MICHAEL J. BIDART #60582
RICARDO ECHEVERRIA #166049
STEVEN MESSNER #259606
SHERNOFF BIDART ECHEVERRIA BENTLEY LLP
600 South Indian Hill Boulevard
Claremont, CA 91711
Telephone: (909) 621-4935
Facsimile: (909) 625-6915

Attorneys for Plaintiff Taub

Harvey Rosenfield #123082
Pamela Pressley #180362
Jerry Flanagan #271272
CONSUMER WATCHDOG
2701 Ocean Park Blvd., Suite 112
Santa Monica, California 90405
Telephone: (310) 392-0522
Fax: (310) 392-8874

Attorneys for Plaintiffs Kassouf, Heath, and Jacobson

SHERNOFF BIDART ECHEVERRIA BENTLEY
LAWYERS FOR INSURANCE POLICYHOLDERS

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ERIC TAUB, individually, and on behalf of others similarly situated,

Plaintiff,

vs.

BLUE CROSS OF CALIFORNIA, d/b/a ANTHEM BLUE CROSS; and DOES 1 - 100, inclusive,

Defendants

Case No.: BC457809 consolidated with Case No.: BC473408

[Hon. Jane L. Johnson Dept. 308]

PLAINTIFF KASSOUF, HEATH, JACOBSON'S OPPOSITION TO DEMURRER TO FOURTH CAUSE OF ACTION FOR VIOLATION OF THE CONSUMERS LEGAL REMEDIES ACT

Date: March 6, 2013
Time: 10:00 a.m.
Place: Dept. 308

Date Action Filed: March 21, 2011
Trial Date: TBD

1 JANET KASSOUF, ALISON HEATH, and DAVID JACOBSON, individually, and on behalf of others similarly situated,

Plaintiffs,

vs.

BLUE CROSS OF CALIFORNIA, d/b/a ANTHEM BLUE CROSS; and DOES 1-100, inclusive,

Defendants

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Plaintiffs submit this Memorandum of Points and Authorities in opposition to Defendant Blue Cross of California's d/b/a Anthem Blue Cross ("Defendant" or "Blue Cross") Demurrer to Plaintiff Kassouf, Heath and Jacobson's Class Action Complaint ("Kassouf Complaint"). Defendant demurred solely to Plaintiffs' Fourth Cause of Action for Violation of the Consumers Legal Remedies Act ("CLRA"), Civil Code section 1750 et seq. For the following reasons, the demurrer must be overruled and Defendant ordered to file an Answer.

I. INTRODUCTION AND SUMMARY OF ALLEGATIONS

Plaintiffs bring this action in part to challenge Blue Cross's adoption of unconscionable contract provisions allowing Blue Cross to unilaterally change, each month, any "terms or conditions" of Class members' coverage, in violation of the CLRA. (Kassouf Complaint, ¶ 38.) The sole basis for Defendant's demurrer, relying on *Fairbanks v. Superior Court* (2009) 46 Cal.4th 56 ("*Fairbanks*"), is Defendant's spurious supposition that the "health service plan" coverage[1] at issue here is the same as "life insurance," which *Fairbanks* held was not a "service" recognized by the CLRA. This contention is ***expressly refuted*** by:

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- The ***California Supreme Court***. The Supreme Court has recognized the ability of consumers to sue companies providing health service plans, such as Defendant, for violations of the CLRA in *Broughton v. Cigna Healthplans* (1999) 21 Cal.4th 1066, 1077, and *Cruz v. PacifiCare Health Systems, Inc.* (2003) 30 Cal.4th 303, 316. Furthermore, *Fairbanks* by its express language does not extend to every form of insurance. In fact, the Supreme Court specifically states that it is only addressing *life insurance* – a fundamentally different product than the services at issue here. (*Fairbanks*, 45 Cal.4th at 60, fn. 1.)

- The fact that ***Blue Cross undeniably provides "services."*** Blue Cross's ongoing "work and labor"[2] on behalf of enrollees to review and approve the quality of health care providers, including doctors and hospitals, and establish

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[1] Defendant Blue Cross is a "health care service plan" regulated by the Department of Managed Health Care. (Health & Saf. § 1345(f).) Coverage provided by a health care service plan is referred to herein as a "health service plan" or "plan."

[2] The relevant CLRA provision defines "services" as "work, labor, and services for other than a commercial or business use, including services furnished in connection with the sale or repair of goods." (Civ. Code § 1761(b).)

1 and maintain "preferred provider" networks, lies at the heart of the PPO ("preferred provider organization") health service plans at issue here. *But for* 2 these *preferred provider* networks, there would be no "PPO."

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- ***Blue Cross itself in front of this Court***. In a previous case before this Court, 4 Blue Cross strenuously argued that it was "not an insurer," equating itself to a health care service plan that provides "services."[3] (See, e.g., Declaration of Jerry 5 Flanagan in Support of Request for Judicial Notice, ["Flanagan Dec."], Exhibit A 6 at 1:9, 3:16-4:17, filed herewith and incorporated by reference.)[4]

7 It has been fifteen months since the Kassouf Complaint was filed. Each month, 8 consumers are harmed by being required to pay more out of pocket for their health care 9 as a result of Defendant's acts. Many face ongoing health problems with coverage that 10 Blue Cross has unilaterally rendered inadequate. The Court should overrule 11 Defendant's demurrer and order Blue Cross to file an Answer to the Kassouf Complaint.

12 ***This Court can and should conclude, as a matter of law, that the Blue Cross 13 health service plans at issue here are "services" recognized by the CLRA. At a 14 minimum, answering this question involves factual disputes, which are not 15 properly resolved by demurrer.*** (See II.A and II.B, *supra*.)

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17 **A. Plaintiffs' Allegations**

18 Plaintiffs bring this action to challenge an insidious and devastating form of bait 19 and switch. Defendant induced Class members to purchase and renew Defendant's 20 health service plans on the basis of attractive premiums, deductibles, and benefit levels. 21 Blue Cross markets its health service plans as having an "annual deductible" and other 22 "annual" and "yearly" benefits. Other than the amount of the monthly premium, the

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25 [3] The only issue before this Court on the instant demurrer is whether the Defendant's health service plans are "services" subject to CLRA.

26 [4] The previous case before this Court concerned whether Blue Cross was an "insurer" required 27 to pay the Gross Premium Tax under Article XIII, Section 28 of the California Constitution. In that case, this Court sustained the demurrer, to which Blue Cross filed supporting briefs as a 28 Real Party in Interest, without leave to amend. (*The Foundation for Taxpayer and Consumer Rights v. State Board of Equalization, et al.* (Super. Ct. Los Angeles County, 2005, No. BC324947).)

deductible is the essential term of the health service plan contract ("Evidence of Coverage" or "EOC"). The amount of the "annual deductible" is so central to the identity of the health service plan that it is incorporated in the name of the plan. For example, the "PPO Share 1500" plan is so named because of its $1,500 "annual deductible." (Kassouf Complaint, ¶¶ 1-3, 28, 30-32.)

In 2011, Blue Cross unilaterally:

- Increased "annual deductibles" and other "annual" and "yearly" out of pocket costs in the *middle* of the year, including annual prescription drug deductibles, and annual copayment/coinsurance maximums. As a result, Plaintiffs and Class members must pay more out of pocket for their health care. (Kassouf Complaint, ¶¶ 33-35.)
- Adopted changes to EOCs allowing Blue Cross to change any "terms and conditions" of its coverage benefits each month on just sixty days notice. (Kassouf Complaint, ¶ 38.)
- Converted individual health service plan contracts from annual to month-to-month in duration. Thus, the health service plans now terminate at the end of each month and "renew" upon payment of the next month's premium. As a result, consumers are more likely to be terminated due to payments delayed by mail or processing errors by Blue Cross. (Kassouf Complaint, ¶ 38.)

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Blue Cross claimed that the mid-year changes to "annual" and "yearly" out of pocket costs were necessary business actions to protect consumers from premium increases (Kassouf Complaint, ¶ 4), yet Blue Cross:[5]

- Simultaneously increased premiums by 20% or more. (Kassouf Complaint, ¶ 34.)
- Had five times the required reserves (tangible net equity ["TNE"])—$1.2 billion in *excess* of state-mandated TNE—as of June 30, 2011 while the company paid $525 million in dividends to shareholders in 2010. (Kassouf Complaint, ¶ 4.)

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[5] As discussed in the Plaintiffs' Oppositions to the Motions to Strike filed herewith, Blue Cross's conduct as described in the Kassouf and Taub Complaints was intended by them to cause injury to members of the Class and/or was despicable conduct carried on by Blue Cross with a willful and conscious disregard of the rights of members of the Class, subjected members of the Class to cruel and unjust hardship in conscious disregard of their rights, and was an intentional misrepresentation, deceit, or concealment of material facts known to Blue Cross with the intention to deprive members of the Class property, legal rights or to otherwise cause injury, such as to constitute malice, oppression or fraud under Civil Code section 3294, thereby entitling Plaintiffs and members of the Class to exemplary damages in an amount appropriate to punish or set an example of Blue Cross.

- *Postponed* similar mid-year changes to its nearly identical policies regulated by the California Department of Insurance. (Kassouf Complaint, ¶ 36.)[6]

B. Blue Cross's Illegal Acts

Through its conduct of unilaterally escalating annual out of pocket costs and unilaterally altering EOCs to allow Blue Cross to change any "terms and conditions" on just sixty days notice, Blue Cross:

- Breached the individual health service plan contracts entered into with Plaintiffs and California consumers and breached its duty of good faith and fair dealing. (Kassouf Complaint, ¶¶ 50-60.)

- Violated Health and Safety Code section 1360, which bars companies providing health service plans from using any advertising or solicitation that is untrue or misleading, or any EOC that is deceptive. Blue Cross's misrepresentations about annual costs also violate Health and Safety Code section 1360. (Kassouf Complaint, ¶¶ 75-88.)

- Violated provisions of the California Code of Regulations barring health service plans from imposing restrictions or limitations that render contract benefits "illusory." (Kassouf Complaint, ¶ 84.)

Pertinent to this Demurrer, Defendant engaged in various unfair and deceptive acts in violation of the CLRA. For example, Blue Cross violated the CLRA by:

- Representing and advertising that its health service plans have an "annual deductible" and other "yearly" out of pocket costs of one amount and then unilaterally increasing that amount during the annual period the costs are accruing. (Civ. Code § 1770(a)(9), (14); Kassouf Complaint, ¶¶ 65-74.)

- Unilaterally adopting unconscionable provisions in its contracts allowing Blue Cross to change "any term and condition" of Plaintiffs' health service plans each month, and reducing the plan contract duration to month-to-month. (Civ. Code § 1770(a)(19); Kassouf Complaint, ¶¶ 65-74.)

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[6] Defendant here is regulated by the Department of Managed Health Care. (See footnote 1.).

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II. ARGUMENT

A. Legal Standard Applied to Demurrers

"A demurrer tests the sufficiency of the complaint as a matter of law; as such, it raises only a question of law." (*Osornio v. Weingarten* (2004) 124 Cal.App.4th 304, 316). "It is not the ordinary function of a demurrer to test the truth of the plaintiff's allegations or the accuracy with which he describes the defendant's conduct. A demurrer tests only the legal sufficiency of the pleading." (*Committee On Children's Television, Inc. v. General Foods Corp.* (1983) 35 Cal.3d 197, 213.) As such, "in considering the merits of a demurrer, 'the facts alleged in the pleading are deemed to be true, however improbable they may be.'" (*Berg & Berg Enterprises, LLC v. Boyle* (2009) 178 Cal.App.4th 1020, 1034.) As long as Plaintiffs and the Class are entitled to some form of relief under the circumstances pled and at least one aspect of the claims for relief would survive, a general demurrer must be overruled. (*Quelimane Co. v. Stewart Title Guaranty Co.* (1998) 19 Cal.4th 26, 38-39; *Kong v. City of Hawaiian Gardens Redevelopment Agency* (2002) 108 Cal.App.4th 1028, 1047.)

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B. Plaintiffs' CLRA Claim is Valid

A CLRA cause of action arises as a result of unfair and deceptive acts in the provision of "goods or services to any consumer." (Civ. Code § 1770(a); see also Civ. Code § 1760 [The CLRA is to be "*liberally construed and applied to promote its underlying purposes*, which are to protect consumers against unfair and deceptive business practices . . . ."], emphasis added.) The sole basis of Blue Cross's demurrer, relying exclusively on *Fairbanks*, is that health service plans are not "services" recognized by the CLRA. (46 Cal.4th at 61.) However, the Supreme Court in *Fairbanks* ***expressly refused*** to extend its ruling that a life insurance policy is neither a "good or a service" to other forms of insurance. (*Ibid.*)[7] As described below, life insurance policies,

[7] As stated by the *Fairbanks* court, "Although the parties have framed the issue as whether insurance in general is a service for purposes of the Consumers Legal Remedies Act, and

which *Fairbanks* characterized as nothing more than a "contractual obligation to pay money," is very different than the health service plans at issue here. (*Ibid.*)

1. The California Supreme Court Found Health Service Plans Subject to the CLRA

The California Supreme Court has recognized the ability of consumers to sue companies providing health service plans such as Blue Cross for violations of the CLRA. (*Broughton v. Cigna Health Plans* (1999) 21 Cal.4th 1066, 1077; see also *Cruz v. PacifiCare Health Systems, Inc.* (2003) 30 Cal.4th 303, 316 [claims based on violation of UCL and CLRA].) As these California Supreme Court decisions were not discussed in *Fairbanks*, let alone overruled, this Court must reconcile them. (*People v. Newman* (1998) 65 Cal.App.4th 352, 354 ["In order to resolve the issue, we must reconcile several decisions by the California Supreme Court."].) The easiest way to do so is to read *Fairbanks* for what it actually says—that life insurance is the only insurance product covered by its decision. As discussed below, health service plans are "services" recognized by the CLRA. (Civ. Code § 1761(b).) This is the only reasonable construction given the substantial differences between life insurance policies and health service plans.

2. Blue Cross's Work and Labor to Establish and Maintain Provider Networks are "Services"

The Blue Cross coverage at issue here are "preferred provider organization" ("PPO") health service plans. The principle characteristic of Blue Cross's PPO health service plans is an ever-changing, extensive network of approved health care providers, including doctors and hospitals, with whom Blue Cross contracts with, after certifying their quality, to provide a range of covered treatments and benefits at a negotiated price to consumers. (See, e.g., *Rubinstein Physical Therapy v. PTPN, Inc.* (2007) 148

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although both the trial court and the Court of Appeal took that broad view of the issue, ***we have narrowed the issue to focus only on life insurance***." (*Fairbanks*, *supra*, 46 Cal.4th 56, 60,

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Cal.App.4th 1130, 1136, review denied; Gasparovich, *Preferred Provider Organizations Providing Contracting: New Analysis Under the Sherman* Act (1985) 37 Hastings L.J. 377, 380.)

Section 1761, subdivision (b) of the CLRA defines "services" as "work, labor, and services for other than a commercial or business use, including services furnished in connection with the sale or repair of goods." Blue Cross's ongoing "work and labor" to establish, maintain, and improve "preferred provider" networks of hospital and doctors is the core of the PPO ("*preferred provider* organization") health service plans at issue here. In fact, *but for* the *preferred provider* networks, there would be no such thing as a "PPO". In short, Blue Cross provides extensive services that do not exist for consumers enrolled in the life insurance policies considered in *Fairbanks*. For example:

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- Blue Cross advertises its PPO coverage by promoting the network services it provides, and the "work and labor" Blue Cross expends in order to ***guarantee quality*** and ***provide consumer choice***: Blue Cross's website promises: "Network – Quality. We work with our network doctors and hospitals, so you can get high-quality care at a low cost…." and, "Network – Choice. Our large networks mean you will likely find doctors that you know."[8] Blue Cross's "work and labor" to certify the "quality" of its health care providers and assure consumer "choice" are not available to consumers enrolled in "indemnity" health insurance policies, as discussed below.

- In order to access the key benefits of their PPO health service plans, a consumer *must visit one of the preferred providers in Blue Cross's network*. PPO consumers benefit from Blue Cross's "work and labor" to establish networks of high-quality hospitals and doctors, as co-payments and/or co-insurance are lower for in-network services.[9]

- As attested by numerous news reports and Blue Cross's own Press Releases, Blue Cross expends a tremendous amount of "work and labor" to maintain its preferred provider networks, which often requires Blue Cross to engage in substantial *contract negotiations with*

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fn.1, emphasis added.)

[8] Blue Cross of California, http://www.anthem.com/ca/health-insurance/home/overview (last visited Feb. 6, 2013) (quoted text appears on the home page, slider 4 and 5.)

[9] See, e.g. Kassouf Complaint, Exhibit A, PPO Share $2,500 Plan, Health Plan Benefits and Coverage Matrix, p. 2-6; Kassouf Complaint, Exhibit B, PPO Share $1,500 Plan, Health Plan Benefits and Coverage Matrix, p. 2-6; Kassouf Complaint, Exhibit C, PPO Share $500 Plan, Health Plan Benefits and Coverage Matrix, p. 2-6. All plan documents were incorporated by reference into the Kassouf Complaint.

physician groups and hospitals that can last more than a year.[10]

- In an effort to attract new customers and retain existing members, Blue Cross expends significant "work and labor" to continuously improve its provider networks by sponsoring initiatives aimed at providing integrated, cost efficient health care.[11]
- Of the enormous resources – $755,498,000 in just the first nine months of 2012 – that Blue Cross spends on administration of health service plans, a massive portion is dedicated to the maintenance and improvement of its preferred provider networks.[12]

The services provided by Blue Cross are in no way diminished by the fact Blue Cross also pays or reimburses doctors and hospital *for other services* in the form of medical care to consumers, contrary to Defendant's demurrer. (Blue Cross Demurrer ["Blue Cross Dem."], 4:28—5.1.) Nor are the services at issue here "ancillary services" to which the CLRA does not extend. "Ancillary services" pertain to truly *peripheral acts.* (*Fairbanks*, 46 Cal.4th at 65 ["ancillary services" are limited to ". . . helping consumers select policies that meet their needs, in assisting policyholders to keep their policies in force, and in processing claims . . . "].) In contrast, the services discussed above lie at the heart of the Plaintiffs' PPO health service plans.

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[10] See, e.g. Press Release, Anthem Blue Cross and Brotman Medical Center Reach Agreement, (Feb. 14, 2012), available at http://www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2012/1046; Press Release, Anthem Blue Cross, University of California Health Reach Agreement, (Jan. 17, 2012), available at http://www.anthem.com/ca/health-insurance/about-us/press-room/CA/2012; Girion, *Blue Cross, L.A. Hospitals Settle Dispute*, L.A. Times (Mar. 16, 2010), available at http://articles.latimes.com/2006/mar/16/business/fi-centinela16; Girion, *Blue Cross Coverage Extended in Dispute*, L.A. Times, (Feb. 25, 2006), available at http://articles.latimes.com/2006/feb/25/business/fi-centinela25.

[11] See, e.g. Press Release, Blue Cross of California, Anthem Blue Cross, University of California Health Form Alliance, (Nov. 13, 2012), available at http://www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2012/1198; Press Release, Blue Cross of California, Hospitals in Patient Safety First Collaborative Reduce Early Elective Deliveries by 65%, (Sept. 12, 2012), available at http://www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2012/1114;

[12] Department of Managed Health Care, September 30, 2012, Revenue, Expenses and Net Worth, line 33, available at and incorporated herein by reference: http://wpso.dmhc.ca.gov/fe/search/#top (Health Plan Type: "Full Service"; Health Plan: "Blue Cross of California"; Statement Type: "Quarterly"; Year: "2012"; Quarterly Date Range: "July 1 – September 30".)

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3. Health Service Plans Are Not Pure "Indemnity" Insurance Like Life Insurance

Defendant also claims that, "[l]ike life insurance . . . health insurance plans . . . are *contracts of indemnity* under which Anthem Blue Cross promises to pay a sum of money to a health care provider that renders covered services . . . ." (Blue Cross Dem., 4:27-5:1.) Blue Cross's argument in support of its demurrer equating the "health care service plan" coverage at issue here with pure "indemnity" life insurance policies fails for two reasons.[13]

First, the distinction between pure "indemnity" contracts like life insurance, and the services offered by health service plans has long been recognized by California courts and the Legislature. In *California Physicians' Service v. Garrison* (1946) 28 Cal.2d 790 ("*Garrison*"), the California Supreme Court considered whether health service plans issued by California Physicians' Services d/b/a Blue Shield of California, which are now regulated by the Department of Managed Health Care as are Defendant's health service plans, should be regulated like the pure indemnity products under the Department of Insurance. The Court found that:

> Absence or presence of assumption of risk or peril is not the sole test to be applied in determining its status. The question, more broadly, is whether, looking at the plan of operation as a whole, *'service' rather than 'indemnity' is its principal object and purpose.*

(*Id.* at 809, emphasis added; see also Flanagan Dec., Exhibit A, 3:3-15.). The court concluded that "[f]or these reasons the respondent is not engaged in the business of insurance within the meaning of the regulatory statutes." (*Id.* at 811.) Following *Garrison*, the Legislature also recognized that PPO contracts are quite different from pure "indemnity" coverage. In fact, in 1982, the Legislature recognized that traditional

[13] "Life insurance is a contract of indemnity under which, in exchange for the payment of premium, the insurer promises to pay a sum of money to the designated beneficiary upon the

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indemnity insurers were prohibited from selling PPO coverage that utilized networks of preferred providers. In response, the legislature enacted 10133, subdivision (b) to allow insurers to sell these service contracts. (Ins. Code § 10133(b).)

In addition, the Second District Court of Appeal has found that although health care service plans like Blue Cross may be considered "engaged in the business of insurance" within the meaning of the federal McCarran-Ferguson Act, they are not "insurers" for regulatory purposes or for determining whether they provide "services." (See e.g., *Smith v. Pacificare Behavioral Health of California, Inc.* (2001) 93 Cal. App. 4th 139, 158; *Imbler v. Pacificare of California, Inc.* (2002) 103 Cal. App. 4th 567, 573; *Malek v. Blue Cross of California* (2004) 121 Cal.App.4th 44, 63; *Rodriquez v. Blue Cross* (2008) 162 Cal.App.4th 330, 332.) Therefore while under the McCarran-Ferguson Act a health care plan is in the "business of insurance" for determining whether state or federal law should be applied to interpret arbitration provisions in health service plan contracts, that does change the fact Blue Cross provides "services" recognized by the CLRA. (See *Smith, supra*, 93 Cal. App.4th at 159, *Fairbanks*, *supra*, 46 Cal.4th at 61.)

Second, in previous litigation Blue Cross has taken the position that PPO health service plans are a *"hybrid of HMO and indemnity plans."* (Flanagan Dec., Exhibit A, 2:23-3:2, emphasis added.) In other words, "indemnity" coverage "is a contract by which [an insurer] engages to save [a policyholder] from a [medical expense]." (Civ. Code § 2772). In PPO health service plans, like in indemnity insurance, consumers have greater latitude to choose their own physician. However, like HMOs, PPO health service plans rely on networks of contracted doctors and other health care providers with whom they have negotiated lower rates.

As discussed above, Blue Cross does not merely pay doctors and hospitals to provide services to consumers. Blue Cross expends significant and ongoing "work and labor" on behalf of its customers to ***identify and contract with high quality hospitals***

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death of the named insured . . . . An insurer's contractual obligation to pay money under a life

and doctors who agree to provide covered benefits at lower co-payment rates. To avail themselves of the lower rates, Blue Cross health service plan members must agree to utilize those preferred providers. It is precisely these networks of approved high-quality "preferred providers"—and the "work and labor" required to identify providers and build and maintain the networks—that distinguishes the PPO health service plans at issue here from the life insurance policies considered in *Fairbanks.* A life insurance policy, unlike a health service plan, is more akin to a financial instrument; it is an asset, it can be monetized, and borrowed against.[14]

4. The California Supreme Court Deemed Health Service Plans to be "Services" Prior to the Enactment of the CLRA

Finally, Defendant's argument that the absence of the term "insurance" or "health service plan" in the CLRA's definition of "services" is dispositive of the Legislature's intent to exclude PPO health service plans from the purview of the CLRA also fails. (Blue Cross Dem., 5:7-5:14.) In California, courts presume the Legislature was aware of the state of the law at the time it enacted remedial legislation. (*People v. Licas* (2007) 41 Cal.4th 362, 367.) Therefore, there was no need for the Legislature to include a reference to "health service plans" in the CLRA, enacted in 1970, because the California Supreme Court had already deemed them to be "services" *twenty-four years earlier* in *California Physicians' Service v. Garrison* (1946) 28 Cal.2d 790, 809 as noted above.

III. CONCLUSION

This Court can and should conclude, as a matter of law, that the Blue Cross PPO health service plans at issue here provide "services" recognized by the CLRA. (*Osornio v. Weingarten, supra*, 124 Cal.App.4th at 316; see II.A, *supra*). At a minimum, answering this question involves factual disputes, which are not properly resolved by demurrer. (*Committee On Children's Television Inc., supra,* 35 Cal.3d at 213; see II.A,

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insurance policy is not work or labor . . . ." (*Fairbanks*, *supra*, 46 Cal.4th at 61.)

[14] ING, http://ing.us/individuals/my-financial-life/preparing-retire/life-insurance-asset-class (last visited Feb. 6, 2013).

SHERNOFF BIDART ECHEVERRIA BENTLEY LAWYERS FOR INSURANCE POLICYHOLDERS

1 *supra*.) For all the above reasons, Defendant's demurrer must be overruled, or leave to
2 amend granted if any reparable deficiencies are identified by the Court. (*Cordonier v.*
3 *Central Shopping Plaza Assoc.* (1978) 82 Cal.App.3d 991, 998-999.)
4
5 DATED: February 7, 2013 Respectfully Submitted,
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7 Harvey Rosenfield
8 Pamela Pressley
Jerry Flanagan
9 **Consumer Watchdog**
10

11 By: ______________________
12 Jerry Flanagan
13 **Attorneys for Plaintiffs Kassouf, Heath,**
and Jacobson
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Re: ***Taub v. Blue Cross***
Case No BC457809

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is: 600 South Indian Hill Boulevard, Claremont, California 91711.

On **February 8, 2013**, I served the foregoing documents described as **PLAINTIFF KASSOUF, HEATH, JACOBSON'S OPPOSITION TO DEMURRER TO FOURTH CAUSE OF ACTION FOR VIOLATION OF THE CONSUMERS LEGAL REMEDIES ACT** on the interested parties in this action by placing __ the original _XX_ a true copy thereof enclosed in sealed envelopes addressed as follows:

PLEASE SEE ATTACHED SERVICE LIST

[] BY MAIL I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Claremont, California in the ordinary course of business. I am aware that on motion of party served, service is presumed invalid if postal cancellation date or postage meter date is more than one (1) day after date of deposit for mailing in affidavit.

[] BY FACSIMILE ("FAX") In addition to the manner of service indicated above, a copy was sent by FAX to the parties indicated on the service List.

[] BY OVERNIGHT MAIL/COURIER To expedite service, copies were sent via FEDERAL EXPRESS.

[XX] VIA ELECTRONIC SERVICE VIA LEXIS-NEXIS FILE & SERVE through electronic transmission to all parties appearing on the electronic service list. Upon completion of said transmission of said document, a certified receipt is issued to the filing party acknowledging receipt by Lexis-Nexis system. Once Lexis-Nexis has served all designated recipients, proof of electronic service/confirmation will be maintained with the original document in this office.

[] BY PERSONAL SERVICE I caused to be delivered such envelope by hand to the individual(s) indicated on the service list.

[XX] (State) I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on **February 8, 2013,** at Claremont, California.

DEBBIE HUNTER

Re: ***Taub v. Blue Cross***
Case No BC457809

SERVICE LIST

Kurt C. Peterson, Esq. REED SMITH LLP 1901 Avenue of the Stars, Suite 700 Los Angeles, CA 90067 310-734-5200 FAX: 310-734-5299 Email: kpeterson@reedsmith.com	Attorneys for Defendant BLUE CROSS OF CALIFORNIA
Harvey Rosenfield, Esq. Pamela Pressley, Esq. Jerry Flanagan, Esq. CONSUMER WATCHDOG 2701 Ocean Park Blvd., Suite 112 Santa Monica, CA 90405 310-392-0522 FAX: 310-392-8874 harvey@consumerwatchdog.org pam@consumerwatchdog.org jerry@consumerwatchdog.org	Attorneys for Plaintiffs JANET KASSOUF, ALISON HEALTH and DAVID JACOBSON