SHEPPARD, MULLIN, RICHTER & HAMPTON LLP
A Limited Liability Partnership
Including Professional Corporations

MOE KESHAVARZI, Cal. Bar No. 223759
333 South Hope Street, 43rd Floor
Los Angeles, California 90071-1422
Telephone: 213.620.1780
Facsimile: 213.620.1398
E-mail: mkeshavarzi@sheppardmullin.com

JOHN T. BROOKS, Cal. Bar No. 167793
501 West Broadway, 19th Floor
San Diego, California 92101
Telephone: 619.338.6500
Facsimile: 619.234.3815
E-mail: jbrooks@sheppardmullin.com

TODD L. PADNOS, Cal. Bar No. 208202
Four Embarcadero Center, 17th Floor
San Francisco, California 94111-4109
Telephone: 415.434.9100
Facsimile: 415.434.3947
E-mail: tpadnos@sheppardmullin.com

Attorneys for Plaintiff & Petitioner,
California Association of Health Plans

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 Director of the California Department of Managed Health Care; CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE; ROB BONTA in his official capacity as the Attorney General of the State of California; and DOES 1 through 10, inclusive,

Defendants and Respondents.

Case No. 21STCP03725

VERIFIED PETITION FOR WRIT OF MANDAMUS AND/OR PROHIBITION AND COMPLAINT FOR DECLARATORY & INJUNCTIVE RELIEF

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Plaintiff and Petitioner, California Association of Health Plans ("CAHP"), pursuant to California Code of Civil Procedure sections 526, 1060 *et seq.*, 1085 *et seq.* and 1102 *et seq.* and Civil Code section 3422, respectfully petitions this Court for:

A. A writ of mandamus and/or prohibition directing Defendants/Respondents, Mary Watanabe in her official capacity as Director of the California Department of Managed Health Care (the "Director"), the California Department of Managed Health Care (the "Department" and collectively with the Director, "DMHC"), and Rob Bonta in his official capacity as Attorney General (the "Attorney General") of the State of California (the "State"), to refrain from enforcing Health and Safety Code section 1342.2 on a retroactive basis relative to any acts or omissions occurring prior to its January 1, 2022 effective date;

B. A judicial declaration that:

1. Subdivision (d) of Health and Safety Code section 1342.2 – which provides that the statute is retroactive – is void and unenforceable, because it violates the California Constitution; and

2. CAHP's members have no obligation to comply with Health and Safety Code section 1342.2 with respect to any acts or omissions occurring prior to such statute's effective date on January 1, 2022; and

C. A preliminary and permanent injunction enjoining the enforcement of subdivision (d) of Health & Safety Code section 1342.2.

By this Verified Petition and Complaint, CAHP alleges as follows:

I. INTRODUCTION

1. CAHP brings this action to challenge the State's after-the-fact attempt to:

a. unconstitutionally modify, retroactively, the existing contractual and legal rights of health care service plans (each a "Plan" and collectively, the "Plans") relative to the allocation of responsibility for the payment of diagnostic and screening COVID-19 laboratory testing (collectively, "Testing" or "COVID-19 Testing") rendered in the past among Plans, health care service plan enrollees (each

an "Enrollee" and collectively, the "Enrollees"), health care service plan sponsors (each a "Sponsor" and collectively, the "Sponsors") and health care providers (each a "Provider" and collectively, the "Providers"); and

b. prohibit and criminalize, retroactively, past acts of Plans that were not only legal when taken, but previously expressly declared to be legal by the State.

2. Senate Bill 510 (Pan 2021-2022) ("SB 510"), which added, among other provisions, section 1342.2 to the California Health and Safety Code (the "H&S Code"), was enacted six months after this very Court issued an order permanently enjoining the enforcement of a cost shifting provision identical to that in SB 510.

3. To be clear, CAHP's challenge is limited to the retroactive application of such statute to acts and omissions occurring prior to the statute's January 1, 2022 effective date, where such retroactive effect creates obligations that were not imposed at the time by then-existing law or contractual arrangements.

4. Specifically, CAHP is challenging subdivision (d) of H&S Code section 1342.2, which calls for the *retroactive* application of section 1342.2 to a date that is ***five hundred eighty-three (583) days prior to the enactment of such statute and six hundred sixty-eight (668) days prior to the effective date of such statute*** – namely, March 4, 2020 – the date on which Governor Newsom declared a public health emergency.

5. The retroactive application of section 1342.2 would materially change existing law after-the-fact, criminalizing conduct that was legal at the time and stripping Plans of contractual rights that existed at the time (collectively, the "Retroactive Mandates/Prohibitions"). For example, existing law permits Plans to enter into agreements with Providers allocating responsibility to pay for certain services, which many Plans and Providers have done historically as a means of managing risk. One cost that Plans have commonly allocated to Providers is the cost of laboratory testing. Upon its effective date of January 1, 2022, section 1342.2 will bar Plans from enforcing existing agreements executed prior to March 4, 2020 that allocated to Providers the cost of Testing. But enforcing such a mandate on a retroactive basis would inappropriately preclude Plans from

enforcing their agreements relative to services rendered during the period from March 4, 2020 through December 31, 2021 and allow Providers to seek reimbursement for amounts that they contractually agreed to pay. By way of further example, from the start of the COVID-19 pandemic to the present, at various times, with DMHC's express approval and authorization, Plans enforced co-payment or other cost-sharing obligations with respect to certain COVID-19 testing. Now, section 1342.2 purports to retroactively declare such conduct as unlawful.

6. CAHP is also challenging the fact that not only does section 1342.2 seek to modify Plans' obligations with respect to past events, it seeks to retroactively criminalize conduct that was legal when committed and declared to be permissible in guidance issued by DMHC.

7. The Retroactive Mandates/Prohibitions violate the Contract, Ex Post Facto, Due Process and Takings Clauses of the California Constitution.

8. There is no public health justification for the Retroactive Mandates/Prohibitions. The Retroactive Mandates/Prohibitions fail to fulfill the Legislature's stated intention for the enactment of section 1342.2 – namely, to avoid discouraging individuals from seeking and receiving COVID-19 Testing. But enforcing the new Mandates/Prohibitions on a retroactive basis logically has no bearing on Enrollees' *prior* decisions made during the period from March 4, 2020 through December 31, 2021 as to whether or not to obtain COVID-19 Testing.

9. In recognition of the likelihood that the retroactive application of section 1342.2 is a legislative overreach likely to be challenged as unconstitutional, section 6 of SB 510 contains a severability clause providing that, "[i]f any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application."

10. This lawsuit is narrowly tailored. The requested relief is limited to challenging the Retroactive Mandates/Prohibitions pursuant to subdivision (d) of section 1342.2, which retroactively have no public health justification.

11. The enactment of subdivision (d) of H&S Code section 1342.2 not only subjects Plans to conflicting statutory directives from the Legislature, but threatens the ability of Plans and Providers alike to carry out their missions of protecting the health of California citizens. California's health care delivery system depends on the ability of Plans to rely upon prior directives from DMHC, the careful balance and distribution of risks inherent in the contracts between Plans and Providers, and the enforcement of such contracts.

12. In the absence of immediate, or near immediate, relief, CAHP's members will suffer irreparable harm, including without limitation the risk of criminal prosecution for past acts and omissions that were legal when taken.

II. THE PARTIES

13. CAHP is a trade association representing 45 full-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 an unlawful statute that violates the constitutional rights of CAHP members and threatens CAHP members with significant and non-recompensed financial losses and potential civil and criminal penalties.

14. The Director is the Department director. She is authorized and charged with overseeing, administering and enforcing the provisions of the California Knox-Keene Health Care Service Plan Act of 1975 (the "Knox-Keene Act"), including H&S Code section 1342.2. The Director is sued solely in her official capacity.

15. The Department is the California state agency charged with overseeing, administering and enforcing the provisions of the Knox-Keene Act, including H&S Code section 1342.2, under the direction of the Director.

16. The Attorney General is the chief law officer of the State pursuant to Article V, Section 13 of the California Constitution and is charged thereunder with the

duty to see that the laws of the State are uniformly and adequately enforced. The Attorney General is sued solely in his official capacity.

17. Does 1 – 10 are individuals and entities whose true names are unknown to CAHP at this time. CAHP will seek leave of this Court to amend their true names and capacities when they have been ascertained.

III. STANDING

18. CAHP has standing to bring this action, because: (i) its members are directly impacted by the enforcement of H&S Code section 1342.2 as to Plans and the Plans would have standing on their own to seek the requested relief, (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 principally driven by individualized factors, but rather involves the overarching question of whether section 1342.2 applied on a retroactive basis to acts and omissions occurring prior to SB 510's effective date violates the California Constitution.

IV. JURISDICTION & VENUE

19. CAHP brings this action under Code of Civil Procedure sections 526, 1060, 1085 and 1102 and Civil Code section 3422.

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

A. Plans, Sponsors, Enrollees, Providers & Plan Contracts.

21. Plans range in size from large entities that operate throughout California to smaller, regional entities. Whatever their size, however, Plans play a vital role in ensuring the health of California citizens by arranging for the provision of health care services for Enrollees, or paying for or reimbursing a part of the cost for those services, in return for a pre-paid or periodic charge paid by the Sponsor or Enrollee. H&S Code § 1345(f).

Further, Plans range in nature from for-profit enterprises, non-profit enterprises and public enterprises.

22. Sponsors: (i) contract with Plans for the provision of health care services to the Sponsor's members or employees – i.e., the Enrollees, and (ii) pay fees, generally monthly, to the Plans for such coverage for Enrollees.

23. Enrollees: (i) are the beneficiaries of the health care service plans purchased by the Sponsor or Enrollee, (ii) may be obligated to pay fees to the Sponsor for the coverage provided by the Plan, and (iii) may be obligated to pay certain fees and/or co-payments to the Provider providing the health care service to the Enrollee.

24. Providers provide health care services to Enrollees. Like Plans, Providers range in size, with many operating through large and sophisticated corporations or other organizations. By virtue of their size and negotiating leverage, Providers often enjoy substantial bargaining power when negotiating the terms of their provider contracts with Plans. These contracts take many forms, including fee-for-service and capitation.

a. In a fee-for-service model, the Plan agrees to pay a certain fee to the Provider if an Enrollee receives a covered health care service from the Provider.

b. In a capitation model, the Plan agrees to pay the Provider a flat, per-month fee per-Enrollee (capitation) to provide health care services to the Plan's Enrollees. In capitated arrangements, certain services may be excluded from the capitated rate, meaning that the 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 to provide the service without any additional payment from the Plan.

25. Plans and Providers carefully negotiate their plan 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 Provider commonly depends upon the degree to which the contract delegates financial risk to the Provider. Generally, the more services the Provider agrees to provide within the capitated

rate, the higher the capitated rate. Conversely, the more services that remain the financial responsibility of the Plan, the lower the capitated rate. One service that typically is negotiated in these contracts is laboratory services, including testing for new diseases like COVID-19. Providers that accept financial responsibility for such testing generally are able to negotiate higher capitated rates than those that do not.

26. The use of capitation agreements greatly benefitted Providers during the COVID-19 pandemic, inasmuch as they received their full capitation payments each month despite having experienced a significant diminution in medical treatments. Indeed, many Providers ceased performing many procedures that were customarily performed each month and Enrollees were instructed to await treatment until COVID-19 infection rates diminished.

27. 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." H&S Code § 1375.5.

B. Obligation of Plans to Provide Medically Necessary Services to their Enrollees.

28. California law compels Plans to cover a variety of services, including all medically necessary "basic health care services." H&S Code §§ 1345(b), 1367(i); Cal. Code Regs. tit. 28, § 1300.67.

29. Among the items and services that 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, Plans contract with Providers to provide health care services to the Plans' Enrollees.

C. DMHC's Emergency Regulation & CAHP's Challenge to a Portion Thereof.

1. DMHC's Emergency Regulation & Its Cost Shifting Mandate.

30. On July 17, 2020, DMHC promulgated its Emergency Regulation on COVID-19 Diagnostic Testing dated July 15, 2020 (the "Emergency Regulation"), without

giving the public any opportunity to submit comments or participate in a public hearing. The Emergency Regulation immediately became effective as section 1300.67.01 of Title 28 of the California Code of Regulations.

31. Subdivision (c) of the Emergency Regulation declared that COVID-19 Testing was a medically necessary basic health care service for Enrollees defined as "essential workers," regardless of whether the enrollee had any symptoms of COVID-19 infection or a known or suspected exposure to a person with COVID-19 infection. In effect, the Emergency Regulation created a broad medical necessity presumption for any person who was an essential worker, regardless of whether a clinician determined that the laboratory test was medically necessary.

32. In addition, subdivision (d) of the Emergency Regulation purported to bar Plans from enforcing their previously negotiated capitation agreements. Specifically, subdivision (d) stated as follows:

> 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).

33. In effect, subdivision (d) of the Emergency Regulation constituted a cost shifting mandate that required Plans to pay the cost of COVID-19 Testing and related services, even if a Plan's existing contract with a Provider delegated the financial risk and related cost of diagnostic testing to the Provider.

34. The cost shifting mandate in the Emergency Regulation immediately and materially disrupted existing carefully bargained-for contractual arrangements – arrangements that have often existed for decades and been relied upon by both Plans and Providers to conduct their operations in a way that promotes the efficient delivery of health

care services to California citizens. The cost shifting mandate in the Emergency Regulation stripped Plans of their bargained-for contractual allocation of financial risk associated with diagnostic testing and the undefined "related items and services."

2. The Los Angeles Superior Court Declares the Cost Shifting Mandate Invalid for Failure to Comply with the Administrative Procedure Act.

35. On November 13, 2020, roughly one year ago, CAHP filed a lawsuit in this Court challenging the cost shifting mandate in the Emergency Regulation on the grounds that it: (i) was promulgated in violation of the California Administrative Procedure Act ("APA"), and (ii) violated the California Constitution. The lawsuit was entitled *California Association of Health Plans v. Mary Watanabe, et al.* and was known as Los Angeles Superior Court Case No. 20STCP03773 ("*Watanabe I*," whereas this lawsuit is referred to as "*Watanabe II*").

36. CAHP explained in *Watanabe I* that DMHC's conduct in enacting the cost shifting mandate in the Emergency Regulation was not only unlawful and irrational, but that it threatened the delivery of reliable, cost-effective health care to California citizens, inasmuch as California's health care delivery system depends on the ability of Plans and 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, DMHC acted capriciously and beyond its authority to increase the risk that Plans, Sponsors, Enrollees and Providers face, and this increased risk ultimately would harm California citizens by driving up the cost of health care.

37. The trial court, Honorable Mitchell L. Beckloff, initially bifurcated the trial on CAHP's challenge to the cost shifting mandate in the Emergency Regulation, taking up the APA claims in the first trial stage, and deferring the constitutional claims for the second trial stage.

38. In its trial brief filed by the Attorney General on behalf of DMHC in *Watanabe I*, DMHC explained the legal landscape and justification for promulgating the Emergency Regulation as follows:

> Under the Families First and Coronavirus Relief Act (FFCRA), as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), health insurers were required to cover COVID-1 test costs for their insured members without any cost sharing required from the patients and without prior authorization or medical management requirements, for as long as the federally-declared public health emergency remains in effect. The federal Departments of Labor, Treasury and Health and Human Services initially issued subregulatory guidance on April 11, 2020, to provide guidance as to the FFCRA and CARES Act requirements for COVID-19 testing and related health coverage issues.
>
> However, on June 23, 2020, federal authorities issued updated sub-regulatory guidance that created uncertainty over the extent to which health care insurers were required to cover COVID-19 testing costs. By way of example, the sub-regulatory guidance explained that the mandate to cover testing with no cost-sharing applies to all types of COVID-10 diagnostics – PCR tests, antigen detection tests, and serology tests – including when a patient is asymptomatic, but it also interpreted testing requirements to only apply to testing done for "diagnostic purposes" and "when medically appropriate for the individual, as determined by the individual's attending health care provider in accordance with accepted standards of current medical practice." In addition, the federal sub-regulatory guidance stated that health plans need not cover testing donc for general workplace safety or public health surveillance, because these tests are not for "individualized diagnosis or treatment." The sub-regulatory guidance suggested that health plans are not required to reimburse for tests than an individual is required to obtain to return to work or because they are essential workers, which meant that workers might be expected to pay for those tests themselves. This created ambiguity about coverage for tests in circumstances where a person has no specific reasons to suspect exposure but wants to be sure of a negative result or where a person needs testing results as part of his or her job.
>
> Around the same time, California was seeing summer surges in COVID-19 cases while seeking to open up sectors of its economy. As a result of this surge, the State faced an acutely critical need to test essential workers regardless of either suspected exposure or whether they were exhibiting symptoms of COVID-19.
>
> In this context, DMHC adopted the regulation on an emergency basis on July 17, 2020.

Watanabe I, Respondents' [DMHC's] Brief for Phase 1 of Action at 6-7 (Internal citations omitted).

39. Further, in its trial brief filed by the Attorney General, DMHC explained its interpretation of subdivision (d) of the Emergency Regulation, in pertinent part, as follows:

> [T]he global COVID-19 pandemic has unexpectedly made it necessary to conduct widespread, recurring testing in an effort to control the spread of the disease. This necessary testing, including the volume of testing required to protect public health, could not have been foreseen when providers and plans negotiated the amount of the monthly payments to be made to provider under pre-pandemic capitation contracts. Therefore, apportionment of the financial responsibility for the tests between health plans and providers constitutes a material change in their contacts, which must be negotiated under both the terms of Subdivision (d) of the Regulation and preexisting California statutory law.

Watanabe I, Respondents' [DMHC's] Brief for Phase 1 of Action at 10.

40. Hence, the cost shifting mandate in the Emergency Regulation stripped Plans of their bargained-for contractual allocation of financial risk associated with Testing and mandated that Plans renegotiate those agreements.

41. DMHC sought to justify its promulgation of the cost shifting mandate on the grounds that Providers, despite their sophistication and experience in negotiating capitation agreements, should be excused from the consequences of their decision.

42. At the conclusion of the first trial stage, on or about April 13, 2021, the Court issued an order finding that DMHC failed to comply with the APA when adopting subdivision (d) of the Emergency Regulation (i.e., the cost shifting mandate).

43. Accordingly, on or about May 5, 2021, the Court issued judgment in favor of CAHP, along with a writ of mandate directing DMHC to: (i) cease any existing enforcement of Subdivision (d), (ii) refrain from any future enforcement activity based upon Subdivision (d), and (iii) withdraw Subdivision (d).

44. In effect, subdivision (d) of the Emergency Regulation, the cost shifting mandate, was stricken from the Emergency Regulation.

45. DMHC did not appeal the Court's judgment in *Watanabe I*.

46. DMHC did not seek to extend the balance of the Emergency Regulation. Accordingly, the Emergency Regulation expired on or about May 15, 2021.

47. In summary, (i) DMHC took the position in *Watanabe I* that, under federal law, "health plans need not cover [COVID-19] testing done for general workplace safety or public health surveillance," and (ii) the Court struck the cost shifting mandate in subdivision (d) of the Emergency Regulation.

D. The Legislature's Enactment of SB 510.

48. On February 17, 2021, roughly three months after the commencement of *Watanabe I*, California State Senator Richard Pan, himself a Provider, introduced SB 510 in the California Legislature (the "Legislature").

49. SB 510 was sponsored by the California Medical Association, a trade association representing California physicians – i.e., Providers.

50. SB 510 added sections 1342.2 and 1342.3 to the H&S Code and sections 10110.7 and 10110.75 to the Insurance Code ("Ins. Code").

51. Among other components, SB 510 includes virtually the same cost shifting mandate as that which was contained in the Emergency Regulation and stricken at the direction of this Court.

52. SB 510 was passed by the Legislature and thereupon signed by Governor Newsom on October 8, 2021.

E. The Components of SB 510 Challenged Herein.

53. CAHP is not challenging the entirety of SB 510. Rather, CAHP is challenging only a single provision thereof – namely, subdivision (d) of H&S Code section 1342.2 as it relates to the statute's Retroactive Mandates/Prohibitions.

54. Moreover, while SB 510 contains similar provisions applicable to Plans (i.e., sections 1342.2 and 1342.3 of the Health & Safety Code) and disability insurers (i.e., sections 10110.7 and 10110.75 of the Insurance Code), CAHP's challenge to SB 510 is limited to the retroactive provision applicable to Plans.

F. **Enforcement Mechanisms for SB 510.**

55. SB 510 gives Providers, Enrollees and possibly Sponsors the right to assert civil claims against Plans for failure to comply with its provisions, including the aforementioned components of SB 510 challenged herein on a retroactive basis. For example, a Provider could rely upon the Retroactive Mandates/Prohibitions to (i) refuse to pay for pre-January 1, 2022 Testing despite existing and enforceable contracts delegating the cost of such Testing to the Provider; (ii) demand that a Plan make co-payments or other cost-sharing payments to a Provider on behalf of an Enrollee, even though the Plan had no obligation to do so under the law or contractual arrangements existing at the time; or (iii) demand that a Plan pay the Provider for Testing that the Plan was not obligated to cover under the law or contractual arrangements existing at the time.

56. By virtue of its inclusion within the Health and Safety Code, SB 510 gives DMHC the power to impose penalties on Plans for the failure to comply with SB 510, including the Retroactive Mandates/Prohibitions. As discussed above, this includes giving DMHC the power to impose penalties on Plans for enforcing co-payment and other cost-sharing provisions that not only were legal and proper at the time, but which DMHC had agreed were legal and proper.

57. Finally, SB 510 exposes Plans to possible criminal penalties.

a. SB 510 added two sections to the Knox-Keene Act (including the aforementioned H&S Code section 1342.2) and existing law provides that a violation of the Knox-Keene Act is a crime. *See, e.g.,* H&S Code § 1390; *Pagarigan v. Superior Court*, 102 Cal. App. 4th 1121 (2002) (noting that anyone who violates the Knox-Keene Act "is subject to criminal prosecution"); *Schmidt v. Foundation Health*, 35 Cal. App. 4th 1702 (1995) (penalties for violating the Knox-Keene Act include "criminal prosecution"); *Solorzano v. Superior Court*, 10 Cal. App. 4th 1135 (1992) (anyone who violates the Knox-Keene Act "is subject to criminal prosecution.")

b. Likewise, the Legislative Counsel's Digest located at the very top of SB 510, just above the bill text itself, states in relevant part as follows:

> ***Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime.*** Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.
>
> This bill would require a health care service plan contract or a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health care service plan contract or health insurance policy, to cover the costs for COVID-19 diagnostic and screening testing and health care services related to the testing for COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, and would prohibit that contract or policy from imposing cost sharing or prior authorization requirements for that coverage. The bill would also require a contract or policy to cover without cost sharing or prior authorization an item, service, or immunization intended to prevent or mitigate COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, that is recommended by the United States Preventive Services Task Force or the federal Centers for Disease Control and Prevention, as specified. The bill would only extend the prohibition on cost sharing for COVID-19 diagnostic and screening testing, or an item, service, or immunization intended to prevent or mitigate COVID-19, with respect to an out-of-network provider for the duration of the federal public health emergency. The bill would also apply these provisions retroactively beginning from the Governor's declared State of Emergency related to COVID-19 on March 4, 2020. The bill would make the provisions of the act severable. The bill would also make related findings and declarations. ***Because a violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.***
>
> The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.
>
> This bill would provide that no reimbursement is required by this act for a specified reason. [Emphasis added.]

58. Section 2 of SB 510 provides, in relevant part, that it operates retroactively. Specifically, H&S Code section 1342.2(d) states as follows:

> This section [i.e., H&S Code section 1342.2] shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020.

Consequently, the determination as to whether the retroactive application of SB 510 is unconstitutional depends, in relevant part, on the law as of the moment immediately prior to the retroactive application of SB 510.

59. The retroactive application of SB 510 modifies existing law.

G. CAHP's Exposure to Harm by Retroactive Application of SB 510.

60. CAHP members will likely suffer significant damages if CAHP's claims alleged herein are not promptly addressed.

61. CAHP's concern as to the Retroactive Mandates/Prohibitions is not merely hypothetical.

a. Despite the fact that SB 510 does not go into effect until January 1, 2022, CAHP members have already received demands from Providers for payments based upon the Retroactive Mandates/Prohibitions.

b. CAHP also reasonably believes that DMHC will enforce the Retroactive Mandates/Prohibitions given DMHC's prior conduct. DMHC originally sought to implement its cost shifting mandate by the promulgation of the Emergency Regulation. CAHP derailed DMHC's plans by obtaining an order from this Court in *Watanabe I* barring DMHC from enforcing the retroactive cost shifting mandate in the Emergency Regulation. But even then, Providers' efforts to achieve a retroactive cost shifting mandate did not end there. Rather, the California Medical Association, a trade association representing Providers, sponsored the enactment of SB 510, which includes virtually the same retroactive cost-shifting mandate as that which this Court struck down in *Watanabe I*. But this time, the Retroactive Mandates/Prohibitions come with the express threat of criminal penalties. Indeed, so as to eliminate any doubt as to that point, the text of SB 510 repeatedly states the word "crime."

H. Plans' Setting of Rates for Health Care Coverage.

62. CAHP's members customarily set their rates at a level at which they collect sufficient revenues to cover the cost of the Plan's operation of that healthcare program.

63. To the extent that the Legislature enacts a statute imposing new coverage mandates, provided that the statute applies solely on a prospective basis, Plans can account for the cost of these new coverage mandates when determining the rates that they will charge for the future period.

64. However, when the Legislature enacts a statute imposing new coverage mandates or limitations on existing cost sharing obligations that apply on a retroactive basis, Plans are unable to account for the cost of these new coverage mandates and limitations on existing cost sharing obligations, inasmuch as the Plans previously determined their rates and collected their charges. Moreover, Plans generally are unable to recoup past losses from future rate increases.

65. Accordingly, the Legislature's enactment of a statute imposing new coverage mandates or limitations on existing cost sharing obligations that apply on a retroactive basis may prevent Plans from collecting sufficient subscription fees and other revenues needed to cover the cost of operating their health care service plans.

I. Requisites for Relief.

66. Providers have already made demands to CAHP member Plans for amounts due by the retroactive application of H&S Code section 1342.2, and thus, CAHP needs relief immediately.

67. CAHP lacks a plain, speedy, and adequate remedy at law except by way of writ of mandate. No money damages or other legal remedy could adequately compensate CAHP and its members caused by Defendants'/Respondents' failure to perform their legal duty.

68. In light of the aforementioned facts and circumstances, no demand has been made upon Defendants/Respondents to perform their duties, as such a demand would be futile.

J. The Requested Relief is Narrowly Tailored & Does Not Affect Vaccinations.

69. The requested relief is narrowly tailored.

70. The requested relief does not affect COVID-19 vaccinations. Indeed, Plans have covered the cost of administering COVID-19 vaccinations without copayments or cost-sharing.

71. The requested relief is limited to (i) preventing the enforcement of the Retroactive Mandates/Prohibitions by DMHC or other interested parties where such mandates and prohibitions conflict with the law and contractual arrangements in existence at the relevant time, and (ii) preventing the ex post facto criminalization of prior conduct.

K. Violation of the California Constitution.

72. The Legislature's enactment of subdivision (d) of H&S Code section 1342.2 violates a host of provisions within the California Constitution.

1. Violation of the Contracts Clause.

73. The Contracts Clause contained in Article I, Section 9 of the California Constitution prohibits the Legislature from passing any law that retroactively impairs the obligation of a contract.

74. Subdivision (d) of H&S Code section 1342.2 substantially impairs the contracts among CAHP's member Plans and Providers that were executed prior to the Governor's declaration of a public health emergency on March 4, 2020.

75. The Legislature did not have a significant and legitimate public purpose in enacting subdivision (d) of H&S Code section 1342.2.

76. The retroactive adjustment of the rights and responsibilities of Plans and Providers to capitated agreements was not based upon reasonable conditions, nor was such adjustment of a character appropriate to the public health purpose supposedly justifying the adoption of subdivision (d) of H&S Code section 1342.2 and the Retroactive Mandates/Prohibitions.

77. Further, there was no economic need for the Retroactive Mandates/Prohibitions. Under the CARES Act, Providers received grants on a massive

scale. These enormous public subsidies provided, or otherwise made available, to Providers under the CARES Act undermine any conclusion that the government needs to shift the cost of COVID-19 Testing away from Providers and onto Plans in derogation of their contractual commitments. Indeed, the federal government itself recognized that there is no need to force Plans to incur the cost of COVID-19 Testing as DMHC sought to accomplish in the Emergency Regulation and the Legislature has sought to accomplish through SB 510. 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 enactment of SB 510, did not require Plans to incur the cost of all COVID-19 Testing, further confirms that there was no legitimate basis for impairing Plan contracts with Providers on a retroactive basis.

78. For the reasons set forth above, the Legislature's enactment of subdivision (d) of H&S Code section 1342.2 violates the Contracts Clause.

2. Violation of the Ex Post Facto Clause.

79. The Ex Post Facto Clause contained in Article I, Section 9 of the California Constitution prohibits the Legislature from passing any law after-the-fact that makes an action done before the passing of the law, and which was lawful when done, criminal or punitive.

80. Subdivision (d) of H&S Code section 1342.2 operates on a retroactive basis and thereby applies to conduct committed before such statute took effect.

81. Subdivision (d) of H&S Code section 1342.2 criminalizes conduct that was lawful when performed.

82. The Legislature meant to impose punishment for a retroactive violation of the Mandates/Prohibitions. Indeed, the very language of SB 510 repeatedly asserts that a violation of the statute constitutes a "crime."

83. In addition, the Knox-Keene Act imposes penalties, including criminal penalties, for a violation thereof. Among other provisions, H&S Code section 1390 provides that a violation of the Knox-Keene Act constitutes a crime for which the offender can be fined and/or imprisoned.

84. Thus, any failure on the part of a Plan to comply with the Retroactive Mandates/Prohibitions exposes the Plan to penalties, including criminal penalties.

85. For the reasons set forth above, subdivision (d) of H&S Code section 1342.2 facially violates the Ex Post Facto Clause.

3. Violation of the Due Process Clause.

86. The Due Process Clause contained in Article I, Section 7 of the California Constitution prohibits the Legislature from passing any law that retroactively deprives a business of its property by impermissibly creating unforeseen liability for past actions.

87. Subdivision (d) of H&S Code section 1342.2 not only readjusts the rights of burdens of Plans under their capitated agreements with Providers, but such law is not supported by a legitimate legislative purpose furthered by rational means, and is harsh and oppressive and/or arbitrary and irrational.

88. Here, the opening subdivision of SB 510 reveals that there does not exist a legitimate legislative purpose furthered by rational means for the retroactive implementation of the Mandates/Prohibitions. Specifically, subdivision 1 of SB 510 states as follows:

> The Legislature finds and declares that a significant public health crisis, including the crisis posed by the COVID-19 pandemic that is the subject of the state of emergency declared by the Governor of the State of California on March 4, 2020, necessitates legislation to ensure that individuals are not discouraged from seeking testing or vaccination due to cost sharing or requirements. **To ensure that health care service plans and health insurers do not impose cost sharing or prior authorization requirements that might discourage**

> **individuals from seeking and receiving testing and vaccinations for a pandemic condition**, it is the intent of the Legislature in enacting this act to require coverage for testing costs without cost sharing or prior authorization and to require coverage for prevention recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. In this regard, **the Legislature further finds and declares that this exercise of the police power imposes a reasonable condition that is of a character appropriate to the public purpose of ensuring that as many individuals as possible receive necessary testing and vaccination in response to a pandemic**. [Emphasis added.]

In other words, the Legislature enacted subdivision (d) of H&S Code section 1342.2 in order to increase COVID-19 Testing. But imposing the Retroactive Mandates/Prohibitions for a past period does nothing to increase COVID-19 Testing performed during that past period; nor could it, inasmuch as nothing enacted by the Legislature can change the history of that past period.

89. Further, even if this Court were inclined to give any deference to the Legislature under the due process standard, no such deference should be granted herein, inasmuch as the State of California is the sponsor and/or beneficiary of: (i) health plans involving CAHP members, and/or (ii) government owned and/or operated Providers.

90. For the reasons set forth above, the Legislature's enactment of subdivision (d) of H&S Code section 1342.2 violates the Due Process Clause.

4. <u>Violation of the Takings Clause</u>.

91. The Takings Clause contained in Article I, Section 19 of the California Constitution prohibits the taking of private property for public use without just compensation.

92. In addition, the Takings Clause offers a safeguard against the Legislature's enactment of retroactive laws affecting property rights.

93. Subdivision (d) of H&S Code section 1342.2 deprives CAHP's members of their property rights without just compensation.

94. For the reasons set forth above, the Legislature's enactment of subdivision (d) of H&S Code section 1342.2 violates the Takings Clause.

VI. CLAIMS FOR RELIEF

FIRST CAUSE OF ACTION

(WRIT OF MANDAMUS AND/OR PROHIBITION)

95. CAHP incorporates by reference paragraphs 1 through 94 of this Petition and Complaint as if fully set forth herein.

96. CAHP contends that the Legislature lacked authority to enact subdivision (d) of H&S Code section 1342.2 because it violates the California Constitution.

97. For the reasons set forth above, CAHP is entitled to a writ of mandamus and/or prohibition ordering the Director, the Department and the Attorney General to refrain from enforcing subdivision (d) of H&S Code section 1342.2.

SECOND CAUSE OF ACTION

(DECLARATORY RELIEF)

98. CAHP incorporates by reference paragraphs 1 through 94 of this Petition and Complaint as if fully set forth herein.

99. CAHP contends that the Retroactive Mandates/Prohibitions are invalid and unenforceable on account of their violation of the California Constitution. CAHP is informed and believes that DMHC disputes this contention. There is accordingly an actual and present controversy concerning the enforceability of subdivision (d) of H&S Code section 1342.2.

100. For the reasons set forth above, CAHP is entitled to a judicial declaration that subdivision (d) of H&S Code section 1342.2 is invalid and unenforceable.

THIRD CAUSE OF ACTION

(INJUNCTIVE RELIEF)

101. CAHP incorporates by reference paragraphs 1 through 94 of this Petition and Complaint as if fully set forth herein.

102. CAHP contends that subdivision (d) of H&S Code section 1342.2 violates the California Constitution.

103. For the reasons set forth above, CAHP is entitled to a preliminary and permanent injunction enjoining the enforcement of subdivision (d) of H&S Code section 1342.2.

REQUEST FOR RELIEF

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

A. A writ of mandamus and/or prohibition directing the Director, the Department and the Attorney General to refrain from enforcing subdivision (d) of H&S Code section 1342.2;

B. A judicial declaration that:

1. Subdivision (d) of H&S Code section 1342.2 is void and unenforceable; and

2. CAHP's members have no obligation to comply with H&S Code section 1342.2 with respect to any acts or omissions occurring prior to January 1, 2022;

C. A preliminary and permanent injunction enjoining the enforcement of subdivision (d) of H&S Code section 1342.2; and

D. Awarding CAHP costs of suit, attorneys' fees pursuant to Code of Civil Procedure section 1021.5, and such other relief as the Court deems appropriate.

Dated: November 10, 2021 SHEPPARD, MULLIN, RICHTER & HAMPTON LLP

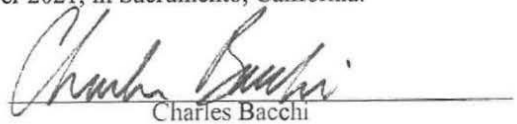
By _____
MOE KESHAVARZI
JOHN T. BROOKS
TODD L. PADNOS
Attorneys for Plaintiff & Petitioner
CALIFORNIA ASSOCIATION OF HEALTH PLANS

Verification

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 and/or Prohibition and Complaint For Declaratory & Injunctive Relief* and know the contents thereof. The facts alleged therein are true of my own knowledge.

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

Executed this 10th day of November 2021, in Sacramento, California.



Charles Bacchi