IN THE COURT OF APPEAL OF CALIFORNIA

THIRD APPELLATE DISTRICT

No. C041091

CALIFORNIA CONSUMER HEALTH CARE COUNCIL, INC., ET AL., Appellants, v. CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE, ET AL., Respondents.	Superior Court No. 01CS01286

Appeal from Superior Court of the State of California, County of Sacramento
The Honorable Talmadge R. Jones and the Honorable Loren A. McMasters, Judges

BRIEF OF *AMICI CURIAE* UNITED POLICYHOLDERS AND CONGRESS OF CALIFORNIA SENIORS IN SUPPORT OF APPELLANTS CALIFORNIA CONSUMER HEALTH CARE COUNCIL, INC., ET AL.

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I hereby certify under penalty of perjury that I am the attorney for *amici curiae* United Policyholders and Congress of California Seniors and that the word count of this brief, as reported by the Microsoft Word word processing program, is less than 14,000.

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INTERESTS OF *AMICI CURIAE*

United Policyholders ("UP") was founded in 1991 as a non-profit organization dedicated to educating the public on insurance issues and consumer rights. The organization is tax-exempt under Internal Revenue Code §501(c)(3). UP is funded by donations and grants from individuals, businesses, and foundations.

In addition to serving as a resource on insurance claims for individuals and commercial insureds, UP monitors legal and marketplace developments affecting the interests of all policyholders. UP receives frequent invitations to testify at legislative and other public hearings, and to participate in regulatory oversight proceedings.

A diverse range of policyholders, including enrollees in managed care plans, communicate on a regular basis with UP regarding their insurance claims. Because UP monitors both marketplace developments and policyholders' real life experiences, the organization is qualified to provide topical information to courts throughout the country via the submission of *amicus curiae* briefs in cases involving insurance principles that are likely to impact large segments of the public.

UP's *amicus curiae* briefs have been accepted by courts throughout the country. *See, e.g., Humana, Inc. v. Forsyth*, 525 U.S. 299, 313-14 (1999) (citing to pages 19-23 of Brief for United Policyholders as *Amicus Curiae*);

Vandenberg v. Superior Court, 88 Cal. Rptr. 2d 366 (Cal. 1999); *Western Alliance Ins. Co. v. Gill*, 686 N.E. 2d 997 (Mass. 1997).[1] UP has filed *amicus* briefs on behalf of policyholders in over one hundred cases throughout the United States since 1992.

Congress of California Seniors ("CCS") is a statewide non-profit education and advocacy organization dedicated to improving the life of seniors and their families. CCS devotes its efforts to legislative and consumer affairs that deal primarily with issues concerning older adults. CCS conducts research, analyzes issues and provides voter and consumer education to its members. Through an effective legislative committee, CCS initiates and monitors legislation, testifies at hearings and takes appropriate grass-roots action on pending and proposed legislation. When necessary, CCS files or joins in lawsuits and *amicus cuiae* briefs[2] to protect consumers. Issues concerning healthcare and the availability of health insurance are of particular importance to CCS.

Amici curiae United Policyholders and Congress of California Seniors have a vital interest in seeing that the California Department of Managed Care protects managed care policyholders against arbitrary or unfair treatment by

[1] *See also Fleming v. United Services Auto. Assoc.*, 988 P.2d 378 (Or. 1999); *Peace v. Northwestern Nat'l Ins. Co.*, 596 N.W. 2d 429 (Wis. 1999); *United States v. Brennan*, 183 F.3d 139 (2d Cir. 1999); *Board of Ed. of Township High School Dist. No. 211 v. International Ins. Co.*, 720 N.E.2d 622 (Ill. App. Ct. 1999), appeal denied, 729 N.E. 2d 494 (Ill. 2000); *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 712 A.2d 1116 (N.J. 1998); *Guaranty Nat'l Ins. Co. v. George*, 953 S.W.2d 946 (Ky. 1997).

[2] *See Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002).

their health care service plans by: (1) ensuring that policyholders' grievances are thoroughly reviewed on a complete and accurate factual record, and (2) providing a reasoned explanation for the final disposition of policyholders' grievances. These procedural protections must be observed and enforced by DMHC or individuals may be unfairly denied insurance coverage for necessary – and in some case, life-saving – medical treatment. Moreover, it is the DMHC's responsibility to pro-actively enforce the laws that protect policyholders' interests. Where the DMHC fails to enforce these laws, insurance companies get the wrong message – i.e., that California does not take the protection of policyholders seriously and will not vigorously enforce insurance regulations that protect policyholders from arbitrary and unfair treatment by insurers.

INTRODUCTION

The Knox-Keene Act (the "Act"),[3] and similar statutes in force in over thirty-two states,[4] are vital in protecting health service plan enrollees ("Enrollees") from arbitrary and unfair treatment by health care service plans ("Plans"). [5] These statutes generally allow Enrollees to obtain an independent and

[3] California Health & Safety Code ("HSC") §§ 1340, *et seq.*

[4] *See* Shirley Eiko Sanematsu, *Taking a Broader View of Treatment Disputes Beyond Managed Care: Are Recent Legislative Efforts the Cure?* 48 U.C.L.A. L. Rev. 1245, 1260 & n.57 (2001) (As of March 2000, thirty-two states provided for some form of independent review of denials of health insurance coverage).

[5] For purposes of this brief, the term "Enrollees" is used interchangeably with the term "policyholders." Health Care Service plans are considered to be in the business of insurance, (Ca. Civ. Code § 3428), and thus subject to the case law that governs traditional insurance companies and insureds. *See Sarchett v.Blue*

unbiased review of their Plans' decisions to deny them insurance coverage for health care services. Despite their noble purpose, these statutes cannot be effective without appropriate state action to implement and enforce their provisions.

In California, the Department of Managed Health Care (the "DMHC") is the state agency responsible for implementing and enforcing the Act. In this action, the DMHC is essentially arguing that it has unbridled discretion to ignore certain provisions of the Act, even though the provisions at issue (1) create nondiscretionary obligations for the DMHC and the Plans it regulates, and (2) are essential to the Act's statutory scheme and purpose. The lower court approved the DMHC's arguments.

United Policyholders respectfully submits that the lower court erred. The DMHC's decision to ignore important procedural safeguards in the independent review process violates the Act because (1) it contravenes the DMHC's legislative mandate to protect and promote the interests of policyholders, and (2) it undermines the legislative purpose of the Knox-Keene Act (and similar legislation in other states) to provide a thorough and fair independent review process for policyholders' grievances to protect them from arbitrary and unfair action by their health plans. The DMHC is also impairing important rights and obligations created by the Act.

Shield of Calif. (1987) 43 Cal.3d 1, 3. Health Care Service plans are subject to the covenant of good faith and fair dealing. *Id.*

Thus, United Policyholders and Congress of California Seniors respectfully request that this Court grant Appellant CCHCC's request for a writ of mandate requiring the DMHC to obey and enforce HSC § 1374.30(n) and HSC § 1368(b)(5).[6]

STATEMENT OF CASE AND FACTS

We adopt the statements of facts and issues in the Introduction section of Appellants' Opening Brief, dated July 29, 2002.

ARGUMENT

I. THE KNOX-KEENE ACT'S PROVISIONS FOR THE INDEPENDENT REVIEW OF ENROLLEES' GRIEVANCES PROVIDE CRITICAL PROCEDURAL PROTECTIONS TO PREVENT ARBITRARY AND UNFAIR ACTIONS BY THE DMHC AND HEALTH PLANS

In passing the Knox-Keene Act in 1999, the California legislature intended to address, *inter alia*, the widespread perception that health care plans were improperly denying Enrollees' claims by applying improper business considerations as opposed to evaluating the merits of their claims.[7] To address this problem, the Act provides for an independent and unbiased review of Enrollees' disputes with their Plans regarding the existence of insurance coverage for certain health care services and other matters (i.e., "grievances"). HSC § 1368(b). The nature and circumstances of a grievance determines whether it is

[6] *Amici curiae* also support Appellants' argument that the DMHC must make available to Enrollees all medical records used in its review process under HSC § 1368(b).

[7] *See* Sanematsu, *supra* note 3, at 1263.

eligible for review by the DMHC or by a designated independent medical review organization ("IMRO"). HSC § 1374.30(d)(1) ("All enrollee grievances involving a disputed health care service [as defined in HSC § 1374.30(b)] are eligible for review under the Independent Medical Review System if the requirements of this article are met . . . . All other enrollee grievances, including grievances involving coverage determinations, remain eligible for review by the [DMHC] pursuant to subdivision (b) of Section 1368.").

The independent review mechanisms provided for in the Act were meant to serve the state's vital public interest in "promot[ing] the delivery of health and medical care to the people of" California. HSC § 1342. The review procedures prescribed in the Act reflect the beliefs of many members of the California state legislature (and the legislatures of other states with that have enacted similar statutes) that when Plans "deny a patient care, those patients should have the right to an independent look from someone concerned with that patient's health, not preoccupied with the company's bottom line."[8] According to the California Assembly Judiciary Report, the independent review mechanisms in the Act "laudably seek[] to address the growing belief held by many Californians that they are being denied medical care simply to maximize corporate profits."[9]

The Act provides a number of procedural safeguards to make its independent review mechanisms effective and meaningful. At issue in this appeal

[8] *Id.*(quoting California Assembly member Carol Migden).

[9] *Id.*

are the DMHC's treatment of two critical safeguards: (1) the requirement that Plans provide Enrollees' with copies of documentation they submit to IMROs, HSC § 1374.30(n), and (2) the requirement that the DMHC send Enrollees written notice of the final disposition of their grievances, which must include a summary of the DMHC's findings and the reasons for its action or inaction. HSC § 1368(b)(5).

1. Plans Must Provide Enrollees With Copies Of Materials Provided To IMROs Pursuant To HSC § 1374.30(n)

When an enrollee requests an independent medical review of a Plan's determination that certain medical treatment is or was not medically necessary, the Act requires Plan to provide certain documentation to the IMRO that would be responsible for reviewing the Plan's decision. HSC § 1374.30(n). The required documentation generally includes all materials relied on by the Plan in making its medical necessity determination. *Id.* The documentation must be provided to the IMRO within three business days of the Plan's receipt of notice from the DMHC that an enrollee has requested an independent review of his or her grievance. *Id.*

Specifically, the Act requires the Plan – in no uncertain terms – to provide the enrollee with the following materials concurrently with the submission of these materials to the IMRO:

> (1)(B) Any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents are provided to the independent medical review

> organization shall be forwarded immediately to the independent medical review organization. *The plan **shall** concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider*, if authorized by the enrollee. . . . .
>
> (3) A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. *The plan **shall** concurrently provide a copy of documents required by this paragraph, except for any information found by the director to be legally privileged information, to the enrollee and the enrollee's provider.*

HSC § 1374.30(n).

The purpose of this requirement is clear and simple: to allow Enrollees to see the materials being sent to the IMRO that would be responsible for reviewing a Plan's medical necessity determination.

Thus, the Act clearly contemplates that Enrollees will have an opportunity to see all of the "evidence" presented by the Plan to support its medical necessity decision.[10] After seeing the evidence presented by the Plan, the Enrollee is in a position to identify and correct erroneous information presented by

[10] To the extent the statute does not require Plans to provide Enrollees with other materials, such as a "copy of all information *provided to the enrollee by the plan* . . . concerning the plan and provider's decision regarding the enrollee's condition and care," HSC 1374.30(n)(2) (emphasis added), it is merely in recognition of the fact that Enrollees in almost all cases have received and seen these materials.

the Plan to the IMRO. Enrollees certainly cannot afford – and should not be forced – to rely on their Plans to submit accurate information to IMROs. Thus, the requirements of HSC § 1374.30(n) are a matter of basic and fundamental fairness to Enrollees who, in many cases, are fighting to protect their health and lives in their disputes with their Plans.

The Act acknowledges that it is imperative that grievances are resolved based on truthful information by, *inter alia*, making it unlawful

> for any person willfully to make any untrue statement of material fact in any application, notice, amendment, report, or other submission filed with the director under this chapter or the regulations adopted thereunder, or willfully to omit to state in any application, notice, or report any material fact which is required to be stated therein.

HSC § 1396.

2. The DMHC Must Provide Enrollees With Written Notice Of The Final Disposition Of Their Grievances, Including Summaries Of Its Findings, Pursuant To HSC § 1368(b)(5)

When an Enrollee's grievance is reviewed and decided by an IMRO, the DMHC is required "to promptly implement the decision." HSC § 1374.34(a). However, in any case not eligible for independent review by an IMRO, the DMHC must: (1) "expeditiously and thoroughly review[]" the enrollee's grievance, HSC § 1342(h); and (2) send the enrollee "a written notice of the final disposition of the grievance, and the reasons therefor." HSC § 1368(b)(5).

The mandatory nature of the DMHC's notification obligations cannot be questioned given the clear language of the Act: the Act states that "[t]he department **shall** send a written notice of the final disposition of the grievance." HSC § 1368(b)(5). The Act further states that "the department's written notice **shall** include," at a minimum:

> (A) *A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.*
>
> (B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.
>
> (C) If the enrollee's grievance is sustained in whole or part, information about any corrective action taken.

Id. (emphasis added).

Again, the purpose of this provision is clear and simple: to provide Enrollees with the basic and fundamental right to a reasoned explanation concerning the final disposition of their grievances. This is consistent with traditional notions of fundamental fairness, due process and proper administrative decisionmaking. Obviously, an Enrollee must have this information to be able to understand the DMHC's decisions, and to decide whether to challenge the DMHC's decision and/or its decisionmaking process. As with any administrative agency that is responsible for adjudicating the rights of citizens, there must be meaningful check on the DMHC's ability to engage in arbitrary and capricious

decisionmaking – i.e., that DMHC "will randomly leap from evidence to conclusions." *Topanga v. Los Angeles* (1974) 11 Cal.3d 506, 514. In the case of the DMHC, checks are particularly important because the proper enforcement of Enrollees' rights under their health insurance policies can have very serious consequences for the health and life of each Enrollee.

II. THE DMHC MUST PROMOTE AND PROTECT ENROLLEES' INTERESTS AND ENSURE A FAIR AND ACCURATE INDEPENDENT REVIEW OF ENROLLEES' GRIEVANCES UNDER THE ACT

In its brief, the DMHC takes the remarkable position that it has no obligation to obey and enforce certain key provisions of the Knox-Keene Act, such as the Plan disclosure requirements in HSC § 1374.30(n), and the DMHC written notification requirements in HSC § 1368(b)(5) (discussed *supra*). The DMHC's position, however, ignores (1) its clear mandate under the Act to promote and protect policyholder interests, and (2) the Act's overall statutory scheme and purpose to provide an fair and accurate independent review mechanism for Enrollees' grievances. HSC §§ 1341, 1342.

The Act gives the DMHC the duty and responsibility to enforce the Knox-Keene Act, including "those laws directing the [DMHC] to ensure that health care services plans provide Enrollees with access to quality health care services and protect and promote the interests of enrollees." HSC § 1341(a). In addition, the Act specifically states that "[i]t is the intent and purpose of the Legislature to promote the delivery of health and medical services to" Enrollees.

HSC § 1342. The Act further states that the legislature achieve its purpose to "promote the delivery of health and medical services" by: (1) "Promoting the effective representation of the interests of subscribers and enrollees," and (2) "Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the [DMHC]." HSC § 1342(h).

Thus, the DMHC is not a neutral agency. The legislature has specifically charged DMHC with promoting and protecting policyholder interests. The legislature has further charged the DMHC with implementing and enforcing the Act's statutory scheme and purpose – i.e., to ensure that Enrollees receive a thorough and fair independent review of their grievances.

III. THE DMHC CANNOT PROPERLY IGNORE HSC §§ 1374.30(a) & 1368(b)(5)

It is a fundamental rule of administrative law that a government agency cannot violate its enabling act or any other statutes. *See Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 392 ("Administrative action must be consistent with the enabling statute. . . . Administrative action that . . . is inconsistent with[] acts of the Legislature is void."); *Henning v. Division of Occupational Safety and Health* (1990) 219 Cal.App.3d 747, 759 ("An administrative body . . . has no authority to enact a regulation which conflicts with a statute."). Moreover, any action by an agency that has the effect of vitiating or impairing the scope of statutory rights and obligations is void. *See Association for Retarded Citizens,* 38 Cal.3d at 391

(declaring agency action void because it would have "vitiated the . . . rights and obligations" defined by the Lanterman Act and "greatly impaired its scope").

Where an agency has acted in violation of a statute, there is no issue of discretion because an agency has no discretion to act in a manner inconsistent with its enabling statute. *See id.* (explaining that "if the court concludes that the administrative action transgresses the agency's statutory authority, it need not proceed to review the action for abuse of discretion; in such a case, *there is simply no discretion to abuse.*") (emphasis added); *Henning*, 219 Cal.App.3d at 759 ("'Administrative regulations that violate acts of the Legislature are void and *no protestations that they are merely an exercise of administrative discretion can sanctify them.*'") (emphasis added).

In determining whether administrative action violates a statute, courts look not only at the wording of the statute, but also at the overall statutory scheme, and the intent and purpose of the legislature in enacting the statute. *See, e.g., Association for Retarded Citizens*, 38 Cal. 3d at 393 (in determining that agency action was inconsistent with the agencies' powers under its enabling statute, court gave the statute "a reasonable construction which conform[ed] to the apparent purpose and intention of the lawmakers."); *Tomlinson v. Qualcomm, Inc.* (2002) 97 Cal.App.4th 934, 940-41 (in determining whether administrative actions are consistent with state statutes, a court should look to, *inter alia*, "the general principles and policies underlying the statutory scheme."); *State Board of Education v. Honig* (1993) 13 Cal.App.4th 720, 752 (invalidating administrative

act and stating that courts, in reviewing agency regulations, must "determine whether agency regulations are consistent, not in conflict with the statutory scheme").[11]

Thus, the DMHC must act in a manner consistent with its legislative mandate and the statutory scheme and purpose that it was created to implement and enforce. Moreover, the DMHC cannot act (or fail to act) if the effect is to vitiate or impair the scope of the rights and obligations created under the Act.

1. The DMHC And The Knox-Keene Act

As explained above, the DMHC is charged with enforcing the Knox-Keene Act and protecting policyholders' interests by, *inter alia*, ensuring that Enrollees have their grievances thoroughly reviewed. HSC §§ 1341, 1342. In addition, one of the main objectives of the Knox-Keene Act is to promote a thorough and fair independent review of Enrollees' grievances. HSC § 1342. Thus, in light of the DMHC's legislative mandate, and the overall statutory scheme and purpose of the Knox-Keene Act, the DMHC has no power or discretion to ignore the Plan disclosure obligations in HSC § 1374.30(n), and the DMHC written notice obligations in HSC § 1368(b)(5). *See Association for Retarded Citizens, supra; Henning, supra.*

[11] *See also Texter v. Department of Human Services*, 443 A.2d 178, 183 (N.J. 1982) ("One measure of the validity of an administrative regulation is whether it is consistent with the expressed policy of the enabling state and related legislation.").

2. **HSC § 1374.30(n)**

HSC § 1374.30(n) is a provision that is vital to ensuring the fairness and accuracy of decisions by IMROs. If Plans are not required to fulfill their obligations under this provision, there is no mechanism to ensure that complete and accurate information is submitted to IMROs. This undermines the entire independent medical review process, which the DMHC is charged with implementing. In addition, it seriously compromises Enrollees' right to a thorough and fair review of their grievances, which the DMHC is charged with protecting. There can be no rational or permissible reason for the DMHC to refuse to enforce this provision under any circumstances. Thus, the DMHC's refusal to enforce this provision against Plans is manifestly inconsistent with DMHC's legislative mandate and the statutory scheme and purpose of the Act. In addition, it constitutes an unlawful impairment of rights and obligations created by the Act. *See Association for Retarded Citizens, supra; Henning, supra.*

3. **HSC § 1368(b)(5)**

HSC § 1368(b)(5) is also vital to ensuring the accuracy of fairness of the independent review process. If the DMHC can ignore its obligations under this provision, Enrollees are left wondering whether their grievances were thoroughly and fairly reviewed by the DMHC and whether they have any basis to challenge the DMHC's decision in court. This seriously compromises the rights of the Enrollees whom the DMHC is specifically charged with protecting. There can be no rational or permissible reason for the DMHC to refuse to obey this

provision under any circumstances. Thus, the DMHC's refusal to obey this provision is illegal because it is manifestly inconsistent with DMHC's legislative mandate and the statutory scheme and purpose of the Act. It is also an unlawful impairment of rights and obligations created by the Act. *See Association for Retarded Citizens, supra; Henning, supra.*

CONCLUSION

The duties of the DMHC in implementing and enforcing the Act for the benefit of Enrollees are very clear. The DMHC must promote and protect the interests of Enrollees and ensure that Enrollees receive a thorough and fair independent review of their grievances. The DMHC cannot be allowed to abdicate its duty to protect and promote the interests of policyholders or to undermine the purposes of the Act. Nor can the DMHC be allowed to impair important rights and obligations under the Act. Allowing the DMHC to do so would have serious consequences for the health and lives of the people of the state of California, as well as the people of the more than thirty states that have enacted legislation similar to the Knox-Keene Act. This would also send the wrong message to insurance companies – i.e., that California courts do not take the protection of policyholders seriously and will not vigorously enforce regulations that protect policyholders from arbitrary and unfair treatment by their insurers.

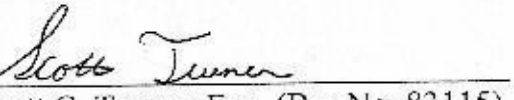
Thus, for the reasons set forth above, United Policyholders and Congress of California Seniors request that this Court reverse the decision of the

Superior Court in *California Consumer Health Care Council, Inc., et al. v. California Dep't of Managed Health Care, et al.*, Superior Court No. 01CS01286.

Dated: October 9, 2002

Respectfully submitted,

ANDERSON KILL & OLICK, P.C.



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California Consumer Health Care Council, et al, Appellants	)	California Court of Appeal Third Appellate District
vs.	)	
California Department of Managed Health Care, et al, Respondents	)	Case Number **C041091**

AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

STEVEN J. SNYDER, being duly sworn, deposes and says:

1. I am over the age of 18 years and not a party to these proceedings and am employed at Anderson Kill & Olick, P.C., 1251 Avenue of the Americas, New York, New York 10020.

2. On October 9, 2002, I caused the following document to be delivered via federal express in sealed envelopes, postage prepaid from 1251 Avenue of the Americas, New York, New York 10020:

BRIEF OF *AMICI CURIAE* UNITED POLICYHOLDERS AND CONGRESS OF CALIFORNIA SENIORS IN SUPPORT OF APPELLANTS CALIFORNIA CONSUMER HEALTH CARE COUNCIL, INC., ET AL.

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STEVEN J. SNYDER

Sworn to before me this
9th day of October, 2002

NOTARY PUBLIC

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Commission Expires June 24, 2006