NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

LORENZA BELL, et al.,

Plaintiffs and Appellants,

v.

HUNTINGTON PROVIDER GROUP, et al.,

Defendants and Respondents.

B132438

(Super. Ct. No. BC193256)

APPEAL from an order of the Los Angeles Superior Court. Edward Ross, Judge. Affirmed in part and dismissed in part.

Coudert Brothers, and Glenn W. Trost and George K. Foster for Plaintiffs and Appellants.

Sedgwick, Detert, Moran & Arnold, and David Humiston, Hall R. Marston, and Robert C. Bohner for Defendants and Respondents Huntington Provider Group, Unihealth, Inc., Reginald Freisen, Bart Wald and Frederic McKay.

Foley & Lardner, and Jonathon E. Cohn and T. Joshua Ritz for Defendants and Respondents Caremark RX, Inc (formerly MedPartners, Inc.).

Plaintiffs and appellants—a large group of medical patients and their physicians—appeal from the order dismissing their third-amended complaint after the demurrers of the defendants and respondents—three medical service provider associations and some of their managing employees—were sustained without leave to amend. For the reasons set forth below, we dismiss in part and in all other respects affirm the order.

FACTS AND PROCEDURAL HISTORY

This action arises from the relationships between a group of healthcare plan enrollees and their physicians and from the relationships between those physicians and certain independent practice associations (IPAs)—entities who contract with the healthcare plans to provide medical services to the plans' enrollees. The operative third-amended complaint identifies three groups of plaintiffs: the patients (the Enrollees), the Group 1 Physicians, and the Group 2 Physicians. The Group 1 and Group 2 Physicians are collectively known as "the Physicians."[1]

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[1] The Enrollee plaintiffs are: Helen A. Boyd, Denise Cartright, Ann S. Euson, John H. Green, Edith Jackson, An Jungerhaus, Minta Lee, Edgar Lyons, Rebecca Nieblas, Rita Oliai, Donna Parra, Telesfor Picella, Carmel Rowles, Marie Steinbaugh, Shannon Tavasolian, Mary Torres, H. Dorothy Treanor, Nancy A. Whalen, and Maxine White. The Group 1 Physicians—all M.D.s unless otherwise indicated—are: Mir Ali, Taqui Ali, Nirmal Banskota, Sohan S. Bassi, Joseph Bornheimer, Dino Clarizio, Sheilah Clayton, Richard Cole, Rao V. Daluvoy, Richard Deatsch, John Easthope, W. Allan Edmiston, Richard Galich, John Gaw, Levon H. Gazarian, Richard B. Gilmore, Mauro Giordani, Michael Habib, Murray Kemp, Michael E. Klein, James Kulczycki, Elizabeth Lee, Michael Luu, Brian Machida, Paul Maher, Lewis H.V. May, Robert Mehler, Mark Myers, Michele M. Montllor, Lori Moore, Samir Mourani, Jay A. Noble, Donald Norquist, Robert Papadopoulus, Robert Peck, Robert Plancey, Thomas Powers, Charles Prickett, Kamalakar Rambhatla, Michael Soliman, Michael Stark, Joel Streng, Jon Tyrell, Karl H. Vogelbach, Bruce J. Weimer, Barbara Widmer, D.P.M., and George Williams. The Group 2 Physicians—all M.D.s —are: Ignacio Acosta, Plaridel Atil, Morris Baumgarten, Manmohan Kumar, I. Michael Minehart, Robert B. Morrison, Joe Oliver, John Oliver, Ali Sahebekhatiari, Norman Shrifter, Glenn Takei, Richard

The defendants and respondents include Huntington Provider Group, a medical group, Inc. (HPG), Unihealth, Inc. (Unihealth), of which HPG is a subsidiary, and MedPartners, Inc. (MedPartners).[2] Also named as defendants were respondents Reginald Freisen, Bart Wald, Frederic McKay, Sharon Olson, Michael Linn and Geoffrey Graham (the individual defendants). The individual defendants are identified as "managers" of, or as holding "high management positions" at, HPG and Unihealth.[3]

The third-amended complaint defines an IPA as an organization which contracts with various healthcare insurers (insurers) to provide medical services to the insurers' enrollees (the patients). In order to provide those services, the IPAs in turn contract with various physicians to actually render medical care to the enrollees. The insurers typically prepay the IPAs a fixed monthly amount per enrollee.

When deciding which healthcare plan to choose, prospective enrollees are typically given a book from the IPA identifying the physicians who are part of the IPA and whose fees are therefore covered by the insurers. Thus, appellants allege, the Enrollees may see a doctor of their choice. HPG is an IPA. MedPartners operates an IPA known as Mullikin. Both distribute books listing their participating physicians to potential healthcare plan enrollees.

Vanis, John White, Greg Withers, and Kenneth York. We will sometimes refer to the Enrollees and the Physicians collectively as "appellants."

[2] Medpartners is now known as Caremark Rx, Inc.

[3] Two days after oral argument, the parties submitted a stipulation by which some appellants dismissed their appeal as to some respondents. Pursuant to that stipulation, appellants Dr. Kamalakar Rambhatla, Dr. Bruce Weimer, Dr. Barbara Widmer, Edith Jackson, Minta Lee, Edgar Lyons, Telesfor Picella and Marie Steinbaugh dismiss their appeal as to only respondents HPG, Unihealth, Friesen, Wald and McKay. As between those parties only, they will each bear their own costs on appeal.

The Physicians had contracts with HPG or Mullikin by which the Physicians would accept a specified payment in full for the services they provided (fee-for-services agreement). Appellants have not, however, alleged any breach of those agreements and have not set forth any terms from their contracts with HPG and Mullikin. Each Physician had a substantial medical practice with numerous patients who periodically needed medical treatment, many on a continuing or repeat basis. Such patients make up the core of the Physicians' practices.

The crux of the third-amended complaint is the allegation that respondents are steering the Enrollees and other patients away from the Physicians by rejecting requests from the enrollees or referrals by their other physicians (the referring doctors) for treatment by the Physicians. Instead, respondents will, by policy, plan or practice, authorize treatment by other physicians (the Preferred Physicians) who belong to the IPA but are paid under so-called capitation agreements rather than the fee-for-service agreements which apply to the Physicians. Capitation agreements reimburse the preferred Physicians based on the number of insureds and therefore result in a substantial savings to the IPAs.

Because the Enrollees have in effect been "captured" by their healthcare plans, respondents have felt free to unilaterally reduce the Physicians' fees, delay payments, terminate the Physicians' contracts, or otherwise retaliate against the Physicians who oppose this practice.[4]

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[4] The third-amended complaint includes a section of background allegations titled "THE UNFAIR BUSINESS PRACTICES," which sets forth 47 examples where the Enrollees and various non-party patients were allegedly directed away from the Physicians. The non-parties are identified by only their first names and last initials. Only two of the 47 examples relate to Medpartners—numbers 32 and 45—and the rest relate to HPG. All but three of the 47 examples simply state that an enrollee was denied access to a specified Physician without amplification of the surrounding circumstances. Three examples specify certain alleged misconduct separate and apart from the act of directing the enrollee to another doctor. Because we affirm on grounds unrelated to these allegations, we will not address them further.

The third-amended complaint goes on to allege four causes of action based on this conduct: (1) intentional interference with prospective economic advantage; (2) negligent interference with prospective economic advantage; (3) violations of the Cartwright Act's antitrust provisions (Bus. & Prof. Code, § 16720); and (4) violations of the Unfair Practices Act. (Bus. & Prof. Code, § 17200.)

The action was originally filed in the superior court on June 25, 1998, but was removed to the United States District Court on July 24, 1998, on the ground that state court jurisdiction was preempted under the federal Employee Retirement Income Security Act of 1974. (29 U.S.C. § 1001, et seq., "ERISA".) A first-amended complaint was then filed in federal court. On October 14, 1998, the district court remanded the action to the state court after finding that the complaint did not encroach on the federal court's jurisdiction under ERISA.

Upon remand to the superior court, the parties stipulated that appellants could file a second amended complaint to rectify certain pleading deficiencies in the first-amended complaint. The second-amended complaint included the same four causes of action at issue here, along with a cause of action for violation of Business and Professions Code section 2056, which prohibits retaliation against physicians for advocating on their patients' behalfs. On January 1, 1999, the court sustained without leave to amend demurrers to the cause of action under Business and Professions Code section 2056. Demurrers to the other four causes of action were sustained with leave to amend because the court felt the complaint was too unwieldy given the number of parties and their disparate relationships and because it failed to adequately advise respondents why they were being sued.

The third-amended complaint was filed February 2, 1999. Demurrers were brought on two main grounds—the allegations were still hopelessly vague and, regardless of those deficiencies, appellants still failed to plead certain essential elements of their causes of action. The demurrers were sustained without leave to amend on April 9, 1999. The court's minute order states that appellants failed to

correct the earlier pleading deficiencies. Despite the attempt to plead specific instances of misconduct, the allegations did not link up in a logical manner and, at bottom, were conclusionary, the court ruled.[5] Respondents' subsequent motion to dismiss was granted and a written order dismissing the third-amended complaint was signed by the court on May 14, 1999. This appeal followed.

STANDARD OF REVIEW

In reviewing a judgment of dismissal after a demurrer is sustained without leave to amend, we must assume the truth of all facts properly pleaded by the plaintiff-appellant. Regardless of the label attached to the cause of action, we must examine the complaint's factual allegations to determine whether they state a cause of action on any available legal theory. Reversible error is committed if the facts alleged show entitlement to relief under any possible legal theory. (*Cochran* v. *Cochran* (1997) 56 Cal.App.4th 1115, 1119-1120.) The plaintiff-appellant bears the burden of showing how the complaint might be amended to state a viable cause of action. (*Hendy* v. *Losse* (1991) 54 Cal.3d 723, 742.) We will affirm an order sustaining a demurrer which is correct on any applicable theory. (*Kennedy* v. *Baxter Healthcare Corp.* (1996) 43 Cal.App.4th 799, 808.)

We will not, however, assume the truth of contentions, deductions or conclusions of fact or law and may disregard allegations that are contrary to the law or to a fact of which judicial notice may be taken. When a ground for objection to a complaint, such as the statute of limitations, appears on its face or from matters of which the court may or must take judicial notice, a demurrer on that ground is proper. (Code Civ. Proc., § 430.30, subd. (a); *Cochran* v. *Cochran*, *supra*, 56

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[5] Despite the wording of the minute order, appellants attack the trial court's ruling in part because of comments made about how the IPAs used a "state mandated" gatekeeper procedure, rendering the complaint nonjusticiable. In any event, we review the court's ruling, not its rationale. (*Orange Unified School Dist.* v. *Rancho Santiago Community College Dist.* (1997) 54 Cal.App.4th 750, 757.)

Cal.App.4th at p. 1120.) We may take judicial notice of the records of a California court. (Evid. Code, § 452, subd. (d).) We must take judicial notice of the decisional and statutory law of California and the United States. (Evid. Code, § 451, subd. (a).)

DISCUSSION

1. Interference With Economic Relations

The first and second causes of action are for, respectively, intentional and negligent interference with prospective economic relations. Both are based on the same conduct[6] and both suffer from the same pleading deficiency—a failure to plead facts showing it was reasonably probable the Physicians' lost economic advantage would have been realized but for respondents' alleged interference. (*Youst* v. *Longo* (1987) 43 Cal.3d 64, 71 [holding this to be a threshold causation requirement].)

The interference claims allege that respondents interfered with the Physicians' prospective economic advantage in two ways—by disrupting the relationships between the Enrollees and the Physicians and by disrupting the relationships between the Physicians and the referring doctors. Respondents allegedly accomplished this in part by lying to the Enrollees or the referring doctors about the Physicians' qualifications or their status as approved providers.[7]

Although appellants have gone into great detail about the nature of the relationships between the Physicians and the Patients, including the role played by

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[6] The captions to both causes of action identify the following parties: Dr. Fisher as against MedPartners, The Group 1 Physicians against all defendants, and the Group 2 Physicians against HPG, Unihealth and the Individual Defendants. Both causes of action incorporate all previous allegations. The negligent interference claim differs from the intentional interference claim only insofar as it makes allegations relating to respondents' duties of care and breaches of those duties.

[7] As with much of the third-amended complaint, this cause of action contains conclusionary statements concerning the importance of the physician-patient relationship, the need for a patient's freedom of choice in selecting a physician, and the serious damage which respondents' conduct has caused those relationships.

the referring doctors, nowhere have they expressly alleged that it was reasonably probable they would have been permitted to treat the Enrollees or any other patients either when requested by the Enrollees or upon a referral from a referring doctor.

Even if this were somehow implicit in the nature of the alleged ongoing relationships between the Physicians and the Enrollees, it is belied by one of Appellants' own allegations, found at paragraph 23 of the third-amended complaint. Because it is fatally dispositive of the economic interference causes of action, we set it forth in full: "Each of the plaintiff Patients (or those providing health coverage for them) voluntarily became 'enrollees' of HPG or Mullikin in order to take advantage of the promised ability to choose the doctors who would provide care to them and/or to members of their families. *So there is no ambiguity on this point, plaintiffs are not basing any claim herein on the particular terms of any patient's health insurance plan (whether provided by a private employer or otherwise). Nor do plaintiffs allege that the defendants' conduct alleged in this complaint involves a violation of any term of any such plan (whether provided by a private employer or otherwise). Instead, defendants' conduct is alleged to be actionable independently of whatever arrangements patients might have with their health insurers.*" (Italics added.)

In short, the Physicians are trying to isolate themselves from the terms of their patients/Enrollees' healthcare plans. As set forth below, they may not do so.

As we understand the relationships between the various parties, the Enrollees, who are patients of the Physicians, became insureds under certain unidentified healthcare plans, which contracted with the respondent IPAs to provide medical treatment. The IPAs, in turn, had contracted with the Physicians and other healthcare professionals to actually render the medical care. The Enrollees were already patients of some of the Physicians and enrolled in healthcare plans which listed the Physicians as providers covered under the plans.

The underlying weakness in the Physicians' economic interference claims is their unstated assumption that a patient's request or a referring doctor's referral will always be honored—in other words that once such a request or referral is made, it is reasonably probable the affected Physician will treat the patient and receive a fee for his services. To a large extent, however, the relationships between the Physicians, the Enrollees, the healthcare plans and the IPAs overlap and are interdependent. Healthcare plans as a rule do not offer their insureds an unlimited and unrestricted right to see a doctor of their choosing. If the terms of the Enrollees' healthcare plans contained such limitations and if the referral decisions at issue here were in accord with those terms, then it was not reasonably probable the Physicians would have realized their disputed economic advantage. This, we believe, is the import of paragraph 23 of the third-amended complaint.

In construing this allegation, we first judicially notice, as we must (Evid. Code, § 451, subd. (a)) several sections of the Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340, et seq. (the Knox Act).) The Knox Act regulates much of the relationship between healthcare insurers and their enrollees. Among its many provisions, the Knox Act requires full disclosure of a healthcare plan's terms to enrollees, including the terms relating to the ability to choose a healthcare provider:[8] "To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability which is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice." (Health & Saf. Code, § 1363, subd. (a)(8).) The disclosure must also include a description of any limitations on the patient's choice of primary care or specialty care physicians based on service area (Health & Saf. Code, § 1363, subd. (a)(12))

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[8] The Knox Act defines the term "provider" to mean, among others, any professional person licensed by the state to deliver or furnish healthcare services. (Health & Saf. Code, § 1345, subd. (i).)

and the general authorization requirements for referral by a primary care physician to a specialty care physician. (Health & Saf. Code, § 1363, subd. (a)(13).) Finally, every healthcare service plan "shall include within its disclosure form and within its evidence or certificate of coverage a statement clearly describing how participation in the plan may affect the choice of physician, hospital, or other health care providers . . . ." (Health & Saf. Code, § 1367.10, subd. (a).) "The plan shall clearly inform prospective enrollees that participation in the plan will affect the person's choice of provider" by stating in a conspicuous place on all required forms, "PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED." (Health & Saf. Code, § 1367.10, subd. (d).)

These provisions implicitly acknowledge that an insured's choice of treating physician will be limited to some extent by the terms of the plan and the insurers were legally obligated to fully advise the Enrollees of any such limitations. Thus, while appellants base their claims on the book or list of participating physicians which the IPAs distribute to potential healthcare plan enrollees (¶¶ 20-23), they may not so easily divorce that list from the terms and conditions of the Enrollees' healthcare plans.

When the Physicians state they allege no violation of the Enrollees' healthcare plan and that respondents' liability for economic interference is based on some independent source we infer from this that no violations of the healthcare plans occurred. (*Marshall* v. *Gibson, Dunn & Crutcher* (1995) 37 Cal.App.4th 1397, 1403 [we accept as true not only facts alleged but facts that may be inferred from those expressly alleged].) As set forth above, if the healthcare plans were not violated and the Enrollees were properly diverted to other doctors pursuant to the terms of their insurance coverage, then it was not reasonably probable the Physicians would have treated those patients on those occasions.

Further, the Physicians' allegations concerning misrepresentations by the IPAs are deficient. At paragraph 20, they allege that the Enrollees are "provided a list of the physicians whose fees the insurer has agreed to cover, which list (often called a 'provider network') is typically set forth in book form by the IPA with whom the insurer has contracted." At paragraph 22, the Physicians allege that "HPG and Mullikin publish books listing their participating physicians or 'provider networks,' which books are distributed to potential enrollees."

The third amended complaint contains no other description of the IPAs' provider lists, yet based on this, the Physicians allege in their introductory allegations that the IPAs made a "promise" of free patient choice. As a result, allegations that any such promises were made by the IPAs in their lists of participating physicians are mere conclusions, which we disregard.

Our reasoning is supplemented by a Blue Shield "65 Plus" list of HPG physicians which appellants submitted in opposition to the demurrers and offered at oral argument on appeal as examples of the IPAs' misrepresentations. Two of the Physicians—Kulczycki and Acosta—were included in a list of "Specialty Physicians" in an HPG provider directory. Kulczycki was listed as one of 10 physicians under the heading "Cardiology." Acosta was listed as one seven physicians under the heading "General Surgery" and as one of two physicians under the heading "Vascular Surgery." The list states, at the top of the first page, "Upon the recommendation of your Personal Physician *and Physicians Group* you will be referred, when medically necessary, *to one of the specialists listed below.*" (Italics added.) Nowhere does the list state that the patient has an unrestricted choice of specialist physicians. Instead, it states that the patient will be sent to one of the listed specialists upon the recommendation of not just the patient's personal physician but also upon the recommendation of the Physicians Group.

Appellants do not contend that other IPA lists are any different and in fact relied on this document as an example of the IPAs' alleged promises. We therefore

treat this document as a judicial admission of the nature of those representations. (*DeRose* v. *Carswell* (1987) 196 Cal.App.3d 1011, 1019.) Based on this, we hold that no promises of unrestricted patient choice were made.

2. Cartwright Act Antitrust Claim

The third cause of action is by the Physicians, asserting that respondents violated the Cartwright Act. (Bus. & Prof. Code, § 16700, et seq.)[9] Section 16720 defines a prohibited "trust" as acts by or two or more persons to carry out certain prohibited conduct. These include: restrictions on trade or commerce (§ 16720, subd. (a)); limiting or reducing the production, or increasing the price of merchandise or commodities (§ 16720, subd. (b)); preventing competition in making, selling, buying or transporting commodities (§ 16720, subd. (c)); and price fixing. (§ 16720, subd. (e).) The Cartwright Act is patterned after the federal Sherman Act and federal court decisions interpreting the federal antitrust statutes are applicable to the Cartwright Act. (*Roth* v. *Rhodes* (1994) 25 Cal.App.4th 530, 542.)

The Physicians allege that they are in competition with the Preferred Physicians, who also belong to the respondent IPAs. The Preferred Physicians have allegedly agreed, by way of conspiracy or coercion, to accept payment under capitation agreements. The Enrollees and other patients have also been coerced into using the Preferred Doctors. A prohibited combination may be shown by a conspiracy between willing parties or by coercion of unwilling parties. (*G.H.I.I.* v. *MTS, Inc.* (1983) 147 Cal.App.3d 256, 266-268.)[10] The alleged object of these combinations was to draw the Physicians' patients, including the Enrollees, into healthcare plans which used the respondent IPAs, then steer the patients to the

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[9] All further section references are to the Business and Professions Code unless otherwise specified.

[10] Respondents dispute the sufficiency of the allegations to show such a combination, but we need not reach that issue.

Preferred Physicians, with respondents and the Preferred Physicians enjoying "the economic rewards, available only to them, flowing from the elimination of competition . . . ." Although the Physicians have not expressly alleged which subdivision of section 16720 forms the basis of their Cartwright Act claim, we deduce from these allegations that they allege a restraint of trade under subdivision (a) and acts to prevent competition under subdivision (c).

Essential to this cause of action are allegations of antitrust injury—a somewhat amorphous term defined as the type of injury the antitrust laws were intended to prevent, and which flows from the defendants' unlawful conduct. (*Cellular Plus, Inc.* v. *Superior Court* (1993) 14 Cal.App.4th 1224, 1232, 1234-1235.) The antitrust laws are designed to protect the public and the immediate victims from a restraint of trade or monopolistic practice which has an anticompetitive effect on the market. (*Id.* at pp. 1232, 1235.) Respondents argue that the Physicians have failed to clear this hurdle because they have not alleged actions in restraint of trade. Instead, respondents contend there is nothing anticompetitive about their preference for dealing with doctors who charge less for their services than do the Physicians. We agree.

In *Cel-Tech Communications, Inc.* v. *Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163 (*Cel-Tech*), the court considered an action for unfair competition under the Unfair Practices Act (§ 17000, et seq.) brought by the sellers of cellular phones against a company that sold cellular phones below cost to gain subscribers for its cellular service. The plaintiffs alleged defendant violated section 17043 by selling below cost in order to injure competitors or destroy competition. The Supreme Court affirmed the appellate court's decision, ordering a remand and a new trial on the issue whether the defendants' status as a government-licensed duopolist in the cellular services and equipment markets posed an incipient threat to the antitrust laws.

In formulating a more precise test for determining what conduct was "unfair' under the unfair competition law, the court looked in part to the antitrust laws. Relying on decisions of the United States Supreme Court, the *Cel-Tech* court noted that the antitrust laws were enacted to protect competition, not competitors. (*Id.* at p. 186, citation omitted.) "They 'do not require the court to protect small businesses from the loss of profits due to continued competition, but only against the loss of profits from practices forbidden by the antitrust laws.' [Citations.] Injury to a competitor is not equivalent to injury to competition; only the latter is the proper focus of antitrust laws. [Citations.]" (*Ibid.*)

Because the case involved an action by one competitor against another alleging anticompetitive practices, the court evaluated the complaint in light of the antitrust laws. (*Cel-Tech, supra,* 20 Cal.4th at pp. 187, fn. 12, 189.) "Courts must be particularly cautious in evaluating claims that a competitor's prices are too low. Pricing practices are not unfair merely because a competitor may not be able to compete against them. Low prices often benefit consumers and may be the very essence of competition. 'Low prices benefit consumers regardless of how those prices are set, and so long as they are above predatory levels, they do not threaten competition.' [Citation.] Courts must not prohibit 'vigorous competition' nor 'render illegal any decision by a firm to cut prices in order to increase market share. The antitrust laws require no such perverse result, for '[i]t is in the interest of competition to permit dominant firms to engage in vigorous competition, including price competition.' [Citation.]" (*Id.* at p. 189.)

Evaluated against this backdrop, we hold that the Physicians have failed to allege the requisite antitrust injury. The Physicians allege they compete with the Preferred Physicians and that the respondents prefer the latter because their services are priced lower under the capitation agreements. This is the essence of competition—one competitor outdoing another by adopting a lower price structure. (*Cel-Tech, supra,* 20 Cal.4th at pp. 186, 189.) The Physicians thus allege nothing

more than their own loss of business, not an anticompetitive effect. (*Blaine* v. *Meineke Discount Muffler Shops, Inc.* (D. Conn. 1987) 670 F.Supp. 1107, 1112.) There is no allegation that the Physicians are unable to compete on this basis. Implicit in the pleadings is that they are unwilling to do so because they believe it compromises the quality of patient care. Even if that is the effect of capitation agreements, and even if respondents acted with evil intent or violated other laws, such is beyond the purview of the antitrust laws. (*Industrial Building Materials, Inc.* v. *Interchemical Corp.* (C.D. Cal. 1967) 278 F.Supp. 938, 959.)[11]

3. Unfair Competition Claim

Under section 17200, any unlawful, unfair or fraudulent business practice is deemed to be unfair competition. Because the statute is written in the disjunctive, liability may be based on any one of the three prongs independent of the others. (*Podolsky* v. *First Healthcare Corp.* (1996) 50 Cal.App.4th 632, 647.) Virtually any state, federal or local law can serve as the predicate for such an action. The independent "unfairness" prong is intentionally broad and involves an examination of the practice's impact on its victims, balanced against the reasons, justifications and motives of the alleged wrongdoer. The court must weigh the utility of the defendant's conduct against the harm caused. An unfair business practice occurs when the practice offends an established public policy or when the practice is immoral, unethical, oppressive, unscrupulous, or substantially injurious to consumers. (*Ibid.*) The fraud prong of section 17200 is not like common law fraud or deception. A violation can be shown even if no one was actually deceived or harmed and it is necessary to show only that members of the public are likely to be deceived. (*Id.* at pp. 647-648.)

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[11] We take no position one way or the other on the wisdom or desirability of capitation agreements but simply note in passing that the Legislature has specifically excluded them from a list of prohibited incentive plans which may not be offered to healthcare providers. (Health & Saf. Code, § 1348.6, subd. (b).)

The fourth cause of action under section 17200 is the only one involving the Enrollees, who have joined with the Physicians to allege a violation on all three bases: (1) the list of participating doctors which the IPAs distributed to potential enrollees was fraudulent because it was likely to deceive the general public about its freedom to choose a treating doctor; (2) the conduct alleged, including the allegedly false reasons given for denying the referrals to the Physicians, was unfair; and (3) it was unlawful because it violated the Cartwright Act and section 2056.

To the extent appellants base their fourth cause of action on alleged deceptions about a patient's right to choose, their claim is barred for the reasons set forth in our discussion on the economic interference claims. As noted there, the healthcare insurers were obligated to fully and accurately inform the Enrollees of any limitations on their rights to choose a doctor. Appellants have alleged no violations of the terms of those plans and instead allege that respondents' liability exists independent of those terms. Since we imply no violation of the healthcare plans, there must have been a full and accurate disclosure of the applicable limitations on choice. (*Shvarts* v. *Budget Group, Inc.* (2000) 81 Cal.App.4th 1153, 1159-1160 [rental car companies' full disclosure in rental agreements of refueling rates precluded suit for deception under § 17200].) Further, as previously discussed, the allegations of misrepresentations concerning patient choice in the IPAs' provider lists are deficient.

To the extent appellants base this cause of action on allegations that respondents sometimes lied to the Enrollees when diverting them to the Preferred Physicians, we disregard those allegations. A complaint must be read as a whole and its parts in their context. (*Hood* v. *Hacienda La Puente Unified School Dist.* (1998) 65 Cal.App.4th 435, 438.) Appellants allege that certain misstatements were sometimes made as the means by which respondents carried out their plan to divert the Enrollees to the Preferred Physicians. (¶¶ 38, 53.) It is the alleged plan which

lies at the heart of the complaint. If the plan is not actionable, then the means by which it was sometimes implemented are secondary and are also not actionable.

Appellants' unlawfulness claim also fails. First, we have held that no Cartwright Act violation occurred and the only remaining basis for such a claim is section 2056. That section was enacted "to provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients pursuant to" *Wickline* v. *State of California* (1986) 192 Cal.App.3d 1630 (hereafter *Wickline*). (§ 2056, subd. (a).)

That provision declares California's public policy that a doctor "be encouraged to advocate for medically appropriate healthcare for his or her patients. For purposes of this section, 'to advocate for medically appropriate health care' means to appeal a payor's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital, medical staff and governing body, or payer, or to protest a decision, policy or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients."

In order to construe this provision, we must first examine *Wickline*. The plaintiff in *Wickline* was a state Medi-Cal recipient. Her physician, daunted by the features of a Medi-Cal cost-cutting program which denied plaintiff an extended hospital stay, prematurely released the plaintiff from the hospital. As a result, she had a leg amputated and sued the state—a third party payor of her medical benefits—based on its implementation of the cost-containment program. The court reversed a judgment for the plaintiff, holding that even though the doctor may well have been intimidated by the state's procedures and his own subjective belief that his medical judgment could be overridden by the state, it was up to the doctor to

exercise his own medical judgment in determining whether to take steps to make sure his patient receives the proper care. (*Wickline, supra,* 192 Cal.App.3d at pp. 1645-1647.)

This case does not concern a refusal to render care—it involves a decision as to who will do so. Appellants have not alleged a denial of payment as was at issue in *Wickline*. Nor have they alleged that an appeal was taken pursuant to the respondent IPAs' grievance procedures. At bottom, their claim is premised on the Physicians' belief that doctors operating under a capitation agreement cannot provide the best medical care. Such an allegation is purely conclusory, premised upon the Physicians' own untested beliefs. That numerous other doctors believe otherwise means the allegation reflects a mere difference of opinion and does not invoke the applicable legal standard of care. Thus, appellants have not alleged a violation of section 2056.

DISPOSITION

As per the parties' stipulation, the appeal is dismissed by appellants Drs. Rambhatla, Weimer and Widmer and appellants Jackson, Lee, Lyons, Picella and Steinbaugh as to only respondents HPG, Unihealth, Friesen, Wald and McKay. As between those parties only, they will each bear their own costs on appeal. For the reasons set forth above, the order dismissing the third-amended complaint is affirmed. Respondents to recover their costs on appeal, in accord with the parties' stipulated dismissal. (See fn. 3, *ante*.)

NOT FOR PUBLICATION.

GODOY PEREZ, J.

I concur:

GRIGNON, J.

Turner, P.J.

I respectfully dissent from the determination to affirm the dismissal order as to the fourth cause of action for unfair business practices. (Bus. & Prof. Code, § 17200 et seq.) I believe there has been adequate pleading of fraudulent misconduct designed to cause the patients to enter into medical care agreements with defendants. The same is true of the physicians' allegations. (See *Cel-Tech Communications, Inc.* v. *Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 180; *Quelimane Co.* v. *Stewart Title Guaranty Co.* (1998) 19 Cal.4th 26, 42.) I am further convinced there is good cause to permit the belated filing of the proof of service which reflects the Attorney General has been served with the pertinent documents. (Bus. & Prof. Code, § 17209.) Otherwise, I fully concur in my colleagues' well stated and thoughtful assessments.

TURNER, P.J.