AN INSURANCE CONSUMER EDUCATION ORGANIZATION

February 20, 2002

The Honorable Chief Justice Ronald M. George
and Honorable Associate Justices
California Supreme Court
350 McAllister Street
San Francisco, CA 94102

Re: California Medical Association, Inc. v. Aetna U.S. Healthcare of California, Inc., et al.
(Supreme Court No. S103631) (Appellate Court No. 4D Civil No. D036140)

Letter Supporting California Medical Association's Petition for Review

Dear Chief Justice Ronald M. George and Associate Justices:

United Policyholders ("UP") respectfully requests leave to file this letter in support of the California Medical Association's Petition for Review. 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.

UP serves as a consumer resource on insurance claims and actively 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 proceedings on rate and policy issues.

A diverse range of policyholders throughout the United States communicate on a regular basis with UP, which allows it to provide important and 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* brief was cited in the U.S. Supreme Court's opinion in Humana, Inc. v. Forsythe (1999) 525 U.S. 299, and its arguments were adopted by this Court in Vandenberg v. Sup. Ct. (1999) 21 Cal.4th 815. UP has filed *amicus* briefs on behalf of policyholders in over ninety cases throughout the United States.

PMB 262 ✦ 110 Pacific Avenue ✦ San Francisco, CA 94111-1900 ✦ (510) 763-9740

UP urges this Court to accept review of the lower court's decision. Under that opinion, health plans regulated by the Department of Managed Health Care are free to delegate all of their licensure obligations, including insurance risks, to unlicensed IPAs and medical groups. The opinion sanctions this delegation of insurance risks where the payment accompanying this delegation is not actuarially sound, and indeed, even where the payments are made after the health plan knows, or should know, that the intermediary is insolvent. The Court of Appeal's decision is premised upon the erroneous conclusion that by paying something to their own agents—their contracting intermediaries, the plans have already paid for physician services. *See* Slip Opinion at 22, 24, and 32. The error lies in the fact that a capitation payment which is not actuarially sound does not constitute a "payment" as the Court's opinion suggests, particularly where the inadequate payments are made to entities known to be insolvent.

When paying premiums for health care coverage, policyholders reasonably expect that the health plan they select will pay fairly for the cost of medically necessary care. Otherwise, policyholders could not be confident that they will receive these services when they need them – the very essence of health insurance. By failing to ensure the financial adequacy of their arrangements with their contracting agents, through, among other things, the payment of inadequate capitation amounts, health plans defeat the reasonable expectations of policyholders who reasonably believe that the care they will need is being paid for on an actuarially sound basis. This conduct breaches the implied covenant of good faith and fair dealing, and is "unfair" for the purposes of Business & Professions Code §17200 et seq.

A. Health Plans Function As Health Insurers

In the context of health care coverage, insureds are purchasing insurance, including coverage through a health maintenance organization (HMO), precisely to ensure that their medical care will be paid for fully and appropriately (with the exception of any cost-sharing amounts imposed by the plan). The dispersal of funds to a health plan's own intermediary which is not sufficient to cover the cost of care does not even remotely meet the reasonable expectations of insureds.

This Court has recognized that HMOs are functionally equivalent to insurance companies. *See* Sarchett v. Blue Shield of California (1987) 43 Cal.3d 1 (the fact that Blue Shield is a health care service plan, rather than an insurance company, is immaterial for the purposes of law concerning breach of the implied covenant of good faith and fair dealing). The reason is clear—health plans in California bear insurance risk, even though they are not titled "insurance companies." It is the health plans, not the physicians (or the health plans' "intermediaries") that:

- are responsible for the cost of care (Health & Safety Code §1345);
- accept premiums (Health & Safety Code §1345);
- engage in underwriting (Health & Safety Code §§1389.1-1389.3);
- have standards for agents and their firms (Health & Safety Code §1359);

- maintain the insurer/insured relationship through, among other things, disclosure forms, evidences of coverages, grievance procedures (Health & Safety Code §§1363, 1368, 1370.4) and mandated coverage benefits (Health & Safety Code §§1367.2-1367.25);
- sell and advertise policies (Health & Safety Code §1360.)

Under these circumstances, it is no wonder that both the courts and Legislature have classified health plans as "insurers" for all practical purposes. *See* Health & Safety Code §1346.4; *see also* Section 1, Stats. 1999, Ch. 536, legislative intent language supporting Civil Code §3428 (stating, in part, "based on the fundamental nature of the relationship involved, a health care service plan and all other managed care entities regulated under the Health & Safety Code are engaged in the business of insurance in this state . . ."); *see also* Sarchett v. Blue Shield of California *supra*; Manasen v. California Dental Services (E.D. Cal. 1976) 424 F.Supp. 657, reversed on other grounds (9th Cir. 1979) 638 F.2d 1152 (dental prepaid health plan engaged in the "business of insurance" for the purpose of the McCarran-Ferguson Act).

B. Health Plans Must Honor Their Obligations Toward Policyholders And Cannot Defeat Their Reasonable Expectations

The state has a strong policy of requiring insurance companies to honor their obligations to policyholders. *See* Kransco v. American Empire Surplus Lines Insurance Company (2000) 23 Cal.4th 390 (insurer cannot assert comparative bad faith against its insured as an affirmative defense). This Court characterized the relationship between the insured and the insurer as "inherently unequal" and recognized the harm that may result when an insurer reneges on its obligations. *Id.* Thus, insurers not only have a duty to fulfill their contractual obligations to insureds, but also to fulfill the covenant of good faith and fair dealing. Kransco, *supra* at 400 (the covenant is aimed at making effective the agreement promises) (citation omitted). Implicit in this duty is the insurer's obligation to be reasonable, to deal with insureds honestly and in good faith, and to "give equal consideration to the interests of its insureds as it does to itself." Lee v. Crusader Ins. Co. (1996) 49 Cal.App.4th 1750.

The covenant of good faith and fair dealing implied in all contracts, including health coverage policies, requires that neither party do anything that will injure the right of the other to receive the benefits of the contract. *See* Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566, 573, 108 Cal.Rptr. 480. To find that a party breached the covenant by failing to act in good faith does not require malicious or immoral conduct; rather, a breach may occur by merely acting unreasonably. *See* McCormick v. Sentinel Life Ins. Co. (1984) 153 Cal.App.3d 1030, 1046–1047, 200 Cal.Rptr. 732; *see also* Neal v. Farmers Ins. Exchange (1978) 21 Cal.3d 910, 921 (fn. 5), 148 Cal.Rptr. 389.

The duty of good faith requires that the insurer act consistently with the reasonable expectations of insureds, in this case, patients. Quoting from the Restatement of Contracts, the Neal Court stated:

> "[t]he phrase 'good faith' is used in a variety of contexts, and its meaning varies somewhat in the context. Good faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party; it excludes [from consideration] a variety of types of conduct characterized [in other contexts] as involving 'bad faith' because they violate community standards of decency, fairness, or reasonableness." Id. at Fn. 5, p. 922.

In the health care context, courts have safeguarded the rights of patients to be afforded the benefits of their coverage, and have viewed patients' "reasonable expectations" broadly. For example, with respect to the issue of whether a particular service is "medically necessary," doubts respecting coverage will be resolved in favor of the patient, and there will be "few cases in which the physician's judgment is so plainly unreasonable or contrary to good medical practice that coverage will be refused." *See* Sarchett v. Blue Shield of California (1987) 43 Cal.3d 1, 13, 233 Cal.Rptr. 76. As a result, a health insurer who uses a restricted definition of medical necessity, or otherwise employs a standard that is significantly at variance with community standards, frustrates the reasonable expectations of patients and breaches the duty of good faith. *See* Hughes v. Blue Cross of Northern California (1989) 215 Cal.App.3d 832, 263 Cal.Rptr. 850.

In addition, to ensure that patients receive the maximum benefits available under their policies, courts have held health plans to an exacting duty of disclosure with respect to the rights and remedies available to patients under the policy. In Sarchett v. Blue Shield of California, *supra*, this Court held that a health plan breached its duty of good faith and fair dealing by its course of conduct designed to mislead patients into forfeiting their contractual right to an impartial review and arbitration of disputed claims. In that case, the patient and others on his behalf repeatedly protested the health plan's denial of hospital claims arising from care authorized by his physician. Although the policy unconditionally provided for arbitration and impartial review, the health plan persisted in denying the patient's claim, implying that the decision was final and that the patient had no further recourse. The Court held that the plan breached its duty of good faith and fair dealing by failing to advise the patient in a timely manner of his right to peer review and arbitration.

In doing so, the Court extended its holding in Davis v. Blue Cross of Northern California (1979) 25 Cal.App.3d 418, 158 Cal.Rptr. 828, in which an arbitration clause was obscured in fine print within a long policy document. Even though in Sarchett the provision was adequately set out, this Court understood that the health plan in that case had reason to know that the patient was uninformed of his rights, because he repeatedly protested the denial without demanding review.

Under these circumstances, the Court concluded that good faith required that the plan bring relevant information to the patient's attention. As the Court stated:

> Once it becomes clear to the insurer that its insured disputes its denial of coverage, however, the duty of good faith does not permit the insurer to passively assume that its insured is aware of his rights under the policy. The insurer must instead take affirmative steps to make sure that the insured is informed of his remedial rights. *Id.* at 15.

C. Policyholders Reasonably Expect Adequate Payment by Health Plans For Their Healthcare

When selecting a health plan, policyholders assume that their health plan is providing adequate payment for all services rendered. This assumption is consistent with the stated objectives of the Knox-Keene Act to assure continuity of care and foster traditional physician-patient relationships. Health & Safety Code §1342. Indeed, the Knox-Keene Act itself reflects the fundamental concern that if capitation payments are actuarially insufficient, the inevitable loss to a physician is too great an incentive to provide substandard care and/or discontinue important physician-patient relationships—either of which defeats policyholders' reasonable expectations. Relevant provisions of the Act and its implementing regulations which demonstrate this recognition include the following:

1. Medical decisions must be rendered by qualified medical providers, unhindered by fiscal and administrative management. Health & Safety Code §1367.
2. Capitation rates must be actuarially sound. 28 C.C.R. §1300.51; 28 C.C.R. §1300.70.
3. Capitation rates must be adequate to reasonably assure the continuance of the relationship between the health plan and provider. 28 C.C.R. §1300.51II2.
4. Appropriate care which is consistent with professionally recognized standards of care must not be withheld or delayed for any reason, including a potential financial and/or an incentive to the plan providers. 28 C.C.R. §1300.70(b)(1)(D).
5. Contracts with providers must be fair, reasonable, and consistent with the objectives of the Knox-Keene Act. Health & Safety Code §1367.
6. Plan arrangements for health care services and schedule of rates must be financially sound. Health & Safety Code §1375.1.

7. Each contracting intermediary must have the administrative and financial capacity to meet the plan's contractual obligations. 28 C.C.R. §1300.70(b)(2)(H).

D. Inadequate Payments Could Compromise Quality Of Care

If capitation rates are not based on actuarially sound principles, there is a dangerous propensity for physicians to protect themselves from financial loss by reducing the level of care below medically optimal practices, that is, by withholding tests, delaying surgery, refusing to refer to a specialist, changing prescription drugs, moving the patient out of the hospital prematurely, etc. While this statement may be difficult to prove empirically, there have been a number of recent studies that are of concern. For example, there is evidence that there has been a significant decline in utilization within advanced managed care groups. As was stated by one study, "[c]ompared with a 1976-1980 fee-for-service plan, 1994 utilization levels in these advanced managed care groups were more than 25% lower for annual physician office visits and more than 80% lower for hospital days." These findings were without accompanying "evidence of safety."[1] Recent studies suggest that "the quality of care within managed care systems has declined, due to extreme reductions in utilization levels."[2]

Another study contained in the Journal of the American Medical Association, comparing health outcomes in HMOs with outcomes under the previous, fee-for-service (FFS) system, supports the concern that medically necessary services are not always being provided in a capitated environment.[3] The study finds that physical and mental health outcomes differ for subgroups of the population according to age and poverty status. Among Medicare patients, declines in physical health over a four-year period were about twice as common in HMOs than in the traditional FFS setting. Patients in low-income groups also had worse physical outcomes in HMOs than in FFS plans. The Study states that,

> . . . physical health was much less stable over time for elderly patients in HMOs compared to those in FFS . . . . The elderly treated in HMOs were nearly twice as likely to decline in physical health over time (54% vs 28%; [citations omitted].

---

[1] *Health Affairs*, "Managing Utilization Management: A Purchaser's View." May/June 1997, p. 87. (Attachment 6).

[2] *Id.* at 88.

[3] Ware, "Differences in Four-year Health Outcome for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-service Systems." (1996) 276 *JAMA* 1039. (Attachment 7)

> The difference in physical health outcomes favoring FFS over HMOs was statistically significant for elderly patients regardless of their initial health . . . . (Id. at pp. 1043-1044.)

The Study further states,

> Elderly patients sampled from an HMO were more likely (than those sampled from a FFS plan) to have a poor physical health outcome in all 3 sites [cities] studied. Second, patients in the poverty group and particularly those most physically limited appear to be at a greater risk of a decline in health in an HMO than similar patients in an FFS plan. (*Id.* at p. 1045.)

To compound the problem, the effect of inadequate capitation rates often cannot be detected as overutilization leaves a record of medical services performed that can be evaluated. With underutilization, there is no record of problems, symptoms, etc. which can be analyzed to determine whether or not necessary care was performed. Stephen R. Latham, "Regulation of Managed Care Incentive Payments to Physicians." *American Journal of Law & Medicine*, Vol. XXII, No. 4 (1996).

Perhaps most importantly, physicians believe that improper financial incentives result in compromised quality care. A recent study of California physicians indicates that financial incentives result in undesirable pressure for physicians and their practices, depending upon the type of incentive. Kevin Grumbach, M.D., et al., "Primary Care Physicians' Experience of Financial Incentives in Managed Care Systems." *New England Journal of Medicine* 1998:339:21-1516. (Attachment 9) The conclusion of this study was as follows:

> High quality care is unlikely to flourish in an environment that leaves physicians demoralized and leads many to believe that the standards of care have been compromised. Our results suggest that the goal of providing high-quality care may be better approached by the use of limited financial incentives based on the quality of care and patients' satisfaction than incentives that reward physicians for restricting access to specialty care or for squeezing in a greater number of visits per day. Policies that emphasize the former approach may enhance satisfaction with the U.S. health care system on the part of both patients and their physicians. (*Id.*)

As can be seen from the ongoing cycle of bankruptcies California's health care system is currently experiencing, the problem of health plans underpaying intermediaries pervades California. Yet health plans that are providing actuarially unsound capitation payments are marketing to the public that they provide comprehensive and preventative coverage, when they, in fact, are not paying for it. Policyholders are never made aware of this fact. Policyholders are coaxed into believing that these plans are paying for comprehensive coverage, and paying for it on an actuarial basis. They are misled into believing that their contracting providers are getting reimbursed sufficiently to provide the care they need.

This conduct must not be countenanced.

Unfortunately, the decision of the Court below allows this behavior to continue. By ruling that health plans are not ultimately responsible to make payments to treating physicians, health plans no longer have the responsibility to ensure the financial soundness of their arrangements with their contracting entities. They no longer need to make sure that their payments are sufficient to cover costs of care. They are no longer responsible to ensure continuity of care. The promises of the Knox-Keene Act are rendered moot. Policyholders' reasonable expectations are defeated.

E. Underfunding Intermediaries And Not Paying Treating Physicians Violates The Unfair Competition Laws.

The practice of underfunding intermediaries will be allowed to continue under the lower court's decision, even though the unfair competition law (UCL) has a very broad remedial purpose and scope. In Kraus v. Trinity Management Services, Inc., 23 Cal.4th 116 (2000), this court reiterated the importance of actions under the UCL in enforcing the law and protecting the public from unfair practices.

> Through the UCL a plaintiff may obtain restitution and/or injunctive relief against unfair or unlawful practices in order to protect the public and restore to the parties in interest money or property taken by means of unfair competition. *These actions supplement the efforts of law enforcement and regulatory agencies.* This court has repeatedly recognized the importance of these private enforcement actions.

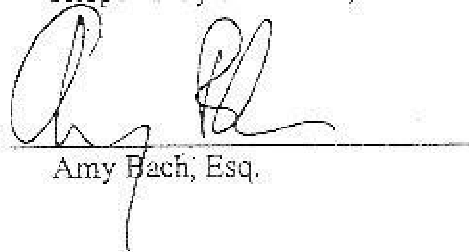
Kraus, supra, 23 Cal.4th at 126 (emphasis added).

The lower court's opinion denies relief under the UCL erroneously on the grounds that the Knox-Keene Act does not prohibit the activity in question. Even assuming the Act contains no such prohibition, which we dispute, the Knox-Keene Act certainly does not authorize health plans to cause massive patient disruption through the never ending cycle of bankruptcies that California is witnessing due to the underfunding of already financially unstable intermediaries. Where, as here, there is no statute expressly authorizing this unfair activity or barring this lawsuit, the UCL claims should be allowed to proceed. *See* Cal-Tech Communications, Inc., v. Los Angeles Cellular Telephone, Co. (1999) 20 Cal.4th 163, (stating "to forestall an action under the unfair competition law, another provision must actually bar the action or permit the conduct.")

For the reasons set forth above, we urge that this Court accept review of this decision.

Dated: February 20, 2002

Respectfully submitted,



By: ______________________
Amy Bach, Esq.

PROOF OF SERVICE

I am employed in the City and County of San Francisco, California, I am a citizen of the United States; I am over the age of 18 years and not a party to the within cause; my business address is 42 Miller Ave., Mill Valley, CA. 94941

I served the document(s) listed below by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, addressed as follows:

Date Served: February 20, 2002

Document: **LETTER SUPPORTING PETITION FOR REVIEW IN CMA V. AETNA, ET AL.**

Parties Served: (See attached list)

■ **(BY MAIL)** I caused such envelope to be placed for collection and mailing on that date in accordance with ordinary business practice for deposit in the United States at San Francisco, California. I am readily familiar with the practice of this office for collection and processing of correspondence for mailing with the United States Postal Service and that this correspondence will be deposited with the United States Postal Service on the same day as I deposit it in the office mail system in the ordinary course of business.

(BY PERSONAL SERVICE) I caused such envelope to be delivered by hand to the offices of the addressee.

(BY FEDERAL EXPRESS) I caused such envelope to be placed for collection and delivery on this date in accordance with standard Federal Express Overnight delivery procedures.

■ (State) I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct.

(Federal) I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

The original of any document filed with the court was printed on recycled paper.

Executed on February 20, 2002, at Mill Valley, California.