In the

Court of Appeal

of the

State of California

SECOND APPELLATE DISTRICT
DIVISION FIVE

B251068

ROBERT MENDOZA, KALANA PENNER, DAVID PENNER and LOS ANGELES COUNTY MEDICAL ASSOCIATION,

Petitioners,

v.

THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES,

Respondent,

HEALTH NET, INC., HEALTH NET OF CALIFORNIA, INC., and HEALTH NET LIFE INSURANCE COMPANY,

Real Parties in Interest.

APPEAL FROM THE SUPERIOR COURT OF LOS ANGELES COUNTY (DEPT. 311)
HON. JOHN S. WILEY, JR. · PHONE NO. (213) 351-8893 · CASE NO. BC491954

BRIEF OF *AMICI CURIAE* AMERICAN CANCER SOCIETY CANCER ACTION NETWORK AND CANCER LEGAL RESOURCE CENTER IN SUPPORT OF PLAINTIFFS' PETITION FOR PEREMPTORY WRIT OF MANDATE

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Court of Appeal

of the

State of California

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

Court of Appeal Case No.: B251068

Case Name: Robert Mendoza, an individual; et al v. Health Net, Inc., et al

☑ There are no interested entities or parties to list in this Certificate per California Rules of Court,

☐ Interested entities or parties are listed below:

Name of Interested Entity or Person	**Nature of Interest**
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Signature of Attorney/Party Submitting Form

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I. INTRODUCTION

This case highlights the importance of access to meaningful health insurance coverage to Californians who have cancer, or may develop cancer in the future. The plaintiffs are two individuals who were denied insurance access to cancer treatment and pain management procedures that their treating physicians deemed appropriate. Their health insurance company, Health Net, decided that the recommended procedures were not "medically necessary" because other alternatives were available, but did not establish that the advice of the plaintiffs' doctors was unreasonable, contrary to good medical practice, or inconsistent with community medical standards.

The plaintiffs (which also include the Los Angeles County Medical Association) and Health Net filed early cross-motions for summary adjudication on the question whether Health Net's definition of medical necessity complies with California law. The trial court granted Health Net's motion and denied plaintiffs' motion. Plaintiffs now ask this Court for a writ directing the trial court to reverse its order.

The American Cancer Society Cancer Action Network ("ACS CAN") and the Cancer Legal Resource Center ("CLRC") seek the Court's leave to present their views as *amici curiae* on this issue, which is of critical importance to Californians, in support of plaintiffs' writ petition. ACS CAN and CLRC believe that any definition of medical necessity should incorporate the views of the treating physician. California law holds that California residents who are suffering from cancer and in need of treatment for the disease or its symptoms should be entitled to rely on their doctors' advice, unless that advice is shown to be misguided. ACS CAN and CLRC join the plaintiffs in asking this Court to issue a writ

directing the trial court to grant plaintiffs' motion on grounds that Health Net's definition of medical necessity is contrary to California law.

II. STATEMENT OF INTEREST

ACS CAN is the nation's leading advocacy organization dedicated to defeating cancer. Created in 2001 as the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society (ACS), ACS CAN supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN encourages lawmakers at all levels of government to join the fight to make cancer a national priority, and advances the mission to defeat cancer by helping to protect and increase public investment in groundbreaking medical research and by improving access nationwide to the latest prevention and early detection measures, treatments, and follow-up care that are proven to save lives. Based on evidence of the importance of health insurance status to cancer outcomes, ACS CAN also advocates for access to meaningful insurance coverage that serves the needs of cancer patients.

The CLRC is a program of the Disability Rights Legal Center (DRLC), a non-profit organization dedicated to championing the rights of people with disabilities and promoting access to adequate, affordable healthcare for those with any kind of health condition, including cancer. CLRC provides free information and resources on cancer-related legal issues such as access to insurance coverage, government benefits and health care, and navigating managed care, to cancer patients, survivors, caregivers, health care professionals, employers, and others coping with cancer nationwide. From its direct work with populations affected by cancer, the CLRC understands that access to affordable and reliable health care coverage is an area of primary concern. Indeed, CLRC routinely

assists individuals whose insurance companies deny payment for treatment based on a definition of medical necessity that differs from what their providers recommend.

III. EXTRAORDINARY RELIEF IS WARRANTED

The parties and the trial court have expressed their belief that writ review is warranted in this case. ACS CAN and CLRC agree.

California courts have recognized that, although the availability of writ relief is limited, "the intervention of an appellate court may be required to consider instances of a grave nature or of significant legal impact, or to review questions of first impression and general importance." *Anderson v. Superior Court*, 213 Cal. App. 3d 1321, 1328 (1989). Writ review is warranted where "the issue tendered in the writ petition is of widespread interest or presents a significant and novel constitutional issue," *Omaha Indemnity Co. v. Superior Court*, 209 Cal. App. 3d 1266, 1273-74 (1989), or where the petition raises significant issues that are likely to recur. *Volkswagen of America, Inc. v. Superior Court*, 94 Cal. App. 4th 695, 702 (2001). "A writ of mandate *should* not be denied when 'the issues presented are of great public importance and must be resolved promptly.'" *Corbett v. Superior Court*, 101 Cal. App. 4th 649, 657 (2002) (emphasis original).

Under the circumstances of this case, writ review is appropriate. The issue tendered in the writ petition – whether California law requires that health insurance providers consider the opinion of the treating physician in determining medical necessity – is of widespread interest to all insured Californians and to the public as a whole. As the parties point out, insurers make decisions every day as to whether a course of treatment recommended by a doctor is medically necessary. Those decisions can

have immediate and drastic impacts on the lives, health, and financial well-being of the individuals who are seeking coverage and potentially on all Californians who are insured and who may someday require medical treatment. The trial court's order sanctioning Health Net's definition of medical necessity is not immediately appealable, and given that discovery has not even started, it may not be appealable for years. In the meantime, patients may be denied coverage for treatments that are desperately needed. *Amici* therefore join the parties in urging this Court to grant the writ petition.

IV. HEALTH NET'S DEFINITION OF MEDICAL NECESSITY IS CONTRARY TO CALIFORNIA LAW

A. Health Insurance Issues Have A Dramatic Impact On Cancer Patients

ACS estimates that about 1,660,290 new cancer cases will be diagnosed in 2013, including 171,330 in California. About 580,350 Americans are projected to die of cancer in 2013 – almost 1,600 people per day. Cancer is the second most common cause of death in the United States, accounting for nearly one of every four deaths. *See* "Cancer Facts and Figures 2013" (ACS 2013).[1] An extensive ACS study published in 2008 determined that uninsured Americans are less likely to get screened for cancer, more likely to have their cancer diagnosed at an advanced stage, and less likely to survive that diagnosis than their insured counterparts. *See* E. Ward et al., "Association of Insurance with Cancer Care Utilization and Outcomes," *CA: A Cancer Journal for Clinicians*

[1] Available at http://www.cancer.org/research/cancerfactsstatistics/cancerfactsfigures2013/.

58:1 (Jan./Feb. 2008).[2] This established link between insurance status and medical outcomes makes access to health insurance benefits a top priority for ACS CAN.

An estimated 70% of cancer patients under age 65 have private health insurance. But even those cancer patients who have insurance are often unprotected against high health care costs. Cancer patients are vulnerable to the high costs of treatment, and often struggle to cope with the complexities of the health insurance system. *See generally* K. Schwartz *et al*., "Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System" (Kaiser Family Found. & ACS, Feb. 2009).[3] Cancer patients and their families often suffer severe financial hardships as a result of the costs of their treatment. A study published in May of this year found that cancer patients are over two and a half times as likely to file for bankruptcy as people who do not have cancer. *See* S. Ramsay *et al.*, "Washington State Cancer Patients Found To Be At Greater Risk For Bankruptcy Than People Without A Cancer Diagnosis," *Health Affairs* 32:1143-1152 (June 2013).[4] Another study found that one-third of families lost most or all of their savings following a cancer diagnosis. *See* M. Arozullah *et al.*, "The Financial Burden of Cancer: Estimates From a Study of Insured Women with Breast Cancer," 2 *J. Support Oncology* 3 (2004).[5]

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[2] Available at http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.

[3] Available at http://www.cancer.org/acs/groups/content/@corporatecommunications/documents/document/acsq-017518.pdf.

[4] Available at http://content.healthaffairs.org/content/early/2013/05/14/hlthaff.2012.1263.

[5] Available at http://jso.imng.com/jso/journal/articles/0203271.pdf.

For these reasons, ACS CAN and CLRC work to promote access to *meaningful* health insurance that is adequate, available, affordable, and administratively simple. ACS CAN and CLRC believe that patients should have timely access to, and coverage for, the complete continuum of quality, evidence-based healthcare services, including treatment of cancer as well as management of pain and other cancer-related symptoms.

The inherent challenges confronted by cancer patients can be magnified by insurance companies' approach to care. One noted commentator on the health care system has observed:

> Many health insurance companies . . . impose barriers – like requiring prior authorization for tests and treatments and denying payment for covered services, which forces patients to appeal – to discourage patients from using the medical services for which they are insured and to attempt to avoid paying for those services. While these barriers can reduce waste by preventing unnecessary care, they can also discourage patients from receiving care they need, as well as impose administrative burdens on doctors and patients.

E. Emanuel and J. Liebman, "The End of Health Insurance Companies" (Jan. 30, 2012).[6]

B. What Is Medical Necessity?

Under many insurance plans, carriers must pay for treatment that is "medically necessary." Determining medical necessity can be complicated, and insurance contracts written by insurers often put the onus of proving what is medically necessary largely on the provider and patient. In many scenarios, this practice results in large administrative burdens for patients and doctors, with the worst scenario being adverse

[6] Available at http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/.

patient outcomes resulting from complete denial of payment for treatment. Accordingly, promoting an appropriate definition of medical necessity is an important element of ACS CAN's and CLRC's goal of ensuring that cancer patients have access to meaningful health insurance.

"Medical necessity" is different from "coverage." Coverage is a broad policy determination as to what an insurance carrier will pay for generally under a policy, while medical necessity encompasses the treatment that is necessary to protect and enhance the health of a particular patient in accordance with accepted standards of medical practice. Medical necessity defines what the carrier will pay for in specific, individual instances. A coverage determination is a policy decision about categories of health interventions provided to a population, and is defined by statutory mandate and by insurance policy terms that may provide coverage above the statutory minimum. A medical necessity determination, on the other hand, concerns the appropriateness of a specific treatment for a specific patient. Thus, medical necessity entails an individual assessment, rather than a general determination of what works in the ordinary case. *See generally* C. Ulmer et al., "Perspectives on Essential Health Benefits: Workshop Report," *Board on Health Care Services* at 51-52 (2012).[7]

Medical necessity can be difficult to determine, and can be defined differently depending on the language of the insurance contract involved and the law of the state that applies to the contract. The United States Supreme Court has emphasized the importance of the medical necessity assessment:

[7] Available at http://books.nap.edu/catalog.php?record_id=13182.

> Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions [the carrier's] obligation to provide or pay for that particular procedure at that time in that case. . . . In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment.

Pegram v. Herdrich, 530 U.S. 211, 229 (2000).

C. The Importance Of The Treating Physician's Role

ASC CAN and CLRC believe that treating physicians must play an important role in the determination of what is medically necessary. The American Cancer Society weighed in on this issue in 2007, in connection with Congressional hearings on the Breast Cancer Protection Act. In its Policy Position, the ACS stated:

> The Society strongly supports the ability of a physician and patient to freely discuss and decide together what treatment . . . is medically necessary and appropriate for the patient. To that end, the Society opposes any effort on the part of a health plan or health insurance organization that seeks to arbitrarily limit patient access to available treatments deemed medically necessary by a physician.

American Cancer Society, Policy Position: Breast Cancer Protection Act (2007).

Many courts have reiterated the principle that the treating physician is in the best position to evaluate his or her patient's history and condition, and should retain "the primary responsibility of determining what treatment should be made available to his patients." *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980); *see, e.g.*, *Sprague v. Bowen*, 812 F.2d

1226, 1230 (9th Cir. 1987) ("The rationale for giving greater weight to a treating physician's opinion is that he is employed to cure and has a greater opportunity to know and observe the patient as an individual."); *Royal v. Cook*, 2012 U.S. Dist. LEXIS 84537, *26 (N.D. Ga. 2012) (opinion of treating physician as to medical necessity "is more persuasive and is entitled to much greater weight" than opinions of reviewing physicians); *Lopez v. Blue Cross of Louisiana*, 397 So. 2d 1343, 1345 (La. 1981) (evaluation of patient "is best done by the treating physician"); *Snyder v. San Francisco Feed and Grain*, 230 Mont. 16, 27 (1987) (treating physician normally has more contact with, and greater knowledge of, patient's condition and is "generally in the best position to give an informed opinion"); *A.M. Medical Services, P.C. v. Deerbrook Ins. Co.*, 859 N.Y.S.2d 892 (NY Civ. Ct. 2008) ("the patient's treating physician is always in the best position to prescribe care and treatment for the patient").[8]

As discussed below, California courts agree that patients should be entitled to rely on the advice and recommendations of their doctors.

D. California Law Requires Consideration Of The Treating Physician's Opinion – Consideration Not Afforded By Health Net's Definition Of Medical Necessity

Sarchett v. Blue Shield of California, 43 Cal. 3d 1 (1987), although decided on different grounds, set forth a key principle concerning the role of the treating physician. The plaintiff sued Blue Shield after his claim for hospitalization benefits was denied. The California Supreme Court

[8] For this reason, Social Security regulations require deference to the treating physician's opinion unless that opinion is "contradicted by substantial evidence" – the so-called "treating physician rule." *See, e.g., Gartmann v. Secretary of HHS*, 633 F. Supp. 671, 680 (E.D.N.Y. 1986).

ultimately found that Blue Shield breached its duty of good faith and fair dealing by failing to advise the plaintiff of his rights to peer review and arbitration. *Id*. at 16. The Court stated that California law permitted Blue Shield to disagree with the judgment of the treating physician as to what treatment was medically necessary after a retroactive review. The Court noted, however, that a subscriber "would reasonably expect to be covered for hospitalization recommended by the treating physician. . . . [T]he subscriber expects coverage because he trusts that his physician has recommended a reasonable treatment consistent with good medical practice." *Id*. at 10. The appropriate way to fulfill subscribers' expectations, the Court held, was to "construe the policy language liberally, so that uncertainties about the reasonableness of treatment will be resolved in favor of coverage." *Id*. The Court concluded:

> We trust that, with doubts respecting coverage resolved in favor of the subscriber, *there will be few cases in which the physician's judgment is so plainly unreasonable, or contrary to good medical practice, that coverage will be refused.*

Id. at 13 (emphasis added).

In *Hughes v. Blue Cross of Northern California*, 215 Cal. App. 3d 832 (1989), the Court of Appeal upheld a verdict that Blue Cross breached the covenant of good faith and fair dealing by denying benefits for the plaintiffs' son's hospitalization. The Court noted that good faith implied consistency with the insured's expectations. Following *Sarchett*, and focusing on the reasonable expectations of the plaintiffs, the Court held:

> If the insurer employs a standard of medical necessity significantly at variance with the medical standards of the community, the insured will accept the advice of his treating physician at a risk of incurring liability not likely foreseen at the time of entering the insurance contract. Such a restricted

> definition of medical necessity, frustrating the justified expectations of the insured, is inconsistent with the liberal construction of policy language required by the duty of good faith. . . . [G]ood faith demands a construction of medical necessity consistent with community medical standards that will minimize the patient's uncertainty of coverage in accepting his physician's recommended treatment.

Id. at 845-46.

Most recently, this Court addressed a claim that an insurer breached the implied covenant of good faith and fair dealing, and committed fraud, by denying hospitalization benefits. *Nickerson v. Stonebridge Life Insurance Co.*, 219 Cal. App. 4th 188 (2013). This Court upheld an award of punitive damages. In assessing the degree of the insurer's reprehensibility, the Court noted that Stonebridge withheld a letter from the plaintiff's primary care physician from the peer reviewer who was assessing medical necessity. Citing *Sarchett*, this Court held, "***Insurers may not ignore the opinion of treating physicians absent a showing the physician's judgment is either 'plainly unreasonable, or contrary to good medical practice.'***" *Id*. at 188 (citing *Sarchett*, 43 Cal. 3d at 13) (emphasis added).

Health Net's definition of medical necessity is not consistent with the holdings of these cases. Health Net's policy includes a threshold requirement that the service at issue be recommended by the treating physician; but in assessing medical necessity, the policy does not mention the opinion of the treating physician or require consideration of that opinion, let alone deference to it. As a result, Health Net has free rein to decide for itself, among other things, whether the treatment at issue is "the most appropriate supply or level of service," whether it is "furnished in the most economically efficient manner," and whether it is "known to be

effective and safe in improving health outcomes." In making those determinations, Health Net can – contrary to the holdings of *Sarchett*, *Hughes*, and *Nickerson* – ignore the opinion of the treating physician, regardless of whether that opinion is "plainly unreasonable" or "contrary to good medical practice." *See Sarchett*, 43 Cal. 3d at 13. Health Net's definition of medical necessary therefore violates California law.

E. *Amici* Oppose Any Definition Of Medical Necessity That Arbitrarily Limits Patient Access To Available Treatments Deemed Medically Necessary By The Patient's Physician

As is obvious from the facts of this case, the question of medical necessity highlights what can be a critical conflict between doctor-recommended treatment and insurance business practices. ACS CAN and CLRC are concerned that the definition of medical necessity set forth in Health Net's policies, and advocated by Health Net in this case, does not accord proper deference to the opinion of the treating physician and interferes unduly with the relationship between provider and patient. Under Health Net's interpretation, the definition places undue burdens on the provider and patient to prove why a treatment *is* medically necessary, rather than placing the burden on the insurance company to establish why the treating physician's recommendation should be disregarded. As this Court plainly indicated in *Nickerson*, that burden properly belongs on the insurer.

Moreover, ACS CAN and CLRC do not believe that deference to the opinion of the treating physician would somehow require insurance companies to accede to treatments or procedures that are not supported by the medical evidence. Evidence-based medicine is not intended to

supplant the recommendations of the treating physician, but to supplement them:

> External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision.

D. Sackett et al., "Evidence Based Medicine: What It Is And What It Isn't: It's About Integrating Individual Clinical Expertise And The Best External Evidence," *Brit. Med. J.* 312:71 (Jan. 13, 1996).[9] Health Net's assumption in its motion for summary adjudication that there is an inherent conflict between deference to the treating physician, and coverage only for treatment that is medically appropriate, is false.

Amici do not question the right of health insurance companies to exercise oversight regarding coverage and medical necessity, including the right to consider cost where appropriate. *Amici* do, however, suggest that Health Net's definition of medical necessity is inadequate to protect the health and needs of cancer patients, because it does not require either (1) appropriate consideration of the recommendation of the treating physician who is in the best position to assess the condition and needs of the patient, or (2) acceptance of that recommendation unless Health Net can establish that there is a substantive and significant reason not to do so. As the California courts have held, cancer patients should be entitled to assume that, barring some evidence to the contrary, the advice of their

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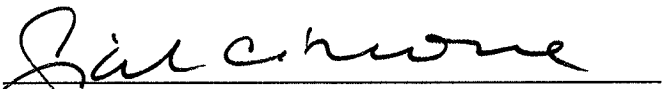
[9] Available at http://www.bmj.com/content/312/7023/71. *See also* D.M. Eddy, "Guidelines for the Cancer-Related Checkup: Recommendations and Rationale," *CA: A Cancer Journal for Clinicians* 30, no. 4 at 193-240 (1980).

doctors will be accepted and followed by their insurance companies. Health Net's policy does not provide that assurance.

V. CONCLUSION

For the reasons set forth above and in Plaintiffs' Petition for Peremptory Writ of Mandate and supporting Memorandum of Points and Authorities, ACS CAN and CLRC urge this Court to grant the writ and direct the Superior Court to grant plaintiffs' motion for summary adjudication on grounds that Health Net's policy does not comply with California law.

DATED: October 9, 2013 KILPATRICK TOWNSEND & STOCKTON LLP

By: 
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CERTIFICATE OF COMPLIANCE

Counsel of Record hereby certifies that pursuant to Rule 8.204(c)(1) or 8.504(d)(1) of the California Rules of Court, the enclosed Brief of Amici Curiae is produced using 13-point or greater Roman type, including footnotes, and contains 3,579 words, which is less than the total words permitted by the rules of court. Counsel relies on the word count of the computer program used to prepare this brief.

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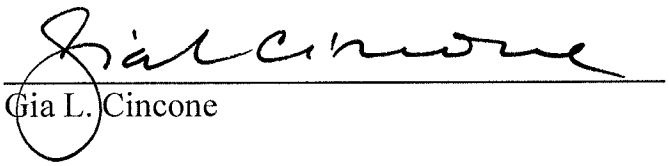
By: 

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I, Stephen Moore , declare that I am not a party to the action, am over 18 years of age and my business address is: 354 South Spring St., Suite 610, Los Angeles, California 90013.

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