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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

PAUL SIMON et al., Plaintiffs and Appellants, v. BLUE CROSS OF CALIFORNIA, Defendant and Respondent.	B292118 (Los Angeles County Super. Ct. No. BC639205)

APPEAL from an order of the Superior Court of Los Angeles County, Lisa Hart Cole, Judge. Affirmed.

Consumer Watchdog, Jerry Flanagan and Benjamin Powell; Shernoff Bidart Echeverria, Michael J. Bidart and Travis M. Corby, for Plaintiffs and Appellants.

Reed Smith, Kim M. Watterson, Kurt C. Peterson, Kenneth N. Smersfelt, Natasha Sung, and Todd S. Kim, for Defendant and Respondent.

In 2016, defendant Blue Cross of California, doing business as Anthem Blue Cross (Anthem), offered preferred provider organization (PPO) health insurance coverage both via "Covered California," California's health insurance exchange, and independently on its own. "On-exchange" consumers enrolled through the Covered California website or phone enrollment process. "Off-exchange" consumers enrolled by signing Anthem's hard copy enrollment application. The on-exchange and off-exchange plaintiffs in the lawsuit giving rise to this appeal brought a putative class action alleging Anthem illegally converted their PPO plans to exclusive provider organization (EPO) plans. The trial court granted Anthem's petition to compel arbitration, which killed the class-based claims. We consider (1) whether Health and Safety Code requirements for arbitration disclosures in health insurance contracts apply to the Covered California insurance enrollment process, and (2) whether the arbitration provision in Anthem's off-exchange enrollment application satisfies Health and Safety Code standards.

I. BACKGROUND

A. Plaintiffs' 2016 Enrollment in Anthem PPO Plans

On-exchange plaintiffs Leah Boyer (as guardian ad litem for her children), Lee Fintel, Lynelle Goodreau, and Rebecca Porrino enrolled through Covered California in Anthem PPO plans for 2016. At the end of the enrollment process, just before electronically endorsing the enrollment application, the on-exchange plaintiffs or their agents who initiated the Covered California enrollment process were presented with a "Binding Arbitration Agreement" disclosure. The language used in the disclosure was set by Title 10, California Code of Regulations,

section 6470—a regulation promulgated in connection with California's establishment of Covered California. The disclosure reads:

> "I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability. I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at CoveredCA.com for my review, or, I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for more information."

(Cal. Code Regs., tit. 10, § 6470, subd. (f)(2)(A).) Before submitting the online application, plaintiffs (or their agents) were required to check a box to signify they had "Read And Agree[d] To The Binding Arbitration Agreement."

Off-exchange plaintiffs Paul Simon (Simon), Leonardo Costello (Costello), Melissa Wallace (Wallace), and Bonnie Shulman (Shulman) enrolled in Anthem PPO plans in 2016. They signed and submitted, either through a broker or directly to Anthem, a hard copy individual enrollment application drafted by Anthem.

The individual enrollment application includes an arbitration provision:

> "**REQUIREMENT FOR BINDING ARBITRATION**
> YOU AND ANTHEM BLUE CROSS AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN
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> [page break[1]]

[1] This is the location of the page break in the applications signed by Simon, Wallace, and Shulman; the page break in the application signed by Costello occurs in the next sentence.

DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. IT IS UNDERSTOOD THAT ANY DISPUTE INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY, INCLUDING ANY DISPUTE AS TO MEDICAL MALPRACTICE, THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THIS CONTRACT WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PERMITTED AND PROVIDED BY FEDERAL AND CALIFORNIA LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. BOTH PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND

> INSTEAD ARE ACCEPTING THE USE OF ARBITRATION. YOU, ANTHEM BLUE CROSS AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY."

Immediately following the disclosure as quoted above is a signature line for the application. The arbitration provision is as formatted in this opinion, i.e., it is printed in all capital letters and set off by a heading in bold typeface.

B. Plaintiffs' Lawsuit and Anthem's Motion to Compel Arbitration

Near the end of 2016, Anthem converted plaintiffs' PPO plans to EPO plans, which eliminated coverage for out-of-network care. Simon sued, alleging Anthem was required to continue to provide out-of-network coverage because the company discontinued the PPO plans without sufficient notice. Simon further alleged Anthem misled consumers by characterizing

automatic enrollment in an EPO plan as a "'renewal'" of their existing PPO plans.

Soon after he filed his complaint, Simon sought a temporary restraining order to enjoin Anthem from discontinuing affected PPO plans. The trial court denied the application, reasoning Simon lacked standing to seek injunctive relief because he was "not a victim of any alleged Anthem deception."

Simon, then joined by the other on- and off-exchange plaintiffs in this appeal, filed a first amended class action complaint in February 2017. The amended complaint elaborated on the ways in which Anthem allegedly misled and harmed consumers who enrolled in PPO plans in 2016 by converting their coverage to EPO plans in 2017.

Anthem responded by filing a petition to compel arbitration, enforce a class action waiver, and stay the proceedings pending resolution of the arbitration. Anthem contended both the on- and off-exchange plaintiffs agreed to individual arbitration upon enrollment.

Plaintiffs opposed Anthem's request to compel arbitration, chiefly relying on Health and Safety Code section 1363.1 (Section 1363.1) to argue the on-exchange and off-exchange arbitration disclosures were defective. That statute, enacted in 1994 and not amended since, provides "[a]ny health care service plan that includes terms that require binding arbitration to settle disputes . . . shall include . . . a disclosure" that "shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice"; that "shall appear as a separate article in the agreement . . . and shall be prominently displayed on the enrollment form signed by each subscriber or

enrollee"; that "shall clearly state [in the wording provided by Code of Civil Procedure section 1295] whether the subscriber or enrollee is waiving his or her right to a jury trial"; and that "shall be displayed immediately before the signature line . . . provided for the individual enrolling in the health care service plan." (§ 1363.1.) Plaintiffs also argued, as to the on-exchange insurance enrollees, that Anthem had not introduced sufficient evidence to show they actually electronically signed the online enrollment agreement at all, and plaintiffs further contended, in the alternative, that even if they were bound to arbitrate disputes concerning their 2016 coverage, they were not bound to arbitrate claims concerning the marketing of their 2017 coverage.

The trial court granted Anthem's petition (with the caveat that if public injunctive relief were not available in arbitration, the court would consider a request for public injunctive relief after arbitration). As to the on-exchange plaintiffs, the trial court found it did not make "practical sense" to refuse to enforce the arbitration provision in Anthem's health insurance policy simply because the terms of that provision were not displayed on the Covered California enrollment webpage (what was displayed instead, as discussed *post*, was the previously quoted "Binding Arbitration Agreement" disclosure mandated by regulation). The court reasoned that "[i]f [Section 1363.1] applied to Covered California consumers, they would not become enrollees until they applied again to Anthem or whatever provider. This would defeat the purpose of the marketplace system envisioned to provide healthcare simply and economically." The trial court also found, as to the off-exchange plaintiffs, that Section 1363.1 *did* apply but the arbitration disclosure was sufficiently prominent because it was printed in all capital letters—in the court's view,

the fact that it spanned two pages did not make it too inconspicuous. The court additionally rejected plaintiffs' argument that they were not bound to arbitrate claims concerning the marketing of their 2017 coverage because the pertinent arbitration provision applies to "all disputes" between plaintiffs and Anthem no matter whether they arose before or after the term of enrollment ended.

Because the trial court's order compelling arbitration would bar class-based relief, plaintiffs noticed an appeal from the order under the "'death knell' doctrine." (See generally *In re Baycol Cases I & II* (2011) 51 Cal.4th 751, 757.)

II. DISCUSSION

Exercising our independent judgment, we conclude arbitration is required.

As to the on-exchange plaintiffs, Anthem satisfied its burden to demonstrate those plaintiffs (or their agents) electronically enrolled in insurance plans through Covered California. The arbitration disclosure they acknowledged as part of that process ("I Have Read And Agree To The Binding Arbitration Agreement") did not have to meet Section 1363.1 requirements because the Legislature, in more recent and more specific statutes, gave Covered California exclusive control over the on-exchange enrollment process—which includes what should be disclosed regarding the various health plans' use of arbitration. Pursuant to these statutes, Covered California promulgated a regulation, which plaintiffs do not challenge, to formulate the arbitration disclosure that exchange customers would see. The on-exchange plaintiffs saw that disclosure, agreed to it, and no more was required. There is accordingly no

basis to refuse to compel arbitration as to the on-exchange plaintiffs based on the asserted failure to comply with Section 1363.1.

The off-exchange plaintiffs' challenge to the enforceability of the individual enrollment application's arbitration provision boils down to an argument that Section 1363.1 requires a prominent arbitration disclosure not only immediately before the application's signature line, but immediately before *and entirely on the same page as* the signature line. The plain text of Section 1363.1 includes no such requirement and Section 1363.1 therefore provides no basis to refuse to enforce the off-exchange arbitration provision.

Finally, the arbitration provisions to which plaintiffs consented in 2016 apply to "all disputes" and "issues related to the plan/policy." All of plaintiffs' claims, including those concerning their enrollment in EPO plans in 2017, fall within the scope of these broad terms.

A. The On-Exchange Plaintiffs Are Bound by the Coverage Contract's Arbitration Provision

Plaintiffs contend the on-exchange plaintiffs are not bound by the arbitration provision in their coverage documents for two reasons: (1) Anthem has not met its burden to show they electronically enrolled in health coverage via Covered California and (2) the arbitration disclosure used in the Covered California enrollment process does not satisfy Section 1363.1. For reasons we now explain, neither argument carries the day.

1. Anthem satisfied its burden to show the on-exchange plaintiffs enrolled in health coverage

"[W]hen a petition to compel arbitration is filed and accompanied by prima facie evidence of a written agreement to arbitrate the controversy, the court itself must determine whether the agreement exists and, if any defense to its enforcement is raised, whether it is enforceable. Because the existence of the agreement is a statutory prerequisite to granting the petition, the petitioner bears the burden of proving its existence by a preponderance of the evidence." (*Rosenthal v. Great Western Fin. Securities Corp.* (1996) 14 Cal.4th 394, 413.) A petitioner may satisfy this initial burden *either* by attaching a copy of the executed arbitration agreement to the petition *or* by reciting the terms of the arbitration agreement in the petition to compel arbitration itself. (*Espejo v. So. Cal. Permanente Medical Group* (2016) 246 Cal.App.4th 1047, 1060; *Condee v. Longwood Management Corp.* (2001) 88 Cal.App.4th 215, 219 (*Condee*).)

In support of its petition, Anthem submitted a declaration by Rick Krum (Krum), its California Exchange Director. Krum explained that "[i]n order to formally enroll in an Anthem health plan, [an] enrollee must go to Covered California's website[ ] and enter his electronic signature on the eSignature webpage . . . ." Krum compiled electronic signature reports for each of the on-exchange plaintiffs, which, as pertinent to this appeal, contain fields labeled "HEAD OF HOUSEHOLD," "CREATED BY USER ID," "CREATED BY USER NAME," "CREATED BY USER ROLE," "ESIGNATURE NAME ENTERED," "ESIGNATURE DATE," and "AGREED TO BINDING ARBITRATION." For each on-exchange plaintiff, there is a report listing them as head of household and indicating "Yes" in the "AGREED TO BINDING

ARBITRATION" field. Krum also provided a "wireframe"[2] of Covered California's electronic signature page, which features, among other things, the beginning of the "Binding Arbitration Agreement" in a text box (with arrows indicating users could scroll to see the rest) above the electronic signature field.

Plaintiffs do not dispute they or their agents checked the arbitration agreement box and submitted an electronic signature. (And really, how could they? The claims in their lawsuit depend on the allegation that they enrolled in Anthem PPO plans in 2016.) Rather, they contend Anthem did not carry its initial burden of submitting "the actual signed agreements" with its petition. In effect, plaintiffs contend Anthem was required to submit an image of each on-exchange plaintiff's electronic signature—i.e., a screenshot of the Covered California webpage with the enrollee's name typed into the signature field—as opposed to records reflecting the date, time, and content of plaintiffs' signatures.

That is not Anthem's initial burden. A party petitioning to compel arbitration is "not require[d] . . . to introduce the agreement into evidence or provide the court with anything more than a copy or recitation of its terms." (*Condee*, *supra*, 88 Cal.App.4th at p. 219 [citing Code of Civil Procedure § 1281.2 and California Rules of Court, rule 3.1330]; *Sprunk v. Prisma LLC* (2017) 14 Cal.App.5th 785, 793 [citing *Condee* and

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[2] A wireframe is "[a]n image or set of images which displays the functional (but not the graphical) elements of a website or page, typically used during the design process for planning a site's structure and functionality." (Oxford English Dict. Online (2019) <https://oed.com/view/Entry/272645> [as of July 15, 2019], archived at <https://perma.cc/4V4K-3XQ9>.)

holding that "unless there is a dispute over authenticity, it is sufficient for a party moving to compel arbitration to recite the terms of the governing provision"].) Here, Anthem submitted the coverage document that includes the arbitration agreement as well as evidence that each on-exchange plaintiff (or their agent) agreed to be bound by it. With no actual dispute as to whether plaintiffs or their agents executed the agreement, that was enough.

2. Compliance with the pertinent arbitration disclosure regulation, not Section 1363.1, is all that was required

If plaintiffs are right that Section 1363.1 governs the form and content of the on-exchange arbitration disclosure, they are correct that the disclosure would not suffice and Anthem could not compel the on-exchange plaintiffs to arbitrate their disputes. (See, e.g., *Malek v. Blue Cross of California* (2004) 121 Cal.App.4th 44, 62 ["[A]n arbitration provision in a health care service plan is unenforceable if it does not meet the mandatory disclosure requirements of [S]ection 1363.1"] (*Malek*).) To state the most obvious deficiency, the conditional language used as part of the Covered California enrollment process ("if I select a health plan that requires binding arbitration to resolve disputes") does not itself "clearly state whether the plan uses binding arbitration to settle disputes . . . ." (§ 1363.1, subd. (a).) But plaintiffs' premise is not right. Recent specific laws and regulations govern the Covered California enrollment process, not Section 1363.1.

The Patient Protection and Affordable Care Act (the Act) passed by Congress in 2010 "requires the creation of an

'Exchange' in each State—basically, a marketplace that allows people to compare and purchase insurance plans. The Act gives each State the opportunity to establish its own Exchange, but provides that the Federal Government will establish the Exchange if the State does not." (*King v. Burwell* (2015) 135 S.Ct. 2480, 2485; see also 42 U.S.C. § 18031(d)(1) ["An Exchange shall be a governmental agency or nonprofit entity that is established by a State"].) The Act gave states flexibility in designing these exchanges but required those states designing their own exchange to "develop and use . . . [a] single, streamlined form" that could be "filed online, in person, by mail, or by telephone" and "is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs."[3] (42 U.S.C. § 18083(b)(1)(A), (B); see also 45 C.F.R. § 155.405.)

California opted to set up its own exchange, enacting several statutes and promulgating regulations to accomplish the task. Government Code section 100500, first enacted in 2010 and later amended, declared "[t]here is in state government the California Health Benefit Exchange, an independent public entity not affiliated with an agency or department, which shall also be known as Covered California." (Gov. Code, § 100500, subd. (a).) Importantly for our purposes, the Legislature directed

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[3] Plaintiffs request that we take judicial notice of various documents submitted in support of their reply brief. The request is granted except as to Exhibit 10, an "issue brief" issued by the Medicaid and CHIP Payment & Access Commission. (Evid. Code, §§ 451, 452.) The judicially noticed documents, however, are not important to our analysis.

the new Covered California entity to "[d]etermine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange" and to coordinate that process with other state and local entities to ensure "consistent eligibility and enrollment processes and seamless transitions between coverage." (Gov. Code, § 100503, subd. (a)(1), added by Stats.2010, ch. 655 (A.B.1602), § 7.) By express grant of statutory authority, the Legislature also authorized Covered California's governing board to "[a]dopt rules and regulations, as necessary." (Gov. Code, § 100504, subd. (a)(6)(A), added by Stats.2010, ch. 655 (A.B.1602), § 8.) And the Legislature further clarified that Covered California "shall not be subject to . . . regulation by . . . the [California] Department of Managed Health Care" notwithstanding any other provision of law. (Gov. Code, § 100507, subd. (a).)

Pursuant to the statutory authority conferred by the aforementioned provisions of the Government Code, the Covered California board promulgated regulations describing the enrollment process the exchange would follow in exhaustive detail. Among the regulations was one first promulgated in September 2013 that established the requirements for the "single, streamlined application [that] shall be used" to determine eligibility and enroll in a health insurance plan.[4] (Cal. Code

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[4] Enrollment in health coverage through Covered California began on October 1, 2013. (News Release, Covered California Is Open for Business (Oct. 1, 2013) <https://www.coveredca.com/newsroom/news-releases/2013/10/01/Covered-California-Is-Open-for-Business/> [as of July 30, 2019], archived at <https://perma.cc/B98J-YGUX>.)

Regs., tit. 10, § 6470.) We have already quoted part of that regulation earlier in this opinion—the part that sets forth the specific language the Covered California application was to use when disclosing binding arbitration requirements that may be incorporated in health plans that would be offered on the exchange. (Cal. Code Regs., tit. 10, § 6470, subd. (f)(2)(A) ["All individuals, responsible parties, or authorized representatives, age 18 or older who are selecting and enrolling into a health insurance plan shall agree to, sign, and date the agreement for binding arbitration, as set forth below . . ."].[5])

The regulatory arbitration disclosure language that was made part of Covered California's enrollment process includes agreement to be bound by the selected plan's arbitration provision, if it has one. (See Cal. Code Regs., tit. 10, § 6470, subd.

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[5] The regulation mandates two different disclosures depending on the health insurance plan at issue. The disclosure for "an Exchange plan" like those offered by Anthem is as we earlier quoted it. Specifically for Kaiser Medi-Cal health plans, however, the regulation required a shorter, more definitive advisement: "I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services, including whether any medical services provided were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered. If I pick Kaiser as my Medi-Cal health plan, I give up my constitutional right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a state hearing of any issue, which is subject to the state hearing process." (Cal. Code Regs., tit. 10, § 6470, subd. (f)(2)(B).)

(f)(2)(A) ["[I]f I select a health plan that requires binding arbitration to resolve disputes, *I accept, and agree to*, the use of binding arbitration to resolve disputes or claims"], italics added.) The question we now confront therefore turns solely on whether Government Code sections 100503 and 100504—in combination with the regulation enacted pursuant to those statutes that establishes Covered California's mandated arbitration disclosure—limit the extent of Section 1363.1's applicability. They do.

"It is well established that a statute enacted later in time controls over an earlier-enacted statute, and it is equally well-established that a specific statute prevails over a statute that is more general. (*State Dept. of Public Health v. Superior Court* (2015) 60 Cal.4th 940, 946, 960-961[ ] (*DPH*) [more specific and later-enacted long-term care statute properly construed as a limited exception to general rule of patient confidentiality set forth in Welf. & Inst. Code § 5328]; see also Gov. Code, § 9605 ['In the absence of any express provision to the contrary in the statute which is enacted last, it shall be conclusively presumed that the statute which is enacted last is intended to prevail over statutes which are enacted earlier at the same session . . .']; Code Civ. Proc., § 1859 ['when a general and particular provision are inconsistent, the latter is paramount to the former'].)" (*Cross v. Superior Court* (2017) 11 Cal.App.5th 305, 322-323.) In a somewhat related vein, precedent describes an """implied amendment [a]s an act that creates an addition, omission, modification or substitution and changes the scope or effect of an existing statute,""" and emphasizes such implied amendments should be found """only where the later-enacted statute creates such a conflict with existing law that there is no rational basis for

harmonizing the two statutes.'"'" (*In re Greg F.* (2012) 55 Cal.4th 393, 407.)

Dispositive of the question at hand are the statutes that created Covered California, gave that agency sole authority to "[d]etermine the . . . process for . . . enrollment . . . in the Exchange" (Gov. Code, § 100503), and empowered the agency to promulgate necessary rules to discharge its responsibility to determine the process for enrollment. These enactments are obviously later in time than Section 1363.1, which was enacted over 20 years earlier in 1994—when the internet was still in its infancy and the idea of a streamlined online insurance marketplace capable of bringing insurance to millions not much better than a pipe dream. We additionally consider the statutes creating Covered California to be more specific in the relevant sense than Section 1363.1: While the Government Code statutes give Covered California control over all aspects of enrollment, and in that manner are less focused on arbitration disclosure than Section 1363.1, the Government Code statutes apply specifically to Covered California (and, thus, to the on-exchange plaintiffs here) whereas Section 1363.1 is a statute that governs arbitration disclosure only generally—and certainly not in the context of an online insurance marketplace that obviously was not in legislators' minds at the time of Section 1363.1's passage. As more specific and later in time, and phrased in terms that confer broad authority, the pertinent Government Code provisions are best viewed as creating a carve-out for the Covered California enrollment process from the dictates of Section 1363.1 that apply elsewhere.[6]

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[6] The Legislature's intent in that regard is further elucidated by its decision to make clear that Covered California is not

Relatedly, we see no need to set forth our own analysis of whether Section 1363.1 and the statutory grant of authority over enrollment processes to Covered California can be harmonized because Covered California—the entity with greatest expertise and the mandate to design a single, streamlined enrollment form, has already undertaken the analysis for us in promulgating the aforementioned Title 10, California Code of Regulations, section 6470, subdivision (f)(2)(A). That regulation, adopted pursuant to an express grant of statutory authority, recites the exact language the exchange enrollment process would use in disclosing health insurance plans' arbitration requirements. The language Covered California's board adopted—with Section 1363.1 then on the books—cannot be reconciled with what that section requires; indeed, that is the key premise of plaintiffs' lawsuit. Under these circumstances, Section 1363.1 should not be read to govern on-exchange enrollment and there is accordingly no basis for refusing to compel arbitration on the theory that the Covered California arbitration disclosure was legally insufficient. (Cf. *Gordon v. New York Stock Exchange, Inc.* (1975) 422 U.S. 659, 689-690 [citing "the expertise of the SEC" and "the confidence Congress has placed in the agency" among reasons for holding the Securities and Exchange Act's

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subject to regulation by the Department of Managed Health Care. The director of the Department of Managed Health Care is empowered to issue rules implementing Section 1363.1. (Health & Saf. Code, § 1344, subd. (a).) Excluding Covered California from the director's regulatory jurisdiction is consistent with the legislative intention we have explained—to take the on-exchange *enrollment process* outside of existing law and make it the exclusive domain of Covered California.

grant of authority to the SEC to fix reasonable commission rates displaced antitrust laws otherwise applicable to rates].)

B. The Enrollment Application Signed by the Off-Exchange Plaintiffs Satisfies Section 1363.1

The arbitration disclosure provision that appears in the hard copy off-exchange Anthem enrollment application "clearly state[s] whether the plan uses binding arbitration to settle disputes" (§ 1363.1, subd. (a)); appears as a separate article (§ 1363.1, subd. (b)); and is expressed in appropriate wording (§ 1363.1, subd. (c)). But plaintiffs contend it fails to satisfy two other requirements of Section 1363.1, namely, the requirement that the disclosure "be prominently displayed on the enrollment form" (§ 1363.1, subd. (b)) and appear "immediately before the signature line" (§ 1363.1, subd. (d)).

Recognizing that the Legislature deliberately eschewed "specific typeface, format, and heading requirements" in favor of the more flexible prominence requirement in subdivision (b), courts have turned to dictionaries to flesh out this requirement. (*Burks v. Kaiser Foundation Health Plan, Inc.* (2008) 160 Cal.App.4th 1021, 1027 (*Burks*).) A prominent disclosure is "'readily noticeable.'" (*Imbler v. PacifiCare of Cal., Inc.* (2002) 103 Cal.App.4th 567, 579.) "[L]ike its synonyms 'noticeable,' 'remarkable,' 'outstanding,' 'conspicuous,' 'salient,' and 'striking'—[prominent] means 'attracting notice or attention.' [Citation.] More specifically, 'prominent' 'applies to something commanding notice by standing out from its surroundings or background.' [Citation.]" (*Burks*, *supra*, at p. 1026.)

The prominence of a disclosure is determined, among other things, by the font in which it is printed, its size, whether it is

bolded, italicized, underlined, or highlighted, whether it is set off by a heading or border, use of uppercase letters, and the use of similar emphasis elsewhere in the text. (See, e.g., *Burks*, *supra*, 160 Cal.App.4th at pp. 1028-1029; *Malek*, *supra*, 121 Cal.App.4th at p. 61; *Zembsch v. Superior Court* (2006) 146 Cal.App.4th 153, 162-165; *Robertson v. Health Net of Cal.* (2005) 132 Cal.App.4th 1419, 1425-1428 (*Robertson*).)

The arbitration provision in the off-exchange enrollment application is set off by a bold heading and, unlike the rest of the individual enrollment application, printed in all uppercase letters. Although plaintiffs argue printing a lengthy paragraph in all capital letters actually may tend to hinder readability, the possibility that there are alternatives to printing a disclosure in all uppercase letters that would make the text more prominent without sacrificing readability is not relevant to the binary, yes-or-no question of whether the arbitration provision stands out in Anthem's individual enrollment application. It does.

Weaving together Section 1363.1's prominence requirement and the statute's "immediately before the signature line" requirement, however, plaintiffs insist the arbitration disclosure must be prominent on the signature page. But the "immediately before the signature line" requirement has its own purpose, independent of the prominence requirement. "In plain and ordinary language, 'immediately before' means that the arbitration agreement must be typed in directly before the signature line provided for the individual on the enrollment form *without any intervening language*." (*Robertson*, *supra,* 132 Cal.App.4th at p. 1426 [compiling dictionary definitions consistent with this construction].) The "immediately before the signature line" requirement is not an inelegantly-phrased

"entirely on the same page as the signature line" requirement. It ensures that the arbitration disclosure is the last thing a consumer sees before enrolling in a health care service plan.

Even if an "entirely on the same page as the signature line" requirement would serve the same purpose as the requirements listed in Section 1363.1, Section 1363.1 does not include such a requirement. The arbitration provision appears immediately before the signature line—there is no other text that intervenes—and that means the hard copy application complies with Section 1363.1.[7] If the Legislature wants a different rule, it is for the Legislature, not us, to say so.

C. All of Plaintiffs' Claims Are Subject to Arbitration

Because plaintiffs were automatically enrolled in EPO plans in 2017, they did not execute new arbitration agreements as part of the 2017 enrollment process.[8] The arbitration provisions to which plaintiffs agreed in 2016, however, apply to all causes of action raised in this case—even those concerning the manner in which Anthem marketed their 2017 plans.

Both the individual enrollment application (for off-exchange plaintiffs) and the coverage document (for on-exchange

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[7] Nothing in the record suggests, and no party contends, Anthem intentionally designed the hard copy application so as to force or artificially insert a page break in the arbitration provision. Rather, the arbitration provision flows continuously from the text that precedes it, and the signature line immediately follows.

[8] Shulman is an exception to this general statement, and we shall return to her situation *post*.

plaintiffs) include arbitration provisions applicable to "ALL DISPUTES" between enrollees and Anthem. After specifying various types of disputes, these provisions also provide for arbitration of "ANY OTHER ISSUES RELATED TO" enrollees' plans.

References to "this contract" (i.e., "[b]oth parties to this contract" and "medical services rendered under this contract") do not restrict the scope of these provisions to disputes arising directly from plaintiffs' coverage in 2016. There is no question that, if plaintiffs' 2016 PPO plans had been renewed with precisely the same coverage, no new arbitration agreement would be necessary to compel arbitration concerning coverage in 2017. (The plans' "guaranteed renewable" provision allowed for renewal by payment of a renewal premium.) There is no reason this case should be any different. Regardless of whether Anthem accurately characterized plaintiffs' re-enrollment in EPO plans in 2017 as a "renewal" of their 2016 coverage, the re-enrollment was related to their initial enrollment.

Plaintiffs point out that Shulman, who was automatically re-enrolled in one EPO plan but cancelled that coverage to enroll in a different Anthem EPO plan, was asked to complete a new enrollment application with a new arbitration provision in 2017. That does not demonstrate an inconsistency in Anthem's position regarding the persistence of the arbitration agreements plaintiffs signed in 2016. The arbitration agreement set forth in Shulman's 2016 individual enrollment application was cancelled when Shulman's renewed coverage was cancelled. The fact that Anthem required her to submit a new enrollment application with a new arbitration provision *post-cancellation* is not only

consistent with, but reinforces, its position that she remained bound by the 2016 agreement *pre-cancellation*.

DISPOSITION

The trial court's order is affirmed. Respondent shall recover its costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

BAKER, J.

I concur:

KIM, J.

Simon v. Blue Cross – B292118

RUBIN, P. J. - Concurring and Dissenting Opinion

I agree with the majority analysis of the arbitration agreement for the online insureds. Government Code section 100503 and related regulations govern the arbitration disclosure statements for policies obtained through the Covered California process. That law both was later-in-time-enacted and is more narrowly drawn than Code of Civil Procedure section 1363.1, and, under principles discussed by the majority, the former prevails.[9] Respondent complied with the arbitration disclosure requirements for online applicants.

I also agree with the majority that all of the claims of the online applicants are subject to arbitration. The purported distinction between 2016 and 2017 claims is not supported by the record. I would affirm those parts of the trial court's decision for the reasons stated in Parts A and C of the majority opinion's Discussion.

I part ways with the majority and would reverse the trial court's ruling – set out in Part B of the majority opinion – only as to the holding – set out in Part B of the majority opinion – that the arbitration agreement for off-exchange applicants complies with section 1363.1, subdivisions (b) and (d). It does not.

I need not repeat the authorities cited in the majority opinion. The principles in those cases are sensibly stated: there is no required or preferred typeface, format or heading

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[9] All future statutory references are to the Code of Civil Procedure.

requirement and "prominently displayed" has an everyday meaning. (*Burks v. Kaiser Foundation Health Plan, Inc.* (2008 160 Cal.App.4th 1021, 1026-1027.)[10]

That does not, however, end the inquiry, and my attention is next drawn to whether the arbitration provision is in fact prominently displayed. I consider this issue in light of the apparent purpose of section 1363.1 and the predicament it was apparently designed to alleviate.

Subdivisions (b) and (d) read together require, among other things, that the arbitration disclosure be "prominently displayed" "immediately before the signature line." The court in *Robertson v. Health Net of California, Inc., supra,* 132 Cal.App.4th at page 1426 held that " 'immediately before' means that the arbitration agreement must be typed in directly before the signature line provided for the individual on the enrollment form *without any intervening language*." (Italics original.) That is how the arbitration clause is presented in the current case. Although a few internal markings appear at the end of page 9 of the agreement, there is no substantive contractual term between the arbitration provision and the signature line.

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[10] Significantly the five cases cited by the majority in Part B of its Discussion all held that the arbitration provision in question did not comply with section 1363.1. (See *Robertson v. Health Net of California, Inc.* (2005) 132 Cal.App.4th 1419, which I discuss in the text, *Burks v. Kaiser Health Foundation, supra,* 160 Cal.App.4th 1021, *Malek v. Blue Cross of California* (2004) 121 Cal.App.4th 44, *Zembsch v. Superior Court* (2006) 146 Cal.App.4th 153, and *Imbler v. PacifiCare of Cal. Inc.* (2002) 103 Cal.App.4th 567.

In my view *Robertson* is more informative on the other element of the test: the requirement in subdivision (b) that the arbitration provision be prominently displayed. In affirming the trial court's denial of a motion to compel arbitration, the *Robertson* court held that the arbitration provision was not prominently displayed. It did so even though the arbitration provision was entirely on the signature page and even though the title, "**Arbitration Agreement**" was in bold.[11]

I acknowledge the arbitration provision in the present case is easier to read than the one in *Robertson*. For example, unlike *Robertson* the font is in all capitals. Of course, this court's task is not simply to compare two provisions, as both may be prominently displayed or not. What the *Robertson* court found significant was that "the arbitration clause itself is not highlighted or bolded. Only the title of that clause is bolded, and says simply '**Arbitration Agreement**.' " (*Robertson, supra,* 132 Cal.App.4th at p. 1428.) So, too, in the present case only the title of the arbitration clause is highlighted or bolded, not the clause itself. A second reason for invalidating the arbitration clause in *Robertson* was the trial court's finding that "the provision is some distance from the enrollees' signature line." (*Id*. at p. 1429.) The finding has particular importance because the signature line and the entire arbitration provision are the same page.

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[11] The page of the enrollment application containing both the signature line and the entire arbitration provision was attached as Appendix A to the *Robertson* opinion. (*Robertson*, *supra*, 132 Cal.App.4th at p. 1433.)

Robertson thus holds that it is not just that the arbitration clause must be immediately before the signature line, but also the prominence of the arbitration clause must be judged in the context of the placement of signature line. In *Robertson*, the court found that even where the signature line and arbitration provision were on the same page, the provision was not prominently displayed. Even putting the title in bold was not enough.

In the present appeal, the title of the clause – the only part that was highlighted in bold – was not on the signature line page. Instead, on page 9 at the end of a section entitled "Recission of Membership," Blue Cross placed only the title of the arbitration clause and the first three lines of the provision. The remaining 19 lines of the unbolded clause is on the next page, page 10. Why does this jump from one page to another undermine the apparent purpose of section 1363.1?[12]

To answer that question, I must digress to one of the cardinal rules of contract law, one not peculiar to arbitration agreements. " 'It is well established, in the absence of fraud, overreaching or excusable neglect, that one who signs an instrument may not avoid the impact of its terms on the ground that he failed to read the instrument before signing it.' " (*Stewart v. Preston Pipeline Inc.* (2005) 134 Cal.App.4th 1565, 1589; s*ee also Brookwood v. Bank of America* (1996) 45 Cal.App.4th 1667, 1674 [employee bound by arbitration provisions regardless of whether she read it or was aware of it when she signed the document].)

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[12] The legislative history of section 1363.1 does not shed light on the purpose of the statute.

Without legislative intervention, enrollees would be entirely on their own as to whether they decided to read the arbitration clause or not. If they chose not to, caveat emptor. Except for unconscionability or the reasons mentioned above, the provision would be enforceable. The principal reason for the enactment of section 1363.1, in my view, is the apparent recognition by the Legislature that health care enrollees, when faced with a daunting 10-page agreement (such as the one here) will not in fact read every part of the contract. They might read some parts, or turn to where they have to sign. The Legislature apparently concluded that one's right to a court trial or a jury trial was too important to be left to the vagaries of what part of a contract the enrollee might read. To remedy, the Legislature imposed the disclosure requirements in section 1363.1. ' "The disclosure requirement is plainly an effort to protect insureds . . . .' " (*Imbler v. PacifiCare of Cal. Inc., supra,* 103 Cal.App.4th at p. 575, quoting *Smith v. PacifiCare Behavioral Health of California, Inc.* (2001) 93 Cal.App.4th 139, 159.) This protection was apparently founded on the reality that an enrollee is most likely to read the contractual provisions on the page on which the signature line is found. Certainly the signature page will catch the attention of every enrollee. Placing the prominently displayed arbitration provision there increases the likelihood the arbitration provision will actually be read and the enrollee in fact informed of the potential loss of the right to trial by judge or jury.

Blue Cross's placement of the arbitration provision starting on a page other than the signature line is particular problematic here. This is so because the four lines on page 9 would have easily fit on page 10, such that the entire arbitration provision with its bolded "**REQUIREMENT FOR BINDING**

ARBITRATION" would have been on the same page immediately before the signature line. Noteworthy is that beneath the signature line on page 10 there is 3½ inches of blank space, more than enough room to place the four lines from page 9 on page 10. Alternatively, if Blue Cross had repeated the title on page 10 such that the top of the page read to the effect, "**REQUIREMENT FOR BINDING ARBITRATION continued**," the arbitration provision would, in my view, have been prominently displayed.

Our review of a trial court's order that an arbitration provision complies with section 1363.1 is de novo, where, as here, the facts are undisputed. As did the courts of appeal in the cases cited in footnote 2 above, I conclude that, as a matter of law, Blue Cross failed to comply with section 1363.1 for the off-exchange enrollment. Accordingly, the trial court's order compelling arbitration of the off-exchange claims should be reversed.

RUBIN, P. J.