IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

CALIFORNIA MEDICAL ASSOCIATION, Plaintiff-Appellant, v. AETNA HEALTHCARE OF CALIFORNIA, INC. d/b/a AETNA U.S. HEALTHCARE INC.; and AETNA HEALTH OF CALIFORNIA, INC., Defendants-Respondents.	Case No. S269212

Petition for Review of a Decision by the Court of Appeal
Second Appellate District, No. B304217
Los Angeles County Superior Court, No. BC487412

BRIEF OF AMICI CURIAE CALIFORNIA ASSOCIATION OF HEALTH PLANS AND ASSOCIATION OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANIES IN SUPPORT OF DEFENDANTS-RESPONDENTS

*MICHAEL J. DAPONDE (SBN 204283)
DARCY L. MUILENBURG (SBN 233787)
DAPONDE SIMPSON ROWE PC
500 Capitol Mall, Suite 2260
Sacramento, California 95814
Telephone: (916) 840-5600
Facsimile: (916) 840-5599
mdaponde@dsrhealthlaw.com

Attorney for Amici Curiae
CALIFORNIA ASSOCIATION OF HEALTH PLANS
and ASSOCIATION OF CALIFORNIA LIFE AND
HEALTH INSURANCE COMPANIES

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

TABLE OF AUTHORITIES
(Continued)

TABLE OF AUTHORITIES
(Continued)

Other

I. INTRODUCTION: IMPORTANCE OF ISSUE AND INTEREST OF AMICI

This Court should uphold the Court of Appeal's determination that Plaintiff and Appellant California Medical Association ("CMA") lacks standing to bring a claim under California's Unfair Competition Law ("UCL").

The California Association of Health Plans ("CAHP") is a statewide trade association representing 45 full-service health care plans licensed in California providing coverage to more than 26 million Californians. CAHP's member health plans provide this coverage through a variety of mechanisms—health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and commercial for-profit and not-for-profit health plans.

The Association of California Life and Health Insurance Companies ("ACLHIC") is the largest life and health insurance trade association in California, representing 48 member insurance companies. ACLHIC advocates key insurance issues before legislative and administrative bodies. ACLHIC's member health insurance companies provide a broad range of insurance coverage options, including PPOs.

Like Amici, CMA is an association comprised of members who operate within the same industry and pay dues for a range of services, the most significant of which is advocacy. Associations advocate on behalf of their dues-paying members before legislatures, the executive branch, regulatory agencies, in the courts, and within the industry itself.

It is one of the chief functions of most any association. In fact, a perusal through the committee notes of any significant piece of legislation will likely reveal a laundry list of associations on one side or the other.

CMA would like this Court to confer it standing to allow CMA to extend its advocacy efforts to include representative actions based on California's Unfair Competition Law ("UCL") in direct contravention of the law itself. Section 17204 expressly limits standing to only those who have lost money or property as a result of the alleged unfair competition. CMA tries to circumvent the UCL's built-in standing limitation by claiming that the use of its own resources to advocate—in this case, against Aetna's policy—establishes the necessary personal harm the UCL requires.

Allowing such an exception to injury-in-fact standing required under the UCL would be both problematic and challenging in the health care industry. As discussed in detail below, the health care industry is heavily regulated. Health plans in particular answer to two different state regulators, each of which has exclusive authority to enforce its respective laws, making private attorney general actions such as this one unnecessary. In addition, many of these laws support a delicate cost structure within the health care industry designed to contain health care expenditures for consumers. If associations such as CMA were conferred standing to bring UCL actions under the present circumstances, there is little doubt that consumers would ultimately be the ones to pay the price.

II. BACKGROUND

CMA is an association of dues-paying physicians, organized to advocate for its members. On its website, CMA boasts of its deep-rooted tradition of physician advocacy, stating that the "association was founded in 1856 by a small group of physicians who understood it was their duty to fight for their patients and profession." *See* https://www.cmadocs.org/about; *see also* Joint Court of Appeal Appendix ("J.A.") 379, 958.

Because CMA was clearly not "injured in fact" by Aetna's policy, CMA instead claims as its injury the allocation of its own resources to advocate on behalf of its member physicians against Aetna's policy. Either way, CMA does not have standing to pursue a UCL claim under Proposition 64 and *Amalgamated Transit Union, Local 1756, AFL-CIO v. Superior Court*, 46 Cal. 4th 993 (2009). CMA argues that it was injured by "reallocat[ing] institutional resources to redress the harms caused by a defendant's unfair or unlawful business practice" (Petitioner's Reply Brief ("Reply")) at 7), but it cites no case in which UCL standing was conferred on a representative organization based on a diversion of resources theory.[1]

---

[1] It is important to note that the resources were not "diverted" but rather were "devoted" to causes like challenging Aetna's policy. Advocacy is the largest component of CMA's program operations. CMA's 2020 and 2021 Annual Reports show that for the years 2019, 2020, and 2021, CMA consistently used about 40 percent of its program services budget on "Physician advocacy," spending approximately $7.7 million annually on advocacy out of approximately $19 million to $20 million in "Total Program Services" expenses. *See* https://www.cmadocs.org/Portals/CMA

III. ANALYSIS

CMA seeks an exception to the UCL standing rule that would open the floodgates to association-driven litigation and would swallow the rule whole. Nearly every association uses some of its resources to address perceived industry-wide issues raised by aggrieved members. Therefore, nearly every association could manufacture standing by "expend[ing] staff time and related organizational resources to respond" to such issues. Reply at 7. CMA seeks to create the type of standing the UCL sought to avoid. *See* Proposition 64 § 1(f), 2016 California General Election Official Voter Information Guide, Text of Proposed Laws, p. 109 (Exh. A to CMA's Motion for Judicial Notice) ("It is the intent of California voters in enacting this act that only the California Attorney General and local public officials be authorized to file and prosecute actions on behalf of the general public."). Certainly no association exception is warranted or justified for associations operating in the health care industry.

First, health care is a heavily regulated industry. Two different regulatory agencies are responsible for ensuring that health plans like Aetna adhere to all applicable laws and regulations including through approval of policies such as the one challenged here. Those agencies have the exclusive authority to

---

/files/public/CMA%20Annual%20Report%202020.pdf (2020 Annual Report), p. 14; https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Annual%20Report%202021.pdf (2021 Annual Report), p. 12. For each year, advocacy expenditures were more than double any other program expense line item.

enforce their respective rules through enforcement actions. Neither agency took action after reviewing Aetna's policy.

Second, CMA's exception would disrupt the delicate cost structure achieved by PPOs through the contractual relationships formed between health insurers and preferred health care providers, which include CMA members. A breach of contract or UCL action by the purportedly injured physician(s) is the appropriate mechanism to challenge Aetna's policy, not the creation of associational standing to bring a UCL claim.

Finally, Aetna's policy itself serves to prevent surprise billing, a significant problem the federal and state governments have both legislated against in an effort to protect consumers. If CMA were granted an exception to statutory standing requirements to challenge this policy, consumers would ultimately be the ones who are injured.

A. Regulatory agencies are responsible for ensuring that health plans, like Aetna, conduct fair and lawful business practices.

Health care in California is a heavily regulated industry. California's Department of Managed Health Care ("DMHC") shares regulatory authority over health plans with the California Department of Insurance ("CDI"). In most instances, the type of product a health plan offers determines which agency oversees that product offering. With regard to PPO products, like Aetna's plan at issue here, there is regulatory overlap between the two agencies. Thus, a health plan offering a PPO product may offer a

PPO product regulated by DMHC or CDI, or may have similar PPO products regulated by each agency.

Health plans that are regulated by DMHC are subject to laws and regulations related to managed care, i.e., the Knox-Keene Act, found in the Health and Safety Code. For health insurers regulated by CDI, the California Insurance Code and related regulations govern. Both regulatory agencies hold significant, and in most cases, exclusive jurisdiction to enforce the applicable managed care or insurance laws under which they operate. Importantly, both DMHC and CDI reviewed and approved of Aetna's policy pursuant to each agency's respective broad statutory and regulatory authority.

1. DMHC

DMHC's mission is to protect consumers' health care rights and ensure a stable health care delivery network. *See* Cal. Health & Safety Code § 1342. DMHC accomplishes this goal by monitoring and regulating health plans through the initial licensing process and periodic audits and reviews of health plan compliance, and by investigating and correcting any violations of the Knox-Keene Act.

For most Knox-Keene Act violations, no private right of action exists. *Unilab Corp. v. Angeles-IPA*, 244 Cal. App. 4th 622, 633-34 (2016) (the Knox-Keene Act "does not create a private right of action for damages. The statute is enforced by the California Department of Managed Health Care."); *Blue Cross of Cal., Inc. v. Super. Ct.*, 180 Cal. App. 4th 1237, 1250 (2009) ("the Knox-Keene Act expressly authorizes the DMHC to enforce the

statute and does not include a parallel authorization for suits by private individuals…"); *Samura v. Kaiser Found. Health Plan, Inc.*, 17 Cal. App. 4th 1284, 1299 (1993) (the DMHC has the exclusive right to enforce the Knox-Keene Act). But this does not leave would-be plaintiffs without recourse. The Legislature granted DMHC significant enforcement authority under the Knox-Keene Act, "preempting even the common law powers of the Attorney General." *Cal. Med. Ass'n, Inc. v. Aetna U.S. Healthcare of Cal., Inc.*, 94 Cal. App. 4th 151, 161 (2001) (noting that the power to enforce health care laws and regulations "has been entrusted exclusively" to the Department of Managed Health Care); *see also County of Santa Clara v. Super. Ct.*, 77 Cal. App. 5th 1018, 1031-32 (2022).

The Court of Appeal in *County of Santa Clara*, *supra*, recently recognized the utility of this enforcement authority as a powerful alternative to private litigation in holding that a public agency was immune from liability under the Government Claims Act ("GCA"). The court justified its holding in part because "although [the GCA] forecloses the [provider's] chosen means of enforcement, they are not without *any* recourse to address their dispute with the county [health plan]." *County of Santa Clara v. Super. Ct.*, 77 Cal. App. 5th at 1032 (emphasis original). The court explained that DMHC "has broad regulatory authority to investigate health care service plans and to impose financial or other penalties for violations of the Knox-Keene Act, including penalties as severe as criminal prosecution and revocation of a

health care service plan's license." *Id.* (internal citations omitted).

Here too, Aetna's policy has not gone unchecked, despite CMA's lack of standing to pursue a UCL claim. DMHC, through its broad regulatory authority to protect providers and plan members from unlawful business practices, specifically reviewed Aetna's policy about which CMA now complains. DMHC asked questions of Aetna about the policy and, apparently satisfied with Aetna's responses, approved of its implementation. Respondent's Brief at 7-8 (citing Respondent's Court of Appeal Appendix ("R.A.") 268-69, 457-58, 162-70, 172-73). Allowing CMA to challenge the policy through the assertion of a UCL claim is thus unnecessary and the finding of an exception to the UCL's standing requirements is unwarranted.

2. CDI

Similar to DMHC, CDI's mission is to protect consumers by ensuring that they are provided with quality insurance services by establishing and enforcing appropriate service standards. Cal. Ins. Code § 12921. To this end, CDI has authority to investigate provider allegations of improper payment or behavior by the health plan, and to bring enforcement actions when warranted. Cal. Ins. Code §§ 12921.1, 12921.3.

Like DMHC's authority to enforce the Knox-Keene Act, CDI has exclusive jurisdiction to enforce the Insurance Code's prohibition on unfair and deceptive acts or practices, codified in section 790.03 of the Insurance Code and referred to as the Unfair Insurance Practices Act. *Moradi-Shalal v. Fireman's*

Fund Ins. Companies, 46 Cal. 3d 287, 304 (1988); Cal. Ins. Code § 790.03 (listing actions defined as "unfair methods of competition and deceptive acts or practices in the business of insurance"). The California Supreme Court in *Moradi-Shalal* noted that its holding that there is no private right of action under Insurance Code section 790.03 did not foreclose enforcement of that statute through sanctions and orders issued by the Insurance Commissioner. *Moradi-Shalal*, 46 Cal. 3d at 304 (holding that its "opinion leaves available the imposition of substantial administrative sanctions by the Insurance Commissioner," including "issuance of cease and desist orders to enjoin further violations of section 790.03," significant fines, and even suspension of the insurer's license); *see also Zhang v. Super. Ct.*, 57 Cal. 4th 364, 374 (2013) (stating that remedies for violations of the Unfair Insurance Practices Act are exclusive to the Insurance Commissioner and no private right of action exists for such violations); *Manufacturers Life Ins. Co. v. Super. Ct.*, 10 Cal. 4th 257, 284 (1995) (holding that, in passing the Unfair Insurance Practices Act, the Legislature did not intend to create new private rights of action based on violations of that Act); *Mabry v. Super. Ct.*, 185 Cal. App. 4th 208, 218 (2010) (noting that in finding no private right of action exists for violations of the Unfair Insurance Practices Act, courts relied on "the presence of a *comprehensive administrative* means of enforcement…"); *Jacobellis v. State Farm Fire & Cas. Co.*, 120 F.3d 171, 174 (9th Cir. 1997) (noting that the "text of the Unfair Insurance Practices

Act specifically provided for enforcement by the Insurance Commissioner in the form of cease and desist orders").

Aetna submitted the policy at issue here to CDI and, after assigning a reviewer to the filing, ultimately took no action, allowing the policy to go into effect. Respondent's Brief at 8 (citing R.A. 269, 458).

There simply is no justification here to create an exception to the UCL's standing requirements for CMA. Two different regulators have exclusive jurisdiction to enforce their respective laws, and specifically reviewed the policy in question. DMHC and CDI will continue to regulate the actions of health plans in connection with PPO products to ensure they are lawful and fair.

B. PPOs are a vital component of containing health care costs.

PPOs, like Aetna's plan at issue here, are an important tool the Legislature has encouraged as a means of containing rising health care costs. *Lori Rubenstein Physical Therapy, Inc. v. PTPN, Inc.*, 148 Cal. App. 4th 1130, 1136 (2007). In a PPO plan, the payor contracts with a designated set of preferred providers to provide medical services to its members. Although the members are not typically precluded from using a non-preferred provider, they will be required to pay significantly more if they choose a provider outside of the plan's network. *Id.* The PPO network providers agree to contracted rates in part because "they are guaranteed a defined pool of patients who have an economic incentive to use a preferred provider." *Id.*

The Legislature has long recognized the cost savings that can be achieved through the use of contracted networks of health care providers. The Legislature enacted the Knox-Keene Act in the 1970s to increase the regulatory oversight for health plans, and to "promote the delivery of health and medical care to the people of the State of California who enroll or subscribe for the services rendered by a health care service plan..." Cal. Health & Safety Code § 1340 et seq.; *Beynon v. Garden Grove Med. Grp.*, 100 Cal. App. 3d 698, 711 n.8 (1980) (quoting Cal. Health & Safety Code § 1342); *Van de Kamp v. Gumbiner*, 221 Cal. App. 3d 1260, 1269, 1273-75 (1990) (explaining that the Knox-Keene Act was enacted to shift regulatory authority to the Department of Corporations (now the DMHC) which can provide a more comprehensive plan of regulation to protect the public).

In the late 1970s and early 1980s, health care costs had increased without adequate "government intervention and regulation." *Lori Rubenstein Physical Therapy, Inc.*, 148 Cal. App. 4th at 1136. Therefore, in 1982, the Legislature enacted legislation "designed to encourage the development of PPO plans." *Id.* This legislation authorized health plans to enter into contracts with providers for alternative rates of payment and to offer the benefit of those rates to members who select the contracted providers. *Id.* at 1136-37 (citing Cal. Ins. Code §§ 10133(b)-(e)).

In this case, providers contracted with Aetna to provide services at alternative rates in exchange for a defined pool of patients likely to use those services. In contracting, the providers agreed to Aetna's terms and conditions, including its policy that

requires providers to use in-network physicians "to the fullest extent possible, consistent with sound medical judgment."[2] Court of Appeal Opinion ("Op.") at 4. This requirement is central to maintain the incentive for physicians to participate in PPO networks at contracted rates, and ultimately to preserve the cost savings that PPO plans offer.[3]

The delicate cost structure offered by PPO plans as envisioned by the Legislature would be completely undermined if CMA were permitted to manufacture standing here. Contracted providers unhappy with their contractual relationship with a

---

[2] Although separate from the standing issue, a significant point in the current litigation is that Aetna's policy was not absolute and allowed for deviation where "sound medical judgment" required. CMA disguises its challenge in this action as that of Aetna "interfer[ing] with the medical judgment of Aetna healthcare providers." Petitioner's Opening Brief ("Br.") 10. In reality, medical judgment rarely comes into play when choosing a facility because health plan networks have facilities capable of handling the vast majority of procedures. Cal. Health & Safety Code §§ 1367, 1367.03, 1367.035; Cal. Code Regs. tit. 28, §§ 1300.51(d)(H), 1300.67.2.1, 1300.67.2.2; Cal. Code Regs. tit. 10, § 2240.1. The real issue to which CMA directed "institutional resources" (Reply at 7) was helping physicians maximize their personal financial gains by circumventing in-network requirements in favor of out-of-network facilities in which they have an ownership interest. Respondent's Brief at 7 (citing R.A. 265, 272, 459).

[3] It is also worth noting that, as part of the policy in favor of cost containment, health plans are required to spend a minimum of 80 percent or 85 percent of their premium dollars directly on medical costs (as opposed to administrative costs), depending on the type of plan. 45 C.F.R. § 158.210 et seq. Plans that do not spend at least these amounts are required to rebate the difference to the consumers paying the premiums. *Id.*

health plan have independent avenues available, including a breach of contract action, or an individual UCL claim, or they are free to end the contractual relationship and leave the plan's PPO network. Allowing an organization like CMA to assert a representative UCL claim on behalf of its purportedly aggrieved members is unnecessary, unsupported by statute or case law, and at odds with the Legislature's intent to encourage PPO plans and the cost savings they afford.

C. Federal and State governments have recognized the dangers of surprise and balance billing, practices Aetna's policy seeks to prevent.

There is no public policy reason to grant CMA an exception in this case. In fact, Aetna's policy was prompted in part by patients complaining about surprise bills they received following referrals by their in-network doctors to facilities outside of their PPO network. Respondent's Brief at 5-7 (citing R.A. 73-74, 96-100, 272, 446-47). This harmful practice of surprise billing by non-contracted providers is something both the federal and state governments have recognized and recently legislated against.

1. California's Assembly Bill ("AB") 72.

California's Legislature passed AB 72 in 2016 to address a surprise billing practice similar to the one Aetna's policy attempts to curb. Aetna's policy seeks to curtail the practice of in-network *physicians* providing services at out-of-network *facilities*. AB 72 was enacted to stop the practice of out-of-

network *providers* providing services at in-network *facilities*. Both practices result in surprise bills.

An example scenario that AB 72 sought to put an end to was as follows: an in-network physician would schedule a procedure at an in-network facility, but other physicians (such as anesthesiologists) that were not in-network would provide additional services, and the patient would receive a surprise bill from the out-of-network physician (anesthesiologist). Under AB 72 (codified at Health and Safety Code sections 1371.30, 1371.31, and 1371.9), the Legislature prohibited the out-of-network provider from billing the patient for any amount over the in-network cost-sharing amount (e.g., co-payment, deductible, etc.) and capped the payment amounts an out-of-network provider could receive from the managed care plan for these services. Cal. Health & Safety Code §§ 1371.31, 1371.9. The intent of this law was to prevent "surprise" bills from the out-of-network physicians (where the patients did not know the physicians had not negotiated a rate of payment with their health plan). *See* Cal. Health & Safety Code § 1371.9. The Legislature recognized that these costly and unexpected medical bills "wreak havoc on people's finances and their ability to pay for basic necessities." Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 72 (2015-2016 Reg. Sess.) as amended August 4, 2016, p. 4. In addition to protecting patients, the legislation was intended to "provide[] certainty for doctors and insurers and keep[] our health care costs under control."[4] *Id.*

[4] CMA opposed the AB 72 legislation (along with the California

2. Federal No Surprises Act and Related Regulations.

The federal Department of Health and Human Services issued interim final rules "implementing certain provisions of the No Surprises Act" effective January 1, 2022. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021) (amending 5 C.F.R. Part 890, 26 C.F.R. Part 54, 29 C.F.R. Part 2590, 45 C.F.R. Parts 144, 147, 149, 156); *see also* 42 U.S.C. § 300gg-111 (No Surprises Act). These rules and the No Surprises Act they implement were promulgated because of the widespread nature of this practice:

> There is extensive research on the incidence of out-of-network providers and facilities billing patients …. The studies reveal that surprise billing is a significant issue for consumers across the country and across all types of coverage.

Id. at 36921). The consequences to consumers when they unwittingly receive services from out-of-network providers are significant, long-term, and are more profound in underserved communities:

> Surprise medical bills can lead to medical debt for individuals who have difficulty paying their bills. The impact is most keenly felt by those communities experiencing poverty and other social risk factors, as surprise medical bills and medical debt can negatively affect individuals' abilities to eliminate debt and create wealth, and ultimately can affect a

---

Society of Anesthesiologists and the California Chapter of the American College of Cardiology). Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 72 (2015-2016 Reg. Sess.) as amended August 4, 2016, p. 6.

> family for generations …. In addition, individuals are often confused by medical bills. A 2016 survey found that 61 percent of individuals are confused by medical bills, and for 49 percent of individuals surveyed, the amount owed was a surprise. These challenges are exacerbated for underserved communities, which are more likely to experience poor communication, underlying mistrust of the medical system, and lower levels of patient engagement than other populations.

Id. at 36875).

3. Aetna's Policy Supports the Objectives of State and Federal Anti-Surprise Billing Laws.

Aetna created a policy that is consistent with these state and federal anti-surprise billing laws. Aetna enrollees were complaining about practices similar to what these laws were aimed at preventing. Respondent's Brief at 5-7 (citing R.A. 73, 272, 446-47). Specifically, the enrollees were upset when they received unexpected medical bills for treatment by their in-network doctors at facilities they did not know were out-of-network. Aetna's policy simply prevented these "surprise" bills by limiting doctors from referring patients for treatment at out-of-network facilities to only those situations in which it is medically necessary. If CMA were allowed to challenge Aetna's policy and CMA's members were permitted to continue the practice of referring patients to more expensive out-of-network facilities, the consumers would ultimately pay the price.[5]

[5] Amici understand that Consumer Watchdog intends to file an application for leave to file an amicus brief. Consumer Watchdog

IV. CONCLUSION

This Court should affirm the lower court's decision that CMA lacked standing to assert a UCL cause of action. CMA is an association of dues-paying members. One of its chief objectives is to advocate on behalf of its members. By using its own resources to carry out this objective, CMA is not "injured in fact" such that it should have standing under the UCL. There are no policy reasons or facts at play here that would support making an exception to this standing requirement for CMA.

Dated: June 15, 2022 DAPONDE SIMPSON ROWE PC

By: /s/ Michael J. Daponde
MICHAEL J. DAPONDE
DARCY L. MUILENBURG
Attorney for Amici Curiae
CALIFORNIA ASSOCIATION
OF HEALTH PLANS and
ASSOCIATION OF CALIFORNIA
LIFE AND HEALTH
INSURANCE COMPANIES

---

is a nonprofit organization "dedicated to providing an effective voice for taxpayers and consumers" according to its website (https://consumerwatchdog.org/about). Consumer groups uniformly support efforts to stop surprise billing. *See, e.g.*, Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 72 (2015-2016 Reg. Sess.) as amended August 4, 2016, pp. 5-6 (listing organizations supporting AB 72 including Health Access California, California Public Interest Research Group, Consumers Union, National Health Law Program, and Western Center on Law and Poverty, among others; none opposed).

CERTIFICATE OF WORD COUNT

Pursuant to Rule 8.204(c) of the California Rules of Court, I hereby certify that this brief contains 4,129 words, including footnotes. In making this certification, I have relied on the word count of the computer program used to prepare the brief.

Dated: June 15, 2022 DAPONDE SIMPSON ROWE PC

By: /s/ Michael J. Daponde
MICHAEL J. DAPONDE
DARCY L. MUILENBURG
Attorney for Amici Curiae
CALIFORNIA ASSOCIATION
OF HEALTH PLANS and
ASSOCIATION OF CALIFORNIA
LIFE AND HEALTH
INSURANCE COMPANIES

PROOF OF SERVICE

I am a citizen of the United States and employed in Sacramento County, California. I am over the age of eighteen years and not a party to the within-entitled action. My business address is 500 Capitol Mall, Suite 2260, Sacramento, California.

On June 15, 2022 I served a copy of the following document titled: **AMICI CURIAE BRIEF OF CALIFORNIA ASSOCIATION OF HEALTH PLANS AND ASSOCIATION OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANIES IN SUPPORT OF DEFENDANTS-RESPONDENTS**

☒ by transmitting via electronic transmission, the document listed above to the TrueFiling website to the persons set forth below:

Alan M. Mansfield
WHATLEY KALLAS, LLP
16870 West Bernardo Drive, Suite 400
San Diego, CA 92127
amansfield@whatleykallas.com

Attorneys for Appellant
California Medical Association

Michael Rubin
Stacey M. Leyton
ALTSHULER BERZON LLP
177 Post Street, Suite 300
San Francisco, CA 94108
sleyton@altber.com
mrubin@altber.com

Attorneys for Appellant
California Medical Association

Enu A. Mainigi
Craig Singer
Grant Geyerman
Benjamin N. Hazelwood
WILLIAMS & CONNOLLY LLP
680 Main Avenue SW
Washington, DC 20024
emainigi@wc.com
csinger@wc.com
ggeverman@wc.com
bhazelwood@wc.com

Attorneys for Respondent
Aetna Health of California, Inc.

Matthew D. Umhofer
Elizabeth A. Mitchell
SPERTUS, LANDES & UMHOFER, LLP
1990 South Bundy Drive, Suite 705
Los Angeles, CA 90025
matthew@spertuslaw.com
elizabeth@spertuslaw.com

Attorneys for Respondent
Aetna Health of California, Inc

Henry Weissmann
MUNGER TOLLES & OLSON LLP
350 South Grand Avenue, 50th Floor
Los Angeles, CA 90071
henry.weissmann@mto.com

Attorneys for Amicus Curiae
Chamber of Commerce of the
United States of America

Sarah Weiner
MUNGER TOLLES & OLSON LLP
601 Massachusetts Avenue NW, Suite 500E
Washington, DC 20001
sarah.weiner@mto.com

Attorneys for Amicus Curiae
Chamber of Commerce of the
United States of America

Ryan Mellino
6330 San Vicente Boulevard, Suite 250
Los Angeles, CA 90048
ryan.m@consumerwatchdog.org

Attorneys for Amicus Curiae
Consumer Watchdog

The Honorable Elihu Berlle
LOS ANGELES SUPERIOR COURT
Department 3
312 North Spring Street
Los Angeles, CA 90012

George Gascón
Los Angeles County District Attorney
211 West Temple Street, Suite 1200
Los Angeles, CA 90012

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on June 15, 2022, at Sacramento, California.

/s/ Kyasia Kelly-Lyon
KYASIA KELLY-LYON

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **CALIFORNIA MEDICAL ASSOCIATION v. AETNA HEALTH OF CALIFORNIA**
Case Number: **S269212**
Lower Court Case Number: **B304217**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **mdaponde@dsrhealthlaw.com**

3. I served by email a copy of the following document(s) indicated below:

Title(s) of papers e-served:

Filing Type	Document Title
APPLICATION	CAHP-ACLHIC Application for Leave to File Amici Curiae Brief (00178055xE1DD2).PDF
BRIEF	CAHP-ACLHIC Amici Curiae Brief (00178057xE1DD2).PDF

Service Recipients:

Person Served	Email Address	Type	Date / Time
Matthew Umhofer Spertus, Landes & Umhofer, LLP 206607	matthew@spertuslaw.com	e-Serve	6/15/2022 3:08:25 PM
Michael Rubin Altshuler Berzon, LLP 80618	mrubin@altber.com	e-Serve	6/15/2022 3:08:25 PM
LaKeitha Oliver Strumwasser & Woocher LLP	loliver@strumwooch.com	e-Serve	6/15/2022 3:08:25 PM
Jon Powell Spertus, Landes & Umhofer LLP	jon@spertuslaw.com	e-Serve	6/15/2022 3:08:25 PM
Alan Mansfield Whatley Kallas, LLP 125998	amansfield@whatleykallas.com	e-Serve	6/15/2022 3:08:25 PM
Suzanne York Whatley Kallas, LLP	syork@whatleykallas.com	e-Serve	6/15/2022 3:08:25 PM
Nolan Burkholder Spertus, Landes & Umhofer, LLP	nolan@spertuslaw.com	e-Serve	6/15/2022 3:08:25 PM
Stacey Leyton Altshuler Berzon LLP	sleyton@altshulerberzon.com	e-Serve	6/15/2022 3:08:25 PM
Craig Singer Williams & Connolly, LLP	csinger@wc.com	e-Serve	6/15/2022 3:08:25 PM
Henry Weissmann Munger Tolles & Olson LLP 132418	henry.weissmann@mto.com	e-Serve	6/15/2022 3:08:25 PM
Michael Daponde Daponde Simpson Rowe PC 204283	mdaponde@dsrhealthlaw.com	e-Serve	6/15/2022 3:08:25 PM

Jonathan Weissglass Law Office of Jonathan Weissglass 185008	jonathan@weissglass.com	e-Serve	6/15/2022 3:08:25 PM
Amy Chmielewski California Attorney General's Office 295352	amy.chmielewski@doj.ca.gov	e-Serve	6/15/2022 3:08:25 PM
Kyasia Kelly-Lyon DAPONDE SIMPSON ROWE OC	klyon@dsrhealthlaw.com	e-Serve	6/15/2022 3:08:25 PM
Raymond Boucher Boucher, LLP 115364	ray@boucher.la	e-Serve	6/15/2022 3:08:25 PM
Elizabeth Mitchell Spertus, Landes & Umhofer 251139	emitchell@spertuslaw.com	e-Serve	6/15/2022 3:08:25 PM
Ryan Mellino Attorney at Law 342497	ryan.m@consumerwatchdog.org	e-Serve	6/15/2022 3:08:25 PM
Benjamin Hazelwood Williams & Connolly, LLP	bhazelwood@wc.com	e-Serve	6/15/2022 3:08:25 PM
Jerry Flanagan Consumer Watchdog 271272	jerry@consumerwatchdog.org	e-Serve	6/15/2022 3:08:25 PM
Jonathan Eisenberg AIDS Healthcare Foundation 184162	jonathan.eisenberg@ahf.org	e-Serve	6/15/2022 3:08:25 PM
Kate Moore Daponde Simpson Rowe PC	kmoore@dsrhealthlaw.com	e-Serve	6/15/2022 3:08:25 PM
Bryce Gee Strumwasser & Woocher, LLP 222700	bgee@strumwooch.com	e-Serve	6/15/2022 3:08:25 PM
Alan Mansfield Whatley Kallas, LLP 125998	echaseton@whatleykallas.com	e-Serve	6/15/2022 3:08:25 PM
Stacey Leyton Altshuler Berzon LLP 203827	sleyton@altber.com	e-Serve	6/15/2022 3:08:25 PM
Darcy Muilenburg Daponde Simpson Rowe PC 233787	dmuilenburg@dsrhealthlaw.com	e-Serve	6/15/2022 3:08:25 PM
Sarah Weiner Munger Tolles & Olson LLP	sarah.weiner@mto.com	e-Serve	6/15/2022 3:08:25 PM

This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

6/15/2022

Date

/s/Kyasia Kelly-Lyon

Signature

Daponde, Michael (204283)

Last Name, First Name (PNum)

Daponde Simpson Rowe PC

Law Firm