Case No. B302426

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT, DIVISION ONE

The State of California, by and through California Insurance Commissioner, Ricardo Lara, et al.,
Plaintiffs and Appellants,

v.

Encino Hospital Medical Center, et al.
Defendants and Respondents.

Appeal from the Los Angeles Superior Court

Case No. BC641254

Honorable William F. Fahey

AMICUS CURIAE BRIEF OF THE COALITION AGAINST INSURANCE FRAUD IN SUPPORT OF PLAINTIFFS AND APPELLANTS

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TO BE FILED IN THE COURT OF APPEAL **APP-008**

COURT OF APPEAL SECOND **APPELLATE DISTRICT, DIVISION** ONE	COURT OF APPEAL CASE NUMBER: B302426
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APPELLANT/ PETITIONER: The State of California, by and through California Insurance Commissioner, Ricardo Lara, et al., RESPONDENT/ REAL PARTY IN INTEREST: Encino Hospital Medical Center, et al.	

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(Check one): [x] INITIAL CERTIFICATE [ ] SUPPLEMENTAL CERTIFICATE

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2. a. [x] There are no interested entities or persons that must be listed in this certificate under rule 8.208.

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(2)		
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[ ] Continued on attachment 2.

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Date: March 17, 2022

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(SIGNATURE OF APPELLANT OR ATTORNEY)

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AMICUS CURIAE BRIEF

I. STATEMENT OF FACTS

The Coalition Against Insurance Fraud (the "Coalition") hereby adopts and incorporates by reference the Statement of Facts from the Opening Brief of Appellant, the State of California represented by and through the California Insurance Commissioner, Ricardo Lara (the "State").

II. SUMMARY OF ARGUMENT

In at least two instances, the superior court found that the Insurance Frauds Prevention Act (Ins. Code § 1871 *et seq*.) (the "IFPA") does not remedy medical fraud perpetrated against insurers and insurance plans regulated by the California Department of Managed Health Care (the "DMHC"). First, on June 10, 2019, the superior court granted a motion for summary adjudication based, in part, on the notion that "HCSPs ['Health Care Service Plans'] and HMOs ['Health Maintenance Organizations'][1] are regulated by the Department of Managed Health Care and that ERISA ['Employee Retirement Income

[1] Under California law, HCSPs are the proper name for such plans, which are more commonly referred to as HMOs. (See *PacifiCare of Cal. v. Bright Med. Assocs.* (2011) 198 Cal.App.4th 1451, 1456 n.2). For purposes of consistency, in this analysis, the Coalition will uniformly use the term "HMO."

Security Act of 1974'] plans are exempt from state laws regulating insurance." (80 AA 21376.) From there, the superior court leaped to the conclusion that any fraud perpetrated against HMOs or ERISA plans was outside the scope of the IFPA. (*Ibid.*)

Similarly, on September 6, 2019, the superior court issued its Final Statement of Decision, following a bench trial. (90 AA 33902-33918.) There, the superior court found that the State did not present evidence that Preferred Provider Organizations ("PPOs") were subject to the jurisdiction of the California Department of Insurance (the "CDI"), as opposed to the DMHC. (90 AA 33916.) Because of this, the superior court held that fraud perpetrated against PPOs were similarly outside the scope of the IFPA.

While there are numerous issues before the Court in this appeal, this *amicus curiae* brief speaks only to whether the IFPA applies to fraud perpetrated against insurance and insurance plans regulated by DMHC, as well as ERISA plans. The Coalition asserts that the superior court erred in limiting the scope of the IFPA to fraud perpetrated only against CDI-regulated insurers. First, the history of the IFPA demonstrates that the IFPA was intended to remedy health care fraud

generally, by promoting whistleblowing. In fact, in passing one of the amendments to the IFPA, the Legislature recognized the need to prevent fraud perpetrated against HMOs. Second, the plain meaning of the IFPA demands that it be applied to HMOs and ERISA plans. Third, HMOs and ERISA plans are "contracts of insurance" under applicable law and common sense. Fourth, the superior court's interpretation is contrary to the purpose and policies behind the IFPA. Finally, the CDI is the only statewide enforcement entity of the IFPA, and has persuasively argued the superior court's narrow interpretation is incorrect. In cases such as these, the enforcement agency's interpretation should be given deference. Thus, on this issue, the superior court should be reversed.

III. ARGUMENT

A. The History of the IFPA

In 1989, the Legislature passed the IFPA to equip the State to effectively investigate, discover, and help fight insurance frauds. (Sen. Bill No. 1103 (1989-1990 Reg. Sess.) § 3.) When it was originally passed, the IFPA's focus was on automobile insurance fraud. (*Ibid.*) Since then, the Legislature amended the IFPA by broadening its scope. One of the most significant

amendments occurred in 1991, through Senate Bill 894. (Sen. Bill No. 894 (1991-1992 Reg. Sess.) § 1.) Senate Bill 894 changed the IFPA in two significant ways. First, it amended Insurance Code section 1871 to expressly recognize the issues caused by health care fraud: "[H]ealth insurance fraud is a particular problem for health insurance policyholders . . . . [I]t is believed that fraudulent activities account for billions of dollars annually in added health care costs nationally. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily." (*Ibid.*) This finding is supported by the Legislative record on Senate Bill 894. For example, in its consideration of Senate Bill 894, the Legislature reviewed newspaper clippings pertaining to individuals who engaged in multi-million dollar fraud rings that targeted "private insurance companies and self-insured firm[s]," such as Blue Cross, Aetna Life & Casualty, and Blue Shield of California. (FRAUD: Several Indicted, Newspaper Clipping in Records of Assem. Com. on Pub. Safety of Sen. Bill No. 894 (1991-1992 Reg. Sess.).) The Legislature's findings are consistent with other reports from that same time discussing the widespread fraud affecting health care payors generally. A 1992 report from the General Accounting

Office ("GAO") concluded that the "size of the health care sector and sheer volume of money involved make it an attractive and relatively easy target for fraudulent and abusive providers," and estimated that "fraud and abuse contribute to some 10 percent of U.S. health care's current" cost. (General Accounting Office (1992), *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse*.) Applying the conclusions of the GAO report, the "cost to private payors" in "the private health care sector in California" in 1992 "could be over $4 billion." (Lopez, *Fraud and Abuse in the Health Care Market of California*, Cal. Research Bureau (Nov. 1997) p. 7.)

Second, Senate Bill 894 added four provisions to Insurance Code section 1871.1, in an effort to combat health care fraud. (Sen. Bill No. 894 (1991-1992 Reg. Sess.) § 1.) This amendment made it unlawful to knowingly (1) "make or cause to be made any false or fraudulent claim for payment of a health care benefit," (2) "submit[] a claim for a health care benefit which was not used by, or on behalf of, the claimant," (3) "present multiple claims for payment of the same health care benefit with an intent to defraud," and (4) "present for payment any undercharges for health care benefits on behalf of a specific claimant unless any

known overcharges for health care benefits for that claimant are presented for reconciliation at that same time." (*Ibid.*) One of the reasons these additions were so critical is because the Court of Appeal had just issued its decision in *People v. Newman* (1991) 233 Cal.App.3d 646.[2] And, the Legislature felt a need to respond to the *Newman* decision:

> "A recent appellate decision has called into question whether offenses under the Insurance Frauds Prevention Act can be used for health fraud prosecutions. Creation of the offenses under this bill may be reasonable in light of the August 21, 1991 decision in [*Newman*]. In the *Newman* case, a health maintenance organization (HMO) entered into an agreement with a pharmacy . . . The pharmacy submitted to the HMO for payment a number of false or fraudulent claim forms indicating that the prescriptions had been ordered by physicians.
>
> The court held that section 5[5]6 of the Insurance Code (now section 1871.1) did not apply to the pharmacy's conduct because the pharmacy did not submit the claim to the HMO on account of a loss. The submissions of these claims for payment for contractual services cannot possibly be considered a submission of a claim for a loss . . . ."

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[2] In *Newman*, the defendant appealed his conviction under the IFPA. (*Id.* at p. 647.) The Court of Appeal overturned the defendant's conviction, finding that the IFPA only applied to "false or fraudulent claim[s] for payment of a *loss*." (*Id.* at 649.) The Court of Appeal found that the defendant merely submitted false claims to an HMO, and such claims were not for a "loss," because the defendant was a provider of the HMO, with which he had a contract to provide services. (*Id.* at 650.)

(Assem. Com. on Pub. Safety, Rep. on Sen. Bill No. 894 (1991-1992 Reg. Sess.) Sept. 5, 1991, p. 3.) Absent the passage of Senate Bill 894, the Legislature felt that the IFPA could be applied narrowly, and swathes of fraud could go largely unremedied.[3] (*Ibid.*) Thus, in passing Senate Bill 894, the Legislature clearly intended for its amendments to apply to health care fraud broadly, including fraud perpetrated against HMOs and similar entities. This makes intuitive sense because, in the 1990s, 49% of California's population was insured through a self-insurance plan or a private managed care plan, like an HMO. (Lopez, *Fraud and Abuse in the Health Care Market of California*, Cal. Research Bureau (Nov. 1997) p. 13.) Conversely, only 3% of the California population was insured through an insurer regulated by the CDI, while the remainder of Californians were either uninsured or insured through a government program. (*Ibid.*) Furthermore, as the Legislature found in passing Senate Bill 894, fraud against self-insurance plans and private managed care plans was causing significant

[3] Respondents briefly discuss *Newman* in their opening brief. (Resp. Br. at p. 89.) However, Respondents decontextualize *Newman* by only discussing the pre-*Newman* amendments to the Insurance Code, but neglect to mention how *Newman* shaped future amendments, namely Senate Bill 894.

market disruption. ((FRAUD: Several Indicted, Newspaper Clipping in Records of Assem. Com. on Pub. Safety of Sen. Bill No. 894 (1991-1992 Reg. Sess.).) Therefore, in light of the *Newman* decision, without Senate Bill 894, the IFPA could be interpreted so narrowly that most health care fraud was unaddressed. Indeed, without Legislature action, the *Newman* decision would have decimated the impact of the IFPA, causing the IFPA to address health care fraud affecting only 3% of the population. (Lopez, *Fraud and Abuse in the Health Care Market of California*, Cal. Research Bureau (Nov. 1997) p. 13.) The Legislature did not allow that to happen, passing Senate Bill 894.

Moreover, disruptions to private health insurance as a result of fraud continue to this day, particularly in California. (Katzenstein, *Recent Trends in Criminal Health Care Fraud Prosecutions*, 66 DOJ J. FED. L. & PRAC. 29 (2018) p. 40 ["Health care fraud involving private health insurance programs continues to rise" and many "significant cases" involving private insurers have been in California]; Stowell, *Investigating Healthcare Fraud: Its Scope, Applicable Laws, and Regulations* (2020) 11 WM. & MARY BUS. L. REV. 479, 482 ["The Federal Bureau of Investigations (FBI) states that the costs associated

with healthcare fraud amount to tens of billions of dollars a year."].) Thus, any decision embracing the narrowed and rejected reasoning of *Newman*—which is what Respondents ask this Court to issue—would effectively be a repeal of Senate Bill 894, and the vast majority of California health care fraud would not find a remedy in the IFPA. Such a result would be contrary to the express actions of the Legislature as embodied in Senate Bill 894.

Following Senate Bill 894, the Legislature, in 1992, migrated the provisions of Insurance Code section 1871.1 to Penal Code section 550. (Assem. Bill No. 3067 (1991-1992 Reg. Sess.) §§ 4, 8.) The following year, Insurance Code section 1871.7 was enacted, which included the *qui tam* provision of the IFPA. (Assem. Bill No. 1300 (1993-1994 Reg. Sess.) § 3.3). Insurance Code section 1871.7 was later amended to incorporate all violations of Penal Code section 550 as predicate acts, including the health care fraud provisions added in 1991. (Sen. Bill No. 574 (1995-1996 Reg. Sess.) § 2.)

The *qui tam* provisions of the IFPA provide a powerful enforcement mechanism against perpetrators of insurance fraud. Like any *qui tam* provision, the IFPA allows individuals or

entities (known as relators) to file suit "for the person and for the State of California" and "in the name of the state." (Ins. Code § 1871.7, subd. (e)(5); *People ex rel. Strathmann v. Acacia Research Corp*. (2012) 210 Cal.App.4th 487, 491-92 [the IFPA "allows a private person to sue as a private attorney general to recover damages or penalties, all or part of which will be paid to the government"].) Indeed, the addition of Insurance Code section 1871.7 was intended to "authorize and *encourage* insurers to bring fraud actions." (*People ex rel. Allstate Ins. Co. v. Weitzman* (2003) 107 Cal.App.4th 534, 546 ("*Weitzman*").) In passing Section 1871.7., the Legislature envisioned relators "working with law enforcement agencies" to prevent and address fraud. (*Ibid.*) Simply put, "[t]he Legislature recognized that this approach benefits insurers, insureds, and government agencies without unnecessarily burdening public resources." (*Id*. at pp. 546-47.) Thus, relators are given the power "to correct injuries to the entire community of consumers." (Cal. Bill Analysis, S.B. 706 Assem. (June 28, 2005).) Namely, relators are entrusted to fulfill the IFPA's purpose to "effectively investigate and discover insurance frauds [and] halt fraudulent activities" across auto,

workers' compensation, and health care insurance. (Ins. Code § 1871, subd. (a)-(h).)

To further provide a benefit to the State, the IFPA contains a bounty provision, which divides the proceeds of an IFPA action between the relator and the State. (Ins. Code § 1871.7, subd. (e)-(g).) The "bounty advances the public purpose and benefit by encouraging private *qui tam* actions," incentivizing insurers and "individual citizens to come forward with information uniquely in their possession and to thus aid the Government in [ferreting] out fraud." (*Strathmann, supra,* 210 Cal.App.4th at p. 502.)

B. The Superior Court Ignored the Plain Meaning of the Statute in Finding that the IFPA is Limited to Fraud Perpetuated Against Health Insurers Regulated by CDI

"It is axiomatic that in the interpretation of a statute where the language is clear, its plain meaning should be followed." (*Great Lakes Props., Inc. v. El Segundo* (1977) 19 Cal.3d 152, 155.) As such, courts "follow the basic maxim that words of a statute are, when unambiguous, to be … given their common and ordinary meaning." (*Rancho Bernardo Dev. Co. v. Super. Ct.* (1992) 2 Cal.App.4th 358, 363.) Of course, though, in interpreting a statute, courts should avoid statutory

constructions that "defy common sense" or lead to "absurdity." (*California Mfrs. Assn. v. Pub. Utilities Com.* (1979) 24 Cal.3d 836, 844.) And, courts should not interpret one provision of a statute inconsistently with the policy of another provision. (See *Gade v. Nat'l Solid Waste Mgt. Assn.* (1992) 505 U.S. 88, 99-100.) Thus, "each sentence must be read not in isolation but in the light of the statutory scheme." (*Absher v. AutoZone, Inc.* (2008) 164 Cal.App.4th 332, 340.) One leading IFPA case put it aptly: "[t]he meaning of a statute may not be determined from a single word or sentence; the words must be construed in context, and provisions relating to the same subject matter must be harmonized to the extent possible." (*People ex rel. Alzayat v. Hebb* (2017) 18 Cal.App.5th 801, 816 ("*Alzayat*").) The superior court's interpretation that the IFPA only applies to CDI-regulated insurers is contrary to the plain meaning and intent of the statute.

First, there is nothing in the text of the IFPA that limits its application to only those insurers regulated by the CDI. In fact, the *qui tam* provision of the IFPA is only limited to the types of fraud enumerated by Insurance Code section 1871.7, subdivisions (a) and (b). Subdivision (a) prohibits the running, capping, and

steering of patients. (Ins. Code § 1871.7, subd. (a).) Subdivision (b) is more expansive, incorporating violations of Penal Code sections 549, 550, and 551 as predicate acts. (*Id.*, subd. (b).) Moreover, as discussed in Section III.A, *supra*, Penal Code section 550 makes unlawful various health care fraud acts, which were originally added by Senate Bill 894. For example, Penal Code section 550, subdivision (a)(6), prohibits persons from "[k]nowingly mak[ing] or caus[ing] to be made any false or fraudulent claim for payment of a health care benefit." However, Penal Code section 550 also prohibits actions that are not specific to health care fraud, and which predated Senate Bill 894. (See, e.g., Pen. Code § 550, subd. (a)(1) (prohibiting "[k]nowingly present[ing] or caus[ing] to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance").) Thus, while the IFPA limits its applicability to certain *types of fraud*, it does not restrict the *type of insurer* against whom the fraud is perpetrated. The superior court added such a limitation where none existed.

Second, the IFPA was expressly enacted to curb fraud perpetuated within the health care industry. Indeed, the IFPA was created "to correct injuries to the entire community of

consumers." (Cal. Bill Analysis, S.B. 706 Assem. (June 28, 2005).) And, one of the "community" issues the IFPA intends to address is health care fraud, which "is believed . . . [to] account for billions of dollars annually in added health care costs nationally" and "causes losses in premium dollars and increases health care costs unnecessarily." (Ins. Code § 1871, subd. (h).) Other types of fraud tackled by the IFPA are automobile insurance fraud and workers' compensation fraud. (*Id.*, subds. (b)-(e).) As discussed more fully in Section III.D, *infra*, if the superior court's interpretation was adopted, the IFPA could not effectively curtail health care fraud because fraud against more than 90% of the health care insurance market, including HMOs and ERISA plans, would not be subject to the IFPA remedies.

Third, the superior court's limited interpretation of the IFPA effectively means numerous fraudulent actions prohibited by Penal Code section 550 are no longer predicate acts. Penal Code section 550 prohibits "[k]nowingly mak[ing] or caus[ing] to be made any false or fraudulent claim for payment of a health care benefit" and "[k]nowingly present[ing] multiple claims for payment of the same health care benefit with an intent to defraud," regardless of whether those health care benefits are

from an insurer regulated by the CDI or are from an "insurer" as defined by Insurance Code section 23. (Pen. Code § 550, subd. (a)(6), (a)(8).) In fact, the Legislative history makes clear that many of the health care subdivisions of Penal Code section 550 were added, at least in part, to overcome an appellate decision (*i.e.*, *Newman*) that restricted the IFPA to only fraud perpetrated against CDI-regulated insurers. (Assem. Com. on Pub. Safety, Rep. on Sen. Bill No. 894 (1991-1992 Reg. Sess.) Sept. 5, 1991, p. 3.) This fact has already been recognized by the California Court of Appeal. Specifically, *People v. Butler*, (2011) 195 Cal.App.4th 535, contained a detailed discussion of the history of Penal Code section 550, which began as a provision of the Insurance Code, as discussed above. *Butler* concluded a defendant that made multiple claims against a manufacturer of an electric razor violated Penal Code section 550. In arriving at this conclusion, *Butler* found that, when the Legislature amended the Insurance Code to add certain provisions now contained in Penal Code section 550, it desired to outlaw the presentation of "false or fraudulent claims to insurance companies *or to individuals*," including corporations. (*Id.* at p. 539.) That is, the Legislature "recognized that fraud is still fraud whether the individual is

partly or wholly self-insured or whether the individual chooses not to submit the claim to its insurer." (*Id.* at p. 540.) As such, *Butler* found that the "class of persons who can violate Penal Code section 550" is not limited to "those who submit fraudulent claims to insurers." (*Id.* at pp. 540-41.) Therefore, the class of persons who can violate Penal Code section 550 is certainly not limited to those who submit fraudulent claims to CDI-regulated insurers.

If the superior court is affirmed on this issue, then certain subdivisions of Penal Code section 550 would not be predicate acts under the IFPA. Such a result would be "absurd" and in contradiction to the clear language of the statute. (*California Mfrs. Assn.*, *supra*, 24 Cal.3d at p. 844.) As *Alzayat* makes clear, any interpretation of the IFPA that only incorporates some offenses of Penal Code section 550 as predicate acts, but not others, is incorrect. (*Alzayat*, *supra*, 18 Cal.App.5th at p. 816.) Indeed, the Court rejected an interpretation of the IFPA that would have functionally removed all predicate acts of Penal Code section 550, subdivision (b), from the IFPA. (*Ibid.*) *Alzayat* found that "the first sentence of Insurance Code section 1871.7(b) has incorporated Penal Code sections 549 through 551 *in toto*." (*Id.*

at p. 817.) In other words, Insurance Code section 1871.7, subdivision (b), was not intended to limit, in any way, Penal Code section 550. (*Ibid.*) Rather, the Legislature intended Insurance Code section 1871.7 to be a tool of enforcement for violations of Penal Code section 550, so that "public resources" were not "unnecessarily burden[ed]." (*Weitzman*, *surpa*, 107 Cal.App.4th at pp. 546-47.)

The superior court's interpretation, whether intentional or not, would moot each of the health care fraud additions made by Senate Bill 894 because those additions would be merely duplicative of subdivisions (a)(1)-(2) and (5) of Penal Code section 550, which were already in existence at the time Senate Bill 894 was contemplated. For example, subdivision (a)(6) of Penal Code section 550, which was added by Senate Bill 894, states that it is unlawful to "[k]nowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit." Of course, though, if subdivision (a)(6) is limited only to false and fraudulent claims for payment of health care benefits to "insurers," as defined by Insurance Code Section 23 and regulated by the CDI, then it becomes duplicative of subdivision (a)(1), which states it is unlawful to "[k]nowingly present or cause to be presented any

false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance." That is, every act that would violate subdivision (a)(6) would also violate subdivision (a)(1), making subdivision (a)(6) useless. This same phenomena is seen when comparing subdivision (a)(8), which was added with Senate Bill 894 and makes it unlawful to "[k]nowingly present multiple claims for payment of the same health care benefit with an intent to defraud," with subdivision (a)(2), which makes it unlawful to "[k]nowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud." This interpretation, which was adopted by the superior court, does not permit the words of the IFPA to "be construed in context," nor does it "harmonize[]" the provisions of the IFPA. (*Alzayat*, *supra*, 18 Cal.App.5th at p. 816; *Absher*, *supra,* 164 Cal.App.4th at p. 340 ["each sentence must be read not in isolation but in the light of the statutory scheme"].) Thus, the superior court's interpretation is improper.

The plain meaning of the IFPA is that it applies to all manner of private health care payors, including HMOs, and ERISA plans. Such was the case in *State ex rel. Wilson v. Super.*

Ct. (2014) 227 Cal.App.4th 579 (*"Wilson*"). In *Wilson*, the relator alleged a kickback scheme between Bristol-Myers Squibb Co. and "physicians who had large numbers of patients enrolled in private health insurance plans." (*Id.* at p. 587.) Those "private health insurance plans" included Cigna, Blue Cross of California, Blue Shield of California, and United Health Plan, without regard to whether they were regulated by the CDI. (Complaint at ¶¶ 30, 53, 63 (March 16, 2007) Los Angeles Super. Ct. Case No. BC367873.)[4]

C. HMOs and ERISA Plans Are "Insurers" that Offer "Insurance" Under the Insurance Code, Applicable Case Law, and Common Sense

The superior court's decision is based on the premise that the IFPA only applies to fraud perpetrated against an "*insurance company*" when the false or fraudulent claim is presented under a "*contract of insurance*" purportedly relying on Insurance Code sections 22 and 23 to reach that conclusion. (See 80 AA 31276 ¶ 3; 80 AA 21375-31276 section C.) As discussed, *supra*, that is not

[4] Many of the insurers in the *Wilson* case are not regulated by CDI. *See* California Health Care Foundation (May 2019) *California Health Insurers: Large Insurers Remain on Top* < https://www.chcf.org/wp-content/uploads/2019/05/CAHealthInsurersAlmanac2019.pdf> [as of March 8, 2021].)

the case. However, even if the IFPA only applied to claims presented to "insurance companies" under "contracts of insurance," the IFPA would apply to fraud perpetrated against HMOs and ERISA plans.

Insurance Code section 22 defines "insurance" as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." And Insurance Code section 23 states that "[t]he person who undertakes to indemnify another by insurance is the insurer, and the person indemnified is the insured." Put another way, insurance "involves two elements: (1) a risk of loss to which one party is subject and a shifting of that risk to another party; and (2) distribution of risk among similarly situated persons." (*Metro. Life Ins. Co. v. State Bd. of Equalization* (1982) 32 Cal.3d 649, 654; *see also* Black's Law Dict. (11th ed. 2019) [defining "indemnity" to mean the "right of an injured party to claim reimbursement for its . . . liability from a person who has such a duty"].)

HMOs are contracts of insurance and those that offer HMOs are insurers. First, HMOs "shift[]" risk from one party "to another party." (*Metro. Life Ins. Co.*, *supra*, 32 Cal.3d at p. 654.)

That is, without an HMO, the HMO's members, participants, or beneficiaries (collectively, "Beneficiaries") possess a risk of unknown losses associated with future health care goods and services. However, the HMO eliminates that risk for the Beneficiaries, and shifts the risk to the company that offers the HMO. The Court of Appeal has described this risk structure in the context of HMOs, stating, "[t]he HMO [] assumes the financial risk of providing the benefits promised: if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant's premiums." (*Smith v. PacifiCare Behav. Health of California, Inc.* (2001) 93 Cal.App.4th 139, 150.) Second, that risk becomes "distribut[ed]" among "similarly situated persons." (*Metro. Life Ins. Co.*, *supra*, 32 Cal.3d at p. 654.)

This is a familiar reality for any member of a HMO. If Beneficiaries of a particular HMO utilize a greater-than-anticipated amount of health care goods and services, the premiums of all Beneficiaries increase. And, if health care costs are artificially inflated as a result of fraud, the premiums of the Beneficiaries will likewise increase. This is principally the

concern of the IFPA; because the costs of one person are inherently distributed among similarly situated persons, if Beneficiaries' costs begin to rise as a result of fraud, the entire group of Beneficiaries will suffer. (See Ins. Code § 1871, subd. (h) ("[h]ealth care fraud causes losses in premium dollars and increases health care costs unnecessarily" for consumers.)

Due to the structure of HMOs, the Court of Appeal has unequivocally stated that "HMO's are engaged in the business of insurance." (*Smith*, *supra*, 93 Cal.App.4th at p. 158.) To reach this conclusion, *Smith* relied heavily on the Ninth Circuit decision *Washington Physicians Serv. Assn. v. Gregoire* (9th Cir.1998) 147 F.3d 1039 ("*Gregoire*"). In *Gregoire*, the Ninth Circuit held that "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk. [Internal citations.] The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service." (*Id.* at pp. 1045-46.) But *Gregoire* called this "a distinction without a difference." (*Id.* at p. 1046.) Of course, "[i]n the end, . . . [t]he policyholder pays a fee for a promise of medical services in the event that he should need

them. It follows that HMOs (and HCSCs) are in the business of insurance." (*Ibid.; see also Smith*, *supra*, 93 Cal.App.4th at 157 ("HMOs function the same way as a traditional health insurer. The policyholder pays a fee for a promise of medical services in the event that he should need them.").)

Courts across the country are in accord, regularly concluding that HMOs are no different from insurers. (*See, e.g.*, *Rush Prudential HMO, Inc. v. Moran* (2002) 536 U.S. 355, 367 (2002) ["The answer to Rush is, of course, that an HMO is both: it provides health care, and it does so as an insurer."]; *Anderson v. Humana, Inc.* (7th Cir.1994) 24 F.3d 889, 892 ["Because HMOs spread risk—both across patients and over time for any given person—they are insurance vehicles under Illinois law."]; *Kentucky Assoc. of Health Plans, Inc. v. Nichols* (6th Cir.2000) 227 F.3d 352, 364 ["The Kentucky Act . . . clearly does regulate insurance. The fact that it includes within its reach HMOs as well as traditional insurance companies does not take it out of the realm of insurance regulation."].) Indeed, this practical reality, which the superior court in this case ignored, was aptly described by the United States Supreme Court nearly two decades ago. (*Rush Prudential HMO*, 536 U.S. at 367

("[V]irtually all commentators on the American health care system describe HMOs as a combination of insurer and provider, and observe that in recent years, traditional 'indemnity' insurance has fallen out of favor.") (citing Weiner & de Lissovoy, Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans, 18 J. of Health Politics, Policy and Law 75, 77 (Spring 1993); Gold & Hurley, The Role of Managed Care "Products" in Managed Care "Plans," in Contemporary Managed Care 7, 8, 13 (M. Gold ed.1998); Aspen Health Law and Compliance Center, Managed Care Law Manual 1 (Supp. 6, Nov. 1997); R. Rosenblatt, S. Law, & S. Rosenbaum, Law and the American Health Care System 552 (1997); and R. Shouldice, Introduction to Managed Care 13, 20 (1991)).)

Likewise, ERISA plans are contracts of insurance. Indeed, the only material difference between an ERISA plan and a HMO is the level of involvement an employer has in the plan's administration. (*Marshall v. Bankers Life & Cas. Co.* (1992) 2 Cal.4th 1045, 1055-57.) Thus, the reasoning provided immediately above equally applies to ERISA plans.

The sole reason the superior court gave for holding that ERISA plans are not "policies of insurance" is that ERISA plans

are federally preempted. (See 80 AA 31276 ¶3; see generally 80 AA 21375-31276 section C.) But ERISA preemption only applies to the *regulation* of ERISA plans. (*De Buono v. NYSA-ILA Medical & Clinical Servs. Fund* (1997) 520 U.S. 806.) The United States Supreme Court recently affirmed this principle: "ERISA is therefore primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status." (*Rutledge v. Pharm. Care Mgmt. Assn.* (2020) 141 S.Ct. 474, 480.) That is, a statute is preempted if it somehow regulates the ERISA plan itself. (*Ibid.*) But the IFPA is an anti-fraud statute that concerns fraudulent claims and writings from claimants and others. (Ins. Code § 1871.7.) The IFPA does not require an ERISA plan to change its operations in any way, or place additional restrictions on ERISA plans, and thus preemption should be of no concern. (See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (1995) 514 U.S. 645, 653-56).) As such, ERISA preemption does not apply. Thus, the simple issue before this Court is whether a person or entity may be liable for a false or fraudulent

claim or writing made to an ERISA plan. This Court should answer in the affirmative.

Finally, relators are frequently not sophisticated insurers, but employees of the wrongdoers. (*See, e.g., Wilson, supra,* 227 Cal.App.4th 579.) The IFPA was created to encourage such individuals to come forward with information concerning insurance fraud. (*Weitzman*, *supra*, 107 Cal.App.4th at p. 546.) Because the IFPA is intended for a broad audience, the Court should also consider the common sense meaning of the term "insurance." The common meaning of "insurance" is not tied to a specific regulatory construct, but who provides coverage for certain expenses (here, medical expenses). It would belie the common understanding of "insurance" to hold that a PPO is insurance, for example, but an HMO is not. The common sense meaning of the word "insurance" demands that it applies to HMOs and PPOs equally. The superior court's interpretation of the IFPA holds otherwise.

D. The Superior Court's Finding that the IFPA Only Applies When Fraud is Perpetrated against Health Insurers Regulated by the CDI Is Contrary to the Purpose and Policies Behind the IFPA

The superior court erred in creating a canon of statutory construction that does not exist. The regulating agency has no bearing on the interpretation of a broad, remedial anti-fraud statute, like the IFPA. "[F]raud is still fraud whether the individual is partly or wholly self-insured or whether the individual chooses not to submit the claim to its insurer." (*Butler*, *supra*, 195 Cal.App.4th at p. 540 [finding that Penal Code section 550, which was formally an Insurance Code section, did not require a claim to be presented to an insurer].) The superior court's interpretation of the IFPA runs contrary to the statute's purpose and policies in four significant ways, and would lead to "absurd" results. (*California Mfrs. Assn., supra,* 24 Cal.3d at p. 844.)

1. The Superior Court's Holding Couches the IFPA as a Regulatory Statute, Not a Remedial Statute

In California, the regulatory construct of an entity is typically irrelevant for non-regulatory purposes. Indeed, contrary to the superior court's holding, the Court of Appeal has

already decided regulatory designations have no bearing on whether an entity is an "insurer" for non-regulatory purposes. (*Myers v. Bd. of Equalization* (2015) 240 Cal.App.4th 722, 741.) In *Myers*, the superior court found that "Blue Cross's status as a licensed HMO was dispositive" in determining Blue Cross's status as an "insurer" for certain tax purposes. (*Id.* at p. 733.) On appeal, the Court of Appeal reversed, finding "it is not determinative that Real Parties in Interest are designated as HMOs for regulatory purposes . . . . [T]he court must look beyond this regulatory label to the true economic substance of Real Parties in Interest's business operations." (*Id.* at p. 741.) In its reversal, the *Myers* Court examined the legislative history of the tax at issue, finding that a "'key reason' for adopting the gross premium tax" was "the fact that insurers receive premiums up front, without knowing what related expenses will be paid on those premiums in the future, thereby rendering them unable to determine the net profits attributable to those premiums at the end of the tax year." (*Ibid.*)

Here, like the tax provision in *Myers*, Insurance Code section 1871.7 is a non-regulatory statute. That is, the purpose of Insurance Code section 1871.7 is not to place any limits or

restrictions on those that meet the definition of "insurer." Instead, the object of Insurance Code section 1871.7 is fraud itself. And, the IFPA makes abundantly clear that the State has an interest in preventing and remedying health care fraud, in particular, because "[h]ealth care fraud causes losses in premium dollars and increases health care costs unnecessarily" for consumers. (Ins. Code § 1871, subd. (h).)

As such, if this Court is not persuaded that the presentation of fraudulent claims or writings to HMOs and ERISA plans is a *per se* violation of the IFPA, then it is faced with deciding the criteria to use in determining whether a HMO or an ERISA plan is "insurance" for purposes of the IFPA. Of course, as *Myers* makes clear, the superior court's analysis is not enough; it is insufficient to simply examine whether the entity that received a fraudulent insurance claim or writing obtained a license under the Knox Keene Act, meaning it is not regulated by the CDI. (*Myers, supra*, 240 Cal.App.4th at p. 741.) Courts must determine whether an entity is an "insurance company" in light of the purpose of the IFPA, as *Myers* did in evaluating the tax code. (*Ibid.*) Conveniently, the Legislature has codified a reason for addressing health care fraud: it "causes losses in premium

dollars and increases health care costs unnecessarily." (Ins. Code § 1871, subd. (h).) More simply, health care fraud does not only impact the person who received health care or the company that is ultimately responsible for the health care expenses. Health care fraud impacts all health care consumers. (*Ibid.*) In passing the IFPA, the Legislature was not interested in whether a fraudulent claim or writing was presented to an "insurer," as defined for certain regulatory purposes. Rather, the Legislature was concerned that a fraudulent claim presented by (or on behalf of) one consumer can impact "the entire community of consumers." (Cal. Bill Analysis, S.B. 706 Assem. (June 28, 2005).) Fraud committed within an HMO can have the same effect as fraud committed within a CDI-regulated insurance plan: consumers at large suffer. Of course, from the consumer's perspective, it makes no difference that they are a member of an HMO versus a CDI-regulated insurance plan when there are "increases [in] health care costs unnecessarily." (Ins. Code § 1871, subd. (h).) Thus, should this Court feel the need to determine whether fraud is committed against an "insurance company," the crux of the analysis in deciding whether an entity is an "insurance company" should be to "look beyond [the]

regulatory label to the true economic substance of [entity's] business operations." (*Myers, supra,* 240 Cal.App.4th at p. 741.) If the entity operates in a way where its risk-distribution can result in a loss of premiums and higher health care costs from fraudulent claims, then it must be an "insurance company" that offers "insurance" for purposes of Insurance Code section 1871.7. (*Metro. Life Ins. Co., supra,* 32 Cal.3d at p. 654 [insurance "involves two elements: (1) a risk of loss to which one party is subject and a shifting of that risk to another party; and (2) distribution of risk among similarly situated persons"].) The Coalition believes that HMOs and ERISA plans categorically fit within that definition.

2. The Superior Court's Interpretation of the IFPA Prevents Relators from Correcting the Community's Injuries

As discussed in Section III.A, *supra*, the IFPA was enacted to "correct injuries to the entire community of consumers." (Cal. Bill Analysis, S.B. 706 Assem. (June 28, 2005).) However, adopting the superior court's interpretation of the IFPA prevents that effect from happening. Similarly, under the superior court's interpretation, the IFPA would not seek to prevent "billions of dollars" from being "annually [] added [in] health care costs," as

the IFPA seeks to do. (Ins. Code § 1871, subd. (h).) Nor would adopting such an interpretation provide the tangible "benefits [to] insurers, insureds, and government agencies without unnecessarily burdening public resources" that the Legislature envisions. (*Weitzman*, *supra*, 107 Cal.App.4th at pp. 546-47.) Indeed, should this Court adopt the interpretation of the superior court, at most, only injuries to a paltry minority of consumers could be addressed and most health care fraud would not be addressed.

As this Court is well-aware, "[i]n California, regulation and oversight of health insurance is split between two state departments"—DMHC and CDI. (Roth, *Making Sense of Managed Care Regulation in California* (November 2001) California HealthCare Foundation.) Despite this, the overwhelming majority of the private health care insurance market in California is not controlled by insurers regulated by CDI. In fact, a July 2020 study found that, for commercial insurance, 13.4 million Californians were enrolled with an insurer regulated by DMHC, while only 1.1 million Californians were enrolled with an insurer regulated by CDI. (See Wilson, Wilson Analytics - California Healthcare Foundation (July 2020)

2020 Edition – California Health Insurers and Enrollment – Almanac Collection – Quick Reference Guide.) That is, CDI-regulated insurers only account for 7.6% of the market. (*Ibid*.) This is consistent with the enrollment distribution of 2019, when 13.1 million Californians were enrolled with an insurer regulated by DMHC, while only 1.1 million Californians were enrolled with an insurer regulated by CDI.[5] Indeed, *no HMO in California is regulated by CDI*.[6] As a result, although the private health insurance market in California is a $183.7 billion industry, only $18.2 billion of that is from CDI-regulated insurers (with the remainder being provided by health care payors regulated by DMHC). (*Ibid*.)

Because insurers regulated by CDI make up such a small share of the overall health care market, correcting fraud perpetrated against only those insurers would have little impact

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[5] (California Health Care Foundation (2019) California Health Insurers: Large Insurers Remain on Top < https://www.chcf.org/wp-content/uploads/2019/05/CAHealthInsurersAlmanac2019QRG.pdf > [as of March 8, 2021].)

[6] California Health Care Foundation (May 2019) *California Health Insurers: Large Insurers Remain on Top* < https://www.chcf.org/wp-content/uploads/2019/05/CAHealthInsurersAlmanac2019.pdf> [as of March 8, 2021].)

on the "entire community of consumers." (Cal. Bill Analysis, S.B. 706 Assem. (June 28, 2005).) At most, under the superior court's interpretation, the IFPA could only ever save the "losses in premium dollars" (Ins. Code § 1871, subd. (h)) for 7.6% of the California market (see Wilson, Wilson Analytics - California Healthcare Foundation (July 2020) *2020 Edition – California Health Insurers and Enrollment – Almanac Collection – Quick Reference Guide*.) Furthermore, there would still be a "burden[] [on] public resources," which the IFPA intended to correct, as the government would be solely responsible for investigating and prosecuting 92.4% of all health care fraud without the help of relators. (*Weitzman*, *supra*, 107 Cal.App.4th at pp. 546-47.) Indeed, in most instances "individual citizens" would not be incentivized "to come forward with information uniquely in their possession and to thus aid the Government in [ferreting] out fraud." (*Strathmann, supra,* 210 Cal.App.4th at p. 502.) Thus, Respondents' interpretation is contrary to the very purpose of the statute. (See Ins. Code § 1871, subd. (h).) Moreover, the Legislature has stated as much. When *Newman* interpreted the IFPA to be inapplicable to false and fraudulent writings presented to an HMO, the Legislature amended the statute to

ensure such an interpretation would never be adopted again. (Assem. Com. on Pub. Safety, Rep. on Sen. Bill No. 894 (1991-1992 Reg. Sess.) Sept. 5, 1991, p. 3.) Because of the important amendments made to the IFPA, relators have brought cases to combat health care fraud, even though the claims were not presented to CDI-regulated insurers. (*People ex rel. Monterey Mushrooms, Inc. v. Thompson* (2006) 136 Cal.App.4th 24, 27; *Wilson, supra,* 227 Cal.App.4th 579.) For example, in *Monterey Mushrooms*, an IFPA action was brought for false claims presented to a self-insured employer. (136 Cal.App.4th at p. 27.) In a seminal IFPA case, the Court of Appeal affirmed the verdict of the lower court, finding that the defendants, who set up sham medical corporations, were liable for IFPA violations. *Id.* at p. 33. Here, Respondents ask this Court to de-claw the IFPA in a manner that would prevent such suits, is inconsistent with the IFPA's purpose, and has been previously rejected by the Legislature. This Court should not oblige.

3. The Superior Court's Interpretation Would No Longer Incentivize Whistleblowing

The IFPA was created to "authorize and encourage" anti-fraud cases. (*Weitzman*, *supra*, 107 Cal.App.4th at p. 546.) This

provides "benefits [to] insurers, insureds, and government agencies without unnecessarily burdening public resources." (*Id.* at pp. 546-47.) While these whistleblowers can be insurers themselves, employee insiders of those committing fraud frequently file lawsuits as relators. (See, e.g., *Strathmann, supra,* 210 Cal.App.4th at p. 502; *Wilson, supra,* 227 Cal.App.4th 579.) The Legislature recognized this and even included an anti-retaliation provision in the IFPA, which prevents any form of employment retaliation against a person who files an action under Insurance Code section 1871.7. (Cal. Ins. Code § 1871.7, subd. (k).)

If the IFPA only pertains to claims presented under CDI-regulated insurance plans, then potential whistleblowers will be required to understand the complex regulatory landscape of California health care. Indeed, whistleblowers will need to know whether the perpetrators of fraud were targeting a private health care payor who offers a CDI or DMHC-regulated insurance plan. Making that determination is even harder than it sounds. For example, many of the widely recognized California "insurance" companies (Anthem Blue Cross, Blue Shield, and United HealthCare) offer multiple insurance plans, some of which are

regulated by CDI and some of which are regulated by DMHC.[7] This type of information may not be readily-available to a whistleblower, but Respondents' interpretation of the IFPA would result in this information being critical to the success of an IFPA action. Due to this large barrier, whistleblowers will begin to become extinct, as the IFPA's contours become harder to decipher.

Furthermore, some employee insiders and would-be whistleblowers may only work for medical providers that present claims to DMHC-regulated insurers (*e.g.*, a physician who only submits claims to an HMO). Those potential whistleblowers, under the superior court's interpretation of the IFPA, have no incentive to correct the fraud of their employers because the IFPA would no longer apply to such fraudulent acts. For example, in *Wilson*, the relator blew the whistle on a kickback scheme between Bristol-Myers Squibb Co. and "physicians who had large numbers of patients enrolled in private health insurance plans." (*Wilson, supra,* 227 Cal.App.4th at p. 586.)

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[7] California Health Care Foundation (May 2019) *California Health Insurers: Large Insurers Remain on Top* < https://www.chcf.org/wp-content/uploads/2019/05/CAHealthInsurersAlmanac2019.pdf> [as of March 8, 2021].)

There, the relator was a former employee of Bristol-Myers Squibb Co., who marketed drugs to physicians. (*Id.* at pp. 586-87.) If the IFPA only applied to claims and writings presented under CDI-regulated insurance plans, then the *Wilson* relator would have had to know before ever blowing the whistle (1) the physicians participating in the scheme, (2) the exact insurance accepted by those physicians, (3) whether the insurance plans accepted by the physicians were regulated by CDI, and, ultimately, (4) whether the claims involving the Bristol-Myers Squibb Co. drugs were presented under CDI-regulated insurance plans. The Legislature surely did not intend to create this many barriers on a potential whistleblower. Indeed, even if the relator went to all that trouble, they may have determined that no false claims were presented to a CDI-regulated insurance plan, and Bristol-Myers Squibb Co. would have been able to continue their fraud scheme. In short, Respondents' interpretation of the IFPA would not "encourage" IFPA investigations and litigation. (*Weitzman*, *supra*, 107 Cal.App.4th at p. 546.)

4. The Superior Court's Interpretation of the IFPA Makes Liability Unpredictable

Under the superior court's approach, an insurance fraud perpetrator's liability under the IFPA is largely based on luck, not their actions. For example, in *Wilson*, Bristol-Myers Squibb Co. was alleged to be paying kickbacks to physicians for prescribing certain medication. (*Wilson, supra,* 227 Cal.App.4th at p. 587.) It is unclear whether Bristol-Myers Squibb Co. knew the insurance plans under which those medications would be billed. It likely did not. However, if the physicians all happened to submit the bills to an HMO then, Respondents would argue, Bristol-Myers Squibb Co. would not have any liability under the IFPA. On the other hand, if those same bills were presented to a CDI-regulated insurer, Respondents would agree that an IFPA action could be filed against Bristol-Myers Squibb Co. It is absurd to think that the IFPA demands such unpredictable outcomes or that such swaths of insurance fraud should go undeterred.

Furthermore, Respondents' interpretation would simply encourage physicians to only treat patients with health insurance regulated by the DMHC. After all, there would be no risk of

IFPA liability if a physician simply stopped accepting CDI-regulated insurance. The IFPA was meant to "encourage" fraud investigations, not limit or determine the type of insurance a provider accepts. (*Weitzman*, *supra*, 107 Cal.App.4th at p. 546.)

E. The Court Should Give Deference to CDI's Interpretation of the IFPA

Under California law, it is well-established that where a "statute is silent or ambiguous with respect to the specific issue," courts should look to the relevant government agency's interpretation if it "is based on a permissible construction of the statute" and is "rational and consistent with the statute." (*Sullivan v. Everhart* (1990) 494 U.S. 83, 88-89.) Furthermore, the degree of deference "turns on a legally informed, commonsense assessment" of the "contextual merit" of the agency's interpretation. (*Yamaha Corp. of Am. v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 14 (*Yamaha*).) Even outside the context of quasi-legislative rulemaking, which is not presented here, deference should be granted to "the agency's view of the statute's legal meaning and effect." (*Id.* at p. 11.) The California Supreme Court has adopted "two broad categories of factors relevant to a court's assessment of the weight due an

agency's interpretation: Those 'indicating that the agency has a comparative interpretive advantage over the courts,' and those 'indicating that the interpretation in question is probably correct.'" (*Id.* at p. 12.) Here, under this two-pronged approach, the CDI's interpretation of the IFPA is entitled to deference.

As a primary matter, the CDI is the sole statewide entity responsible for enforcing the IFPA. (Assem. Bill No. 1050 (1999-2000 Reg. Sess.) § 2.) By way of background, the California Attorney General was initially the enforcer of the IFPA. However, in 1995, the Legislature amended the IFPA to add the CDI as an enforcement agency of the IFPA. (Sen. Bill No. 465 (1995-1996 Reg. Sess.) § 2.) Then, in 1999, the Attorney General was removed as an enforcer of the IFPA, making the CDI the sole statewide entity responsible for enforcing the IFPA. (Assem. Bill No. 1050 (1999-2000 Reg. Sess.) § 2.)

In this capacity, the CDI has "an intimate knowledge of the problems dealt with in the [IFPA] and the various administrative consequences arising from particular interpretations." (*Yamaha*, 19 Cal.4th at p. 20 (conc. opn. of Mosk, J.).) This Court should draw on the CDI's experience and knowledge of the IFPA. Indeed, as the California Supreme Court has held, where "the

legal text to be interpreted is . . . entwined with issues of fact, policy, and discretion," a court should "assume the agency has expertise" entitling it to deference. (*Yamaha*, 19 Cal.4th at p. 12.) Here, as discussed at length above, whether the IFPA applies to fraud perpetrated on HMOs and ERISA plans involves significant policy and factual consequences. The sole statewide agency that has the ability to bring or intervene in IFPA suits should be given deference on the statute's applicability. It would be ironic to ignore the interpretation espoused by the only California agency charged with enforcing the IFPA. Courts have deferred to agency interpretations of statutes in similar circumstances. (*See Yamaha*, 19 Cal.4th at pp. 14–15 [agency opinions on tax consequences of hypothetical business transactions entitled to some deference]; *Holland v. Assessment Appeals Bd. No. 1* (2014) 58 Cal.4th 482, 494 [affording "a degree of deference to the [agency's] interpretation of the statute, even though that interpretation is embodied only in an informal advice letter to the county assessors"].) This Court should do the same here.

Additionally, the CDI's interpretation is entitled to deference because it is correct—and at the very least, it is "probably correct," which is all that is required. (*Yamaha*, 19

Cal.4th at p. 12.) Circumstances suggesting correctness include "careful consideration by senior agency officials" and evidence that the agency has "consistently maintained" its interpretation. (*Id*. at p. 13). Here, the CDI has consistently expressed the same views regarding the scope and reach of the IFPA, to both the trial court and now this Court. This is not a case involving, for example, "interpretations prepared in ad hoc advice letters by individual [agency] staff members" that the agency did not intend "to be considered by anyone other than the recipient," which the Supreme Court has deemed a "poor guide[ ]" as to an agency's position on an issue. (*McHugh v. Protective Life Ins. Co.* (2021) 12 Cal.5th 213, 245 (*McHugh*).) Rather, the CDI's myriad briefs are thoughtfully reasoned, present a thorough analysis of the IFPA, and reflect a "careful consideration" of these issues that the CDI intended for this Court to rely on. (*Ibid*.) Indeed, these extensive briefs authored by the CDI are more reliable than agency "annotations" of "only a sentence or two," regarding "tax consequences of specific hypothetical business transactions," which the Supreme Court in *Yamaha* still deemed "entitled to some consideration by the Court." (*Yamaha*, 19 Cal.4th at pp. 4–5, 15.) The circumstances of the authorship of and careful

analysis contained in its numerous filings indicate the CDI's interpretation merits deference in this case. Therefore, the CDI's interpretation is "rational and consistent with the statute" and should be given deference. (*Sullivan, supra,* 494 U.S. at pp. 88-89.)

IV. CONCLUSION

This Court should reverse the superior court's determination that the IFPA only applies to claims and writings presented to CDI-regulated insurers. The superior court's interpretation is inconsistent with the express purpose of the IFPA, the plain meaning of the statute, the policies behind the IFPA, and the interpretation of the only statewide agency that enforces the IFPA.

Dated: March 17, 2022

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

Pursuant to California Rules of Court, rule 8.204, subdivision (c), I hereby certify that this brief contains 8,753 words, not including the tables of contents and authorities, the caption page, the signature block, this Certification page, or the Proof of Service.

Dated: March 17, 2022

/s/ Ryan M. Fawaz
Ryan M. Fawaz

PROOF OF SERVICE

STATE OF CALIFORNIA, ORANGE COUNTY

I am employed in Orange County, State of California. I am over the age of 18 and not a party to the within action; my business address is 100 Spectrum Center Drive, Suite 1050, Irvine, CA 92618.

On **March 17, 2022,** I served the foregoing document described as: ***AMICUS CURIAE* BRIEF OF THE COALITION AGAINST INSURANCE FRAUD IN SUPPORT OF PLAINTIFFS AND APPELLANTS** on the parties in this action by serving:

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BY E-SERVICE VIA TRUEFILING: All participants in this case who are registered TrueFiling users will be served by the TrueFiling system.

Executed on **March 17, 2022**, at Irvine, California.

I declare under penalty of perjury under the laws of the

State of California that the foregoing is true and correct.

/s/ Ryan M. Fawaz
Ryan M. Fawaz

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in Los Angeles County, State of California. I am over the age of 18 and not a party to the within action; my business address is 2029 Century Park East, Suite 2600 Los Angeles, California 90067.

On **March 17, 2022,** I served the foregoing document described as: ***AMICUS CURIAE*** **BRIEF OF THE COALITION AGAINST INSURANCE FRAUD IN SUPPORT OF PLAINTIFFS AND APPELLANTS** on:

Office of the Clerk
Attn: Honorable William F. Fahey
Stanley Mosk Courthouse, Dept. 69
111 N. Hill Street, Room 621
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Executed on **March 17, 2022,** at Los Angeles, California.

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

/s/ Lora E. Anderson
Lora E. Anderson