending to the basic needs of elders and dependent adults that are unable to care for themselves should be subject to greater liability where those caretakers or custodians act with recklessness, oppression, fraud, or malice. (§ 15657.) The statutory scheme further persuades us that the concept of neglect—though broad enough to encompass settings beyond residential care facilities—is not intended to apply to any conceivable negligent conduct that might adversely impact an elder or dependent adult. Instead, neglect requires a caretaking or custodial **1019 relationship that arises where an elder or dependent adult depends on another for the provision of some or all of his or her fundamental needs.

Our reading of section 15610.57 also fits our conclusions in prior cases. *Delaney* concluded that " 'neglect' as defined in former section 15610.57 and used in section 15657 ... [refers] to the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligations." (*Delaney, supra,* 20 Cal.4th at p. 34, 82 Cal.Rptr.2d 610, 971 P.2d 986; see *Covenant Care, supra,* 32 Cal.4th at p. 786, 11 Cal.Rptr.3d 222, 86 P.3d 290.) In both *Delaney* and in *Covenant Care,* the defendants had explicitly assumed responsibility for attending to the elders' most basic needs. In *Delaney,* the elder resided at a skilled nursing facility where she had been left lying in her own urine and feces for extended periods of time *161 because the defendants, upon whom she had relied to provide basic care, had failed to carry out their caretaking and custodial obligations. (*Delaney,* 20 Cal.4th at p. 27, 82 Cal.Rptr.2d 610, 971 P.2d 986.) Similarly, in *Covenant Care,* we noted that the elder suffered "from Parkinson's disease and was unable to care for his personal needs." (*Covenant Care,* 32 Cal.4th at p. 778, 11 Cal.Rptr.3d 222, 86 P.3d 290.) The elder in *Covenant Care* relied on the defendants to provide nutrition, hydration, and medication—needs that an able-bodied and fully competent adult would ordinarily be capable of handling on his or her own. (See *ibid.*) Our prior case law thus illustrates the type of caretaking or custodial relationship that the Act requires: one where a party has accepted responsibility for attending to the basic needs of an elder or dependent adult.

11 12 Appearing not only in section 15610.57 but also elsewhere in the Act, the phrase "care or custody" evokes a bond that contrasts with a casual or temporally limited affiliation. We generally presume that when the Legislature uses a word or phrase "in a particular sense in one part of a statute," the word or phrase should be understood to carry the same meaning when it arises elsewhere in that statutory scheme. (*People v. Dillon* (1983) 34 Cal.3d 441, 468, 194 Cal.Rptr. 390, 668 P.2d 697.) Section 15610.05 defines " 'abandonment,' " for example, as the "desertion or willful

forsaking of an elder or a dependent adult by anyone having care or custody of that person" where a reasonable person "would continue to provide care and custody." (§ 15610.05.) It is difficult to imagine under what circumstances an individual could "abandon" an elder or dependent adult absent the existence of a caretaking or custodial relationship (e.g., a degree of dependence and reliance that would make abandonment possible). Similarly, section 15656, which imposes fines and jail time for subjecting an elder to great bodily harm or death, defines " 'caretaker' " as it ***457 is used in that section as a "person who has the care, custody, or control of ... an elder or a dependent adult." (§ 15656, subd. (d).) Here again, the terms "care" and "custody" are used together, and are best understood to denote a distinctive caretaking or custodial relationship.

It is this reading of the Act that most readily fits with how we have interpreted analogous statutory provisions arising beyond the Act that nonetheless use the phrase "having the care or custody." We construe this phrase in context, with the understanding that statutes "relating to the same subject must be harmonized, both internally and with each other, to the extent possible." (*Dyna–Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1387, 241 Cal.Rptr. 67, 743 P.2d 1323; see *Lexin v. Superior Court* (2010) 47 Cal.4th 1050, 1090–1091, 103 Cal.Rptr.3d 767, 222 P.3d 214 ["It is a basic canon of statutory construction that statutes in pari materia should be construed together so that all parts of the statutory scheme are given effect"].) For example, Penal Code section 368 imposes criminal *162 liability upon any person "having the care or custody of any elder or dependent adult" who "willfully causes or permits" the elder or dependent adult to be injured or endangered.[3] In **1020 *People v. Heitzman* (1994) 9 Cal.4th 189, 204, 37 Cal.Rptr.2d 236, 886 P.2d 1229 (*Heitzman*), we considered the scope of Penal Code section 368, and noted that the statutory language was "derive[d] verbatim from the felony child abuse statute." Analyzing the statutory language and legislative history, we concluded that the underlying purpose of both felony abuse statutes was to " protect the members of a vulnerable class from abusive situations," which usually arose where caretakers or custodians responsible for the basic needs of these vulnerable, dependent populations failed to provide for their charges. (*Heitzman*, at p. 203, 37 Cal.Rptr.2d 236, 886 P.2d 1229.) Though section 15610.57 defines neglect for civil liability purposes, the statutory language invokes a similar caretaking or custodial relationship requirement.

What the text of section 15610.57 conveys about the Legislature's purpose here—along with related provisions, and similar language in other statutes—supports tethering the concept of neglect to caretaking or custodial situations. But the legislative history of the Act likewise suggests that the Legislature was principally concerned with particular caretaking and custodial relationships, and the abuse and neglect that can occur in that context. First, the legislative declarations accompanying the Elder Abuse Act tend to reinforce a reading of section 15610.57 that imposes a caretaking or custodial prerequisite. The Legislature recognized "that most elders ... who are at the greatest risk of abuse, neglect, or abandonment by their families or caretakers suffer physical impairments and other poor health that place them in a *dependent and vulnerable* ***458 *position*." (§ 15600, subd. (d), italics added.) The Legislature took note of the "factors which contribute to abuse, neglect, or abandonment of elders and dependent adults [such as] economic instability of the family, resentment of caretaker responsibilities, stress on the caretaker, and abuse by the caretaker of drugs or alcohol." (*Id.*, subd. (e).) As these declarations make clear, the Legislature expressed concern for those who are vulnerable and dependent on others for their most basic needs. And the Legislature recognized certain factors that might arise in a custodial setting—emphasizing *163 abuse and neglect by caretakers—in highlighting its rationale for the Act's passage.

Second, the legislative history tends to support the view that the Legislature enacted section 15657 in large part to combat pervasive abuse and neglect in certain health care facilities. (*Delaney, supra*, 20 Cal.4th at pp. 35–36, 82 Cal.Rptr.2d 610, 971 P.2d 986.) As we concluded in *Delaney*, "one of the major objectives of this legislation was the protection of residents of nursing homes and other health care facilities." (*Id.* at pp.

36–37, 82 Cal.Rptr.2d 610, 971 P.2d 986.) That recognition led us to hold as "contrary" to the Legislature's objective the exemption of nursing homes and other similar facilities from section 15657's reach. (*Delaney*, at p. 37, 82 Cal.Rptr.2d 610, 971 P.2d 986.)

Third, nothing in the legislative history suggests that the Legislature intended the Act to apply *whenever* a doctor treats any elderly patient. Reading the act in such a manner would radically transform medical malpractice liability relative to the existing scheme. Senate Bill No. 679 [1991–1992 Reg. Sess.] was the bill that contained the Act. No portion of its legislative history contains any indication that the Legislature's purpose was to effectuate such a transformation of medical malpractice liability. (See *Jones v. Lodge at Torrey Pines Partnership* (2008) 42 Cal.4th 1158, 1169, 72 Cal.Rptr.3d 624, 177 P.3d 232 [discussing "the *absence* of legislative history" in concluding that amendment described as " 'technical and conforming' " was not intended to effect a substantial ***1021** change in the law]; *Donovan v. Poway Unified School Dist.* (2008) 167 Cal.App.4th 567, 597, 84 Cal.Rptr.3d 285 ["the *absence* of legislative history [can] be of significance in deciphering legislative intent" (citing *Lodge at Torrey Pines*, at p. 1169, 72 Cal.Rptr.3d 624, 177 P.3d 232)].) While the absence of legislative history alone is of limited significance, here we see only evidence that cuts against any argument that the Legislature was not aware of the scope of health care providers' potential liability under the Act. (See *Delaney, supra*, 20 Cal.4th at p. 41, 82 Cal.Rptr.2d 610, 971 P.2d 986 [noting that § 15657's "legislative history suggests that nursing homes and other health care providers were among the primary targets of the Elder Abuse Act"]; see also section 15657.2 [distinguishing claims "based on the health care provider's alleged professional negligence" from those governed by the Elder Abuse Act].)

Moreover, finding a caretaking or custodial relationship prerequisite is also consistent with our prior case law, and the Court of Appeal's reliance on *Mack, supra*, 80 Cal.App.4th 966, 95 Cal.Rptr.2d 830, in holding to the contrary is unpersuasive. The defendant doctor in *Mack* assumed a caretaking relationship with a reliant, vulnerable patient who was unable to access other health care providers—indeed, the defendant actively prevented the patient from being hospitalized and failed to provide any medical care. (*Ibid.* ["When her condition worsened ... Dr. Soung abruptly abandoned [decedent] as her *164 physician without further notice"].) In resolving the dispute arising from these ***459** facts, the *Mack* court ignored a key limiting factor in *Delaney*—the presence of a custodial relationship. Moreover, as *Mack* predated *Covenant Care*, the *Mack* court did not have the benefit of our clear pronouncement on the Act's caretaking or custodial prerequisite. (See *Covenant Care, supra*, 32 Cal.4th at p. 786, 11 Cal.Rptr.3d 222, 86 P.3d 290 ["[C]laims under the Elder Abuse Act are not brought against health care providers *in their capacity as providers* but, rather, against *custodians and caregivers* that abuse elders and that may or may not, incidentally, also be health care providers"].) Accordingly, we disapprove of *Mack v. Soung, supra*, 80 Cal.App.4th 966, 95 Cal.Rptr.2d 830, to the extent it finds claims of neglect under the Elder Abuse Act may be brought irrespective of a doctor's caretaking or custodial relationship with an elder patient.

13 In the alternative, plaintiffs contend that if neglect under section 15610.57, subdivision (a)(1), requires a caretaking or custodial relationship,[4] then defendants assumed "custody" of Mrs. Cox by treating her at **Pioneer's** outpatient facilities. According to plaintiffs, section 15610.17's definition of a care custodian under the Act includes clinics, **Pioneer's** outpatient facilities are clinics, and **Pioneer** is therefore a care custodian. This argument also fails to persuade. What plaintiffs erroneously assume is that the Act's definition of care custodian in section 15610.17 will, as a matter of law, always satisfy the particular caretaking or custodial relationship required to show neglect under section 15610.57. While it may be the case that many of the " 'care custodian[s]' " defined under section 15610.17 could have "the care or custody of" an elder or a dependent adult as required under section 15610.57, plainly the statute requires a separate analysis to determine whether such a relationship exists. Neither the text of section 15610.17 nor anything else in the statute supports plaintiffs'

argument that the presence of such a relationship may be assumed whenever the definition of "care custodian" is met.

Section 15610.17 broadly defines a care custodian as an "administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff." (§ 15610.17.) It then lists a variety of public and private agencies and facilities, from "[t]wenty-four- ***1022** hour health facilities" (§ 15610.17, subd. (a)), to "[h]umane societies and *165 animal control agencies" (§ 15610.17, subd. (v)). The list concludes with a catchall provision for "[a]ny other ... person providing health services or social services to elders or dependent adults." (*Bernard v. Foley* (2006), 39 Cal.4th 794, 807, 47 Cal.Rptr.3d 248, 139 P.3d 1196 [describing § 15610.17, subd. (y) as a "broad catchall provision"].) While one might reasonably conclude that a 24–hour health facility (§ 15610.17, subd. (a)), or a residential care facility for the elderly (§ 15610.17, subd. (j)), could have "the care or custody" of an elder or dependent adult, it is less evident why fire departments (§ 15610.17, subd. (w)), animal control agencies (§ 15610.17, subd. (v)), or offices of environmental health and building code enforcement (§ 15610.17, subd. (x)), would ***460** necessarily have the type of caretaking or custodial relationship with an elder or a dependent adult required to show neglect under section 15610.57.

Beyond the assertion that defendants treated Mrs. Cox at outpatient "clinics" operated by defendants, plaintiffs offer no other explanation for why defendants' intermittent, outpatient medical treatment forged a caretaking or custodial relationship between Mrs. Cox and defendants. No allegations in the complaint support an inference that Mrs. Cox relied on defendants in any way distinct from an able-bodied and fully competent adult's reliance on the advice and care of his or her medical providers. Accordingly, we hold that defendants lacked the needed caretaking or custodial relationship with the decedent.

III. CONCLUSION

Plaintiffs cannot bring a claim of neglect under the Elder Abuse Act unless the defendant health care provider has a caretaking or custodial relationship with the elder or dependent adult. Here, plaintiffs rely solely on defendants' allegedly substandard provision of medical treatment, on an outpatient basis, to an elder. But without more, such an allegation does not support the conclusion that neglect occurred under the Elder Abuse Act. To elide the distinction between neglect under the Act and objectionable conduct triggering conventional tort remedies—even in the absence of a care or custody relationship—risks undermining the Act's central premise. Our conclusion is grounded in the text of sections 15657 and 15610.57 and related provisions, the extent to which those provisions make heightened remedies available only in specific circumstances, the applicable legislative history, and the light these shed on the Legislature's intended purpose. Our conclusion that a claim of neglect under the Elder Abuse Act depends on the existence of a caretaking or custodial relationship is also consistent with our prior cases.

*166 Accordingly, we reverse the Court of Appeal and remand to that court for further proceedings consistent with our opinion.

We Concur: CANTIL–SAKAUYE, C.J., WERDEGAR, CHIN, CORRIGAN, LIU, and KRUGER, JJ.

All Citations

63 Cal.4th 148, 370 P.3d 1011, 202 Cal.Rptr.3d 447, 16 Cal. Daily Op. Serv. 5145, 2016 Daily Journal D.A.R. 4703

Footnotes

1 All subsequent statutory references are to the Welfare and Institutions Code, unless otherwise noted.

2 The Court of Appeal further concluded that even if section 15610.57 requires a defendant to have a custodial relationship with the elder or dependent adult, defendants in the instant case were "care custodians." As discussed *post,* the Court of Appeal erred on both counts.

3 Penal Code section 368, subdivision (b)(1) provides: "Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars ($6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years."

4 Amicus curiae California Advocates for Nursing Home Reform contends that Senate Bill No. 1681 [1993–1994 Reg. Sess.], which enacted section 15610.17, "has nothing to do with the [Elder Abuse] Act." We disagree, and we interpret provisions added by later legislation "to preserve statutory harmony and effectuate the intent of the Legislature." (*McLaughlin v. State Bd. of Education* (1999) 75 Cal.App.4th 196, 219–220, 89 Cal.Rptr.2d 295.).

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25 Cal.4th 412
Supreme Court of California

Barbara **McCALL**, Individually and as Trustee, etc., Plaintiff and Appellant,

v.

PACIFICARE OF CALIFORNIA, INC., et al., Defendants and Respondents.

No. S082236.
May 3, 2001.

Synopsis

Patient and spouse sued health maintenance organization (HMO) and its physician provider group for negligence, intentional and negligent infliction of emotional distress, unfair business practices, and fraud in connection with treatment of progressive lung disease. The Superior Court, Orange County, No. 788545, Thierry Patrick Colaw, J., sustained a demurrer without leave to amend. Patient and spouse appealed. The Court of Appeal, reversed. Petition for review was granted, superseding the opinion of the Court of Appeal. The Supreme Court, Werdegar, J., held that state law claims against HMO, arising out of its refusal to provide services under a Medicare-subsidized health plan, did not fall within the exclusive review provisions of the Medicare Act requiring exhaustion of administrative remedies, disapproving *Redmond v. Secure Horizons, **Pacificare**, Inc.*, 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174.

Affirmed.

Baxter, J., filed a dissenting opinion, in which Brown, J., joined.

Opinion, 87 Cal.Rptr.2d 784, superseded.

West Headnotes (13)

Change View

1 **Appeal and Error** Objections and exceptions; demurrer
On review of the judgment of the Court of Appeal reversing the superior court's orders sustaining defendants' demurrers, the Supreme Court examines the complaint de novo to determine whether it alleges facts sufficient to state a cause of action under any legal theory, such facts being assumed true for this purpose.

502 Cases that cite this headnote

2 **Health** Finality requirement
Judicial review of a Medicare claim for benefits is available only after the Secretary of Health and Human Services has rendered a final decision on the claim, and only in the manner provided for claims for old age and disability benefits arising under the Social Security Act. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1).

3 Cases that cite this headnote

3 **States** Congressional intent
Supreme Court presumes that in enacting laws, Congress does not intend to preempt state regulation of the same subject matter unless a contrary intent

is made clear.

4 Cases that cite this headnote

4 **Health** Preemption
States Social security and public welfare
Congress did not preempt, but rather left open a wide field for the operation of state law pertaining to standards for the practice of medicine and the manner in which medical services are delivered to Medicare beneficiaries. Social Security Act, § 1876(b), as amended, 42 U.S.C.A. § 1395mm(b).

4 Cases that cite this headnote

5 **Health** Preemption
Health Administrative Proceedings
States Social security and public welfare
Medicare regulations provide for administrative review of a limited class of claims, not including those pertaining to quality of care, marketing problems, and forced disenrollment; thus, absent clear indication of congressional intent, Supreme Court would decline to find preemption of claims, founded in state law, that find no remedy under the Medicare administrative process. 42 C.F.R. § 417.600 et seq.

6 **Health** Administrative review
Medicare provider may violate state common law or statutory duties owing to beneficiaries, unrelated to its Medicare coverage determinations; thus, Medicare Act's administrative review process sweeps in only those claims that, "at bottom," seek reimbursement or payment for medical services, but not a claim not seeking such reimbursement or payment, which claim as pleaded incidentally refers to a denial of benefits under the Medicare Act. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1).

11 Cases that cite this headnote

7 **Health** Standing
State law claims by Medicare beneficiaries which do not seek reimbursement or payment and which as pleaded incidentally refers to a denial of benefits under the Medicare Act are not subject to the administrative review process and may be pursued in state courts; such claims are collateral to, not inextricably intertwined with, Medicare benefit claims; disapproving *Redmond v. Secure Horizons, **Pacificare**, Inc.*, 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1).

7 Cases that cite this headnote

8 **Health** Exhaustion of administrative remedies
Medicare beneficiaries' state law claims against health maintenance organization (HMO) for negligence and wilful misconduct, arising out of its refusal to provide services under Medicare-subsidized health plan, did not fall within exclusive review provisions of Medicare Act requiring exhaustion of administrative remedies; beneficiaries alleged HMO negligently failed to use ordinary skill and care in treating beneficiary's progressive lung disease, failed to properly advise beneficiary concerning disease or appropriate treatment options, whether or not such options were covered by Medicare, and failed to provide appropriate referrals to specialists. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1).

8 Cases that cite this headnote

9 **Health** Exhaustion of administrative remedies
Medicare beneficiaries' state law claims against health maintenance organization (HMO) for fraud and misrepresentation, based on its application for HMO licensure to the Department of Corporations and marketing materials disseminated to potential enrollees, which claims arose out of HMO's refusal to provide services under Medicare-subsidized health plan, did not necessarily implicate coverage determinations or fall within exclusive review provisions of Medicare Act requiring exhaustion of administrative remedies. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1).

11 Cases that cite this headnote

10 **Appeal and Error** Scope of Issues
To the extent that Medicare beneficiaries' complaint against health maintenance organization (HMO) alleged fraud on the Health Care Financing Administration (HCFA), HMO and its physician provider group, on remand, could assert claim was preempted by the Federal Food, Drug, and Cosmetic Act, as amended by the Medical Device Amendments. Federal Food, Drug, and Cosmetic Act, § 1 et seq., 21 U.S.C.A. § 301 et seq.

4 Cases that cite this headnote

11 **Health** Administrative Proceedings
Medicare beneficiaries' state law claim against health maintenance organization (HMO), alleging that HMO breached fiduciary duty it owed to beneficiary by permitting its financial interest detrimentally to affect treatment decisionmaking or failing to disclose such interest, did not necessarily implicate coverage determinations or fall within the scope of the Medicare administrative review process. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1).

1 Case that cites this headnote

12 **Health** Administrative Proceedings
Medicare beneficiaries' state law claims against health maintenance organization (HMO) for negligent or intentional infliction of emotional distress, based on HMO's violations of state law duties, did not necessarily implicates coverage determinations or falls within the scope of the Medicare administrative review process. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1).

1 Case that cites this headnote

13 **Health** Exhaustion of administrative remedies
Medicare beneficiaries' state law claim against health maintenance organization (HMO) for unfair practices, arising out of its refusal to provide services under Medicare-subsidized health plan, did not fall within exclusive review provisions of Medicare Act requiring exhaustion of administrative remedies. Social Security Act, §§ 205(g, h), 1869(b)(1), as amended, 42 U.S.C.A. §§ 405(g, h), 1395ff(b)(1); West's Ann.Cal.Bus. & Prof.Code § 17200.

8 Cases that cite this headnote

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Opinion

WERDEGAR, J.

We granted review in this case, limited to the issue whether state law claims against a health maintenance organization (HMO), arising out of its refusal to provide services under a Medicare-subsidized health plan, fall within the exclusive review provisions of the Medicare Act requiring exhaustion of administrative remedies. (42 U.S.C. § 1395 et seq.) ***415** As will appear, some disagreement exists among state and federal courts on this question, which has not yet been addressed by the United States Supreme Court. We conclude the claims made here do not fall within Medicare's exclusive review provisions. ****274** Accordingly, we affirm the judgment of the Court of Appeal.

FACTS

1 On review of the judgment of the Court of Appeal reversing the superior court's orders sustaining defendants' demurrers, we examine the complaint de novo to determine whether it alleges facts sufficient to state a cause of action under any legal theory, such facts being assumed true for this purpose. (*Santa Monica Beach, Ltd. v. Superior Court* (1999) 19 Cal.4th 952, 957, 81 Cal.Rptr.2d 93, 968 P.2d 993; *Blank v. Kirwan* (1985) 39 Cal.3d 311, 318, 216 Cal.Rptr. 718, 703 P.2d 58.)

George **McCall**, who suffered from progressive lung disease, was a Medicare beneficiary enrolled in **PacifiCare** of California, Inc. (**PacifiCare**), an HMO. His primary care physician was Dr. Lakshmi Shukla; his physician provider group, Greater Newport Physicians, Inc. (GNP). Allegedly, Dr. Shukla, **PacifiCare** and GNP repeatedly refused to refer Mr. **McCall** to a specialist for a lung transplant or provide other needed care, and ultimately forced him to disenroll from **PacifiCare** in order to get on the Medicare list for a transplant. During that time, Mr. **McCall's** condition worsened. [1]

George **McCall** and his wife, Barbara (the **McCalls**), brought suit against Dr. Shukla, **PacifiCare** and GNP, alleging in their operative first amended complaint eight causes of action for tort damages (negligence, wilful misconduct, four counts of fraud including fraudulent misrepresentation and constructive fraud, and negligent and intentional infliction of emotional distress) and a ninth cause of action for injunctive relief from unfair business practices. The complaint alleged defendants had violated statutory duties they owed plaintiffs, including (A) the duty to provide ready referrals consistent with good professional practice (Health & Saf.Code, § 1367, subd. (d)); (B) the duty to render medical decisions unhindered by fiscal and administrative management (*id.*, § 1367, subd. (g)); (C) the duty to provide for expedited review and to notify Mr. **McCall** of his right to expedited review from the California Department of Corporations when defendants' decisions involved imminent and serious threat to his health (*id.*, § 1368.01, subd. (b)); (D) the duty to engage in sufficient quality assurance activities to ensure that the requirements of California law were met in providing

services to Mr. **McCall** (*id.*, § 1370); (E) the duty not to require Mr. **McCall** to **416* disenroll except for very limited reasons, such as nonpayment of premiums (*id.*, § 1365, subd. (a)); (F) **PacifiCare's** duty to retain responsibility for all services, including those that it contracted with others to provide Mr. **McCall** (42 C.F.R. § 417.401 (1999)); (G) the duty to ensure that required services were available and accessible to Mr. **McCall** (42 C.F.R. § 417.416 (1999)); (H) the duty to provide written notice of noncoverage, including the reason for noncoverage *****1193*** and Mr. **McCall's** appeal rights, before discharging him from hospital care (42 C.F.R. § 417.440(f) (1999)); (I) the duty not to disenroll Mr. **McCall**, and not to encourage him to disenroll, from **PacifiCare** (42 C.F.R. § 417.460(a) (1999)); and (J) the duty to provide grievance procedures for issues that do not involve organizational determinations and Medicare appeal rights (42 C.F.R. §§ 417.600, 417.604, 417.606 (1999)).

******275*** GNP and **PacifiCare** (hereafter defendants)[2] demurred, arguing each of plaintiffs' causes of action arose under the Medicare Act, 42 United States Code section 1395 et seq. and, pursuant to 42 United States Code section 405(g), was therefore subject to judicial review only in federal court, after exhaustion of administrative review procedures. The trial court sustained the demurrers without leave to amend and entered judgment accordingly. The Court of Appeal reversed, and we granted review.

DISCUSSION

The Medicare Act, 42 United States Code section 1395 et seq. (the Act or Medicare), a part of the Social Security Act, established a federally subsidized health insurance program that is administered by the Secretary of Health and Human Services (the Secretary) through the Health Care Financing Administration (HCFA). Part A of Medicare, 42 United States Code section 1395c et seq., covers the cost of hospitalization and related expenses that are "reasonable and necessary" for the diagnosis or treatment of illness or injury. (42 U.S.C. § 1395y(a)(1)(A).) Part B of Medicare (42 U.S.C. § 1395j et seq.) establishes a voluntary supplementary medical insurance program for Medicare-eligible individuals and certain other persons over age 65, covering specified medical services, devices, and equipment. (See 42 U.S.C. §§ 1395k, 1395o.) The Act provides for the delegation of Medicare benefit administration to HMO's, which are authorized, pursuant to contracts with the HCFA, to manage benefit requests by Medicare beneficiaries. (*Wartenberg v. Aetna U.S. Healthcare, Inc.* (E.D.N.Y.1998) 2 F.Supp.2d 273, 276.)

2 The determination whether an individual is entitled to benefits, and the amount of benefits, is entrusted to the Secretary in accordance with regulations prescribed by him or her. (42 U.S.C. § 1395ff(a).) Judicial review of a **417* claim for benefits is available only after the Secretary has rendered a " 'final decision' " on the claim, and only in the manner provided for claims for old age and disability benefits arising under the Social Security Act. (*Heckler v. Ringer* (1984) 466 U.S. 602, 605, 104 S.Ct. 2013, 80 L.Ed.2d 622 (*Ringer*); 42 U.S.C. §§ 405(g), (h), 1395ff(b)(1).)[3] The relevant provisions of ******276*** the Social Security Act, 42 United States Code section 405(g) and (h), read together, provide that a final decision by the Secretary on a claim "arising under" Medicare may be *****1194*** reviewed by no person, agency or tribunal except in an action brought in federal district court, and then only after exhausting administrative remedies as described above. (42 U.S.C. §§ 405(h), 1395ii; see 42 U.S.C. §§ 1395ff(b)(1), 1395mm(c)(5)(B).)

The question in this case, then, is whether the **McCalls'** complaint alleges a claim "arising under" the Medicare Act, even though none of the claims seeks payment or reimbursement of Medicare claims. The seminal decision in this area, *Ringer, supra,* 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, held that a claim arises under Medicare if (1) " 'both the standing and the substantive basis for the presentation' " of the claim is the Medicare Act (*id.* at p. 615, 104 S.Ct. 2013), or (2) the claim is " 'inextricably intertwined' " with a claim for Medicare benefits (*id.* at p. 614, 104 S.Ct. 2013). The high court, however, recognized that a claim that is "wholly 'collateral' " to a claim for benefits under the Act is not subject to the administrative process; the court also suggested exhaustion would be excused if a claimant made a colorable showing that an

erroneous denial of benefits would injure him or her in a ***418** way that could not be remedied by the later payment of benefits. (*Id.* at p. 618, 104 S.Ct. 2013.)[4]

In *Ringer,* the plaintiffs were four Medicare beneficiaries who suffered from respiratory distress; three had had surgery known as bilateral carotid body resection (BCBR) and were seeking reimbursement of the cost thereof, and one sought to have BCBR surgery but claimed he could not afford it absent Medicare coverage. (*Ringer, supra,* 466 U.S. at pp. 605, 609–610, 104 S.Ct. 2013.) The Secretary had ruled that Medicare did not cover BCBR when performed to relieve respiratory distress because the procedure lacked the general acceptance of the professional medical community and thus was not "reasonable and necessary" within the meaning of Medicare. (*Id.* at p. 607, 104 S.Ct. 2013.) The *Ringer* plaintiffs, none of whom had exhausted their administrative remedies, filed a complaint in federal district court seeking declaratory and injunctive relief. (*Id.* at pp. 610–611, 104 S.Ct. 2013.) The district court dismissed the complaint in its entirety for lack of jurisdiction, concluding the essence of the claim was one of entitlement to benefits for the BCBR procedure and that the plaintiffs therefore were required to exhaust administrative remedies before seeking relief in federal court. (*Id.* at p. 611, 104 S.Ct. 2013.) The Court of Appeals for the Ninth Circuit reversed, concluding exhaustion would be futile and might not fully compensate the plaintiffs for the injuries they asserted. (*Id.* at p. 612.) The Supreme Court reversed.

The high court noted that, in *Weinberger v. Salfi* (1975) 422 U.S. 749, 760–761, 95 S.Ct. 2457, 45 L.Ed.2d 522, where the plaintiffs had sought an award of Social Security benefits (a type of claim that, as noted above, is subject to the same administrative exhaustion provisions as ****277** those seeking Medicare benefits), it had construed the " 'claim arising under' language quite broadly to include any claims in which 'both the standing and the substantive basis for the presentation' of the claims is the Social Security Act." (*Ringer, supra,* 466 U.S. at p. 615, 104 S.Ct. 2013; see *Weinberger v. Salfi, supra,* at pp. 760–761, 95 S.Ct. 2457 [constitutional challenge to the duration-of-relationship eligibility statute was a " 'claim arising under' " the Social Security Act, even though it was also, in another sense, a claim arising under the Constitution].) Any other conclusion, the high court reasoned, would allow claimants substantially to undercut Congress's carefully crafted scheme for administering Medicare. (*Ringer, supra,* at p. 621, 104 S.Ct. 2013.)

***419** Because the Medicare beneficiaries in *Ringer,* at bottom, sought Medicare reimbursement or authorization for a particular surgical procedure, the high court had no difficulty concluding the claim was one in which both the standing and the substantive basis of the claim was the Act, and that the complaint was, thus, one "arising under" Medicare. Perhaps for that reason, the court did not define the phrase "inextricably ***1195** intertwined," as used in this context, or elaborate on the extent to which a state law claim may be "intertwined" with a Medicare claim before it becomes inextricably so. (See *Ringer, supra,* 466 U.S. at pp. 611, 614–615, 104 S.Ct. 2013.) A closer question than that posed in *Ringer,* however, arises where the complaint seeks, on state tort law grounds, not reimbursement for an assertedly covered procedure, but, rather, damages assertedly flowing from conduct only incidentally related to the wrongful denial of a benefits claim.

Such a situation was present in *Ardary v. Aetna Health Plans of California, Inc.* (9th Cir.1996) 98 F.3d 496, certiorari denied (1997) 520 U.S. 1251, 117 S.Ct. 2408, 138 L.Ed.2d 174 (*Ardary*), on which the **McCalls** rely. In *Ardary,* a Medicare beneficiary who lived in a rural area and was enrolled in an HMO suffered a heart attack and was refused airlift transportation to a more sophisticated medical facility than those available nearby. When the beneficiary died, her family sued the HMO and its contractor, Arrowest Physician Association, in state court. They sought compensatory and punitive damages on six state tort law theories: negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence. (*Id.* at pp. 497–498.) The defendants in *Ardary* removed the case to federal court and sought dismissal, arguing all of the plaintiffs' state law causes of action related to the denial of Medicare benefits and, therefore, were preempted by federal law requiring they be addressed through the

Medicare administrative appeals process. The Court of Appeals for the Ninth Circuit concluded the complaint did not state any claims in which both the standing and the substantive basis for the presentation of the claims was the Medicare Act; rather, the complaint was predicated on state common law theories. (*Ardary, supra,* at pp. 499–500.) The *Ardary* court also concluded the plaintiffs' state law claims were not " 'inextricably intertwined' " with the assertedly wrongful denial of Medicare benefits because the plaintiffs were not seeking to recover benefits, and because the harm the defendants allegedly caused could not be remedied by the payment of benefits. (*Id.* at p. 500.)[5]

***278 **1196** Defendants suggest that, although the *Ardary* court recited the test articulated in *Ringer, supra,* 466 U.S. at pages 614–615, 104 S.Ct. 2013, ***420** it did not address or resolve the potential conflict between an award of state law tort damages proximately resulting from a wrongful denial of Medicare benefits, on the one hand, and the possibility that an exhaustive administrative appeal would determine that Medicare benefits were not *wrongly* denied in the particular case, on the other. Because, as *Ringer* made clear, Congress has vested in the Secretary the exclusive power to administer the Medicare system, defendants contend that any state court damage award that is logically dependent on a finding of wrongful denial of benefits is " 'inextricably intertwined' " (*Ringer, supra,* at p. 614, 104 S.Ct. 2013) with a Medicare claim.

Such was the conclusion of the Court of Appeal in *Redmond v. Secure Horizons, **Pacificare**, Inc.* (1997) 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174 (*Redmond*). In that case, the plaintiff HMO subscriber sued her HMO on various state contract and tort law theories for its initial denial of coverage and subsequent delay in reimbursing her for health care expenses covered *421 under her Medicare-subsidized plan. The superior court dismissed the complaint, ruling it lacked jurisdiction because the plaintiff's causes of action arose under Medicare. The Court of Appeal affirmed. The fact the plaintiff's causes of action were based on her contractual relationship with the HMO did not mean her ***279** claims did not arise under Medicare, the court reasoned; indeed, the contract expressly provided that coverage determinations would be based on the Medicare Act and resolved through the multilevel Medicare administrative review process. (*Redmond, supra,* at p. 101, 70 Cal.Rptr.2d 174.) Moreover, the Court of Appeal held, each of the plaintiff's state law causes of action was inextricably intertwined with a claim that she was entitled to the reimbursement she eventually received. (*Id.* at p. 102, 70 Cal.Rptr.2d 174.)

The plaintiff in *Redmond* argued her claim was based, not on her entitlement to benefits, but on the defendant's conduct with respect to her claim for benefits. The Court of Appeal disagreed: "This argument fails because the alleged wrongfulness of defendant's conduct depends on whether plaintiff was entitled to payment of her claim. The fact that defendant ultimately paid her claim does not necessarily establish that plaintiff was *entitled* to such payment." (*Redmond, supra,* 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174.)

Finally, the *Redmond* plaintiff contended her case fell outside the administrative exhaustion requirement because, as recognized in *Ringer, supra,* 466 U.S. at page 618, 104 S.Ct. 2013, and *Ardary, supra,* 98 F.3d at page 500, the initial denial and subsequent delay in paying benefits caused injury that could not be remedied by the later payment of benefits. The Court of Appeal dismissed the contention, concluding the plaintiff could have pressed her claim through the administrative review process. The court opined the administrative process governs not only coverage determinations but also " 'any other determination *with respect to* a claim for benefits' " (*Redmond, supra,* 60 Cal.App.4th at p. 103, 70 Cal.Rptr.2d 174), and observed that the Secretary can order civil money penalties or " 'any other remedies authorized by law' " (*ibid.*).[6] *Redmond,* however, cited no authority for the implied proposition that the Secretary is empowered to award damages for violations of state tort law.[7]

**1197 The *Redmond* court's rationale—i.e., that the plaintiff's state tort law claims were inextricably intertwined with a Medicare claim because the *422 alleged wrongfulness of the defendant's conduct depended on whether the plaintiff was, in fact, entitled to payment of her claim—has a certain logic. In applying one portion of the *Ringer* analysis, however, the *Redmond* court elided over the other. That is, it failed adequately to explain how the alleged harms suffered by the *Redmond* ***280 plaintiff could be remedied through the Medicare administrative review process. If those harms could not be so remedied, then the *Redmond* court's holding hinges on a conclusion that, by establishing an administrative process for Medicare benefit determinations, Congress must have intended to oust state courts of jurisdiction to enforce such of their own tort laws as may be implicated by conduct incidental to benefit determinations. We are directed to no evidence supporting such a conclusion.

3 We presume that in enacting laws, Congress does not intend to preempt state regulation of the same subject matter unless a contrary intent is made clear. (*Medtronic, Inc. v. Lohr* (1996) 518 U.S. 470, 485, 116 S.Ct. 2240, 135 L.Ed.2d 700; *Cipollone v. Liggett Group, Inc.* (1992) 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407.) The classic example of clear congressional intent to preempt state remedies is found in the Employee Retirement Income Security Act of 1974 (ERISA), 29 United States Code section 1001 et seq., governing employee benefit plans, including health insurance. ERISA expressly and broadly preempts state law, providing it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." (29 U.S.C. § 1144(a); see *Ingersoll Rand Co. v. McClendon* (1990) 498 U.S. 133, 139–140, 111 S.Ct. 478, 112 L.Ed.2d 474 [ERISA preempts employee's state law claim of wrongful discharge in order to avoid paying pension benefits]; *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 47–48, 107 S.Ct. 1549, 95 L.Ed.2d 39 [ERISA preempts state law tort and contract claims against insurer for bad faith denial of claim].)

4 No intent to displace state tort law remedies was expressed in the Medicare Act as it read at the time relevant to this case. (*Ardary, supra,* 98 F.3d at pp. 501–502.) To the contrary, "[t]he first section of the Medicare Act explicitly states [Congress's] intent to minimize federal intrusion in the area." *423 (*Massachusetts Medical Soc. v. Dukakis* (1st Cir.1987) 815 F.2d 790, 791; *Shands Teaching Hosp. v. Humana Medical* (Fla.Dist.Ct.App.1999) 727 So.2d 341, 344.) Title 42, section 1395 of the United States Code provides: "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." Indeed, the Act specifically requires HMO's and other Medicare providers to be state licensed. (42 U.S.C. § 1395mm(b).) By clear implication, therefore, Congress left open a wide field for the operation of state law pertaining to standards for the practice of medicine and the manner in which medical services are delivered to Medicare beneficiaries.

The conclusion that Congress, in enacting the Medicare Act, did not intend to displace the state tort remedies with which we are here concerned is strengthened by consideration of subsequent amendments to the Act. Shortly before the **McCalls** filed the initial complaint in this case, the Balanced Budget Act of 1997 (the BBA) became law. (Pub.L. No. 105–33 (Aug. 5, 1997) 111 Stat. 328, codified at 42 U.S.C. § 1395w–21 et seq.) **1198 The BBA enacted a new part of Medicare known as "Medicare + Choice" that allows a new range of Medicare managed care options. HMO's contracting with Medicare, such as **PacifiCare**, automatically became Medicare ***281 + Choice plans effective January 1, 1999. (See 42 U.S.C. § 1395mm(k).) The BBA is noteworthy for its addition of an express limited preemption provision to the Medicare Act. By its terms, Medicare now preempts state laws mandating benefits to be covered, mandating inclusion of providers and suppliers, and coverage determinations. (42 U.S.C. § 1395w–26(b)(3).) Pursuant to the related regulations, determinations on issues other than whether a service is covered under a Medicare + Choice contract fall outside the

definition of coverage determinations. (42 C.F.R. § 422.402 (1999).) All other types of state laws not inconsistent with Medicare standards are permitted. (*Ibid.*) The preamble to HCFA's request for final comments on the interim final rule implementing the amendments states: "Prior to the BBA, section 1876 of the Act [(42 U.S.C. § 1395mm)] (governing Medicare risk and cost contracts with HMOs and competitive medical plans) did not contain any specific preemption provisions. However, section 1876 requirements could preempt a State law or standard based on general constitutional Federal preemption principles.... Put another way, if Federal law permitted the HMO to do what State law required, there was no preemption. In practice, rarely, if ever, did Federal law preempt State laws affecting Medicare prepaid plans. For example, Medicare risk plans operating in States with mandated benefit laws ***424** were generally required to comply with such State laws. Compliance with the State mandated benefit law was not viewed as interfering with the ability of plans to function as Medicare risk contractors under Federal standards.... [¶] ... [¶] ... [T]he specific preemption [added by the BBA] does not preempt State remedies for issues other than coverage under the Medicare contract (i.e. tort claims or contract claims under State law are not preempted). The same claim or circumstance that gave rise to a Medicare appeal may have elements that are subject to State remedies that are not superseded. For example, [a Medicare + Choice] organization's denial of care that a beneficiary believes to be covered care is subject to the Medicare appeals process, but under our interpretation of the scope of the specific preemption on coverage decisions, the matter may also be the subject of a tort case under State law if medical malpractice is alleged, or of a state contract law claim if an enrollee alleges that the [Medicare + Choice] organization has obligated itself to provide a particular service under State law without regard to whether it is covered under its [Medicare + Choice] contract." (63 Fed.Reg. 34967, 35012, 35013 (June 26, 1998).) Because, prior to the BBA, Medicare preemption of state law claims was even narrower than the limited preemption enacted by the BBA, these comments strongly imply that state law claims such as those involved in the present case were not preempted under then applicable law.

5 As the **McCalls** observe, Medicare regulations provide for administrative review of a limited class of claims (42 C.F.R. § 417.600 et seq. (1999)), not including those pertaining to quality of care, marketing problems and forced disenrollment such as the **McCalls** have alleged in their complaint. Absent clear indication of congressional intent, we decline to find preemption of claims, founded in California law, that find no remedy under the Medicare administrative process.

We must now turn to the specific causes of action contained in the first amended complaint to determine whether any is "inextricably intertwined" with a claim for Medicare benefits. Neither the high court in *Ringer, supra,* 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, nor the Ninth Circuit in *Ardary, supra,* 98 F.3d 496, essayed ****282** a definition of this key phrase. The Court of Appeal in *Redmond, supra,* 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174, may be understood to have held that any claim incidental to a coverage determination, whether it seeks payment (or reimbursement) for medical services or tort damages resulting from the manner in which coverage was denied, is inextricably intertwined with a claim for Medicare benefits. (*Id.* at pp. 102–103, 70 Cal.Rptr.2d 174.) Defendants ***1199** urge us to adopt such a reading of the Act.

6 7 We believe *Redmond* painted with too broad a brush in so holding. A Medicare provider may violate state common law or statutory duties owing ***425** to beneficiaries, unrelated to its Medicare coverage determinations. The "inextricably intertwined" language in *Ringer* is more correctly read as sweeping within the administrative review process only those claims that, "at bottom," seek reimbursement or payment for medical services, but not a claim *not* seeking such reimbursement or payment, which claim as pleaded incidentally refers to a denial of benefits under the Medicare Act. (See *Ringer, supra,* 466 U.S. at pp. 614–615, 104 S.Ct. 2013.) The latter type of state-law-based claim by Medicare beneficiaries is not subject to the administrative review process and may be pursued in our state courts. In the language of *Ringer,* at page 618, 104 S.Ct. 2013, such claims are collateral to, not inextricably intertwined with, Medicare benefit claims.

8 For example, a provider may negligently fail to use ordinary skill and care in treating a beneficiary, or properly to advise the beneficiary concerning his health condition or appropriate treatment options, whether or not such options are covered by Medicare, thus preventing the beneficiary from seeking such treatment even at his own expense. Or a provider may fail to provide appropriate referrals to specialists, and thus prevent the beneficiary from obtaining appropriate care, again without regard to coverage. The **McCalls**' first and second causes of action, for negligence and wilful misconduct, respectively, set forth such allegations and enumerate the statutory and regulatory bases of the relevant duties (see *ante,* 106 Cal.Rptr.2d p. 274, 21 P.3d p. 1192), none of which necessarily implicates a coverage determination or falls within the scope of the Medicare administrative review process.

9 10 A provider may make misrepresentations regarding the nature or extent of the services it intends to provide, either in its application for HMO licensure to the California Department of Corporations or in its marketing materials disseminated to potential enrollees. If the injury to the enrollee is foreseeable, a *Randi W.* cause of action[8] or a claim of fraud may be stated.[9] The **McCalls**' third, fourth and ***283 fifth causes of action allege such claims, none of *426 which necessarily implicates coverage determinations or falls within the scope of the Medicare administrative review process.

11 A provider may breach the fiduciary duty it owes the enrollee (see *Moore v. Regents of University of California* (1990) 51 Cal.3d 120, 129, 271 Cal.Rptr. 146, 793 P.2d 479), inter alia, by permitting its financial interest detrimentally to affect treatment decisionmaking or failing to disclose such interest. The **McCalls**' sixth cause of action alleges such a claim, which does not necessarily implicate coverage determinations or fall within the scope of the Medicare administrative review process.

12 If a defendant's violations of state law duties are sufficiently outrageous, a claim for negligent or intentional infliction of emotional **1200 distress may be stated; the **McCalls**' seventh and eighth causes of action allege such violations, none of which necessarily implicates coverage determinations or falls within the scope of the Medicare administrative review process.

13 Finally, such violations of statutory duties, none necessarily implicating coverage determinations or falling within the scope of the Medicare administrative review process, may amount to unfair practices as prohibited by Business and Professions Code section 17200; the **McCalls**' ninth cause of action so alleges.[10]

Because the **McCalls** may be able to prove the elements of some or all of their causes of action without regard, or only incidentally, to Medicare coverage determinations, because (contrary to the dissent's characterization of the complaint) none of their causes of action seeks, at bottom, payment or reimbursement of a Medicare claim or falls within the Medicare administrative review process, and because the harm they allegedly suffered thus is not remediable within that process, it follows that the Court of Appeal correctly reversed the trial court's orders sustaining defendants' demurrers without leave to amend.[11]

We therefore affirm the judgment of the Court of Appeal and disapprove the decision in *Redmond v. Secure Horizons, **Pacificare**, Inc., supra,* 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174, to the extent it is inconsistent with this opinion.

*427 GEORGE, C.J., MOSK, J., KENNARD, J., and CHIN, J., concur.

BAXTER, J., dissenting.

The Medicare Act (42 U.S.C. § 1395 et seq.) (hereafter sometimes referred to as Medicare or the Act) is a massive federally insured program that covers health services for the elderly and disabled. Congress ***284 has decreed that any enrollee of a Medicare health maintenance organization (HMO) plan who wishes to challenge the HMO's denial of health services under Medicare must do so through Medicare's

administrative review process; if that process yields a final decision that is adverse to the enrollee, then judicial review must be sought in federal court. (42 U.S.C. § 1395ff.)

Disregarding that congressional mandate and key United States Supreme Court authority, the majority opinion allows virtually any Medicare HMO plan enrollee to bring suit in state court to challenge an HMO's denial of Medicare benefits. Enrollees may bypass Medicare's exhaustion requirements simply by styling their challenges as claims for tort damages. As a result, questions regarding which medical procedures are or should be covered by Medicare may now be decided outside of Medicare's exclusive review process by California judges and juries on an ad hoc basis.

Congress acted deliberately to ensure uniform administrative and federal accountability for Medicare HMO decisionmaking. Yet today's decision sets the stage for potential conflict between an award of state law tort damages following a determination in a state court that Medicare benefits were wrongly denied, on the one hand, and the possibility that an exhaustive administrative appeal, followed by federal court review, would determine that Medicare benefits were *not wrongly denied* in the particular case and in other comparable cases, on the other. The two cannot be squared; accordingly, I dissent.

I.

The Medicare Act is a part of the Social Security Act that establishes a federally subsidized health insurance program for elderly ***1201** and certain disabled persons. (42 U.S.C. § 1395 et seq.) In the year 2000, the program provided health insurance coverage for 39 million persons, or one in seven Americans, and paid benefits in the total amount of approximately $217 billion. (The Henry J. Kaiser Family Foundation, Medicare at a Glance (Feb. 2001) p. 1.)

To ensure the orderly and efficient functioning of this enormous federal program, Congress has entrusted its administration to the Secretary of Health *428 and Human Services (the Secretary), who manages the program through the Health Care Financing Administration (HCFA). Pursuant to congressional authorization, the Secretary has established an extensive set of regulations to govern the program. (42 U.S.C. § 1395hh.)

Briefly, the Medicare system works like this. Eligible patients may obtain Medicare benefits in two ways. Where a patient elects to receive health care on a fee-for-service basis, the patient first consults with a physician and receives the recommended health services. The health care provider submits the bill for payment to a Medicare fiscal intermediary, typically a private company that has contracted with the Secretary to act as an adjuster. The intermediary then determines whether the services in question are covered by Medicare and the amount due for the services. (See *Bodimetric Health Services, Inc. v. Aetna Life and Casualty* (7th Cir.1990) 903 F.2d 480, 482 & fn. 3 (*Bodimetric*).) Alternatively, an eligible patient may elect to receive Medicare benefits through enrollment with an HMO that has contracted with the Secretary through HCFA to be reimbursed for services rendered to enrollees. In such situations, the patient receives treatment either from the HMO's own physicians or from physicians who have contracted with the HMO, as in the case of defendant **PacifiCare** of California, Inc. (**PacifiCare**), here. When HCFA contracts ***285** with an HMO, there is no separate fiscal intermediary and the HMO makes an "organization determination" (an initial determination) whether health services requested on behalf of an enrollee are covered under Medicare and whether they should be furnished, arranged for, or reimbursed. (42 C.F.R. § 417.606 (2000).)

Health services covered under Medicare, whether or not provided through an HMO, are subject to the following important limitation: "Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services—[¶] ... which ... are not *reasonable and necessary* for the diagnosis or treatment of illness or injury...."[1] (42 U.S.C. § 1395y(a)(1)(A), italics added; see *Roen v. Sullivan* (D.Minn.1991) 764 F.Supp. 555, 557.) Thus, if an HMO plan enrollee requests a health service that is not medically reasonable and

necessary, the enrollee generally is not entitled to the benefit and the HMO is not obligated to provide for it.

Under the Act, an individual's entitlement to Medicare benefits must be determined in the manner provided for by the Secretary: "The determination ***429** of whether an individual is entitled to benefits ..., and the determination of the amount of benefits ..., and any other determination with respect to a claim for benefits ... shall be made by the Secretary in accordance with regulations prescribed by him." (42 U.S.C. § 1395ff(a).) The Secretary is authorized to impose, in addition to "any other remedies authorized by law," civil monetary penalties and to suspend payment to or enrollment of a contracting HMO or fiscal intermediary where, among other things, such an organization "fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual" (42 U.S.C. § 1395mm(i)(6)(A)(i)) or "misrepresents or falsifies information that is furnished—[¶] ... to the Secretary ... or—[¶] ... to an ****1202** individual" (*id.*, § 1395mm(i)(6)(A)(v)). (See also 42 C.F.R. § 417.500 (2000).)

Integral to the Medicare scheme is a thorough administrative review process for an individual "dissatisfied with a determination regarding his or her Medicare benefits." (42 C.F.R. § 417.600(a)(1) (2000); see *id.*, § 417.600 et seq.; 42 U.S.C. § 1395ff(b)(1).) Judicial review of claims arising under the Medicare Act is available only in federal court, and only then if the amount in controversy is at least $1000 and the Secretary has rendered a "final decision" on the claim, in the same manner as is provided for old age and disability claims arising under Title II of the Social Security Act. (42 U.S.C. §§ 405(g), (h), 1395ff(b)(1)(C).)

Pursuant to rulemaking authority granted by Congress, the Secretary has provided that a final decision is rendered on a Medicare claim only after the individual claimant has presented the claim through all designated levels of administrative review, including review by HCFA or its agent, an administrative law judge (ALJ), and the departmental appeals board. (*Heckler v. Ringer* (1984) 466 U.S. 602, 606–607, 104 S.Ct. 2013, 80 L.Ed.2d 622 (*Ringer*); 42 C.F.R. § 417.600 et seq.) ****286** Portions of the administrative review process must be expedited where the usual time frames "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." (42 C.F.R. §§ 417.609(b), 417.617(b) (2000).) As the legislative history explains, "[i]t is intended that the remedies provided by these review procedures shall be *exclusive*." (Sen.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1965 U.S.Code Cong. & Admin. News, pp.1943, 1995, italics added.)

The broad scope of Medicare's exclusive review process was emphasized in *Ringer, supra,* 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, the United States Supreme Court's seminal decision on the issue. In *Ringer,* four individual Medicare beneficiaries filed ***430** a federal court action for declaratory and injunctive relief that challenged the Secretary's formal policy of denying Medicare coverage for a surgical procedure known as bilateral carotid body resection (BCBR). Three of the plaintiffs had undergone BCBR surgery but were denied reimbursement for the surgery by fiscal intermediaries. Although some of the levels of the administrative review process had been completed, none of the three had received a final decision on their benefit claims from the Secretary. (466 U.S. at pp. 609–610, 104 S.Ct. 2013.) The fourth plaintiff, who did not have the surgery because he could not afford it, had not submitted a claim for reimbursement. (*Id.* at p. 610, 104 S.Ct. 2013.) The four plaintiffs contended in federal court that the Secretary had a constitutional and statutory obligation to provide payment for BCBR surgery and that the Secretary's formal ruling refusing to find the BCBR surgery "reasonable and necessary" under the Act was unlawful. (*Ringer, supra,* 466 U.S. at pp. 610–611, 104 S.Ct. 2013.)

In *Ringer,* the Supreme Court considered whether the plaintiffs, who were not seeking an award of benefits, could bring an action directly in federal court without pursuing administrative remedies. In analyzing the issue, the court initially observed that judicial review is unavailable for " 'claim[s] arising under' " the Medicare Act, and that claims

arise under Medicare if they are " 'inextricably intertwined' " with claims for Medicare benefits. (*Ringer, supra,* 466 U.S. at pp. 614–615, 104 S.Ct. 2013.) Noting that the phrase "claim arising under" had been judicially construed "quite broadly," the high court concluded that a claim arises under Medicare where " 'both the standing and the substantive basis for the presentation' " of the claim is the Medicare Act. (*Ringer, supra,* 466 U.S. at p. 615, 104 S.Ct. 2013.)

Turning to the facts of the case, the Supreme Court first noted that the Secretary's formal ruling was inapplicable to the claims of the first three plaintiffs due to timing. But their claims, which did not seek an actual award of benefits, nonetheless "[arose] under" the Medicare Act because the Act furnished both the standing and the substantive basis for their claims. (*Ringer, supra,* 466 U.S. at p. 615, 104 S.Ct. 2013.) As for the fourth plaintiff, whose claim was in fact subject to the Secretary's ruling, the Supreme Court viewed him as clearly seeking "to establish a right to future payments should he **1203 ultimately decide to proceed with BCBR surgery." (*Id.* at p. 621, 104 S.Ct. 2013.) That the fourth plaintiff was not seeking the immediate payment of benefits was of no importance; his claim " must be construed as a 'claim arising under' the Medicare Act," the court reasoned, "because any other construction would allow claimants substantially to undercut Congress' carefully crafted scheme for administering the Medicare *431 Act. [¶] If we allow claimants ***287 ... to challenge in federal court the Secretary's determination ... that BCBR surgery is not a covered service, we would be inviting them to bypass the exhaustion requirements of the Medicare Act by simply bringing declaratory judgment actions in federal court before they undergo the medical procedure in question." (*Ibid.*) As part of its analysis, the court found that the administrative review process provided an adequate remedy for challenging both the Secretary's decision that a particular medical service was not reasonable and necessary, and the means by which the Secretary implemented such a decision. (*Id.* at p. 617, 104 S.Ct. 2013.)

In holding that a claim may arise under Medicare while also arising under some other law (i.e., the federal Constitution), the *Ringer* decision looked to *Weinberger v. Salfi* (1975) 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (*Salfi*), for guidance. (*Ringer, supra,* 466 U.S. at p. 615, 104 S.Ct. 2013.) In *Salfi,* a claimant who had been denied Social Security benefits based on "duration-of-relationship" requirements of the Social Security Act filed an action in federal court on behalf of herself, and others similarly situated, challenging the constitutionality of the statutory requirements.[2] In response to the claimant's argument that the action arose under the Constitution and not under the Social Security Act, the high court stated: "It would, of course, be fruitless to contend that appellees' claim is one which does not arise under the Constitution, since their constitutional arguments are critical to their complaint. But it is just as fruitless to argue that this action does not also arise under the Social Security Act. For not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions." (*Salfi, supra,* 422 U.S. at pp. 760–761, 95 S.Ct. 2457.) The Supreme Court ultimately concluded in *Salfi* that compliance with the administrative review process was required, even though the claims had a constitutional basis and even though the Secretary had no power to affect an unconstitutional denial of benefits. (*Salfi, supra,* 422 U.S. at p. 764, 422 U.S. 749.)

Taken together, *Ringer* and *Salfi* make clear that claims challenging an HMO's denial of reasonable and necessary health services covered by Medicare must undergo an administrative review for a final decision prior to any judicial review to ensure Medicare's efficient and orderly functioning. As the Supreme Court emphasized in both decisions, "the purpose of the exhaustion requirement is to prevent 'premature interference with agency *432 processes' and to give the agency a chance 'to compile a record which is adequate for judicial review.' " (*Ringer, supra,* 466 U.S. at p. 619, fn. 12, 104 S.Ct. 2013, quoting *Salfi, supra,* 422 U.S. at p. 765, 95 S.Ct. 2457.) That purpose is frustrated substantially when HMO plan enrollees are permitted to bypass the administrative process. As one court aptly summarized, "[t]he lack of a developed record means that plaintiffs in effect call upon the court to play doctor in their cases.

The prescribed HMO and agency decisionmaking procedures were designed to avoid that problem." (*Roen v. Sullivan, supra,* 764 F.Supp. at pp. 560–561.)

In California, *Ringer* 's analysis was followed in ***288 *Redmond v. Secure Horizons,* ***PacifiCare**, Inc.* (1997) 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174 (*Redmond*). In that case, a Medicare HMO plan enrollee underwent a "life-saving" surgery after the HMO initially denied coverage. The enrollee subsequently requested reimbursement for the surgery and the HMO ultimately acquiesced. The enrollee then sued the HMO in state court for breach of contract, breach of the implied **1204 covenant of good faith and fair dealing, and negligent and intentional infliction of emotional distress. The HMO demurred, contending that the tort and contract causes of action were inextricably intertwined with the denial of Medicare benefits and were therefore subject to Medicare's administrative procedures.

On review, the Court of Appeal ruled in favor of the HMO: "[W]hile plaintiff's causes of action are not actually a claim for benefits, since she has already obtained reimbursement of her medical expenses, her causes of action *are* 'inextricably intertwined' with a claim that she was entitled to the reimbursement she received. Plaintiff argues that her complaint was not based on her entitlement to benefits but on defendant's 'conduct' with respect to her claim for benefits. This argument fails because the alleged wrongfulness of defendant's conduct depends on whether plaintiff was entitled to payment of her claim." (*Redmond, supra,* 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174; accord, *Wilson v. Chestnut Hill Healthcare* (E.D.Pa., Feb. 22, 2000, Civ. A. No. 99–CV–1468), 2000 WL 204368, at p. *4 ["courts must discount any 'creative pleading' which may transform Medicare disputes into mere state law claims, and painstakingly determine whether such claims are ultimately Medicare disputes"].)

Additionally, federal decisions arising in analogous contexts have followed *Ringer* in foreclosing state law claims by health care providers pertaining to the withholding of Medicare benefit reimbursements.[3] For example, in *Bodimetric, supra,* 903 F.2d 480, a provider filed suit against a *433 Medicare fiscal intermediary, alleging state law claims for fraud and for wrongful misconduct in the processing of its reimbursement claims. Although the action sought recovery of tort damages, not benefit reimbursements, the Seventh Circuit Court of Appeals concluded that the plaintiff could not avoid the Medicare Act's review process "simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits." (*Bodimetric,* at p. 487.) While recognizing that the federal administrative process might not afford the provider all the relief it sought pursuant to its state law claims, the appeals court nonetheless emphasized that "Congress, through its establishment of a limited review process, has provided the remedies it deems necessary to effectuate the Medicare claims process." (*Id.* at p. 486, fn. 5; ***289 see also *Marin v. HEW, Healthcare Financing Agency* (9th Cir.1985) 769 F.2d 590.)

Similarly, in *Midland Psychiatric Associates, Inc. v. United States* (8th Cir.1998) 145 F.3d 1000 (*Midland*), a health care provider sued a Medicare fiscal intermediary for tortiously interfering with its contracts with hospitals by denying the hospitals' payment claims for services rendered by the provider to Medicare beneficiaries. In affirming dismissal of the provider's action, the Eighth Circuit Court of Appeals reasoned that the intermediary could not be held liable for tortious interference if it had a right to deny the hospitals' payment claims and that hearing the tortious interference claim would mean reviewing the merits of the intermediary's Medicare claims decisions. (*Midland,* at pp. 1002, 1004.) Relying on *Ringer* and *Salfi,* the Eighth Circuit concluded that the tortious interference claim arose under the Medicare Act and was therefore subject to the exclusive federal administrative review procedures, even though, as pleaded, the claim also arose under state law.[4] (**1205 *Midland,* at p. 1004; see also *Jamaica Hospital Nursing Home v. Oxford Health* *434 *Plans* (S.D.N.Y., Sept. 26, 2000, No. 99 Civ. 9541(AGS)) 2000 WL 1404930 [where nursing home alleged that an assignment of insurance rights from a treated patient entitled it to payment from an HMO for the cost of treatment, claim arose under the Medicare Act even though it was presented as a contract claim].)

II.

Under the foregoing authorities, it is evident that what plaintiffs have asserted in this action are "claims arising under" the Medicare Act. Specifically, plaintiffs allege that (1) **PacifiCare** breached its duty to comply with state and Medicare regulations governing the provision of health care services and failed to secure for plaintiff George **McCall** "reasonably necessary" health care services to which he was entitled (negligence, willful misconduct, unfair business practices); (2) **PacifiCare** misrepresented to government officials and to its own enrollees that it would comport with California Health and Safety Code provisions and with Medicare regulations, yet failed to do so after having secured HMO licensure through the state and an HMO contract through HCFA, and after having induced enrollment by individuals entitled to Medicare benefits (fraud, constructive fraud, unfair business practices); and (3) **PacifiCare** wrongfully denied plaintiff George **McCall** the level of health services to which he was entitled under both state law and Medicare by refusing surgical intervention to save his life (a lung transplant ***290) and instead providing a much less expensive course of treatment (intentional and negligent infliction of emotional distress, unfair business practices).

At bottom, plaintiffs challenge **PacifiCare's** failure to furnish or arrange for "reasonable and necessary" health services covered by Medicare. (42 U.S.C. § 1395y(a)(1)(A).) Critically, plaintiffs' ability to prevail on their state law causes of action inevitably turns upon a determination that plaintiff George **McCall** was entitled to a Medicare benefit, i.e., a lung transplant, and that **PacifiCare** had no right to deny such benefit because it was reasonable and necessary for treatment of his condition. (See *Ringer, supra,* 466 U.S. at pp. 610–611, 104 S.Ct. 2013; *Redmond, supra,* 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174.) The consequential damages sought by plaintiffs also are dependent upon such a determination. That being the case, plaintiffs' claims are *435 "inextricably intertwined" with a Medicare benefits determination and are subject to Medicare's administrative review process.

As *Ringer* instructs, it matters not that plaintiffs carefully avoid any formal claim for reimbursement of sums they expended to obtain the services otherwise covered under Medicare. (*Ringer, supra,* 466 U.S. at p. 621, 104 S.Ct. 2013.) Nor does it make a difference that plaintiffs' claims are based in part on state law, for it is the Medicare Act that furnishes both the standing and the substantive basis for the presentation of their state law contentions. (See *Ringer,* at p. 620, 104 S.Ct. 2013; *Salfi, supra,* 422 U.S. at pp. 760–761, 95 S.Ct. 2457.) Distilled to their essence, the state law causes of action necessarily rely upon plaintiff George **McCall's** status as an individual entitled to Medicare benefits and upon the Medicare Act itself to define the benefits and health services to which he was legally entitled but wrongly denied. Consequently, such claims do not, as the majority suggests, only "incidentally" refer **1206 to a denial of benefits under Medicare. (See maj. opn., *ante,* 106 Cal.Rptr.2d at p. 282, 21 P.3d at p. 1199.)

The Supreme Court, I note, has suggested that an exception to exhaustion may arise when a claim is "wholly 'collateral' to [a] claim for benefits," but that such exception will not apply where there is "no colorable claim that an erroneous denial of ... benefits in the early stages of the administrative process will injure [the claimant] in a way that cannot be remedied by the later payment of benefits." (*Ringer, supra,* 466 U.S. at p. 618, 104 S.Ct. 2013.) As discussed, however, plaintiffs' state law claims are not wholly collateral to a claim for benefits because, at bottom, they ultimately derive from the contention that plaintiff George **McCall** was entitled to a lung transplant and other reasonable and necessary medical services denied him by **PacifiCare**. Moreover, nothing in the record (limited as it may be) suggests plaintiffs could not have overcome **PacifiCare's** denial of such services through the administrative process if in fact Medicare coverage existed. Indeed, had George **McCall** initially elected to receive health care on a fee-for-service basis and consulted a physician of his choice for purposes of receiving a lung transplant, and had he been denied reimbursement for the physician's services by a Medicare fiscal intermediary, there would be no question that he would have been required to seek reconsideration of the denial through Medicare's administrative review process. The fact that a Medicare HMO denied his request for a transplant in a managed care setting should make no difference in the legal analysis.

At oral argument on this matter, counsel for plaintiffs could not and did not dispute ***291 that the claims concerning **PacifiCare's** alleged wrongful refusal to arrange for a lung transplant would necessitate a determination whether *436 the transplant was a reasonable and necessary medical treatment to which plaintiff George **McCall** was entitled under Medicare. Counsel instead argued, and the majority evidently agrees, that no benefit determination would be involved in deciding whether **PacifiCare** fraudulently induced plaintiff to enroll in **PacifiCare**, whether **PacifiCare** wrongfully withheld information regarding treatment options, and whether **PacifiCare** wrongfully forced plaintiff to disenroll from **PacifiCare**.

That argument fails to convince. Essentially all of plaintiffs' claims are predicated on the central theory that **PacifiCare**, as a Medicare HMO, was required to comply with all Medicare rules and regulations, that reasonable and necessary health services covered by Medicare would not be denied, and that all available Medicare treatment options would be discussed and provided. As a result of **PacifiCare's** alleged misconduct, plaintiff George **McCall** enrolled in **PacifiCare** and allegedly was harmed thereby. Moreover, to the extent plaintiffs allege that **PacifiCare** made fraudulent misrepresentations to Medicare in order to obtain a Medicare HMO contract and to induce enrollment, such claims are, as plaintiffs apparently recognize, barred under the reasoning of *Buckman Co. v. Plaintiffs' Legal Committee* (2001), 531 U.S. 341[, 121 S.Ct. 1012] (finding similar fraud claims preempted by the Federal Food, Drug, and Cosmetic Act, as amended by the Medical Device Amendments of 1976). As for the disenrollment claim, plaintiff George **McCall** allegedly had to disenroll in order to get the lung transplant he sought. Since the harm resulting from all of **PacifiCare's** alleged misconduct is inseparable from the harm resulting from its denial of the lung transplant, there appears no basis for finding any of the claims exempt from the administrative review process.

In purporting to analyze plaintiffs' complaint, the majority suggests that malpractice may be committed under state law based on a provider's failure to properly advise of treatment options or its failure to provide appropriate referrals to specialists, whether or not such options or referrals were covered by Medicare, and that malpractice as such may prevent a beneficiary from seeking noncovered services at his own expense. (Maj. opn., *ante,* 106 Cal.Rptr.2d at p. 282, 21 P.3d at p. 1199.) This sort of malpractice claim, the majority asserts, would not implicate a coverage determination or fall within the scope of the Medicare review process.

Even assuming the majority states the law correctly in the abstract, the complaint here lacks such a claim. The allegations make no specific reference to any "noncovered" medical treatment about which plaintiff George **McCall** should have been advised. Nor do they suggest that plaintiff would have undergone a particular noncovered treatment at his own expense but for *437 **PacifiCare's** alleged misconduct, or that any harm flowed from his ignorance of noncovered treatments. Rather, the crux of the complaint is that plaintiff was harmed by **PacifiCare's** failure to secure the lung transplant and other reasonable and necessary medical treatment to which he was entitled under Medicare.

**1207 To support its contrary conclusion, the majority invokes the Ninth Circuit Court of Appeals' decision in *Ardary v. Aetna Health Plans of California, Inc.* (9th Cir.1996) 98 F.3d 496 (*Ardary*). In *Ardary,* the heirs of a deceased Medicare beneficiary brought state law claims for wrongful death against a private Medicare provider ***292 seeking compensatory and punitive damages on the basis that the provider improperly denied medical services (an emergency airlift transfer) and misrepresented its managed care plan to the beneficiary. The provider removed the action to federal court, arguing, among other things, that relief was limited to federal administrative remedies under *Ringer*. The Ninth Circuit disagreed.

Notably, the Ninth Circuit acknowledged that the heirs' state law claims were all predicated on the provider's failure to authorize the emergency airlift transfer. (*Ardary, supra,* 98 F.3d at p. 498.) Yet the court determined their complaint did not arise under the Medicare Act because it did not " 'include any claims in which "*both* the standing

and the substantive basis for the presentation" of the claims' is the Act." (*Ardary*, at p. 499.) In its view, standing for the heirs' claims was provided by state common law (e.g., negligence, infliction of emotional distress, misrepresentation, and professional negligence), not the Act. (*Id.* at pp. 499–500.) The court also concluded the claims were not "inextricably intertwined" with a benefits claim because the heirs were not seeking to recover benefits. (*Id.* at p. 500.) Finally, the court emphasized the inappropriateness of relegating the wrongful death claims to the administrative process because the injury complained of—the beneficiary's death—could not be remedied by the retroactive authorization or payment of the airlift transfer. (*Ibid.*)

Ardary is analytically flawed and cannot support the majority's disregard of the principles articulated by the Supreme Court in *Ringer* and *Salfi*. Contrary to *Ardary* 's reasoning, those decisions affirm that claims may arise under the Medicare Act and be subject to its administrative review process, *even though the claims also arise under some other law*. Thus, even where claims have a state law basis, as exemplified in *Ardary* and in the instant case, they also arise under the Medicare Act where, at bottom, they challenge the correctness of the defendant's denial of health services covered by Medicare. (See *Ringer, supra*, 466 U.S. at p. 615, 104 S.Ct. 2013; *Redmond, supra*, 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174; *Wilson v. Chestnut Hill* ***438** *Healthcare, supra*, 2000 WL 204368, at p. *4; see also *Salfi, supra*, 422 U.S. at pp. 760–761, 95 S.Ct. 2457; *Midland, supra*, 145 F.3d 1000; *Bodimetric, supra*, 903 F.2d 480.) Moreover, the high court firmly rejected the notion that the absence of a formal request for payment of benefits is controlling. (*Ringer, supra*, 466 U.S. at p. 621, 104 S.Ct. 2013.) In any event, the result in *Ardary* was largely influenced by the fact that it was a wrongful death action brought by the heirs of a Medicare beneficiary. (*Ardary, supra*, 98 F.3d at p. 500.) Here, of course, the action was brought by the Medicare beneficiary himself and contains no wrongful death component.

The majority also supports its holding with the observation that the Secretary has no authority to assess the validity or merit of plaintiffs' tort claims or to grant relief for such claims. (Maj. opn., *ante*, 106 Cal.Rptr.2d at p. 279, fn. 7, 21 P.3d at pp. 1196–1197, fn. 7, citing *Kelly v. Advantage Health, Inc.* (E.D.La., May 11, 1999, Civ. A. No. 99–0362), 1999 WL 294796.) The Secretary, however, is authorized to impose civil monetary penalties and to suspend payment to or enrollment of a contracting HMO if the HMO ****1208*** " fails substantially to provide medically necessary items and services that are required" to be provided to an individual covered under the contract, where "the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual." (42 U.S.C. § 1395mm(i)(6)(A)(i); see also 42 C.F.R. § 417.500 (2000).) The Secretary may also impose such penalties if the *****293*** HMO "misrepresents or falsifies information that is furnished" to the Secretary or to an individual. (42 C.F.R. § 417.500(a)(5) (2000).) Accordingly, it appears the Secretary has been amply armed by Congress to address the type of wrongdoing alleged here.

More to the point, Congress has determined that questions regarding a claimant's entitlement to benefits under the Medicare Act must be decided through Medicare's administrative process to ensure the efficient and even administration of the federally insured program. An individual who is "dissatisfied with [an HMO's] determination regarding his or her Medicare benefits" (42 C.F.R. § 417.600(a)) should not be permitted "to undercut Congress's carefully crafted scheme for administering the Medicare Act" (*Ringer, supra*, 466 U.S. at p. 621, 104 S.Ct. 2013) by making state law contentions that necessitate a state court's review of an HMO's decision to deny benefits covered by Medicare. Where, as here, such contentions are central to a plaintiff's claims for recovery, they remain properly subject to the Act's mandatory administrative process where they may receive a thorough and expedited review. (See *Ringer, supra*, 466 U.S. at p. 619 & fn. 12, 104 S.Ct. 2013; see also *Salfi, supra*, 422 U.S. at p. 765, 95 S.Ct. 2457; *Redmond, supra*, 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174; *Wilson v. Chestnut Hill Healthcare, supra*, 2000 WL 204368, at pp. *3, *6.)

***439** The majority also justifies its decision by invoking the general presumption that Congress, in enacting laws, does not intend to preempt state regulation of the same subject matter unless a contrary intent appears, and by relying on title 42, section 1395

of the United States Code,[5] and on the Medicare Act's requirement that HMO's and other Medicare providers be state licensed (42 U.S.C. § 1395mm(b)). (Maj. opn., *ante,* 106 Cal.Rptr.2d at pp. 280–281, 21 P.3d at pp. 1197–1198.)

It is inconceivable that Congress did not intend to oust state courts of jurisdiction to review the merits of an HMO's denial of Medicare benefits. Not only are the provisions of the Act crystal clear on the point (42 U.S.C. §§ 1395ff(a), (b)(1), 405(g), (h)), but the legislative history expressly indicates that the remedies provided by the administrative review procedures are intended to be *exclusive.* (Sen.Rep. No. 404, 89th Cong., 1st Sess., *supra,* reprinted in 1965 U.S.Code Cong. & Admin. News, pp. 1943, 1995.) The legislative declaration codified at title 42, section 1395 of the United States Code (*ante,* fn. 5) and the state license requirement (42 U.S.C. § 1395mm(b)) offer no support for a contrary inference.

Nor is the majority's holding supported by the Balanced Budget Act of 1997 (the BBA), which added a provision to the Medicare Act expressly preempting state standards relating to benefit requirements, coverage determinations, and requirements relating to the inclusion or treatment of providers. (42 U.S.C. § 1395w–21 et seq.) As the HCFA comments quoted by the majority explain (maj. opn., *ante,* 106 Cal.Rptr.2d at pp. 280–281, 21 P.3d at pp. 1197–1198), even though the Medicare Act did not previously contain an express preemption clause, preemption of state laws and standards was proper "based on ***294* general constitutional Federal preemption principles." (63 Fed.Reg. 35012 (June 26, 1998).) The quoted comments also clarify the following: that while a claim regarding a Medicare + Choice[6] organization's "denial of care that a beneficiary believes to be covered **1209* care is subject to the Medicare appeals process," "the matter may also be the subject of a tort case under State law if medical malpractice is alleged, or of a state contract law claim if an enrollee alleges that the [Medicare + Choice] organization has obligated itself to provide a particular service under State law without regard to whether it is covered under its [Medicare + Choice] contract." (63 Fed.Reg.,*supra,* p. 35013.)

Contrary to the majority's assertion, HCFA's comments do not "strongly imply that state law claims such as those involved in the present case were **440* not preempted under then applicable law." (Maj. opn., *ante,* 106 Cal.Rptr.2d at p. 281, 21 P.3d at p. 1198.) If anything, both the comments and the BBA itself settle any doubt regarding Medicare's preemptive scope over claims that essentially rely on state standards and requirements to establish coverage of benefits. Indeed, as HCFA elucidates, "[s]tate laws requiring, for example, a second opinion from non-contracted physicians" would be superseded by the BBA preemptions "because these requirements in essence mandate the 'benefit' of access to a particular provider's services even where the services of that provider would not otherwise be a covered benefit." (63 Fed.Reg., *supra,* p. 35013.) Although HCFA further explains that preemption does not extend to all medical malpractice and contract claims, that has always been the case where the claims were not inextricably intertwined with a benefits determination. As discussed, however, the claims asserted here do not fall within those long acknowledged categories of exempted claims.

III.

The Medicare Act represents a "carefully crafted scheme" for administering a massive federally insured program (*Ringer, supra,* 466 U.S. at p. 621, 104 S.Ct. 2013). Central to that scheme is Congress's determination that administrative remedies, followed by federal court review if necessary, are appropriate to fully and consistently address the claims of those who seek to challenge an HMO's benefits decision, and that administrative sanctions are appropriate to address certain misconduct by errant HMO's. While the system may not afford the range of relief available under state law, it is designed to provide that coverage decisions are reviewed in a thorough and expeditious manner by HCFA or its agent, and by ALJ's and departmental review boards that have special expertise in such matters. It is not the prerogative of this court to second-guess the measured trade-offs enacted by Congress.

Today's decision all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review. I cannot, and will not, join in its undoing.

BROWN, J., concurs

All Citations

25 Cal.4th 412, 21 P.3d 1189, 106 Cal.Rptr.2d 271, 01 Cal. Daily Op. Serv. 3477, 2001 Daily Journal D.A.R. 4283

Footnotes

1 Mr. **McCall** died shortly before the Court of Appeal rendered its decision in this case, immediately after undergoing a lung transplant paid for by Medicare.

2 GNP and Dr. Shukla also demurred on other, more limited grounds, none of which is before this court.

3 In a case involving a non-HMO, fee-for-service claim, the United States Supreme Court described the administrative appeals process as follows: "[T]he Medicare Act authorizes the Secretary to enter into contracts with fiscal intermediaries providing that the latter will determine whether a particular medical service is covered by Part A, and if so, the amount of the reimbursable expense for that service. 42 U.S.C. § 1395h; 42 CFR § 405.702 (1983). If the intermediary determines that a particular service is not covered under Part A, the claimant can seek reconsideration by the ... (HCFA) in the Department of Health and Human Services. 42 CFR §§ 405.710–405.716 (1983). If denial of the claim is affirmed after reconsideration and if the claim exceeds $100, the claimant is entitled to a hearing before an administrative law judge (ALJ) in the same manner as is provided for claimants under Title II of the Act. 42 U.S.C. § 1395ff(b)(1)(C), (b)(2); 42 CFR § 405.720 (1983). If the claim is again denied, the claimant may seek review in the Appeals Council. 42 CFR §§ 405.701(c), 405.724 (1983) (incorporating 20 CFR § 404.967 (1983)). If the Appeals Council also denies the claim and if the claim exceeds $1,000, only then may the claimant seek judicial review in federal district court of the 'Secretary's final decision.' 42 U.S.C. §§ 1395ff(b)(1)(C), (b)(2)." (*Ringer, supra,* 466 U.S. at pp. 606–607, 104 S.Ct. 2013; see generally 42 C.F.R. § 405.701 et seq. (1999) [describing the Medicare fee-for-service appeals process].) A Medicare beneficiary enrolled in an HMO may challenge the Secretary's final determination in the same manner. (42 U.S.C. § 1395mm(c)(5)(B); see 42 C.F.R. §§ 417.600–417.638 (1999).)

4 The dissent (106 Cal. Rptr.2d pp. 292–293, 21 P.3d 1207–1208) suggests the possible imposition by the Secretary of civil monetary penalties against contracting HMO's for violations of the Medicare Act justifies a conclusion that plaintiffs' state law claims are preempted. The suggestion, however, ignores *Ringer* 's focus on the presence or absence of a *remedy for injuries suffered.*

5 A number of subsequent decisions have favorably cited and relied on *Ardary.* (E.g., *Plocica v. Nylcare of Texas, Inc.* (N.D.Tex.1999) 43 F.Supp.2d 658, 663 [complaint alleging wrongful death under state law was not preempted by Medicare; case remanded to state court]; *Zamora–Quezada v. HealthTexas Medical Group* (W.D.Tex.1998) 34 F.Supp.2d 433, 440 [complaint by physicians and Medicare HMO beneficiaries, alleging that HMO's created contractual arrangement that resulted in discrimination against the disabled in violation of the Americans with Disabilities Act, the Rehabilitation Act and various state law theories, did

not arise under Medicare; federal district court denied defendants' motion to dismiss for failure to exhaust administrative remedies]; *Wartenberg v. Aetna U.S. Healthcare, Inc., supra,* 2 F.Supp.2d at pp. 277–278 [complaint alleging wrongful death under state law not preempted by Medicare; case remanded to state court]; *Albright v. Kaiser Permanente Medical Group* (N.D.Cal., Aug. 3, 1999, No. C98–0682 MJJ), 1999 WL 605828, at pp. *3–*4 [a complaint alleging unfair business practices, violation of the covenant of good faith and fair dealing, and fraud did not arise under Medicare; case remanded to state court]; *Kelly v. Advantage Health, Inc.* (E.D.La., May 11, 1999, Civ. A. No. 99–0362), 1999 WL 294796, at pp. *4–*5, *7 [a complaint alleging negligence and violation of Louisiana Health Maintenance Organization Act, La.Rev.Stat. § 22:2001 et seq., did not arise under Medicare; case remanded to state court]; *Berman v. Abington Radiology Associates* (E.D.Pa., Aug. 14, 1997, Civ.A. No. 97–3208), 1997 WL 534804, at p. *3 [a complaint alleging professional negligence did not arise under Medicare; case remanded to state court]; see also *Wright v. Combined Ins. Co. of America* (N.D.Miss.1997) 959 F.Supp. 356, 363 [not citing *Ardary,* but concluding fact that disposition of the plaintiff's state law claims might require some interpretation of the Medicare Act did not mean such claims arose under the Act; case remanded to state court].)

Other decisions have distinguished *Ardary* without criticizing its reasoning. (E.g., *Jamaica Hospital Nursing Home v. Oxford Health Plans* (S.D.N.Y., Sept. 26, 2000, No. 99 Civ. 9541(AGS)) 2000 WL 1404930, at p. *3 [nursing home's complaint alleging it provided medical treatment to beneficiary and, under its assignment of insurance rights from beneficiary, was entitled to payment from HMO for the cost of the treatment was, at bottom, a claim for reimbursement of Medicare benefits; because nursing home had failed to exhaust administrative remedies, federal district court dismissed complaint for lack of subject matter jurisdiction]; *Helping Hands Professional Home Health Services, Inc. v. Shalala* (S.D.Cal., Aug. 1, 1997, No. 97–1043 IEG(LSG), 1997 WL 778990, at p. *4 [service provider's complaint, alleging that fiscal intermediary failed to comply with regulations governing payments under Medicare system, arose under Medicare; because provider had failed to exhaust administrative remedies, federal district court dismissed complaint for lack of subject matter jurisdiction].)

6 The federal district court in *Albright v. Kaiser Permanente Medical Group, supra,* 1999 WL 605828, at p. *4, observed that "*Redmond* has not been cited as persuasive authority in any subsequent opinions interpreting whether state law claims arise under the Act." A decision not citing *Redmond,* but employing a similar analysis to reach a similar conclusion, is *Wilson v. Chestnut Hill Healthcare* (E.D.Pa., Feb. 22, 2000, Civ. A. No. 99–CV–1468), 2000 WL 204368.

7 *Kelly v. Advantage Health, Inc.,* asserts the contrary. "Indeed, the legislative history indicates that the administrative remedies and specific judicial review procedures were established for 'quite minor matters,' such as amount determinations of specific Medicare benefits. See *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667, 680, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986); *Ardary,* 98 F.3d at 501. The administrative agency in charge of applying the administrative procedure set forth in the Act does not even possess the authority to assess the validity or merit of tortious claims or to grant relief for the types of state law causes of action at issue here. Thus, under the administrative process, plaintiff would most likely be precluded from receiving damages for any of the wrongs that have allegedly been committed against him." (*Kelly v. Advantage Health, Inc., supra,* 1999 WL 294796, at p. *7.)

8 See *Randi W. v. Muroc Joint Unified School Dist.* (1997) 14 Cal.4th 1066, 60 Cal.Rptr.2d 263, 929 P.2d 582.

9 We note that the recent decision in *Buckman Co. v. Plaintiffs' Leg. Com.* (2001) 531 U.S. 341, 121 S.Ct. 1012, 148 L.Ed.2d 854, concluded that a state law action seeking damages for injuries allegedly caused by Food and Drug Administration (FDA) approved bone screws, predicated on a "fraud-on-the-FDA" theory, was preempted by the Federal Food, Drug, and Cosmetic Act, as amended by the Medical Device Amendments of 1976, 21 United States Code section 301. The high court reasoned that "[p]olicing fraud against federal agencies is hardly 'a field which the States have traditionally occupied,' [citation], such as to warrant a presumption against finding federal pre-emption of a state-law cause of action." (*Buckman, supra,* 531 U.S. at p. 348, 121 S.Ct. at p. 1017, 148 L.Ed.2d at p. 860.) The court contrasted "situations implicating 'federalism concerns and the historic primacy of state regulation of matters of health and safety,' " where a "presumption against pre-emption obtains." (*Id.* at p. 348, 121 S.Ct. at p. 1017, 148 L.Ed.2d at p. 861, citing *Medtronic, Inc. v. Lohr, supra,* 518 U.S. at p. 485, 116 S.Ct. 2240.) To the extent the **McCalls**' complaint alleges fraud on the HCFA, defendants may, on remand, assert it is preempted under the rule in *Buckman.*

10 This case does not call upon us to determine the sufficiency of any of the **McCalls**' allegations to state a cause of action under California law, and we express no opinion on whether the claims ultimately will be proven.

11 Defendants' reliance on *Bodimetric Health Services v. Aetna Life & Cas.* (7th Cir.1990) 903 F.2d 480, *Midland Psychiatric Associates, Inc. v. U.S.* (8th Cir.1998) 145 F.3d 1000, and *Marin v. HEW, Health Care Financing* (9th Cir.1985) 769 F.2d 590, is misplaced: those cases are distinguishable from the present one, in that they were actions seeking tort damages for harm allegedly sustained as a result of improper denial of claims, not, as here, claims arising from violations of duties separate from the duty to pay Medicare benefits.

1 Part A of Medicare is a mandatory hospital insurance program covering the cost of hospitalization and related expenses. (42 U.S.C. § 1395c et seq.) Part B establishes a voluntary supplemental medical insurance program covering specified medical services, devices, and equipment. (*Id.,* § 1395j et seq.)

2 Claims seeking payment of ordinary Social Security benefits are subject to the same administrative exhaustion provisions as those seeking Medicare benefits. (Maj. opn., *ante,* 106 Cal.Rptr.2d at pp. 276–277, 21 P.3d at pp. 1194–1195.)

3 The United States Supreme Court subsequently invoked *Ringer* in a decision holding that damage claims arising from decisions concerning payment of ordinary Social Security benefits are foreclosed by the Secretary's exclusive administrative jurisdiction over such decisions. In *Schweiker v. Chilicky* (1988) 487 U.S. 412, 108 S.Ct. 2460, 101 L.Ed.2d 370, claimants whose Social Security disability benefits were improperly terminated during disability reviews but were later restored, sued federal and state program administrators for alleged violations of their Fifth Amendment right to due process, and sought recovery of damages for emotional distress and for loss of food, shelter, and other necessities proximately caused by the denial of benefits without due process. In that case, the high court determined that since the harm resulting from the alleged constitutional violation was inseparable from that resulting from the denial of benefits, both claims were remediable, if at all, only through

the federal administrative review process. (487 U.S. at pp. 428–429, 108 S.Ct. 2460.)

4 In a footnote, the majority expresses awareness of *Bodimetric, supra,* 903 F.2d 480, *Midland, supra,* 145 F.3d 1000, and *Marin v. HEW, Healthcare Financing Agency, supra,* 769 F.2d 590. (Maj. opn., *ante,* 106 Cal. Rptr.2d at p. 283, fn. 11, 21 P.3d at p. 1200, fn. 11.) The majority does not dispute those courts' conclusions that claims "arising under" the Medicare Act, as that phrase was defined in *Ringer, supra,* 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, may encompass state law claims seeking tort damages for harm allegedly sustained as a result of improper denial of claims. (Maj. opn., *ante,* at p. 283, fn. 11, 21 P.3d at p. 1200, fn. 11.) Rather the majority attempts to distinguish the instant case on the basis that it involves "claims arising from violations of duties separate from the duty to pay Medicare benefits." (*Ibid.*) Contrary to the majority's suggestion, and as I explain in part II, *post,* plaintiffs here similarly seek tort damages arising from the alleged improper denial of a benefit, i.e., a lung transplant, to which plaintiffs claim entitlement under Medicare. Although the complaint also alleges violations of "duties" that purport to extend beyond **PacifiCare's** alleged duty to pay Medicare benefits, the harm supposedly resulting from those violations appears inseparable from the harm resulting from **PacifiCare's** denial of the lung transplant. (See pt. II, *post.*)

5 That section provides: "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." (42 U.S.C. § 1395.)

6 HMO's contracting with Medicare, such as **PacifiCare** here, automatically became Medicare + Choice plans effective January 1, 1999. (See 42 U.S.C. § 1395mm(k).)

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620 F.3d 1134
United States Court of Appeals,
Ninth Circuit.

DO SUNG **UHM**; Eun Sook **Uhm**, a married couple, individually and for all others similarly situated, Plaintiffs–Appellants,

v.

HUMANA, INC., a Delaware corporation; **Humana** Health Plan, Inc., a Kentucky corporation doing business as **Humana**, Defendants–Appellees.

No. 06–35672.
Argued and Submitted March 14, 2008.
Opinion Filed Aug. 25, 2008.
Rehearing Granted and Opinion Withdrawn July 22, 2009.
Filed Aug. 30, 2010.

Synopsis

Background: Medicare beneficiaries brought putative class action against health care insurer, alleging failure to receive promised coverage for prescription drugs. The United States District Court for the Western District of Washington, Ricardo S. Martinez, J., 2006 WL 1587443,dismissed action. Beneficiaries appealed.

Holdings: The Court of Appeals, Paez, Circuit Judge, held that:
1 beneficiaries' claims for breach of contract and unjust enrichment, stemming from alleged failure to receive promised coverage under prescription drug plan (PDP), were required to be administratively exhausted;
2 Medicare Act's administrative exhaustion requirement did not apply to fraud and consumer protection claims;
3 beneficiaries qualified as "enrollees" within the meaning of the Medicare Act;
4 claims against insurer for violation of state consumer protection laws were expressly preempted; and
5 fraud claims were also preempted.

Affirmed.

B. Fletcher, Circuit Judge, filed concurring opinion.

West Headnotes (19)

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Appeal from the United States District Court for the Western District of Washington, Ricardo S. Martinez, District Judge, Presiding. D.C. No. CV–06–00185–RSM.

Before: BETTY B. FLETCHER, RICHARD A. PAEZ and MARSHA S. BERZON, [1] Circuit Judges.

Opinion by Judge PAEZ; Concurrence by Judge B. FLETCHER.

OPINION

PAEZ, Circuit Judge:

Plaintiffs–Appellants Do Sung **Uhm** and Eun Sook **Uhm** ("the **Uhms**") appeal the district court's order dismissing their complaint against Defendants–Appellees **Humana** Health Plan, Inc., and **Humana**, Inc., (collectively, "**Humana**") on the ground that their claims are preempted by the express preemption provision of the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA" or "the ***1138** Act"). The **Uhms** also appeal the district court's order denying their partial motion for reconsideration in which they argued that, unlike **Humana** Health Plan, Inc., **Humana**, Inc., is not regulated under the Act, and therefore the claims against it cannot be preempted. Having concluded that all of the **Uhms'** claims were preempted by the Act, the district court declined to reach **Humana's** argument that the **Uhms** had failed to properly exhaust their claims pursuant to the Act's exhaustion requirements. *See* 42 U.S.C. § 405(g), (h). We affirm. [2] We hold that the district court lacked jurisdiction to consider the **Uhms'** breach of contract and unjust enrichment claims because they were not properly exhausted under the Act. We further hold that the **Uhms'** fraud and consumer protection act claims, while not subject to the Act's exhaustion provisions, are expressly preempted. Thus, the district court properly dismissed all of the **Uhms'** claims.

I. FACTS

The Act established Medicare Part D ("Part D"), a voluntary prescription drug benefit program for seniors. *See* 42 U.S.C. § 1395w–101 *et seq.* Under the Act, health insurance providers contract with the Centers for Medicare and Medicaid Services ("CMS"), [3] part of the Department of Health and Human Services, to offer Part D prescription drug plans ("PDPs") to Medicare beneficiaries. **Humana** Health Plan, Inc., is a CMS-approved PDP provider; **Humana**, Inc., its parent company, is not. [4]

In late 2005, the **Uhms**—Medicare beneficiaries—chose **Humana** as their Part D provider based in part on the representations **Humana** made in its marketing materials. [5] In particular, the **Uhms** relied on **Humana's** representation that they would be enrolled in the benefits plan and accordingly receive coverage for their prescription drugs beginning January 1, 2006, the first day Part D sponsors could provide benefits under the Act.

Intending to enroll in **Humana's** program, the **Uhms** submitted the **Humana** Prescription Drug Plan Enrollment Form. The **Uhms** chose "Social Security Check Deduction" as their method of premium payment. Accordingly, the $6.90 plan premium was deducted from their January 2006 and February 2006 social security checks.

***1139** As their enrollment date approached, the **Uhms** had not yet received any information from **Humana** about their prescription drug plan, including their identification cards, mail-order forms required to order prescription drugs, or

instructions on how to complete the forms and request their drug benefits. The **Humana** plan required beneficiaries to allow for at least two weeks between submission of the request for prescription drugs and receipt of their medications. Accordingly, the **Uhms** became concerned about their ability to obtain their medications through the plan. They and their son repeatedly requested pertinent information from **Humana**. They called, they sent e-mails—but **Humana** was unresponsive. In late December 2005, the **Uhms** called **Humana's** toll-free telephone number to determine their status under the plan and they were told by a **Humana** representative that they were "not recognized as members of the **Humana** Part D PDP."

January 1, 2006, came and passed, and the **Uhms** did not receive the materials necessary for obtaining their drug benefits. The **Uhms** were forced to buy their prescription medications out-of-pocket at costs higher than those provided by **Humana's** plan, despite the fact that the PDP premium was deducted from their social security checks in both January and February of that year.

On February 6, 2006, the **Uhms** filed a complaint against **Humana** Health Plan, Inc., and **Humana**, Inc.,[6] in the U.S. District Court for the Western District of Washington, claiming breach of contract, violation of several state consumer protection statutes, unjust enrichment, fraud, and fraud in the inducement. The **Uhms** filed the complaint on behalf of themselves and a putative class consisting of "all persons who paid and/or were billed by **Humana**, for enrollment in the **Humana** Part D PDP and (a) did not receive benefits under the **Humana** Part D PDP, and/or (b) whom **Humana** failed to actually enroll in the **Humana** Part D PDP, and/or (c) whom **Humana** enrolled in the **Humana** Part D PDP on a date or dates later than the date or dates promised by **Humana**." They invoked federal subject matter jurisdiction over the suit under the Class Action Fairness Act of 2005 and 28 U.S.C. § 1332(d).

Humana responded with a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), for failure to state a claim, which the district court granted. The district court concluded that the standards promulgated by CMS under the Act governed the grievances that the **Uhms** alleged in their complaint, that the administrative process established by the Act was the appropriate vehicle for addressing each of the **Uhms'** grievances, and that the **Uhms'** state law claims were therefore preempted by the Act's express preemption provision.

The **Uhms** filed a motion for partial reconsideration, arguing that their claims were not preempted with respect to **Humana**, Inc., because **Humana**, Inc., is not a CMS-approved PDP provider. The district court denied that motion. The **Uhms** timely appealed both orders.

II. ANALYSIS

A. Standard of Review

1 2 3 We review de novo the district court's dismissal of a case under Rule 12(b)(6) for failure to state a claim, *Marder v. Lopez*, 450 F.3d 445, 448 (9th Cir.2006), as well as the district court's determination that a federal statute preempts state ***1140** law claims, *Niehaus v. Greyhound Lines, Inc.*, 173 F.3d 1207, 1211 (9th Cir.1999). We review for abuse of discretion the district court's denial of a motion for reconsideration. *Bliesner v. Commc'n Workers of Am.*, 464 F.3d 910, 915 (9th Cir.2006). We consider de novo the question of subject matter jurisdiction. *See Sommatino v. United States*, 255 F.3d 704, 707 (9th Cir.2001).

B. Exhaustion of Administrative Remedies

4 **Humana** argues that the **Uhms'** claims must be exhausted through the Act's administrative remedial scheme before a federal court may exercise jurisdiction under the Medicare Act. The issue of exhaustion bears on the district court's jurisdiction, *see Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107, 1115 (9th Cir.2003), so we address this argument first.

5 6 The Act's exhaustion requirement, 42 U.S.C. § 405(h),[7] makes judicial review under a related provision, 42 U.S.C. § 405(g),[8] "the sole avenue for judicial review" for claims " 'arising under' the Medicare Act." *Heckler v. Ringer*, 466 U.S. 602, 614–15, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984).[9] The Supreme Court has held that "the exhaustion requirement of § 405(g) consists of a non-waivable requirement that a claim for benefits shall have been presented to the Secretary, and a waivable requirement that the administrative remedies prescribed by the Secretary be pursued fully by the claimant." *Id.* at 617, 104 S.Ct. 2013 (internal quotations and citation omitted).[10] Only once the Secretary has issued a "final decision" may the individual seek judicial review of that determination. *Id.* at 605, 104 S.Ct. 2013. A "final decision" is rendered only after the individual has "pressed his claim" through all levels of administrative review. *Id.*; *Ardary v. Aetna Health Plans of Cal., Inc.*, 98 F.3d 496, 498 (9th Cir.1996). In sum, "[j]urisdiction over cases 'arising under' Medicare exists only under ***1141** 42 U.S.C. § 405(g), which requires an agency decision in advance of judicial review." *Kaiser*, 347 F.3d at 1111.[11]

Humana contends that the **Uhms**' claims are subject to these provisions and that the **Uhms** have failed to exhaust those claims. The **Uhms** admit they have not pursued any of their claims through the Act's administrative processes, but argue that they need not exhaust their administrative remedies because their claims do not "arise under" the Medicare Act. They further contend that because their claims arose before they were enrolled in the program, they did not have access to the Act's remedial mechanisms and therefore cannot be subject to the exhaustion requirements. We address these arguments in turn.

(1) "Arising Under" the Medicare Act

7 The key inquiry in determining whether § 405(h) requires exhaustion before we can exercise jurisdiction is whether the claim "arises under" the Act. *Ardary*, 98 F.3d at 499 (citing *Heckler*, 466 U.S. at 614–15, 104 S.Ct. 2013). Accordingly, we must determine whether any of the **Uhms**' state law claims "arises under" the Medicare Act. If so, we cannot exercise subject matter jurisdiction until those claims are properly exhausted. *Id.* at 498–99. The **Uhms** argue that their claims do not "arise under" the Act because they seek return of their premiums, not reimbursement for benefits owed under the Act. These arguments are unpersuasive.

8 The Supreme Court has identified two circumstances in which a claim "arises under" the Medicare Act: (1) where the "standing and the substantive basis for the presentation of the claims" is the Medicare Act, *Heckler*, 466 U.S. at 615, 104 S.Ct. 2013 (internal quotations omitted); and (2) where the claims are "inextricably intertwined" with a claim for Medicare benefits, *id.* at 614, 104 S.Ct. 2013. *See also Kaiser*, 347 F.3d at 1112. One category of claims that we and other courts have found to "arise under" the Act are those cases that are " '[c]leverly concealed claims for benefits.' " *Kaiser*, 347 F.3d at 1112 (quoting *United States v. Blue Cross & Blue Shield of Ala., Inc.*, 156 F.3d 1098, 1109 (11th Cir.1998)). For example, in *Heckler*, the Supreme Court denied jurisdiction in a case brought by plaintiffs seeking Medicare coverage for certain medical procedures. 466 U.S. at 609–10, 627, 104 S.Ct. 2013. There, plaintiffs had formulated their claims under various sources of law other than the Medicare Act, including claims brought under the Constitution and under other statutes. *Id.* at 610, 104 S.Ct. 2013. The Supreme Court held that, despite the various causes of action, the claim was ultimately one for benefits under the Act, was therefore "inextricably intertwined" with the Medicare Act, and thus had to be exhausted under § 405(g). ***1142** *Id.* at 614–17, 104 S.Ct. 2013. The Eleventh Circuit has described *Heckler* as holding that "[s]ubsection 405(h) prevents beneficiaries and potential beneficiaries from evading administrative review by creatively styling their benefits and eligibility claims as constitutional or statutory challenges to Medicare statutes and regulations." *Blue Cross & Blue Shield of Ala.*, 156 F.3d at 1104.

In *Kaiser*, we held that even a state law claim may "arise under" the Medicare Act. 347 F.3d at 1113–15. There, a Medicare provider sued a state's fiscal intermediary, which had ceased reimbursing the provider for Medicare services. *Id.* at 1110–11. The provider

brought a variety of tort and contract claims against the intermediary. *Id.* at 1111. We concluded that the district court had correctly dismissed some of the claims—including some of the common law claims—for lack of subject matter jurisdiction. *Id.* at 1115. In addressing whether claims brought under state law can also "arise under" the Medicare Act, we held that a " 'claim may arise under the Medicare Act even though ... it also arises under some other law.' " *Id.* at 1114 (quoting *Midland Psychiatric Assoc., Inc.*, 145 F.3d at 1004).

Kaiser also forecloses the **Uhms**' argument that, because they are not seeking reimbursement of lost benefits, their claims do not "arise under" the Act. We held in *Kaiser* that whether or not plaintiffs seek reimbursement of benefits is not "strongly probative" of whether a claim "arises under" the Medicare Act. *Id.* at 1112. The plaintiffs there argued that their claims did not "arise under" the Medicare Act because they were seeking damages beyond the reimbursement of benefits. *Id.* We disagreed, pointing to a number of cases in which the Supreme Court had refused to treat the remedy sought as dispositive of the "arising under" question. *Id.*; *see also Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 14, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000) (refusing to "accept a distinction that limits the scope of § 405(h) to claims for monetary benefits"); *Marin v. HEW, Health Care Fin. Agency*, 769 F.2d 590, 592 (9th Cir.1985) (holding that a suit seeking extra-Medicare monetary damages may also be a suit arising under Medicare because "[t]he substantive cause of action [was] anticipated by the statute" and the plaintiff's argument to the contrary "would render meaningless the jurisdiction restriction of § 405(h)"). For example, we noted that in *Heckler*, "the Court found that suits for injunctive relief not available under Medicare may still be found to arise under Medicare." *Id.* (citing *Heckler*, 466 U.S. at 615, 104 S.Ct. 2013). In light of those authorities, we held that the "fact that [plaintiffs] seek damages beyond the reimbursement payments available under Medicare does not exclude the possibility that their case arises under Medicare." *Id.*

Our opinion in *Ardary*, 98 F.3d 496, is also instructive. There, the heirs of a deceased Medicare beneficiary sought damages in a state wrongful death action against Aetna, alleging that Aetna improperly denied emergency medical services and misrepresented its managed care plan to the beneficiary. *Id.* at 497–98. We held that the wrongful death action did not "arise under" the Medicare Act, and was therefore not subject to the exhaustion provisions, because it was *"at bottom* not seeking to recover *benefits* " and because the injury complained about could not have been redressed at all via the Medicare Act's administrative review process. *Id.* at 500.

9 In sum, contrary to the **Uhms**' argument, our case law establishes that where, at bottom, a plaintiff is complaining about the denial of Medicare benefits—here, drug benefits under Part D—the ***1143** claim "arises under" the Medicare Act. We accordingly assess the **Uhms**' various claims under this rule.

(a) Breach of Contract and Unjust Enrichment

10 The **Uhms**' primary complaint, and the basis of their breach of contract and unjust enrichment claims, is that, despite having paid their monthly premiums and having filed the appropriate enrollment documents, **Humana** failed to provide them with drug benefits. *See, e.g.*, Compl. ¶ 4.12 ("Plaintiffs **Uhm** bring this action against Defendants on behalf of themselves and all persons who paid and/or were billed by **Humana**, for enrollment in the **Humana** Part D PDP and (a) did not receive benefits under the **Humana** Part D PDP...."); ¶ 6.4 ("Defendants breached each contract with Plaintiffs and with each Class member when they failed to provide prescription drug benefits as promised."); ¶ 8.2 ("Defendants received monies as a result of payments made by Plaintiffs and Class members for prescription drug benefits that Defendants failed to provide to Plaintiffs and Class members."). More specifically, the **Uhms**' breach of contract claim is premised on the fact that **Humana** "failed to provide prescription drug benefits as promised." Likewise, the **Uhms**' unjust enrichment claim alleges that "[**Humana**] received monies as a result of payments made by [the **Uhms**] and Class members for prescription drug benefits that [**Humana**] failed to provide."

11 After a careful review of these claims, we conclude that they are, at bottom, merely creatively disguised claims for benefits. While the **Uhms** assert that they are not seeking to remedy a denial of benefits due under the Act, we find this argument unconvincing. Indeed, the **Uhms** have not alleged that **Humana** promised anything more than to abide by the requirements of the Act. Nor did they identify or describe in their complaint any provision creating obligations above and beyond **Humana's** obligations under the Act. Thus, there is no claim that the alleged contract imposed upon **Humana** any duties above and beyond compliance with the Act itself. Instead, the **Uhms'** breach of contract claim is a backdoor attempt to enforce the Act's requirements and to secure a remedy for **Humana's** alleged failure to provide benefits. For example, the **Uhms** claim that **Humana** promised to provide them with benefits beginning January 1, 2006—the date that the Act's implementing regulations set. *See* 42 C.F.R. § 423.40(a) (2005)[12] (setting effective dates of enrollment which would have required the **Uhms'** coverage to begin January 1, 2006). The **Uhms'** unjust enrichment claim fares no better, as it seeks to vindicate the same alleged injury, based upon the same alleged promises, and thereby to enforce the benefit requirements of the Act via an implied contract, rather than an express one.[13]

*1144 Nor do the **Uhms** allege any injury that could not be remedied through the retroactive payment of Medicare drug benefits. The mere fact that the **Uhms** no longer wish to receive those benefits—and instead seek return of their premium—is of no consequence. This court consistently has held that claimants cannot circumvent the § 405(h) exhaustion requirement by restyling the remedy sought. *See Kaiser,* 347 F.3d at 1112 ("[T]he type of remedy sought is not strongly probative of whether a claim falls under § 405(h).").

Furthermore, the **Uhms'** claim for benefits could have been remedied through the Act's administrative review process. *Cf. Ardary,* 98 F.3d at 500 (holding that a claim did not "arise under" the Act in part because "[the beneficiary]'s death ... cannot be remedied by the retroactive authorization or payment of [benefits]."). As we explain in greater detail in the following section, at the time their claims arose, the **Uhms** were enrollees, and thus the Act's administrative remedial mechanisms—including the coverage determination and grievance processes—were available to them. *See* 42 U.S.C. § 1395w–104(f), (g) (providing for the coverage determination and grievance processes). The coverage determination process, in particular, would have allowed the **Uhms** to secure the benefits to which they were entitled as enrollees. The coverage determination process is meant for disputes arising from "[a] decision not to provide or pay for a Part D drug." 42 C.F.R. § 423.566(b)(1) (2005). Although the **Uhms** do not allege that **Humana** affirmatively denied any request for benefits, its failure to make benefits available to the **Uhms** on January 1, 2006, was tantamount to such a denial. Furthermore, we note that CMS, in its amicus brief, specifically represents that, "[e]ven if the **Uhms** were belatedly enrolled in **Humana's** plan, so that they were required to pay for drugs out of pocket for some initial period, once retroactively enrolled, they could have still taken advantage of this congressionally mandated review scheme to try to obtain benefits."

In sum, because the **Uhms'** contract and unjust enrichment claims arise under the Medicare Act, they should have exhausted their claims for benefits through the coverage determination or grievance process and then sought judicial review under 42 U.S.C. § 405(g). The **Uhms** do not allege that they did so, and until they do, the federal courts may not assert jurisdiction over these claims.

The **Uhms**, however, argue that, even if the exhaustion requirements apply to them, they should be excused from those requirements because pursuit of administrative remedies would be futile. *See S.E.C. v. G.C. George Sec., Inc.,* 637 F.2d 685, 688 n. 4 (9th Cir.1981) (discussing a number of exceptions to the general rule requiring exhaustion, including where exhaustion would be futile). More specifically, the **Uhms** argue that, even assuming they are required to exhaust administrative remedies against **Humana** Health Plan, Inc., there is no analogous administrative scheme for pursuing their claims against **Humana**, Inc., and thus no exhaustion is required. We disagree.

As we concluded above, the **Uhms**' breach of contract and unjust enrichment claims are, at bottom, claims for benefits. That they have also brought those claims against a non-Part D sponsor does not change the conclusion that those claims "arise under" the Act. In *Illinois Council,* the Supreme Court reaffirmed that 42 U.S.C. § 405(g) and (h) preclude federal court review of claims "arising under" the Medicare Act before administrative remedies have been exhausted. 529 U.S. at 10, 120 S.Ct. 1084. In doing so, the Court noted that, "[t]he fact that the agency might not provide a hearing for [a] *particular contention,* or may lack the power to provide one is beside the point because it is the 'action' ***1145** arising under the Medicare Act that must be channeled through the agency." *Id.* at 23, 120 S.Ct. 1084 (internal citations omitted). Similarly, in *Kaiser,* we noted that the mere fact that an administrative remedy is not available for a particular claim does not mean that the claim does not "arise under" the Medicare Act. 347 F.3d at 1116 n. 4. We reasoned that:

> Exhaustion is generally required as a matter of preventing premature interference with agency processes, so that the agency may function efficiently and so that it may have an opportunity to correct its own errors, to afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review. If a court were to prematurely tackle a question inextricably intertwined with an issue properly resolved by an agency, the court would defeat the purposes of § 405(g) and (h) even if the question was not one that the agency has the authority to answer fully.

Id. (internal citation and quotation omitted). Despite the fact that administrative remedies may not be available against **Humana**, Inc., claims "arising under" the Act must be brought before the Secretary before judicial review can be sought. Thus, we hold that the **Uhms** cannot circumvent § 405(h)'s requirements by suing **Humana**, Inc. To allow otherwise would "defeat the purposes of" the Act's exhaustion requirement.

We thus conclude that the district court lacked jurisdiction over the **Uhms**' breach of contract and unjust enrichment claims.

(b) Fraud and Consumer Protection Act Claims

12 The **Uhms**' consumer protection act and fraud claims allege that **Humana** made material misrepresentations and engaged in other systematic deceptive acts in the marketing and advertising of their Part D plan to induce the **Uhms** and putative class members to enroll. Specifically, the **Uhms** allege that **Humana** misrepresented that their prescription drug coverage would begin on January 1, 2006, and that **Humana** is committed to providing "reliable customer service" and "has been a trusted Medicare insurer for more than 20 years, helping the Medicare population with their health insurance needs." We hold that these claims do not "arise under" the Act and therefore are not subject to its exhaustion requirements. The basis of these claims is an injury collateral to any claim for benefits; it is the misrepresentations themselves which the **Uhms** seek to remedy. The **Uhms** may be able to prove the elements of these causes of action without regard to any provisions of the Act relating to provision of benefits. To the extent that is the case, the **Uhms** claims are not subject to the Act's exhaustion provisions. *See Heckler,* 466 U.S. at 618, 104 S.Ct. 2013 (noting that where a claim is "wholly 'collateral' " to a claim for benefits, it is not subject to § 405(h)); *see also Kaiser,* 347 F.3d at 1115 (suggesting that the plaintiff's defamation and invasion of privacy claims were not subject to the Medicare Act's exhaustion requirements because they were "largely independent of the underlying Medicare law").

*(2) The **Uhms**' Enrollment Status When the Claims Arose*

13 The **Uhms** argue that, even assuming our analysis of exhaustion is correct, the Act's exhaustion provisions do not apply to them because they were not enrolled in the program at the time their claims arose. We find that the pertinent question is not whether the **Uhms** were "enrolled," but rather whether they were "enrollees" within

the meaning of the Act and its regulations. We conclude that they are properly classified as "enrollees."

The **Uhms** allege that **Humana** "failed to actually enroll" them in the PDP, and ***1146** therefore that the Act's terms do not apply to them. They maintain that **Humana** representatives explicitly told them that they were "not recognized as members of the **Humana** Part D PDP" when they called **Humana's** toll-free line in late December 2005. At oral argument, counsel for the **Uhms** argued that we must accept the **Uhms'** assertion that they were not enrolled in the PDP because their claims were dismissed under Rule 12(b)(6). As far as purely factual assertions are concerned, that is correct. However, insofar as "enroll" (or its derivative forms—enrollee, enrolled, enrollment, etc.) has a *legal* meaning under the statute, our task is to determine the meaning of that term, and whether the facts as alleged by the **Uhms** comport with it or not.

The relevant section of the implementing regulations in force at the time of the alleged injury, titled "Enrollment process," provides:

> A Part D eligible individual who wishes to enroll in a PDP may enroll during the enrollment periods specified in § 423.38, by filing the appropriate enrollment form with the PDP or through other mechanisms CMS determines are appropriate.

42 C.F.R. § 423.32(a) (2005). Thus, according to this regulation, an eligible individual "enrolls" by "filing the appropriate enrollment form with the PDP." That is precisely what the **Uhms** allege they did. Their complaint alleges that "Plaintiffs **Uhm** signed the **Humana** Prescription Drug Plan Enrollment Form (for Medicare Part D prescription drug plan benefits) that **Humana** drafted and presented to Plaintiffs **Uhm**." The regulations also required, however, that the "PDP sponsor must timely process an individual's enrollment request in accordance with CMS enrollment guidelines *and enroll* Part D eligible individuals *who are eligible to enroll* in its plan under § 423.30(a) *and who elect to enroll* or are enrolled in the plan during the periods specified in § 423.38." *Id.* § 423.32(c) (emphasis added).

"Enroll," therefore has two distinct (if related) usages. An eligible individual "enrolls" by filing the enrollment form with the PDP sponsor. *See id.* § 423.32(a). The PDP sponsor, in turn, "enrolls" the individual "during the periods specified" by "process[ing]" the individual's "enrollment request in accordance with CMS enrollment guidelines." *Id.* § 423.32(c). The question remains, therefore, at which point an eligible individual is enrolled in the PDP: when that individual submits an enrollment form, or only after the PDP sponsor has processed it? [14]

Although the **Uhms** allege, and we accept, that a **Humana** customer service representative told the **Uhms** that they were "not recognized as members of the **Humana** Part D PDP," the **Uhms** do not allege that **Humana** issued them a "notice of ... denial of [their] enrollment request, in a format and manner specified by CMS." *See id.* § 423.32(d). Moreover, on the facts alleged in the complaint, we can reasonably infer that **Humana** engaged in some "processing" of the **Uhms'** enrollment request because **Humana** managed to obtain premium deductions from their social security checks.

Fortunately, this case does not require us to discern the exact moment at which a ***1147** Medicare beneficiary becomes "enrolled" in a PDP. [15] That is because, as will be discussed in greater detail below, the operative term for our purposes is "enrollee." The exhaustion provision of the Act applies to "enrollees." Part D's provision on appeals, 42 U.S.C. § 1395w–104(h), incorporates Part C's provision on appeals, 42 U.S.C. § 1395w–22(g). The Part C provision states, in relevant part, that "[a]n *enrollee* ... shall ... be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title...." 42 U.S.C. § 1395w–22(g) (emphasis added). [16]

According to the regulation, "[e]nrollee means a Part D eligible individual who has elected or has been enrolled in a Part D plan." 42 C.F.R. § 423.560 (2005). That is, the **Uhms** were enrollees if they "elected ... a Part D plan." Although the term "elected" is not defined, we discern from the above regulations that an eligible individual "elects" a Part D plan when he submits an enrollment form to the Part D sponsor. *See id.* § 423.32(c) ("A PDP sponsor must timely process an individual's enrollment request in accordance with CMS enrollment guidelines and enroll Part D eligible individuals who are eligible to enroll in its plan under § 423.30(a) *and who elect to enroll* or are enrolled in the plan during the periods specified in § 423.38." (emphasis added)); *id.* § 423.32(a) ("A Part D eligible individual who wishes to enroll in a PDP may enroll during the enrollment periods specified in § 423.38, by filing the appropriate enrollment form with the PDP or through other mechanisms CMS determines are appropriate."); *see also Webster's New Universal Unabridged Dictionary* 731 (1993) (defining elect as "to pick out, choose, select").[17] Because the **Uhms'** ***1148** complaint alleges that they filed an enrollment form with **Humana**, the **Uhms** are properly classified as "enrollees" for purposes of the Act, and therefore their contract and unjust enrichment claims are subject to its exhaustion provisions.[18]

C. Preemption

(1) The Preemption Provision

Humana contends, and the district court ruled, that each of the **Uhms'** state law claims is preempted by the Act's express preemption provision. As we have concluded that the **Uhms'** breach of contract and unjust enrichment claims fall within the Act's exhaustion requirements and have yet to be exhausted, we turn to the **Uhms'** fraud, fraud in the inducement, and consumer protection act claims.

14 15 16 The Supreme Court has made clear that Congress may displace state law through express preemption provisions. *Altria Group, Inc. v. Good*, 555 U.S. 70, 129 S.Ct. 538, 543, 172 L.Ed.2d 398 (2008). Our task is to "identify the domain expressly pre-empted by that language." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 484, 116 S.Ct. 2240, 135 L.Ed.2d 700 (1996) (internal quotation marks omitted). That task must "in the first instance focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent." *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 664, 113 S.Ct. 1732, 123 L.Ed.2d 387 (1993). We may find preemption only where it is the "clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 91 L.Ed. 1447 (1947).

Medicare Part D incorporates the express preemption provision contained in Part C, the Medicare Advantage ("MA") program, which provides medical benefits to seniors through managed care.[19] The Part D preemption provision states:

> The provisions of sections 1395w–24(g) [(prohibition of premium taxes)] and 1395w–26(b)(3) [(preemption)] of this title shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C of this subchapter. 42 U.S.C. § 1395w–112(g).

The Part C preemption provision in turn provides:

> The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

42 U.S.C. § 1395w–26(b)(3); *see also* 42 C.F.R. § 423.440(a) (2005) (adopting the same language in the Part D implementing regulation: "The standards established under this part supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) for Part D plans offered by Part D plan sponsors."). The plain

language of the statute therefore provides that CMS "standards" [20] supersede "any State law or regulation *1149 ... with respect to" a "prescription drug plan" offered by a "PDP sponsor." [21]

The issue here is precisely *which* claims fall within the ambit of this provision. In other words, what qualifies as a state law or regulation "with respect to" a PDP? The phrase "with respect to" is not defined in the Act, but the Act's legislative history provides guidance as to its meaning. Prior to the 2003 amendments, the preemption clause provided that federal standards would supersede state law and regulations "with respect to" MA plans only "to the extent such law or regulation is inconsistent with such standards" and specified several "[s]tandards specifically superseded." 42 U.S.C. § 1395w–26(b)(3)(A) (2000). [22] The 2003 amendments struck both that qualifying clause and the enumerated standards from the provision. *See* 42 U.S.C. § 1395w–26(b)(3)(A) (2003). The Conference Report accompanying the Act explains that, in striking the clause, Congress intended to broaden the preemptive effects of the Medicare statutory regime:

> The conference agreement clarifies that the MA program is a federal program operated under Federal rules. State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency. There has been some confusion in recent court cases.
>
> H.R.Rep. No. 108–391, at 557 (2003) (Conf. Rep.). [23] That passage indicates that Congress *1150 intended to expand the preemption provision beyond those state laws and regulations inconsistent with the enumerated standards.

For present purposes, however, the precise degree to which the 2003 amendment expanded the preemption provision beyond state laws and regulations "inconsistent" with the enumerated standards does not matter. Rather, it is sufficient for our purposes that, at the very least, any state law or regulation falling within the specified categories and "inconsistent" with a standard established under the Act remains preempted. [24] That limited scope, it turns out, is sufficient to decide this appeal. [25] To explain why, we turn to evaluating the **Uhms'** claims.

(2) State Consumer Protection Statutes

17 To recall, the **Uhms'** consumer protection act claims allege that **Humana** violated the consumer protection statutes of various states in which **Humana** operates by "systematically represent[ing] ... that prescription drug coverage would begin January 1, 2006 for those Class members who enrolled by December 31, 2005, when in fact [**Humana**] knew, or should have known, that Defendants would not be providing prescription drug coverage" beginning on that date. According to the **Uhms'** complaint, these misrepresentations were both written and oral: written in the **Humana** Prescription Drug Plan Enrollment Form and orally stated by **Humana's** employees in the course of marketing the plan. We hold that the **Uhms'** claims are preempted by the extensive CMS regulations governing PDP marketing materials.

The Act provides that CMS must approve all PDP marketing materials before they are made available to Medicare beneficiaries. *See* 42 U.S.C. § 1395w–101(b)(1)(B)(vi) (incorporating *id.* § 1395w–21(h)). The Act requires that each Part D sponsor "shall conform to fair marketing standards," *id.* *1151 § 1395w–21(h)(4), and that CMS "shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation," *id.* § 1395w–21(h)(2). In 2005, CMS promulgated detailed regulations governing how Part D sponsors market their plans. *See* 42 C.F.R. § 423.50(a)–(f) (2005). [26] Under those regulations, Part D sponsors were not to "distribute any marketing materials ... or enrollment forms, or make such materials or forms available to Part D eligible individuals" unless they had been CMS-approved. *Id.* § 423.50(a)(1). [27] Moreover, under both the 2005 version of these provisions and their most recent amendment in 2008, CMS is required to screen marketing materials or enrollment forms to ensure they are not "materially inaccurate or misleading" and do

not "otherwise make material misrepresentations." *Id.* § 423.50(d)(4) (redesignated as *id.* § 423.2264(d) (2008)). CMS must also ensure that all marketing materials and enrollment forms provide adequate descriptions of all rules, an explanation of the grievance and appeals process, and "[a]ny other information necessary to enable beneficiaries to make an informed decision about enrollment." *Id.* § 423.50(d)(1) (redesignated as *id.* § 423.2264(a) (2008)).

The regulations define marketing materials as "any informational materials targeted to Medicare beneficiaries which—(1) Promote the Part D plan. (2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in a Part D plan. (3) Explain the benefits of enrollment in a Part D plan, or rules that apply to enrollees. (4) Explain how Medicare services are covered under a Part D plan, including conditions that apply to such coverage." *Id.* § 423.50(b) (redesignated as *id.* § 423.2260 (2010)). Examples of marketing materials include "brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the Internet," "[m]arketing representative materials such as scripts or outlines for telemarketing," and "[l]etters to members about contractual changes." *Id.* § 423.50(c) (redesignated as *id.* § 423.2260 (2010)).[28]

The **Humana** Prescription Drug Plan Enrollment Form on which the **Uhms** base their misrepresentation claim is "marketing material" as defined by the regulations. The vague oral misrepresentation that the **Uhms** allege as the basis for their state consumer protection act claim—that **Humana's** representatives "systematically represented" to them that they would receive Medicare Part D prescription drug plan coverage and benefits beginning January 1, 2006—is also preempted. Those representations appear to have been made pursuant to "marketing representative materials such as scripts or outlines for telemarketing," and, in any event, were identical ***1152** to the representations made in the marketing materials. Thus, those oral representations also fall within the definition of "marketing materials."[29]

Standards relating to these materials therefore fall within a category—"Requirements relating to marketing materials"—specified under the 2000 preemption clause as "superseded." 42 U.S.C. § 1395w–26(b)(3)(B) (2000). The state consumer protection acts on which the **Uhms** base their claims are "inconsistent" with these standards in that they are much less specific and also in that they do not provide for CMS review. Take, for instance, the New York consumer protection statute. It provides that "[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state are hereby declared unlawful." N.Y. Gen. Bus. Law § 349(a) (McKinney 2009). Any court attempting to evaluate a claim based on that statute must determine whether the particular action in question is "[d]eceptive." To do so, the court must determine whether "the defendant made misrepresentations or omissions that were likely to mislead a reasonable consumer in the plaintiff's circumstances ... and that as a result the plaintiff suffered injury." *Solomon v. Bell Atl. Corp.*, 9 A.D.3d 49, 777 N.Y.S.2d 50, 52 (2004). Yet, under the Act, CMS is charged with reviewing marketing materials and determining whether they are "materially inaccurate or misleading or otherwise make[ ] a material misrepresentation." 42 U.S.C. § 1395w–21(h)(2). If the materials are misleading, CMS is instructed to disapprove them or later require their correction. *Id.*

Thus, allowing a suit to proceed based on a state statute such as New York's consumer protection law risks the possibility that materials CMS has deemed not misleading—and therefore allowed to be distributed—will later be determined "likely to mislead" by a state court. In other words, application of these state laws could potentially undermine the Act's standards as to what constitutes non-misleading marketing.[30] That is precisely the situation that both the current version of the Act's preemption provision as well as its previous incarnations contemplated and sought to avoid. As noted, in enacting Title VI of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub.L. No. 106–554, 114 Stat. 2763, Congress amended 42 U.S.C. § 1395w–26(b)(3) by specifically including "[r]equirements relating to marketing materials" as "[s]tandards specifically superseded" by the preemption provision. Because ***1153** the reach of the 2003 provision is at least as broad as that of

the 2000 version, it follows that state causes of action inconsistent with the CMS's role in reviewing and approving marketing materials distributed by Part D sponsors are preempted.

Therefore, we hold that the **Uhms**' cause of action premised on these state consumer protection statutes is inconsistent with the standards established under the Act and therefore is expressly preempted.

(3) Fraud and Fraud in the Inducement

18 As to the **Uhms**' common law claims for fraud and fraud in the inducement, the parties dispute whether the phrase "any State law or regulation" in the preemption provision also refers to common law actions. At first blush, the scope of that phrase would appear to be controlled by the Supreme Court's interpretation of a similar phrase —"a law or regulation"—in *Sprietsma v. Mercury Marine*, 537 U.S. 51, 123 S.Ct. 518, 154 L.Ed.2d 466 (2002). There, the Supreme Court interpreted the phrase "a law or regulation" in the Federal Boat Safety Act's (FBSA) express preemption clause as indicating Congressional intent to expressly preempt only positive state enactments and not common law. *Id.* at 63, 123 S.Ct. 518.

In reaching that conclusion, however, the Court relied on three statutory features of the FBSA, two of which the Act does not share. First, the Court reasoned that "the article 'a' before 'law or regulation' implies a discreteness—which is embodied in statutes and regulations—that is not present in the common law." *Id.* Medicare Part D, by contrast, uses the phrase "*any* State law or regulation." 42 U.S.C. § 1395w–26(b)(3) (emphasis added). The use of "any" negates the "discreteness" that the Court identified in *Sprietsma*. *See Ali v. Fed. Bureau of Prisons*, 552 U.S. 214, 218–19, 128 S.Ct. 831, 169 L.Ed.2d 680 (2008) (use of the word "any" "suggests a broad meaning" because "[r]ead naturally, the word 'any' has an expansive meaning, that is, one or some indiscriminately of whatever kind" (internal quotation marks omitted)); *Fleck v. KDI Sylvan Pools Inc.*, 981 F.2d 107, 115 (3d Cir.1992) ("The word 'any' is generally used in the sense of 'all' or 'every' and its meaning is most comprehensive." (internal quotation marks and citation omitted)).

Second, and critically, the Court noted that the FBSA contains a savings clause which states that "[c]ompliance with this chapter or standards, regulations, or orders prescribed under this chapter does not relieve a person from liability at common law or under State law." *Sprietsma*, 537 U.S. at 59, 123 S.Ct. 518 (citing 46 U.S.C. § 4311(g)). The Court reasoned that such a clause " 'assumes that there are some significant number of common-law liability cases to save [and t]he language of the pre-emption provision permits a narrow reading that excludes common-law actions.' " *Id.* at 63, 123 S.Ct. 518 (quoting *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 867–68, 120 S.Ct. 1913, 146 L.Ed.2d 914 (2000)). Indeed, in *Geier*, the Court also relied heavily on the presence of a savings clause to read common law claims out of a preemption provision superseding state "standard[s]." *See* 529 U.S. at 867–68, 120 S.Ct. 1913. Importantly, there is no parallel savings clause in the Act, nor any similar indication that Congress intended to save any common law claims.

Third, the *Sprietsma* Court reasoned that:

> [B]ecause "a word is known by the company it keeps," *Gustafson v. Alloyd Co.*, 513 U.S. 561, 575, 115 S.Ct. 1061, 131 L.Ed.2d 1 (1995), the terms "law" and "regulation" used together in the pre-emption clause indicate that Congress ***1154** pre-empted only positive enactments. If "law" were read broadly so as to include the common law, it *might* also be interpreted to include regulations, which would render the express reference to "regulation" in the pre-emption clause superfluous.

Id. at 63, 123 S.Ct. 518 (emphasis added). While this observation provided additional justification for *Sprietsma*'s narrow construction of the FBSA's preemption clause, we are not convinced that, on its own, this reasoning—using the word "might"—could justify completely excluding common law claims from the scope of the Act's preemption clause. "[O]ur hesitancy to construe statutes to render language superfluous does not require us to avoid surplusage at all costs." *United States v. Atl. Research Corp.*, 551

U.S. 128, 137, 127 S.Ct. 2331, 168 L.Ed.2d 28 (2007). Moreover, given the tentative nature of *Sprietsma*'s superfluity point—using the word "might"—as well as the key differences we have identified between the FBSA and the Act, we hold that *Sprietsma* does not control here.

If *Sprietsma* does not control, we are still left to determine whether the Act's preemption clause encompasses common law claims. Having found no clear congressional intent on the face of the statute, we turn to the legislative history of the Act. *Medtronic*, 518 U.S. at 485–86, 116 S.Ct. 2240 (noting that, to divine Congressional intent as to the scope of a preemption clause, a court may look to the legislative history and purpose of the statute as a whole). The Part C preemption provision, upon which Part D's preemptive force relies, was created in 1997. *See* 42 U.S.C. § 1395w–26(b)(3) (1997). That provision was largely similar to the current preemption provision, and also used the phrase "any State law or regulation."[31] *Id.* Pursuant to this former version of the statute, CMS promulgated the following interim final rule in 1998:

> (a) General preemption. Except as provided in paragraph (b) of this section, the rules, contract requirements, and standards established under this part supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to M+C organizations and their M+C plans only to the extent that such State laws are inconsistent with the standards established under this part. 42 C.F.R. § 422.402(a) (1998). In CMS's request for comments on this interim final rule, the Secretary stated that neither the statute nor the regulation "preempt[ed] State remedies for issues other than coverage under the Medicare contract (i.e. tort claims or contract claims under State law are not preempted)." 63 Fed.Reg. 34968, 35013 (June 26, 1998). Subsequently, in promulgating the final version of the rule in 2000, the Secretary noted the following comment:
>
> > Comment: A commenter asked that we revisit our position that State tort or contract remedies may be available to ***1155*** beneficiaries whose coverage determination dispute goes through the Medicare appeals process. This commenter believes that coverage determination cases are contract disputes, and therefore should be the sole province of the Medicare appeals process.
>
> 65 Fed.Reg. 40170, 40261 (June 29, 2000).

In response, CMS retreated from its former position that "tort claims or contract claims under State law are not preempted":

> Response: In some cases, a case that is cast as a State contract claim may amount to a claim that services are covered under an organization's M+C contract. We agree with the commenter that in that case, the claim would be pre-empted. However, there are other tort or State contract law, or consumer protection-based claims that would be entirely independent of the issue of whether services are required under M+C provisions.

Id.

19 Obviously, CMS's revised interpretation of the preemption clause admits that some common law claims may be preempted. While we emphasize that the Secretary's interpretation of the statute does not speak to congressional intent, it is important in helping to divine Congress's subsequent intent when it amended the Part C preemption clause in December 2000[32] and again in 2003 when it passed the Medicare Modernization Act. Because, as early as June 2000, the Secretary had interpreted the phrase "any State law or regulation" to include some common law claims, we may reasonably presume that Congress was aware of that interpretation while crafting the

two subsequent amendments to the Part C preemption provision. *See Abebe v. Gonzales,* 493 F.3d 1092, 1101 (9th Cir.2007) ("Congress is presumed to be familiar with the background of existing law when it legislates...."). In fact, it is well established that " 'Congress is presumed to be aware of an administrative or judicial interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change.' " *Forest Grove Sch. Dist. v. T.A.,* 557U.S. 230, 129 S.Ct. 2484, 2492, 174 L.Ed.2d 168 (2009) (quoting *Lorillard v. Pons,* 434 U.S. 575, 580, 98 S.Ct. 866, 55 L.Ed.2d 40 (1978)). Thus, as there were no contrary administrative interpretations and no federal court had yet confronted the issue, we also may presume that Congress adopted CMS's interpretation in leaving the statutory language unchanged. Thus, we conclude that Congress intended the Part C preemption provision—as incorporated into Part D—to preempt at least some common law claims.

CMS's interpretations of the Part D preemption provision, while requiring no deference, further bolster our conclusion. *See Wyeth v. Levine,* 555U.S. 555, 129 S.Ct. 1187, 1201, 173 L.Ed.2d 51 (2009) ("While agencies have no special authority to pronounce on preemption absent delegation by Congress, they do have a unique understanding of the statutes they administer and an attendant ability to ***1156** make informed determinations about how state requirements may pose an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." (internal quotation marks and citations omitted)). In the proposed rulemaking pronouncements following the Act's enactment, CMS noted, "We continue to believe that generally applicable State tort, contract, or consumer protection law would not be preempted under [the Act]." 69 Fed.Reg. 46866, 46913 (Aug. 3, 2004). That position attracted a number of critical comments,[33] and CMS responded by retreating from that position in the pronouncements on the final rule, declaring that "all State standards, *including those established through case law,* are preempted to the extent they specifically would regulate MA plans, with exceptions of State licensing and solvency laws." 70 Fed.Reg. at 4665 (emphasis added). In other words, CMS's latest position on the "any State law or regulation" language of the preemption clause is that it includes a subspecies of common law causes of action—here, those common law causes of action specifically applicable to Part D plans.[34] Again, while CMS's position does not bind this court, we note that it accords with our reading of the Part D preemption provision.

Having concluded that some common law claims fall within the ambit of the Act's preemption clause, the remaining question is whether the **Uhms**' fraud and fraud in the inducement claims do. The **Uhms** allege that **Humana** made misrepresentations "that were material to the subject transactions" and that **Humana** "knew of the false representations of fact and intentionally entered into contracts with Plaintiffs and Class members with knowledge of these misrepresentations." For substantially similar reasons as those discussed in reference to the **Uhms**' state consumer protection claims, these common law claims are preempted.

In the same way that an action brought under the auspices of a state consumer protection statute would be inconsistent with those standards established under the Act, so too could these tort actions pose such a problem. Indeed, the Supreme Court has indicated, and we agree, that both positive state enactments and liability under state common law may be inconsistent with standards imposed by federal statutes. *See Geier,* 529 U.S. at 868, 120 S.Ct. 1913 (considering whether "standards imposed in common-law tort actions, as well as standards contained in state legislation or regulations" might interfere with standards imposed by the National Traffic and Motor Vehicle Safety Act). *Cf. Riegel,* 552 U.S. at 323–24, 128 S.Ct. 999 ("In *Lohr,* five Justices concluded that common-law causes of action for negligence and strict liability do impose 'requirement[s]' and would be preempted by federal requirements" under the Medical Device Amendments to the Federal Food, ***1157** Drug, and Cosmetic Act (citing *Lohr,* 518 U.S. at 512, 116 S.Ct. 2240)).

Here, in order to determine whether **Humana** committed a fraud or fraud in the inducement, a court would necessarily need to determine whether the written and oral

statements were misleading. *See W. Coast, Inc. v. Snohomish Cnty.*, 112 Wash.App. 200, 48 P.3d 997, 1000 (2002) ("The nine elements of intentional misrepresentation, or fraud, are: (1) representation of an existing fact; (2) materiality; (3) falsity; (4) the speaker's knowledge of its falsity; (5) intent of the speaker that it should be acted upon by the plaintiff; (6) plaintiff's ignorance of its falsity; (7) plaintiff's reliance on the truth of the representation; (8) plaintiff's right to rely upon the representation; and (9) damages suffered by the plaintiff."); *Pedersen v. Bibioff*, 64 Wash.App. 710, 828 P.2d 1113, 1120 (1992) ("Fraud in the inducement ... is fraud which induces the transaction by misrepresentation...."). Were a state court to determine that **Humana's** marketing materials constituted misrepresentations resulting in fraud or fraud in the inducement, it would directly undermine CMS's prior determination that those materials were not misleading and in turn undermine CMS's ability to create its own standards for what constitutes "misleading" information about Medicare Part D. Thus, the **Uhms'** fraud and fraud in the inducement claims must be preempted. [35]

*(4) Preemption of Claims Against **Humana**, Inc.*

The **Uhms** argued in their motion for reconsideration that regardless of whether the Act preempts their claims against **Humana** Health Plan, Inc., their claims against **Humana**, Inc., are not preempted because **Humana**, Inc., is not a CMS-approved PDP sponsor, and the Act's preemption provision applies only to PDP sponsors. **Humana**, Inc., argues that preemption under the statute is determined by whether federal standards exist with respect to the prescription drug plan, not by the identity of the defendant. We assess this argument with respect to the claims against **Humana** Health Plan, Inc., that we have found preempted—the fraud and consumer protection claims—and conclude that the **Uhms'** claims against **Humana**, Inc., are also preempted.

To recall, the Act's preemption provision provides:

> The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [PDPs] which are offered by [Part D sponsors] under this part.

42 U.S.C. § 1395w–26(b)(3) [36]; *see also* 42 C.F.R. § 423.440(a) (2005).

Section 1395w–26(b)(3) provides that standards preempt state laws with respect to PDPs; the language about PDP sponsors modifies or describes what a PDP is—it does not shift the locus of preemption from the prescription drug plan to the sponsor. Here, the fraud and consumer protection claims against **Humana**, Inc., are entirely derivative of its relationship with **Humana** Health Plan, Inc. The **Uhms** allege that **Humana**, Inc., participated ***1158** alongside its subsidiary **Humana** Health Plan, Inc., in marketing the PDP. As we discussed above, the conduct underlying these allegations is directly governed by federal standards. Therefore the **Uhms'** state law claims, with respect to the PDP, are preempted. This case does not require us to consider whether allegations related to a third party's involvement with a PDP that differ from those alleged here might be preempted under the Act.

III. CONCLUSION

Because the **Uhms'** state consumer protection claims and fraud claims fall within the ambit of the federal standards provided for in the Act and its implementing regulations, those claims are preempted. Because the breach of contract and unjust enrichment claims fall squarely within the Act's exhaustion provision, the district court lacked jurisdiction over those claims. Accordingly, the judgment of the district court is AFFIRMED.

B. FLETCHER, Circuit Judge, concurring.

I concur in the opinion, which carefully and painstakingly analyzes the claims. I add this concurrence simply to vent my frustration. What have **Uhms'** counsel

accomplished for the **Uhms**, for justice, or for the law?

The **Uhms** suffered a frustrating and bureaucratic "snafu" that temporarily cost them two months' prescription costs. They filled out the forms to receive Part D prescription drug benefits from **Humana**. The process obviously enrolled them to the point where automatic deductions were made from their social security checks. But the other half of the process failed—their status as beneficiaries was denied and, as a consequence, the **Uhms** had to pay for their prescriptions. Frustrating indeed. But what to do? Make a federal case of it—start a class action where simply following the administrative appeal process would suffice? A class action all for the recovery of two months' prescriptions?

Today the **Uhms** receive the prescription drug benefits to which they are entitled. But not as a result of this lawsuit. The cost to the court system and to the **Uhms** is unconscionable. A bit of common sense and attention to the available administrative remedies should have been applied. Instead we have an opinion with endless pages of legal analysis, months of study and delay, and a determination that no benefit can be awarded to the **Uhms**. Counsel particularly should take heed.

All Citations

620 F.3d 1134, Med & Med GD (CCH) P 303,534, 10 Cal. Daily Op. Serv. 11,278, 2010 Daily Journal D.A.R. 13,676

Footnotes

1 Due to the unavailability of Senior District Judge William Schwarzer, a member of the original panel in this case, Judge Berzon was randomly drawn as a replacement judge.

2 We revisit this appeal after having granted the **Uhms**' Petition for Rehearing and withdrawing our original opinion in this matter. *See* ***Uhm v. Humana,*** *Inc.*, 540 F.3d 980 (9th Cir.2008), *reh'g granted, opinion withdrawn by* 573 F.3d 865 (9th Cir.2009). After we granted rehearing and at our request, the Centers for Medicare and Medicaid Services filed an amicus brief in support of **Humana**. We also received amicus briefs from America's Health Insurance Plans, Inc., the National Senior Citizens Law Center, California Health Advocates, the Center for Medicare Advocacy, the Medicare Rights Center, and the American Association for Justice. The parties have also filed supplemental briefs. We have carefully considered the additional briefing and express our appreciation to the parties and amici for their thoughtful briefs.

3 Prior to 2001, CMS was known as the Health Care Financing Administration.

4 The **Uhms** allege that **Humana**, Inc., was involved in marketing and administering **Humana** Health Plan, Inc.'s PDP. Because the **Uhms** do not distinguish between **Humana** Health Plan, Inc., and **Humana**, Inc., with respect to any specific factual allegations, we refer to them collectively as "**Humana**." In Parts II(B)(1)(a) and II(C)(4), *infra*, which address the **Uhms**' claim that the Act does not apply to **Humana**, Inc., we address the two entities separately.

5 Because this appeal is from an order granting a motion to dismiss, we take the material facts alleged in the **Uhms**' complaint as true and construe them in the light most favorable to the **Uhms**. *Sprewell v. Golden State Warriors*, 266 F.3d 979, 988 (9th Cir.2001).

6 The **Uhms** initially sued **Humana** Medical Plan, Inc., as well, but later voluntarily dismissed the complaint against that entity.

7 42 U.S.C. § 405(h) reads in relevant part:

> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

8 42 U.S.C. § 405(g) reads in relevant part:

> Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides.... The court shall have power to enter ... a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing.

9 Although codified elsewhere in the Social Security Act, § 405(g) applies to Part D of the Medicare Act. Part D's provision that addresses judicial review, 42 U.S.C. § 1395w–104(h), incorporates Part C's judicial review provision, 42 U.S.C. § 1395w–22(g), which in turn provides for judicial review under § 405(g), located in the Social Security Act. Section 405(h) is incorporated into the Medicare Act in 42 U.S.C. § 1395ii.

10 A narrow exception to these requirements, not applicable here, exists where a plaintiff challenges the validity of the Act's provisions or the Secretary's implementation of regulations pursuant to those provisions. *See Bowen v. Mich. Acad. of Family Physicians*, 476 U.S. 667, 678, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986).

11 We note that, at first blush, *Kaiser's* rule might seem to conflict with our prior holding that: "[s]ection 405(h) only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334." *In re Town & Country Home Nursing Servs. Inc.*, 963 F.2d 1146, 1155 (9th Cir.1991). *Cf. Midland Psychiatric Assoc., Inc. v. United States*, 145 F.3d 1000, 1004 (8th Cir.1998) (holding that actions brought pursuant to § 1332 are also subject to the Act's exhaustion provisions); *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 488–90 (7th Cir.1990) (same). But upon closer reading, *Kaiser* and *In re Town & Country* can be reconciled. *In re Town & Country*'s reasoning relies almost exclusively on the special status of § 1334's "broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate...." 963 F.2d at 1155. Thus, its reading of 42 U.S.C. § 405(h) can reasonably be understood to apply only to actions brought under § 1334, while not bearing on the relationship between § 405(h) and other jurisdictional provisions such as § 1332.

12 Since CMS initially promulgated the Act's implementing regulations in 2005, they have been amended on a number of occasions. *See, e.g.*, 75 FR 19825 (Apr. 15, 2010); 73 FR 54208–01 (Sept. 18, 2008). In this opinion, we refer to the regulations in place at the time of the **Uhms**' alleged injury. Where the regulations have been subsequently amended or redesignated, we will so note for ease of reference. As discussed below, however, none of the amendments or redesignations affect our analysis.

13 Assuming that there was a valid express contract between the **Uhms** and **Humana**, we further note that under Washington state law, "[a] party to

a valid express contract is bound by the provisions of that contract, and may not disregard the same and bring an action on an implied contract relating to the same matter, in contravention of the express contract." *Chandler v. Wash. Toll Bridge Auth.*, 17 Wash.2d 591, 137 P.2d 97, 103 (1943).

14 The regulations also required that "[t]he PDP sponsor must provide the individual with prompt notice of acceptance or denial of the individual's enrollment request, in a format and manner specified by CMS," *id.* § 423.32(d). This requirement suggests that an individual is not enrolled simply by filing the enrollment form, which in this provision is styled as an enrollment "request." And yet, the regulations require the Part D sponsor to enroll all eligible individuals who elect to enroll (i.e. who submit a completed form). *See id.* § 423.32(c).

15 We note that reading sections 423.32(a), 423.32(c), and 423.32(d) together suggests that an individual is not "enrolled" until the plan sponsor provides her with "notice of acceptance ... of the individual's enrollment request."

16 42 U.S.C. § 1395w–104(h) provides:

> An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the organization shall be entitled to be parties to that judicial review.

17 The **Uhms** argue that the term "elected" means someone who is automatically enrolled in a PDP (i.e., dual-benefit individuals who are entitled to both Medicare and Medicaid coverage). In support of this argument, they point to a passage in the Act's implementing regulations, which provides:

> Comment: We received one comment requesting that the definition of enrollee be revised to include people who are automatically enrolled in a PDP or MA–PD.
>
> Response: We agree with the commenter and have revised the definition of enrollee in this final rule to mean a Part D eligible individual who has elected or has been enrolled in a Part D plan.

70 Fed.Reg. 4194, 4344 (Jan. 28, 2005). The **Uhms**' reading of the term "elected" is not persuasive. The plain text of the regulation permits only one reading—that a person who has "elected ... a Part plan" is one who has chosen or selected it; a person who has "been enrolled" is one who has been automatically enrolled. The proposed regulation provides further support for this reading. Before it was amended to clarify the inclusion of dual-benefit individuals, it read: "Enrollee means a Part D eligible individual, or his or her authorized representative, who has elected a prescription drug plan offered by a PDP sponsor." 69 Fed.Reg. 46632, 46841 (Aug. 3, 2004).

18 The **Uhms** also argue that the Act's preemption provisions do not apply to them because they were not enrolled in the program at the time their claims arose. For precisely the same reasons that this argument fails as applied to the exhaustion provision, it also fails as applied to the preemption provisions.

19 Prior to the Act, Medicare Advantage was called "Medicare+Choice." *See* 42 U.S.C. § 1395w–21.

20 Although the term "standard" is not defined in the Act, at the narrowest cut, a "standard" within the meaning of the preemption provision is a statutory provision or a regulation promulgated under the Act and published in the Code of Federal Regulations. **Humana** points to a broad definition of the term "standard" in *Black's Law Dictionary*, which reads "criterion for measuring acceptability, quality, or accuracy." *Black's Law Dictionary* 1441 (8th ed. 2004); *see also Webster's New Universal Unabridged Dictionary* 1857 (1996) (defining a standard as "something considered by an authority or by general consent as a basis of comparison; an approved model ...; a rule or principle that is used as a basis for judgment"). Under those definitions, **Humana** contends that the Act's administrative remedial mechanisms are "standards" with preemptive effect. We decline to take such a broad view of the term. *Cf. Gorman v. Wolpoff & Abramson, LLP*, 584 F.3d 1147, 1171 (9th Cir.2009) (holding that a statutory provision creating a private cause of action to seek redress for violations of other portions of a state statute does not impose any "requirement or prohibition," but instead "merely provide[s] a vehicle for private parties to enforce other sections").

21 CMS replaced the phrase "PDP sponsor" in its implementing regulations with "Part D sponsor," because it "believe[d] that the preemption of State law ... should operate uniformly for all Part D sponsors." 70 Fed.Reg. 4194, 4319 (Jan. 28, 2005). A PDP provides "prescription drug coverage that is offered under a policy, contract, or plan that has been approved ... and that is offered by a PDP sponsor that has a contract with CMS...." 42 C.F.R. § 423.4 (2005). Part D plans also include MA–PD plans (which are offered through Medicare Advantage organizations), Programs of All–Inclusive Care for the Elderly (PACE) plans offering qualified prescription drug coverage, and cost plans offering qualified prescription drug coverage. *See id.*

22 In full, that prior preemption clause read:

> (A) In general
>
> The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph (B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.
>
> (B) Standards specifically superseded
>
> State standards relating to the following are superseded under this paragraph:
>
> (i) Benefit requirements (including cost-sharing requirements).
>
> (ii) Requirements relating to inclusion or treatment of providers.
>
> (iii) Coverage determinations (including related appeals and grievance processes).

(iv) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare+Choice plan.

42 U.S.C. § 1395w–26(b)(3) (2000) (emphasis added).

23 The Secretary adopted the same reading of the Conference Report in promulgating the final rules: "We believe that the Conference Report was clear that the Congress intended to broaden the scope of preemption in the MMA." 70 Fed.Reg. 4588, 4663 (Jan. 28, 2005).

24 We stress that, in using the term "inconsistent," we do not mean to be incorporating the same standards used in implied preemption cases. *Cf. Gade v. Nat'l Solid Wastes Mgmt. Assoc.*, 505 U.S. 88, 98, 112 S.Ct. 2374, 120 L.Ed.2d 73 (1992) (plurality) (stating that conflict preemption applies "where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress").

25 Amicus American Association of Justice argues that because consumer protection laws are laws of general applicability, they should not be considered laws "with respect to" Part D plans. That same argument was specifically rejected in *Riegel v. Medtronic, Inc.*, 552 U.S. 312, 128 S.Ct. 999, 169 L.Ed.2d 892 (2008). There, the Supreme Court considered the meaning of the phrase "with respect to" in the preemption clause of the Medical Device Amendments to the Federal Food, Drug, and Cosmetic Act. *Id.* at 315–16, 128 S.Ct. 999. That preemption provision read, in relevant part: "no State or political subdivision of a State may establish or continue in effect with respect to a device intended for human use any requirement —(1) which is different from, or in addition to, any requirement applicable under this chapter to the device, and (2) which relates to the safety or effectiveness of the device or to any other matter included in a requirement applicable to the device under this chapter." *Id.* at 316, 128 S.Ct. 999 (quoting 21 U.S.C. § 360k(a)). The petitioners argued that their negligence, strict liability, and implied warranty claims were not preempted because "common-law duties are not requirements maintained 'with respect to devices.' " *Id.* at 327, 128 S.Ct. 999. The Court rejected that argument, reasoning that "[n]othing in the statutory text suggests that the pre-empted state requirement must apply *only* to the relevant device ... and not to all products and all actions in general." *Id.* at 328, 128 S.Ct. 999. Similarly, we hold that nothing in the statutory text of the Act suggests that a state law or regulation must apply *only* to a PDP in order to constitute a law "with respect to" a PDP.

26 These regulations have since been amended and renumbered. *See* 73 FR 54208–01 (Sept. 18, 2008). These amendments added a number of new regulatory provisions regarding the marketing process of PDP plans, none of which affect our analysis.

27 As amended in 2008, these regulations mandate a slightly different process for approval of Part D marketing materials. Part D sponsors must now submit materials to CMS for review at least 45 days prior to distribution (or 10 days, in certain cases), and are allowed to distribute those materials if CMS does not object. *See* 42 C.F.R. § 423.2262 (2008).

28 Under the 2005 version of the regulations, "marketing materials" also included "membership or claims processing activities," *id.*, although the current version of the regulations has revised that category to include only "membership activities (for example, materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or nonclaim-specific notification information)," *id.* § 423.2260 (2010).

29 We note, however, that in the most recently amended version of the implementing regulations, the term "marketing materials" excludes "ad

hoc enrollee communications materials, meaning informational materials that ... (iv) Apply to a specific situation or cover member-specific claims processing or other operational issues." *Id.* § 423.2260(6)(iv) (2010). Although oral representations might fall within that exclusion, the **Uhms** allege that **Humana's** oral misrepresentations were made "systematically" and to the entire class. We therefore cannot surmise how they could have been "ad hoc" communications.

30 The same result is possible under the other state consumer protection statutes on which the **Uhms** rely. For example, Washington's consumer protection law prohibits "[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce." Wash. Rev.Code § 19.86.020. According to Washington courts, "[i]mplicit in the definition of 'deceptive' under [§ 19.86.020] is the understanding that the practice misleads." *Holiday Resort Cmty. Ass'n v. Echo Lake Assoc., LLC,* 134 Wash.App. 210, 135 P.3d 499, 507 (2006). Thus, material deemed not to be misleading by CMS may subsequently be declared "unfair or deceptive" under Washington state law.

31 The Medicare Part C preemption provision created in 1997 read:

> In general
>
> The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph (B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.
>
> (B) Standards specifically superseded
>
> State standards relating to the following are superseded under this paragraph:
>
> (i) Benefit requirements.
>
> (ii) Requirements relating to inclusion or treatment of providers.
>
> (iii) Coverage determinations (including related appeals and grievance processes).

42 U.S.C. § 1395w–26(b)(3) (1997).

32 Again, in enacting Title VI of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub.L. No. 106–554, 114 Stat. 2763, Congress amended subsection (B) of § 1395w–26(b)(3) by adding the following italicized words:

> (B) Standards specifically superseded
>
> State standards relating to the following are superseded under this paragraph:
>
> (i) Benefit requirements *(including cost-sharing requirements).*
>
> (ii) Requirements relating to inclusion or treatment of providers.
>
> (iii) Coverage determinations (including related appeals and grievance processes).
>
> *(iv) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare+Choice plan.*

33 For example, "[a] commenter expressed concern that while State contract and tort law principals [sic] may have general application, State standards

developed through case law based on interpretations of State contract and tort law may be specific to health plans, and may apply State standards that would otherwise be preempted under Section 232(a) of the [Act]." 70 Fed.Reg. 4588, 4665 (Jan. 28, 2005).

34 In its amicus brief to this court, CMS took the position that, under *Sprietsma,* the Act's express preemption provision does not contemplate common law claims (although such claims can, argued CMS, be impliedly preempted). We accord that position no deference here. *See United States v. Trident Seafoods Corp.*, 60 F.3d 556, 559 (9th Cir.1995) ("No deference is owed when an agency has not formulated an official interpretation of its regulation, but is merely advancing a litigation position.").

35 We emphasize that this holding does not mean that all common law fraud and fraud in the inducement claims would be preempted under the Act. The preemption inquiry turns on the specific allegations forming the basis of those claims, not their labels.

36 *See* 42 U.S.C. § 1395w–112(g) (providing that "[t]he provisions of sections 1395w–24(g) and 1395w–26(b)(3) of this title shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C of this subchapter").

End of Document

Effective: January 1, 2003

West's Ann.Cal.Welf. & Inst.Code § **15610.57**

§ **15610.57**. Neglect

Currentness

(a) "Neglect" means either of the following:

(1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise.

(b) Neglect includes, but is not limited to, all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) Failure to prevent malnutrition or dehydration.

(5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

Credits

(Added by Stats.1994, c. 594 (S.B.1681), § 3. Amended by Stats.1998, c. 946 (S.B.2199), § 7; Stats.2002, c. 54 (A.B.255), § 8.)

Editors' Notes

Relevant Additional Resources

Additional Resources listed below contain your search terms.

RESEARCH REFERENCES

Treatises and Practice Aids

Judicial Council of California Civil Jury Instructions 3103, Neglect-Essential Factual Elements (Welf. & Inst. Code, § **15610.57**).
Judicial Council of California Civil Jury Instructions VF-3102, Neglect-Individual or Individual and Employer Defendants (Welf. & Inst. Code, §§ **15610.57**, 15657; Civ. Code, § 3294(B)).
Judicial Council of California Civil Jury Instructions VF-3103, Neglect-Employer Defendant Only (Welf. & Inst. Code, §§ **15610.57**, 15657; Civ. Code, § 3294(B)).

Notes of Decisions containing your search terms (0) View all 57

[West's Ann. Cal. Welf. & Inst. Code § **15610.57**, CA WEL & INST § **15610.57**
Current with urgency legislation through Ch. 26 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

West's Annotated California Codes
Welfare and Institutions Code (Refs & Annos)
Division 9. Public Social Services (Refs & Annos)
Part 3. Aid and Medical Assistance (Refs & Annos)
Chapter 11. Elder Abuse and Dependent Adult Civil Protection Act (Refs & Annos)
Article 2. Definitions (Refs & Annos)

West's Ann.Cal.Welf. & Inst.Code § **15610.63**

§ 15610.63. Physical abuse

Effective: January 1, 2019
Currentness

"Physical abuse" means any of the following:

(a) Assault, as defined in Section 240 of the Penal Code.

(b) Battery, as defined in Section 242 of the Penal Code.

(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.

(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.

(e) Sexual assault, that means any of the following:

(1) Sexual battery, as defined in Section 243.4 of the Penal Code.

(2) Rape, as defined in Section 261 of the Penal Code.

(3) Rape in concert, as described in Section 264.1 of the Penal Code.

(4) Spousal rape, as defined in Section 262 of the Penal Code.

(5) Incest, as defined in Section 285 of the Penal Code.

(6) Sodomy, as defined in Section 286 of the Penal Code.

(7) Oral copulation, as defined in Section 287 or former Section 288a of the Penal Code.

(8) Sexual penetration, as defined in Section 289 of the Penal Code.

(9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.

(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:

(1) For punishment.

(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.

(3) For any purpose not authorized by the physician and surgeon.

Credits

(Added by Stats.1994, c. 594 (S.B.1681), § 3. Amended by Stats.1996, c. 1075 (S.B.1444), § 22; Stats.2000, c. 287 (S.B.1955), § 29; Stats.2004, c. 823 (A.B.20), § 18; Stats.2018, c. 423 (S.B.1494), § 129, eff. Jan. 1, 2019.)

West's Ann. Cal. **Welf. & Inst.** Code **§ 15610.63**, CA WEL & **INST § 15610.63**
Current with urgency legislation through Ch. 120 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

Enacted Legislation Amended by 2019 Cal. Legis. Serv. Ch. 21 (S.B. 314) (WEST)

Effective: January 1, 2005

West's Ann.Cal.Welf. & Inst.Code § 15657

§ 15657. Defendant liable for physical abuse or neglect; attorney's fees and costs; limits on damages; punitive damages

Currentness

Where it is proven by clear and convincing evidence that a defendant is liable for physical abuse as defined in Section 15610.63, or neglect as defined in Section 15610.57, and that the defendant has been guilty of recklessness, oppression, fraud, or malice in the commission of this abuse, the following shall apply, in addition to all other remedies otherwise provided by law:

(a) The court shall award to the plaintiff reasonable attorney's fees and costs. The term "costs" includes, but is not limited to, reasonable fees for the services of a conservator, if any, devoted to the litigation of a claim brought under this article.

(b) The limitations imposed by Section 377.34 of the Code of Civil Procedure on the damages recoverable shall not apply. However, the damages recovered shall not exceed the damages permitted to be recovered pursuant to subdivision (b) of Section 3333.2 of the Civil Code.

(c) The standards set forth in subdivision (b) of Section 3294 of the Civil Code regarding the imposition of punitive damages on an employer based upon the acts of an employee shall be satisfied before any damages or attorney's fees permitted under this section may be imposed against an employer.

Credits

(Added by Stats.1991, c. 774 (S.B.679), § 3. Amended by Stats.1997, c. 724 (A.B.1172), § 38; Stats.2002, c. 664 (A.B.3034), § 237.5; Stats.2004, c. 183 (A.B.3082), § 390; Stats.2004, c. 886 (A.B.2611), § 3.)

Notes of Decisions (93)

West's Ann. Cal. Welf. & Inst. Code § 15657, CA WEL & INST § 15657
Current with urgency legislation through Ch. 26 of the 2019 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

42 USC 1395w-26(b)(3)

(b) Establishment of other standards

(1) In general

The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part.

* * *

(3) Relation to State laws

The standards established under this part **shall supersede any State law or regulation** (other than State licensing laws or State laws relating to plan solvency) **with respect to MA plans** which are offered by MA organizations under this part.