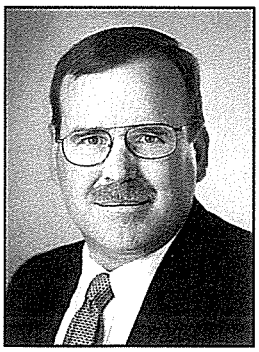
Developments in California Health Care Law in 2014

H. Thomas Watson, Carol Scott, David Johnson, and Ellin Davtyan



H. Thomas Watson is a partner at Horvitz & Levy LLP. He has served as appellate counsel in the California Supreme Court and Courts of Appeal, the Ninth Circuit, and other jurisdictions. He has extensive experience in health care law, as well as in other areas of substantive and procedural law.

Carol D. Scott, J.D., M.P.H., is a healthcare law partner with the law firm of Hinshaw & Culbertson, LLP in Los Angeles, CA. She is the Legislative Committee Co-Chair for the State Bar of California Health Law Committee and the Chair of the Beverly Hills Bar Healthcare Law Committee. She is a graduate of UCLA Law School and the Harvard School of Public Health. She can be reached at 310-909-8000 or cscott@hinshawlaw.com.

David Johnson is an attorney in the San Francisco office of Crowell & Moring. He focuses on health care litigation and state and federal regulatory issues. David graduated from the University of Texas at Austin School of Law. He is Vice-Chair of the California State Bar Health Law Committee.

Ellin Davtyan is an Associate Counsel at L.A. Care Health Plan, nation's largest public health plan, providing affordable health care to over one million members in Los Angeles County. Ellin routinely advises on health care matters, including provider disputes. In addition to overseeing litigation, she has significant experience with public entity compliance regulations.

The pace of change in California health care law slowed during 2014, allowing health care consumers, providers, payors, and regulators to absorb and react to the sweeping legislative changes enacted at the state and federal levels from 2010 to 2013. In November, California voters rejected two propositions that would have given the State Insurance Commissioner the right to review and reject health insurance rate increases (Proposition 45) and raised the cap on non-economic personal injury damages against health care providers (MICRA) from $250,000 to $1.1 million (Proposition 46). However, the Legislature passed, and the Governor signed, approximately 50 bills that made incremental changes to individual areas of health care law. California appellate courts also handed down important decisions affecting such things as the valuation of services by non-contracted providers and the tort damages and defenses available to health care providers and patients.

2014 Legislation

Residential Care Facilities for the Elderly Reform Act of 2014

The most substantial reform to any one sector of health care law was the passage of ten separate bills that are popularly referred to as the Residential Care Facilities for the Elderly (RCFE) Reform Act of 2014. These bills, which focus on improving RCFE care, empowering residents, and protecting their rights, were passed in response to investigative reports about failures in oversight and enforcement of RCFEs. RCFEs provide 24-hour non-medical care to persons over 60 who need care, supervision, and assistance with the activities of daily living, such as bathing and grooming.[1] These facilities house some of the most medically fragile and impaired elderly in California. Residents in these facilities require varying levels of personal care and protective supervision. RCFEs are licensed and regulated by the Community Licensing Division of the California Department of Social Services (DSS).[2]

The most significant provisions of the RCFE Reform Act include:

- Effective July 1, 2015, each RCFE, as a condition of licensure, is required to obtain and maintain liability insurance in the minimum amounts of $1 million per occurrence and $3 million in the aggregate annually, covering injuries to residents or guests (A.B. 1523 2013-2014 Reg. Sess.).[3]

- The Act amends current laws to enhance the rights of resident councils and family councils in RCFEs. It requires facilities to assist in establishing and to not interfere with such councils and ensures that councils have more input into residents' daily living and the promotion of residents' rights (A.B. 1572 2013-2014 Reg. Sess.)[4].

- The Act provides that a person whose license has been revoked or forfeited for abandonment of a facility is permanently ineligible for reinstatement of a facility license (A.B. 1899 2013-2014 Reg. Sess.)[5].

- Facilities are required to have an administrator or facility manager (as well as sufficient staff) on the premises at all times, as well as at least one staff member with CPR and first aid training. Facility staff must be trained in building safety, fire safety and emergency response procedures (A.B. 2044 2013-2014 Reg. Sess.). The Act increases the qualifications and training requirements for RCFE administrators from 40 to 80 hours, including 60 hours of in-person instruction, adds additional topics to the uniform core of knowledge, including the adverse effects of using psychotropic drugs to control the behavior of dementia clients, and prohibits a licensee, officer, or employee of the licensee from discriminating or retaliating against any resident or employee because they called 911 (S.B. 911 2013-2014 Reg. Sess.)[6].

- The Act includes a comprehensive bill of rights, including, but not limited to, such issues as visitation, privacy, confidentiality, personalized care, autonomy, reasonable personal accommodation, decisions over rooms and roommates, right to send and receive mail and to make phone calls, informed consent, freedom from abuse and restraints (including physical and chemical restraints), and adequate staffing (A.B. 2171 2013-2014 Reg. Sess.).[7]

The RCFE Reform Act also:

- Establishes a tiered civil penalty system for facilities, including a $10,000 fine against RCFEs for physical abuse or serious bodily harm and a $15,000 fine for deaths resulting from statutory violations, and creates four levels of appeal for RCFE providers who wish to appeal their fines (A.B. 2236 2013-2014 Reg. Sess.)[8];

- Requires RCFEs to correct deficiencies within 10 days, unless otherwise specified, and requires DSS to post online instructions on how to obtain inspection reports offline, how to design informational posters on reporting complaints and emergencies for display in RCFEs, and how to notify the State Ombudsman Office when DSS issues a temporary suspension or revocation of a facility's license (S.B. 895 2013-2014 Reg. Sess.)[9];

- Creates new penalties for facility non-compliance, including authorizing DSS to suspend the admission of new residents to facilities where there is a substantial probability of harm (S.B. 1153 2013-2014 Reg. Sess.)[10]; and

- Increases the licensing fees for RCFEs and makes legislative findings that it is essential that DSS be given adequate resources to support its consumer protection mandate.

Continued Expansion of the Availability of Providers

In past sessions, the California Legislature responded enthusiastically to the federal Affordable Care Act by establishing one of the more effective private insurance exchanges, namely Covered California, and adopting the optional expansion of its Medicaid program (called Medi-Cal in California). While estimates vary, over 2 million Californians appears to have gained health care coverage as a result of these programs. This expansion in coverage, however, is also expected to cause a major expansion in the demand for healthcare services.

One way that California has been addressing the demand is by expanding the scope of practice for medical providers. This trend continued incrementally in 2014. For example, in 2014 the state enacted bills permitting dental assistants to expose x-rays (A.B. 1174 2013-2014 Reg. Sess.), medical assistants to hand prescriptions to patients (A.B. 1841 2013-2014 Reg. Sess.), and

pharmacy technicians to perform packaging and other manual nondiscretionary tasks while under supervision of a pharmacist (S.B. 1039 2013-2014 Reg. Sess.). The Legislature, however, rejected a bill that would have permitted optometrists to diagnose and treat eye diseases, including by prescribing drugs and performing minor surgery (S.B. 492 2013-2014 Reg. Sess.).

The California Legislature also enacted a bill permitting medical schools to offer accelerated medical degrees. While prior law required 4 years or 32 months of instruction, under Assembly Bill No. 1838, schools can now issue degrees in less time, so long as these programs are accredited by the recognized medical and osteopathic bodies. The State similarly eased licensing requirements for marriage and family therapists and for licensed professional clinical counselors (A.B. 2213 2013-2014 Reg. Sess.).

In a seemingly small, but actually very significant, piece of legislation, California also made it far easier for medical practitioners to serve patients *via* telehealth. Under prior law[11], telehealth could not be delivered unless the health care provider first obtained verbal consent from the patient in person (where the patient was located). Providers complained that this provision made telehealth unworkable because a provider was required to repeatedly visit a patient's home before providing telehealth services. Under the newly enacted law (A.B. 809 2013-2014 Reg. Sess.), a provider may administer telehealth services so long as the provider informs the patient about the use of telehealth and obtains either verbal or written consent.

Managed Care Reforms

The increasing prevalence of managed care in Medicaid, Medicare, and the private sector has led to increased scrutiny over health plan medical management practices. In 2014, California again proceeded cautiously with new managed care rules. The state's most significant reforms were bills addressing narrow networks (S.B. 964 2013-2014 Reg. Sess.) and drug formularies (S.B. 1052 2013-2014 Reg. Sess.).

The term "narrow network" refers to a health plan's contracting with a limited pool of providers in order to offer more economically-priced coverage to its enrollees. Supporters of SB 964 argued that the use of narrow networks could make it more difficult for enrollees to find providers. The Knox-Keene Act already required health care service plans to demonstrate that members had timely access to health care providers.[12] SB 964 bolstered these requirements by, *inter alia*, adding a new section to the Knox-Keene Act, namely Health & Safety Code section 1367.035, which requires plans to produce to their regulator, the Department of Managed Health Care (DMHC), detailed information on their contracted providers' office locations, specialties, hospital privileges, and capacity to take patients. Plans that use networks for Medi-Cal managed care or individual market product lines that are different from their other lines of business may also have to report this information separately for these separate lines of business.

The term "drug formulary" refers to the specific drugs covered by a health plan. In many cases, multiple drugs are available to treat specific conditions, and health plans sometimes choose to cover only some of these options. This can sometimes mean that a health plan may not cover the specific brand of drug that a member prefers. The Knox-Keene Act has long required health care service plans to provide the public with copies of the drug formulary for their plans upon request.[13] To make it easier for health plan shoppers to ensure that the plan in which they are enrolling covers their drug of choice, Senate Bill No. 1052 requires health care service plans and insurers to now post their formularies on their websites and to update them monthly. The bill also requires the DMHC and the Department of Insurance to develop a standardized template that plans and insurers will be required to use to report this information beginning on July 1, 2017.

The Legislature rejected certain other significant proposals, such as Assembly Bill No. 2418, which would have permitted health plan members to opt-out of mail order prescriptions. The only significant new coverage mandate adopted by the State was Senate Bill No. 1053. This requires group and individual health plan contracts and insurance policies to provide coverage to women for all prescribed and FDA-approved contraceptive drugs, devices, and products, as well voluntary sterilization, contraceptive education, and counseling services. Plans are also prohibited from imposing cost-sharing for these services.

Changes to Medi-Cal

The Legislature enacted a number of changes to California's Medi-Cal program. Most notably, in Senate Bill No. 508, the Legislature took steps to codify existing

Medi-Cal eligibility requirements and clarify the changes resulting from the optional expansion permitted by the Affordable Care Act.[14] The ACA required modifications to Medicaid (Medi-Cal in California) eligibility determination methodology. As of January 1, 2015, Medi-Cal eligibility for most individuals is based on modified adjusted gross income (MAGI), making the prior resource and asset and income disregard tests no longer applicable for most non-elderly non-disabled adults.[15] Senate Bill No. 508 established income eligibility thresholds based on MAGI for parents, pregnant women, children, and caregivers.[16] The bill also increased the income levels at which premiums for Medi-Cal coverage for children are assessed. Premiums can now be assessed for children in families with incomes above 160-261% of the federal poverty level (FPL). The levels were previously set at 150-250% of FPL.[17] The bill further addresses eligibility for tuberculosis-related services and provides clarifications relating to Medi-Cal eligibility for foster youth.[18]

The Legislature also passed Senate Bill No. 1004,[19] which requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to Medi-Cal managed care plans for delivery of palliative care[20] services.[21] Covered services can include hospice services for an individual whose condition may result in death, regardless of the estimated length of the individual's remaining period of life, hospice services that are provided at the same time that curative treatment is available (as long as not duplicative), and other services determined appropriate by DHCS.[22] These services can be offered in addition to those available through the Medi-Cal hospice benefit.[23] Authorized service providers can include hospice and home health agencies that are licensed to provide hospice care and contracted with Medi-Cal managed care organizations to provide palliative care services.[24]

Mental Health Law Changes

Several waves of broad mental health care coverage mandates have been made at the state and federal level in recent years which are still being processed by health plans and regulators. California legislation in 2014 was incremental and focused on serious mental health conditions.

Senate Bill No. 973 liberalized rules for state-licensed narcotic replacement therapy (*e.g.*, methadone maintenance) and detoxification programs. Under prior law, individuals with substance abuse disorders were required to wait seven days after leaving a withdrawal treatment program before they could be admitted to a new maintenance or detoxification program.[25] Critics argued that making patients wait seven days to re-enter treatment made it more likely that they would return to substance abuse in order to cope with withdrawal symptoms. Senate Bill No. 973 provides that patients may now be admitted to a new program at the discretion of the medical director without a seven-day wait after discontinuing other treatment. The bill also authorizes treatment programs to provide self-administered doses of narcotic replacements to patients who are closely adhering to program requirements and whose employment, education, disability, or homemaking duties prevent daily attendance at the clinic.

California's Department of Developmental Services oversees a state-wide program, administered by regional centers, which provides services and support to persons with developmental disabilities such as autism and cerebral palsy. Senate Bill No. 1093 added section 4688.05 to the Welfare & Institutions Code to require the regional centers to provide independent living skills services to adult program participants to enable them to live independently in their own homes or to achieve greater independence in homes shared with family.

Hospital Management

California also enacted several bills that directly impact hospital operations. Senate Bill No. 1276 provides stricter rules for hospital payment plans. Under prior law, hospitals were required to offer payment plans to uninsured patients or patients with high medical costs having incomes at or below 350% of the FPL, with the terms of the payment plans determined by the hospital and patient.[26] Senate Bill No. 1276 now provides that if the parties cannot agree on the terms of the payment plan, then the hospital must use a formula that sets payments at no more than 10% of the patient's monthly family income, excluding "essential living expenses" such as rent or house payments, food, utilities, telephone, clothing, insurance, transportation, child care, child and spousal support, etc. Senate Bill No. 1276 also provides similar rules for emergency physicians.

Other legislation of note included Senate Bill No. 1299, which requires hospitals to establish workplace violence protection plans as part of their workplace safety

programs, and Senate Bill No. 1311, which requires hospitals to formalize their antimicrobial stewardship programs by creating antimicrobial stewardship policies and committees.

2014 Appellate Decisions

California Supreme Court decisions

The California Supreme Court published the following three decisions on health law issues in 2014:

- *Rashidi v. Moser*, 60 Cal. 4th 718 (2014) [MICRA's $250,000 cap on noneconomic damages applies only to judgments, not settlements].

After losing his sight in one eye following surgery, plaintiff Hamid Rashidi sued his surgeon, Dr. Franklin Moser, the hospital where he was treated, and the manufacturer of a medical device used during the procedure. Prior to trial, the hospital settled for $350,000 and the manufacturer settled for $2 million. At trial, Dr. Moser failed to prove that the hospital or the manufacturer was liable for Rashidi's loss, so no fault was apportioned to them. The jury awarded $125,000 in economic damages and $1,325,000 in noneconomic damages against Dr. Moser, and the trial court reduced the noneconomic damage award to $250,000 pursuant to the MICRA cap.[27] The court of appeal, resolving a perceived conflict between Civil Code sections 1431.2 (Proposition 51, which makes liability for noneconomic several rather than joint) and 3333.2 (the MICRA cap on noneconomic damages against healthcare providers), held Dr. Moser was entitled to offset the $250,000 in noneconomic damage award based on an allocation of his codefendants' pretrial settlements to noneconomic damages.

The Supreme Court reversed the court of appeal, holding that there was no conflict between Proposition 51 and the MICRA cap, because the MICRA cap applies only to noneconomic damages awarded in a judgment, not to the amount of money paid to settle a claim prior to trial. Settlement amounts are only indirectly influenced by the MICRA cap, since defendants are unlikely to pay more than the statutory cap to settle a claim governed by MICRA. A plaintiff in an action governed by MICRA may recover both the noneconomic portion of a pretrial settlement and the capped award of noneconomic damages at trial. A non-settling defendant seeking to limit his liability for noneconomic damages must prove the liability of any settling codefendants at trial and secure the jury's apportionment of fault between all parties liable for the injury. If the defendant secures such an apportionment of fault, "he would [be] . . . entitled to a proportionate reduction in the capped award of noneconomic damages" pursuant to Proposition 51."[28] However, because Dr. Moser failed to prove that any of the settling defendants were at fault in this case, he alone was solely liable for the entire $250,000 in noneconomic damages awarded in the judgment.

- *Gregory v. Cott*, 59 Cal. 4th 996 (2014) [primary assumption of risk doctrine bars claims by home caregiver against Alzheimer's patient and patient's husband].

An in-home caregiver sued her patient, who suffered from Alzheimer's disease, and her patient's husband for battery, negligence, and premises liability following a confrontation with the patient that resulted in injury to the caregiver. The superior court granted summary judgment to patient and husband, and the court of appeal affirmed. The Supreme Court granted review, and likewise affirmed the summary judgment.

The California Supreme Court held that a patient with Alzheimer's disease and her husband were not liable for injuries the patient inflicted on a health care worker hired to care for the patient at home. The Supreme Court relied on the primary assumption of risk doctrine, which is most often applied in cases involving recreational activity, but also governs claims arising from inherent occupational hazards. The application of the primary assumption of risk doctrine in the occupational context first developed as the "firefighter's rule," which precludes firefighters and police officers from suing members of the public for the conduct that makes their employment necessary. The Supreme Court held that the primary assumption of risk doctrine likewise applied to the relationship between hired caregivers and Alzheimer's patients because violent behavior is a common symptom of the disease and no duty should be owed to protect caregivers from the very dangers they are hired to confront.

- *Fahlen v. Sutter Central Valley Hospitals*, 58 Cal. 4th 655 (2014) [whistleblower claim alleging retaliatory peer review in violation of Health and Safety Code

section 1278.5 may proceed regardless whether administrative remedies have been exhausted].

A hospital declined to renew Dr. Fahlen's medical staff privileges in accordance with the recommendation of the Medical Executive Committee of the hospital's medical staff, and that decision was upheld by the hospital's board of trustees after internal peer review proceedings. Dr. Fahlen did not seek judicial review of that administrative decision. Instead, he brought a whistleblower suit against the hospital, claiming that his privileges were denied in retaliation for his complaints about nursing issues. The hospital filed an anti-SLAPP motion seeking to dismiss the complaint, which the trial court denied. The court of appeal affirmed in part, holding that Dr. Fahlen's whistleblower cause of action under California Health and Safety Code section 1278.5 could proceed despite his failure to exhaust administrative remedies.

The California Supreme Court granted the hospital's petition for review, but then ruled against the hospital. The Court held that a doctor who believes that a hospital initiated peer review proceedings in order to terminate his staff privileges—in retaliation for his complaints about substandard care—may file a whistleblower action under Health and Safety Code section 1278.5 without first exhausting his judicial remedy of challenging the peer review decision through a state-court mandamus action.

In *Westlake Community Hospital v. Superior Court*, 17 Cal. 3d 465(1976), the Supreme Court had held that doctors must exhaust both hospital administrative peer review and judicial mandamus remedies—and must succeed—before initiating any tort suit. *Fahlen* creates an exception to the exhaustion requirement when a doctor files a section 1278.5 whistleblower action contending that peer review proceedings were the very means of retaliation.

California Court of Appeal decisions

The California Court of Appeal published numerous opinions in 2014 addressing various health law issues. The following nine represent some of the more significant decisions:

- *Hale v. Sharpe Healthcare*, 232 Cal. App. 4th 50 (2014) [A putative class action against hospital for allegedly charging excessive amounts to uninsured patients was properly decertified because the class was not ascertainable and common questions of law and fact did not predominate].
- *Norasingh v. Lightbourne*, 229 Cal. App. 4th 740 (2014) [The In–Home Supportive Services Program administered by the California Department of Social Services cannot deny protective supervision benefits to a client on the improper ground that psychogenic pseudoseizures were a "medical condition" that required "medical" supervision].
- *Dameron Hospital Association v. AAA Northern California*, 229 Cal. App. 4th 549 (2014) [A hospital may not seek to recover from the liability insurer of a tortfeasor who injured the hospital's patients amounts in excess of the negotiated rates the patients' healthcare insurer paid to the hospital, where the agreement between the hospital and the health insurer extinguished the patients' debts to the hospital upon payment of the negotiated rates].
- *Sutter Health v. Superior Court*, 227 Cal. App. 4th 1546 (2014) [Class action complaint based on the theft of a computer in which protected medical information had been stored failed to state an actionable claim under the Confidentiality of Medical Information Act absent any allegation that anyone viewed the stolen information].
- *Children's Hospital Central California v. Blue Cross of California*, 226 Cal. App. 4th 1260 (2014) [In an action by hospital against health care service plan for breach of implied-in-fact contract to reimburse the reasonable value of post-stabilization emergency medical services rendered to Medi-Cal beneficiaries, the trial court erred by admitting evidence of the hospital's full "billed" rates for services and refusing to admit evidence of the amounts the hospital typically accepted as payment in full for those services from all types of payers, including from those paying pursuant to negotiated healthcare agreements].
- *Rea v. Blue Shield of California*, 226 Cal. App. 4th 1209 (2014) [California's Mental Health Parity Act requires health care service plans to provide residential treatment for eating disorders where "medically necessary," regardless of whether the

treatment qualified as a "basic health service" under the Knox-Keene Act].

- *Worsham v. O'Connor Hospital*, 226 Cal. App. 4th 331 (2014) [Complaint alleging that understaffing and inadequate training of hospital personnel caused the plaintiff to fall and injure herself failed to state an actionable elder abuse cause of action because the complaint alleged mere negligence, and failed to allege facts demonstrating reckless, oppressive, fraudulent, or malicious misconduct].
- *Maher v. County of Alameda*, 223 Cal. App. 4th 1340 (2014) [The "no therapeutic or diagnostic purpose or effect" qualification in the "foreign body" tolling rule of the MICRA statute of limitations means the tolling rule does not apply to objects and substances intended to be permanently implanted, but items temporarily placed in the body as part of a procedure and meant to be removed at a later time do come within the tolling rule. A hospital does not violate the Patient Access Law by declining a patient's attorneys' request for the patient's medical records, because the attorneys were neither "patients" nor "patient representatives" within the meaning of that statute].
- *Coleman v. Medtronic, Inc.*, 223 Cal. App. 4th 413, review granted April 30, 2014, review dismissed and opinion ordered published Aug. 20, 2014 (S217050) [Federal law does not preempt patient's manufacturing defect claim, the patient's failure to warn and negligence per se claims based on a medical device manufacturer's alleged failure to file adverse event reports, or the patient's negligence per se claim based on the manufacturer's promotion of off-label uses, but federal law does preempt the patient's failure to warn claims based on the manufacturer's promotion of off-label uses].

Conclusion

Healthcare reform is still causing major structural changes in California's healthcare system. While legislative and judicial actions in 2014 did not make quite the sweeping changes to California health law seen in prior years, there were important changes. Because the system is still in a state of flux, significant developments should be expected in 2015 and the coming years.

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1 RCFEs also serve persons under 60 with compatible needs.

2 California currently has 7,500 RCFEs.

3 CAL. HEALTH AND SAFETY CODE § 1569.605.

4 CAL. HEALTH AND SAFETY CODE §§ 1569.157 & 1569.158.

5 CAL. HEALTH AND SAFETY CODE §§ 1569.19, 1569.50, & 1569.682

6 CAL. HEALTH AND SAFETY CODE §§ 1569.616, 1569.62, AND 1569.69, 1569.371, 1569.39, & 1569.696

7 CAL. HEALTH AND SAFETY CODE § 1569.261 *ET. SEQ.*

8 CAL. HEALTH AND SAFETY CODE §§1548, 1568.0822, 1569.49, 1596.99, & 1597.58

9 CAL. HEALTH AND SAFETY CODE §§1569.33, 1569.335, & 1569.331

10 CAL. HEALTH AND SAFETY CODE § 1569.545

11 CAL. BUS. & PROF. CODE § 2290.5.

12 CAL. HEALTH & SAFETY CODE §1367.03.

13 CAL. HEALTH & SAFETY CODE § 1363.01(b).

14 CAL. WELF. & INST. CODE §§ 14005.26, 14005.27, 14005.28, 14005.285, 14005.287, 14005.288, 14005.30, 14005.64, 140051, 14148, 14148.5.

15 *Id.* at § 14005.26.

16 *Id.* at §§ 14005.64, 14005.26, 14005.30, 14148.

17 *Id.* at §14005.26.

18 *Id.* at §§ 14005.20, 14005.27, 14005.28.

19 Codified in CAL. WELF. & INST. CODE § 14132.75.

20 Section 14132.75 (a) describes palliative care to include:

1. Specialized medical care and emotional and spiritual support for people with serious advanced illnesses.
2. Relief of symptoms, pain and stress of serious illness, c) improvement of qualify of life for both the patient and family.
3. Improvement of quality of life for both the patient and family.
4. Appropriate care for any age and for any stage of serious illness, along with curative treatment.

21 CAL. WELF. & INST. CODE § 14132.75(b).

22 *Id.* at § 14132.75(c).

23 *Id.*

24 *Id.* at § 14132.75(e).

25 Prior HEALTH & SAFETY CODE § 11839.3.

26 Prior HEALTH & SAFETY CODE § 12400 *et seq.*

27 *See* CAL. CIV. CODE § 3333.2.

28 *See* CAL. CIV. CODE § 1431.2.