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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

CALIFORNIA ASSOCIATION OF HEALTH PLANS,

Plaintiff and Petitioner,

v.

MARY WATANABE, in her official capacity as Acting Director of the California Department of Managed Health Care; CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE; DOES 1 through 10, inclusive

Defendants and Respondents.

Case No.

VERIFIED PETITION FOR WRIT OF MANDAMUS, PROHIBITION, OR OTHER APPROPRIATE RELIEF (CODE CIV. PROC. § 1085 *et seq.*) AND COMPLAINT FOR DECLARATORY RELIEF (GOV. CODE § 11350 & CODE CIV. PROC. § 1060 *et seq.*)

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1 Plaintiff and Petitioner, California Association of Health Plans ("CAHP"), pursuant
2 to California Code of Civil Procedure sections 1060 *et seq.*, 1085 *et seq*. and Government
3 Code section 11350, respectfully petitions this Court for:
4 A. A writ of prohibition and/or mandamus directing Defendants and
5 Respondents, Mary Watanabe, in her official capacity as Acting Director of the
6 California Department of Managed Health Care (the "Director") and the California
7 Department of Managed Health Care (the "Department" and collectively with the
8 Director, "DMHC"), pursuant to Government Code section 11350 and Code of
9 Civil Procedure section 1060, to refrain from enforcing and to immediately
10 withdraw subdivision (d) of Cal. Code Regs. tit. 28, § 1300.67.01 because it was
11 enacted in violation of the California Administrative Procedures Act, Government
12 Code section 11340 *et seq.* ("APA") and violates the California Constitution; and
13 B. A judicial declaration that subdivision (d) of Cal. Code Regs. tit. 28, §
14 1300.67.01 is void and unenforceable because it was enacted in violation of the
15 APA and violates the California Constitution.
16 By this verified Petition and Complaint, CAHP alleges as follows:
17 ## I. INTRODUCTION
18 1. CAHP brings this action to combat the DMHC's unlawful enactment of an
19 emergency regulation that mandates that health plans pay the cost for *all* COVID-19
20 testing and related services, *even if the health plan's existing contract with a provider*
21 *delegated the financial risk of testing to the provider* (the "Cost Shifting Mandate"). Cal.
22 Code Regs. tit. 28, § 1300.67.01(d). The Cost Shifting Mandate is extremely broad and
23 applies not only to diagnostic testing services provided to essential workers, but to *all* plan
24 enrollees. Further, the regulation shifts costs not only for actual testing, but also for
25 undefined, "related items and services." In short, through the Cost Shifting Mandate the
26 DMHC has attempted to substantially re-write existing contracts between plans and
27 providers.
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2. The DMHC promulgated Section 1300.67.01 as the highest level emergency regulation without *any* public notice and opportunity for comment, not even the 5-days' notice required for emergency regulation. Such drastic rulemaking is permitted only in exigent circumstances and only upon a detailed showing that "immediate, serious harm" will occur if the regulation is delayed even five days. Here, the DMHC failed to identify any "immediate, serious harm" justifying its suspension of *all* due process and statutory requirements under Knox-Keene Act and the APA in order to promulgate the Cost Shifting Mandate, and indeed no such exigency existed. In fact, the DMHC waited more than four months after the Governor declared a state of emergency before acting, which demonstrates that there was no urgency sufficient to support the DMHC not allowing the public and health care service plans even five days to point out flaws or problems in the proposed regulation.

3. While there is no doubt that the COVID-19 pandemic presents a state and national emergency, the DMHC failed to provide any factual basis or empirical evidence as required even where (and especially where) an emergency regulation is promulgated, that could explain the nexus between the COVID-19 pandemic and any imminent need to nullify existing contract terms allocating risk and expense as between health care service plans and health care providers. In particular, the DMHC did not and could not provide evidence of any threat of imminent collapse of the ability of health care providers to honor their contractual commitments to bear the financial risk of providing diagnostic testing services. Nor did the DMHC justify why it could not provide health plans at least the five-day comment period as required by California's emergency regulation statute. The DMHC has eviscerated complex and carefully constructed contract terms between plans and providers without any economic justification, and without any rational relationship between the shifting of financial risk and the stated goal of ensuring access to COVID-19 testing.

4. California's health care delivery system depends on the careful balance and distribution of risks inherent in the contracts between health care service plans and health

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care providers. Permitting the DMHC to disrupt these carefully calibrated contractual expectations is antithetical to the goals promoted by the Knox-Keene Act and threatens the ability of health care service plans and health care providers alike to carry out their missions of protecting the health of California citizens.

5. The Cost Shifting Mandate is in excess of the DMHC's statutory authority. It violates the requirements of the APA, and constitutes a substantial impairment of obligations between private parties in violation of the Contract Clause of the California Constitution. It also offends constitutional due process, because it imposes a dramatic and potentially confiscatory economic burden on health plans, who must unexpectedly bear the financial risk of services which they now are, by the regulation at issue, required to cover, without providing any *ex ante* mechanism, such as an expedited hearing, to obtain relief from the Cost Sharing Mandate before it imposes significant, non-recompensable financial losses on health plans. CAHP brings this action to reverse this illegal conduct and to restore the bargained-for contract terms on which California's health care service delivery system depends.[1]

II. THE PARTIES

6. CAHP is a trade association representing 45 full-service health care service plans that provide health care coverage to more than 26 million Californians through the individual and group markets and by participating in government programs that provide health care coverage to children, adults, and seniors. CAHP is beneficially interested in obtaining relief protecting its members from the enforcement of a regulation that the DMHC lacked authority to adopt; that violates the California constitutional rights of

[1] The Cost Shifting Mandate was part of a broad set of emergency regulations the DMHC adopted in response to the COVID-19 pandemic which include, among other things, a mandate by the DMHC that COVID-19 testing for certain individuals identified as "essential workers" is medically necessary. By this Complaint CAHP challenges the Cost Shifting Mandate in the regulation.

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CAHP members; and that threatens CAHP members with significant and non-recompensed financial losses and potential civil and criminal penalties.

7. From its creation in 2000, the Department has served as the state agency charged by law with the responsibility to license and regulate compliance of California health care service plans with the provisions of the Knox-Keene Act and its accompanying regulations. The Department's authority to enact regulations is limited to the authority duly delegated to it by the Legislature, and is also constrained by the APA. The Department has no authority to usurp the role of the Legislature by enacting regulations in excess of its delegated authority, and no authority to enact regulations without complying with the APA.

8. The Director is the current acting director of the Department. She is named solely in her official capacity.

III. STANDING

9. CAHP has standing to bring this action, because: (i) CAHP's members are directly impacted by the DMHC's conduct and would have standing on their own to seek the relief requested herein, (ii) the case is germane to CAHP's organizational purpose of advocating for the interests of its members, and (iii) the case does not require the participation of CAHP's individual members because this case does not involve a question driven by individualized factors, but rather involves the overarching questions of whether the DMHC had the authority to impose the Cost Shifting Mandate (at all or on an emergency basis) and whether the Cost Shifting Mandate violates the California Constitution.

IV. JURISDICTION & VENUE

10. CAHP brings this action under Code of Civil Procedure sections 1085, 526 and 1060, Government Code section 11350, and Civil Code section 3422.

11. Venue is proper in the County of Los Angeles because the causes of action asserted here, or some part of these causes of action, arose in the County of Los Angeles.

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See Code Civ. Proc., § 393(b). Venue is also proper in the County of Los Angeles because the California Attorney General has an office in Los Angeles. *See* Code Civ. Proc., § 401.

V. BACKGROUND

12. On July 17, 2020, on a purported emergency basis and in derogation of due process and the notice-and-public-comment requirements under the APA, the DMHC enacted the regulation now codified at Cal. Code Regs. tit. 28, §1300.67.01. Among other things the regulation (Section 1300.67.01(c)) declares that COVID-19 diagnostic testing is a medically necessary basic health care service for an extremely broad class of enrollees defined as "essential workers," regardless of whether the enrollee has any symptoms of COVID-19 infection or is asymptomatic, or whether the enrollee has had a known or suspected exposure to a person with COVID-19. The regulation also prohibits health care service plans from imposing utilization management requirements on COVID-19 diagnostic tests for essential workers. A health plan may inquire whether an enrollee is an essential worker as defined by the regulation, but shall require no further evidence or verification. In short, the regulation creates a broad medical necessity presumption for any person who is an essential worker regardless of whether a clinician actually considers the test medically necessary.

13. In addition to the medical necessity presumption, the regulation also contains the Cost Shifting Mandate -- a provision requiring health plans to pay the cost of COVID-19 testing and related services, even if the health plan's existing contract with a provider delegated the financial risk of testing to the provider. The Cost Shifting Mandate is extremely broad. Whereas the testing coverage and medical necessity mandates apply to testing by "essential workers," the Cost Shifting Mandate applies to *all* testing, regardless of whether the enrollee is an essential worker. Specifically, in an "All Plan Letter" issued on September 18, 2020, the DMHC confirmed the broad scope of the Cost Shifting Mandate: "The prohibition on delegating financial risk unless the parties have negotiated and agreed upon a new provision of their contract applies to all COVID-19 diagnostic

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testing, regardless of whether the enrollee is asymptomatic or has symptoms of or known/suspected exposure to COVID-19, ***and regardless of whether the enrollee is an 'essential worker' as defined by the emergency regulation*.**" (emphasis added). Moreover, the Cost Shifting Mandate requires health plans to pay for "related items and services" without defining that term.

14. Health care service plans range in size from large organizations that operate throughout much or all of California to smaller, regional entities. Whatever their size, however, health care service plans play a vital role in ensuring the health of California citizens by arranging for the provision of health care services for members, or paying for or reimbursing a part of the cost for those services, in return for a pre-paid or periodic charge. Health & Saf. Code., § 1345(f). California law compels health care service plans to cover a variety of services, including all medically necessary "basic health care services." Health & Saf. Code, § 1345(b), 1367(i); Cal. Code Regs. tit. 28, § 1300.67. Among the services that health care service plans must cover are medically necessary diagnostic laboratory services. *Id.* To carry out their vital role and ensure that they comply with the "coverage" mandates of the Health & Safety Code, health care service plans contract with health care providers to provide health care services to the members of the plans.

15. Health care provider organizations likewise range in size, with many operating through large and sophisticated corporations or other organizations. By virtue of their size and for other reasons, health care providers often enjoy substantial bargaining power when negotiating the terms of such contracts. The contracts between health care service plans and health care providers take many forms, including fee-for-service and capitation. In a fee-for-service model, the health care service plan agrees to pay a certain fee to the health care provider if a member receives a covered health care service from the provider. In a capitation model, the health care service plan agrees to pay a group of medical care providers a flat per-enrollee, per-month amount (capitation) to provide health care services to the health plan's enrollees. In capitated arrangements, certain services

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may be excluded from the capitated rate, meaning that the health care service plan retains responsibility to pay for all or part of the excluded service in addition to the capitated rate. But if the service is not excluded from the capitated rate, it is the financial responsibility of the contracting provider group to provide the service without any additional payment from the health care service plan.

16. Health care service plans and health care providers carefully negotiate their contracts, including capitated contracts, to rationally allocate financial risk as between the parties. For example, in a capitated arrangement, the capitated amount payable to the health care provider generally depends upon the degree to which the contract delegates financial risk to the health care provider. Generally, the more services the health care provider agrees to provide within the capitated rate, the higher the capitated rate. Conversely, the more services that remain the financial responsibility of the health care service plan, the lower the capitated rate. One service that typically is negotiated in these contracts is diagnostic laboratory services, including testing for infectious diseases like COVID-19. Health care providers that contract to accept financial responsibility for such diagnostic testing are able to negotiate higher capitated rates than those who do not.

17. The Knox-Keene Act specifically allows for such allocation of financial risk by way of capitated-payment arrangements where "the provision has first been negotiated and agreed to between the health care service plan and the risk-bearing organization." Health & Saf. Code, § 1375.5.

18. The Cost Shifting Mandate immediately and materially disrupted existing carefully bargained-for contract arrangements – arrangements that have often existed for decades and been relied upon by both health care service plans and health care providers to conduct their operations in a way that promotes the efficient delivery of health care services to California citizens. The Cost Shifting Mandate strips health care service plans of their bargained-for contractual allocation of financial risk associated with diagnostic testing and the undefined "related items and services." It reads:

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> Delegation of Financial Risk for Diagnostic Testing. Changes to a contract between a health plan and a provider delegating financial risk for COVID-19 diagnostic testing, including related items and services, shall be considered a material change to the parties' contract. A health plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Health and Safety Code section 1375.7.

Cal. Code Regs. tit. 28, §1300.67.01, subd. (d). As detailed below, the DMHC lacked the authority to enact the Cost Shifting Mandate, and the mandate lacks any reasonable relationship to the public health emergency (the COVID-19 crisis) that it purports to address.

19. The DMHC enacted the Cost Shifting Mandate without following the notice and public comment requirements ordinarily required under the APA. In a normal rulemaking process, the APA requires the DMHC to provide health plans and the public, at a minimum, 45 days to review and comment on the proposed regulations. In narrow "emergency" circumstances (a situation that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare), the DMHC is permitted to dispense with these requirements but must still provide 5 days' notice and opportunity for comment. In extremely rare circumstances, the DMHC may promulgate a regulation without any public comment but only if the emergency situation "clearly poses such an immediate, serious harm that delaying action to allow public comment would be inconsistent with the public interest." Government Code section 11349.6(b). To invoke this rare exception and dispense with all due process, the agency must specifically and factually justify the need to adopt each part and provision of the regulation on an emergency basis. Moreover, if the emergency existed and was known by the agency in sufficient time to have been addressed through nonemergency regulations, the finding of emergency must include facts explaining why the agency failed to address the situation through nonemergency regulations. Government Code section 11346.1(b)(2). In short, to adopt the Cost Shifting Mandate without any notice and the opportunity for comment, the DMHC was required, at a minimum, to: (1) set forth specific facts demonstrating that the

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absence of the Cost Shifting Mandate posed such an "immediate and serious harm" and was so critical to public health that it could not wait even five days for public comment; and (2) explain why the DMHC did not adopt the Cost Shifting Mandate through nonemergency regulations during the more than four months that had passed since the start of the COVID-19 pandemic and since the Governor's declaration of emergency. The DMHC failed to meet these obligations.

20. The DMHC partially acknowledged the foregoing obligations by stating the reasons that it contended supported the adoption of Section 1300.67.01(d) without notice and public comment. The DMHC purported to justify the adoption of the Cost Shifting Mandate on the highest emergency basis as follows:

> Subdivision (d) is added to address delegation of financial risk for diagnostic tests. This provision is necessary because it is common for health plans to delegate risk to other entities. For example, a health plan may agree to pay the medical group a flat per enrollee, per month amount (capitation), whereby the medical group is responsible for providing necessary care to the health plan's enrollees assigned to the medical group. That medical group has taken on "risk" because it is possible the cost of necessary care will exceed the amount of capitation it receives from the health plan. Subdivision (d) is necessary to ensure health plans do not shift the financial risk for COVID-19 tests pursuant to the proposed rule without treating that shift as a material change to the parties' contract. This is necessary to ensure the parties negotiate and agree upon the new contractual provision in accordance with the Health Care Providers' Bill of Rights (Health and Safety Code section 1375.7). This subdivision is necessary to ensure contracted providers take on financial risk for COVID-19 tests only under specifically negotiated terms, and with appropriate notice.

This purported justification is utterly conclusory and without any factual support. In particular, the DMHC provided (i) no facts supporting a conclusion that nullifying pre-existing contract terms for the delegation of financial risk related to diagnostic testing would do anything to increase access to COVID-19 testing for California citizens, and (ii) no facts supporting a conclusion that "imminent and serious harm" would occur if the DMHC allowed five days for public comment. Further, the DMHC did not even attempt to explain why it had not adopted the Cost Shifting Mandate through non-emergency regulations in the preceding four months.

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21. The DMHC's conduct in enacting the Cost Shifting Mandate is not only unlawful and irrational, but it threatens the delivery of reliable, cost-effective health care to California citizens. California's health care delivery system depends on the ability of payors (like health care service plans) and health care providers to rationally and predictably order their affairs and to set prices based on the expectation that their contracts will not unjustifiably and unexpectedly be modified by government fiat. By upending these bargained-for contract obligations, the DMHC acted capriciously and beyond its authority to increase the risk that both health care payors and providers face, and this increased risk ultimately will harm California citizens by driving up the cost of health care.

VI. THE COST SHIFTING MANDATE IS UNLAWFUL

22. As described below, the Cost Shifting Mandate is illegal and improper for several independent reasons, each of which is by itself a sufficient basis for the Court to grant the relief CAHP seeks by this action.

A. In Enacting the Cost Shifting Mandate, the DMHC Exceeded Its Authority

23. Administrative agencies, such as the DMHC, are entities of limited jurisdiction that have only the powers conferred on them, expressly or by implication, by statute or constitution. "In the absence of valid statutory or constitutional authority, an administrative agency may not, under the guise of regulation, substitute its judgment for that of the Legislature." *California State Restaurant Ass'n. v. Whitlow*, 58 Cal.App.3d 340, 346-347 (1976). When an administrative agency acts in excess of the powers conferred upon it by statute or constitution, its action is void. *See Ferdig v. State Personnel Bd.*, 71 Cal.2d 96, 103-104 (1969).

24. The DMHC was created and empowered by the Knox-Keene Health Care Service Plan Act. Accordingly, the DMHC has only the authority delegated to it under the Knox-Keene Act. Not one of the provisions of the Knox-Keene Act cited by the DMHC in support of the Cost Shifting Mandate, such as the authority to require plan-provider contracts to be "fair" and "reasonable" (Health & Saf. Code, § 1367(h)(1)), confer the

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authority to alter or nullify existing agreements providing for the allocation of financial risk between health plans and health providers. That, however, is precisely what the Cost Shifting Mandate purports to do.

25. To the contrary, other provisions of the Knox-Keene Act—not cited by the DMHC as authority for the emergency regulation—specifically *provide* for the shifting of financial risk by way of capitated payment arrangements where "the provision has first been negotiated and agreed to between the health care service plan and the risk-bearing organization." Health & Saf. Code, § 1375.5. Then-Governor Davis recognized the importance of these types of arms-length agreements in deciding to sign Section 1375.5 into law, explaining "since the bill still allows doctor groups and HMOs to voluntarily agree that the risks associated with these services can be delegated, an approach I endorsed by signing SB 168 in 2000, I will sign this measure into law." Historical and Statutory Notes to § 1375.5.

26. Health & Safety Code section 1375.8 further demonstrates that the DMHC exceeded its authority in enacting the Cost Shifting Mandate. Section 1375.8 creates a discrete list of specific items for which a plan may not delegate financial risk to a provider (absent a request from the provider). The list includes certain injectables and adult vaccines, but does not include any form of diagnostic testing nor the vaguely-defined "related items and services" specified in the regulation. Section 1375.8 does not delegate to the DMHC the power to expand the narrow list. Section 1375.8 reflects a legislative judgment that, except for the items on this narrow list, plans and providers should retain freedom of contract with respect to delegation of financial risk. The Cost Shifting Mandate contravenes that intent.

27. Because nothing in the Knox-Keene Act gives the DMHC authority to impose the Cost Shifting Mandate, and because the Legislature in fact gave health care service plans and health care providers broad leeway to negotiate risk shifting agreements without interference, the DMHC exceeded its delegated authority in enacting the Cost Shifting Mandate.

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B. The Cost Shifting Mandate Was Enacted in Violation of the APA and Due Process Rights of CAHP Members.

28. Due process generally requires public notice and comment before an agency enacts regulations. An animating purpose behind the APA is that "[f]undamental fairness in decisionmaking demands both that factual inputs and arguments to the decisionmaker on law and policy be made openly and be subject to argument by all parties." *Dep't of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.*, 40 Cal.4th 1, 9 (2006). The DMHC can only avoid the APA's notice and comment mandate if its regulation is properly adopted as an emergency regulation under Government Code section 11346.1. Otherwise, the regulation is an improper "underground regulation" that cannot be enforced until it is properly promulgated. Cal. Code Regs. tit. 1, § 250; *Tidewater Marine Western, Inc.*, 14 Cal.4th 557, 576 (1996).

29. As detailed above, an emergency regulation can only be issued without "at least five working days" notice "if the emergency situation clearly poses such an immediate, serious harm that delaying action to allow public comment would be inconsistent with the public interest." Gov't Code § 11346.1(a)(3). Additionally, each provision of any emergency regulation must be accompanied by a "finding of emergency" setting forth:

- a "description of the ***specific facts*** demonstrating the existence of an emergency and the ***need for immediate action*,** and demonstrating, ***by substantial evidence,*** the ***need*** for the proposed regulation to effectuate the statute being implemented, interpreted, or made specific ***and to address only the demonstrated emergency***; and
- the identification of any "technical, theoretical, and empirical study, report, or similar document, if any, upon which the agency relies" that would support the need for the regulation.

Gov't Code § 11346.1(b)(2) (emphasis added). "A finding of emergency based only upon expediency, convenience, best interest, general public need, or speculation, shall not be adequate to demonstrate the existence of an emergency." *Id.* Moreover, the finding of

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emergency must include facts explaining why the agency failed to address the situation through nonemergency regulations. *Id.*

30. The DMHC offered partial reasons purporting to justify enacting Cal. Code Regs. tit. 28, section 1300.67.01 on an emergency basis, thus acknowledging its obligation to do so. But the Cost Shifting Mandate plainly was not properly enacted on an emergency basis consistent with Government Code section 11346.1. The purported justification offered by the DMHC for the Cost Shifting Mandate was utterly conclusory and without factual support. It provided no facts supporting a conclusion that nullifying pre-existing agreements for the delegation of financial risk related to diagnostic testing would do anything to increase access to COVID-19 testing for California citizens, and no facts supporting a conclusion that there was a need to act on an emergency basis at all, let alone to dispense entirely with notice and comment.

31. Further, the DMHC did not set forth "substantial evidence" demonstrating that the Cost Shifting Mandate is needed for any reason, much less "to address only the demonstrated emergency."

32. The DMHC also failed to identify any reports or other documents that would justify the agency's inclusion of the Cost Shifting Mandate in the regulation. None of the authorities cited by the DMHC suggests that health care service plans and health care providers must renegotiate their contracts to make testing more widely available.

33. The fact that the DMHC did not set forth any facts or justification for the Cost Shifting Mandate is not surprising: there was no economic need for the mandate and the actual facts do not justify it. Under the CARES Act, which Congress passed months before the Cost Shifting Mandate, health care providers, including those in California have received grants on a massive scale. The enormous public subsidies made available to health care providers under the CARES Act undermines any conclusion that the government needs to shift the cost of COVID-19 testing away from health care providers and onto health care service plans in derogation of the parties' contractual commitments. Indeed, the federal government itself recognized that there is no need to force health plans

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to incur the cost of COVID-19 testing as the DMHC has done. The CARES Act expressly leaves intact any existing contractual delegation of risk as between plans and providers. Specifically, Section 3202 of the CARES Act states: "If the health plan or issuer has a negotiated rate with such provider in effect before the public health emergency declared under section 319 of the Public Health Service Act (42 U.S.C. 247d), *such negotiated rate shall apply throughout the period of such declaration*." (emphasis added). The fact that the CARES Act, which was enacted in response to the same national health crisis that precipitated the DMHC's COVID-19 regulations, did not require plans to incur the cost of all COVID-19 testing, further confirms that there was no emergency necessitating the Cost Shifting Mandate.

34. Thus, while COVID-19 has certainly created a public health emergency, the DMHC did nothing to justify the enactment of the Cost Shifting Mandate without the notice and public comment period generally mandated by the APA and principles of due process.

C. The Cost Shifting Mandate Violates the Contracts Clause of the California Constitution.

35. The Cost Shifting Mandate substantially impairs the obligations of existing contracts and thus violates the Contracts Clause of the California Constitution. Cal. Const., Art. I, Section 9. A law or regulation that substantially impairs existing contractual obligations violates the Contracts Clause of the California Constitution unless (i) the state has a significant and legitimate public purpose behind the regulation; and (ii) the adjustment of the rights and responsibilities of the contracting parties is based on reasonable conditions and is appropriate to the public purposes justifying the state regulation. *Fourth La Costa Condo. Owners Ass'n v. Seith*, 159 Cal.App.4th 563, 584 (2008).

36. The Cost Shifting Mandate substantially impairs plan-provider contracts that delegated to the health care provider the responsibility of paying for the cost of COVID-19 diagnostic testing and "related items and services." The delegation of financial

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responsibilities contained in plan-provider contracts, including capitated arrangements, is part of a carefully balanced allocation of risk that is essential to the proper functioning of California's health care system. Given the number of Californians who have been tested or will be tested, the fact that many Californians will be tested more than once, and the cost of testing, the impairment will be enormous. The additional requirement shifting the cost of "related items and services" increases the impairment even further.

37. No public purpose relating the COVID-19 pandemic or otherwise is served by erasing existing contract terms about the delegation of financial risk for diagnostic testing. The DMHC is unable to identify any facts supporting a conclusion that, but for the Cost Shifting Mandate, access by essential or non-essential workers to COVID-19 diagnostic services will collapse, or be so constricted as to eliminate the availability of COVID-19 testing for California citizens. Indeed, capitated health care providers generally have seen lower patient utilization (and thus dramatically lower costs) during the COVID-19 crisis, and many such providers are also recipients of federal financial support under the CARES Act. Capitated providers are therefore very capable of bearing their bargained-for contractual responsibilities as they relate to the cost of diagnostic testing.

38. Because the Cost Shifting Mandate substantially impairs existing contracts and is not justified by a significant public purpose nor appropriately tailored to such a purpose, it violates the Contracts Clause of the California Constitution.

D. The Cost Shifting Mandate Violates the Due Process Rights of CAHP Members by Failing to Provide for Any Mechanism to Avoid Confiscatory Results.

39. The Cost Shifting Mandate operates to regulate contract pricing as between health plans and providers by obliterating existing contractual relationships while failing to provide (a) guidelines to insure that any new financial arrangements between plans and providers would protect the health plan's settled contractual expectation of a reasonable rate of return to plans; (b) any mechanism that would ensure an adequate remedy for relief from confiscatory contractual terms where health plans required, whether by law or

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contract, to provide coverage and reimbursement for COVID-19 related services; (c) any "emergency" findings that could reasonably justify suspension or evisceration of existing contracts, particularly where such "emergency" measures result in depriving health plans of a fair return; (d) any assurance that these "emergency" measures were enacted to combat an emergency of limited duration," and (e) any justification that the Cost Shifting Mandate is necessary to address "a temporary situation of such enormity that all individuals might be reasonably required to make sacrifices for the common weal." *CalFarm Insurance Company v. Deukmejian*, 48 Cal.3d 805, 821 (1989). Accordingly, it is subject to the same constitutional protections that apply to other rate regulation regimes.

40. The absence of any mechanism in the Cost Shifting Mandate to afford a health care service plan a remedy from confiscatory rates violates due process.

FIRST CAUSE OF ACTION

(WRIT OF PROHIBITION AND/OR MANDAMUS)

41. CAHP incorporates by reference paragraphs 1 through 40 of this Petition and Complaint as if fully set forth herein by reference.

42. For the reasons set forth above, the DMHC lacked authority to adopt the Cost Shifting Mandate on any basis. It specifically lacked the authority to adopt the Cost Shifting Mandate on an emergency basis, without compliance with the due process notice and comment requirements of the APA, because it did not and cannot justify the Cost Shifting Mandate as an emergency provision rationally connected to the goal of ensuring adequate access to COVID-19 diagnostic testing. Further, the Cost Shifting Mandate violates the due process and Contracts Clause rights of CAHP members.

43. CAHP is entitled to, and requests that this Court issue, a writ of prohibition and/or mandate ordering DMHC to refrain from enforcing and to immediately withdraw subdivision (d) of Cal. Code Regs. tit. 28, § 1300.67.01.

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SECOND CAUSE OF ACTION
(DECLARATORY RELIEF)

44. CAHP incorporates by reference paragraphs 1 through 43 of this Petition and Complaint as if fully set forth herein by reference.

45. CAHP contends that the Cost Shifting Mandate is invalid and unenforceable for the reasons discussed above and that financial responsibility for COVID-19 testing should be based on existing agreement between plans and providers. CAHP is informed and believes that the DMHC disputes this contention. In fact, after the promulgation of the Cost Shifting Mandate the DMHC has issued All Plan Letters which confirm and reinforce the DMHC's position that the Cost Shifting Mandate is valid and enforceable and that CAHP member plans must pay for all COVID-19 testing regardless of what the plans' contracts with providers state and even if those contract require providers to incur the cost and expense of such testing. Indeed, on August 27, 2020, CAHP wrote a letter to the DMHC regarding Section 1300.67.01 in which it stated, among other things "we strongly disagree with the DMHC's position prohibiting the delegation of financial risk for COVID-19 diagnostic testing to delegated providers. We believe that the DMHC's position regarding financial risk for COVID-19 diagnostic testing is inconsistent with existing contract provisions and negotiated financial liability allocation between health plans and providers and disrupts established payment arrangements." The DMHC ignored CAHP's letter and did not respond to CAHP's objections. There is accordingly an actual and present controversy concerning the enforceability of the Cost Shifting Mandate.

46. For the reasons set forth above, CAHP is entitled to a judicial declaration, pursuant to Government Code section 11350 and Code of Civil Procedure section 1060, that the Cost Shifting Mandate is invalid and unenforceable.

REQUEST FOR RELIEF

WHEREFORE, CAHP respectfully requests the entry of an order providing:

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A. A writ of prohibition and/or mandamus directing the Director and the DMHC to refrain from enforcing and to immediately withdraw subdivision (d) of Cal. Code Regs. tit. 28, § 1300.67.01;

B. A judicial declaration that subdivision (d) of Cal. Code Regs. tit. 28, § 1300.67.01 is void and unenforceable because it was enacted in violation of the APA and violates the California Constitution for the reasons explained above; and

C. Awarding costs of suit and such other relief as the Court deems appropriate to CAHP.

Dated: November 13, 2020 SHEPPARD, MULLIN, RICHTER & HAMPTON LLP

By

MOE KESHAVARZI
JOHN T. BROOKS
TODD L. PADNOS
Attorneys for Plaintiff & Petitioner
CALIFORNIA ASSOCIATION OF HEALTH PLANS

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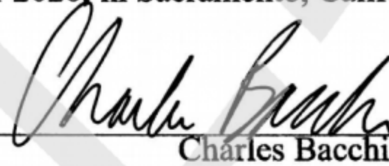
<u>Verification</u>

I, Charles Bacchi, am the President and Chief Executive Officer of the California Association of Health Plans ("CAHP"), Plaintiff and Petitioner herein. I have read the foregoing Verified Petition For Writ of Mandamus/Prohibition and Complaint for Declaratory Relief and know the contents thereof. The facts alleged therein are true of my own knowledge, except as to those matters which are therein stated on information and belief, and, as to those matters, I believe them to be true.

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

Executed this 13th day of November 2020, in Sacramento, California.



Charles Bacchi

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