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CLERK SUPREME COURT

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

Re: Audrey Timmis et al v. Kaiser Permanente et al
(Supreme Court No. S) (Appellate Court No. 1D Civil No. A102962)

Letter Supporting Plaintiffs/Appellants' 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 Petition for Review in the above-referenced case. UP was founded in 1991 as a non-profit charity dedicated to educating the public on insurance issues and consumer rights. The organization's work is funded by donations and grants from individuals, businesses, and foundations.

UP serves as a non-commercial resource on insurance coverage and claims by monitoring legal and marketplace developments and by publishing materials that give practical guidance to policyholders. UP participates in legislative and regulatory proceedings, as well as industry forums and other proceedings on insurance-related issues.

United Policyholders' Amicus Project serves as a resource for the judiciary by filing briefs in cases that present significant insurance disputes. UP's *amicus* brief was cited in the U.S. Supreme Court's opinion in *Humana Inc. et al v. Mary Forsyth*, 525 U.S. 299 (1999). Arguments from our *amicus curiae* brief have been considered by this Court in many cases, including *Vandenburg v. Superior Court*, 21 Cal.4th 815 (1999), and in *Watts Industries, Inc. v. Zurich American Ins. Co*, ___ Cal. App. 4th ____, ___ Cal.Rptr.3d ____, 2004 WL 1879291 4 Cal. Daily Op. Serv. 7811, 2004 Daily Journal D.A.R. 10,523 (Cal.App. 2 Dist.).

UP urges this Court to accept review of the lower court's decision.

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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 treatments and prescriptions. That is the essence of health insurance. Petitioners presented evidence showing that Defendant/Respondents have a protocol that requires policyholders to physically alter medications to take the proper dosage. The evidence showed that this protocol could result in imprecise and sub-optimal dosages of medications. Petitioners' thereby established triable issues of fact as to whether or not Defendant//respondents are engaging in an improper business practice that defeats the reasonable expectations of their customers. It is the court system's proper function to allow a full fact finding proceeding and redress.

Review by this Court is warranted on the substantive issue the evidence raised as to the safety of forcing consumers to manually split pills, as well as the jurisdictional and procedural questions relating to judicial abstention and the parameters of this Court's holding in *Cel-Tech Communications, Inc. v. Los Angeles Telephone Co.* (1999) 20 Cal. 4th 163.

A. Health Plans Function As Health Insurers

In the context of health care coverage, employers and individual consumers are purchasing insurance, including coverage through a health maintenance organization (HMO), to ensure that medical care will be paid for fully and appropriately (with the exception of any cost-sharing amounts imposed by the plan). A condition of coverage that *de facto* requires imprecise pill splitting does not 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 makes sense 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.

C. Health Plans Cannot Be Permitted to Impose Unreasonable Conditions on Payment For Medically Necessary Prescriptions.

When selecting a health plan, policyholders fairly assume that the plan will impose only reasonable conditions on payment for medically necessary services and prescriptions. 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.

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).

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 14, 2005

Respectfully submitted,

By: _____

Amy Bach, Esq.
On behalf of United Policyholders

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF MARIN

I am employed in the County of Marin, State of California. I am over the age of 18 and not a party to the within action; my business address is 42 Miller Ave., Mill Valley, CA. 94941.

On this date, I served the within document described as: **Letter Brief in Support of Appellants' Petition for Review** on the interested parties in this action by placing true copies thereof, enclosed in sealed envelopes addressed and delivered as set forth below.

Service List

X **By Hand** Orig. + 13 — I personally delivered to::

California Supreme Court
350 McAllister Street
San Francisco, CA 94102

X **By Mail:** I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under practice, it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid at Newport Beach, CA in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

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Executed on February 14, 2005, at Mill Valley, California.

Amy Bach