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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION EIGHT

RICHARD FEDER, Plaintiff and Appellant, v. BLUE CROSS OF CALIFORNIA, Defendant and Respondent.	B239534 (Los Angeles County Super. Ct. No. BC427943)

APPEAL from the judgment of the Superior Court of Los Angeles County. John Shepard Wiley, Jr., Judge. Affirmed.

Kiesel Boucher Larson, William L. Larson, Shehnaz Bhujwala; Herbert L. Greenberg for Plaintiff and Appellant.

Morgan, Lewis & Bockius, Brian M. Jazaeri, Molly M. Lane, and Thomas M. Peterson for Defendant and Respondent.

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Plaintiff and appellant Richard Feder appeals from the entry of summary judgment in favor of defendant and respondent Blue Cross of California, doing business as Anthem Blue Cross (Blue Cross). For approximately two years, plaintiff was a subscriber to an individual health insurance plan with Blue Cross. Plaintiff contends Blue Cross violated Health and Safety Code sections 1399.805, 1399.811 and 1399.815 by charging him premiums that exceeded the statutory rate limitations for his type of individual policy. Plaintiff filed suit, on behalf of himself and a putative class, stating claims for unlawful business practices under Business and Professions Code section 17200 et seq., and fraud by omission. The trial court granted Blue Cross's motion for summary judgment, essentially concluding there was no showing Blue Cross engaged in unlawful conduct. We conclude summary judgment was properly entered in favor of Blue Cross, and therefore affirm.

BACKGROUND

The parties submitted a significant amount of supporting and opposing evidence. However, resolution of this appeal turns largely on the legal question of the construction of the relevant statutes. We therefore summarize only those material facts pertinent to an understanding of the statutory issue, as well as additional facts for context, keeping in mind our standard of review and accepting plaintiff's evidence and Blue Cross's undisputed evidence as true. (*Raghavan v. Boeing Co*. (2005) 133 Cal.App.4th 1120, 1125.)

1. General Background Law

We begin with a brief summary of the pertinent federal and state statutes regarding health insurance which provide a framework for understanding the factual issues. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). (Pub. L. 104-191, 110 Stat. 1936, codified in part at 42 U.S.C. § 300gg et seq.) As relevant here, HIPAA requires health care service plans that offer individual policies to guarantee availability of health care coverage (sometimes referred to as "guaranteed issue products") to certain defined eligible individuals following exhaustion

of their COBRA[1] benefits. HIPAA allows states to enforce the federal mandate or enact and enforce an "acceptable alternate mechanism" that provides comparable coverage in accordance with HIPPA. (See 42 U.S.C. § 300gg-44.)

The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) at Health and Safety Code section 1340 et seq.[2] is a " 'comprehensive system of licensing and regulation' " covering the operation of health care service plans in California. (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 504.) Under the Knox-Keene Act, health care service plans operating in California, like Blue Cross, fall under the jurisdiction of the California Department of Managed Health Care (Department). (See § 1341 [the Department "has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business"].)

In 2000, the Legislature passed Senate Bill No. 265, implementing an "acceptable alternative mechanism" within the meaning of HIPAA to ensure California's compliance with the federal mandate. The bill amended the Knox-Keene Act and became effective January 1, 2001 (codified in part at §§ 1366.35, 1399.801 et seq.). Sections 1399.805 and 1399.811 include premium rate limitations for HIPPA products in California, and also limit the rate of annual increases for such premiums. Section 1399.815 requires participating health care service plans to file an annual statement with the Department certifying that their rates for HIPAA products comply with sections 1399.805 and 1399.811.

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[1] COBRA is an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. (See 29 U.S.C. § 1161 et seq.) COBRA gives eligible individuals, who lose coverage under a group plan, the option of paying premiums to maintain coverage for a limited period of time. California subsequently enacted the California Continuation Benefits Replacement Act or "Cal-COBRA" (Health & Saf. Code, § 1366.20 et seq.) to provide temporary continuation coverage for individuals who are not eligible for federal COBRA benefits.

[2] All further undesignated statutory references are to the Health and Safety Code unless otherwise indicated.

The key provision at issue here is the rate limitation set forth in sections 1399.805 and 1399.811 which provides that any premium for a HIPPA guaranteed issue PPO[3] plan shall not exceed the "average premium paid" by subscribers in the Major Risk Medical Insurance Program (MRMIP) of the same age and living in the same geographic region as the applicant for the HIPPA policy. (§§ 1399.805, subd. (a)(1)(A), 1399.811, subd. (a)(1).)

The MRMIP is California's state-sponsored program, established in 1990, providing subsidized health insurance to Californians who are unable to obtain coverage in the individual health insurance market due to preexisting conditions. (Ins. Code, § 12700 et seq.) The Managed Risk Medical Insurance Board (Board), appointed by the governor, administers the MRMIP. (Ins. Code, §§ 12710, 12710.1.) For purposes of establishing subscriber rates for the MRMIP, the Board adopted a regulation dividing the state into six geographic regions and 12 age groups, ranging from "[u]nder 15 years of age" to "75 years of age and over." (Cal. Code Regs, tit. 10, § 2698.400.) Under the MRMIP, a limited number of eligible high-risk subscribers are covered by participating health plans, with the subscribers paying a portion of the premiums, and the balance subsidized by state funds.

2. Facts

Following enactment of sections 1399.805 and 1399.811, the Board reviewed the premiums paid by subscribers of the MRMIP throughout the state. The Board collected the data concerning the premiums paid by MRMIP subscribers and, according to its interpretation of the statutory language, calculated the "average premium paid" using its age and geography categories in a weighted average formula. Starting in 2001, the Board prepared annual schedules reflecting these calculations and forwarded them to the Department's Division of Licensing. There was some dispute as to if, and when, the calculations for years 2003, 2004 and 2005 were transmitted to the Department.

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[3] PPO means preferred provider organization, as distinguished from an HMO, or health maintenance organization. The statutes cover HIPPA HMO products as well, but only the PPO language is pertinent to this appeal.

The Board's annual calculations were not routinely made public or forwarded as a matter of course to any health care service plans. However, if a plan requested copies of the rate calculations or "premium schedules," the Board would provide copies. Before January 2010, the Board had no written agreement with the Department to provide such data or to calculate the "average premium paid." The Board simply sent the information voluntarily to the Department.

Blue Cross is a health care service plan operating in California, regulated by the Department. Blue Cross participates in the individual health insurance market and is therefore required to make HIPAA guaranteed issue products available to individual subscribers who meet the HIPAA eligibility requirements. (See § 1399.801, subd. (c) ["federally eligible defined individual" means someone with 18 months of prior coverage with certain enumerated types of group plans, not presently able to qualify for group coverage, Medicare or Medi-Cal or other health insurance, not terminated from prior coverage due to fraud or nonpayment, and who has exhausted all COBRA or Cal-COBRA coverage].)

In addition, pursuant to an administrative contract with the state, Blue Cross is the administrator of the MRMIP program, reviewing applications and connecting applicants with health care service plans providing state-subsidized MRMIP coverage.

Blue Cross developed a weighted average formula for calculating the "average premium paid" by MRMIP subscribers. Blue Cross relied on actuaries to develop the formula, using standard actuarial principles. The actuaries obtained publicly available MRMIP premium rates for the following year from MRMIP, by contract type, age, bracket, area and plan. Blue Cross maintained in its own database of MRMIP enrollment data, which provided the number of subscribers in each age band and geographic area. From this information, Blue Cross determined each plan's market share by area. Using the market share by area as the weight for each rate cell, Blue Cross calculated an average rate for MRMIP plans for the upcoming year. Finally, Blue Cross set its HIPAA PPO premium rates not to increase by more than the average increase in the premiums charged to an MRMIP subscriber. There is no evidence suggesting Blue Cross used unreliable or unreasonable data or methods in developing its formula.

Plaintiff enrolled in one of Blue Cross's individual HIPAA PPO plans as of January 1, 2006, following expiration of his COBRA benefits. Plaintiff was a subscriber of the plan until February 2008 when, due to changed employment circumstances, he was able to join a group health insurance plan. In April 2009, plaintiff received a letter from Blue Cross advising him that it had determined errors had been made in its premium rates between the years "2006 through January 2009," and plaintiff had been overcharged. Shortly thereafter, Blue Cross mailed plaintiff a refund check in the amount of $663.71, which Blue Cross stated was for overpaid premiums of $559 on his individual HIPAA plan, plus 10 percent interest in the amount of $104.71.

In 2009, the Department, which regulates Blue Cross, brought an enforcement action against Blue Cross (as well as another health plan not a party to this appeal) to investigate allegations of noncompliance with the premium rate limitations for HIPAA products. The Department conducted an investigation and resolved the enforcement action against Blue Cross by way of a letter agreement. The Department made no public finding that Blue Cross violated the statutory rate limitations for HIPAA guaranteed issue PPO products contained in sections 1399.805 and 1399.811. The Department found only that Blue Cross had filed, but had failed to certify in accordance with section 1399.815, that its rates during the years 2005 through 2008 were in compliance with the statutory scheme. The Department imposed a $25,000 penalty, which Blue Cross paid pursuant to the agreement, resolving the enforcement action.

The Department's enforcement counsel testified that, during the investigation of Blue Cross, the Department was unable to definitively determine the statutory rate limitation because the statute does not provide any formula or method for calculating the "average premium paid" by MRMIP subscribers. Recognizing that "[t]he phrase 'average premium' has been interpreted differently by regulators, as well as regulated entities, over the past several years," the Department took the position that legislation was needed to provide a clear and consistent method to calculate the "average premium paid" for HIPAA PPO products.

The Department, relying on an actuarial consultant, developed a methodology based on its interpretation of what the statutes required and cooperated in drafting

proposed language for an amendment to sections 1399.805 and 1399.811 (Assem. Bill No. 718) which would incorporate its methodology. At no time did the Department adopt the Board's rate calculations as its own or recommend the Board's rate methodology be adopted by the Legislature.

The Department's methodology uses a single weight factor based on the MRMIP geographic regions, and also factors in MRMIP subscriber numbers, health care service plan market share, and age and dependency categories. The Department's methodology is substantially similar to the weighted average formula Blue Cross had been using as a benchmark for setting its rates on its HIPAA PPO products up through 2009.

As part of the resolution of the enforcement action, the Department ordered Blue Cross to use the new methodology to calculate the "average premium paid" in connection with setting its rates for all existing and future HIPAA guaranteed issue PPO products "unless the Department approves another rate methodology, or unless superseded by law." In early 2010, the Department and the Board executed an interagency agreement whereby the Board agreed to calculate, for the Department, the "average premium paid" by subscribers in the MRMIP, by age, area of residency, and family size (number of dependents) on an annual basis, using the weighted average formula developed by the Department during its investigation of Blue Cross.

Assembly Bill No. 718 was eventually withdrawn and not enacted into law. There is no evidence the Department has formally promulgated any regulation interpreting the statutory language or adopting its methodology, or any other methodology, for calculating the "average premium paid."

3. Procedural Background

Plaintiff filed suit against Blue Cross, stating a claim under Business and Professions Code section 17200 et seq. (Unfair Competition Law or UCL) for unfair business practices (charging rates in excess of the statutory caps), and a claim for fraud by omission (failure to disclose statutory rate limitations and rates in excess of those limitations). Blue Cross moved for summary judgment. After extensive briefing and oral argument, the trial court granted Blue Cross's motion and entered judgment in its favor.

The court did not rule on the voluminous evidentiary objections submitted by the parties. This appeal followed.

DISCUSSION

Plaintiff contends the trial court erred in granting summary judgment to Blue Cross. "We independently review an order granting summary judgment. (*Aguilar v. Atlantlic Richfield Co*. (2001) 25 Cal.4th 826, 860.) We determine whether the court's ruling was correct, not its reasons or rationale. [Citation.] 'In practical effect, we assume the role of a trial court and apply the same rules and standards which govern a trial court's determination of a motion for summary judgment.' [Citation.] We review for abuse of discretion any evidentiary ruling made in connection with the motion." (*Shugart v. Regents of University of California* (2011) 199 Cal.App.4th 499, 504-505 (*Shugart*).)

Plaintiff's operative third amended complaint stated a claim under the UCL and a claim for fraud by omission. Plaintiff alleged that Blue Cross engaged in unlawful business practices by overcharging plaintiff premiums for a HIPAA guaranteed issue PPO plan in violation of the rate limitation set forth in sections 1399.805 and 1399.811. Plaintiff also alleged Blue Cross failed to disclose the rate limitation and fraudulently certified that its rates were lawful and compliant with the statutory scheme. Specifically, plaintiff alleged Blue Cross "knowingly employed rate calculation methodologies" that violated the statutory rate caps, including by using "area-wide" weighted averages "in violation of the statutory requirement to use weights for each separate age-range rate cell."

Blue Cross moved for summary judgment contending, in essence, that it had not engaged in any unlawful conduct. In opposing the motion, plaintiff argued Blue Cross failed to discharge its movant's burden, failed to submit admissible evidence warranting judgment as a matter of law, that the evidence was undisputed the Department adopted the Board's annual calculations of the "average premium paid" by MRMIP subscribers in order to set the maximum rate ceiling for HIPAA products, and that Blue Cross's rates

unequivocally exceeded those maximum rates in violation of the statutory scheme. Plaintiff reasserts those arguments here, none of which is availing.[4]

First, despite plaintiff's argument to the contrary, Blue Cross did not fail to discharge its movant's burden of proof. The gist of Blue Cross's motion was that plaintiff could not show its conduct was unlawful, an essential element of plaintiff's cause of action under the UCL. (See Bus. & Prof. Code, § 17200; *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co*. (1999) 20 Cal.4th 163, 180; *Klein v. Earth Elements, Inc*. (1997) 59 Cal.App. 4th 965, 968-969.) Under the summary judgment statute, a defendant has met its "burden of showing that a cause of action has no merit if that party has shown that one or more elements of the cause of action, even if not separately pleaded, cannot be established, or that there is a complete defense to that cause of action. Once the defendant or cross-defendant has met that burden, the burden shifts to the plaintiff or cross-complainant to show that a triable issue of one or more material facts exists as to that cause of action or a defense thereto." (Code Civ. Proc., § 437c, subd. (p)(2).)

The record establishes plaintiff cannot show the requisite unlawfulness as a matter of law, and that the bulk of the evidence presented by both parties, admissible or not, is simply not relevant or material to resolving the motion. As we explain below, these points doom both of plaintiff's causes of action, and summary judgment was therefore properly granted.

1. Construction of the Phrase "Average Premium Paid"

The determination whether defendant acted unlawfully, as alleged by plaintiff, depends largely on the purely legal issue of interpreting the phrase "average premium paid" in sections 1399.805 and 1399.811. As plaintiff concedes, it is not a question of how Blue Cross internally calculated its rates, but whether the premium rates it charged its HIPAA PPO subscribers violated applicable law. In other words, plaintiff's claims

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4 We do not address the balance of plaintiff's arguments (mostly focusing on the trial court's rationale) which we do not find dispositive. Our role is to determine whether, on the record presented, the ruling was correct, not the propriety of the trial court's rationale in so ruling. (*Shugart, supra*, 199 Cal.App.4th at pp. 504-505.)

fail unless it can be shown Blue Cross charged premiums in excess of the "average premium paid" within the meaning of the statutory scheme.

The rules of statutory construction are well-settled. "[W]e must look first to the words of the statute, 'because they generally provide the most reliable indicator of legislative intent.' [Citation.] If the statutory language is clear and unambiguous our inquiry ends. 'If there is no ambiguity in the language, we presume the Legislature meant what it said and the plain meaning of the statute governs.' [Citations.]" (*Murphy v. Kenneth Cole Productions, Inc*. (2007) 40 Cal.4th 1094, 1103 (*Murphy*).) Where the statutory language is ambiguous or " 'permits more than one reasonable interpretation, courts may consider other aids, such as the statute's purpose, legislative history, and public policy. [Citations.]' [Citations.]" (*Joyce v. Ford Motor Co.* (2011) 198 Cal.App.4th 1478, 1490 (*Joyce*); accord, *Murphy*, at p. 1103; *Metropolitan Water Dist. v. Imperial Irrigation Dist.* (2000) 80 Cal.App.4th 1403, 1424-1425 (*Metropolitan Water Dist.*).) "In reading statutes, we are mindful that words are to be given their plain and commonsense meaning." (*Murphy*,-at p. 1103.) Words and sentences are not to be viewed in isolation, but rather, " 'read in context, considering the nature and purpose of the statutory enactment.' [Citation.]" (*Torres v. Automobile Club of So. California* (1997) 15 Cal.4th 771, 777.)

Sections 1399.805 and 1399.811 are lengthy provisions, both of which contain the same premium rate limitation language. We set forth the statutes in their entirety to show the context in which the rate limitation language is used, highlighting the key language in italics.

Section 1399.805 provides:

> "(a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. *In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:*
>
> "(A) *For health care service plan contracts that offer services through a preferred provider arrangement, the average premium paid by a*

subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

"(B) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

"(2) *A plan may adjust the premium based on family size, not to exceed the following amounts:*

"(A) *For health care service plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual*.

"(B) For health care service plans identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

"(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

"(c) During the first 30 days after the effective date of the plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no

later than the first day of the following month. If an enrolled individual notified the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification." (Italics added.)

Section 1399.811 provides:

"Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2001, shall be subject to the following requirements:

"(a) *The premium for new business for a federally eligible defined individual shall not exceed the following amounts:*

"(1) *For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.* However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

"(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

"(b) *The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:*

"(1) *For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual*. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

"(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

"(c) *The premium applied to a federally eligible defined individual may not increase by more than the following amounts:*

"(1) *For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual*.

"(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

"(3) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract." (Italics added.)

Nowhere in this detailed statutory scheme is the phrase "average premium paid" defined, nor is there any language setting forth a methodology for how the average MRMIP premium should be calculated. The statute does not require or suggest that the Board should determine how the average MRMIP premiums be calculated.[5] Because the

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[5] Plaintiff concedes the Board is not the relevant regulatory agency, and that his position has never been that the Board's interpretation of the statute, on its own, is determinative of the issue.

phrase was not given an express technical or special definition, we look to the plain and ordinary meaning of the words used. "To determine the plain meaning of statutory language, courts often look to dictionaries." (*Joyce*, *supra*, 198 Cal.App.4th at p. 1491; see also *People ex rel. Lungren v. Superior Court* (1996) 14 Cal.4th 294, 302-303.)

Webster's Third New International Dictionary identifies multiple related meanings for the word "average," including "equaling an arithmetic mean . . . approximating or resembling an arithmetic mean specif[ically] in being about midway between extremes: not out of the ordinary for members of the group under consideration. . . ." (Webster's Third New Internat. Dict. (2002) p. 150, col. 3.) Black's Law Dictionary defines "average" as "[a] single value that represents the midpoint of a broad sample of subjects; esp., in mathematics, the mean of a series." (Black's Law Dict. (9th ed. 2009) p. 155, col. 2.)

Similarly the word "mean," a synonym for average, has been described as ambiguous and susceptible to multiple reasonable definitions. " 'There are many means defined in Mathematics. Among the most commonly used means are the arithmetic mean (also known as the arithmetic average), the weighted mean (also known as the weighted average), the geometric mean, and the harmonic mean. The appropriateness of a particular mean as a statistical tool depends upon its purpose.' " (*Garfield Medical Center v. Belshe* (1998) 68 Cal.App.4th 798, 807 (*Garfield Medical Center*).)

In sum, the word "average" in its ordinary and customary usage is inherently ambiguous. An "average" may be calculated in a number of ways. The propriety of using any particular method for arriving at an "average" is dependent on the context. Nothing about the context in which the statutory phrase "average premium paid" is used in sections 1399.805 and 1399.811 indicates what method for arriving at an "average" was intended. For instance, there is no indication whether a straight or weighted average was intended, nor any basis for finding that the Legislature believed either type of averaging was more reasonable than the other in this context, or more likely to effectuate the policies behind the statutory scheme. There is also no indication how the age and geography qualifiers set forth in the statute are to be factored into the calculation. Moreover, looking at the full text of both statutory provisions and construing the phrase

in that greater context provides no guidance on what was intended. Therefore, the statutory phrase is ambiguous on its face. " 'Ambiguity exists if reasonable persons can find different meanings in a statute . . . .' " (*Garfield Medical Center, supra*, 68 Cal.App.4th at p. 806.)

Given the patent ambiguity of the statutory language, we may look to the legislative history. However, the legislative history here is not useful in illuminating the Legislature's intent. As originally introduced, Senate Bill No. 265 provided a rate cap that was based on a set percentage ("not . . . more than 110 percent or less than 90 percent") of the health care service plan's "applicable standard individual risk rate." The rate cap was subsequently amended to require that all HIPAA plan premiums not "exceed the overall average premium paid by Major Risk Medical Insurance Program subscribers." (Italics omitted.) The language was amended again and changed to require premiums not to exceed the "actual" premium paid by a MRMIP subscriber of a "similar" age and who resides in a "similar" geographic region as the HIPAA applicant. (Italics omitted.) The next version of the bill maintained the "actual" premium language but changed the age and residence qualifying factors to the "same" age group and geographic region. (Italics omitted.)

The final version of the bill returned to the "average" premium paid language for setting the rate limitation for HIPAA PPO products, and used an entirely separate standard based on a set percentage for HIPAA HMO products. However, none of the legislative history materials indicate the Legislature considered any specific methodology for arriving at the "average premium paid." For instance, there are no early versions of the bill using the word "straight" or "weighted" to modify average, with such terms then subsequently being deleted, or any similar modifications of the bill language evincing an intent to reject any methodology for calculating an average in favor of any other. It appears plain the Legislature sought to tie rate limitations for HIPAA products to MRMIP premiums, but beyond that, no intent to calculate the average in any particular manner appears in the legislative materials. We will not read an intent to use a particular means for arriving at the average that is not clearly supported by the legislative materials. (See *Campbell v. Regents of University of California* (2005) 35 Cal.4th 311, 331

[legislative history equivocal at best regarding intent to abrogate exhaustion of administrative remedies requirement and court could therefore not read intent into statute that history did not clearly support].)[6]

There is nothing in the statutory language or the legislative history that dictates the use of only one identifiable methodology for calculating the "average premium paid," or more specifically, nothing that dictates the use of the Board's methodology. It is not a question of the Board's pre-2010 weighted average methodology being reasonable or unreasonable, but the fact that the statutory language cannot be read as requiring only that methodology. Therefore, reference to the statutory language alone fails to raise a triable issue that Blue Cross engaged in any unlawful conduct by using a different methodology than the Board for arriving at an average and setting its HIPAA PPO rates accordingly.

2. The Board's Pre-2010 Methodology for Calculating the "Average Premium Paid"

Plaintiff nonetheless contends Blue Cross's premium rates, which purportedly exceeded the Board's pre-2010 annual rate schedules, violated applicable law because the Department impliedly adopted the Board's annual rate schedules as an informal interpretative rule or regulation, and that informal rule is entitled to great deference. Plaintiff further contends the Department was not required to comply with the Administrative Procedure Act (APA) at Government Code section 11340 et seq. in adopting such a rule because it falls within one, or both, of two express exceptions to the APA: (1) the informal rule or regulation "embodies the only legally tenable interpretation of a provision of law" (*id*., § 11340.9, subd. (f)); or (2) the informal rule or regulation "establishes or fixes rates, prices, or tariffs" (*id.*, § 11340.9, subd. (g)). We disagree.

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6 To the extent argument is made that the bill's author, Senator Jackie Speier, may have initially intended a straight average to be employed, it is not germane as only those legislative materials that are indicative of the Legislature's collective intent in passing a measure may be considered. (*Metropolitan Water Dist., supra*, 80 Cal.App.4th at pp. 1425-1426.)

a. Summary of the APA framework

The purpose of the APA is to "establish basic minimum procedural requirements for the adoption, amendment, or repeal of administrative regulations." (Gov. Code, § 11346, subd. (a).) The procedural requirements embodied in the APA "promote the APA's goals of bureaucratic responsiveness and public engagement in agency rulemaking." (*Morning Star Co. v. State Bd. of Equalization* (2006) 38 Cal.4th 324, 333 (*Morning Star*).) The APA's provisions are "applicable to the exercise of any quasi-legislative power conferred by any statute." (Gov. Code, § 11346, subd. (a).)

Failure to comply with the APA renders the agency regulation void. (Gov. Code, § 11340.5, subd. (a); *Morning Star, supra*, 38 Cal.4th at p. 333; *Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 576 (*Tidewater Marine*).) The only exceptions are emergency regulations adopted in conformity with Government Code section 11346.1, or regulations that fit within one of the enumerated statutory exceptions to the APA set forth at Government Code section 11340.9.

Under the APA, the definition of "regulation" is broad: " ' "[R]egulation" means *every* rule, regulation, order, or *standard of general application* or the amendment, supplement, or revision of any rule, regulation, order, or standard *adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it*, or to govern its procedure.' (Gov. Code, § 11342.600 [italics added].) 'A regulation subject to the APA . . . has two principal identifying characteristics. [Citation.] First, the agency must intend its rule to apply generally, rather than in a specific case. . . . Second, the rule must "implement, interpret, or make specific the law enforced or administered by [the agency], or . . . govern [the agency's] procedure." [Citation.]' [Citation.]" (*Morning Star*, *supra*, 38 Cal.4th at pp. 333-334.)

A rule or guideline of general applicability in which an agency interprets a governing statute is deemed a "regulation" subject to the APA. "[A]bsent an express exception, *the APA applies to all generally applicable administrative interpretations of a statute*." (*Morning Star, supra,* 38 Cal.4th at p. 335, italics added.) And while a valid agency regulation is ordinarily accorded deference by a reviewing court (*Tidewater Marine*, *supra*, 14 Cal.4th at p. 568), a valid regulation embodying only an agency's

interpretation of a governing statute "commands a commensurably lesser degree of judicial deference." (*Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 11.)

b. Plaintiff's proffered evidence

It is undisputed the Department did not *formally* adopt an interpretative regulation pertaining to the phrase "average premium paid" in accordance with the APA. Rather, plaintiff contends he raised a triable issue that the Department *informally* adopted the Board's annual rate calculations as its own general interpretation of the phrase "average premium paid," thus defining the maximum rate ceiling for HIPAA PPO products.

Plaintiff's evidence in support of this contention is not strong, but construing the evidence and the reasonable inferences therefrom in the light most favorable to plaintiff, as we must, there is arguably sufficient evidence to raise a triable issue that the Department informally adopted the Board's interpretation of the statutory language as its own. For instance, the record contains competent deposition testimony from Board employees that the Board forwarded its annual rate calculations regarding the premiums paid by MRMIP subscribers to the Department for most of the years between 2001 and 2009. Plaintiff also cites deposition testimony of Department employees, within the division of licensing, acknowledging receipt of those annual rate calculations. Plaintiff further cites to the deposition testimony of Amal Abu-Rhama, the Department's senior enforcement counsel, that she was not aware of any other source of information about MRMIP subscriber rates other than the annual rate schedules supplied by the Board, and that the Board's premium data was confidential and not obtainable from any other source. Plaintiff also points to additional testimony of Ms. Abu-Rhama, as well as from Laura Rosenthal, chief counsel for the Board, regarding an informal agreement for the Board to forward such information to the Department.

Further, plaintiff cites to various pieces of email correspondence from 2009 between Board employees, one Department employee and another health plan that is not a party to this appeal. Assuming for the sake of argument that these hearsay documents are admissible over Blue Cross's objection, they show that the Board and one Department

employee, in 2009, provided some annual rate calculations to a separate entity (not Blue Cross) pursuant to that party's specific request for the relevant rate calculations.

However, the record contains no material evidence the Department ever publicly represented or told its licensees, like Blue Cross, that the Board's annual rate calculations established the maximum rates for HIPAA guaranteed issue PPO products. Indeed, the only evidence on this point shows that the Department, as of 2009, brought only two enforcement actions regarding alleged noncompliance with the rate limitations. And, in the action against Blue Cross, the Department took the position that the "average premium paid" could not be fairly and reasonably determined, and at no time during that proceeding asserted the Board's rate calculations as its own.

The question then becomes whether the potential triable issue as to the Department's informal adoption of the Board's rate calculations warrants reversal of the summary judgment. As we explain, it does not.

c. The exceptions to the APA

Accepting as true plaintiff's contention that the Department informally adopted the Board's rate calculations, such an informal interpretative rule would trigger the APA. An informal rule purportedly clarifying the definition of "average premium paid" and setting a maximum rate ceiling for all HIPAA PPO products offered by all health plans operating in California would constitute a rule of general applicability meant to interpret or make specific the law enforced by the Department. (*Morning Star, supra,* 38 Cal.4th at pp. 333-334.) Therefore, the informal rule would necessarily be void for failure to comply with the APA, absent a showing that one of the statutory exceptions to the APA applied.

We are not persuaded by plaintiff's argument invoking two of the exceptions to the APA. First, the sole "legally tenable" interpretation of law exception is narrowly construed. Our Supreme Court has explained the exception "applies only in situations where the law 'can reasonably be read only one way' [citation], such that the agency's actions or decisions in applying the law are essentially rote, ministerial, or otherwise patently compelled by, or repetitive of, the statute's plain language." (*Morning Star, supra,* 38 Cal.4th at pp. 336-337.) As we have already explained above, the statutory language at issue here is *not* plain, but ambiguous on its face. There is nothing in the

record supporting a determination that the Board's pre-2010 methodology for calculating the "average premium paid" by MRMIP subscribers is the only tenable interpretation of the statutory language.

The rate-setting exception, upon which plaintiff also relies, is equally unavailing. Like the sole legally tenable exception, the rate-setting exception is also ordinarily given a narrow construction. (See *California Assn. of Nursing Homes etc., Inc. v. Williams* (1970) 4 Cal.App.3d 800, 821.) It applies, as relevant here, only to exempt from the APA an agency regulation that "establishes or fixes rates." (Gov. Code, § 11340.9, subd. (g).)

The Department's informal rule, accepting plaintiff's evidence as true, provides a specific definition for the phrase "average premium paid" contained in sections 1399.805 and 1399.811, but plaintiff offered no evidence or argument demonstrating how this translates into a *rule establishing* premium rates. Indeed, under the Knox-Keene Act, the director of the Department is *precluded* from setting premium rates for health care service plans. (§ 1367, subd. (j) ["Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services."].) We are not persuaded by plaintiff's citation to *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216 and *Winzler & Kelly v. Department of Industrial Relations* (1981) 121 Cal.App.3d 120, neither of which concerns the regulatory authority of the Department over health care service plans but, instead, concern completely unrelated and dissimilar statutes and regulatory agencies.

Accordingly, plaintiff has not shown any exception to the APA applies, and therefore, even if he could establish that the Department informally adopted the Board's pre-2010 interpretation of "average premium paid," such a rule would constitute a void underground regulation. Plaintiff could not rely on it to attempt to establish the unlawfulness of Blue Cross's conduct.

d. Blue Cross's pre-enforcement action conduct

Plaintiff argues there may be a triable issue whether Blue Cross's conduct was unlawful because it had a duty to be in compliance with the statutory scheme. This is of course true, in principle. However, given the lack of clarity in the governing statutes as to what was required to be "in compliance," the lack of Department regulations or

guidelines in that regard, and the potential for criminal penalties for violations of the statutes (§ 1390), we conclude it cannot be shown, as a matter of law, that Blue Cross's conduct violated the statutory scheme. Plaintiff succinctly states in his reply brief that resolving the question of Blue Cross's unlawful behavior is "just plain arithmetic." We agree. But plaintiff fails to recognize that an essential element of the equation was not, and cannot, be established. Plaintiff cannot show that between 2006 and 2008, the statutory scheme required Blue Cross to set its HIPAA PPO premiums below the Board's annual rate calculations. His claims, based on that faulty premise, therefore fail.

3. Blue Cross's Voluntary Premium Refund

One final point bears mentioning. It is undisputed Blue Cross made a refund of premium payments to plaintiff for "overcharges." However, this evidence provides no basis for raising a triable issue on plaintiff's claims. The record shows, including judicial admissions in plaintiff's complaint, that Blue Cross voluntarily issued the refund pursuant to its determination that internal errors had been made in calculating its HIPAA PPO plan rates during the years 2005 through 2008. Such evidence raises no inference the "overcharges" were a violation of any law. At most, it establishes Blue Cross made internal errors in calculating its premium rates, for which it voluntarily paid refunds with interest to subscribers, including plaintiff. (Plaintiff concedes that Blue Cross's internal bases for setting its premiums rates is not the issue.) Plaintiff can raise no inference of unlawfulness from such evidence.

4. The Evidentiary Objections

Just as the trial court found it unnecessary to consider the extraordinarily numerous objections to evidence, we too can think of no useful purpose to be served by describing the objectionable, and largely immaterial, evidence or individually ruling on the objections. Previous appellate opinions have discussed at length the judicial burden of ruling on hundreds of objections, many of which are frivolous. (See, e.g., *Reid v. Google, Inc*. (2010) 50 Cal.4th 512, 532-533; *Nazir v. United Airlines, Inc*. (2009) 178 Cal.App.4th 243, 254-257.) This case does not inspire us to add to the literature on the inutility of evidentiary rulings in deciding many summary judgment motions, in the trial

court or on appeal. Hopefully, our opinion has made plain why nothing more needs to be said concerning the evidence or the objections.

The evidence recited in this opinion on which our analysis rests was mostly in the undisputed facts and judicial admissions in plaintiff's operative pleading. The few facts recited in this opinion to which objections were made include: (1) the legislative history materials; (2) declaration of Terry German – paragraphs 1 to 4, paragraph 8 (lines 21-24 only), paragraph 10 (lines 16-19 only), paragraph 14, exhibits A and D attached thereto; (3) declaration of Erin Weber and the exhibits attached thereto; (4) declaration of Ali Khan – paragraphs 1 to 4; (5) deposition testimony of Amal Abu-Rahma – pages16 to 18, 23 to 30, 39 to 40, 83 to 85, 96, 99, 108 to 110, 119 to 121, 132 to 133, 136; and (6) deposition testimony of Bryan Curley – pages 54, 71 to 72, 83 to 86, and 111 to 114. We have considered the objections to this evidence and overrule the objections.

DISPOSITION

The judgment is affirmed. Defendant and respondent Blue Cross of California shall recover its costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

GRIMES, J.

WE CONCUR:

RUBIN, Acting P. J.

FLIER, J.