G035579

IN THE COURT OF APPEAL
FOURTH APPELLATE DISTRICT, DIVISION THREE

CINDY HAILEY and STEVEN HAILEY,

Plaintiffs and Appellants,

vs.

CALIFORNIA PHYSICIANS' SERVICE dba
BLUE SHIELD OF CALIFORNIA,

Defendant and Respondent.

Appeal from a Judgment of the Orange County
Superior Court, the Hon. Corey S. Cramin, Judge Presiding

AMICUS BRIEF OF UNITED POLICYHOLDERS IN SUPPORT OF APPELLANTS

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CERTIFICATE OF INTERESTED PARTIES

Pursuant to California Rule of Court 8.208, *amicus* and its counsel certify that *amicus* and its counsel know of no other person or entity that has a financial or other interest in the outcome of the proceeding that the *amicus* or its counsel reasonably believe the justices of this Court should consider in determining whether to disqualify themselves under canon 3E of the Code of Judicial Ethics.

Dated: June 7, 2007

By:_____
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United Policyholders - The financial security that insurance policies provide is critical to consumers and is an integral part of the fabric of our economy and our society. United Policyholders, ("UP") is a non-profit charitable organization founded in 1991that is helping preserve the integrity of the insurance system by serving as an information resource on policyholders' interests, rights and duties. Donations, grants and volunteer labor support the organization's work.

UP monitors the national insurance marketplace with a particular focus on California. The organization's staff and volunteers participate in public policy forums, disseminate information about the claim process, and file *amicus* briefs in cases involving coverage and claim disputes. UP serves as a clearinghouse on consumer issues related to commercial and personal lines insurance products. **www.unitedpolicyholders.org**

The issue in this case - what constitutes post-claim underwriting in violation of Health & Safety Code section 1398.3 - is an issue of overwhelming importance to California consumers. If health care plans are permitted to conduct cursory underwriting investigations and issue health

care policies only to be permitted to rescind them when claims are submitted, consumers will, as demonstrated in this and numerous other cases, be devastated - both physically and financially - by medical bills they thought they had purchased protection from. UP has a compelling interest in assuring that both the letter and the spirit of section 1398.3 are fulfilled.

LEGAL ARGUMENT

1.

INTRODUCTION

Many of the issues relevant to the resolution of the issues raised in this Court's order of January 12, 2007 have been addressed by the appellants and the briefs of other *amici* submitted in support of the appellants. In order to avoid reiteration of the very compelling arguments asserted in those other briefs, this brief will be confined to three distinct issues not discussed elsewhere:

(1) The ability of a health care plan to cost-effectively conduct a comprehensive medical underwriting investigation ***before*** issuing a health care policy;

(2) The duty and ability of a health care plan to recognize when reasonable questions arise from information submitted in the application; and,

(3) The effect on a health care plan's ability to rescind a policy where its agent has breached its duties.

2.

A HEALTH CARE PLAN CAN - AND SHOULD - INVESTIGATE AN APPLICANT'S MEDICAL HISTORY PRIOR TO ISSUING COVERAGE, AND CAN DO SO EFFICIENTLY AND COST-EFFECTIVELY

As the *amicus* brief of the Department of Managed Health Care points out, section 1389.3 imposes two distinct obligations on a health care plan before it issues a policy. It must ***both*** (1) conduct medical underwriting, which consists of an investigation of the medical history of the applicant, ***and*** (2) resolve any conflicts arising from the information provided in the application and materials submitted in conjunction with it. Blue Shield's entire argument is predicated on prong (2) - arguing that the information on the application did not raise any issues that needed to be

resolved because the Haileys allegedly did not provide the requested information. The question of whether that, in fact, is a reasonable argument will be addressed in the next section of the brief.

For purposes of this discussion, however, Blue Shield's argument virtually ignores the first prong - its duty to actually conduct medical underwriting - claiming that the cost and delay in conducting a medical investigation before issuing the policy would be prohibitive.

Blue Shield asserts that it "had no duty (or, indeed, ability) to investigate matters" that were not included on the face of the Hailey's application for coverage. (RB 13.) Similarly, at page 44 of its brief, Blue Shield asserts that if it were required to conduct an extensive investigation of an applicant's medical history prior to issuing a policy, "that would slow the issuance of coverage and vastly increase its cost." Not only has Blue Shield failed to provide any factual or empirical evidence to support these statements, the statements are false.

First, as extensively discussed by the California Medical Association in its *amicus* brief, as confirmed by the DMHC in its brief, and as mandated by section 1389.3, Blue Shield does, indeed, have a ***duty*** to conduct an investigation of an applicant's medical history prior to issuing a policy. Indeed, that is the essence of "medical underwriting" as mandated in section 1389.3.

More importantly, and contrary to Blue Shield's assertions, such an investigation can be efficient and cost effective. Indeed, empirical evidence exists which demonstrates that fact. A study conducted by Milliman, Inc., and authored by Jon Shreve, FSA, MAAA, demonstrated that the use of medical history database services, such as that provided by the MIB Checking Service, improved a health care plan's loss ratio and actually ***saved*** the company between $43 and $51 for every dollar spent. (Shreve, *The Impact of the MIB Checking Service on Health Insurance Underwriting; Loss Ratio and Protective Value Analysis*, Milliman, Inc., available at http://www.mib.com/webcontent/Milliman%20Health%20PV%20Summary.pdf, last accessed 6/6/07, a copy of which is attached as Exhibit A.)

As discussed in the Milliman study, a health care plan, USHEALTH Group, uses the MIB Checking Service to assess the medical risks of applicants for health care coverage. MIB is a not-for-profit trade group founded in 1902 which has built an extensive historical database of medical information about consumers acquired from member insurers. (See Miller, *Fraud Finding* , Managed Healthcare Executive, September 2005, available at http://www.mib.com/webcontent/200509_HealthMarket_MHE9-25-05e.pdf, last accessed 6/6/07, a copy of which is attached as Exhibit B.)

In the study, Shreve reviewed 894 uses of the MIB Checking Service

by USHEALTH and "calculated projections of premiums and claims, both with and without using the MIB Checking Service." (Shreve, p. 1.) An independent underwriting consultant reviewed the information from USHEALTH and MIB, estimated the usefulness of the MIB information and assessed both the direct indirect costs associated with using MIB for underwriting each application. (*Id.*, p. 2.)

Notably - in contrast to Blue Shield's assertion that medical underwriting would be prohibitively expensive - the MIB cost per policy charged to USHEALTH was a mere $2.42. And even the indirect costs are minimal: The study assumed that if useful information was returned from the MIB system, an additional $50 in indirect costs would be required to further investigate that information. More importantly, the study concluded that, even with the additional indirect costs, the use of the system resulted in overall savings of up to $51 for each dollar spent on the MIB check - because high-risk applicants would be declined and the losses associated with those applicants were avoided.

Other tools for efficient and cost-effective medical underwriting also exist. For example, Ingenix is a company that has developed a predictive model for assessing health care risks of health care plan applicants based on prescription profiling. Notably, the prescription profiling is based on database information about consumers legally obtained from multiple

sources that includes the name of the drug, the possible diagnosis and the prescribing physician - ***thus wholly "eliminating reliance on health questionnaires***." (See Ingenix, Real Time Medical Underwriting: Accelerating small group underwriting while improving efficiency, accuracy, and effectiveness, **http://www.ingenix.com/content/ attachments/06-10304%**20RTMU%20Exec%20Briefing.pdf, p. 2; emphasis added, last accessed 6/6/07.)

The availability of these services belie Blue Shield's assertion that it could not reasonably be expected to conduct a thorough medical investigation before issuing a policy to the Haileys or that it could not look beyond the application for information about the medical risks involved. Blue Shield not only had the duty to conduct an pre-claim investigation rather than a post-claim investigation, it had the resources to do it.

This point is critically important. As the evidence in the trial court made clear, Cindy Hailey made a mistake when she filled out the Blue Shield application: She thought the medical history questions only pertained to her. Blue Shield, however, did not make a mistake - it made a deliberate choice to conduct something far less than a full medical underwriting assessment of the application; it made a deliberate choice to "roll the dice," issue the policy and wait and see what happened. The Haileys had no way to protect themselves from Cindy Hailey's mistake. The Haileys had no

way to protect themselves from Blue Shield's deliberate decision. As a matter of equity and public policy, the burden of Blue Shield's choice should not and cannot be placed on the Haileys. Having failed to fulfill its obligation to conduct a reasonable medical underwriting investigation on Steven Hailey, it is Blue Shield that must suffer the consequences, not the Haileys.

2.

THE LACK OF MEDICAL INFORMATION REGARDING STEVEN HAILEY PUT BLUE SHIELD ON NOTICE THAT THE APPLICATION WAS INCOMPLETE AND IT WAS BLUE SHIELD'S BURDEN TO SEEK FURTHER INFORMATION

3.

THE NEGLECT OF ITS AGENT IN FAILING TO OBTAIN THE NECESSARY INFORMATION IS IMPUTED TO BLUE SHIELD AND PRECLUDES BLUE SHIELD FROM RESCINDING THE HAILEY'S POLICY

Finally, there is one other issue that is wholly ignored by Blue Shield: its liability arising from the negligence or fraud of its own agent. As the evidence in the trial court made clear, Cindy Hailey mistakenly thought that the medical history questions in the application pertained only to her and she provided that information. She did not realize that she was supposed to provide information regarding each of her family members. That was a mistake. But Blue Shield's agent engaged in what is at least negligence and potentially fraud by falsely certifying that he had asked Cindy Hailey each question and accurately reported her responses.

As set forth in the evidence submitted to the trial court, Cindy Hailey filled out the application and forwarded it to Blue Shield's agent, Tim Patrick. Although Mr. Patrick spoke to Cindy Hailey about some of the information in the application, he did not go over any of the questions, he did not specifically ask her each question on the application, and he did not

inform her that the application questions applied to her husband and son. (AOB, p. 5; AA 608-609.) More importantly, the undisputed evidence before the trial court is that, had Mr. Patrick informed Cindy Hailey that the questions were to be responded to with regard to the health history of her husband and son, she would have truthfully answered those questions. (*Id.*) Thus, the facts demonstrate that it was the negligence (or fraud) of Blue Shield's own agent that caused the application to be insufficient.

It has been the law in California since 1872 that the neglect of an agent inures to the detriment of the agent's principal, not to the third parties with whom the agent transacts business. As Civil Code section 2330 explains, all the "rights ***and liabilities"*** of a transaction entered into by the agent "accrue to the principal." (Emphasis added.) Moreover, Civil Code section 2332 also provides that notice to either is notice to both:

> As against a principal, both principal and agent are deemed to have notice of whatever either has notice of, and ought, in good faith and the exercise of ordinary care and diligence, to communicate to the other.

Section 2332 is a rule of constructive notice that precludes a principal - like Blue Shield - from claiming material omissions when, in fact, those omissions are caused by the conduct of its own agent. As the

court in *Columbia Pictures Corp. v. DeToth* (1948) 87 Cal.App.2d 620, 630-631:

> The fact that the knowledge acquired by the agent was not actually communicated to the principal, as contended by appellant, does not prevent operation of the rule. The knowledge is, in law, imputed to the principal. The agent may have been guilty of a breach of duty to his principal, yet the knowledge has the same effect as to third persons as though his duty had been faithfully performed. The agent acting within the scope of his authority, is, as to the matters existing therein during the course of the agency, the principal himself. [Citations.] ***This rule of law is not a rebuttable presumption. It is not a presumption at all. It is a rule which charges the principal with the knowledge possessed by his agent***. (Emphasis added.)

What this means is that ***Blue Shield is deemed in law to have known that the Haileys weren't asked each question and that the responses were not accurately recorded***. That means Blue Shield was on notice that the information in the application was not necessarily complete. Knowing that, and failing to investigate the omissions violated Blue Shield's duty under section 1389.3 and renders its attempted rescission

invalid.

Nor can Blue Shield attempt to argue that because it was Mr. Patrick's negligence that resulted in the harm to the Haileys, the Haileys must look to Mr. Patrick for their remedy. Obviously, another fundamental precept of agency law is the fact that the principal is liable for the negligence of its agent, even when those acts are unauthorized. (Civil Code sections 2338, 2334.) Although Blue Shield may have a right to seek indemnification from its agent, it still remains primarily liable for the harm to the Haileys caused by its agent.

The bottom line here is that Blue Shield's agent did not do his job correctly; there are, at the very least, triable issues of fact as to whether his negligent failure to go through the application with Cindy Hailey resulted in the Hailey's damage; and, Blue Shield cannot benefit from the negligence of its agent. Because it constructively knew that the application was incomplete and it failed to investigate and obtain complete information, its later investigation and rescission violated section 1389.3 and its duty of good faith and fair dealing.

CONCLUSION

The facts in this case demonstrate the imbalance evident from a health care plan's failure to do its job in underwriting a policy before issuing it. Because the health care plan can engage in post-claim "investigation" in stealth, without notice to the member that their insurance is at risk and can "hedge its bets" by failing to investigate the health risks of the applicants before issuing the policy, safe in the knowledge that it can always rescind later, it can create a "win-win" situation for itself: It can save money by not underwriting the policy before its issuance, while collecting premiums without risk; if extensive medical claims arise, it can then do its "investigation," escape the risk and simply tender back the premiums. Health & Safety Code section was designed to stop this practice and to require a health care plan to retain the risk it assumed when it issued the policy unless fraud is involved. Blue Shield cannot be permitted to undermine the public policies underlying section 1389.3 by simply turning a blind eye to information it either knew or had access to and ignored. Its attempted rescission was invalid and the invalidity of that rescission warrants the issuance of the supersedeas order in this case.

Dated: June 6, 2007

ARKIN & GLOVSKY

By: _____
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CERTIFICATION REGARDING LENGTH OF BRIEF

I hereby certify that this brief contains 2831 words, including footnotes, as established by the word count of the computer program utilized for the preparation of this brief.

I declare and certify under the laws of the State of California that the foregoing statement is true and correct and that this certification was executed on April 30, 2007 at Lake Forest, California.

By:_____
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