Alan M. Mansfield (SBN: 125988)
amansfield@whatleykallas.com
WHATLEY KALLAS LLC
580 California Street, 16th Floor
San Francisco, CA 94104
Tel: (415) 860-2503
Fax: (888) 331-9633

Edith M. Kallas
ekallas@whatleykallas.com
(Admitted *Pro Hac Vice*)
WHATLEY KALLAS LLC
380 Madison Avenue, 23rd Floor
New York, NY 10017
Tel: (212) 447-7060
Fax: (800) 922-4851

Harvey Rosenfield (SBN: 123082)
harvey@consumerwatchdog.org
Pamela Pressley (SBN: 180362)
pam@consumerwatchdog.org
Jerry Flanagan (SBN: 271272)
jerry@consumerwatchdog.org
CONSUMER WATCHDOG
2701 Ocean Park Blvd., Suite 112
Santa Monica, CA 90405
Tel: (310) 392-0522
Fax: (310) 392-8874

Attorneys for Plaintiffs

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SAN FRANCISCO

ROBERT MARTIN and DEBORAH GOODWIN, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA; BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY; and DOES 1-25,

Defendants.

Case No. CGC-12-521539

CLASS ACTION

PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANTS' DEMURRERS TO PLAINTIFFS' COMPLAINT

Date: November 6, 2012
Time: 2:30 p.m.
Courtroom: Hon. Richard A. Kramer

Complaint Filed: June 12, 2012

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Plaintiffs submit this Memorandum of Points and Authorities in opposition to Defendants' Demurrer to the original Class Action Complaint ("Complaint"). For the following reasons, the demurrer must be overruled and Defendants ordered to file an Answer.

I. INTRODUCTION

A "Death Spiral" occurs when a health care service company[1] ceases offering health care plans in a particular block of business[2] to new applicants. The result is a vicious cycle of exodus by healthier members and/or spiraling rate increases, causing consumers with pre-existing health conditions trapped in the closed plans to either forego coverage altogether because rates have spiraled beyond their ability to pay, or transfer to bare-bones service plans providing skimpier benefits compared to their closed plans. Complaint, ¶¶ 1-4, 19-21. This process is highly advantageous for health care service companies such as Blue Shield, because such closures provide an opportunity for Blue Shield to improve its portfolio by closing older blocks of business that provide richer benefits, thereby imposing spiraling rates while retaining more desirable, less-risky consumers, all the while eliminating its more costly enrollees. Complaint, ¶ 57.

Plaintiffs filed this action to remedy Blue Shield's attempts to create "Death Spirals" in multiple blocks of its health care service business resulting from two separate sets of plan closures. California law protects consumers from such illegal practices. In order to prevent a Death Spiral from taking place and to optimize consumer choice, California law requires that health care service companies such as Blue Shield desiring to close one or more blocks of business must implement one of two statutorily mandated alternatives. The health care service company may "pool[] the experience of the closed block of business with all appropriate blocks

[1] Two regulatory agencies – the California Department of Managed Health Care ("DMHC") and the California Department of Insurance ("CDI") oversee different segments of Blue Shield's health care services business at issue in this action. The DMHC regulates California Physicians' Service dba Blue Shield of California's business under the Health & Saf. Code. The CDI regulates Blue Shield Life & Health Insurance Company's business under the Ins. Code. Both corporate entities sell substantially similar Preferred Provider Organization ("PPO") coverage that is issue in the Complaint. "Blue Shield" as used in this Opposition refers to both Defendants unless otherwise indicated.

[2] A block of business is one or more individual health care service plans with distinct benefits, services and terms. Health & Saf. Code § 1367.15(b); Ins. Code § 10176.10(b).

of business that are not closed for the purpose of determining the premium rate of any plan contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool." Health & Saf. Code § 1367.15(c); Ins. Code § 10176.10(d). As the government report accompanying the Death Spiral legislation explained, the pooling provision of the Death Spiral statutes protects consumers enrolled in closed blocks by "ensur[ing] that individuals in closed plans obtain affordable rates based on an appropriately large risk pool."[3] Alternatively, a health care service plan may "permit[] an enrollee to receive health care services from any block of business that is not closed and which provides comparable benefits, services, and terms, with no additional underwriting requirement." Health & Saf. Code § 1367.15(c); Ins. Code § 10176.10(d). A health care service company that closes blocks of business in California has no other options and must adhere to these statutorily defined alternatives.

Yet, as set forth in detail in Plaintiffs' Complaint, Blue Shield failed or was unable to comply with these statutory mandates. In two consecutive plan closures Defendants intentionally kept only one high deductible Blue Shield health plan open while closing all other available plans. As a result, Blue Shield could not properly pool enrollees in closed health care service plans with appropriate open blocks of sufficient size. *See e.g.,* Complaint, ¶¶ 32-38. Nor did Blue Shield offer enrollees comparable coverage. *Id.* Worse here, Blue Shield choreographed an end-run around California's dual regulator health insurance system by alternatively closing older blocks of business regulated by one agency and keeping one plan open, then opening new blocks of business to be regulated by the other agency, then not permitting enrollees to transfer into comparable plans regulated by the other agency. Complaint, ¶¶ 57-58. Blue Shield also failed to inform members that Blue Shield's rate increases were not calculated based on an appropriate pooling of risk or that Class members were entitled to transfer to comparable coverage without medical underwriting. Complaint, ¶ 27.

/ / /

[3] Enrolled Bill Report on AB 1743, Consumer Services Agency, ("Enrolled Bill Report"), September 15, 1993, p. 3 (AB 1743 was codified as section 1367.15 of the Health & Saf. Code and section 10176.10 of the Ins. Code (collectively, the "Death Spiral statutes"). Attached and incorporated into the Complaint as Ex. 4 is a true and correct copy of the Enrolled Bill Report.

Plaintiffs allege Blue Shield's conduct constitutes unlawful, unfair and fraudulent business practices, thereby violating all three independent prongs of California Bus. & Prof. Code § 17200, *et seq*. ("UCL"), as well as the Consumers Legal Remedies Act ("CLRA"), Civ. Code § 1750. Blue Shield's conduct also uniformly breached express or incorporated contractual provisions between Blue Shield and the proposed Class, as well as breached the implied covenant of good faith and fair dealing.

Blue Shield's arguments to the contrary are meritless. Notably, Blue Shield does not contest Plaintiffs' claim alleging that Blue Shield's conduct violates the "unlawful" prong of the UCL, and Plaintiffs have properly asserted a claim under each independent prong of the UCL. Moreover, California law does not preclude Plaintiffs from asserting a CLRA claim against Blue Shield for health care services. The Complaint alleges how Blue Shield breached its contracts that either expressly or by law incorporated the provisions of the Health and Safety Code and the Insurance Code. Finally, Plaintiffs' claims for declaratory relief and common counts are likewise sufficiently pled. For the reasons stated, Blue Shield's demurrer should be overruled.

II. STATEMENT OF FACTS FROM COMPLAINT

As of March 2, 2010, Blue Shield had closed the following eight DMHC-regulated plans: Shield Spectrum PPO 500, Shield Spectrum PPO 750, Shield Spectrum PPO 1500, Shield Spectrum PPO 1500 HIPAA GI, Shield Spectrum PPO 2000, Shield Spectrum PPO 2000 HIPAA GI, Shield Spectrum PPO 2000 Conversion, and Shield Savings 2400/4800. ("Closed Health Plans"). Complaint, ¶ 29. Plaintiff Martin was an enrollee in a Shield Spectrum PPO 2000 health plan. Mr. Martin's Shield Spectrum PPO 2000 health plan contained a provision stating the parties' agreement is subject to the Knox-Keene Health Care Service Plan Act. Complaint, ¶ 44.

At the time of these closures, Blue Shield had no open PPO health plans regulated by the DMHC and no other appropriate DMHC-regulated blocks of business to pool with the Closed Health Plans.[4] Complaint, ¶ 31. Blue Shield also did not offer enrollees in the Closed Health

[4] Blue Shield had three open HMO policies. However, due to the significant structural differences, and differences in benefits between HMO health plans and PPO health plans, HMO blocks of business are not "appropriate" blocks of business to pool with PPO blocks of business under the Death Spiral statutes. Complaint, ¶ 31.

Plans coverage with comparable benefits, services and terms with no underwriting. *Id*. Blue Shield had open CDI-regulated plans providing a range of benefits at the time the Closed Health Plans were closed; however these plans were not offered to older and sicker consumers in the Closed Health Plans. Complaint, ¶¶ 31, 48, 57. Blue Shield also did not inform the enrollees of the Closed Health Plans at the time the plans were closed of their options to change coverage, or even inform them that their health care service plans were in fact closed. Complaint, ¶ 36. Consumers were instead left with the option of paying higher premiums for existing coverage or switching to high deductible plans with significantly less coverage. Complaint, ¶ 57.

Months after the Closed Health Plans were closed, Blue Shield opened one DMHC-regulated PPO Plan, Shield Spectrum 5500. Complaint, ¶ 32. In January 2011, Blue Shield publicly announced it was implementing an average 39.5% rate increase in the eight Closed Health Plans. Complaint, ¶ 33. As a result of this threatened rate increase, Plaintiff Martin moved his family into the only DMHC-regulated PPO plan available and the only PPO Blue Shield offered to him in response to his inquiries, the Shield Spectrum PPO 5500 plan. Complaint, ¶ 48. This plan offered fewer benefits and skimpier coverage compared to his former Shield Spectrum PPO 2000 plan. Complaint, ¶¶ 33, 46-49. When Blue Shield did not ultimately implement the 2011 rate increase as it said it would, Mr. Martin sought to return to his former Shield Spectrum PPO 2000 plan. Complaint, ¶ 33. However, Blue Shield refused to allow Mr. Martin to transfer back to his now closed Shield Spectrum PPO 2000 plan. Complaint, ¶ 33.

Effective March 1, 2012, Blue Shield implemented a 14.8% rate increase affecting approximately 50,000 consumers who remained enrolled in the eight Closed Health Plans. Complaint, ¶ 35. To calculate such rates, Blue Shield either improperly pooled the Closed Health Plans with HMO health plans or with a single open block of business with *de minimis* enrollment, resulting in improper charges based on improper pooling. Complaint, ¶¶ 37, 39.

As a result of being pushed out of his higher benefit policy due to Defendants' claimed 2011 rate increase, Mr. Martin suffered a loss of money or property by being forced to pay for a plan that offers less coverage. Complaint, ¶ 50. Mr. Martin was harmed as he would not have downgraded his health plan if truly comparable coverage was made available, or if the Closed

Health Plans had been appropriately pooled. Complaint, ¶ 50. Mr. Martin also suffered a loss of money by having to pay $176 per month more for a Shield Spectrum PPO 5500 health plan as a result of the 2012 rate increase, which is higher than it should have been due to Blue Shield's illegal pooling practices, and by not being allowed to return to his original health plan. Complaint, ¶ 50.

Blue Shield also announced on its website that as of July 2, 2012, it was closing twenty-three PPO health care service plans regulated by the CDI (the "Closed Policies"), which have now been officially closed. Complaint, ¶ 39. Ms. Goodwin received no written notice from Blue Shield of this closure, nor was she informed by Blue Shield or given the right to obtain truly comparable coverage from available open blocks. Complaint, ¶¶ 8, 39, 52. In fact, Blue Shield misleadingly did not give Ms. Goodwin any information about which policies, if any, with or without medical underwriting, would be available to her after July 2, 2012. Complaint, ¶ 52. Just as it had previously done on the DMHC side, Blue Shield again left open a single open, high deductible, non-comparable CDI-regulated PPO policy, Shield Spectrum PPO 5000, which provides lesser benefits that the Closed Policies. Complaint, ¶¶ 39, 56. While Blue Shield again claimed it was complying with the Death Spiral statutes by utilizing the pooling option, pooling is not possible because the only remaining open CDI-regulated PPO policy has a far smaller enrollment than the twenty-three Closing Policies. Blue Shield thus does not have an appropriately large risk pool with which to pool the Closing Policies. It therefore must offer truly comparable coverage options, which Plaintiffs allege it did not. Complaint, ¶ 56.

Simultaneous to announcing the closure of the twenty-three CDI-regulated plans, Blue Shield announced that it would open eleven new PPO health plans regulated by DMHC, not CDI. Complaint, ¶ 40. With the eleven newly-opened DMHC PPO health care service plans, Blue Shield is now selling new coverage only to healthy applicants while trapping older, less healthy consumers in the closed DMHC and CDI regulated plans in a Death Spiral. Complaint, ¶ 57.

III. 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*, 124 Cal.App.4th 304, 316 (2004). "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.*, 35 Cal.3d 197, 213 (1983). 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*, 178 Cal.App.4th 1020, 1034 (2009). 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.,* 19 Cal.4th 26, 38-39 (1998); *Kong v. City of Hawaiian Gardens Redevelopment Agency,* 108 Cal.App.4th 1028, 1047 (2002). If, despite defects in form or substance, it is reasonably probable any alleged deficiencies in the complaint can be cured by amendment, leave to amend should be granted. *Cordonier v. Central Shopping Plaza Assoc.,* 82 Cal.App.3d 991, 998-999 (1978).

B. Plaintiffs State Causes of Action Based Upon All Three Prongs of the UCL

The UCL proscribes "unfair competition", which is defined as any "unlawful," "unfair" or "fraudulent" business act or practice. As Defendants do not challenge the First Cause of Action for violation of the "unlawful" prong of the UCL (Complaint, ¶¶ 68-80), the relevant question posed by this demurrer is whether Plaintiffs can assert claims under the other two alternate prongs of the UCL.

California courts consistently broadly interpret the UCL and uphold such claims against pleading challenges. *See People v. McKale*, 25 Cal.3d 626, 632 (1979). This is because California courts "have recognized that whether a business practice is deceptive will usually be a question of fact not appropriate for decision on demurrer." *Williams v. Gerber Prods. Co.*, 523 F.3d 934 (9th Cir. 2008); *see also Cel-Tech Comm'n Inc. v. Los Angeles Cellular Tel. Co.*, 20 Cal.4th 163, 180 (1999) ("Whether a business act or practice constitutes unfair competition is a question of fact."); *Linear Technology Corp. v. Applied Materials, Inc.*, 152 Cal.App.4th 115, 134-35 (2007) ("Whether a practice is deceptive, fraudulent or unfair is generally a question of fact which requires 'consideration and weighing of evidence from both sides' and which usually

cannot be made on demurrer."). The very reason the Legislature enacted the UCL was to permit courts "to enjoin on-going wrongful business practices in whatever context such activity might occur." *Cel-Tech*, 20 Cal.4th at 181 (citations omitted). Such allegations establish a *per se* violation of the UCL and thus should be upheld against demurrer. *Cortez v. Purolator Air Filtration Products, Co.,* 23 Cal.4th 163, 173-74 (2000); *Saunders v. Superior Court*, 27 Cal.App.4th 832, 845 (1994).

1. Plaintiffs State a Cause of Action for Unfair Competition Based on the "Fraudulent" Prong of the UCL.

In *In re Tobacco II Cases*, 46 Cal.4th 298 (2009), the California Supreme Court clarified important issues regarding allegations of causation in class actions brought under the UCL's "fraudulent" prong. The Supreme Court held that the standing requirements of the UCL are applicable only to the class representatives, not all absent class members. *Id.* at 321, 324. As a result, the pleading of "reliance" demanded by Defendants is only as to the named Plaintiffs.

The Court also recognized that "California courts have repeatedly held that relief under the UCL is available without individualized proof of deception, *reliance* and injury." *Id.* at 320, 326, *citing Massachusetts Mutual Life Ins. Co. v. Superior Court,* 97 Cal.App.4th 1282, 1288 (2002). In addition, in providing guidance regarding the pleading requirements for a fraudulent business practice, the Court stated that using the word "reliance" was not required:

> It is not . . . necessary that [the plaintiff's] reliance upon the truth of the fraudulent misrepresentation be the sole or even the predominant or decisive factor influencing his conduct. . . . *It is enough that the representation has played a substantial part, and so had been a substantial factor, in influencing his decision. Moreover, a presumption, or at least an inference, of reliance arises wherever there is a showing that a misrepresentation was material. A misrepresentation is judged to be material if a reasonable man would attach importance to its existence or nonexistence in determining his choice of action in the transaction in question, and as such materiality is generally a question of fact unless the fact misrepresented is so obviously unimportant that the jury could not reasonably find that a reasonable man would have been influenced by it.*

Id. at 326-27 (internal citations omitted; emphasis added).

Plaintiff Martin has affirmatively asserted that he was misled by Blue Shield's claims and omissions about its improper pooling and the lack of availability of comparable health care plans as required by law; that such issues were material to him; and if he had known the true facts he

would not have left his closed plan or paid the premiums he did. Complaint, ¶¶ 47-51. Plaintiff Goodwin asserted she was similarly misled in the run-up to the closure of the Closed Policies and injured as a result. Complaint, ¶¶ 52-56. These allegations establish that the UCL's standing requirements are satisfied as such claims and calculations were a substantial factor for Plaintiffs to take the actions they did, and they lost money or property as a result. Nothing in *Tobacco II* altered the standard that in order to state a claim under the UCL that it is necessary only to show that members of the public are likely to be deceived by the conduct or business practice in question. As Plaintiffs have sufficiently alleged for purposes of the Complaint that members of the public were likely to be deceived by the conduct in question (Complaint, ¶¶ 91-92), Plaintiffs properly plead a claim based on the "fraudulent" prong of the UCL.

Moreover, Blue Shield fails to address the fact a fraudulent business practice can also be based on omissions of material facts. *See Mass. Mutual, supra*, 97 Cal.App.4th at 1288. In California,

> [a] *failure to disclose* or concealment can constitute actionable fraud in four circumstances:
>
> (1) When the defendant is in a fiduciary relationship with the plaintiff; (2) when the defendant had exclusive knowledge of material facts not known to the plaintiff; (3) when the defendant actively conceals a material fact from the plaintiff; and (4) when the defendant makes partial representations but suppresses some material fact.

LiMandri v. Judkins, 52 Cal.App.4th 326, 336 (1997) (emphasis added). Each of these "*Judkins* factors" gives rise to a "duty to disclose" that, when unfulfilled, provides alternate grounds for asserting a fraudulent business practice claim. Where plaintiffs, as in this case, plead that had omitted information regarding Defendants' failure to follow these statutory requirements been disclosed they would not have acted as they did, any applicable "reliance" element is satisfied. *Falk v. GMC*, 496 F.Supp.2d 1088, 1099 (N.D. Cal. 2007); *see also Mirkin v. Wasserman*, 5 Cal.4th 1082, 1111 (1983) (conc. & dis. opn. of Kennard, J.) (quoted with approval in UCL context by *Tobacco II*, *supra*). Plaintiffs have alleged such material omissions were a substantial factor in deciding to stay with or switch plans and/or pay the premiums they did. Complaint, ¶ 91.

2. <u>Plaintiffs State a Cause of Action for Unfair Competition Based on the "Unfair" Prong of the UCL.</u>

The independent "unfairness" prong of the UCL is "intentionally broad," thus allowing courts maximum discretion to prohibit new schemes to defraud. *Schnall v. Hertz Corp.*, 78 Cal. App.4th 1144, 1166 (2000). UCL claims, particularly the "unfair" prong, generally are not amenable to resolution on demurrer. *Motors, Inc. v. Times-Mirror Co.*, 102 Cal.App.3d 735, 740 (1980). Contrary to the suggestion of Defendants that such a claim is superfluous where there is an allegation of a statutory violation, an "unfair" business practice is actionable even if it is not technically "fraudulent" or "unlawful". *See Buller v. Sutter Health,* 160 Cal.App.4th 981, 990 (2008). The Supreme Court specifically rejected Defendants' argument that an "unlawful" business practice claim makes an "unfair" claim superfluous: "The statutory language referring to 'any unlawful, unfair or fraudulent' practice . . . makes clear that a practice may be deemed unfair *even if not specifically proscribed by some other law*." *Cel-Tech*, 20 Cal.4th at 180, 184 (emphasis added). "In other words, a practice is prohibited as 'unfair or deceptive' even if not 'unlawful' and vice versa." *Id*. This is an appropriate alternative basis for asserting UCL liability against Defendants.

Moreover, the standard for "unfair" cited by Defendants does not apply to consumers, nor was it intended to. *Id.* at 187, n. 12. Numerous California courts have declined to extend *Cel-Tech's* formulation of the unfair prong to UCL consumer claims. *See, e.g., Camacho v. Automobile Club of So. Cal.*, 142 Cal.App.4th 1394, 1400 (2006); *Smith v. State Farm Mutual Automobile Ins. Co.*, 93 Cal.App.4th 700, 720, n. 23 (2001); *Community Assisting Recovery, Inc. v. Aegis Security Ins. Co.*, 92 Cal.App.4th 886, 894 (2001); *Pastoria v. Nationwide Ins.*, 112 Cal.App.4th 1490, 1497-1498 (2003). Plaintiffs appropriately allege "unfairness" under this case law. Complaint, ¶¶ 57-58.

Even if a finding of unfairness needs to be "tethered to some legislatively declared policy or proof of some actual or threatened impact on competition" (*Cel-Tech*, 20 Cal.4th 186-87), by "tethered," *Cel-Tech* meant that a business practice is unfair if it "violates the policy or spirit" of a statute. *Id*. at 187. As set forth in the Complaint, even if found not to violate the letter of the

Death Spiral statutes, Blue Shield's conduct of keeping one small health plan open and closing all remaining plans, then opening for sale plans governed by another regulatory agency, violated the policy or spirit of that law. Thus, even if Defendants are able to convince this Court their practice technically complies with the Death Spiral statutes (which, as alleged, it does not), as set forth in *Cel-Tech* their practices can still be found "unfair" for violating the underlying spirit or intent of the statutes, which is what Plaintiffs allege. *See* Complaint, ¶¶ 38, 50.

C. <u>Plaintiffs State a Cause of Action for Violations of the Consumers Legal Remedies Act</u>

Defendants' only argument in opposing Plaintiffs' CLRA claim (Complaint, ¶¶ 96-101) is that Plaintiffs' claim arises from and relates to "insurance", and thus is not actionable under the CLRA, relying on *Fairbanks v. Superior Court*, 46 Cal.4th 56 (2009). However, *Fairbanks* by its express language does not extend to every form of insurance. In fact, in footnote 1 the Court specifically states it was only focusing on *life insurance* – a fundamentally different product than the services provided by Defendants at issue here.

The California Supreme Court has recognized the ability of consumers to sue health care service companies such as Defendants in court for violations of the CLRA. *Broughton v. Cigna Health Plans*, 21 Cal.4th 1066, 1077 (1999); *see also Cruz v. PacifiCare Health Systems, Inc.*, 30 Cal.4th 303, 316 (2003) (claims based on violation of UCL and CLRA). Indeed, a significant aspect of *Broughton's* analysis at pages 1077-1079 went to discussing the underlying structure and purpose of the CLRA, which would be unnecessary if the Supreme Court believed the CLRA did not apply to health care services in the first place. As these California Supreme Court decisions were not discussed in *Fairbanks*, let alone overruled, this Court must try to reconcile them. *People v. Newman,* 65 Cal.App.4th 352, 354 (1998) ("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 products are the only insurance product covered by its decision. Health care service plans are appropriately found to be a "service" under Civ. Code § 1761(b). This is the only reasonable construction as Health & Saf. Code § 1367.15 refers to the provision of "*health care services*" (emphasis added), and given the

substantial differences between life insurance and health care services.

A "service" is defined by the CLRA 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." Cal. Civ. Code § 1761(b). In *Fairbanks*, the Court found that an interest-sensitive universal life insurance policy purchased by the plaintiff amounts to an abstract financial transaction, and therefore the life insurer's "contractual obligation to pay money under a life insurance policy is not work or labor, nor is it related to the sale or repair of any tangible chattel." 46 Cal.4th at 61. Health care service plans regulated by the Health & Saf. Code and under the Ins. Code provide "services" in the form of Blue Shield's arranging for and providing consumers on-going access to its provider networks at negotiated rates. Complaint, ¶ 97. *See also* Shield Spectrum PPO 2000, Evidence of Coverage and Health Service Agreement 1-19, 23 ("Blue Shield of California has a statewide network of nearly 50,000 Physician Members and contracted Hospitals known as Preferred Providers."), which can be viewed at https://www.blueshieldca.com/producer/ifp/helpclients/eoc.sp#closed_march2010. A life insurance policy can be monetized, borrowed against and listed as an asset; a health care service plan cannot. The services at issue are not abstract financial transactions as was at issue in *Fairbanks*.

The distinction between abstract "indemnity" coverage, like life insurance, and health care "service" contracts is critical and has been long recognized in California. In *California Physicians' Service v. Garrison*, 28 Cal.2d 790, 809 (1946), the California Supreme Court found that Blue Shield's health care service contracts (predecessors to the PPO coverage at issue here) indisputably provide "services": "[c]ertainly the objects and purposes of the corporation organized and maintained by the California physicians have a wide scope in the field of social service." At a minimum, answering this question involves factual disputes, which are not properly resolved via demurrer. *See* Section III.A, *supra*.

D. <u>Plaintiffs Have Properly Alleged Breach of Contract Claims and Breach of the Implied Covenant of Good Faith and Fair Dealing</u>

Defendants next challenge Plaintiffs' claim for breach of contract on the basis that

Plaintiffs have not "identified any contractual provision allegedly violated by Blue Shield or BSL." Demurrer, p. 11:2-4. Contrary to Defendants' position, Plaintiffs have adequately alleged a breach of contract claim based on Defendants' wrongful conduct with respect to the health care service plan closures directly violating the Death Spiral statutes. First, as set forth in the Complaint, Mr. Martin's contract expressly incorporates the Knox-Keene Health Care Service Plan Act (Health & Saf. Code §§ 1340-1399.835), which contains the Death Spiral statute at Health & Saf. Code § 1367.15. *See* Complaint, ¶ 44. Second, "all applicable laws in existence when an agreement is made . . . necessarily enter into the contract and form a part of it, without any stipulation to that effect, as if they were expressly referred to and incorporated." *McKell v. Washington Mutual, Inc.*, 142 Cal.App.4th 1457, 1489-90 (2006) (internal quotations and citations omitted). Numerous courts have recognized the existence of this well-settled rule. *Miracle Auto Center v. Superior Court*, 68 Cal.App.4th 818, 821 (1998) (finding that relevant statutes in existence at the time of contract must incorporated into the contract); *City of El Cajon v. El Cajon Police Officers' Assn.*, 49 Cal.App.4th 64, 71 (1996) (noting that "'[a]pplicable law becomes part of the contract as fully as if incorporated by reference.'") (citations omitted); *Century 21 Region V., Inc. v. Pondoff Realty, Inc.*, 203 Cal.App.3d.Supp. 11, 15 (1988) (noting that a "lengthy line of decisions" hold that all applicable laws enter into an agreement regardless of any express inclusion or stipulation to that effect) (citation omitted). Accordingly, it is not necessary for Plaintiffs' contracts to explicitly identify the terms of every applicable statute, although as Blue Shield concedes (Demurrer, 11:10-14), Mr. Martin's contract does. Complaint, ¶ 44. Under California law, these provisions are automatically incorporated by law. A violation of the relevant statute thereby results in a breach of the contract. Complaint, ¶¶ 103-104.

In a similar case, the plaintiff sued for breach of contract arising from fire loss and subsequent cancellation of a policy. *Miracle Auto Center v. Superior Court, supra*, 68 Cal.App.4th at 820-21. Notably, the court stated "[a]s a general rule of construction, the parties are presumed to know and to have had in mind all applicable laws extant when an agreement is made. These existing laws are considered part of the contract *just as if they were expressly referred to and incorporated*." *Id*. at 821 (emphasis added).

1 As set forth in Plaintiffs' Complaint at ¶¶ 28-40, Defendants' conduct in closing
2 Plaintiffs' health care service plans violated section 1367.15 of the Health & Saf. Code and
3 section 10176.10 of the Ins. Code, resulting in a breach of the terms of Plaintiffs' and Class
4 members' uniform agreements. Ms. Goodwin's health plan agreement also incorporates these
5 provisions by law as set forth above.
6 Defendants argue that if no breach of contract claim exists then Plaintiffs' implied
7 covenant of good faith and fair dealing claim fails. Demurrer, 11-12. However, as the contract
8 claim must be upheld, Plaintiffs' implied covenant of good faith and fair dealing claims are also
9 viable. Complaint, ¶¶ 111-116. *Wolkowitz v. Redland Ins. Co.*, 112 Cal.App.4th 154, 162 (2003)
10 (noting that "[i]mplied in every contract is a covenant of good faith and fair dealing that neither
11 party will injure the right of the other to receive the benefits of the agreement.") (citation
12 omitted); *Gabriel v. Wells Fargo Bank, N.A.*, 188 Cal.App.4th 547, 554, n. 3 (2010) (citing CACI
13 No. 325 as requiring that a plaintiff allege "that the defendant unfairly interfered with [plaintiff]'s
14 right to receive the benefits of the contract." (internal quotations omitted).
15 Defendants also mischaracterize Plaintiffs' case as one that is based on excessive rates.
16 Demurrer, 12:4-19. In referencing Cal. Health & Saf. Code § 1163 in passing as somehow
17 limiting rate increases and citing several cases that address excessive rates in the context of the
18 covenant of good faith and fair dealing, Defendants confuse the tort of bad faith with a breach of
19 the implied covenant of good faith. Plaintiffs' case is based on violation of the Death Spiral
20 statutes for closing plans and not providing the required alternatives, which in turn resulted in a
21 breach of Plaintiffs' health care service plan contracts. To what extent rates are "excessive" (*see*
22 Complaint, ¶¶ 78, 86, 93, 101) goes to the question of available remedies. A demurrer cannot
23 properly raise a challenge to a particular remedy. *Venice Town Council v. City of Los Angeles,*
24 47 Cal.App.4th 1547, 1562 (1996).

25 **E. <u>Plaintiffs Have Properly Pled Declaratory Relief and Common Count Claims</u>**

26 Defendants next argue that Plaintiffs' claims for declaratory relief and common counts
27 are completely derivative of their other claims and therefore cannot succeed. Demurrer, 13-14.
28 As set forth above, however, since other claims survive, these claims must survive as well.

Additionally, contrary to Defendants' position, Plaintiffs' declaratory relief and common count claims are, in fact, independently actionable regardless of the viability of other claims.

1. Plaintiffs' Declaratory Relief Claim is Valid.

Defendants seemingly take the position that if Plaintiffs lack a valid breach of contract claim, Plaintiffs' declaratory relief claim (Complaint, ¶¶ 107-110) must also fail. Demurrer, 13:18-23. However, a declaratory relief claim is independent from Plaintiffs' other claims. A party does not actually need to allege a breach of contract in order to assert a declaratory relief claim. *Supervalu, Inc. v. Wexford Underwriting Managers, Inc.*, 175 Cal.App.4th 64, 82 (2009). ("Code of Civil Procedure section 1060 permits a declaration of the parties' rights and duties even if no other relief is requested, *and even if there has not been a breach of contract*."); *Meyer v. Sprint Spectrum L.P.*, 45 Cal.4th 634, 647 (2009) (noting that "[c]ode of Civil Procedure section 1060 does not require a breach of contract in order to obtain declaratory relief, only an 'actual controversy.'") (Emphasis added.)

Here, the Complaint alleges at ¶ 108 that substantive contractual rights are at issue and present an actual controversy regarding those rights. By closing policies without pooling or offering comparable health plans without medical underwriting for those individuals remaining in Closed Plans, Blue Shield has or may have withheld benefits and breached their agreements. The purpose of a declaratory relief claim is to declare the rights and liabilities of parties under contracts, which is precisely what Plaintiffs are also asking this Court to do.

Defendants cite to *Ball v. Fleetfeet Financial Corp.*, 164 Cal.App.4th 794 (2008), for the proposition that a demurrer may be sustained when a plaintiff fails to state facts sufficient to support a primary claim. Demurrer, 13:19-23. However, the *Ball* court recognized that a claim for declaratory relief may be brought in the absence of another cause of action, but found the plaintiff's declaratory relief claim in that case "wholly derivative" of the underlying contractual provisions on which her CLRA claim was based. *Id.* at 800. The *Ball* court concluded that plaintiff could not seek relief because the issuance of a credit card did not fall within the scope of the CLRA. *Id.* at 798.

/ / /

2. **Plaintiffs' Common Counts Claim is Valid.**

Blue Shield asserts Plaintiffs cannot assert a claim for common counts (Complaint, ¶¶ 107-110) because it is not a specific cause of action. Demurrer, 13-14. However, Plaintiffs' claim for common counts is viable as a stand-alone claim. *Farmers Ins. Exchange v. Zerin*, 53 Cal.App.4th 445, 460 (1997) (holding that "[i]n California, it has long been settled the allegation of claims using common counts is good against special or general demurrers."). A common counts claim is so widely recognized in California there is a California Judicial Council Form stating the elements for such a claim. *See* Cal. Jud. Council Form PLD-C-0001(2) ("Cause of Action – Common Counts). California's Civil Jury Instructions specifically provide instructions for a claim for common counts. *See* CALJIC No. 370.

Defendants also contend that Plaintiffs' common counts claim is entirely derivative of their other claims. Demurrer, 13-14. However, Plaintiffs have stated sufficient grounds for an independent common counts claim based on the "'receipt of a benefit and [the] unjust retention of the benefit at the expense of another.'" *Peterson v. Cellco Partnership*, 164 Cal.App.4th 1583, 1593 (2008) (citation omitted); *Ghirardo v. Antonioli*, 14 Cal.4th 39, 51 (1996). The concept behind such an equitable claim is that if there is a fair and reasonable doubt whether plaintiffs can recover on a contract, the equities require such a claim proceed. The facts as plead give rise to a claim for common counts as an alternate basis for the jury to grant relief. *McKell v. Washington Mut., Inc, supra.*, 142 Cal.App.4th at 1490; *First Nationwide Savings v. Perry*, 11 Cal.App.4th 1657, 1669-70 (1992); *Leoni v. Delany*, 83 Cal.App.2d 303, 307-08 (1948).

IV. CONCLUSION

For the reasons stated herein, Defendants' demurrer should be overruled. However, in the event that the Court sustains the demurrer in whole or in part, Plaintiffs request leave to amend the Complaint, as the alleged defects asserted by Defendants are curable.

DATED: October 17, 2012

WHATLEY KALLAS, LLC

By: [signature]

ALAN M. MANSFIELD (SBN: 125988)
amansfield@whatleykallas.com

580 California Street, 16th Floor
San Francisco, CA 94104
Tel: (415) 860-2503
Fax: (888) 331-9633

Edith M. Kallas
ekallas@whatleykallas.com
(Admitted *Pro Hac Vice*)
WHATLEY KALLAS LLC
380 Madison Avenue, 23rd Floor
New York, NY 10017
Tel: (212) 447-7060 / Fax: (800) 922-4851

CONSUMER WATCHDOG
JERRY FLANAGAN (SBN: 271272)
jerry@consumerwatchdog.org
Harvey Rosenfield (SBN: 123082)
harvey@consumerwatchdog.org
Pamela Pressley (SBN: 180362)
pam@consumerwatchdog.org
2701 Ocean Park Blvd., Suite 112
Santa Monica, CA 90405
Tel: (310) 392-0522
Fax: (310) 392-8874

Attorneys for Plaintiffs ROBERT MARTIN and DEBORAH GOODWIN

Alan M. Mansfield (Of Counsel)
(SBN: 125988)
amansfield@whatleykallas.com
WHATLEY KALLAS LLC
580 California Street, 16th Floor
San Francisco, CA 94104
Tel: (415) 860-2503
Fax: (888) 331-9633

Edith M. Kallas
ekallas@whatleykallas.com
(Admitted *Pro Hac Vice*)
WHATLEY KALLAS LLC
Madison Avenue, 23rd Floor
New York, NY 10017
Tel: (212) 447-7060
Fax: (800) 922-4851

Harvey Rosenfield (SBN: 123082)
harvey@consumerwatchdog.org
Pamela Pressley (SBN: 180362)
pam@consumerwatchdog.org
Jerry Flanagan (SBN: 271272)
jerry@consumerwatchdog.org
CONSUMER WATCHDOG
2701 Ocean Park Blvd., Suite 112
Santa Monica, California 90405
Tel: (310) 392-0522
Fax: (310) 392-8874

Attorneys for Plaintiffs

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SAN FRANCISCO

ROBERT MARTIN and DEBORAH GOODWIN, on behalf of themselves and all others similarly situated, **Plaintiffs,** **v.** **CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA; BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY; and DOES 1-25,** **Defendants.**	**Case No. CGC-12-521539** **CLASS ACTION** **PROOF OF SERVICE**

I, the undersigned, declare under penalty of perjury that I am employed with WHATLEY KALLAS, LLC, whose address is 580 California Street, 16th Floor, San Francisco, California 94104. I am over the age of eighteen years and not a party to this action; that I served the below named persons the following documents:

PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANTS' DEMURRERS TO PLAINTIFFS' COMPLAINT

[ ] By personally delivering copies to the person served at the following address:

[ ] Via electronic service to the addresses listed below [as noted].

[ ] By Fax Transmission: Based on an agreement of the parties* to accept service by fax transmission, I faxed the documents to the persons at the fax numbers listed below. No error was reported by the fax machine that I used. A copy of the record of the fax transmission which I printed out is attached.

<u>**SEE ATTACHED SERVICE LIST**</u>

[X] By placing a copy in a separate envelope [as noted], with postage fully prepaid, for each address named below and depositing each for collection and mailing pursuant to the ordinary business practice of this office, which mail is deposited with the U.S. Postal Service on the same day at San Diego, California [mailed from San Diego Office: 10200 Willow Creek Rd., Suite 160, San Diego, CA 92131].

[ ] By NORCO Overnite delivery service by placing an Overnite/Federal Express Envelope addressed to each of the persons on the service list attached hereto and depositing said envelope in the NORCO Overnite/Federal Express Pickup Boxes located at 9903 Business Park Avenue, in San Diego, California 92131.

Executed this 17th day of October, 2012 at San Diego, California.

SALLY CORMIER

SERVICE LIST

CONSUMER WATCHDOG Harvey Rosenfield, Esq. (SBN: 123082) harvey@consumerwatchdog.com Pamela Pressley, Esq. (SBN: 180362) pam@consumerwatchdog.com Jerry Flanagan, Esq. (SBN: 271272) jerry@consumerwatchdog.org 2701 Ocean Park Blvd., Suite 112 Santa Monica, CA 90405 Tel: (310) 392-0522 Fax: (310) 392-8874 (VIA E-MAIL ONLY) Attorneys for Plaintiffs	WHATLEY KALLAS, LLC Edith M. Kallas, Esq. (Admitted *Pro Hac Vice*) ekallas@whatleykallas.com 380 Madison Avenue, 23rd Floor New York, NY 10017 Tel: (212) 447-7060 Fax: (800) 922-4851 (VIA E-MAIL ONLY) Attorneys for Plaintiffs
MANATT, PHELPS & PHILLIPS, LLP Amy B. Briggs (SBN: 94028) abriggs@manatt.com Amanda M. Knudsen (SBN: 252752) aknudsen@manatt.com One Embarcadero Center, 30th Floor San Francisco, CA 94111 Tel: (415) 291-7400 Fax: (415) 291-7474 (VIA U.S. MAIL and E-MAIL) Gregory N. Pimstone (SBN 150203) gpimstone@manatt.com Brad W. Seiling (SBN 143515) bseiling@manatt.com 11355 West Olympic Boulevard Los Angeles, CA 90064-1614 Tel: (310) 312-4000 Fax: (310) 312-4224 (VIA U.S. MAIL and E-MAIL) Attorneys for Defendants CALIFORNIA PHYSICIANS' SERVICE d/b/a BLUE SHIELD OF CALIFORNIA and BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY	