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United States District Court,
C.D. California.

Local Initiative Health Authority for Los Angeles County, Plaintiff,
v.
OneBeacon Professional Insurance, Inc. et al., Defendants.

EDCV 16-4810-VAP (AGRx)
|
Filed 07/07/2017

Order (1) Granting in Part and Denying in Part Defendants' Motion for Summary Judgment and (2) Denying Plaintiff's Motion for Summary Judgment (Doc. Nos. 67, 69)

Virginia A. Phillips Chief United States District Judge

***1** On May 22, 2017, Local Initiative Health Authority for Los Angeles County ("Plaintiff") filed its Motion for Summary Judgment ("Plaintiff's Motion"). (Doc. No. 69.) On May 22, 2017, Homeland Insurance Company of New York ("Homeland") and OneBeacon Professional Insurance, Inc. ("OneBeacon") filed their Motion for Summary Judgment ("Defendants' Motion"). (Doc. Nos. 67.) On June 2, 2017, the parties filed their oppositions, and on June 12, 2017, the parties filed their replies. (Doc. Nos. 71–74.) After considering all papers filed in support of and in opposition to the Motions as well as the arguments advanced at the June 26, 2017 hearing, the Court (1) DENIES Plaintiff's Motion and (2) GRANTS in part and DENIES in part Defendants' Motion.

I. BACKGROUND

A. The Underlying Suit

Plaintiff is a public California agency that provides free and low cost health insurance plans—such as Medi-Cal, IHSS Health Care, L.A. Care Covered, and Cal Medi Connect—to vulnerable populations in Los Angeles County. (Doc. No. 25 at 2.) Plaintiff is authorized to provide these insurance plans by the California Department of Health Care Services ("DHCS"), which is responsible for administering California's Medicaid program established under the Social Security Act. (Doc. No. 67-4 at 32.) This authorization is embodied in a contract between Plaintiff and DHCS. (Doc. No. 67-4 at 30–31.) For each member enrolled in one of Plaintiff's health insurance plans, Plaintiff receives a fixed sum of money from the federal government, and in return, Plaintiff assumes the responsibility for paying for its members' care. (Id. at 34.) In order to carry out this directive, Plaintiff subcontracts with Care 1st Health Plan ("Care 1st") and Community Health Plan ("CHP"). (Id. at 35.) Care 1st and CHP are responsible for paying hospitals and other health care providers for services rendered to Plaintiff's members. (Id.) Nonetheless, should either Care 1st or CHP fail to pay, Plaintiff is still responsible for paying the costs associated with services rendered to its members. (Id. at 35, 39; Cal. Code Regs. tit. 22, § 53867.)

Lancaster Hospital Corporation DBA Palmdale Regional Medical Center (the "Hospital") is a hospital operating in Los Angeles County. (Doc. No. 67-4 at 36.) The Hospital maintains no contracts with Plaintiff, Care 1st, or CHP. (Id.) The Hospital, however, regularly admits Plaintiff's members into its emergency care facilities and provides them with emergency and post-stabilization care. (Id. at 38.) Even though the Hospital does not have a contract with either Plaintiff, Care 1st, or CHP, the Hospital is still entitled to receive payment for these services pursuant to 42 U.S.C. § 1396u-2(b)(2)(D).[1] (Id. at 36.) As there is no contract between the Hospital and Plaintiff, Care 1st, or CHP that establishes the cost for the Hospital's services, this is determined by the Hospital's "interim rate." (Id. at 32.) The interim rate is essentially a cost-to-charge ratio—calculated via a methodology set forth in DHCS's State Plan—by which the Hospital's bill is multiplied. (Id. at 32.) Thus, for example, if (1) a given healthcare provider's interim rate is 20% (i.e. 1/5) and (2) the healthcare provider charges $2,000 for services rendered to one of Plaintiff's members, then Plaintiff would pay the healthcare provider $400 for those services. Here, the Hospital asserted its interim rate was 20%. (Doc. No. 69-1 at 12.)

[1] 42 U.S.C. § 1396u-2 states, "[a]ny provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of

> medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity." 42 U.S.C. § 1396u-2.
> 2 CCR 53698 states, "[t]he plan's financial liability to the provider, if any, shall not exceed the lower of the following rates applicable at the time the services were rendered by the provider: (1) The usual charges made to the general public by the provider. (2) The fee-for-service rates for similar services under the Medi-Cal program. Upon determination of the plan's liability, if no final rate has been established for a provider for the period and type of services in question, then the applicable interim rate shall be used for final determination of plan liability."

***2** The Hospital sued Plaintiff, Care 1st, and CHP in the California Superior Court, alleging they failed to pay the Hospital its 20% interim rate. (Doc. No. 67-4 at 42.)[2] Instead, Plaintiff, Care 1st, and CHP payed the Hospital a "per diem" rate—under which medical facilities get paid a flat rate for each day a member is treated in the medical facility.[3] (Id.) Because the per diem rate payments were less than the Hospital would have received under its interim rate, and the Hospital claimed it was entitled to payments pursuant to its interim rate, the Hospital claimed Plaintiff owed the Hospital the difference. (Id. at 40, 42–43.)[4]

[2] Defendants have requested the Court take judicial notice of the filings in the Hospital's underlying action. (Doc. No. 68.) Plaintiff has not opposed the request, and the Court finds such filings are appropriate for judicial notice. Mullis v. U.S. Bankr. Court for Dist. of Nevada, 828 F.2d 1385, 1388 n.9 (9th Cir. 1987). Accordingly, Defendants' request is GRANTED.

[3] The per diem rate is also set by the State Plan.

[4] The Hospital claimed Plaintiff paid the per diem rate because DHCS di-rected Plaintiff to pay the per diem rate in a number of "All Plan Letters," which were sent to all Medi-Cal managed care health plans. (Id. at 42.) The Hospital alleged that DHCS's directives were contrary to case law. (Id. at 41–42.) Thus, according to the Hospital, it was owed its interim rate, notwithstanding DHCS's directives that Plaintiff pay the lesser per diem rate. (Id.)

The Hospital's complaint asserted seven claims based on the above facts: (1) declaratory relief; (2) "breach of implied-in-law contract"; (3) "breach of implied-in-fact contract"; (4) "services rendered"; (5) "account stated"; (6) "breach of written contract - third party beneficiary"; (7) "breach of written contract - third party beneficiary." (Id. at 67-4 at 29.) Plaintiff demurred to the complaint, and the Superior Court of the State of California for the County of Los Angeles dismissed the Hospital's first through fifth claims. (Doc. No. 69-14 at 8.) The court reasoned that (1) "[p]ursuant to Cal. Gov. Code § 815, public entities are not subject to common law or judicially declared forms of liability, [and thus] a public entity cannot be sued on an implied-in-law or quasi-contract theory" and (2) "no suit for money or damages may be maintained against a public entity unless a formal claim has been presented to such entity." (Doc. No. 69-14 at 8.) The court, however, allowed the Hospital's sixth and seventh claims—i.e. its third party beneficiary claims—to continue because "[w]hether a party is an intended beneficiary of a contract is generally a question of fact and inappropriate for a demurrer." (Id. at 9.)

The Hospital and Plaintiff then settled the lawsuit after attending two mediation sessions on July 21, 2014, and August 15, 2014. (DSUF 13–14.)

B. The Policy

In early 2012, Plaintiff purchased a "Managed Care Errors and Omissions Liability Policy" ("Policy") from OneBeacon, which was issued through Homeland. (Doc. No. 67-4 at 106.) The Policy period spanned from April 1, 2012, to April 1, 2013, during which the Hospital's claims were brought. (Id.; Doc. No. 67-4 at 68.) The Policy's claim limit and aggregate limit of liability are both $10,000,000, and the Policy has a $250,000 retention. (Doc. No. 67-4 at 106) The Policy's insuring clause states the following:

> We will pay on your behalf Damages and Claim Expenses in excess of the Retention that you are legally obligated to pay as a result of a Claim for: (A) an act, error, or omission, or series of acts, errors, or omissions, committed or allegedly committed by you or on your behalf in the performance of a Managed Care Activity ... (C) Vicarious Liability for an act, error, or omission, or series of acts, errors, or omissions, by a person or entity other than you in the performance of a Managed Care

Activity;

***3** (Id. at 127.)

The parties agree the Hospital's suit constituted a Claim committed in the performance of a Managed Care Activity. (Doc. No. 67-4 at 69.) The parties disagree, however, whether the Hospital's claims were for Damages, as that term is defined in the Policy. (Id. at 70.) The Policy defines Damages as follows:

> Damages means any settlements, judgments, pre-judgment interest, post-judgment interest, claimant's attorney's fees in an amount equal to the percentage that any Damages covered under this Policy for any settlement or judgment bear to the total amount of such judgment or settlement, or other amounts (including punitive, multiple, or exemplary damages if insurable under the Law Most Favorable to Insurability) which you are legally obligated to pay as a result of a Claim. Damages does not include:
>
> (1) any fine, penalty, forfeiture, sanction, tax, fee, liquidated damages, or amount imposed by statute, rule, regulation, or other law; provided that Damages will include fines or penalties which you are legally obligated to pay as a result of a Claim for Antitrust Activity if such fine or penalty is insurable under the Law Most Favorable to Insurability;
>
> (3) any payment, restitution, return, or disgorgement of any fee, profit, royalty, premium, commission, or charge, or any fund allegedly wrongfully or unjustly held or obtained, including but not limited to any profit, remuneration or advantage to which you were not legally entitled;
>
> (4) any amount any of you pay or may be obligated to pay under any contract or agreement, including but not limited to any policy, bond, benefit plan, or provider agreement;

(Id. at 131.)

For ease of reference, the Court will refer to number (1) as the "Fine Carve Out"; number (3) as the "Wrongfully Obtained Carve Out"; and number (4) as the "Contract Carve Out."

II. EVIDENTIARY OBJECTIONS

A. Plaintiff's Objections

Plaintiff makes a number of objections to Linda E. Unger's declaration, which Defendants produced in support of their Motion. (Doc. No. 71-2.) The Court addresses Plaintiff's objections in turn.

1. Personal Knowledge Objections

Plaintiff objects to paragraphs 6 through 12 of Unger's testimony, which describe events that occurred before she was assigned to be the claims handler for the Hospital's lawsuit. (Doc. No. 71-2 at 4.) Plaintiff bases these objections on the grounds that Unger lacks personal knowledge of events that occurred before she became the claims handler. (Id.) Plaintiff also objects to paragraphs 21 through 28 of Unger's testimony, which describe the actions of OneBeacon and Homeland, on the ground that Unger lacks personal knowledge because she was never an employee of OneBeacon or Homeland. (Id. at 13.)

Despite Plaintiff's objections based on Unger's personal knowledge, Unger is not required to have personal knowledge because she is testifying as Homeland's and OneBeacon's 30(b)(6) designee. "The testimony of a Rule 30(b)(6) designee 'represents the knowledge of the corporation, not of the individual deponents.' " Great Am. Ins. Co. of N.Y. v. Vegas Const. Co., 251 F.R.D. 534, 538 (D. Nev. 2008). "A corporation has a duty under Rule 30(b)(6) to provide a witness who is knowledgeable in order to provide 'binding answers on behalf of the corporation.' " Id. Thus, a "Rule 30(b)(6) designee is not required to have personal knowledge on the designated subject matter." Id.; All. for Glob. Justice v. D.C., 437 F. Supp. 2d 32, 37 (D.D.C. 2006) ("By its very nature, a Rule 30(b)(6) deposition notice requires the responding party to prepare a designated representative so that he or she can testify on matters not only within his or her personal knowledge, but also on matters reasonably known by the responding entity"); Sprint Commc'ns Co., L.P. v. Theglobe.com, Inc., 236 F.R.D. 524, 528 (D. Kan. 2006) ("In other words, personal knowledge of the designated subject matter by the selected deponent is of no consequence").

***4** Accordingly, Plaintiff's objections on these grounds are OVERRULED.

2. Objection to Paragraph 14

In paragraph 14 of her declaration, Unger states, "[t]he Hospital Lawsuit was mediated on July 1, 2014 and again on August 15, 2014. Homeland did not attend mediation of the Hospital Lawsuit, but [Plaintiff] certainly knew how to contact Homeland if anything new arose during

mediation." (Doc. No. 67-4 ¶ 14.)

Plaintiff argues this statement lacks foundation because Unger has no personal knowledge of when the Hospital's claims were mediated. (Doc. No. 71-2 at 9.) As the evidence submitted by both parties shows, Defendants did not participate in the mediation of the Hospital's claims. Thus, Defendants have not identified the means by which they had personal knowledge of whether the Hospital's claims were actually mediated. Accordingly, Plaintiff's objection is SUSTAINED.

3. Objection to Paragraph 17

In paragraph 17 of her declaration, Unger states, "[p]rior to filing this lawsuit, [Plaintiff] did not contradict Homeland's September 9, 2014 communication that $104,061 of the Retention remained. At no time during the Hospital Lawsuit, or prior to the instant action, did [Plaintiff] advise that Claim Expenses had exceeded the Retention." (Doc. No. 67-4 ¶ 17.)

Plaintiff argues Unger lacks personal knowledge to make this statement. (Doc. No. 71-2 at 10.) To support its position, Plaintiff states, "Defendants' own March 2015 [letter], of which the Declarant apparently is unaware, refers to a different [retention] figure."

Although Plaintiff argues Unger's statement is untrue and asserts a letter exists showing a different amount of remaining retention, this does not show Unger lacks personal knowledge to make the above statement. Indeed, the fact that another letter referenced a different figure does not contradict Unger's statement that "Homeland's September 9, 2014 communication [stated] that $104,061 of the Retention remained." Accordingly, Plaintiff's objection is OVERRULED.

4. Objection to Paragraph 18

Plaintiff objects to paragraph 18 of Unger's declaration, which states the following:

> Homeland agreed to defense counsel requested by [Plaintiff] at the hourly rate of $320 (and later $325) (a true and correct copy of the January 6, 2014 email confirming rates, as produced in this action, is attached as Exhibit L). At the highest agreed rate of $325/hour, Claim Expenses do not exceed the $250,000 Retention.
>
> At the $325/hour attorney rate, with no reductions for reasonableness and/or necessity, the total fees applicable to the Retention would be $174,715.50 based on the invoices produced in this action by [Plaintiff] [($325/hr x 505.9hrs) + ($230/hr x 3.8hrs) + ($198/hr x 9hrs) + ($195/hr + 9.5hrs) + ($160/hr x 4.7hrs) + ($155/hr x 32.5hrs)]
>
> Including both fees and costs (based on proof of payment and [Plaintiff's] allegations), the total Claim Expenses at the $325/hour attorney rate would be no more than $182,388.83 ($174,715.50 + $3,040 + $2,025 + $2,608.33). (See Stipulation of Facts, ¶¶ 2a, 3.)

(Doc. No. 67-4 ¶ 18.)

Plaintiff argues Unger's testimony lacks foundation because "[t]he email confirming rates was actually dated May 23, 2013." (Doc. No. 71-2 at 11.) Thus, Plaintiff is arguing that Unger's testimony is incorrect. Whether or not testimony is correct, however, is a question for the factfinder—not a basis for asserting a declarant lacks personal knowledge.

***5** Plaintiff also argues Unger's testimony lacks foundation because she sets forth no basis for stating the parties agreed to the rates she recites. (Doc. No. 71-2 at 11.) In paragraph 18, however, Unger states Defendants "agreed to defense counsel requested by [Plaintiff] at the hourly rate of $320 (and later $325)." (Doc. No. 67-4 ¶ 18.) Further, Unger states her calculations are based on the invoices Plaintiff produced showing its attorneys' charges. Hence, the Court finds Defendants have produced evidence "sufficient to support a finding that [Unger] has personal knowledge of the matter."

Additionally, Plaintiff argues Unger's calculations are "improper expert witness testimony." (Doc. No. 71-2 at 11.) The Court is not persuaded by Plaintiff's argument. Unger's calculations are simple arithmetic and not based on the type of "scientific, technical, or other specialized knowledge" within the scope of Federal Rule of Evidence 702. Fed. R. Evid. 701, 702.

Accordingly, Plaintiff's objections are OVERRULED.

5. Objection to Paragraph 19

Plaintiff objects to paragraph 19 of Unger's declaration, which states, "[Plaintiff] has not produced any evidence that the Hospital Settlement addressed anything other than the Hospital's claims of underpayment for services provided to [Plaintiff's] plan members." (Doc. No. 67-4 ¶ 19.) Plaintiff argues "[t]his 'testimony' is not factual," and thus Unger lacks personal knowledge. (Doc. No. 71-2 at 12.) The Court disagrees. Here, Unger is stating

Plaintiff sent her nothing showing "the Hospital Settlement addressed anything other than the Hospital's claims of underpayment." This is a statement of fact, and thus the Court OVERRULES Plaintiff's objection. To the extent Unger's statement is making a legal conclusion, however, the prejudicial effect of the statement substantially outweighs any minimal probative value it possess. Thus, to the extent Unger's statement is expressing a legal conclusion, the Court SUSTAINS the objection under Federal Rule of Evidence 403. Accordingly, the Court will consider paragraph 19 only to the extent it indicates what documents Unger did or did not receive.

B. Defendants' Objections

1. Objections to the Declaration of Gregory Douglas

In support of Plaintiff's Motion, Plaintiff provided a declaration by Gregory Douglas, a claims quality auditor in Plaintiff's claims department. (Doc. No. 69-4.) In his declaration, Douglas states, "out-of-network claims are paid in accordance with a combination of statutes, regulations and directives from federal and state agencies." (Id. ¶ 4.) Douglas also states, after reviewing Plaintiff's payments to the Hospital, he "concluded that the paid claims were processed and paid in accordance with the applicable Medi-Cal rates for emergency and post-stabilization services provided by out-of-network provider as established by applicable law and the All Plan Letters issued by DHCS." (Id. ¶ 7.) Defendants argue Douglas's statements are irrelevant and thus inadmissible because only "[t]he allegations in the operative pleadings of the Hospital Lawsuit are what determine coverage." (Doc. No. 72-2 at 2–3.)

Douglas's statements, however, are relevant to Plaintiff's unfair competition claim that Defendants knowingly sold Plaintiff an insurance policy Defendants knew would not cover Plaintiff's business operations. Accordingly, Defendants' objections are OVERRULED.

2. Objections to the Declaration of Ellin Davtyan

i) Davtyan's Statements She Dealt with OneBeacon

In support of its Motion, Plaintiff provided a declaration by Ellin Davtyan, Plaintiff's associate general counsel. (Doc. No. 69-3.) In her declaration, Davtyan states a number of times that she dealt with OneBeacon. (E.g. id. ¶¶ 8–11, 20.) Defendants argue Davtyan's statements that she dealt with OneBeacon in paragraphs 8, 9, 11, 14, 17, and 20 are conclusory and thus inadmissible because the entity to which she refers is not the OneBeacon entity sued in this action. (Doc No. 72-2 at 4.)

***6** In Davtyan's declaration, she states that in the process of submitting Plaintiff's claim to Defendants, she corresponded with "Brittany Dworman, who identified herself as a Claims Examiner with OneBeacon Professional Insurance." (Doc. No. 69-3 ¶ 8.) Plaintiff also attached a letter addressed to her from Brittany Dworman stating, "OneBeacon Professional Insurance ("OPBI") is the claims manager for Homeland Insurance Company of New York ("Homeland") in relation to the Managed Care Organizations Errors & Omission Liability Policy that was issued to [Plaintiff]." (Doc. No. 69-12.) Accordingly, the Court finds Davtyan has sufficient foundation under Federal Rule of Evidence 602 to make the assertion that she dealt with OneBeacon, and Defendants' objections are OVERRULED. To the extent Defendants assert Davtyan's statements are incorrect, Defendants may test their accuracy upon cross examination, but this not a basis for excluding Davtyan's statements.

ii) Davtyan's Statements that Plaintiff Denied the Hospital's Claims

Defendants also argue Davtyan's statement in paragraph 6, which alleges Plaintiff "denied all of [the Hospital's] allegations," is irrelevant under Federal Rule of Evidence 402. (Doc. No. 72-2 at 3–4.) According to Defendants, "[w]hether the allegations were true or not is irrelevant to whether the settled claims were covered under the Policy." (Id.)

Whether Plaintiff denied the Hospital's allegations, however, is at least relevant to (1) whether Plaintiff incurred defense costs and (2) the amount of defense costs Plaintiff incurred. Here, because Plaintiff claims defense costs are owed under the policy, Defendants' objection is OVERRULED.

iii) Davtyan's Statement that She Never Communicated with Anybody Who Identified Herself or Himself as an Agent, Employee or Officer of Homeland

In Davtyan's declaration, she states, "[a]t no time have I ever communicated with anybody who identified herself

or himself as an agent, employee or officer of Homeland with respect to [Plaintiff's] claim for defense and indemnity for the [Hospital's] Action under the 2012 Policy." (Doc. No. 69-3 ¶ 9.) Defendants argue this contradicts (1) Davtyan's statement that OneBeacon was acting "as Homeland's 'claims manager' " and (2) the letter Davtyan references in her declaration stating "OneBeacon Professional Insurance ('OPBI') is the claims manager for Homeland Insurance Company of New York." (Id. ¶ 17; Doc. No. 69-12; Doc. No. 72-2 at 5.)

"[A] party cannot create a genuine issue of fact sufficient to survive summary judgment simply by contradicting his or her own previous sworn statement (by, say, filing a later affidavit that flatly contradicts that party's earlier sworn deposition) without explaining the contradiction or attempting to resolve the disparity." Cleveland v. Policy Mgmt. Sys. Corp., 526 U.S. 795, 806 (1999). Accordingly, as Davtyan has stated she dealt with OneBeacon while it was acting as Homeland's claims manager, the Court SUSTAINS Defendants' objection as to Davtyan's statement that she never "communicated with anybody who identified herself or himself as an agent" of Homeland.

iv) Davtyan's Statement that She Repeatedly Requested Defendants Provide an Accounting of Fees and Costs

In paragraph 20 of her declaration, Davtyan states the following:

> Beginning in April 2013, I have repeatedly requested that OBPI provide an accurate accounting of the fees and costs that had been credited towards the [retention]. But OBPI has only provided partial, incomplete accountings, and only after numerous requests from me. Neither Homeland nor OBPI has ever provided [Plaintiff] with a complete and accurate accounting of [Plaintiff's] [retention] balance under the 2012 Policy.

(Doc. No. 69-3 ¶ 20.)

Defendants argue this is irrelevant under Federal Rule of Evidence 402 because Plaintiff's "motion does not assert Homeland owes Claim Expenses." (Doc. No. 74-2 at 6.) Nonetheless, Defendants' lack of communication is one of the bases on which Plaintiff makes its bad faith claims. (Doc. No. 69-1 at 27 n.12.) Thus, Davtyan's statement is relevant to the bad faith claims in Plaintiff's Motion, and Defendants' Objection is OVERRULED.

III. LEGAL STANDARD

***7** A motion for summary judgment or summary adjudication shall be granted when there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986). The moving party must show that, "under the governing law, there can be but one reasonable conclusion as to the verdict." Anderson, 477 U.S. at 250.

Generally, the burden is on the moving party to demonstrate that it is entitled to summary judgment. Margolis v. Ryan, 140 F.3d 850, 852 (9th Cir. 1998); Retail Clerks Union Local 648 v. Hub Pharm., Inc., 707 F.2d 1030, 1033 (9th Cir. 1983). The moving party bears the initial burden of identifying the elements of the claim or defense and evidence that it believes demonstrates the absence of an issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986).

Where the non-moving party has the burden at trial, however, the moving party need not produce evidence negating or disproving every essential element of the non-moving party's case. Celotex, 477 U.S. at 325. Instead, the moving party's burden is met by pointing out that there is an absence of evidence supporting the non-moving party's case. Id.

"If a moving party fails to carry its initial burden of production, the nonmoving party has no obligation to produce anything, even if the nonmoving party would have the ultimate burden of persuasion at trial." Nissan Fire & Marine Ins. Co. v. Fritz Co., 210 F.3d 1099, 1102–03 (9th Cir. 2000). "In such a case, the nonmoving party may defeat the motion for summary judgment without producing anything." Id. at 1103.

If the moving party carries its burden of production, however, the burden then shifts to the non-moving party to show that there is a genuine issue of material fact that must be resolved at trial. See Fed. R. Civ. P. 56(e); Celotex, 477 U.S. at 324; Anderson, 477 U.S. at 256; Nissan Fire, 210 F.3d at 1103. The non-moving party must make an affirmative showing on all matters in issue by the motion as to which it has the burden of proof at

trial. Celotex, 477 U.S. at 322; Anderson, 477 U.S. at 252. See also William W. Schwarzer, A. Wallace Tashima & James M. Wagstaffe, Federal Civil Procedure Before Trial, § 14:144. "This burden is not a light one. The non-moving party must show more than the mere existence of a scintilla of evidence." In re Oracle Corp. Secs. Litig., 627 F.3d 376, 387 (9th Cir. 2010) (citing Anderson, 477 U.S. at 252).

A genuine issue of material fact will exist "if the evidence is such that a reasonable jury could return a verdict for the non-moving party." Anderson, 477 U.S. at 248. In ruling on a motion for summary judgment, a court construes the evidence in the light most favorable to the non-moving party. Barlow v. Ground, 943 F.2d 1132, 1135 (9th Cir. 1991); T.W. Elec. Serv. Inc. v. Pac. Elec. Contractors Ass'n, 809 F.2d 626, 630-31 (9th Cir. 1987).

IV. DISCUSSION

A. Burden of Proof

In California, "[t]he burden is on an insured to establish that the occurrence forming the basis of its claim is within the basic scope of insurance coverage." Aydin Corp. v. First State Ins. Co., 18 Cal. 4th 1183, 1188 (1998). Once the insured establishes the occurrence is within the basic scope of coverage, the burden shifts to the "insurer to establish that the claim is specifically excluded." MacKinnon v. Truck Ins. Exch., 31 Cal. 4th 635, 648 (2003). If the insurer can show the occurrence is specifically excluded, the burden shifts back to the insured to show an "exception affords coverage." Aydin, 18 Cal. 4th at 1192. ("Once the insurer has established that the pollution exclusion applies, coverage depends on the applicability of the exception. Because the insured bears the burden of establishing coverage under an insurance policy, it makes sense that the insured must also prove that the exception affords coverage after an exclusion is triggered.").

***8** Here, however, it is unclear who bears the burden of showing the Hospital's claims fall into any of the carve-outs in the Policy's definition of damages. On one hand, Defendants argue the carve outs are incorporated into the definition of Damages, which is then incorporated into the Policy's insuring provision that defines the "basic scope of insurance coverage." Under this view, the insured would bear the burden of showing the Hospital's claims do not fall into any of the carve outs because the insured bears the burden of "establish[ing] that the occurrence ... is within the basic scope of insurance coverage." Aydin, 18 Cal. 4th at 1188. On the other hand, Plaintiff argues the carve outs function as exclusionary language. Under this view, Defendants would bear the burden of showing the Hospital's claims fall into the carve outs because the burden is "on the insurer to establish that the claim is specifically excluded." MacKinnon, 31 Cal. 4th at 648.

California law is split on this issue. Intel Corp. v. Hartford Acc. & Indem. Co., 952 F.2d 1551, 1558 (9th Cir. 1991). ("existing caselaw provides no clear answer as to how a California court would allocate the burden of proof on the 'occurrence' issue"). When an insuring clause contains specific carve outs, some courts hold that the insurer bears the burden of showing an occurrence falls into the carve outs' exclusionary language. Clemco Indus. v. Commercial Union Ins. Co., 665 F. Supp. 816, 820 (N.D. Cal. 1987), aff'd, 848 F.2d 1242 (9th Cir. 1988) (holding that when a policy covers bodily injury, and bodily injury is defined to "include accidents ... which result [ ], during the policy period, in bodily injury neither expected nor intended from the standpoint of the insured," the insurer bore the burden of showing an occurrence was "expected or intended"); Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 45 Cal. App. 4th 1, 77 (1996) ("although the evidence of Armstrong's general knowledge of asbestos dangers might support a finding that Armstrong should have expected the asbestos bodily injuries, the insurer's burden was to prove, directly or circumstantially, that Armstrong actually did expect them"); Butler v. Clarendon Am. Ins. Co., No. C06-03619 MJJ, 2007 WL 1033470, at *7 (N.D. Cal. Apr. 4, 2007) (where a policy's insuring clause covers only "accidents" and an exclusion similarly excludes "expected or intended" injury, the burden is on the insurer to prove an occurrence is not an "accident."); see Clemmer v. Hartford Ins. Co., 22 Cal. 3d 865, 879, 587 P.2d 1098, 1105 (1978) (holding burden was on insurer to show that section 533 of the California Insurance Code, which precludes insurance from covering willful acts, applied);

Other Courts have held the insured bears the burden of showing the occurrence does not fall into the carve outs' exclusionary language. FMC Corp. v. Plaisted & Cos., 61 Cal. App. 4th 1132, 1159 (1998) ("the phrase 'unexpectedly and unintentionally' is an integral part of the 'occurrence' definition before us in this case, and thus is subject to the rule assigning the burden of proof of coverage to the insured."); Royal Globe Ins. Co. v. Whitaker, 181 Cal. App. 3d 532, 537 (1986); Alco Iron & Metal Co. v. Am. Int'l Specialty Lines Ins. Co., 911 F. Supp. 2d 844, 856 (N.D. Cal. 2012) ("because this definition is part of the insuring agreement and not part of an exclusion, it need not be narrowly construed and the

burden of proof is on [the insured] to establish that its claim falls within the scope of coverage.")

The California Supreme Court has not addressed whether the insured or the insurer bears the burden of showing whether an occurrence falls into a carve out in the insuring clause. Thus, the Court must use its judgment to predict how the California Supreme Court would rule if this issue were to come before it. Gen. Motors Corp. v. Doupnik, 1 F.3d 862, 865 (9th Cir. 1993). Although decisions of the California Courts of Appeal are persuasive, the Court is not bound by such decisions. Id. at 865 n.4.

***9** While California courts are split this issue, there is a closely analogous issue on which the California Supreme Court has clearly expressed the state of the law: exclusions and exceptions thereto. To explain, insurance policies contain exclusions which remove certain occurrences from coverage. Often these exclusions themselves contain carve outs, referred to as "exceptions." These exceptions place occurrences that would otherwise be included in the exclusion's definition back into coverage. In such a situation, the California Supreme Court has clearly stated the insured bears the burden of proving an occurrence falls into an exception. State v. Allstate Ins. Co., 45 Cal. 4th 1008, 1024 (2009) (the insured "bears the ultimate burden of proving the exception applicable"); Aydin Corp. v. First State Ins. Co., 18 Cal. 4th 1183, 1194 (1998) ("the insurer carries its burden of proving that the general pollution exclusion applies, the insured bears the burden of proving that a claim comes within the "sudden and accidental" exception."); Aeroquip Corp. v. Aetna Cas. & Sur. Co., 26 F.3d 893, 895 (9th Cir. 1994) ("The 'sudden and accidental' exception creates coverage where it would otherwise not exist and thus the insured's burden of proving coverage extends to proof of this exception").

Aydin is the California Supreme Court case most squarely addressing the insured's burden on exceptions. In Aydin, an insured purchased a comprehensive general liability policy from an insurer. 18 Cal. 4th at 1186. The policy stated the insurer would indemnify the insured for "all sums which the INSURED shall be obligated to pay ... because of ... PROPERTY DAMAGE." Id. The policy also contained an exclusion stating the insurer would not cover any liability "arising out of the discharge, dispersal, release or escape of ... contaminants." Id. at 1187. The exclusion, however, contained an exception stating the exclusion would not apply if "such discharge, dispersal, release or escape is sudden and accidental." Id. When the California Department of Health Services ordered the insured to clean up soil contamination the insured caused, the insured sued the insurer for coverage under the policy. Id. at 1186. The court held that once the insurer showed the contamination fell within the exclusion's language, it was the insured's burden to show the exception brought the contamination back within coverage. Id. at 1194. The court reasoned that "in the context of [the] broad exclusionary language, the 'sudden and accidental' exception serves to 'reinstate coverage' where it would otherwise not exist." Id. at 1192. Thus, "[b]ecause the insured bears the burden of establishing coverage under an insurance policy, it makes sense that the insured must also prove that the exception affords coverage after an exclusion is triggered." Id.

Here, the Policy's insuring clause and carve outs function the same way as the exclusion and exception in Aydin. In, Aydin, the insured's policy contained a broad exclusionary clause, excluding coverage for any liability "arising out of the discharge, dispersal, release or escape of ... contaminants." Similarly here, the Policy contains a broad insuring clause, stating Defendants will "pay on your behalf Damages ... that you are legally obligated to pay as a result of a Claim for: (A) an act, error, or omission ... committed or allegedly committed by you or on your behalf in the performance of a Managed Care Activity." In Aydin, the exclusion contained an exception, which acted to limit the broad exclusion by stating it would not apply if "such discharge, dispersal, release or escape is sudden and accidental." Similarly here, the insuring clause contains a carve out, which acts to limit the broad insuring clause by stating "Damages does not include: (1) any fine, penalty, forfeiture, sanction, tax, fee, liquidated damages, or amount imposed by statute." Thus, the structure of the exclusion and exception in Aydin is identical to the structure of the insuring clause and carve out here.

The court in Aydin held, "in the context of [the] broad exclusionary language, the 'sudden and accidental' exception serves to 'reinstate coverage' where it would otherwise not exist." Thus, "[b]ecause the insured bears the burden of establishing coverage under an insurance policy, it makes sense that the insured must also prove that the exception affords coverage after an exclusion is triggered." Accordingly, the Aydin court held that the insured bears the burden of showing an exception to an exclusion provides coverage. Here, however, the same reasoning the Aydin court applied demands the insurer bear the burden of showing a carve out in an insuring clause excludes coverage. This is because here, "in the context of the broad" insuring clause, the carve outs serve to exclude coverage "where it would otherwise" exist. Further, whereas the insured bears the burden of establishing coverage, it is the insurer who bears the

burden of "establish[ing] that a claim is specifically excluded." MacKinnon, 31 Cal. 4th at 648. Thus, in the context of a carve out contained in an insuring clause, it makes sense that the insurer must also prove that the insuring clause's exception excludes coverage after the insuring clause is triggered.[5]

[5] It could be argued that the insuring clause is, by definition, not triggered until the insured shows the carve out does not apply. In other words, since the carve out only serves to establish the reach of coverage, the insured should bear the burden of negating the carve out before coverage is triggered. The same argument, however, was made and rejected in Aydin. In Aydin, the insured argued that the insurer should have to negate the exclusion's exception because the exception "serves only to establish the reach of the exclusion," and the insurer has the burden of proving the exclusion is triggered. The Aydin court, however, rejected this argument by reasoning that (1) the exclusion's exception "serves to 'reinstate coverage' where it would otherwise not exist" and (2) the insured has the burden of showing the exception applies because the insured bears the burden of showing coverage. Thus, when Aydin's reasoning is applied here, the insurer must bear the burden of showing an insuring clause's carve out applies because (1) the carve out serves to exclude coverage where it would otherwise exist and (2) the insurer bears the burden of showing coverage is specifically excluded from an insurance policy.

***10** In other words, settled California law states the insured generally has the burden of proving coverage whereas the insurer has the burden of proving a lack of coverage. Aydin holds that once an exclusion is triggered, the insured has the burden of proving an exception applies because (1) the exception reinstates coverage and (2) the insured has the burden of proving coverage. Thus, it follows that once an insuring clause is triggered, the insurer has the burden of showing a carve out applies because (1) the carve out removes coverage and (2) the insurer has the burden of showing a lack of coverage. Accordingly, following the California Supreme Court's reasoning in Aydin, the Court finds that—if this issue were to come before the California Supreme Court—it would hold insurers must bear the burden of showing an insuring clause's carve out excludes coverage after an insuring clause is triggered.

This interpretation is also bolstered by California case law holding that language in an insurance policy can be deemed an exclusion even if it is found outside the policy's "exclusions" section. Saltarelli v. Bob Baker Grp. Med. Trust, 35 F.3d 382, 385 (9th Cir. 1994) (language excluding coverage for pre-existing conditions was treated as an exclusion even though it was placed in the "definitions" chapter of an insurance policy); Fields v. Blue Shield of California, 163 Cal. App. 3d 570, 578 (1985) (holding a paragraph entitled "services not covered," which was "placed at the end of a series of granted coverage" and excluded coverage for psychoanalysis, was still treated as exclusion.) Ponder v. Blue Cross of S. California, 145 Cal. App. 3d 709, 722 (1983) (holding that exclusionary language placed in a paragraph labeled "dental care," which excluded coverage for dental care, was to be treated as an exclusion); Shepard v. CalFarm Life Ins. Co., 5 Cal. App. 4th 1067, 1076 (1992), modified (Apr. 30, 1992) (holding that a "transfer provision," which was placed under the heading "PLAN B MEDICARE SUPPLEMENT" and terminated coverage when the insured qualified for Medicare, was to be treated as an exclusion). Hence, even though the Policy's carve outs are listed under the definition of Damages, and not in the Policy's exclusions section, it is clear they operate to exclude certain occurrences from coverage. Thus, as the insurer bears the burden of "establish[ing] that a claim is specifically excluded," it makes sense to place the burden of showing the carve outs apply on Defendant.

This interpretation is also consistent with California Supreme Court precedent stating that exclusionary language must be conspicuously placed. Haynes v. Farmers Ins. Exch., 32 Cal. 4th 1198, 1211 (2004) ("Conspicuous placement of exclusionary language is only one of two rigid drafting rules required of insurers to exclude or limit coverage"); Avemco Ins. Co. v. Davenport, 140 F.3d 839, 842 (9th Cir. 1998) ("Exclusionary language that limits coverage under an insurance policy must be conspicuous and phrased in clear language"); E.M.M.I. Inc. v. Zurich Am. Ins. Co., 32 Cal. 4th 465, 471 (2004) ("The exclusionary clause "must be conspicuous, plain and clear"); Manzarek v. St. Paul Fire & Marine Ins. Co., 519 F.3d 1025, 1032 (9th Cir. 2008) ("An 'exclusionary clause must be conspicuous, plain and clear.' "). Whether exclusionary language is conspicuously placed is determined by whether it is "positioned in a place and printed in a form which would attract a reader's attention." Haynes, 32 Cal. 4th at 1207. One factor considered in making this determination is whether the language is placed under the heading "exclusions." Alterra Excess & Surplus Ins. Co. v. Snyder, 234 Cal. App. 4th 1390, 1404 (2015). If the Court were to hold insurers could shift their burden of "establish[ing] that a claim is specifically excluded" to insureds by placing exclusory language within a policy's definitions section, this would incentivize insurers to place exclusionary language in definitions

sections—instead of under separately labeled exclusions sections. This, however, would make the exclusionary language less conspicuous. Thus, holding Defendants can shift their burden of "establish[ing] that a claim is specifically excluded" to Plaintiff—by placing exclusionary language in the Policy's definitions section—would undermine the California Supreme Court's policy choice that exclusory language should be conspicuously placed under the heading "exclusions."

***11** Accordingly, the Court finds Defendants bear the burden of showing the insuring clause's carve outs exclude the Hospital's suit from coverage.

B. Does the Hospital Settlement Qualify as Damages Under the Policy?

The Policy states Defendants "will pay on [Plaintiff's] behalf Damages and Claim Expenses ... that you are legally obligated to pay as a result of a Claim for: (A) an act, error, or omission, or series of acts, errors, or omissions, committed or allegedly committed by you or on your behalf in the performance of a Managed Care Activity." (Doc. No. 67-4 at 127.) The parties agree the Hospital's suit constituted a Claim committed in the performance of a Managed Care Activity. (Doc. No. 67-4 at 69.) Thus, the Court need only determine whether the Hospital's suit constitutes Damages as defined by the Policy.

In California, the rules for insurance policy interpretation are clear. "The fundamental goal of contractual interpretation is to give effect to the mutual intention of the parties." Bank of the W. v. Superior Court, 2 Cal. 4th 1254, 1264 (1992). "If contractual language is clear and explicit, it governs." Id. "If the terms are ambiguous [i.e., susceptible of more than one reasonable interpretation], [courts] interpret them to protect 'the objectively reasonable expectations of the insured.' " Minkler v. Safeco Ins. Co. of Am., 49 Cal. 4th 315, 321 (2010). When determining if a term is ambiguous, "a contract must be interpreted as a whole, and in the circumstances of the case, and cannot be found to be ambiguous in the abstract." TRB Investments, Inc. v. Fireman's Fund Ins. Co., 40 Cal. 4th 19, 27 (2006). "[I]f these rules do not resolve a claimed ambiguity [courts] resort to the rule that ambiguities are to be resolved against the insurer." Boghos v. Certain Underwriters at Lloyd's of London, 36 Cal. 4th 495, 501 (2005). "The 'tie-breaker' rule of construction against the insurer stems from the recognition that the insurer generally drafted the policy and received premiums to provide the agreed protection." Minkler, 49 Cal. 4th at 321.

"Moreover, insurance coverage is 'interpreted broadly so as to afford the greatest possible protection to the insured, [whereas] ... exclusionary clauses are interpreted narrowly against the insurer.' " TRB Investments, Inc., 40 Cal. 4th at 27 (quoting Mackinnon, 31 Cal. 4th at 647–48). "The insured has the burden of establishing that a claim, unless specifically excluded, is within basic coverage, while the insurer has the burden of establishing that a specific exclusion applies." Minkler, 49 Cal. 4th at 322.

Here, the Policy defines damages as follows: "Damages means any settlements, judgments, ... or other amounts ... which you are legally obligated to pay as a result of a Claim." (Doc. No. 67-4 at 131–32.) As both parties agree Plaintiff settled the Hospital's claims, and the Damages definition undoubtedly covers settlements, Plaintiff has satisfied its burden of establishing the claim is "within basic coverage." Hence, as discussed above, the burden now shifts to Defendants to establish the Hospital settlement falls into one of the insuring clause's carve outs.

1. The Contract Carve Out

***12** The Contract Carve Out states Damages do not include "any amount any of you pay or may be obligated to pay under any contract or agreement, including but not limited to any policy, bond, benefit plan, or provider agreement." (Doc. No. 67-4 at 131–32.) Defendants argue this provision bars coverage of Plaintiff's claims because the settlement with the Hospital was based on claims the Hospital asserted for money owed under a "contract or agreement." (Doc. No. 67 at 19–20.) According to Defendant, this is because the only claims remaining at the time Plaintiff settled the underlying suit were (1) the Hospital's claim it was owed money as a third party beneficiary of the contract between Plaintiff and DHCS, which specified how medical service providers were to be paid and (2) the Hospital's claim it was owed money as a third party beneficiary of the contracts between Plaintiff, Care 1st, and CHP, which also specified how medical service providers were to be paid. (Id. at 20.) On the other hand, Plaintiff argues that even though the Hospital couched its claims in contractual terms, the crux of its claims was that Plaintiff violated 42 U.S.C. § 1396u-2(b)(2)(D) by not paying the Hospital's interim rate. (Doc. No. 69-1 at 21.) Accordingly, the nature of the Hospital's injury "was that [Plaintiff] ... violated a statute," not that Plaintiff breached a contract. (Id.)

In California, coverage of a claim under an insurance policy is "not based upon the fortuity of the form of action chosen by the injured party." Vandenberg v. Superior Court, 21 Cal. 4th 815, 838 (1999); John K.

DiMugno & Paul E.B. Glad, California Insurance Law Handbook § 44:31 (2017) ("The simple fact that a lawsuit against an insured seeks contract rather than tort damages does not, by itself, relieve the insured's liability insurer to provide coverage in the suit."). Indeed, "[p]redicating coverage upon an injured party's choice of remedy or the form of action sought is not the law of this state" because doing so would "permit the injured third party to determine insurance coverage." Vandenberg, 21 Cal. 4th at 840. Thus, to determine whether a claim is covered under an insurance policy, "courts must focus on the nature of the risk and the injury, in light of the policy provisions." Id.; Shade Foods, Inc. v. Innovative Prod. Sales & Mktg., Inc., 78 Cal. App. 4th 847, 870 (2000).

Here, it is clear the Hospital based its claims on Plaintiff's alleged violation of 42 U.S.C. § 1396u-2(b)(2)(D), which the Hospital alleged required Plaintiff to pay the Hospital's interim rate. (Doc. No. 67-4 at 38, 41, 44.) Although the Hospital chose to assert its claims via a third party beneficiary theory, it could have chosen to bring its claims in tort, an action under the Administrative Procedure Act, or any other theory that might impose liability for breach of the statute. Thus, the fact the Hospital asserted its claim via a third party beneficiary theory is not determinative of coverage. Instead, the "nature of the risk and the injury" all spring from § 1396u-2(b)(2)(D), which Plaintiff had an obligation to follow due to its status as a "Medicaid managed care entity." 42 U.S.C. § 1396u-2(b)(2)(D). Thus, a violation of § 1396u-2(b)(2)(D)—and not a breach of contract—is what the Hospital alleged was the cause of its injury.

Further, although the Hospital based its complaint on contracts Plaintiff had with DHCS, Care 1st, and CHP, these contracts were necessary to establish Plaintiff's ability to manage the Medicaid plans and become a "Medicaid managed care entity." As Defendants admit, Plaintiff "is a health care service plan, created and funded by the State of California to provide low-income plan members access to medical care." (Doc. No. 9 at 27.) Thus, Plaintiff's only business purpose is to provide public health care pursuant to its contracts with state agencies. If the Court were to hold the Hospital's claims were barred because the "nature of the risk and the injury" originate from Plaintiff's contracts with DHCS, a state agency, this would effectively bar all coverage under the Policy because all Plaintiff's business is conducted pursuant to contracts with state agencies. As Plaintiff must have contracted with Defendants for at least some degree of coverage, this interpretation would not comport with "the objectively reasonable expectations of the insured." Minkler, 49 Cal. 4th at 321.

***13** Accordingly, keeping in mind the principle that "insurance coverage is 'interpreted broadly so as to afford the greatest possible protection to the insured, [and] ... exclusionary clauses are interpreted narrowly against the insurer," the Court finds the Contract Carve Out does not bar coverage for the Hospital's claims. TRB Investments, Inc., 40 Cal. 4th at 27 (quoting Mackinnon, 31 Cal. 4th at 647–48).

2. The Fine Carve Out

Defendants argue the Fine Carve Out bars coverage for the Hospital's claims against Plaintiff because the Hospital's claims are for "amount[s] imposed by statute." (Doc. No. 67 at 20.) On the other hand, Plaintiff argues the Fine Carve Out does not bar coverage because the Fine Carve Out "is limited by its own terms to Damages arising out of a Claim for Antitrust Activity." (Doc. No. 71 at 23.)

Here, the Fine Carve Out states Damages do not include:

> any fine, penalty, forfeiture, sanction, tax, fee, liquidated damages, or amount imposed by statute, rule, regulation, or other law; provided that Damages will include fines or penalties which you are legally obligated to pay as a result of a Claim for Antitrust Activity if such fine or penalty is insurable under the Law Most Favorable to Insurability;

(Doc. No. 67-4 at 131.)

Plaintiff admits the "nature of the risk and the injury" alleged in the Hospital's complaint was "that [Plaintiff] ... violated a statute." (Doc. No. 71 at 20.) Further, as discussed above, the Court has found the Hospital alleged a violation of § 1396u-2(b)(2)(D) by asserting § 1396u-2(b)(2)(D) imposed a requirement on Plaintiff to pay the Hospital's interim rate. Thus, it is clear the Hospital's claims are included in the carve out's language excluding "amount[s] imposed by statute." Hence, whether the Fine Carve Out bars coverage depends on resolution of Plaintiff's contention that the carve out "is limited by its own terms to Damages arising out of a Claim for Antitrust Activity."

Here, the Court finds no indication in the Fine Carve Out's language that it is entirely limited to "Damages arising out of a Claim for Antitrust Activity." The first

clause of the Fine Carve Out states Damages do not include "any fine, penalty, forfeiture, sanction, tax, fee, liquidated damages, or amount imposed by statute, rule, regulation, or other law[.]" Then, there is a semicolon. The second clause of the carve out states, "provided that Damages will include fines or penalties which you are legally obligated to pay as a result of a Claim for Antitrust Activity if such fine or penalty is insurable under the Law Most Favorable to Insurability." Grammatically, the phrase "which you are legally obligated to pay as a result of a Claim for Antitrust Activity" acts as an appositive that adds information about the preceding nouns—"fines or penalties." Bryan A. Garner, The Redbook: a Manual on Legal Style 1.6 (3d ed. 2013). There is no indication that "Antitrust Activity" modifies any of the other nouns in the carve out.

Further, a semicolon separates the phrase "provided that Damages will include fines or penalties which you are legally obligated to pay as a result of a Claim for Antitrust Activity" from the phrase "amount imposed by statute." Semicolons are often used to (1) "separate independent clauses that are not joined by a conjunction"; (2) separate phrases joined by a coordinating conjunction "when one of the clauses contains an internal comma" and "another comma may not be strong enough to separate them"; (3) "separate independent clauses if the second clause begins with a conjunctive adverb or transitional expression rather than a conjunction"; or (4) "separate items in a series if any of the items contains an internal comma or if semi colons would make the sentence clearer." Id. 1.16–1.18. The exact function the carve out's semicolon serves is unclear, as it sets off a phrase preceded by "provided that," which is a subordinating conjunction, and subordinating conjunctions ordinarily do not require a semicolon. Nonetheless, the fact that a semicolon instead of a comma was used to separate the "Claim for Antitrust Activity" language from the phrase "amount imposed by statute" evinces an intent to disassociate the two phrases.

***14** Thus, despite Plaintiff's arguments, the carve out's first clause excludes "amount[s] imposed by statute" from the definition of Damages. The second clause then limits this language by adding back into coverage "fines or penalties which you are legally obligated to pay as a result of a Claim for Antitrust Activity." Indeed, the two clauses are separate, and the phrase "which you are legally obligated to pay as a result of a Claim for Antitrust Activity" modifies only the "fines or penalties" referenced in the second clause. Hence, contrary to Plaintiff's contentions, the carve out is not "limited by its own terms to Damages arising out of a Claim for Antitrust Activity." (Doc. No. 71 at 23.)

Accordingly, the carve out's "clear and explicit" language shows "amount[s] imposed by statute" are excluded from coverage, and thus the Hospital's claims for amounts imposed by § 1396u-2(b)(2)(D) are excluded from coverage. Hence, Defendants' Motion is GRANTED as to Plaintiff's indemnification claims. As Plaintiff has moved for summary judgment on the same claims, Plaintiff's Motion is DENIED as to these claims.

C. Claim Expenses

Defendants argue Plaintiff is not entitled to Claim Expenses because under the parties' agreed hourly rate, Plaintiff's attorneys' fees have not exceeded the Policy's $250,000 retention. (Doc. No. 67 at 22.) Plaintiff, on the other hand, argues its claim expenses did exceed the Policy's $250,000 retention, and thus Defendants are required to reimburse Plaintiff for the overage. (Doc. No. 69-1 at 16; Doc. No. 71 at 16.)

Plaintiff admits it agreed the parties would apply an hourly rate of $325 per hour towards the Policy's retention, even though Plaintiff's chosen counsel charged $500 per hour. (DSUF 26, 28.) Further, Plaintiff admits it was responsible for the $175 per hour difference. (Id.) Plaintiff also admits it paid its counsel a total of $261,140.50 in attorney's fees (at $500 per hour) and $7,673.33 in costs to defend against the Hospital's suit. (DSUF 31.)

Defendants have put forth evidence showing that, at most, Plaintiff's counsels' charges, when calculated at $325 per hour, total only $182,388.83, which is much less than the Policy's $250,000 retention. (Doc. No. 67-4 ¶ 18.) Plaintiff produced no evidence showing either (1) $325 per hour is not the correct rate to use when calculating attorneys' fees against the Policy's retention or (2) Plaintiff's counsel's charges, at $325 per hour, exceed the Policy's retention. Hence, the Court finds Defendants are not liable for Plaintiff's Claim Expenses because Plaintiff failed to show it exhausted the Policy's $250,000 retention. Accordingly, Defendants' Motion is GRANTED as to Plaintiff's Claim Expenses claim.

D. Bad Faith Claims

When a bad faith claim is brought against an insurer for failure to indemnify or defend, "California law is clear, that without a breach of the insurance contract, there can be no breach of the implied covenant of good faith and fair dealing." Manzarek v. St. Paul Fire & Marine Ins. Co., 519 F.3d 1025, 1034 (9th Cir. 2008) (citing Waller v. Truck Ins. Exch., Inc., 11 Cal. 4th 1 (1995)). When a bad

faith claim is brought based on an insurer's handling of a claim, however, California law is unclear on whether the claim can prevail in the absence of a breach of contract. Compare Carter v. Superior Court, 194 Cal. App. 3d 424, 428 (1987) ("Establishing the fault of third parties is not a prerequisite to ... the suit against her insurer. Petitioner's argument that in the resolution of the coverage issue her insurer acted in bad faith is not necessarily dependent—either in law or in fact—upon the entry of judgment in petitioner's action for or against the third parties") and Judah v. State Farm Fire & Cas. Co., 227 Cal. App. 3d 1133 (1990) ("the jury could have found State Farm guilty of improper claims handling practices which were independent of the coverage issue") with McMillin Scripps N. P'ship v. Royal Ins. Co., 19 Cal. App. 4th 12, 1222 (1993).

***15** Here, the evidence shows Plaintiff gave notice of the Hospital's lawsuit, through its broker Marsh McLennan Agency ("Marsh"), to Defendants on March 27, 2013. (Doc. No. 67-4 at 10.) On April 1, 2013, Defendants acknowledged receipt of the notice. (Id. at 16.) On April 17, 2013, Plaintiff, through Marsh, forwarded a copy of the Hospital's complaint in the underlying action. (Id. at 18.) On May 3, 2013, Defendants sent a letter to Plaintiff stating it would defend Plaintiff against the Hospital's suit, subject to a reservation of rights. (Id. at 68.) This letter also stated Defendants' preliminary opinion that the Hospital's underlying claims would not be covered by the policy because of the Damages' carve outs discussed above. (Id.) On September 28, 2013, Defendants followed up with Plaintiff, asking if an amended complaint had been filed by the Hospital, and Plaintiff forwarded a copy of the amended complaint. (Id. at 74–75.) On May 22, 2014, Plaintiff's counsel sent an email to Defendants regarding an upcoming mediation session. (Id. at 82.) Defendants replied, informing Plaintiff's counsel that the May 3, 2013 reservation of rights letter stated there would be no coverage under the Policy for the Hospital's claims. (Id.) On July 14, 2014, Defendants sent another letter to Plaintiff stating Defendants would provide defense costs in excess of the Policy's $250,000 retention and that the Hospital's claims were not covered under the Policy. (Id. at 86–89.) On August 21, 2014, Defendants sent an email to Plaintiff again stating Defendants would provide defense costs, but the Hospital's claims were not covered under the Policy. (Id. at 91–92.) On September 9, 2014, Defendants sent an email to Plaintiff stating that the remaining amount of retention was $104,061 and providing a simplified calculation showing how Defendants arrived at this amount. (Id. at 94–96.)

Plaintiff cites case law showing the above conduct may constitute bad faith had Plaintiff been entitled to coverage under the Policy. E.g. Haynes v. Farmers Ins. Exch., 32 Cal. 4th 1198, 1212 (2004); Fleming v. Safeco Ins. Co. of America, Inc., 160 Cal. App. 3d 31, 37 (1984); Silberg v. California Life Ins. Co., 11 Cal. 3d 452, 462 (1974); Villalpando v. Transguard Ins. Co. of Am., 17 F. Supp. 3d 969, 980 (N.D. Cal. 2014). Plaintiff, however, cites no law showing a bad faith action can survive summary judgment in view of the above facts and given that the Court has found there is no coverage under the Policy. Accordingly, without expressing an opinion on whether California law allows an insured to maintain a bad faith claim based on an insurer's improper handling of claims in the absence of coverage, the Court holds Plaintiff has not shown such a claim is viable given the above facts. Hence, the Court GRANTS Defendants' Motion as to Plaintiff's bad faith claims. Further, because Plaintiff has moved for summary judgment on the same claims, Plaintiff's Motion is DENIED as to these claims.

E. Unfair Competition Claims

Defendants argue Plaintiff's unfair competition claims fail because Plaintiff has not produced evidence showing "Defendants publicly disseminated advertising that was untrue or misleading, which defendants knew, or in the reasonable exercise of care should have known, was untrue or misleading." (Doc. No. 67 at 25.) Plaintiff, on the other hand, argues its unfair competition claims survive because Defendants sold Plaintiff a policy that Defendants knew would not cover essentially any of Plaintiff's business operations. (Doc. No. 71 at 27–28.)

"California's unfair competition statute prohibits any unfair competition, which means 'any unlawful, unfair or fraudulent business act or practice.' " In re Pomona Valley Med. Grp., Inc., 476 F.3d 665, 674 (9th Cir. 2007). "An unlawful act is one 'forbidden by law, be it civil or criminal, federal, state, or municipal, statutory, regulatory, or court-made.' " Id. To bring a claim based on "unfair" business practices, "[a] plaintiff must be able to show that his claim is 'tethered' to an underlying law." Abbit v. ING USA Annuity, No. 13CV2310-GPC-WVG, 2015 WL 7272220, at *9 (S.D. Cal. Nov. 16, 2015) (citing Cel-Tech, 20 Cal. 4th at 186-87); Aleksick v. 7-Eleven, Inc., 205 Cal. App. 4th 1176, 1191 (2012). "[I]n order to state a cause of action based on a "fraudulent" business act or practice, [a] plaintiff must allege that consumers are likely to be deceived by the defendant's conduct." VP Racing Fuels, Inc. v. Gen. Petroleum Corp., 673 F. Supp. 2d 1073, 1087 (E.D. Cal. 2009); Yanting Zhang v. Superior Court, 57 Cal. 4th 364, 380, 304 P.3d 163, 174 (2013) ("Under the UCL, it is necessary only to show that the plaintiff was likely to be deceived, and suffered economic injury as a result of the deception.").

Under the "unfair" prong, an insured may maintain an unfair competition claim against an insurer if the insurer fails to disclose "impending amendments to the policies changing premiums and benefits, even before the plaintiffs purchased their policies." Pastoria v. Nationwide Ins., 112 Cal. App. 4th 1490, 1496 (2003); Iorio v. Allianz Life Ins. Co. of N. Am., No. 05CV633 JLS CAB, 2008 WL 8929013, at *16 (S.D. Cal. July 8, 2008). Such an action is unfair because it is contrary to section 332 of the California Insurance Code, which states "[e]ach party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining." Pastoria, 112 Cal. App. 4th at 1496; Cal. Ins. Code § 332.

***16** Here, Plaintiff has produced evidence showing Defendants knew claims by non-contracted providers, such as those made by the Hospital, were the types of claims Plaintiff regularly encountered. (Doc. No. 69-8 at 20.) Plaintiff also produced evidence showing (1) that the only claims it handles are "claims for payment by the contracted and non-contracted providers who provide medical services to L.A. Care's members" and that (2) Defendants should have known this prior to issuing the Policy. (Doc. No. 69-4 ¶ 4; Doc No. 69-20 at 8.) Further, as discussed above, Defendants sold Plaintiff insurance coverage which did not cover such claims.

Thus, the Court finds Plaintiff's evidence creates a material issue of fact as to whether Defendants failed to "communicate to [Plaintiff], in good faith, all facts within [Defendants'] knowledge which are or which [Defendants] believe [ed] to be material to the contract and as to which [Defendants] ma[de] no warranty, and which [Plaintiff] ha[d] not the means of ascertaining." Indeed, here Plaintiff presented sufficient facts showing Defendants knew the entirety of Plaintiff's business consisted of processing (1) claims by contracted health care providers and (2) claims by non-contracted providers, as Plaintiff is obligated to do so by statute. (Doc. No. 69-4 ¶ 4; Doc No. 69-20 at 8.) Further, Defendants adopted their "level 1 policy" in 2011, and thus Defendants knew that their "level 1 policy" did not cover (1) "any amount [Plaintiff] pay [s] or may be obligated to pay under any contract or agreement" or (2) "amount [s] imposed by statute." (Doc. No. 69-8; Doc. No. 67-4 at 131.) Accordingly, as the "level 1 policy" excludes claims arising from essentially the entirety of Plaintiff's business, this fact was material, and a reasonable trier of fact could find Defendants knew it was material. Also, as the "level 1 policy" was newly adopted in 2011, Plaintiff had no way of ascertaining that it excluded this coverage, and Defendants failed to communicate the exclusions in the Policy prior to selling Plaintiff the Policy. (Doc. No. 71-6 at 16, 19–21, 35.)

Thus, Plaintiff produced enough evidence for a reasonable factfinder to determine Defendants ran afoul of the requirements of section 332 of the California Insurance Code. As a violation of section 332 is enough to maintain an unfair competition claim under California law, Defendants' Motion is DENIED as to Plaintiff's unfair competition claim.

F. OneBeacon's Potential Liability

"Under [California unfair competition law], an individual may recover profits unfairly obtained to the extent that these profits represent monies given to the defendant or benefits in which the plaintiff has an ownership interest." Korea Supply Co. v. Lockheed Martin Corp., 29 Cal. 4th 1134, 1148, 63 P.3d 937, 947 (2003).

Here, Defendants argue Plaintiff cannot maintain its unfair competition claim against OneBeacon because OneBeacon "did not receive premiums from [Plaintiff]. ... Only Homeland did." (Doc. No 67 at 26.) Plaintiff, however, has produced Homeland's 2012 Annual Statement which shows that (1) Homeland is a wholly owned subsidiary of OneBeacon (Doc. No. 69-21 at 13); (2) Homeland and OneBeacon filed consolidated income tax returns (id.); and (3) OneBeacon and Homeland operate under common management (id. at 14). Accordingly, the Court finds Plaintiff has presented a genuine issue of material fact regarding whether OneBeacon received any profit due to Homeland's receipt of Plaintiff's insurance premium payments. Hence, Defendants' Motion is DENIED as to Plaintiff's unfair competition claims against OneBeacon.

V. CONCLUSION

***17** For the reasons stated above, Plaintiff's Motion is DENIED. Further, Defendants' Motion is GRANTED as to Plaintiff's indemnification, claim expenses, and bad faith claims. Defendants' Motion is DENIED as to Plaintiff's unfair competition law claims.

IT IS SO ORDERED.

All Citations

Slip Copy, 2017 WL 3579491

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