

No. B215035

**IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT, DIVISION ONE**

**ANTHEM BLUE CROSS OF CALIFORNIA, INC.; ANTHEM BLUE
CROSS LIFE AND HEALTH INSURANCE COMPANY;
WELLPOINT, INC.;**

Defendants-Petitioners,

v.

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

Respondent,

PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff-Real Party in Interest

Superior Court of California, County of Los Angeles
Case No. BC 389110
Honorable Anthony J. Mohr, Judge

**APPLICATION OF AMERICAN COLLEGE OF EMERGENCY
PHYSICIANS, STATE CHAPTER OF CALIFORNIA, INC. FOR
PERMISSION TO FILE *AMICUS CURIAE* BRIEF; *AMICUS
CURIAE* BRIEF IN SUPPORT OF REAL PARTY IN INTEREST**

Andrew H. Selesnick, SBN 160516
Jason O. Cheuk, SBN 245768
MICHELMAN & ROBINSON, LLP
15760 Ventura Boulevard, Fifth Floor
Encino, California 91436
Telephone: (818) 783-5530
Facsimile: (818) 783-5507

Attorneys for Amicus Curiae
American College of Emergency Physicians,
State Chapter of California, Inc. (CAL/ACEP)

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**APPLICATION OF CAL/ACEP FOR PERMISSION TO FILE
BRIEF AS *AMICUS CURIAE* IN SUPPORT OF REAL PARTY IN
INTEREST THE PEOPLE OF THE STATE OF CALIFORNIA**

The American College of Emergency Physicians, State Chapter of California, Inc. (CAL/ACEP) hereby respectfully applies for permission to file the accompanying brief as *amicus curiae* in support of Real Party in Interest The People of the State of California.

CAL/ACEP is an organization comprised of over 2,500 emergency physicians in California. Its membership includes emergency physicians who practice in a wide variety of settings, including large and small groups, academic centers, and managed care. CAL/ACEP represents and advocates for its members and their patients to improve the practice of emergency medicine through legislative, educational, advisory, and social endeavors.

CAL/ACEP's members regularly interact with health care service plans, including Petitioner Blue Cross and *amicus curiae* Blue Shield, regarding the provision of emergency medical services and care to their enrollees. These relationships necessarily implicate the business practices of health plans on a continuous and ongoing basis.

As emergency physicians, CAL/ACEP's members share a unique and unparalleled interest in this litigation, as violations of the Unfair Competition Law, False Advertising Law (collectively, the "UCL") and the Knox-Keene Act by health plans have an unprecedented impact on their livelihood and their patients' health, given the climate of the emergency medical care industry in recent years. Emergency physicians do not have a choice as to whether or not to treat a patient who enters the emergency room. Under California law, they are mandated not to turn away any patients seeking emergency care, regardless of the patients' "insurance status, economic status, or ability to pay for medical services." Cal. Health & Safety Code § 1317(b); accord, 42 U.S.C. § 1395dd. In fact, emergency

care providers must render treatment without first even inquiring as to their patients' ability to pay. Cal. Health & Safety Code § 1317(d). As a result, emergency physicians across the state treat over 10 million Californians each year.¹

When a health plan violates the UCL by engaging in post-claims underwriting to improperly and prematurely rescind an enrollee's coverage, physicians are left to pursue their reimbursement claims from individual patients, which results in lower rates of reimbursement and collection than when seeking reimbursement from covered enrollees. Emergency room patients often have extremely serious health issues requiring intensive treatment by emergency physicians, and many cannot afford such services due to overwhelming debt, frequently from prior medical bills. As a result, emergency physicians already provide free care to many Californians at their own expense. Predictably, fewer physicians are willing to enter the field without the assurance of fair and reliable reimbursement, and many emergency departments have no choice but to eventually shut down operations.

Despite the growing number of emergency room patients, which has increased by 1 million from 1998 to 2006,² over 60 emergency departments in California have been forced to shut down in the last 10 years, primarily due to inadequate reimbursement. The effects of these closures are ultimately felt most by the patients, as they are left with fewer, overcrowded emergency rooms in which to seek care. Further, because the lower-income population is less able to afford the costs of medical treatment, unlawful business practices of health plans particularly prejudice this demographic. Emergency department closures occur in

¹ See http://democrats.sen.ca.gov/index.asp?Type=B_BASIC&SEC={97BEECE E-97E0-4F9C-AD54-C80C74C901D6}

² *Id.*

disproportionately higher numbers in these socio-economic regions than others across the state. Until these practices are ended, the increasing inability of emergency facilities to serve California's residents will continue to become a growing concern.

In committing the unlawful acts alleged by the People, health plans view patients as consumers in the marketplace, seeking to exploit them for economic gain. What they are really doing, however, is marginalizing patients with serious health conditions and thus, the greatest need for care, at their most vulnerable state. These patients are the most susceptible to false and misleading advertisements and solicitations from health plans. Just as many of these patients cannot afford medical care, they also cannot afford advocates on their behalf against plans that unfairly target them with wrongful marketing tactics.

Health plans cannot be permitted to capitalize on the desperation of these patients by soliciting them as applicants and enrollees without appropriate investigation. Health plans should be investigating applicants before issuing coverage, rather than waiting until after the patient has enrolled and rightfully received medical services. To determine which enrollees are the least profitable for the plan and rescinding coverage on that basis, based on claims received, is fraudulent and unethical. For patients whose coverage has been rescinded after the onset of a serious medical condition, post-claims underwriting can have serious, long-term consequences for their health and financial well-being.

When health plans view their participation in the health care industry as purely an economic endeavor, they lower the quality of medical services available to everyone. Patients who receive coverage have a higher probability of maintaining good health and staying away from the emergency room, while those most in need face a higher probability of rescission and getting left behind as helpless victims.

It is evident that other parties to a health plan's relationships suffer most when a health plan engages in unlawful business practices. It is therefore crucial that courts recognize the need for health plans to properly approve and assign coverage so that patients receive coverage consistent with representations from health plans.

This case reaches far beyond merely terminating the reprehensible business practices of a health plan and levying sanctions accordingly. It also implicates larger social and ethical issues in an industry where the importance of candor and accountability cannot be overstated. These issues loom especially large today, a time when access to affordable health care is widely considered the biggest concern of our citizens.

Physicians and patients alike should be able to rely on representations from health plans regarding approval of coverage without having to fear unlawful rescission of coverage after patient claims are filed. Honesty, integrity and consistency must be reinforced as the foundation of health plan-physician and health plan-patient relationships, as tens of thousands of claims are filed everyday across the state. Thus, CAL/ACEP has a strong interest in ensuring that health plans that undermine these relationships by violating the UCL face the absolute maximum consequences of their actions under the law. Because the law permits public prosecution of health plans beyond an administrative slap on the wrist, CAL/ACEP supports the right of the People of the State of California through their representative, the Los Angeles City Attorney, to pursue their UCL claims.

CAL/ACEP files this *amicus curiae* brief to seek accountability and to promote the use of ethical business practices within the health care industry so that the practice of medicine can retain its focus on providing medical services to the patients who need them. While health plans may benefit financially from the violations alleged herein, the costs are borne on

the innocent victims entangled in their web of greed—the patients and their physicians. CAL/ACEP uses the strength of its organized and collective membership to not only advocate for the interests of its member physicians and their patients, but also lend a voice for all emergency physicians and their patients across the state. Health care litigation shapes a body of law that impacts everybody's lives—not just those of CAL/ACEP members.

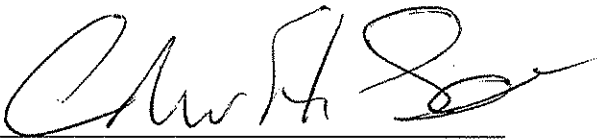
After reviewing the briefs filed by the parties and *amici curiae*, CAL/ACEP believes the Court will benefit from further briefing. CAL/ACEP believes it is particularly important to note that in its *amicus* brief, the DMHC has completely reversed its previous position on exclusive jurisdiction, presented in another *amicus* brief filed four years ago in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211. In fact, neither its earlier stance, nor the *Bell* case was mentioned at all in the brief, despite that *Bell* was adjudicated by this same district and involved similar issues regarding exclusive jurisdiction. It thus follows that the DMHC's new position here should be given no deference, absent a valid explanation. Also, while case law on these issues has been briefed by the parties and their *amici curiae*, some discussion of *People ex rel. Orloff v. Pacific Bell* (2003) 31 Cal.4th 1132 may be relevant to the Court in determining this matter. *Orloff*, a decision from our state's highest court, addresses a situation where a public prosecutor filed a UCL claim after an agency had already instituted administrative enforcement proceedings for the same violations. Because other cases discussed did not involve previous administrative enforcement action, briefing on this case offers guidance on resolving the issues in this case. Finally, CAL/ACEP seeks to address some of the policy concerns raised in Blue Shield's *amicus curiae* brief regarding potential effects of denying the writ petition.

CAL/ACEP has complied with the filing deadline requirements under CRC Rule 8.200(c)(1), which provides that an *amicus curiae*

application must be filed within 14 days after the last appellant's reply brief is filed. This brief is filed within 14 days of July 8, 2009, when Petitioners filed their reply to the People's answer and demurrer to the writ petition.

Dated: July 20, 2009

MICHELMAN & ROBINSON, LLP

By: 

Andrew H. Selesnick
Jason O. Cheuk
Attorneys for *Amicus Curiae*
The American College of
Emergency Physicians, State Chapter
of California, Inc. (CAL/ACEP)

INTRODUCTION AND SUMMARY OF ARGUMENT

The City Attorney of Los Angeles, on behalf of the People of the State of California (the “People”) filed the underlying action against Petitioners Anthem Blue Cross of California, Inc., Anthem Blue Cross Life and Health Insurance Company, and Wellpoint, Inc. (collectively, “Petitioners” or “Blue Cross”) under the Unfair Competition Law and False Advertising Law (collectively, the “UCL”) for various violations of the Knox-Keene Act (the “Act”). In this lawsuit, the People seek to put an end to Petitioners’ unlawful business practices, primarily post-claims underwriting. The California Department of Managed Health Care (DMHC) has already investigated and taken administrative enforcement actions against Petitioners for violations of the Act related to the same misconduct as the subject of this lawsuit, resulting in a settlement agreement that imposed a \$10 million penalty and other obligations on Petitioners. DMHC Brief, p. 5. While the People seek relief that would impose greater obligations on Petitioners than the terms of the DMHC settlement agreement, such relief, if granted, would not interfere with performance of the DMHC settlement agreement.

After unsuccessfully arguing their first writ petition relating to the trial court’s motion to compel order involving many of the same issues, Petitioners filed the underlying second writ petition in this case to review the trial court’s order overruling their demurrer. Petitioners, who clearly do not want to be subjected to cumulative remedies as provided for in the UCL, grasp at straws to argue their position. Similarly, Blue Shield filed an *amicus* brief in support of the writ petition. Blue Shield’s misconduct has also been the subject of a UCL action by the People, and they also demurred to the complaint. The demurrer hearing has been postponed until the resolution of this writ proceeding. Because Blue Shield relies on abstention and primary jurisdiction in its brief and in its demurrer, it

appears to recognize that the DMHC does not have exclusive jurisdiction over UCL claims, even where it has investigated and initiated settlement proceedings and the remediation process.

This is a narrowly drawn case limited to a specific set of facts, dealing specifically with whether the People, represented by a public prosecutor, may properly file an action under the UCL for violations of the Act after the DMHC has already investigated and taken an administrative enforcement action against the same defendant for similar misconduct.

Petitioners and their *Amici* contend their businesses will be hugely impacted and the DMHC rendered powerless if the People's case is permitted to proceed, invoking a "sky is falling" mentality. In reality, the People seek only to stop certain unlawful practices, yet Petitioners, fearful of facing additional civil liability for their Knox-Keene violations, throw every argument they can think of into the equation. It cannot be lost in the rhetoric that Petitioners have repeatedly engaged in post-claims underwriting to rescind the health coverage of many patients, significantly harming those in the greatest need of coverage in times of vulnerability. Many of these patients receive treatment in emergency departments from CAL/ACEP members, but have no means to pay for services received. This adds to emergency physicians' already large "unfunded mandate," pursuant to which they are forced to treat large numbers of patients for free, while Petitioners and their counterparts increase their profits by not paying providers. For further discussion, see Application, *ante*. The People's lawsuit, if successful, would stop Petitioners' unlawful acts.

Notwithstanding Petitioners' attempts to portray the DMHC as the Act's exclusive enforcer, it is well settled that the DMHC does not have exclusive enforcement jurisdiction over violations of the Act. Because the DMHC only has exclusive regulatory jurisdiction, a plaintiff may not bring a UCL suit alleging violation of a regulatory provision of the Act, but may

do so alleging violation of a provision that specifies an “unlawful” act. Petitioners attempt to blur the distinction by arguing that the DMHC has broad authority under the Act, but cite no authority to establish that the DMHC has exclusive jurisdiction, whether regulatory or unlawful, over the *entire* Act. Like a private plaintiff, a public prosecutor’s UCL claim alleging unlawful acts in violation of the Act is also not barred, where the relief sought is penal in nature, and not regulatory, and action will not infringe on the DMHC’s exclusive regulatory authority. In some instances, even when administrative enforcement proceedings have been initiated related to the same misconduct, a prosecutor may bring a UCL claim, if steps are taken to prevent improper infringement on the DMHC’s jurisdiction.

Petitioners’ exclusive jurisdiction contention is contrary to the DMHC’s position in an *amicus* brief filed four years ago in this district, in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211. Because the DMHC did not explain the change in its position, its interpretation should be given no deference. Further, the DMHC misconstrues legislative intent of the relevant statutes in impermissibly attempting to expand the scope of its exclusive regulatory jurisdiction to UCL actions. The People’s underlying UCL claims are valid because they will not infringe on the DMHC’s jurisdiction, despite the ongoing remedial process, as the action does not seek duplicative remedies and proper steps can be taken to avoid improper overreaching. Any policy concerns raised by Petitioners and their *Amici* related to the People’s UCL action and the proposed remedies should be addressed at a later stage in the proceedings, as it is too early at this juncture to determine which violations will be proven and subject to injunctive relief. Finally, this case should not be subject to judicial abstention or primary jurisdiction, as CAL/ACEP agrees with and adopts the People’s position on the inapplicability of these doctrines. This is

already the second writ petition filed in this case involving similar issues. Like the first one, this Petition should be denied, and the People permitted to proceed with their lawsuit.

ARGUMENT

I. PLAINTIFF MAY FILE A UCL ACTION FOR VIOLATION OF A KNOX-KEENE ACT PROVISION THAT PROSCRIBES AN UNLAWFUL ACT.

Courts have consistently recognized that despite the Act's comprehensive statutory scheme, the DMHC does not have exclusive jurisdiction over it. *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 216; *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, 1299; *Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693, 706 ("We conclude that the department does not have exclusive jurisdiction"). In *Bell*, this district held that emergency service providers may properly file a UCL claim based on a violation of section 1371.4 of the Act for reimbursement for emergency medical services rendered to a health plan's enrollees, because the DMHC only has non-exclusive jurisdiction over the subject matter of the Act, and nothing in the Act precludes a private action under the UCL or on a common law quantum meruit theory. *Bell, supra*, 131 Cal.App.4th at 216. In so holding, the court quoted directly from the *amicus curiae* brief filed by the DMHC in that action, in which the Department conceded that "unlike the courts," it lacked the appropriate authority and jurisdiction to "provide an adequate forum" to determine and enforce plaintiffs' claims. *Id.* at 218. In its brief, the DMHC declared the extent of its jurisdiction as follows:

In defining the bounds of the Department's jurisdiction, the courts and the Department have recognized a distinction between the provisions of the Knox-Keene Act that are "purely regulatory" in nature and those that clearly make a practice "unlawful." Sections that are "purely regulatory" in nature are within the exclusive jurisdiction of the Department to enforce, for they require the exercise of discretion. A private party may, however, bring an unfair practices claim based on sections of the Knox-Keene Act that clearly make a practice "unlawful" without interfering with the Department's authority.

DMHC *Bell* Brief, pp. 1-2.³

The DMHC explained that by limiting the basis of a UCL claim to statutory provisions that define unlawful acts, "the courts protect the Department's exclusive jurisdiction over the Knox-Keene Act's purely regulatory provisions and properly refrain from assuming the Department's regulatory powers over health plans under the 'guise' of enforcing [the UCL]." *Id.* at 5. In other words, recognizing and adhering to the distinction between "regulatory" and "unlawful" is what prevents improper infringement on the Department's exclusive regulatory authority. Therefore, the DMHC only has exclusive jurisdiction over "regulatory" provisions of the Act, but not over "unlawful" provisions.

Although the DMHC did not directly address whether a lawsuit brought by a public prosecutor on behalf of the public for "unlawful" violations was also outside the DMHC's jurisdiction, it made clear that it does not retain exclusive enforcement authority. While it may appear that the main difference among the cases is whether the plaintiff is a private party or a public prosecutor, courts have indicated that the key factor in determining the jurisdictional validity of a claim is not the status of the

³ See CAL/ACEP's Request for Judicial Notice, Exh. 1.

plaintiff, but the provision of the Act that is allegedly violated. *Samura*, *supra*, 17 Cal.App.4th at 1299; *Coast Plaza*, *supra*, 105 Cal.App.4th at 706; *In Re: Managed Care Litigation* (2003) 298 F.Supp.2d 1259, 1301-1302.

Recognizing that the distinction between regulatory actions and actions enforcing “unlawful” provisions could be fatal to its Petition, Petitioners repeatedly attempt to blur the dividing line in their briefs. *See* Reply, p. 8 (“the DMHC can regulate by way of enforcing and securing prospective relief in actions to enforce prohibitory parts of the [Act].” *See* also Reply, pp. 16-17 (“corrective action itself is a form of regulatory action by the DMHC”); Reply, p. 17 (“Here, the agencies achieve regulatory changes by way of prosecuting actions against regulated entities and securing forms of relief”). Similarly, the DMHC asserts that “[n]ecessarily, regulation must consist of not only licensure [and] supervision ... but also of the power and discretion to assure compliance.” DMHC Brief, p. 15. As the People properly allege in their Answer relating to Petitioner’s previous unsuccessful writ petition, their allegations correspond directly to violations of the Act’s provisions which proscribe unlawful acts, including sections 1360, 1363.5, 1365, 1389.3, 1363.1 and 1371.8. Answer, pp. 12-13. Therefore, the DMHC does not have exclusive jurisdiction over the People’s claims under *Samura* and *Bell*, *supra*.

Petitioners, the DMHC, and Blue Shield desperately attempt to get around this key distinction by characterizing the UCL enforcement action as the People’s “new effort to circumvent the regulatory scheme created by the Legislature.” BS Brief, p. 25. Blue Shield asserts that “[e]ven the *Samura* court recognized that “courts cannot assume general regulatory powers over health maintenance organizations through the guise of enforcing Business and Professions Code section 17200.” BS Brief, p. 11. However, the *Samura* court was specifically referring to situations where a plaintiff brings a UCL claim for an alleged violation that is not actually

proscribed as “unlawful” under the relevant statutory scheme. *Samura, supra*, 17 Cal.App.4th at 1301. As the DMHC articulated in its *Bell* brief, “[a]n ‘unlawful’ practice is one in which the legislation clearly delineates and either requires or proscribes certain acts.” DMHC *Bell* Brief, p. 4. Thus, where no Knox-Keene provision makes an alleged act “unlawful,” there is no proper basis for a UCL claim. Because each UCL violation alleged in the People’s action is properly based on a provision in the Act identifying “wrongful” acts (see Opposition, p. 22), and the People have made their intentions to end these “wrongful” acts clear, the action does not seek to assume general regulatory powers over HMOs as alleged by Blue Shield. Thus, the DMHC does not have exclusive jurisdiction over enforcement of the “unlawful” acts alleged in the People’s action, and any efforts to characterize the People’s allegations differently are unavailing.

II. A PUBLIC PROSECUTOR MAY ALSO FILE A UCL ACTION FOR VIOLATION OF A KNOX-KEENE ACT PROVISION THAT PROSCRIBES AN UNLAWFUL ACT WHERE THE ACTION WILL NOT INFRINGE ON THE DMHC’S EXCLUSIVE JURISDICTION.

Courts have also upheld UCL claims brought by public prosecutors to enjoin acts declared unlawful under a comprehensive statutory enforcement scheme. *People v. McKale* (1979) 25 Cal. 3d 626; *People v. Los Angeles Palm, Inc.* (1981) 121 Cal.App.3d 25; *People v. Casa Blanca Convalescent Homes, Inc.* (1984) 159 Cal.App.3d 509, 531 (administrative enforcement and UCL proceedings “are two separate legal processes involving two separate, distinct law enforcement agencies”). Again recognizing the distinction between a regulatory action and an enforcement action, the California Supreme Court emphasized that if the relief sought by the prosecutor is penal in nature and to “protect the public and prevent

defendants from committing future unlawful acts,” pursuit of the claim will not infringe on the agency’s exclusive authority to regulate. *State of California v. Altus Finance* (2005) 36 Cal.4th 1284, 1305-1308. Therefore, regardless of plaintiff’s status as a public or private entity, a court must evaluate the nature of the claim, by looking at both the code section alleged to have been violated and the relief sought to determine whether a claim is regulatory or enforcement in nature.

Petitioners and Blue Shield attempt to distinguish the instant facts because they know that relying on the distinction is a losing proposition for them. “No California decision suggests that the UCL can be used to enforce the same regulatory scheme against the same defendant for the same conduct already addressed in an action by the entity with primary authority.” BS Brief, p. 12 fn. 4. However, our state Supreme Court suggested that there are at least some instances when a prosecutorial UCL action can be filed, despite the fact that an agency with regulatory jurisdiction has already instituted enforcement proceedings for some of the same violations. *People ex rel. Orloff v. Pacific Bell* (2003) 31 Cal.4th 1132, 1138. Like this case, the district attorneys in *Orloff* filed UCL and FAL causes of action, seeking injunctive relief, civil penalties, and restitution. *Id.* at 1138-1139. By the time the case reached the Supreme Court, the agency had issued its final decision and ordered defendant to pay over \$15 million in fines and perform other remedial acts. *Id.* at 1143. While recognizing the broad regulatory authority of the Public Utilities Commission, the Supreme Court held that it was error for the appellate court to rely solely on the fact that the allegations in both actions were the same to deny the action, without “considering the extent to which the remedies in the two proceedings were likely to be inconsistent and thus were likely to undermine any ongoing authority or regulatory program.” *Id.* at 1156. The *Orloff* decision is consistent with previous court decisions

in that the Court emphasized the importance of avoiding any interference with the agency's jurisdiction, and upheld the UCL action where no such infringement was apparent. Therefore, the People should also be permitted to maintain their action because it will not interfere with the DMHC's enforcement proceedings. The People can work with the court to fashion remedies to avoid interfering with the DMHC's authority.

III. PETITIONERS AND THE DMHC IMPERMISSIBLY ATTEMPT TO EXPAND THE DMHC'S EXCLUSIVE JURISDICTION.

Contrary to the DMHC's aforementioned position, Petitioners attempt to expand the DMHC's exclusive jurisdiction from solely regulatory provisions to encompass enforcement provisions as well. They contend the claims at issue fall within DMHC's exclusive jurisdiction because they "[relate] to [Petitioners'] activities as a DMHC-licensed health plan." Reply, p. 8. Petitioners also contend that the DMHC has exclusive jurisdiction over "virtually every aspect of the relationship among health care plans, their enrollees, and service providers." Petition, p. 27. Needless to say, Petitioners cite no authority for such overreaching propositions, as there is nothing to support that the DMHC has the sole authority to enforce violations involving all activities of a health plan and every aspect of its relationships. Instead, they reference provisions that merely grant authority, but state nothing to establish *exclusive* authority, a relative term. Petition, pp. 28-30. Curiously, Petitioners also rely on § 1394, which expressly and unambiguously states that the DMHC's available remedies are "not exclusive," to support their argument that those remedies *are* in fact exclusive to the director. Petition, p. 28. Petitioners' arguments fail to acknowledge that the People's action is to enforce the UCL, a separate statutory scheme, not the Act itself. The Act is only used as a standard to

determine whether an “unlawful” act, and therefore a violation of the UCL, actually occurred. Therefore, Petitioners’ references to provisions granting general regulation and enforcement authority to the DMHC miss the mark.

The DMHC conveniently ignores its earlier position in *Bell* in now contending it has “the exclusive authority to regulate plans and *everything* related to the plan industry.” DMHC Brief, p. 17 (emphasis added); see also *Id.*, p. 10 (“all oversight of California-licensed health plans is to be exclusively performed by” the DMHC); see also *Id.*, p. 11 (“The Knox-Keene Act specifically regulates every facet of health plan conduct and relationships, and commits oversight, licensing, and enforcement powers exclusively to the Department”). Just four years ago, the DMHC admitted that it lacked the appropriate authority and jurisdiction to “provide an adequate forum” for the private UCL claims alleging unlawful acts under the Act, and recommended that the courts handle those claims. *Bell, supra*, 131 Cal.App.4th at 218, quoting DMHC brief. As discussed above, the DMHC argued this point so convincingly in its brief that this district relied on it heavily in reversing the trial court’s decision. Moreover, earlier this year, the Supreme Court in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 507-508, cited *Bell* with approval on at least 13 occasions in affirming that emergency care providers may sue health plans directly to resolve billing disputes, further evidencing that the DMHC does not have exclusive jurisdiction to enforce “everything related to the plan industry.”

Even Petitioners have acknowledged this about-face, noting that “in quite opposite fashion, the DMHC agrees with petitioners [and] asserts its exclusive jurisdiction in an amicus curiae brief.” Petition, p. 32 fn. 8.

Courts should not defer to an administrative agency that has taken a “vacillating position” as to the meaning of the statute in question. *Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th at p. 13.

The Supreme Court has refused to extend deference to an agency's interpretation of a regulation when it conflicts with the agency's previous interpretation of the same regulation. *Norfolk S. Railway Co. v. Shanklin* (2000) 529 U.S. 344, 356; *Bowen v. Georgetown University Hospital* (1988) 488 U.S. 204, 212 (“Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate”).

Like Petitioners, the DMHC failed to set forth any reasons for its unfounded departure from the case law. It also failed to explain its sudden change in position, or explain why the “purely regulatory” vs. “unlawful” dichotomy it had so fervently argued four years ago no longer applies today. The DMHC also does not contend that there has been a change in law in recent years, so we are only left to speculate as to what prompted the shift. Not only does the DMHC fail to mention its previous stance on this issue in its brief, but also it fails to mention the *Bell* case entirely. The DMHC’s vague and baseless allegation that it has exclusive jurisdiction over almost everything related to health plans should be given no deference. Despite its broad regulatory authority, the DMHC’s exclusive authority does not extend to enforcement of the “unlawful” provisions of the Act.

IV. THE DMHC MISCONSTRUES LEGISLATIVE INTENT IN IMPERMISSIBLY ATTEMPTING TO EXPAND ITS EXCLUSIVE JURISDICTION TO ENFORCEMENT OF UCL CLAIMS

In analyzing the relevant statutes, the DMHC improperly interprets legislative intent, contending that the Legislature “did not intend to duplicate enforcement through other general laws, be they common law or general statutes.” DMHC Brief, p. 11. It reasons that because the Act

specifically incorporates the UCL at Health and Safety Code section 1386(b)(7), “the only permissible interpretation” is that the Legislature “committed jurisdiction of the UCL over health plans to the Director of the Department” and intended that “only the [DMHC] prosecute UCL violations against health plans, ... to the exclusion of other prosecutors.” DMHC Brief, pp. 22, 28. A detailed review of the statutes actually indicates an opposite construction.

Under the UCL, remedies and penalties are cumulative to those available under any other state laws, unless otherwise expressly provided. Bus. & Prof. Code § 17205. Evidently, the Legislature sought to retain the authority to select the statutory enforcement schemes it wanted to exclude from the default rule—that UCL remedies are cumulative. The DMHC itself admits the Act does not expressly state that remedies are not cumulative. DMHC Brief, p. 33. The Legislature then inserted the UCL provision into the Act and remained silent as to exclusivity, therefore intending that UCL violations under the Act remain subjected to potential cumulative remedies. In fact, had the provision *not* been inserted into the Act, the DMHC would have a stronger argument in contending inadvertence or oversight on the part of the Legislature. Further, the Legislature made clear that the remedies available to the DMHC director “are not exclusive.” Health & Safety Code § 1394. In sum, it is clear that the Legislature did not want the DMHC to have exclusive jurisdiction over UCL; it was merely enlisting the DMHC’s assistance in prosecuting UCL violations involving health plans.

V. THE PEOPLE'S ACTION WILL NOT INTERFERE WITH THE DMHC'S JURISDICTION UNDER THE KNOX-KEENE ACT.

In its brief, Blue Shield raises numerous concerns regarding potential infringement of the DMHC's authority by interfering with its administration of the terms of the settlement agreement with Petitioners and remedial actions yet to be finalized. Specifically, it contends that allowing the People to go forward would create a risk of inconsistent rulings, duplicative civil regulation and would breach separation of powers.

There is no risk of inconsistent rulings because the court will not interfere with the DMHC's determination. It will not reverse the decision or take away any remedies, but merely decide whether or not to impose additional obligations on Petitioners, as the People have made clear.

As for duplicative regulation, Blue Shield acknowledges that the People's action "seeks different remedies." BS Brief, p. 13. Different remedies that are cumulative to other remedies for the same violation are expressly permitted under the UCL. The People do not seek any of the same, duplicative remedies that the DMHC has already accounted for in its settlement agreement with Petitioners. If there is any overlap, it can be addressed later, but it is premature at this stage to dismiss a claim on this basis. Further, as the People have argued, a demurrer is not the appropriate channel to strike particular remedies from a claim.

As none of the relief sought in the People's action will duplicate any remedies already granted, *Orloff, supra*, is instructive as to the steps that may be taken to avoid undermining any general regulatory policy or frustrating any administrative program when a prosecutor's UCL claim is permitted to proceed despite a concurrent or previous administrative enforcement action. Specifically, the Supreme Court advised that where there are two parallel proceedings, the UCL action may be stayed until the

outcome of the administrative action is determined. The trial court may also tailor a preliminary injunction such that it is “subject to modification” should the agency issue a different order relating to the same unlawful acts. *Id.* at 1153. Also, the court may “take into account any fines imposed” by the agency before imposing its own civil penalties. *Id.* Further, a permanent injunction will not infringe on the DMHC’s jurisdiction if the court defers to any contrary DMHC ruling on issues within the DMHC’s exclusive jurisdiction, “[b]ecause injunctive relief is subject to modification by the court upon a showing of changed circumstances.” *Id.* at 1154. Finally, claims for penalties or restitution for past misconduct would not interfere with any of the DMHC’s ongoing efforts. *Id.* Thus, the Supreme Court has recognized that it is possible to reconcile enforcement actions by an agency and a prosecutor without violating separation of powers by carefully fashioning the remedies to prevent any improper infringement into the DMHC’s administrative program.

Blue Shield acknowledges that the DMHC can fashion remedies to avoid interference with the court’s jurisdiction. (“Here, the agencies have identified and addressed the very same conduct challenged in the Complaint, providing some remedies for former plan members and insureds without interfering with or prejudging the private actions brought by others who were subject to rescission”). BS Brief, 31. Likewise, the Court can do the same to avoid interference with the DMHC’s jurisdiction. Petitioners themselves recognize that “a court has discretion about whether and how to fashion equitable relief.” Reply, p. 15. Because the People seek only cumulative, but not duplicative remedies, and with the assistance of the court will carefully fashion any remedy to avoid undermining any regulatory policy by the DMHC or infringing on any terms of the settlement agreement, the People will not interfere with the DMHC’s jurisdiction under the Act.

VI. POLICY CONCERNS RELATING TO THE PEOPLE'S UCL ACTION ARE SPECULATIVE AND PREMATURE AND SHOULD BE ADDRESSED AT A LATER STAGE IN THE PROCEEDINGS.

Petitioners, the DMHC, and *amicus curiae* Blue Shield have adopted a “sky is falling” mentality in their briefs regarding the difficulties that they speculate could possibly arise in appropriating, administering and enforcing proper relief. Blue Shield attempts to paint a doomsday scenario, claiming that a denial of the writ petition will inevitably lead to chaos in the health care industry. It contends that the People are using the UCL “to turn the administration of state-wide regulatory policy into an unpredictable, balkanized, free-for-all,” and that they are “[asking] this Court to take over enforcement of the Act’s limits on application forms, provider payment, *and practically everything in between.*” BS Brief, pp. 2, 11 (emphasis added). Continuing the theme of expanding the true scope of the claims in this action, Blue Shield contends the People “[ask] the trial court to prescribe and monitor compliance with a host of specific conduct regulations ... covering *every aspect of the health coverage relationship,*” and have “asked a single superior court to *assume control over* [Petitioners’] past and future” activities. BS Brief, pp. 5, 22 (emphasis added). Blue Shield’s brief is full of hypothetical scenarios, identifying a number of speculative results and problems that will arise if the petition is not granted. Blue Shield concludes with a series of questions regarding the requisite contents of applications and advertisements, completion of pre-enrollment underwriting, the rescission process, etc. hoping to establish how ill-prepared the People and the court are to handle the issues in this case. BS Brief, p. 37-38.

However, Blue Shield itself highlights just how speculative and premature its own concerns are when it first contends that the People’s

“plea for restitutionary relief would complicate the action further and increase the burden on the Court, while directly interfering with the agencies’ policy judgments about economics of coverage.” BS Brief, p. 24. Then just two lines later, it admits, “[y]et it is not clear that the [People’s] claims for restitutionary relief have substance.” *Id.* This demonstrates precisely why the court should not dismiss the People’s action prematurely—the People have pled all that is required, which are allegations. It is too early at this juncture to deny any claims on a hypothetical basis. It is still undetermined as to which, if any, provisions Petitioners violated and will be found liable for, and what obligations should be imposed on them. While these concerns may at some point be appropriate to consider, it is mere conjecture by Blue Shield at this early stage to assume complete liability and skip ahead to the issues that could possibly arise in fashioning relief.

The parties are still at the pleading stage and Petitioners have filed two writ petitions already on a purely hypothetical basis regarding what may or may not happen. The facts have not fully developed, and much more discovery needs to be completed. To rely on mere speculation to dismiss the action before seeing how the parties and the court proceed is unnecessary. Many of the issues raised by Blue Shield assume liability, which has yet to be established. There is no reason to prejudice the People when the court can wait until the issues are ripe before determining what will be necessary to fashion proper relief.

Blue Shield also tries to make the case appear so complex that no trial court could possibly comprehend the issues, contending the court “will enter a morass of highly technical and prescriptive policy determinations,” and the obligations involved require “expert definition and assessment based on economic regulatory policy in an economic field of recognized cost sensitivity and fragility.” BS Brief, pp. 4, 10-11. However, as the


People have made clear, they only ask Respondent Court “to apply legal standards and public policies that the Legislature and the courts have already established.” Opposition, p. 36.

CONCLUSION

Based on the foregoing reasons, the Court should deny the petition for writ of mandate.

Dated: July 20, 2009

MICHELMAN & ROBINSON, LLP

By: 

Andrew H. Selesnick
Jason O. Cheuk
Attorneys for *Amicus Curiae*
The American College of
Emergency Physicians, State Chapter
of California, Inc. (CAL/ACEP)

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

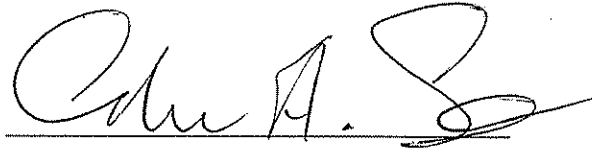
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No entities or persons have either (1) an ownership interest of 10 percent or more in the party or parties filing this certificate (Cal. Rules of Court, rule 8.208(d)(1)), or (2) a financial or other interest in the outcome of the proceeding that the justices should consider in determining whether to disqualify themselves (Cal. Rules of Court, Rule 8.208(d)(2)).

Dated: July 20, 2009

MICHELMAN & ROBINSON, LLP

By: _____



Andrew H. Selesnick

Jason O. Cheuk

Attorneys for *Amicus Curiae*

The American College of

Emergency Physicians, State Chapter

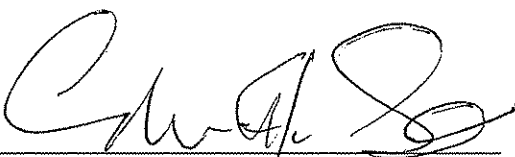
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In accordance with Rule 14(c)(1) of the California Rules of Court, I certify that this brief contains 6485 words. In making this certification, I have relied upon the word count function of Microsoft Word, Version 2003, the computer program used to prepare this Brief.

Dated: July 20, 2009

MICHELMAN & ROBINSON, LLP

By: 

Andrew H. Selesnick
Jason O. Cheuk
Attorneys for *Amicus Curiae*
The American College of
Emergency Physicians, State Chapter
of California, Inc. (CAL/ACEP)

PROOF OF SERVICE

Anthem Blue Cross v. Superior Court, Appeal No. B215035 (Second Appellate District, Division One)

I, Amie Nguyen, hereby declare:

I am employed in Encino, California. I am over the age of eighteen years and am not a party to the above-entitled action. My business address is 15760 Ventura Boulevard, Fifth Floor, Encino, California 91436.

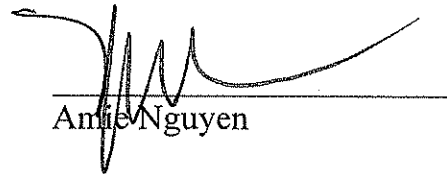
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U.S. Mail: By placing a true copy thereof in a sealed envelope with first-class postage thereon fully prepaid, in the United States Postal Service Mail at Encino, California addressed as set forth below:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 20th day of July 2009, at Encino, California.


Amie Nguyen

SERVICE LIST

Anthem Blue Cross v. Superior Court, Appeal No. B215035 (Second Appellate District, Division One)

Rockard J. Delgadillo, City Attorney
Jeffrey B. Isaacs
James W. Colbert III
Anthony M. Miera

OFFICE OF THE CITY ATTORNEY
Criminal and Special Litigation
200 N. Main St., 500 City Hall East
Los Angeles, CA 90012-4131

*Attorneys for Real Party in Interest and Plaintiff
People of the State of California*

Richard S. Odom, Esq.
Kathleen A. Waters, Esq.
MORGAN, LEWIS & BOCKIUS LLP
300 S. Grand Avenue, 22nd Floor
Los Angeles, CA 90071

Molly Moriarty Lane, Esq.
MORGAN, LEWIS & BOCKIUS LLP
One Market, Spear Street Tower
San Francisco, CA 94105-1126

*Attorneys for Defendants-Petitioner Anthem Blue Cross of California, Inc.;
Anthem Blue Cross Life and Health Insurance Company; Wellpoint, Inc.*

Francisco J. Silva, Esq.
Long X. Do, Esq.
Armand Feliciano, Esq.
CALIFORNIA MEDICAL ASSOCIATION
1201 J Street, Suite 200
Sacramento, CA 95814

*Attorneys for Amicus Curiae California Medical Association and Los
Angeles Medical County Medical Association*

Bryan D. Daly, Esq.
Peter Morris, Esq.
SHEPPARD MULLEN RICHTER & HAMPTON, LLP
333 S. Hope Street
48th Floor
Los Angeles, CA 90071

Gregory M. Pimstone, Esq.
MANATT PHELPS & PHILLIPS, LLP
11355 W. Olympic Blvd
Los Angeles, CA 90064

Donald M. Falk, Esq.
MAYER BROWN, LLP
Two Palo Alto Square, Suite 300
Palo Alto, CA 94306

Robert E. Bloch
(admitted pro hac vice)
1909 K. Street, N.W.
Washington, D.C. 20006

*Attorneys for Amicus Curiae California Physicians' Service, Inc. dba Blue
Shield of California, and Blue Shield of California Life and Health
Insurance Company*

Amy L. Dobberteen, Esq.
Michael D. McClelland, Esq.
Department of Managed Health Care
Office of Enforcement
980 Ninth Street, Suite 500
Sacramento, CA 95814

Attorneys for Amicus Curiae Department of Managed Health Care

Frances T. Grunder
St. Assistant Attorney General
Office of the Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102

Office of the Supreme Court
SUPREME COURT OF CALIFORNIA
350 McAllister Street
San Francisco, CA 94102
(4 copies)

Hon. Anthony J. Mohr
LOS ANGELES SUPERIOR COURT
Central Civil West Courthouse, Dept. 309
600 S. Commonwealth Ave.
Los Angeles, CA 90005

DISTRICT ATTORNEY'S OFFICE
Los Angeles County
Consumer Law Section
210 W. Temple St., Suite 18000
Los Angeles, CA 90012-3210

OFFICE OF THE ATTORNEY GENERAL
Consumer Law Section
1800 I Street
Sacramento, CA 95814

Rodriguez v. Blue Cross of California, LASC Case No. BC 347 797

Robert S. Gianelli, Esq.
Jully C. Pae, Esq.
GIANELLI & MORRIS
626 Wilshire Blvd
Suite 800
Los Angeles, CA 90017

Counsel for Plaintiff

Horton v. Wellpoint, LASC Case No. BC 341823

Andrew S. Friedman
Tonna K. Farrar
BONNETT FAIRBORN FRIEDMAN & BALINT, PC
600 West Broadway, Suite 900
San Diego, CA 92101

Randy D. Curry, Esq.
LAW OFFICES OF RANDY D. CURRY
2901 West Coast Highway, Suite 200
Newport Beach, CA 92663

Attorneys for Plaintiff

Kenneth N. Smersfelt, Esq.
Amir Shlesinger, Esq.
REED SMITH, LLP
355 S. Grand Avenue, Suite 2900
Los Angeles, CA 90071-1514

Kurt Peterson, Esq.
Eric Schaffer, Esq.
REED SMITH, LLP
1901 Avenue of the Stars, Suite 700
Los Angeles, CA 90067

Attorneys for Defendants

Methodist Hospital v. Wellpoint, LASC Case No. BC 352 178
Coast Plaza Doctors Hospital v. Wellpoint, Inc.,
LASC Case No. BC 360235

Daron L. Tooch, Esq.
Glenn e. Solomon, Esq.
HOOPER LUNDY & BOOKMAN, INC.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

Attorneys for Plaintiff

Bruns v. Wellpoint, LASC Case No. BC 359 135

Scott C. Glovsky, Esq.
LAW OFFICES OF SCOTT C. GLOVSKY
225 S. Lake Avenue, Suite 100
Pasadena, CA 91101

Attorneys for Plaintiff

Bailey v. BC Life Health Ins. Co., LASC Case No. BC 379 047

Raymond E. Mattison, Esq.
Christopher D. Edgington, Esq.
Don A. Ernst, Esq.
ERNST & MATTISON
1020 Palm Street
San Luis Obispo, CA 93406

Attorney for Plaintiff

***Patti D. Siegner v. Wellpoint Health Networks, Inc.,
LASC Case No. BC 371060***

Thomas V. Girardi, Esq.
Graham B. Lippsmith, Esq.
GIRARDI KEESE
1125 Wilshire Blvd
Los Angeles, CA 90017

Attorneys for Plaintiff

Lovato v. BC Life & Health Ins. Co., LASC Case No. BC 386818

Harvey Rosenfield, Esq.
Pamela M. Pressley, Esq.
Todd Foreman, Esq.
THE FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS
1750 Ocean Pak Blvd, Suite 200
Santa Monica, CA 90405

Attorneys for Plaintiff

