B142321

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION

LISA ELLEN SMITH,

Plaintiff and Respondent,

vs.

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC. ,

Defendant and Appellant.

Respondent's Brief

Appeal from the Superior Court of Los Angeles County
Honorable David Doi

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INTRODUCTION

Pacificare's opening brief contains two critical concessions:

- That its plan documents did not comply with the requirements of Health & Safety Code section 1363.1, and
- That its failure to comply with the statutory requirements renders its arbitration clause invalid unless § 1363.1 is preempted.

In view of these concessions, this appeal turns on a single issue -- whether § 1363.1 is saved from preemption by Federal Arbitration Act by operation of the McCarran-Ferguson Act. Another way to frame the same issue is to ask whether § 1363.1 is a state law enacted for the purpose of regulating the business of insurance. If so, the McCarran-Ferguson Act applies, and trumps the Federal Arbitration Act.

In order to argue that § 1363.1 does not regulate insurance PacifiCare is forced to take a host of unreasonable positions. For example, it contends that because it is a health care service plan (an HMO) it is not engaged in the "business of insurance." Yet five federal circuit courts of appeal have held that HMOs are in the "business of insurance." None have come out PacifiCare's way on this issue.

Similarly, PacifiCare argues that even if it is involved in the business of insurance, a law that regulates arbitration clauses in health insurance policies does not qualify as a law enacted to regulate insurance. This argument has been rejected by three federal circuit courts. Again, no court has accepted the position advanced by PacifiCare here.

Perhaps the most unreasonable aspect of PacifiCare's position is that if it were ever accepted, it would radically narrow the scope of state regulatory power over HMOs. In the McCarran-Ferguson Act and in ERISA, Congress expressly allowed states to regulate insurance by saving

state laws that do so from federal preemption. It is for this reason that a state can mandate the minimum benefits that all health insurers must provide to its citizens -- such as coverage for cancer screening. These laws survive preemption by ERISA because they regulate insurance, and fall within ERISA's saving clause.

Under PacifiCare's view, states could mandate the benefits that must be provided in traditional "indemnity" health insurance plans subject to ERISA (i.e., those obtained through an employer), but would be unable to mandate the benefits that HMOs must provide. There is simply no evidence that Congress or the Supreme Court ever contemplated, or would approve such a curtailment of state regulatory power.

The Supreme Court has held that laws that regulate the *contents* of insurance policies are laws enacted for the purpose of regulating insurance. Health & Safety Code section 1363.1 regulates the contents of policies -- HMOs that wish to include an arbitration clause in their plans must comply with the statutory requirements or the clause is invalid.[1]

Here, it is undisputed that PacifiCare did not comply with the law, so the arbitration clause in its plan is invalid. The trial court therefore correctly denied its petition to compel arbitration, and that order should be affirmed.

STATEMENT OF THE CASE

For the purposes of deciding the issue presented by this appeal PacifiCare's opening brief adequately states the relevant facts and procedural history of the case. Although the federal preemption question at issue in this appeal can be resolved without reference to the underlying

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[1] *Erickson v. Aetna Health Ins. Plans of Cal.* (1999) 71 Cal.App.4th 946, 650 ("It is undisputed Aetna's arbitration clause did not comply with [the] requirements [of § 1363.1]. Accordingly, if section 1363.1 applies, the clause is invalid.")

insurance bad-faith dispute, plaintiffs will briefly summarize the dispute to provide the court with some context.

The plaintiffs are Lisa Ellen Smith ("Lisa") and her mother, Kathy Battle. Lisa is the stepdaughter and dependent of Thomas S. Battle ("Mr. Battle"), an administrator for the Rim of the World Unified School District in Lake Arrowhead.[2] As an employee of the school district, Mr. Battle had the option of enrolling in the health plan offered through the Southern California Schools Employee Benefits Association. Under this plan, Mr. Battle received the bulk of his health care coverage from the Blue Cross Plus Preferred Provider Plan.

The mental health benefits available to Mr. Battle and his dependents, however, were derived solely from a supplementing health plan sponsored by Defendant Pacificare and marketed as Pacificare Behavioral Health of California ("PBHC"). Lisa, as Mr. Battle's dependent was also covered under the PBHC mental health plan.

When Lisa became suicidal in 1998 due to an uncontrolled major psychiatric depressive disorder, bulimia nervosa, and anorexia nervosa, PBHC terminated her physician-recommended inpatient treatment after only six days and refused to authorize or pay for additional inpatient care when her condition deteriorated further over the next two months.[3]

The termination of benefits after only six days was no coincidence. PBHC's plan provides coverage for only one inpatient stay per year. Stays of fewer than five days do not count toward this limit.[4] Hence, by allowing Lisa to stay in the hospital for six days (the shortest period that constitutes an "inpatient stay," and then overruling her physician's treatment plan and

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[2] Complaint, para. 1, (Appellant's Appendix ("AA") 1.)
[3] *Id.*, para. 2. (AA 1.)
[4] *Id.*, para 3. (AA. 1.)

requiring that she be discharged, PBHC guaranteed that it would not have to pay for any additional inpatient stays that year, cheating Lisa out of 24 days of potential coverage at a time when she critically needed it.

After this lawsuit was filed, PacifiCare filed its motion to compel arbitration. (AA 190.) Plaintiffs opposed the motion, arguing that PacifiCare's plan documents did not comply with § 1363.1 and were therefore invalid. (AA 377-379.) PacifiCare argued below, as it does here, that § 1363.1 was preempted by the Federal Arbitration Act, and plaintiffs argued, as they do here, that the McCarran-Ferguson Act operated to save § 1363.1 from preemption. The trial court accepted this argument, and denied PacifiCare's motion. (AA. 520.) PacifiCare filed a timely appeal.

ARGUMENT

A. Overview of the McCarran-Ferguson Act

1. History and purpose of the Act

The U.S. Supreme Court has recognized that the language Congress used in the McCarran-Ferguson Act "takes on a different coloration"[5] given its history. Accordingly, it would be helpful for this Court to be cognizant of its history in deciding this case.

Supreme Court decisions that detail the history of the Act[6] explain that it was enacted in 1945 in response to the Court's decision in *United States v. South-Eastern Underwriters Ass'n.*[7] That case overruled *Paul v. Virginia*,[8] which had held that issuing an insurance policy was not a transaction of commerce. Based on *Paul*, "the states enjoyed a virtually

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[5] *Securities and Exchange Commission v. National Securities, Inc.* (1969) 393 U.S. 453, 459, 89 S.Ct. 564, 21 L.Ed.2d. 668.
[6] *See, e.g. United States Dept. of Treasury v. Fabe* (1993) 508 U.S. 491, 499, 113 S.Ct. 2202, 124 L.Ed.2d 44.
[7] *United States v. South-Eastern Underwriters Ass'n.* (1944) 322 U.S. 533, 64 S.Ct. 1162, 88 L.Ed. 1440.
[8] *Paul v. Virginia* (1869) 75 U.S. (8 Wall) 168, 19 L.Ed. 357.

exclusive domain over the insurance industry."[9] In *South-Eastern Underwriters* the Court held that an insurer that conducted a significant portion of its business across state lines was engaged in interstate commerce, and was therefore subject to the federal antitrust laws.[10]

The holding in *South-Eastern Underwriters* was "widely perceived as a threat to state power to tax and regulate the insurance industry."[11] Congress passed the McCarran-Ferguson Act to allay those fears and to "restore the supremacy of the States in the realm of insurance regulation."[12]

2. Text of the relevant provisions of the McCarran-Ferguson Act

For the purposes of this proceedings only the second section of the Act, codified at 15 U.S.C. § 1012, is relevant. Section Two deals with state and federal regulation of insurance. It states:

> (a) State regulation
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> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) Federal regulation
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> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26,

[9] *Fabe*, 508 U.S. at 499.
[10] *Ibid.*
[11] *Id.* at 499, 500.
[12] *Id.* at 500.

1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

The two clauses in section 2(b) of the Act were intended to do different things. In *Fabe*, the Court explained that "the first clause of § 2(b) was intended to further Congress' primary objective of granting the States broad regulatory authority over the business of insurance."[13] The second clause was intended to achieve "Congress's secondary goal, which was to carve out only a narrow exemption for 'the business of insurance' from the federal antitrust laws."[14]

3. The Supreme Court's construction of the Act

a. Cases construing the language at issue here -- dealing with state laws

The Supreme Court has twice construed the first clause of section 2(b) of the Act, which is the provision at issue here. Both the 1969 decision in *Securities and Exchange Commission v. National Securities, Inc.*,[15] and the 1993 decision in *Fabe* turned on what, exactly, was a "state law enacted for the purpose of regulating the business of insurance.

The guiding principles were enunciated in *National Securities*. There, the SEC sued to rescind the merger of two Arizona insurance companies, which had been approved by the Arizona Director of Insurance under state law. The SEC contended that that the merger solicitation papers contained material misstatements and therefore violated the federal securities laws. The issue was whether the Arizona law giving its Director

[13] *Fabe*, 508 U.S. at 505.
[14] *Ibid.*
[15] *National Securities, Inc.*, 393 U.S. 453.

of Insurance supervisory authority of the merger was a state law that regulated insurance.

The Court held that, insofar as the Arizona law was an attempt to protect the insurance company's shareholders, it did not fall within the scope of the McCarran-Ferguson Act.[16] Another portion of the Arizona law, requiring the Director to make sure the proposed merger would not substantially reduce the security and service to be rendered to policyholders was held to be within the scope of the Act.[17] Ultimately, the Court found that the Arizona law and the federal law were not in conflict.

The portion of *National Securities* that is directly relevant here discusses the meaning of the key language in the statute. Because it is dispositive here, it is quoted at length. The Court explained:

> The statute did not purport to make the States supreme in regulating all the activities of insurance companies; its language refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the business of insurance.' Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the statute apply. Certainly the fixing of rates is part of this business; that is what *South- Eastern Underwriters* was all about. The selling and advertising of policies, *FTC v. National Casualty Co*., 357 U.S. 560, 78 S.Ct. 1260, 2 L.Ed.2d 1540 (1958), and the licensing of companies and their agents, cf. *Robertson v. People of State of California*, 328 U.S. 440, 66 S.Ct. 1160, 90 L.Ed. 1366 (1946), are also within the scope of the statute. Congress was concerned with the type of state regulation that

[16] *Id*., 393 U.S. at 460; see also *Fabe*, 508 U.S. at 502.

> centers around the contract of insurance, the transaction which *Paul v. Virginia* held was not 'commerce.' **The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement--these were the core of the 'business of insurance.'** Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they to must be placed in the same class. But whatever the exact scope of the statutory term**, it is clear where the focus was--it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly are laws regulating the 'business of insurance.'**[18] (Emphasis added.)

In *Fabe*, the issue was whether an Ohio statute setting the priorities for various classes of creditors of dissolved insurance companies was preempted by the federal priority statute. The two priority schemes conflicted, particularly because the Ohio scheme gave priority to unpaid claims by the company's insureds and subordinated the federal government's tax claims. If the Ohio statute was a law enacted for the purpose of regulating the business of insurance, then the McCarran-Ferguson Act protected it from preemption by the federal priority statute.

Fabe held that, to the extent the Ohio law gave priority to claims by insureds, its purpose was to ensure the performance of insurance contracts, and therefore the statute regulated insurance.[19] Specifically, the Court explained, "Because the Ohio statute is 'aimed at protecting or regulating'

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[17] *Ibid.*
[18] *SEC v. National Securities*, 393 U.S. at 459, 460.
[19] 508 U.S. at 505.

the performance of an insurance contract, *National Securities*, 393 U.S. at 469, 89 S.Ct. at 568, it follows that it is a law 'enacted for the purpose of regulating the business of insurance,' within the meaning of the first clause of § 2(b)."[20]

Fabe is particularly instructive here because it expressly acknowledged that the scope of the first clause of section 2(b) of the Act (protecting state laws) is *broader* than the antitrust exemption contained in the second clause. Rejecting the same argument made by PacifiCare here the Court stated:

> The language of § 2(b) is unambiguous: The first clause commits laws 'enacted . . . for the purpose of regulating the business of insurance' to the States, while the second clause exempts only 'the business of insurance' itself from the antitrust laws. **To equate laws 'enacted . . . for the purpose of regulating the business of insurance' with the 'business of insurance' itself, as petitioner urges us to do, would be to read words out of the statute.** This we refuse to do.
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> The broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention, or aim' of adjusting, managing or controlling the business of insurance. Black's Law Dictionary 1236, 1286 (6th Ed. 1990). **This category necessarily encompasses more than just the 'business of insurance.'**[21] (Emphasis added, ellipses in text.)

[20] *Ibid.*
[21] *Fabe*, 508 U.S. at 504, 505.

b. Cases construing the second clause, dealing with the antitrust exemption

Much of the litigation involving the McCarran-Ferguson Act has involved the antitrust exemption in the second clause of section 2(b). The Supreme Court has decided two important cases involving this part of the statute, the 1979 decision in *Group Life & Health* v. *Royal Drug Co*.[22], and *Union Labor Life Ins. Co. v. Pireno*,[23] decided in 1982. PacifiCare's argument is based primarily on these decisions.

In *Royal Drug*, independent pharmacists brought an antitrust action against Blue Shield claiming that it was engaged in price-fixing of prescription drugs. The lawsuit attacked Blue Shield's use of "Pharmacy Agreements" between it and any pharmacy in the state that wanted to participate in its program. Under the agreements, a Blue Cross insured would pay the pharmacy $2.00 for a prescription, and Blue Cross would reimburse the pharmacy for the actual cost of the drugs dispensed. The agreements essentially limited the participating pharmacy's profit on any prescription to $2.00.[24]

The issue in *Royal Drug* was whether Blue Shield's conduct in entering into the Pharmacy Agreements was "the business of insurance" and therefore exempt from the antitrust laws.[25] The Court held that the Pharmacy Agreements were not "the business of insurance" under the Act.

The Court first noted that "insurance" inherently involves the spreading of risk between the insurer and its insureds, and that the Pharmacy Agreements did not spread risk because they did not involve any contract between the insurer and its insured. Rather, Blue Shield assumed

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[22] *Group Life & Health* v. *Royal Drug Co.* (1979) 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261.
[23] *Union Labor Life Ins. Co. v. Pireno* (1982) 458 U.S. 199, 102 S.Ct. 3002, 73 L.Ed.2d 647.
[24] *Royal Drug*, 440 U.S. at 209.

the risk providing its insureds with prescription drugs for $2.00, and the Pharmacy Agreements were simply the means of providing the promised benefit at a low cost.[26]

In the Court's view, the Pharmacy Agreements were indistinguishable from "countless other business arrangements that may be made by insurance companies to keep their costs low."[27] Because of this, and because the agreements were between the insurer and entities outside of the insurance industry, the Court held that the McCarran-Ferguson Act did not protect the practice.

In *Pireno*, a chiropractor challenged an insurer's use of a peer review panel to determine which claims for chiropractic care the insurer would pay. The insurer defended by claiming that the use of a peer review committee was exempt from the antitrust laws as part of the business of insurance.[28] The Court held that the use of peer review to determine whether to pay claims was not the "business of insurance" within the scope of the McCarran-Ferguson Act, and hence not exempt from the antitrust laws.

Pireno distilled from *Royal Drug* "three criteria relevant in determining whether *a particular business practice* is part of the 'business of insurance' exempted from the antitrust laws by § 2(b):"[29]

> First, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the

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[25] *Id.* at 210.
[26] *Royal Drug*, 440 U.S. at 213, 214.
[27] *Royal Drug*, 440 U.S. at 215.
[28] *Pireno*, 458 U.S. at 122.
[29] *Id.* at 129 (emphasis added.)

insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.[30]

These three criteria have become the "three-part test" that forms the basis for PacifiCare's arguments before this Court. In *Pireno*, the Court cautioned that, "none of these criteria is necessarily determinative in itself."[31]

Applying the criteria to the peer review practice, the Court determined that the practice did not spread risk, since the transfer of risk occurred when the policy was issued, and the peer review process was "logically and temporally unconnected to the transfer of risk."[32] The Court also determined that peer review did not involve an integral part of the policy relationship between the insurer and its insured, nor was it limited to entities within the insurance industry, since the chiropractors performing the review were neither insureds nor within the insurance industry.[33]

4. Interplay between ERISA and the McCarran-Ferguson Act

As this Court is no doubt well aware, ERISA[34] preempts state laws that "relate to" employee benefit plans.[35] ERISA's preemptive scope is narrowed by its savings clause, which applies to, *inter alia*, state laws that "regulate insurance."[36] The Supreme Court has observed that ERISA's saving clause and the first clause of section 2(b) of the McCarran-Ferguson

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[30] *Ibid.*
[31] *Ibid*.
[32] *Pireno*, 458 U.S. at 130.
[33] *Id.* at 131, 132.
[34] "ERISA" is the acronym for the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001.
[35] ERISA's preemption clause is section 514(a), 29 U.S.C. § 1144(a).
[36] The saving clause is section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

Act "serve the same federal policy and utilize similar language to define what is left to the States." [37]

The Supreme Court has accordingly borrowed from its McCarran-Ferguson Act jurisprudence in construing ERISA's saving clause to determine if a particular state law "regulates insurance" and is therefore saved from ERISA preemption.[38] The most recent example is the 1999 decision in *UNUM Life Ins. Co. of America v. Ward*.[39]

In *Ward*, a unanimous Court held that California's common-law "notice prejudice" rule, which prohibits insurers from denying claims based on the insured's failure to provide timely notice of the claim, absent substantial prejudice to the insurer, is a state law that "regulates insurance" and is therefore saved.

Ward refined and clarified the Supreme Court's analysis of whether a state law regulates insurance. The Court explained that the principal inquiry was whether, as a matter of common sense, the law in question regulates insurance. The three-factor test is then applied, to check the resulting conclusion.[40]

The Court emphasized that the factors were to be applied flexibly, reiterated its statement in *Pireno* that none of the factors was necessarily determinative, and explained that the factors were merely "relevant," not "required."[41] The Court rejected the insurer's argument that the notice-

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[37] *Metropolitan Life Ins. Co. v. Massachusetts* (1985) 471 U.S. 724, 744 n. 21, 105 S.Ct. 2380, 85 L.Ed.2d 728.
[38] *See, e.g.*, *Metropolitan Life*, 471 U.S. at 743.
[39] *UNUM Life Ins. Co. of America v. Ward* (1999) 526 U.S. 358, 119 S.Ct. 1380, 143 L.Ed.2d 462.
[40] *Id.* 526 U.S. at 367, 373-374.
[41] *Id.*, 526 U.S. at 373.

prejudice rule did not regulate insurance because it did not spread risk and hence did not meet all three parts of the *Pireno* three-factor test.[42]

B. Health care service plans are engaged in the "business of insurance" for the purposes of the McCarran-Ferguson Act

1. All of the federal appellate courts to consider the issue have held that HMOs are engaged in the business of insurance

The Knox-Keene Health Care Service Plan Act of 1975, as amended[43] defines a "health care service plan" as "[a]ny person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees."[44]

California courts appear to use the terms "health care service plan" and "HMO" interchangeably to refer to either the organization offering the plan, or to the plan itself.[45] Pacificare refers to itself as a health care service plan licensed under the Knox-Keene Act.[46]

The case that HMOs are in the business of insurance was made by the Ninth Circuit in *Washington Physician's Service Ass'n. v. Gregoire*,[47] an ERISA case. The Court held that a Washington law that required health plans, including HMOs, to provide coverage for certain "alternative"

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[42] *Ibid.*
[43] Cal. Health & Safety Code section 1340. et seq.
[44] Cal. Health & Safety Code section 1345, subd. (f)(1).
[45] Compare *Warren-Guthrie v. Health Net* (2000) 84 Cal.App.4th 804, 814 n. 5 (referring to the organization offering the plan as the HMO and the plan as the health care service plan) with *Aetna Health Plans of California, Inc. v. Yucaipa-Calimesa Joint Unified School Dist* (1999) 72 Cal.App.4th 1175, 1179 (referring to plan as HMO). These cases were decided by the same court.
[46] Declaration of Victoria Bowers, para. 2, (AA 215.)

medical treatments was within the ERISA saving clause because it regulated insurance. Rejecting the claim that HMOs were not involved in the business of insurance, the Court explained:

> The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical service directly, while a traditional insurer does so indirectly by paying for the service [citation omitted] but this is distinction without a difference. [citations omitted] In the end, HMOs function the same way as a traditional health insurer: The policy holder pays a fee for a promise of medical services in the event he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

The Fifth and Sixth Circuits have expressly adopted the Ninth Circuit's reasoning in *Gregoire*.[48] In addition, even before *Gregoire* the First and Seventh Circuits had held that HMOs were engaged in the business of insurance. [49]

The First Circuit's decision, *Ocean State Physicians Health Plan v. Blue Cross Blue Shield of Rhode Island*,[50] was a McCarran-Ferguson Act case, which held that Blue Cross's conduct in offering an HMO product was "the business of insurance" and exempt from attack under the antitrust laws.

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[47] *Washington Physician's Service Ass'n. v. Gregoire* (9th Cir. 1998) 147 F.3d 1039, 1045-1046, cert denied 525 U.S. 1141 (1998)
[48] *Kentucky Assoc. of Health Plans, inc. v. Nichols* (6th Cir. 2000) 227 F.3d 352, 364; *Corporate Health Ins., Inc. v. Texas Dep't. of Ins.* (5th Cir. 2000) 215 F.3d 526, 538.
[49] *Ocean State Physicians Health Plan v. Blue Cross Blue Shield of Rhode Island* (1st Cir. 1989) 883 F.2d 1101, 1107-08; *Anderson v. Humana, Inc.* (7th Cir. 1994) 24 F.3d 889, 892.
[50] *Id.*

The court rejected the argument that because Blue Cross was a "service benefit plan" and not a traditional insurer, it should not be deemed an insurer under the McCarran-Ferguson Act. The court noted that *Royal Drug* carefully distinguished between the provider agreements at issue, which it held were not within the business of insurance, and *subscriber contracts*, which it explained might be within the business of insurance.[51]

The First Circuit adopted Justice Brennan's contention, made in dissent in *Royal Drug*, that the Court and all parties conceded that the subscriber agreements in *Royal Drug* were within the business of insurance, and that the subscriber agreements operated exactly like an "insurance" policy, because they both transferred and distributed risk.[52] (Subscriber agreements were not at issue in *Royal Drug*. The four dissenters would have held that the provider agreements at issue were also within the business of insurance.)

The First Circuit noted that since *Royal Drug*, the focus of the McCarran-Ferguson Act inquiry has been on "the nature of the conduct alleged to violate the antitrust laws, not whether the defendant is a traditional insurance company."[53] Hence, regardless of Blue Cross's status, "the challenged activities still constitute the 'business of insurance.'"[54]

The Seventh Circuit relied on similar analysis in *Anderson v. Humana*.[55] It explained that HMOs are insurance vehicles under

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[51] *Ocean State*, 883 F.2d at 1107, 1108, citing *Royal Drug*, 440 U.S. at 230 n. 37.
[52] *Id.*, citing *Royal Drug*, 440 U.S. at 239 (Brennan, J. dissenting.)
[53] *Ocean State*, 883 F.2d at 1108.
[54] *Ibid*, n.7.
[55] *Anderson v. Humana, Inc.* (7th Cir. 1994) 24 F.3d 889, 892.

Illinois law because they spread risk -- "both across patients and over time for any given person."

2. The California Legislature has expressly acknowledged that HMOs are engaged in the business of insurance; likewise, the California Supreme Court treats HMOs like insurers for the purposes of insurance bad-faith actions

The Legislature has expressly acknowledged that health care service plans in California are engaged in the business of insurance within the meaning of the McCarran-Ferguson Act. In 1999 it enacted the Managed Health Care Insurance Accountability Act of 1999, Stats. 1999, c. 536 (S.B. 21) partially codified at Civil Code § 3428 ("Accountability Act")

The Accountability Act provides a non-exclusive state-law based remedy for injuries caused by the failure of managed care entities and health care service plans to provide medically appropriate treatment to their subscribers.[56] The uncodified portion of the Accountability Act, section 2, subd. (a)(1) of Stats. 1999, c. 36 (S.B. 21) states, in relevant part:

> Based on the fundamental nature of the relationships involved, ***a health care service plan and all other managed care entities regulated under the Health & Safety Code are engaged in the business of insurance in this state*** as that term is defined for purposes of the McCarran-Ferguson Act (15 U.S.C. § 1101 and following.) (Emphasis added.)

[56] The Accountability Act was necessary because plan subscribers who received their health coverage through their employment were often left with no remedy under ERISA. ERISA is not at issue here because Mr. Battle is a public employee. 29 U.S.C. § 1002(33) exempts "government plans" from the scope of ERISA.

The California Supreme Court has likewise held that health care service plans are treated like traditional insurers for the purposes of an action for insurance bad-faith.[57]

3. The case on which PacifiCare Relies, *Williams v. California Physician's Service*, does not address whether HMOs are in the business of insurance under the McCarran-Ferguson Act

PacifiCare is likely to argue in its reply brief that whether an HMO is engaged in the business of insurance under the McCarran-Ferguson Act is a matter of federal law, and therefore the views of the California Legislature or the California Supreme Court are not controlling. Yet, the only authority PacifiCare can muster to support its contention that it is not engaged in the business of insurance is a state law decision, *Williams v. California Physician's Service*.[58]

PacifiCare correctly explains that *Williams* held that a health care service plan regulated by the Knox-Keen Act was not the equivalent of insurance "for the purposes of applying an Insurance Code regulation governing disability insurance."[59] *Williams* did not purport to address the issue confronting this Court. Rather, it simply recognized that the Legislature has elected to subject insurers and health care service plans to distinct regulatory regimes.

Insurers are regulated by the Insurance Code and the Insurance Commissioner. Health care service plans fall under the jurisdiction of the Department of Managed Care and the Knox-Keene Act. Hence, when the plaintiff in *Williams* sought to challenge the conduct of her health care service plan by invoking a provision of the Insurance Code, the court correctly held that the statute did not apply.

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[57] *Sarchett v. Blue Shield of California* (1987) 43 Cal.3d 1, 3 n. 1.
[58] *Williams v. California Physician's Service* (1999) 72 Cal.App.4th 722.
[59] Appellants' opening brief at 28.

This division of regulatory authority does not speak to the issue of whether the contract between the HMO and the enrollee is part of the business of insurance under the McCarran-Ferguson Act, and therefore subject to state regulation without federal interference. Nothing in *Williams* is contrary to recognition by the federal appellate courts and the California Legislature, that HMOs are in the business of insurance.

C. Health & Safety Code § 1363.1 is a state law enacted for the purpose of regulating the business of insurance under the McCarran-Ferguson Act

1. Under *National Securities* and *Fabe*, § 1363.1 Regulates Insurance Because It Protects Policyholders, Governs the Type Of Policy That Can Be Issued, and Its Enforcement

Section 1363.1 falls squarely within the standard announced in *National Securities.* It regulates the language and terms of the policies that HMOs can offer in California, by requiring HMOs that want to use mandatory arbitration to provide certain disclosures in the documents issued to its plan enrollees. (See, e.g. PacifiCare's "Combined Evidence of Coverage and Disclosure" here, at AA 47. This document reads exactly like an insurance policy, detailing the coverages, exclusions and definitions of terms.)

Because § 1363.1 defines the language that HMOs must use in their plan documents, it operates directly on the relationship between the HMO and its insured/enrollee. The disclosure requirement is plainly an effort to protect insureds, hence the State has exercised its power to protect or regulate the relationship between the HMO and its members. This is exactly what *National Securities* says falls within the "core" of the business of insurance. Remarkably, PacifiCare does not even cite *National Securities* in its opening brief.

Nothing in *Fabe* cut back on the test announced in *National Securities*. To the contrary, *Fabe* re-affirmed the test, holding that the Ohio

law fell within the Act's protection because it was "aimed at protecting or regulating" the performance of the insurance contract.[60] The *Fabe* court rejected the Federal Government's contention that *Royal Drug* and *Pireno* had somehow supplanted the *National Securities* test, distinguishing those cases, and noting that they did not address the first clause of section 2(b) of the Act.

PacifiCare is wrong in suggesting that *Fabe* was decided under the *Pireno* test. Rather, the Court first decided that the Ohio statute was within the business of insurance, and *then* explained that even under a broad view of the *Perino* test the Ohio statute was intended to regulate the business of insurance.

2. The Cases holding that state restrictions on arbitration in insurance contracts are within the McCarran-Ferguson Act are consistent with *National Securities* and *Fabe*

As explained in the introduction, three federal appellate courts have concluded that state laws that restrict arbitration in the context of insurance are "state laws enacted for the purpose of regulating the business of insurance."[61] In *Mutual Reinsurance*, (which pre-dated *Fabe*) the Tenth Circuit held that a Kansas law prohibiting arbitration clauses in insurance policies was not preempted by the Federal Arbitration Act, because it was state law that regulated insurance.[62]

The *Mutual Reinsurance* court relied primarily on *National Securities*, explaining that the Kansas statute regulated the relationship between the insured and the policyholder, and was therefore at the core of

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[60] *Fabe*, 508 U.S. at 505.
[61] *Mutual Reins. Bureau v. Great Plains Mutual Ins. Co.* (10th Cir. 1992) 969 F.2d 931, cert denied 506 U.S. 1001 (1992); *Stephens v. American Int'l. Ins. Co.* (2d Cir. 1995) 66 F.3d 41, 43-44; and *Quackenbush v. Allstate Ins. Co.* (9th Cir. 1997) 121 F.3d 1372, 1381.
[62] *Mutual Reinsurance*, 969 F.2d at 933.

the business of insurance. PacifiCare's comments aside, there is nothing "nonsensical" about this application of *National Securities*.

The Second Circuit reached the same conclusion in *Stephens*, holding that Kentucky's legislative scheme for liquidating failed insurance companies, which contained an anti-arbitration provision, was protected by the McCarran-Ferguson Act. The court also relied on *National Securities* and *Fabe*, concluding that the statute in question was part of a state liquidation scheme that regulated the performance of insurance policies once an insurer (or reinsurer) is placed in liquidation.[63]

The Ninth Circuit's discussion of the issue in *Quackenbush* is admittedly dictum because the court explained that unlike the Kentucky liquidation scheme, California's liquidation scheme lacked an anti-arbitration provision.[64] But the Court was clear that, "if a California law prohibited arbitration of disputes involving an insolvent insurer, then that law would undoubtedly also be saved [by the McCarran-Ferguson Act] from preemption by the [Federal Arbitration Act.][65]

3. PacifiCare misapplies the *Pireno* factors

PacifiCare does not address *Stephens* or *Quackenbush*, but it is clear that its response to each case would be the same -- that the courts deciding those cases failed to properly apply the 3-part *Pireno* test. This response suffers from two flaws. First, it fails entirely to take into account the distinction, recognized in *Fabe*, between the first and second clauses in section 2(b) of the Act. PacifiCare asks this court to do what the Supreme Court refused to do in *Fabe*, evaluate a state law under the criteria identified to evaluate business practices. This approach ignores the fact that the State's power to regulate under the first clause of the Act is broad,

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[63] *Stephens*, 66 F.3d at 44.
[64] *Quackenbush*, 121 F.3d at 1381.
[65] *Ibid.*

while the antitrust exemption in the second clause was intended to be narrow.

Second, it seeks to apply the *Pireno* factors far more restrictively than the Supreme Court ever has. PacifiCare notes that § 1363.1 does not transfer risk. Plaintiffs do not contend otherwise, but the issue is irrelevant. *Ward* makes clear that if the *Perino* test is applied, not all three parts must be met.

PacifiCare argues that the second prong is not met because § 1363.1 regulates arbitration provisions, which (it claims) are not an integral part of the policy relationship between the insurer and the insured. PacifiCare notes that arbitration is presumptively nothing more than a shift in forum, leaving a party's substantive rights under the policy unchanged.

Ward forecloses this argument. There, UNUM argued that the notice-prejudice rule "regulates only the administration of insurance policies, not their substantive terms [and] it [therefore] cannot be an integral part of the policy relationship."[66] The Court expressly rejected this argument.[67] Here, because § 1363.1 directly regulates that words that the HMO may use in its plan if it wants to include an enforceable arbitration clause, it regulates an integral part of the policy relationship.

PacifiCare also founders on the third prong, arguing only that because § 1363.1 affects health care service plans, and not insurance companies, that the statute is not limited to insurance entities. This contention was addressed above. HMOs are engaged in the business of insurance when they offer health coverage to their members, and the statute regulates this aspect of their endeavor. The fact that they are also involved in other activities that do not constitute the business of insurance is of no consequence.

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[66] *Ward*, 526 U.S. at 375 n.5.

Section 1363.1 is limited solely to HMOs, and parallels Insurance Code § 12123.19, which requires disability insurers (which includes health insurers) who wish to include arbitration clauses in their policies to make the same disclosures to their insureds as HMOs. These provisions, which were simply different sections of the same bill, evidence a Legislative effort to regulate the relationship between insureds and their insurers, regardless of the type of coverage being provided.

Ultimately, § 1363.1 meets the *Pireno* test as applied in *Ward*. As a matter of common sense, by conditioning the availability of arbitration in HMO subscriber contracts on the HMOs' compliance with the mandated disclosures, § 1363.1 regulates insurance. Application of the 3-factor *Pireno* test confirms this conclusion.

D. PacifiCare's construction of the McCarran-Ferguson Act is irreconcilable with Supreme Court precedents and would divest states of the power to regulate insurance

If PacifiCare's view of the McCarran-Ferguson Act were correct states would lack the power to regulate the advertising of insurance. Advertising does not spread risk; it is not a part of the policyholder relationship, and neither advertising nor its regulation is not limited to entities within the insurance business. Laws that regulate advertising of insurance do not readily meet any of the three *Pireno* factors. Under PacifiCare's view, this would be dispositive.

Yet, state laws that regulate the advertising of insurance policies are clearly within the scope of the first clause of section 2(b) of the McCarran-Ferguson Act. In *Federal Trade Commission v. National Casualty Co.*,[68] the Supreme Court applied the Act to conclude that it deprived the Federal

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[67] *Ibid.*

[68] *Federal Trade Commission v. National Casualty Co.* (1958) 357 U.S. 560, 78 S.Ct. 1260, 2 L.Ed.2d 1540.

Trade Commission of authority to issue cease and desist orders forbidding insurers to engage in deceptive advertising practices.

In *National Securities*, the Court listed other types of activities concerning insurance that were within the scope of the Act, but which would not pass PacifiCare's "test." These include "the selling and advertising of policies" and the "licensing of companies and their agents."[69] Quite recently, the Ninth Circuit concluded that a California law that required insurers to report certain information to the State was a law that regulated insurance under the McCarran-Ferguson Act.[70]

The fact that PacifiCare's construction of the statute would lead a court to conclude that these activities were outside of the business of insurance strongly indicates that PacifiCare's approach is flawed. This conclusion becomes inescapable if PacifiCare's view is superimposed over ERISA cases, for it would mean that states possess plenary power to regulate ERISA plans that purchase "insurance" coverage, but now power to regulate plans that purchase identical coverage provided by HMOs.

In *Metropolitan Life*,[71] the Court held that state laws that mandated insurers to provide certain types of benefits, so called "mandated benefit" laws, regulated insurance and were therefore saved from ERISA preemption. The Court explained that it was "to state the obvious" to say that a law that regulates the terms of insurance policies is a law that regulates insurance.[72]

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[69] *National Securities*, 393 U.S. at 459, 460.
[70] *Gerling Global Reinsurance Corp. of America v. Low* (9th Cir. 2001) __ F.3d __, 2001 WL 99396, *6 [holding that the Holocaust Victims Insurance Relief act of 1999, Ins. Code §§ 13800-13807 was within the McCarran-Ferguson Act.]
[71] *Metropolitan Life*, 471 U.S. at 740.
[72] *Ibid.*

Under PacifiCare's view, since HMOs are not traditional insurers, laws that regulate the content of their plans are not laws that regulate "insurance." These laws therefore do not implicate the McCarran-Ferguson Act, and would not be "saved" under ERISA's saving clause. This result would mean that states could mandate benefits provided by insurers, but not by HMOs. PacifiCare cannot point to any authority that supports this radical position, and, as explained above, several circuits have reached the contrary conclusion, with good reason.

E. PacifiCare concedes that its plan documents do not comply with § 1363.1

Nowhere in its opening brief does PacifiCare contend that its plan documents complied with § 1363.1. Rather, in this Court, as in the trial court, PacifiCare has effectively conceded that its plan documents were not in compliance. In its opening brief, at pages 7-8, PacifiCare carefully details the arguments that both parties made in the trial court. Its brief explains that plaintiffs argued in their opposition to PacifiCare's motion to compel arbitration that PacifiCare was not in compliance with § 1363.1, and that in its reply, PacifiCare argued *only* that § 1363.1 was not a law regulating insurance.

Having never argued in the trial court, or in this Court, that its plan documents comply with § 1363.1, PacifiCare has conceded the point. (*Tiernan v. Trustees of Cal. State Colleges* (1982) 33 Cal.3d 211, 216.) Likewise PacifiCare has never disputed in this Court, or below, that if § 1363.1 applies here because it is not preempted by the Federal Arbitration Act, PacifiCare's arbitration clause is invalid. (*Erickson*, 71 Cal.App.4th at 650.)

CONCLUSION

Health & Safety Code section 1363.1 is a state law that was enacted for the purpose of regulating insurance under the McCarran-Ferguson Act.

It is therefore not preempted by the Federal Arbitration Act. Because PacifiCare's plan documents fail to comply with § 1363.1, the arbitration clause is invalid. This Court should accordingly affirm the trial court's order denying PacifiCare's petition to compel arbitration.

Dated: February 15, 2001. Respectfully submitted,

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