Filed 10/25/05 Pagarigan v. Aetna US Healthcare of Cal. CA2/7

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

TERI PAGARIGAN et al., Plaintiffs and Appellants, v. AETNA U.S. HEALTHCARE OF CALIFORNIA, INC., et al., Defendants and Respondents.	B167722 (Los Angeles County Super. Ct. No. PC027083)

APPEAL from a judgment of the Superior Court of Los Angeles County. John P. Farrell and L. Jeffrey Wiatt, Judges Presiding. Reversed in part, affirmed in part, and remanded.

Houck & Balisok, Balisok & Associates, Russell S. Balisok, Steven C. Wilheim, Patricia L. Canner; Law Office of Carol S. Jimenez and Carol S. Jimenez for Plaintiffs and Appellants.

Gibson, Dunn & Crutcher, Louis E. Shoch III, Kirk A. Patrick and Antoinette D. Paglia for Defendants and Respondents.

In this case we consider the liability of an HMO which contracts out its health care responsibilities to various providers when one or more of those providers denies medically necessary services or commits malpractice in the delivery of those services. We conclude the HMO owes a duty to avoid contracting with deficient providers or negotiating contract terms which require or unduly encourage denials of service or below-standard performance by its providers. While appellants' complaint in its present form even with the amendments it tendered fails to adequately state a cause of action based on this theory, we find facts alleged which imply they may be able to do so if offered the chance. Accordingly, we allow appellants one more opportunity to file good faith amendments as to two of the nine proposed causes of action involving Aetna. But regarding the remaining seven counts of appellants' complaint in which they failed to cure defects in their pleadings when responding to a "last chance" opportunity afforded by this court, we deny relief from the trial court's order sustaining demurrers without leave to amend.

FACTS AND PROCEEDINGS BELOW

Appellants (and plaintiffs) are the children of an elderly woman, Johnnie Pagarigan (decedent) who died at a nursing home, allegedly as a result of elder abuse and malpractice. The respondents are the HMO which the decedent had joined and its parent corporation (collectively Aetna). Aetna, in turn, had contracted with a management organization, Greater Valley Management Services Organization, which contracted with medical groups Greater Valley Medical Group and Greater Valley Physician Association (collectively "Greater Valley") which contracted with Magnolia Gardens nursing home (owned and operated by Libby Care Center, Inc. and Longwood Management Corp.) and a physician, Dr. Buttleman, to care for decedent.

After their mother's death, and learning of what they saw as serious deficiencies in the care provided her by the physician and the nursing home, appellants sued all layers of this complex arrangement – including the HMO at the top, Aetna. They asserted ten causes of action as successors-in-interest to their mother (negligence, willful misconduct, elder abuse, constructive fraud, and fraud) and one for wrongful death. (This appeal, however, only involves the HMO and the trial court's action sustaining a demurrer and dismissing the complaint as to the HMO and its parent company.)

According to the allegations of this complaint, decedent was already on Medicare in 1995 when she enrolled in an Aetna HMO, Aetna Health Care of California, Inc., and remained a member of that HMO until her death in June 2000. In February of 2000, decedent suffered a debilitating stroke. As a member of the HMO, she was assigned to Magnolia Gardens and under the supervision of Dr. Buttleman. Allegedly, the deficient care she received at Magnolia Gardens caused her condition to deteriorate rapidly. In quick order she became malnourished and dehydrated, developed a huge pressure sore on her lower back and a severe infection and abscess at the site of the gastric tube insertion, and eventually her abdomen became protuberant and discolored.

Despite the critical nature of her condition, Dr. Buttleman delayed months before transferring decedent to an acute care hospital. By that time, it was too late for the hospital to cure her condition and she was sent home to die. In their brief but not in their complaint, appellants allege Aetna as well as Greater Valley requested the delay for economic reasons. As long as decedent remained at Magnolia Gardens the state's MediCal program reimbursed Aetna for her medical care. But if and when she moved to an acute care hospital Aetna and its contracting parties would be financially responsible.

Appellants' complaint was filed on February 26, 2001. On December 20, 2001, the trial court granted Aetna's petition to compel arbitration. This court reversed that order in a published opinion on October 15, 2002, *Pagarigan v. Superior Court.*[1] While trial court proceedings were stayed during the appellate process in the case against Aetna, the action continued against Greater Valley and Dr. Buttleman. During the course of those proceedings, appellants amended their complaint against these other parties twice. Consequently, when the trial court lifted its stay in this case on January 14, 2003, it also permitted appellants to file a second amended complaint against Aetna. On February 28, 2003, Aetna filed a demurrer and motion to strike. (Appellants complain the tight time frame after the trial proceedings resumed against Aetna deprived it of an adequate opportunity to discover facts which would have allowed them "to more fully and adequately state their causes of action.")

On April 8, 2003, the trial court sustained Aetna's demurrer and motion to strike, without leave to amend and on April 15 entered an order of dismissal in appellants' action against Aetna. Appellants timely appealed. After reviewing the briefing, this court determined it was possible appellants conceivably might have been able to cure some of the deficiencies in their complaint had the trial court allowed amendments. As a precaution, and in an effort to avoid a further exchange between trial and appellate courts, we requested supplemental briefing. We asked appellants to tender any proposed amendments, including specific language where possible, along with an explanation how and why those amendments were sufficient to adequately remedy any inadequacies in their complaint. We allowed respondents, in turn, to submit a supplemental brief arguing why the amendments failed to accomplish that purpose. Thus, it is the allegations of appellants'

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[1] *Pagarigan v. Superior Court* (2002) 102 Cal.App.4th 1121. Earlier this court had affirmed the trial court's denial of the nursing home's petition to compel arbitration, also in a published opinion, *Pagarigan v. Libby Care Center et al.* (2002) 99 Cal.App.4th 298.

complaint as they propose to amend them in their supplemental brief which we consider in this appeal.

DISCUSSION

Before discussing the nine counts of the complaint implicating Aetna, we set the scene by providing some necessary background information about the health care industry and the specie of Health Maintenance Organization involved in this case. The core issue here is when, if ever, an HMO that contracts out its coverage decisions as well as its medical care responsibilities to health care providers like physician groups or to intermediary health management firms, or both, can be held liable when those contracting parties deny service or commit malpractice in the delivery of those services.

I. BACKGROUND ON HMOS AND THEIR USE OF CAPITATION-BASED CONTRACTS TO ARRANGE FOR THE PROVISION OF HEALTH CARE TO THEIR MEMBERS THROUGH HEALTH CARE PROFESSIONALS AND INTERMEDIARIES.

At the beginning, health insurance plans – and later Medicare and Medicaid funded plans – were primarily organized on a pure fee-for-service reimbursement basis. A pure fee-for-service health insurance plan employs no doctors and owns no hospitals. It merely pays the bills doctors and hospitals submit for the services they provide to patients from the insured population. Consequently, the insurer normally is not liable for malpractice the doctors whose bills they pay may commit. Moreover, only to the extent the health insurance company makes coverage decisions and refuses to pay for certain services a patient may require and a doctor or hospital stands ready to supply, may it be held liable if a court decides that denial was improper and caused injury or death to one of the plan's insureds.

In contrast, the classic form of HMO, such as the original Kaiser Permanente plan, employs its own doctors and operates its own hospitals. Thus, these HMOs are liable both for any improper denials of coverage and for any malpractice their patients experience.

Aetna calls its plan an HMO, but it is far from the classic model. Rather, in common with a classic fee-for-service health insurer, Aetna's plan employs no doctors and owns no hospitals. Consequently, it purports to avoid liability for any malpractice its insureds may suffer. But unlike many current fee-for-service insurance plans, it also makes no coverage decisions, and thus claims to avoid liability for denials of service, as well. Instead of making coverage decisions itself, Aetna shifts that decision-making responsibility, financial risk, and attendant liability for service denials and malpractice to the providers and intermediary management organizations with which it contracts.

The shift in decision-making responsibility and financial risk is accomplished through what the industry calls a "capitation" arrangement. Aetna agrees to pay the management firm or provider a specified amount per year for each person its "HMO" has admitted into its "HMO" plan and then assigns to that firm or provider. The management firm or provider receives the same amount for a particular person whether that insured is so healthy he or she never incurs a single health-related expense the entire year as it receives for one who instead experiences a serious disease requiring hospitalization and a series of operations entailing hundreds of thousands of dollars in medical expenses over the year. Furthermore, if some patient's only chance for recovery is some expensive but experimental or otherwise problematical treatment, in theory at least it is not Aetna but the management firm or provider who must decide whether to offer – and pay for – that treatment. It also is that management firm or provider Aetna expects to bear the consequences should an insured or the insured's survivors successfully sue because

the denial of some extraordinary or even ordinary treatment caused the insured serious injury or death.

In 2001, the California Supreme Court determined many of the claims appellants plead in this case avoid federal preemption under the Medicare laws. In that opinion, *McCall v. PacifiCare*,[2] our high court, however, expressly reserved the question whether these claims state valid causes of action. "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."[3] True, there is some ambiguity whether the Supreme Court meant to question the viability of the theories of liability embodied in the claims it discussed in *McCall* or merely the adequacy of the words used in the complaint to invoke those theories. Nonetheless, we assume it is both when addressing appellants' attempt to state those same theories in their complaint.

II. STANDARD OF REVIEW.

The Supreme Court's *McCall* case conveniently provides us with a concise statement of the standard of review appropriate when considering this or any trial court's order sustaining a demurrer. "On review of 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."[4]

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[2] *McCall v. PacifiCare of Cal., Inc.* (2001) 25 Cal.4th 412.

[3] *McCall v. PacifiCare of Cal., Inc.*, *supra*, 25 Cal.4th at page 426, footnote 10.

[4] *McCall v. PacifiCare of Cal., Inc.*, *supra*, 25 Cal.4th at page 415 (italics added).

III. APPELLANTS' PRESENT ALLEGATIONS FAIL TO STATE A VALID NEGLIGENCE CAUSE OF ACTION OR WRONGFUL DEATH CAUSE OF ACTION, ALTHOUGH IT IS POSSIBLE APPELLANTS COULD SUBMIT AMENDMENTS WHICH WOULD CURE THE DEFECTS IN THEIR PLEADINGS AS TO THESE CAUSES OF ACTION.

In their first cause of action the Pagarigans essentially allege Aetna's negligent conduct caused decedent's injuries and ultimate death. Aetna responded and the trial court ruled Aetna owed no duties to decedent which it breached. Whatever happened to decedent at Magnolia Gardens nursing home was the responsibility of the nursing home staff and the supervising physician (Dr. Buttleman). Vicarious liability may extend to the owners and operators of the nursing home, but not to Aetna which was just the insurance company that paid the nursing home and physician to take care of decedent.

As their primary theory of liability, the Pagarigans focus on Aetna's role as a health management organization. They urge as such Aetna has "non-delegable" duties toward its enrollees for the quality of the care they receive from the health care providers Aetna contracts to provide that care. The Pagarigans find these "non-delegable" duties in the language of certain statutes. While we conclude Aetna is not directly responsible for its contractees' breaches of duties they owe the plan's enrollees, we also conclude Aetna owes its own duties to those enrollees. These include a duty of due care when choosing the providers who will supply health services to enrollees. They also include a duty to avoid executing contracts with those providers containing terms, especially low levels of capitation payments, which foreseeably require or unduly encourage below-standard care.

Section 3428 appears to exempt health insurance plans, such as Aetna, from liability for acts of malpractice committed by health care providers it contracts to care for its enrollees. "This section does not create any new or additional liability on the part of a health care service plan or managed care entity for harm caused that

is attributable to the medical negligence of a treating physician or other treating health care provider."[5]

That same code section, however, also imposes a general duty on Aetna and like plans – a duty of due care when arranging health care services for its enrollees. "A health care service plan or managed care entity . . . shall have a duty of ordinary care to arrange for the provision of medically necessary health care service to its subscribers and enrollees . . . and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care . . ."[6]

Such a duty of due care is not satisfied by contracting with just any old providers or on any terms whatsoever. To select a provider or to allow the selection of a provider the plan knows or should know is deficient or prone to malpractice is to violate that duty. Moreover, this breach of the plan's own specific duty toward its enrollees also constitutes a contributing cause when an enrollee suffers injury or death due to malpractice attributable in part to the plan's careless selection of the deficient provider organization.

A plan likewise breaches this duty when "arranging" services for its enrollees if it negotiates contract terms with a provider – or allows the negotiation of contract terms with such provider – that foreseeably enhance the likelihood the provider will offer below-standard services that will injure or kill a substantial number of the plan's enrollees. Although other terms may have this result, the most critical term is the level of the "capitation" payment. The plan breaches its duty of ordinary care in arranging services for its enrollees if the plan negotiates a per capita payment so low the plan knows or should know it will require the provider to furnish substandard services and/or deny medically necessary services in order to survive. And, once again this breach of the plan's own duty to its enrollees qualifies as a contributing cause of any injury or death an enrollee suffers at the

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5 Civil Code section 3428, subdivision (g).

6 Civil Code section 3428, subdivision (a).

hands of a provider the plan is seriously underpaying for the services it is expected to supply.

Throughout their complaint, the Pagarigans repeat a refrain – Aetna creates economic incentives for providers to deny medically necessary services or to supply below-standard services. Aetna responds with its own refrain. What the Pagarigans are complaining about is the "capitation" system, which the Legislature has expressly endorsed. Thus, the Pagarigans cannot predicate a cause of action on economic incentives this legislatively-approved system may generate.

It is true economic analysis and anecdotal data both tell us a "capitation" system creates incentives to underinvest in health care services just as a "fee for service" approach creates incentives to overinvest. A provider maximizes profits by furnishing fewer services (and thus spending less) per capita if compensated on a "capitation" basis, but maximizes profits by furnishing more services (and billing more) per capita when compensated on a "fee for service" basis.

For this reason, the Pagarigans' repetitive allegations charging Aetna's providers had "conflicts of interest" in the sense of economic incentives to deny services, fail to make outside referrals, and the like, are not inaccurate. But Aetna also is correct in pointing out these incentives are inherent in the "capitation" compensation system both the federal and state governments have approved. Thus, as a general proposition, the ordinary incentives and "conflicts of interest" inherent in a "capitation" approach to health care financing cannot supply the foundation for a negligence cause of action against an HMO like Aetna.

But this does not mean Aetna cannot be held liable for breaches of due care in the way it carries out this "capitation" system. If the way it "arranges for the provision of medically necessary health care service to" enrollees generates economic incentives to deny services or furnish low quality care which are substantially stronger than those inherent in the "capitation" system, Aetna or any other HMO can be liable for this negligent conduct. Thus, for example, as

discussed earlier, an HMO violates its duty of due care if it negotiates a "capitation" rate with a given provider which it knows or should know is so low the provider will have an undue economic incentive to deny medically necessary services or to deliver below-standard care. Likewise, as discussed above, an HMO can be liable where it chooses to arrange for the provision of services through a provider it knows or should know is seriously understaffed, poorly administered or otherwise likely to deny medically necessary services or deliver below-standard levels of care.[7]

The Pagarigans' complaint contains fragments of allegations which together approach, but do not quite state a valid cause of action claiming Aetna indeed violated its duty of due care in arranging medically necessary health care services by selecting – or allowing selection of – at least one deficient provider, Magnolia Gardens nursing home. In paragraph 15, it is alleged Aetna and Greater Valley contracted with the owners and operators of Magnolia Gardens "to provide long term care services to enrollees . . . [in order to] satisfy Aetna's own obligation under a written agreement with Decedent and with Medicare , by which it had agreed to provide such long term care services to Decedent." In paragraph 25, the Pagarigans then allege, decedent "developed a very severe pressure sore . . . because the [Magnolia Gardens] skilled nursing facility . . . was *improperly administered* and their care operations were *inadequately funded*. Because of said *maladministration and inadequate funding*, there was insufficient staff to provide the care which Decedent required. . . . And when Decedent needed careful supervision of her 'G-Tube" and a prompt and proper response to the development of an infection, such

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[7] These duties and potential breaches of duty are akin to the "institutional negligence" cause of action the Illinois Supreme Court approved as a basis for holding an HMO liable for its provider's negligence in *Jones v. Chicago HMO of Illinois* (Ill. 2000) 730 N.E.2d 1119. In that case the HMO breached its duty to arrange adequate care by allowing the assignment of too many patients to a small group of physicians. This closely resembles the action of contracting with or allowing patient assignments to an understaffed and underfunded medical provider such as a nursing home.

care was not provided because such care was not available from an *undertrained and understaffed* nursing service." (Italics added.)

Missing from the above set of allegations, however, is an essential element – that Aetna *knew or should have known* Magnolia Gardens was improperly administered and inadequately funded and inadequately staffed. Nor is it alleged Aetna had itself negotiated – or knew or should have known the capitation rate negotiated with Magnolia Gardens by an intermediary management company – was so low it meant Magnolia Gardens would be inadequately funded and staffed to care for Aetna insured patients.

It is one thing when an HMO negotiates a contract with a reasonably capable provider and at a reasonable capitation level and then sees that provider make an erroneous decision, deliberate or negligent, to deny some medically necessary service, or commit malpractice in delivering that service. That is not a violation of the HMO's own duty of due care in arranging the provision of services to its enrollees. But it is quite another thing when an HMO chooses to contract with a provider that is "improperly administered" with an "undertrained and understaffed" nursing corps or at a capitation level which supplies the provider "inadequate funding" to give the HMO's enrollees proper care.

We have no idea whether the Pagarigans in good faith will be able to allege – to say nothing of proving – Aetna knew or should have known it was choosing a "maladministered, understaffed, and undertrained" provider – or indeed if Magnolia Gardens skilled nursing facility fits that characterization. Nor is it clear they will be able to honestly allege and later demonstrate Aetna knew or should have known the capitation rate negotiated with Magnolia Gardens left the latter so underfunded the nursing home was destined to deny needed care and/or deliver inadequate care – or whether the capitation rate indeed was that low. But we are convinced appellants should be afforded the opportunity to determine whether they can file such amendments in good faith.

In their eleventh and final cause of action, the Pagarigans reallege many of the earlier allegations in the complaint, including the facts discussed above which bear on Aetna's own duties and negligence. The count then simply alleges : "As a result of the wrongful conduct of the Defendants [including Aetna] as alleged, Decedent died." This death, in turn, caused the Pagarigans to be "deprived of the care, comfort, society and love of the Decedent . . . ." For the same reasons we concluded the Pagarigans should be offered another opportunity to state a valid negligence action against Aetna, we find they should be afforded the same opportunity to plead a valid wrongful death action against this HMO.

IV. THE TRIAL COURT PROPERLY SUSTAINED DEMURRERS AS TO THE CAUSES OF ACTION FOR ELDER ABUSE AGAINST THE AETNA HMO.

In their fourth cause of action the Pagarigans allege Aetna, along with the nursing home and most other defendants, is liable for elder abuse under Welfare and Institutions Code sections 15610.57[8] and 15610.07.[9] This count is based on the same conduct and suffering alleged in support of the negligence count. But in a two sentence count the Pagarigans allege these earlier allegations also represent "neglect" as defined in 15610.57 and "abuse of an elder" as defined in 15610.07.

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[8] "(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.

In their fifth cause of action the Pagarigans allege the same conduct and suffering also violated a criminal statute, Penal Code section 368[10] designed to

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(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." (Welf. & Inst. Code, § 15610.57.)

[9] "'Abuse of an elder or a dependent adult' means either of the following:

(a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.

(b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering." (Welf. & Inst. Code, § 15610.07.)

[10] Penal Code section 368 reads as follows:

"(a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor children, because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.

(b)(1) 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.

(2) If in the commission of an offense described in paragraph (1), the victim suffers great bodily injury, as defined in Section 12022.7, the defendant shall receive an additional term in the state prison as follows:

(A) Three years if the victim is under 70 years of age.

(B) Five years if the victim is 70 years of age or older.

(3) If in the commission of an offense described in paragraph (1), the

defendant proximately causes the death of the victim, the defendant shall receive an additional term in the state prison as follows:

(A) Five years if the victim is under 70 years of age.

(B) Seven years if the victim is 70 years of age or older.

(c) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions other than those 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 may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars ($2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

(d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars ($400); and by a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars ($400).

(e) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars ($400), and by a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars ($400).

(f) Any person who commits the false imprisonment of an elder or a dependent adult by the use of violence, menace, fraud, or deceit is punishable by imprisonment in the state prison for two, three, or four years.

protect the elderly along with other vulnerable population groups such as children. The violation of this criminal statute, the Pagarigans claim, constitutes a "tort per se" and thus another source of liability.

Either of these causes of action may be viable as to those who were in a position to personally neglect decedent or deprive her of goods or services. But it is difficult to impose liability – or in the case of the alleged tort per se, actual guilt – on the HMO for its role. As the trial court properly found, to be held responsible for elder abuse based on "neglect" or "deprivation of goods or services" a defendant must be a "care custodian." This the Aetna HMO is not. As defined in Welfare and

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(g) As used in this section, 'elder' means any person who is 65 years of age or older.

(h) As used in this section, 'dependent adult' means any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. 'Dependent adult' includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(i) As used in this section, 'caretaker' means any person who has the care, custody, or control of, or who stands in a position of trust with, an elder or a dependent adult.

(j) Nothing in this section shall preclude prosecution under both this section and Section 187 or 12022.7 or any other provision of law. However, a person shall not receive an additional term of imprisonment under both paragraphs (2) and (3) of subdivision (b) for any single offense, nor shall a person receive an additional term of imprisonment under both Section 12022.7 and paragraph (2) or (3) of subdivision (b) for any single offense.

(k) In any case in which a person is convicted of violating these provisions, the court may require him or her to receive appropriate counseling as a condition of probation. Any defendant ordered to be placed in a counseling program shall be responsible for paying the expense of his or her participation in the counseling program as determined by the court. The court shall take into consideration the ability of the defendant to pay, and no defendant shall be denied probation because of his or her inability to pay." (Penal Code, § 358 (2005).)

Institutions Code section 15610.17, an HMO of Aetna's nature does not qualify as a care custodian.[11]

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[11] "'Care custodian'" means 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:

(a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(b) Clinics.

(c) Home health agencies.

(d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services.

(e) Adult day health care centers and adult day care.

(f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders.

(g) Independent living centers.

(h) Camps.

(i) Alzheimer's Disease day care resource centers.

(j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.

(k) Respite care facilities.

(l) Foster homes.

(m) Vocational rehabilitation facilities and work activity centers.

(n) Designated area agencies on aging.

(o) Regional centers for persons with developmental disabilities.

(p) State Department of Social Services and State Department of Health Services licensing divisions.

(q) County welfare departments.

(r) Offices of patients' rights advocates and clients' rights advocates, including attorneys.

(s) The office of the long-term care ombudsman.

(t) Offices of public conservators, public guardians, and court investigators.

(u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following:

(1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities.

(2) The Protection and Advocacy for the Mentally Ill Individuals Act of

Nor does anything the Pagarigans allege in their complaint support a conclusion what Aetna did violated Penal Code section 368. To impose per se tort liability based on this criminal statute, the allegations, if true, must demonstrate Aetna committed a violation of this criminal statute. That includes the mens rea element – that Aetna *intended* to abuse decedent. The allegations fall far short of satisfying that element. As explained earlier, Aetna's alleged conduct in arranging its insured's medical care may qualify as negligence that could have contributed to the decedent's injuries and eventual death. But its conduct lacked the mens rea of a crime, including the crime defined in Penal Code section 368.

V. THE TRIAL COURT PROPERLY SUSTAINED A DEMURRER AS TO THE CAUSE OF ACTION FOR INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS.

In their third cause of action the Pagarigans describe many of the same failures to properly treat decedent while she was resident at Magnolia Gardens as were mentioned in earlier portions of the complaint[12] and then claim this caused her

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1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness.

(v) Humane societies and animal control agencies.

(w) Fire departments.

(x) Offices of environmental health and building code enforcement.

(y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults." (Welf. & Inst. Code, § 15610.17.)

[12] These allegations are found in paragraphs 27-29 of the Pagarigans' complaint.

"¶ 27. While Decedent was a resident at the nursing facility operated by LIBBY CARE and LONGWOOD she developed a very severe pressure sore over her coccyx, became dehydrated and malnourished and septic. This sore (as well as the dehydration, malnutrition and sepsis) developed because the skilled nursing facility operated by LIBBY CARE and LONGWOOD was improperly administered and their care operations were inadequately funded. In other words, these

conditions developed because of the failure of Defendants, including AETNA, as alleged above to provide ready referrals consistent with good professional practice, to render medical decisions unhindered by fiscal and administrative management, to monitor the quality of care rendered to Decedent by GREATER VALLEY, LIBBY CARE and BUTTLEMAN, to engage in sufficient quality assurance activities to ensure that the requirements of California law are met in providing services to Decedent, to retain responsibility for all services including services which it contracts with others to provide Decedent, and to ensure that required services including skilled nursing services are available and accessible to Decedent. Without limiting the generality of the foregoing, because of said maladministration and inadequate funding, there was insufficient staff at LIBBY CARE to provide the care which Decedent required. In particular, Decedent needed assistance with mobility in bed, hydration and feeding, but such care was routinely not provided, even though staff at Libby Care Center's facility well knew of Decedent's care requirements and of the direct causal relationship between immobility in bed, malnutrition and the development and progression of pressure sores. And when Decedent needed careful supervision of her "G-Tube" and a prompt and proper response to the development of an infection, such care was not provided because such care was not available from an undertrained and understaffed nursing service.

"¶ 28. During the aforesaid period of Decedent's residence at the skilled nursing facility operated by LIBBY CARE and LONGWOOD, she also developed an infection at the site where a gastric tube or "G-Tube" had previously been surgically implanted to assist with her nutritional needs. The infection abscessed. The infection became so well developed that Decedent's abdomen became protuberant and discolored with the appearance of a 'sunburn.' Because of the aforesaid maladministration of LIBBY CARE's facility and because of AETNA's, GREATER VALLEY's and BUTTLEMAN's failure to monitor Decedent's care and treatment, both custodial as well as medical, this condition was not assessed, not treated properly and the infection progressed. This infection was later noted by Defendants but concealed from the Plaintiffs. Ultimately, when Decedent's family became unsure about the care provided to Decedent and successfully demanded that Decedent be transferred to hospital, surgeons treated the abscess, but the infection was by then too advanced and Decedent too debilitated to be treated successfully; she was sent home pre-morbid for care in a hospice-like setting and she soon died.

"¶ 29. The conduct of Defendants and each of them as aforesaid, and also in failing to treat, failing to notify, and failing to supervise the care provided to Decedent was motivated by improper 'risk management concerns' and improper financial concerns, because the cost of providing proper care to Decedent was deemed to be high in relation to the alternative which was to deny care and simply let Decedent die. Each Defendant, having the aforesaid duties, including affirmative duties to provide medically reasonable and necessary health care and

"severe mental and emotional distress." However, as the trial court properly observed, they failed to allege how Aetna rather than the nursing home staff committed outrageous acts in order to intentionally inflict severe mental or emotional injury on her. It is true, as observed earlier, it may be the Pagarigans can amend their complaint to allege a viable cause of action based on Aetna's breach of its duty to insure all its contractees, including and especially Magnolia Gardens, were administratively sound, or adequately funded and staffed and received an adequate level of capitation payments. But such negligence falls far short of the sort of outrageous or intentional conduct which inevitably would cause a certain patient to suffer severe mental and emotional harm.

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treatment, to maintain and or improve a patient's health, to provide basic and necessary custodial care, and the subsequent failure to comply with such duties because of profit considerations, acted outrageously and beyond the norms of civilized society. In addition, Decedent was totally dependent upon each Defendant to provide proper care and treatment, to inform her family of Defendant's failure to provide proper care and treatment, to adequately assess her condition, and to make decisions concerning her day-to-day activities and to supervise her care. Decedent was totally dependent upon each Defendant including AETNA, BUTTLEMAN, GREATER VALLEY, and DOES 6-10 to monitor and respond to information concerning Decedent's changing condition and to inform Decedent's family. Decedent was totally dependent upon each Defendant including AETNA, LIBBY CARE and LONGWOOD to provide essential nursing services, including care for her pressure sores, assistance with her hygiene, assessment of her condition, reports to her physician concerning her condition and changes of her condition, and implementation of orders from her physician. Decedent was totally dependent on all Defendants to make decisions on her behalf regarding her care and treatment and to do so without regard to consideration of the cost of said care. Decedent was totally dependent on all Defendants to meet her custodian needs while in their care and custody."

VI. APPELLANTS HAVE FAILED TO STATE A VALID CONSTRUCTIVE FRAUD CAUSE OF ACTION FOR AETNA'S ALLEGED FAILURE TO DISCLOSE TO DECEDENT AND OTHER ENROLLEES ITS CONTRACTS WITH PROVIDERS WERE BASED ON A "CAPITATION" PAYMENT SYSTEM.

In their sixth cause of action, the Pagarigans allege defendants including Aetna were liable for constructive fraud because at the time they were making treatment decisions while decedent was at Magnolia Gardens they failed to disclose Aetna's financial arrangements with its provider organizations were based on a capitation basis. This capitation arrangement, the Pagarigans allege, created conflicts of interest Aetna (and the other defendants) were required to disclose to the Pagarigans.

Aetna responds it had no duty to disclose because a constructive fraud claim depends on the existence of a fiduciary relationship between Aetna and its enrollees.[13] Because no fiduciary relationship exists between an insurer and its insured,[14] Aetna further argues, it is not liable on a constructive fraud cause of action, even if it did fail to disclose it was paying its providers on a capitation basis.

We have some question whether an insurance company which chooses to operate an entity it labels a "health maintenance organization," as opposed to an insurance plan, can deny it has a fiduciary relationship with those who choose to become members of that health maintenance organization. We also have some question whether, assuming no fiduciary relationship, such an HMO at least owes a duty to reveal its financial relationships with entities providing health care to its members – especially when those arrangements affect the economic incentives influencing the behavior of those providers.

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13 *Younan v. Equifax* (1980) 111 Cal.App.3d 498, 516.

14 *Vu v. Prudential Property & Casualty Ins. Co.* (2001) 26 Cal.4th 1142, 1150-1152.

Nonetheless, we have no reason to inquire further into these concerns at this point, because the Pagarigans do not allege a failure to disclose at the time it would be reasonable to require Aetna to do so. Instead they object to the failure to disclose these financial arrangements only "at the time [the Magnolia Gardens owner and operator], Greater Valley and Buttleman considered treatment options, recommended treatment, and during the time they provided care and treatment to the Decedent." The Pagarigans did not allege Aetna failed to disclose its "capitation" arrangements earlier, especially in the various documents it provided decedent and other enrollees in its HMO when they were deciding to enroll. Accordingly, despite appellants' "last chance" amendments, we find the present allegations fall short of stating a viable cause of action against Aetna for constructive fraud.

VII. THE TRIAL COURT PROPERLY SUSTAINED A DEMURRER TO THE PROPOSED CAUSE OF ACTION FOR FRAUDULENT CONCEALMENT OF DECEDENT'S DETERIORATING CONDITION.

In their seventh cause of action,[15] the Pagarigans allege Aetna, along with most of the other defendants, concealed from the Pagarigan children the true facts about their mother's deteriorating condition. According to the complaint, defendants failed to disclose the serious nature of the "stage 4" pressure sore which required surgical intervention. In addition, when one of the Pagarigans inquired

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[15] This cause of action was mis-numbered as a "Sixth Cause of Action (Actual Fraud-Concealment)" immediately after the true "Sixth Cause of Action (Constructive Fraud)" and immediately before the "Eighth Cause of Action (Actual Fraud)."

about decedent's protuberant abdomen, a nursing home staff member represented the condition was normal and being treated when in fact it was not normal but the result of an infection. Nor did defendants reveal the progression of a "very serious infection" at the site of the G-Tube, or abscesses, or other facts indicating decedent needed hospitalization. It is further alleged these acts of concealment were intended to mislead the family so they "would not demand appropriate and more expensive care." As a result, decedent's "family did not insist upon [her] transfer to hospital for appropriate care for her pressure sore or her infection and abscessed infection."

As a cause of action against the nursing home and its owners and managers, the allegations of the Pagarigans' complaint may well state a valid claim. But, as the trial judge properly found, it fails as a cause of action against Aetna. It does not and could not allege Aetna had knowledge about the physical condition of one particular enrollee, decedent. As the trial court found, Aetna was ignorant of "the conditions concealed by . . . [decedent's] health care providers." It is difficult to conceal information one does not possess. And it is impossible to *intend* to conceal such information. Accordingly, the trial court properly sustained a demurrer as to this count of the Pagarigans' complaint against Aetna and did so without leave to amend.

VIII. APPELLANTS FAILED TO STATE A VALID *RANDI W.* CAUSE OF ACTION.

The Pagarigans' eighth cause of action, unlike the earlier counts, is directed solely against Aetna (and Does 1-5), and none of the other entities who are defendants in this action. It alleges another specie of "actual fraud" based on representations Aetna made to the state in order to obtain an HMO license and to the federal government in order to receive authorization to enroll Medicare beneficiaries. These representations are alleged to have been false. It is further alleged the state would not have granted Aetna a license if it had not made these

false representations. Nor would the federal government have allowed it to serve Medicare recipients. As a result, decedent would not have enrolled with Aetna's HMO and would have not been subjected to the malpractice and abuse she suffered while in the care of Aetna's contractees – Magnolia Gardens nursing home and Dr. Buttleman.

In *McCall v. PacifiCare*,[16] the Supreme Court described such a cause of action which had been alleged in that case and suggested it might support a *Randi W.* claim. This referred to *Randi W. v. Muroc Unified School District* decided in 1997.[17] In that case, our high court authorized the victim of sex abuse to sue a school district for sending favorable but false letters of recommendation to other prospective employers about one of its administrators the district knew had been charged with sexual misconduct. One of those employers hired the administrator who then abused the plaintiff.

The Supreme Court approved a cause of action based on a finding the abuser in *Randi W.* would not have been hired and thus would not have been in a position to abuse the plaintiff in the absence of the school district's false representations.[18] Similarly, it could be argued here that Aetna would not have been licensed as an HMO and thus its provider network would not have been in a position to commit malpractice and elder abuse against decedent in the absence of Aetna's false representations to the licensing agencies. Aetna, on the other hand, suggests representations to a government licensing agency are different because those agencies have many other sources of information and a capacity to investigate. Thus, they do not rely primarily on the accuracy of the representations in the application in deciding whether to issue a license to the HMO applicant. (Aetna also points out, correctly, any misrepresentations to the federal government are

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16 *McCall v. PacifiCare of Cal., Inc.*, *supra*, 25 Cal.4th 412.

17 *Randi W. v. Muroc Unified School District* (1997) 14 Cal.4th 1066.

18 *Randi W. v. Muroc Unified School District*, *supra*, 14 Cal.4th at page 1075.

irrelevant for purposes of this cause of action. That is because fraud actions for misrepresentations to federal licensing agencies are preempted.[19])

We are not convinced by Aetna's argument it is impossible for blatant misrepresentations on an HMO licensing application filed with the state of California to provide the fodder for a *Randi W*. cause of action. Aetna's position rests on empirical assertions about the capacity and behavior of the state's HMO licensing process which may or may not prove accurate. As such and if proved, they may supply a ground for defeating appellants' *Randi W*. cause of action at the summary judgment stage or at trial. But these empirical assertions are not so self-evident they can justify a trial court's order sustaining a demurrer to this cause of action.

On the other hand, setting aside Aetna's concerns, the representations appellants alleged here are insufficient to state a *Randi W* cause of action. These were not false statements of facts. At most, they were promises about quality and performance that Aetna and its provider network allegedly failed to live up to. The Pagarigans also fail to allege how Aetna could and did know those promises were false when made. Accordingly, even though it may be possible to conjure misrepresentations that would sustain this theory of liability, the appellants have fallen far short of adequately alleging facts which would support such a claim.

IX. FALSE REPRESENTATIONS IN AN HMO'S MARKETING MATERIALS CAN BE ACTIONABLE, BUT APPELLANTS' ALLEGATIONS ARE NOT SUFFICIENTLY SPECIFIC OR OF A NATURE TO STATE A VALID CAUSE OF ACTION UNDER THAT THEORY OF LIABILITY.

In their ninth cause of action, again focused only on Aetna (and Does 1-5) the Pagarigans allege "fraud" based on misrepresentations and false promises the HMO allegedly included in its "marketing materials" aimed at prospective

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[19] *Buckman v. Plaintiffs' Legal Committee* (2001) 531 U.S. 341, 348.

enrollees. The complaint describes the alleged misrepresentations and promises in the most general of terms, e.g., the care would include all benefits Medicare covers, would comply with state law, and the like.[20] It then alleges "[s]aid representations and promises were, when made, false." And the motive? For economic reasons. Aetna, allegedly "had no intention of providing such care . . . if the cost . . . was higher than [that consistent with the] goals for the financial performance of AETNA's business operation . . . even if . . . reasonably . . . necessary for . . . good medical practice and even if . . . required under the law."[21]

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[20] "¶ 53. At the time Decedent enrolled as member of Aetna, Defendants AETNA and DOES 1-5, inclusive, represented and promised in writing, in the marketing materials provided to Decedent, and to virtually all of its prospective and actual enrollees, that the care offered would include all of the benefits covered by Medicare, plus more, and would afford Decedent and all of its enrollees certain protections if she or they felt that the care was not of sufficient quality, and would comply with all of the requirements of state law, that Decedent and all of its enrollees would be informed of their medical condition and be given the opportunity to participate in treatment decisions and that Decedent and all of its enrollees would receive ready referrals as needed. In addition, AETNA represented and promised in writing, in the marketing materials provided to Decedent and to virtually all of its prospective and actual enrollees, that they were licensed by the State of California, that Decedent and all of its enrollees could not be dis-enrolled from Defendants except for certain limited reasons such as failure to pay premiums, and that Decedent would be provided an avenue to challenge Defendants on quality of care and other issues that are not subject to the Medicare appeals process. The time and place and specifics of such misrepresentations are known to AETNA."

[21] "¶ 54. Said representations and promises were, when made, false. The true facts were that although Aetna was interested in obtaining persons who were entitled to Medicare benefits, including Decedent, to enroll as members, it had no intention of providing such care and protections to members if such care and protections could be avoided, or if the cost of that care was higher than levels which were established and adopted as part of goals for the financial performance of AETNA's business operation or for the financial performance of its co-defendants' business operations, even if such care was medically reasonable and necessary for Decedent and its other patients, in order for the care given to be consistent with good medical practice and in order for Decedent and its other enrollees to be provided care to meet their basic needs while in Aetna's and its co-defendants' care and custody, even if such care and protections were required under the law."

The complaint then alleges the purpose of the fraud was "tricking and inducing" decedent and others to enroll as members of the Aetna HMO. Finally, it alleges decedent enrolled because she relied on the fraudulent marketing materials.[22]

We find the trial court reached the correct result, sustaining a demurrer to this cause of action, but apparently for the wrong reason. The court appeared to rule it would be impossible to found a fraud claim on misrepresentations made in "marketing materials" issued by an HMO or other health provider. It found such representations are inherently merely generalized expressions of opinion and "puffery" on which no one is entitled to rely. In so ruling, the court appeared to rely heavily on *Pulvers v. Kaiser Foundation Health Plan, Inc*.[23] In that case involving an HMO's marketing materials, Division Four held representations the plan "would provide 'high standards' of medical service" represent "generalized puffing" not amounting to a warranty of high quality service.[24]

While we have no quarrel with that portion of the *Pulvers* opinion, we find it is a limited observation about certain types of representations commonly found in advertising, including HMO marketing materials. We do not read it to rule out the possibility of other misrepresentations an HMO's marketing materials might contain which would be actionable. Imagine, for instance, Aetna's marketing materials claimed this HMO employed its own physicians and owned its own hospitals and nursing homes – or would lead an average reader to gain that

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[22] These allegations are contained in paragraphs 55 and 56 of the Pagarigans' complaint.

> "55. Nonetheless, said representations and promises were made for the purpose of tricking and inducing Decedent and others into enrolling as members of AETNA.
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> "56. Decedent relied upon those representations and promises, and enrolled as a member of AETNA and DOES 1-5."

[23] *Pulvers v. Kaiser Foundation Health Plan, Inc*. (1979) 99 Cal.App.3d 560.

[24] *Pulvers v. Kaiser Foundation Health Plan, Inc, supra*, 99 CalApp.3d at pages 564-566.

impression. Or perhaps those materials asserted Aetna's HMO provided certain specified services which it did not. Or what if the materials advised prospective enrollees Aetna did not pay its contracting providers on a capitation basis. Could such brazen lies be excused as "mere puffery"? Obviously not.

Indeed Medicare enrollees, like decedent, have been allowed to sue an HMO for misrepresentations in the plan's marketing materials. For example, in *Solorzano v. Superior Court*,[25] Division One issued a writ overturning a judgment on the pleadings and allowing a lawsuit by Medicare recipients against an HMO for fraudulent representations in its marketing materials.[26] The suit sought compensatory and punitive damages as well as injunctive relief.

The problem here for the Pagarigans is not the viability of their theory, but the manner of its execution. As is true of their other fraud-type counts, their present allegations lack both specificity and substance.

Ordinarily, plaintiffs must specifically plead the time, place and content of every misrepresentation they allege.[27] The Pagarigans seek to excuse the lack of specificity because the marketing materials were part of a large scale advertising program and thus "the defendant must necessarily possess full information concerning the facts . . ."[28] Certainly, in such situations plaintiffs should not be required to identify each of the scores or hundreds or thousands of brochures, advertisements, broadcasts and the like they allege contain misrepresentations. But this does not mean they need not be specific about the *content* of the statements those plaintiffs deem to constitute fraud. Here, the Pagarigans describe the statements in only the most general of terms – far short of the specificity required in fraud actions.

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[25] *Solorzano v. Superior Court* (1992) 10 Cal.App.4th 1135.

[26] *Solorzano v Superior Court*, *supra*, 10 Cal.App.4th at page 1149.

[27] *Wilhelm v. Pray, Price, Williams & Russell* (1986) 186 Cal.App.3d 1324, 1331.

[28] *Committee on Children's Television v. General Foods* (1983) 35 Cal.3d 197, 217.

The alleged misrepresentations also lack substance. They are not statements of fact but only vague promises. Indeed they are too vague and modest even to qualify as true "puffery" – instead merely claiming the HMO will adhere to California law, will provide what Medicare requires, and something more, etc. But although they fall short of "puffery" they clearly are akin to the sort of statements the *Pulvers* court found not to be actionable.

Notably, in these counts as amended, the Pagarigans never tender factual allegations supporting an inference Aetna's marketing materials even imply the Aetna HMO is a traditional HMO which employs or otherwise controls the physicians, hospitals, nursing homes, and other providers who will be supplying the enrollees' health care. As a result, they are in no position to claim the marketing materials create an "apparent agency" (or "ostensible agency") cause of action, as has been recognized in Illinois, Pennsylvania and other states.[29] Nor do those allegations, at present, even imply the materials suggest the Aetna HMO does not pay its providers on a capitation basis, or state anything else that is both material and false.

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[29] In *Petrovitch v. Share Health Plan of Illinois* (Ill. 1999) 719 N.E.2d 756, the Illinois Supreme Court issued a unanimous opinion holding an HMO which contracted with independent medical groups and practitioners to supply health care and paid them on a "capitation" basis was nonetheless liable for malpractice by those medical groups and practitioners. The reason? The written materials the HMO supplied its members created an agency relationship under the "apparent authority doctrine." Those materials "stated SHARE [the HMO] will provide 'all your healthcare needs' and 'comprehensive high quality services.' . . . . [The materials] referred to the physicians as 'your Share physician,' 'Share physicians' and 'our staff.' Share also referred to the physicians' offices as 'your Share physician's office.'" (719 N.E.2d at p. 768.) See also, *Jones v. Chicago HMO* (Ill. 2000) 730 N.E.2d 1119; *Boyd v. Albert Einstein Medical Center* (Pa 1988) 547 A.2d 1229; *Ramos v. Preferred Medical* Plan (Fla.App. 2003) 842 So.2d 1006; Annotation, *Liability of Health Maintenance Organizations (HMOs) For Negligence of Member Physicians* (1997) 51 A.L.R.5th 271; *HMO Liability for the Medical Negligence of Member Physicians* (1998) 43 Vllr. L.Rev. 499.

X. APPELLANTS SHALL BE AFFORDED AN ADDITIONAL OPPORTUNITY TO AMEND THEIR COMPLAINT TO STATE A VALID CAUSE OF ACTION FOR NEGLIGENCE AND WRONGFUL DEATH.

We had hoped to entirely avoid another round of pleading when before oral argument we offered appellants an opportunity to submit proposed amendments as if the trial court had sustained the demurrer *with* leave to amend. As explained above, even with the amendments appellants tendered in response to that request none of their counts at present adequately states a viable cause of action. At the same time, however, fragments of allegations scattered throughout their latest set of proposed amendments approach stating a cause of action under the theory discussed in Section III above.[30] Accordingly, we will reverse and instruct the trial court to sustain the demurrer with leave to amend as to the first and eleventh causes of action. This will afford appellants one more chance to craft an amended complaint as to those causes of action which can survive demurrer. Turning to the remaining counts, however, we find appellants' proposed amendments fail to suggest an ability to cure fatal defects in their pleadings. Thus, we will affirm the trial court's order sustaining demurrers without leave to amend as to those counts.

DISPOSITION

The judgment is reversed and the cause remanded to the trial court with instructions to sustain the demurrer with leave to amend as to the first and eleventh causes of action in the Pagarigans' complaint and to sustain the demurrer without

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[30] See pages 8-13, ante.

leave to amend as to the remaining counts against Aetna, and for further proceedings consistent with this opinion. Each side to bear its own costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

JOHNSON, J.

We concur:

PERLUSS, P.J. WOODS, J.