UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	SACV 12-02022 JVS (RNBx)	Date	March 6, 2013
Title	Martha Garcia v. Pacificare of California Inc.,e t al.		

Present: The Honorable	James V. Selna
Karla J. Tunis	Not Present
Deputy Clerk	Court Reporter
Attorneys Present for Plaintiffs:	Attorneys Present for Defendants:
Not Present	Not Present

Proceedings: (IN CHAMBERS) Order Denying Plaintiff's Motion for Summary Judgment as to Claim for ERISA Benefits (fld 1-8-13)

Plaintiff Martha Garcia ("Garcia") moves for summary judgment against Defendants PacifiCare of California, Inc. and UHC of California d/b/a UnitedHealthCare of California (collectively, "PacifiCare"), pursuant to Federal Rule of Civil Procedure 56, on her claim for benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). (Motion for Summary Judgment ("Motion"), Docket No. 18.) PacifiCare opposes. (Opposition to Motion for Summary Judgment ("Opposition"), Docket No. 24.) Garcia has replied. (Reply Supporting Motion for Summary Judgment ("Reply"), Docket No. 30.) For the following reasons, the Court **DENIES** the motion and **GRANTS** summary judgment in favor of PacifiCare.

I. FACTUAL BACKGROUND

This case requires the statutory interpretation of Cal. Health & Safety Code § 1367.18 ("Section 1367.18" or "§ 1367.18"). The parties do not materially dispute the underlying facts. Garcia contends that § 1367.18 requires health plans that provide benefits for orthotic and prosthetic devices ("O&P devices") to pay for all types of original and replacement prosthetic devices, as long as they are medically necessary and prescribed by qualified healthcare professionals. (Motion, at 1.) PacifiCare counters that § 1367.18 allows it to agree with Garcia's employer to specifically exclude coverage for myoelectric prostheses. (Opposition, at 1.)

Garcia contracted spinal meningitis in 1989, which necessitated the amputation of her hands at the wrists and her feet below the knees. (Statement of Uncontroverted Facts ("SUF") ¶ 1, Docket No. 11.) She uses myoelectric upper-extremity prostheses for improved hand function. (Id.) The myoelectric devices provide her a higher degree of function than body-powered

prosthetics, because they have a stronger pinch force, better grip, and are more flexible. (Id. ¶ 2.)

Since 2006, Garcia has worked full-time as a Service Coordinator for the Regional Center of Orange County ("the Regional Center"). (Id. ¶ 3.) The Regional Center provides health coverage as a benefit for its employees through either Kaiser or PacifiCare. (Id. ¶ 5.) As of 2008, Garcia selected coverage from PacifiCare. (Id. ¶ 6.) Under the terms of Garcia's health plan, PacifiCare would cover prosthetics, but the plan excluded prosthetic devices that were "bionic, myoelectric, microprocessor controlled, [or] computerized." (Id.)

In August 2009, Garcia's upper-extremity prostheses began failing. (Id. ¶ 7.) Her physician, Dr. Matthew Davis, requested their replacement with similar myoelectric devices. (Id.) Dr. Davis submitted a request to Memorial Healthcare, the independent practice association ("IPA") under contract with PacifiCare to provide care to members of the plan purchased by the Regional Center. (Id. ¶ 8.) Memorial Healthcare denied the request on August 26, 2009, explaining that "[m]yoelectric prosthetics are not a benefit covered under [Garcia's] health plan." (Id. ¶¶ 8, 9.) Garcia timely appealed to PacifiCare on November 16, 2009. On December 16, 2009, PacifiCare affirmed the denial, stating that myoelectric prostheses are not covered. (Id. ¶ 10.) PacifiCare also stated that it reviewed Garcia's "health condition in relation to PacifiCare's medical necessity criteria or guidelines," but the justifications detailed in the denial only explained the terms of the policy. (December 16, 2009 Letter ("Dec. Letter"), Docket No. 15-1.)

II. LEGAL STANDARD

Summary judgment is appropriate only where the record, read in the light most favorable to the nonmoving party, indicates that "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c)(2); see also Celotex Corp. v. Catrett, 477 U.S. 317, 323-24 (1986). Material facts are those necessary to the proof or defense of a claim, and are determined by reference to substantive law. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). "[A] complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." Celotex, 477 U.S. at 322. A fact issue is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Anderson, 477 U.S. at 248. To demonstrate a genuine issue, the opposing party "must do more than simply show that there is some metaphysical doubt as to the material facts. . . . [T]he nonmoving party must come forward with specific facts showing that there is a genuine issue for trial." Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586–87 (1986) (citations and internal quotation marks

omitted). In deciding a motion for summary judgment, "[t]he evidence of the nonmovant is to be believed, and all justifiable inferences are to be drawn in his favor." Anderson, 477 U.S. at 255. Nevertheless, inferences are not drawn out of the air, and the opposing party must produce a factual predicate from which the inference may be drawn. See Richards v. Nielsen Freight Lines, 602 F. Supp. 1224, 1244-45 (E.D. Cal. 1985), aff'd, 810 F.2d 898, 902 (9th Cir. 1987).

The burden initially is on the moving party to demonstrate an absence of a genuine issue of material fact. Celotex, 477 U.S. at 323. If the moving party meets its burden, then the nonmoving party must produce enough evidence to rebut the moving party's claim and create a genuine issue of material fact. See id. at 322–23. If the nonmoving party meets this burden, the motion will be denied. Nissan Fire & Marine Ins. Co. v. Fritz Co., 210 F.3d 1099, 1103 (9th Cir. 2000).

III. DISCUSSION

The disposition of this motion, and Garcia's lawsuit, depends on the interpretation of § 1367.18.[1] The Court interprets the language of § 1367.18 below and finds as a matter of law that PacifiCare's health care coverage complies with § 1367.18 and that Garcia was not wrongfully denied benefits under ERISA.

Cal. Health & Safety Code § 1367.18 provides in pertinent part and with the disputed provisions underlined:

> (a) Every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of that coverage to all group contractholders and to all prospective group contractholders with whom they are negotiating. Any coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within

[1]PacifiCare does not dispute that Garcia's plan is an ERISA plan, see Stuart v. UNUM Life Ins. Co. of Am., 217 F.3d 1145, 1149 (9th Cir. 2000), or that she cannot sue for wrongfully-denied benefits, see Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1008 (9th Cir. 1998).

> the scope of his or her license. . . . Every party shall have the right to conduct a utilization review to determine medical necessity prior to authorizing these services.
>
> (b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under Section 1367. If the contract does not include any annual or lifetime benefit maximums applicable to basic health care services, the amount of the benefit for orthotic and prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under Section 1367.

No state court in California has interpreted the entirety of § 1367.18, although the California Court of Appeal discussed the statute when it interpreted Cal. Health & Safety Code § 1374.55 in Yeager v. Blue Cross of Cal., 175 Cal. App. 4th 1098 (2009). Thus, the Court's task is to "predict how the highest state court would decide the issue using intermediate appellate court decisions, decisions from other jurisdictions, statutes, treatises, and restatements as guidance." Credit Suisse First Boston Corp. v. Grunwald, 400 F.3d 1119, 1126 (9th Cir. 2005) (internal quotation marks and citation omitted).

In interpreting § 1367.18, the Court must look to California principles of statutory construction. Id. (citing In re First T.D. & Inv., Inc., 253 F.3d 520, 527 (9th Cir. 2001)). These principles require the Court to "ascertain the intent of the Legislature so as to effectuate the purpose of the law by first looking to the words of the statute." Id. (internal quotation marks and citation omitted). The Court must "utilize the ordinary meaning of words in a statute unless the Legislature has defined the terms," and "where the language is clear, its plain meaning should be followed." Id. (internal quotation marks and citation omitted). "This 'plain meaning' rule, however, 'does not prohibit a court from determining whether the literal meaning of a statute comports with its purpose or whether such a construction of one provision is consistent with other provisions of the statute.'" Id. (quoting Lungren v. Deukmejian, 45 Cal. 3d 727, 735 (1988)). Thus, "the intent prevails over the letter, and the letter will, if possible, be so read as to

conform to the spirit of the act." Id. (internal quotation marks, citation, and modification omitted). If the letter of the law is ambiguous, the Court must examine the legislative history for further guidance.[2] Id. (citation omitted).

By its plain language, § 1367.18 obligates PacifiCare to offer coverage for orthotic or prosthetic devices, leaving to PacifiCare's and the Regional Center's mutual agreement the terms of that coverage. See § 1367.18(a) ("Every . . . plan . . . shall offer coverage . . . under the terms and conditions that may be agreed upon between the group subscriber and the plan."); accord Yeager, 175 Cal. App. 4th at 725 (reasoning that similar language in Cal. Health & Safety Code § 13744.55 only obligated Blue Cross to offer coverage for treatment of infertility). PacifiCare offered such coverage, and its agreement with the Regional Center excluded "bionic, myoelectric, microprocessor controlled, [or] computerized" devices.

Garcia contends that the balance of the statute does not allow her plan to categorically exclude certain prosthetic devices, especially if they are medically necessary and prescribed by a physician. (Reply, at 1.) Her argument for such coverage finds no support in the statute's language, the legislative history, or the reasoning in Yeager. No ambiguity exists in the statute to help Garcia and require PacifiCare to cover myoelectric prostheses.

The statute plainly requires that any offered coverage include original and replacement devices, as prescribed by a qualified medical professional. § 1367.18(a). This ensures that a plan cannot be limited to only original or only replacement prosthetic devices. The language does not address the *type* or *quality* of the covered prosthetic devices or establish that the physician's prescription supersedes the agreement between a plan and the employer. The Court will not insert such terms into the statutory text, because it "may not make a silent statute speak by inserting language the Legislature did not put in the legislation."[3] Yeager, 175 Cal. App. 4th at

[2]Garcia and PacifiCare request judicial notice of the legislative history of § 1367.18. (Plaintiff's Request for Judicial Notice ("PRJN"), Docket No. 16; Defendant's Request for Judicial Notice ("DRJN"), Docket No. 29.) The Court takes judicial notice pursuant to Fed. R. Evid. 201, which authorizes judicial notice of the legislative history of state statutes. See Louis v. McCormick & Schmick Rest. Corp., 460 F. Supp. 2d 1153, 1156 n.4. (C.D. Cal. 2006).

[3]Garcia argues that "[i]t would be illogical for the Legislature to expressly give plans the right to impose a medical-necessity requirement on O&P coverage if plans were already allowed to limit that coverage however they wanted." (Motion, at 12.) The Court disagrees. The provision logically assumes that a plan could determine that a person has no medical need for a covered prosthetic, because, *e.g.*, she is not an amputee.

726 (citing Camarena v. State Personnel Bd., 54 Cal. App. 4th 698, 702 (1997)). Legislative history confirms that mutual agreement can limit the type of device a doctor may prescribe. The Legislative Counsel's Digest for the 2006 amendment to § 1367.18 states that "[t]his bill would specify that a doctor of podiatric medicine, acting within the scope of his or her license, may prescribe the orthotic or prosthetic devices *covered by the plan or insurer*."[4] (DRJN, at 18 (emphasis added).)

Section 1367.18(b), by its plain terms, also circumscribes the flexibility of a group subscriber and a plan to set the terms and conditions of coverage. It mandates that the *amount* of the benefit for prosthetic devices "be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under Section 1367." § 1367.18(b). Because this limits the scope of subsection (a), the language must be strictly construed. See Lungren, 45 Cal. 3d at 735–36 ("The second sentence is a proviso, *i.e.*, an exception or limitation on the operation of the first. As such, it has to be strictly construed.").

The Yeager Court addressed this language, reasoning that "the Legislature . . . tethered a class of benefits to an objective standard measured by the carrier's already existing coverage." 175 Cal. App. 4th at 727. The court explained that the 2006 amendment to § 1367.18, which added subsection (b), "capp[ed] copayments and the like and set[] a minimum benefit equal to the plan's annual and lifetime benefits for other basic health care services." Id. at 727–28. This amendment "shows the Legislature knows how to limit or end the parties' prerogative to define by mutual agreement the scope and expense of coverage under their health plan." Id. at 728. The Legislature, however, specifically chose to dictate only particular "terms and conditions"—the *amount* of coverage and its cost. It declined to entirely end the parties' prerogative to define the scope of the coverage for prosthetics, including the *type* or *quality* of the covered prosthetic devices and services, even though it has mandated particular coverage before. Compare § 1367.18(b) (dictating amount of benefit and copay) with Cal. Health & Safety Code § 13741.10

[4]The legislative history of the earlier amendment to § 1367.18 in 1991, which required offered coverage to include original and replacement devices, supports this conclusion. One opposition noted that it would require plans to "include within their offer of prosthetic and orthotic coverage, replacement of such devices when prescribed by a physician." (Second Supplemental Request for Judicial Notice ("Supp. RJN"), Docket No. 33, at 19.) This would address the problem that providers were limiting coverage "to one device for the lifetime of the contract," depriving amputees of replacements for devices that were damaged or required refitting. (Id. at 24.) Legislators clearly were concerned that plans were not covering replacement devices. They did not address providers' decision to exclude specific types of devices, such as myoelectric ones, from coverage.

(dictating two components of the obligatory home care offer by capping deductible at fifty dollars per year and requiring that a plan provide for at least one hundred home visits per year).[5] Adopting Garcia's reading would require the Court to ignore this background and read out the "terms and conditions" language in the statute, which it will not do, and to insert language the Legislature did not put into the statute, which it will not do. See Lungren, 45 Cal. 3d at 736 (rejecting petitioner's reading because "the construction he offers would virtually read the first sentence out of the section"); Yeager, 175 Cal. App. 4th at 726.

The legislative history of the amendment to § 1367.18 in 2006 confirms that the Legislature did not intend to require a particular type of prosthetic device to be covered. The State Senate Committee on Banking, Finance, and Insurance stated that "what the bill would require is that when [the O&P] benefits are purchased, they must have maximum benefit caps and out-of-pocket costs (e.g., deductibles) that are similar to other benefits." (California Bill Analysis of A.B. 2012, Sen. Comm. on Banking, Fin., & Ins. (6/21/2006), PRJN, at 232.) It explained that "[t]he author and sponsor of AB 2012 are concerned that currently health plans and insurers offer coverage for O&P that has low maximum benefit limits – limits so low that the insurance does not cover a substantial portion of" the prosthesis, rendering the insurance "virtually worthless." (Id.) A bill sponsor, the California Orthotics and Prosthetics Association, explained that "amputees and persons recovering from surgery or disease have found their devices have been subject to annual caps as low as $2,000 per year," leaving patients "essentially . . . without coverage by the time they have left the hospital and are in need of a device to replace a limb or support ongoing treatment." (Id. at 234–35.) For example, if a plan limits coverage to $2000 per year but the prosthetic costs $25,000, the enrollee must cover $23,000, making the benefit "illusory." (Enrolled Bill Memorandum to Governor (9/06/2006), DRJN, at 719.) These coverage limitations arose because prosthetic devices were classified as "durable medical equipment" ("DME"), although they are not DMEs because they are custom-

[5]Similarly, California's mental health statute requires every health care plan to "provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses," including outpatient and inpatient services, partial hospital services, and prescription drugs. Cal. Health & Safety Code § 1374.72(a)–(b). In Harlick v. Blue Shield of Cal., 686 F.3d 669 (9th Cir. 2012), the court concluded that "plans within the scope of the Act must provide coverage of all 'medically necessary treatment' for 'severe mental illnesses' under the same financial terms as those applied to physical illnesses." Id. at 719. The statute is more restrictive than § 1367.18, which gives a plan and employer more flexibility to craft the scope of the coverage. Thus, Harlick does not require the Court to interpret § 1367.18 to require a plan to pay for all medically necessary O&P devices even if they are excluded from a plan's terms and conditions.

made and not mass-produced for a range of uses. (Id. at 728.) Therefore, the history confirms that the Legislature was concerned with costs and cost-sharing. The legislative statements say nothing about a desire to eliminate any limitations to the *type* of prosthetic device covered by a plan.

The Court finds that Cal. Health & Safety Code § 1367.18 requires a health plan to offer prosthetics coverage for original and replacement devices. Other than satisfying the requirements of subsection (b) as to the amount of the benefit and out-of-pocket expenses, however, a health plan and an employer may negotiate the remaining "terms and conditions," including coverage exclusions or limitations as to the specific type or orthotic or prosthetic device or service. Thus, PacifiCare and the Regional Center legally could exclude coverage for myoelectric devices from Garcia's health care service plan, and PacifiCare lawfully denied Garcia's requested myoelectric prostheses.[6] Accordingly, the Court **DENIES** Garcia's Motion for Summary Judgment and her request for benefits under 29 U.S.C. § 1132(a)(1)(B). Additionally, although the instant motion was filed by Garcia, the Court **GRANTS** summary judgment in favor of PacifiCare because it determines that the issue has been fully ventilated. See Cool Fuel, Inc. v. Connett, 685 F.2d 309, 311–12 (9th Cir. 1982). This also requires the dismissal of Garcia's second claim for injunctive relief.

IV. CONCLUSION

For the foregoing reasons, the Court **DENIES** Garcia's Motion for Summary Judgment, **GRANTS** summary judgment in favor of PacifiCare, and **DISMISSES** Garcia's claim for injunctive relief in view of her abandonment of this claim (Motion, at 23). The Court directs PacifiCare to submit a proposed judgment within three (3) days.

IT IS SO ORDERED.

: 00

Initials of Preparer kjt

[6]Although the Court's holding deprives Garcia of coverage for replacement myoelectric prosthetic devices, an unfortunate circumstance, its interpretation does not renders her prostheses coverage illusory. It is one thing to only cover $2000 of a $25,000 prosthetic, which is what concerned the Legislature. It is another to exclude a particular type of device, such as a myoelectric device, while still covering body-powered or passive prosthetic devices.