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No. S218497

In the Supreme Court of the State of California

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CENTINELA FREEMAN EMERGENCY MEDICAL ASSOCIATES, ET AL.,
Plaintiffs, Appellants, and Respondents

vs.

HEALTH NET OF CALIFORNIA, INC., ET AL.,
Defendants, Respondents, and Petitioners

SUPREME COURT
FILED

MAR 22 2016

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AMICUS CURIAE BRIEF OF THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE IN RESPONSE TO THE COURT'S INVITATION

After an Opinion By The Court of Appeal
Second Appellate District, Division Three, No. B238867

Appeal from a Judgment of the Los Angeles County
Superior Court Case No. BC415203, Hon. John Shepard Wiley

Service on the Attorney General and the Los Angeles District Attorney Required by Bus. & Prof. Code § 17209 and California Rules of Court Rule 8.29(a) and (b)

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QUESTION PRESENTED

In response to this Court's order of February 3, 2016, and pursuant to California Rules of Court, rule 8.520, the Department of Managed Health Care (DMHC) submits this brief as amicus curiae expressing its views on the specific two-part question posed:

"In light of the Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340 et seq.) and the DMHC's implementing regulations, does a health care service plan owe a common law tort duty of care to non-contracting emergency service providers, who provide emergency care on a statutorily compelled basis to the health plan's enrollees, in either (1) making or (2) continuing a delegation of its financial responsibility for payment of the providers' claims to [a risk-bearing organization]?"[1]

INTRODUCTION

The Department of Managed Health Care (DMHC) appreciates this Court's invitation to be heard on an issue that could significantly impact the

[1] The Court's question uses the phrase "individual practice association," while the parties and amici curiae used "independent physicians association" and "independent practice association." The DMHC uses the term risk-bearing organization (or RBO), because it is the label used by the Legislature and encompasses all of the terms used by the Court, parties, and amici curiae, to mean the organized group of physicians to whom the Respondent Health Plans delegated their obligation. (See Health & Saf. Code, § 1375.4, subd. (g)(1).)

health plans that the Department regulates and the consumers that it protects. The Court of Appeal's holding – that a health care service plan has an initial and continuing duty not to delegate its obligation to reimburse emergency care providers to a risk-bearing organization (RBO) that the plan knows or has reason to know will be unable to make payment – creates a common law duty that is outside of the existing statutory and regulatory mandates of the DMHC. The parties and amici curiae have extensively briefed their respective arguments on this holding, and especially the general law regarding tort duties and the foreseeability of harm to the non-contracted emergency providers who brought suit. Therefore, the DMHC – with expertise grounded in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the DMHC's implementing regulations – instead will provide an analysis absent (for the most part) in the arguments to date: the overall impact such torts would have on the delivery of managed care, with particular focus on the impact to California consumers.

The DMHC is charged with protecting the public through its licensing and regulation of health care service plans. (Health & Saf. Code, §1342.)[2] It has broad jurisdiction to execute California laws relating to health care service plans[3] and the health care service plan industry. (§

[2] All further statutory references are to the Health and Safety Code unless otherwise noted.

[3] Hereinafter, referred to as "health plans."

1341, subd. (a).) The DMHC's mission is to ensure a stable and accessible health care delivery system, and in so doing, to protect the health care rights of the more than 25 million Californians who receive their care by way of health care service plans.

To answer the Court's specific question, although the Knox-Keene Act and its implementing regulations relating to health plan and RBO financial oversight do not expressly preempt tort causes of action in the narrow circumstances of this case, the DMHC respectfully submits that judicial recognition of tort causes of action in this area is unwarranted, and could ultimately be harmful to California's managed care system and the very consumers the Knox-Keene Act was designed to protect. To make this point, the DMHC will focus on the value of, and risks associated with, the delegated model of health care, the underlying regulatory scheme governing the delegation relationship between health plans and RBOs, and the lessons learned from the RBO failure at issue in this case. Woven into this discussion is an evaluation of how a common law cause of action for negligent delegation or negligent continuation of that delegation, created in response to these infrequent circumstances, could adversely impact health plans, RBOs, and ultimately, consumers.

ARGUMENT

I. The Delegated Health Care Model Provides Valuable Benefits to Members Through a Carefully Balanced Structure for Assigning Risk

A. The Legislative Intent Favoring Delegation

As will be discussed, many of the statutes and regulations within the DMHC's jurisdiction impose stringent requirements and obligations on health plans. Others are permissive (such as the emergency claims payment delegation per § 1371.4, subdivision (e)), allowing health plans the flexibility to structure their businesses and contractual arrangements to better serve consumers, achieve efficiency, and provide affordable care. Health plan delegation of various functions to providers, including claims payment risk, is a fundamental concept of managed care, an area where California remains a national leader.

Delegated obligations include the provision of health care services, coordination of care, utilization management of medical services, assurance of quality services, and payment of claims. The delegated model not only allows, but also encourages, health plans and the provider groups with which they contract to better manage the care of health plan members. Medical decision-making is transferred to those physicians closest to the actual care of plan members and who know their patients best.

Additionally, the delegated model helps to lower health care costs for patients "by transferring the financial risk of health care from patients to

providers." (§ 1342, subd. (d).) A health plan assigns risk by delegating its obligations to an RBO. In exchange for the RBO's assumption of these delegated responsibilities, the health plan agrees to pay the RBO a fixed amount ("capitation") for each member (on a per member, per month basis.) (Cal. Code Regs., tit. 28, §§ 1300.76, subd. (f) & 1300.75.4, subd. (d).)[4] Under the delegated model, members pay their health plan premiums with the expectation they will receive all basic health care services; and, in turn, the health plan pays a capitated rate to the RBO with the expectation that the RBO will deliver high-quality services and perform the delegated duties.

The health plan is incentivized to delegate the risk responsibly to an RBO that is financially able to perform the delegated functions, or the health plan risks dissatisfaction by its members due to disruption and potential medical and financial harm to those consumers if the RBO fails to perform. Likewise, the RBO has an incentive to control overall costs by effectively managing member care, because the capitation payment it receives from the health plan is fixed. The delegated model is favorable to consumers because it is designed to keep members' health care costs predictable and affordable and bring the medical decision-making closer to the members.

[4] All citations to Title 28 of the California Code of Regulations are hereinafter abbreviated as "Regs."

B. Health Plans, RBOs, and Providers Are Sophisticated Entities in a Carefully Balanced Industry

Health plan members have a reasonable, and statutory, expectation that their health plans will cover the costs of their emergency care. (§ 1371.4, subd. (b).) It is one of the main reasons consumers buy health coverage. In fact, for generally healthy people, the highest costs of their care are associated with unexpected emergencies.

The provision of emergency care is improved by the incentives inherent in managed care, and the delegated model specifically. RBOs, with the knowledge, experience, and good management of their members' chronic conditions and provision of early preventative treatment, are often able to avoid otherwise preventable medical costs, including reducing and re-directing members away from unnecessary emergency visits, in favor of care that is more directly managed and delivered by members' primary care physicians. This contains costs and improves health outcomes.

Even so, financial risk for RBOs is ever-present because primary care physicians are not always able to direct and manage emergency care in every circumstance. When an emergency arises, health plan members often go to the nearest emergency facility – whether the facility and its attending physicians have a contract with the members' health plan or not – where under the law, the members must be treated to the point of stabilization. (§ 1371.4, subd. (b).) Non-contracted emergency providers are by law entitled

to reimbursement at the reasonable and customary rate for the emergency services they perform. (Regs., § 1300.71, subd. (a)(3)(B).)

The risk that health plans, and correspondingly any RBO to whom they have delegated risk, must pay for what is often expensive, non-contracted emergency care for its members is therefore inherent in the managed care model. The cost risk of emergency services is initially shifted from members to their health plans; then by health plans to their delegated RBOs. The law supports this relationship, which is grounded in good public policy, as the Legislature intended that members pre-pay for their emergency care, leaving any payment disputes to be resolved by health plans and providers. (See *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group* (2009) 45 Cal.4th 497, 509 [emergency room doctors, in delegated managed care context, may not "bill patients for any amount in dispute"]; § 1371.4, subd. (e).) Non-contracted emergency providers operate with full knowledge of the inherent financial risk associated with the very nature of emergency care – the legal requirement that they treat all persons who present at the emergency room, regardless of ability to pay.

As the system is currently calibrated, health plans, RBOs, and emergency providers are all incentivized to look to their experience with the delegated model, rely on their business judgment, weigh their respective financial risks, and plan and negotiate accordingly. In the vast majority of

circumstances, that system works well. Imposing a tort duty based on the narrow circumstances here of non-contracted emergency providers seeking reimbursement would likely cause health plans, RBOs, and providers to cautiously plan for additional litigation and costs for their emergency risk, and at the expense of consumers by way of higher premiums. As a result, while health plans might respond to the new tort duty with greater diligence regarding RBO financial solvency, they may also decide that higher premiums, co-pays, and deductibles may be necessary. Further, as explained more fully below, the health plans will likely seek to avoid this new tort liability by, as a matter of risk management, more quickly terminating a delegation at the first sign of trouble, which may not always be a good indicator of an RBO's ultimate demise. And these hastier actions will work to the detriment of members by necessitating their re-assignment to potentially new medical providers.

II. Existing Oversight of RBO Financial Solvency is Extensive, But Does not Expressly Preclude the Specific Tort Claims Here

A. The Regulations Are Designed to Facilitate Delegation To RBOs, But Do Not Preclude Greater Scrutiny of Their Finances

The laws governing the formation of the delegation relationship between health plans and RBOs consistently encourage delegation, but the overall structure does not expressly preclude the specific tort claims at issue in this case – provided that the claims remain appropriately narrow.

Health plan delegation contracts with RBOs are governed by statute and regulation. (*See* § 1375.4 and Regs. § 1300.75.5, subds. (b) & (c).) The RBO must be qualified under the statutory definition of section 1375.4, subdivision (g)(1), and must show it is an appropriately structured medical organization (not an individual or a health plan) that does all of the following:

> "(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.
> (B) Receives compensation for those services on any capitated or fixed periodic payment basis.
> (C) Is responsible for processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization."

Instead of a license, the DMHC assigns a qualified RBO an identification (ID) number and then adds the RBO to the DMHC List (List), available on the DMHC's website.[5] (Regs. § 1300.75.4.4, subd. (b)(1)(A).) With an ID number, the RBO is permitted to accept contractually delegated risk from health plans. (Regs. § 1300.75.4, subd. (d)(2).)

The relevant statutes and regulations are clear that health plans and RBOs are expected to thoroughly negotiate the risk to be assumed. (§

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[5] *Licensing and Reporting/Risk Bearing Organizations* (Cal. Dept. of Managed Health Care) <http://www.dmhc.ca.gov/licensingreporting/riskbearingorganizations.aspx#.vsayte0uwic>

1375.5.) The health plan must disclose information for the RBO to make an informed decision regarding the financial risk. (§ 1375.4, subd. (a)(1) and (a)(2).) Regulations require detailed risk arrangement disclosures, including (but not limited to) information about the group or individual members delegated to the RBO, the type of risk arrangement, a matrix of responsibility for medical expenses, projected utilization, and all factors used to adjust payments or risk-sharing targets. (Regs. §1300.75.4.1.)

In turn, the RBO must provide to the health plan certain financial solvency information regarding its financial ability to assume the risk. (Regs. §1300.75.4.2.) Such information includes (but is not limited to) balance sheets, income and cash flow statements, and cash and claims payment information. Through this information, the RBO demonstrates financial solvency through the statutory Grading Criteria defined by regulation. (§ 1375.4, subds. (b)(1)(A) (i)-(iv) and Regs. §1300.75.4.4, subd. (b)(1)(B).)

The purpose of these mandates is to ensure that the health plan obtains sufficient information about the RBO's financial solvency and ability to maintain the delegated duties, and the RBO is adequately informed of the financial risk it is assuming. (§ 1375.4, subds. (a)(1) and (a)(2); and Regs. §§ 1300.75.4.1 & 1300.75.4.2.)

Because these disclosure mandates are designed to facilitate successful and informed delegation, they leave latitude for health plans and

RBOs to exercise any greater due diligence they may deem necessary when they enter into a delegation arrangement. A health plan may elect to demand significantly more information about an RBO than is necessary for regulatory compliance. Thus, the Knox-Keene Act and its implementing regulations do not expressly preclude a common law cause of action by a non-contracted emergency provider against a health plan for negligence in the initial delegation of risk to an RBO.

B. Continuing the Delegation of Risk: Current Laws Require Health Plans to Demonstrate the Continued Financial Solvency of their Delegated RBOs and for Corrective Action to Restore Solvency of Distressed RBOs

As with the initial delegation, the current regulatory framework balances the competing interests of the health plans and the RBOs. Again, the balance favors delegation, but also adds in additional protections to guard members against RBO failures and the resulting disruptions to care.

Because the DMHC licenses health plans, but not RBOs, the regulatory structure places primary emphasis on the DMHC's jurisdiction and enforcement authority over the licensed health plans. (§§ 1375.4, 1375.5, 1375.6; and Regs. §§ 1300.75.4 through 1300.75.4.8.) Although a health plan may delegate its obligations to an RBO, it retains continuing contractual responsibilities to the health plan members, and of course, ongoing obligations under the Knox-Keene Act and regulations. The delegation does not relieve the health plan of its statutory duties to have

adequate organizational and administrative capacity, and to demonstrate to the DMHC that it is fiscally sound. (§§ 1367, subd. (g), 1375.1, subd. (a); and Regs. § 1300.75.1.) Specifically, section 1375.1, subdivision (a)(1), requires a health plan to demonstrate to the DMHC that it has "a fiscally sound operation and adequate provision against the risk of insolvency." In determining whether the health plan meets this requirement, the DMHC considers numerous factors, including the "financial soundness' of the plan's arrangement for health care services" and the plan's "agreements with providers for the provision of health care services," which include the very type of capitated delegation contracts that are at issue in this case. (§ 1375.1, subds. (b)(1) & (b)(3).)

Over time, the actual risk delegated and the health plan's capitated payment obligations for that risk do not remain static. The health plan must continue to pay close attention to whether the RBO maintains the financial ability to perform the delegated duties, or face potential scrutiny by the DMHC for its noncompliance with section 1375.1. In fact, continued health plan oversight of the RBO is built into the delegation contract. Per DMHC regulations (specifically defined as "Solvency Regulations") (Regs. §§ 1300.75.4 through 1300.75.4.8) delegation contracts must include regular reporting by the RBO to the DMHC regarding its RBO Grading Criteria performance. Additionally, RBOs must submit to the DMHC financial surveys (essentially financial reports) as well as an annual audit report,

performed by an independent auditor. (Regs. §§ 1300.75.4.1, 1300.75.4.2 & 1300.75.4.3.)

The law also requires a health plan contracting with an RBO to report information to the DMHC within five business days of discovering that a contracted RBO has "experienced any event which materially alters the organization's financial situation or threatens its solvency." (Regs. § 1300.75.4.3, subd. (e).)

Importantly, when an RBO's financial distress becomes apparent, both the health plan and the RBO must take action. RBOs that report deficiencies in any of the financial solvency Grading Criteria must implement a Corrective Action Plan (CAP) to which the health plans must agree. (Regs. §§ 1300.75.4, subd. (g), and 1300.75.4.5.)[6] The RBO first submits a self-initiated CAP proposal to the DMHC and every plan with which the RBO has a risk arrangement contract. (Regs. § 1300.75.4.8, subd. (a).) To the extent possible, the RBO must submit the CAP proposal as a single document that addresses the concerns of all the contracted health plans. (Regs. § 1300.75.4.8, subd. (b).) The Solvency Regulations detail

[6] In addition to the requirement for an RBO to submit a self-initiated CAP when it does not meet the grading criteria, the DMHC may direct an RBO to initiate a CAP if the DMHC determines that an RBO has experienced an event that materially alters its ability to remain compliant with the Grading Criteria, or when the DMHC's financial review process indicates the RBO may lack sufficient financial capacity to meet its contractual obligations. (Regs. §1300.75.4.8, subd. (k).)

the timelines for the CAP proposal approval process, which include deadlines for the health plans to submit objections and recommended revisions, and a provision for attending a CAP Settlement Conference. (Regs. § 1300.75.4.8, subds. (c) through (i).)

The DMHC plays a crucial role as the facilitator in this process among health plans and RBOs, to collectively safeguard against RBO failure and to help the RBO restore financial solvency to meet the Grading Criteria. During the CAP approval process for a struggling RBO, the contracting health plans have a contemporaneous right to terminate the risk arrangement before the CAP is final. Since a fundamental term of the delegation contract between the RBO and the health plans is the requirement that the RBO meet the DMHC-established financial Grading Criteria, failure to meet the Grading Criteria could contractually serve as a basis for the health plan to terminate the agreement. (See § 1375.4, subd. (a)(1); see also Regs. § 1300.75.4.5, subd. (b).) The health plans have the option to continue to participate in the approval process and ultimately partner with the DMHC and the RBO in developing and defining a realistic solution to restore the RBO's financial solvency. They also have the option to refuse.

The CAP is not final until it is approved by the DMHC, which does not happen until: (1) all of the contracting health plans have had full opportunity to raise objections and make recommendations; (2) the RBO

has had a full opportunity to modify the self-initiated CAP; and (3) the DMHC has made its recommendation to approve, disapprove, or modify the final self-initiated CAP proposal. (Regs. § 1300.75.4.8.) When the CAP is final, the DMHC assumes greater control and may exercise authority to enforce the CAP terms, including issuing cease and desist orders for noncompliance with the terms of an approved CAP. The RBO begins implementing the final CAP (Regs. § 1300.75.4.8, subd. (l)(1) & (2)), and the DMHC considers the RBO to be provisionally compliant with the final CAP. Health plans must have DMHC approval before they take action to transfer or reassign members. (Regs. § 1300.75.4.5, subd. (a)(6).) This helps a compliant RBO get back on, and stay on, financial track by preventing health plans from unilaterally, and prematurely, transferring members out of the RBO, thereby potentially causing the RBO's financial failure.

RBOs often contract with multiple health plans that have competing interests (as seen here with the numerous Respondent health plans [the Health Plans])[7] delegating to the RBOs collectively known as La Vida[8]).

[7] The Respondents include Health Net of California, Inc., Blue Cross of California dba Anthem Blue Cross, PacifiCare of California, California Physicians' Service dba Blue Shield of California, Cigna HealthCare of California, Inc., Aetna Health of California, Inc. and SCAN Health Plan. Collectively, they are referred to as Health Plans to distinguish from the general use of the term health plans.

Additionally, different health plans may have varying amounts of financial information, depending on specific reporting requirements in their delegation contracts. The interactive CAP approval process – with a dynamic back-and-forth exchange of information, objections, and recommended revisions by the participants, with input and facilitation by the DMHC – provides all plans with an opportunity to be heard, so that no single plan has an unfair advantage over others. This helps ensure that plans and RBOs stay focused on the goals of financial solvency, performance of the delegated duties, and ultimately, serving the interests of all of the health plans' members.

C. While Tort Claims Are Not Expressly Precluded By the Regulatory Structure, Allowing Such Lawsuits Could Interfere With Procedures for Delegating Risk, Monitoring RBOs, and Implementing Corrective Action for Financially-Troubled RBOs

While the statutory and regulatory procedures for initial delegation to an RBO, monitoring that RBO, and taking corrective action do not expressly preclude the tort causes of action at issue here, neither do they invite the creation of these torts. Such torts are likely to encourage health plans to protect themselves from liability by being overly protective in the initial delegation of risk and being too hasty to end delegation agreements in response to early signs of potential RBO financial trouble.

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[8] La Vida refers to La Vida Medical Group & IPA, La Vida Prairie Medical Group and La Vida Multispecialty Medical Centers.

Further, tort actions could lead to a reduction in the number and diversity of RBOs, particularly in geographic areas with fewer numbers of providers and medical groups, to which health plans are willing to delegate, thereby impacting consumers' choices about who provides their medical care. The regulatory framework encourages delegation and emphasizes a structure surrounding continued delegation focused on protection of the members' interests in accessible and stable health care delivery, including continuity of care. To that end, the CAP process is designed to rehabilitate RBOs and preserve delegation, where possible. As discussed next, historically that process has usually worked well and served the interests of consumers. These new tort causes of action could undermine that success.

III. Recognizing the New Torts Could Harm the Delegated Model and Consumers

Failure of an RBO is disruptive for the affected members. Their established relationships with their physicians are usually severed, and members are required to establish care with new providers who may not yet be familiar with their health history. In the DMHC's experience, such disruptions also often result in a significant strain on the medical group to which the members are transferred. At times, there may not even be another option in a particular geographic region to reassign health plan members. Owing to these challenges, such reassignments often result in disruption in member care.

An RBO failure and consequent reassignment of patients are not a desirable outcome for any of the parties involved. It is far preferable when an RBO can be rehabilitated, if there is a viable means to do so. With foremost consideration for the health plan members' interests, the DMHC encourages health plans to be mindful of their obligations to their members and discourages health plans from terminating risk arrangements with RBOs when rehabilitation appears possible. The DMHC's actions relative to La Vida were guided by this principle.

A. The Financial Failure of La Vida Provides Valuable Lessons, but Does Counsel Recognizing a Tort Cause of Action for Negligent Delegation

In La Vida's case, the CAP approval process ultimately failed. But La Vida, with its unusual circumstances, does not necessarily lead to the conclusion that recognition of new tort causes of action for negligent delegation or negligent continuation of delegation is generally warranted.

The circumstances of La Vida and the magnitude of its financial failure are rare. According to the facts alleged in Centinela's complaint, beginning in 2007 and continuing quarterly thereafter, La Vida failed to comply with several of the DMHC financial Grading Criteria; and the Health Plans were aware of La Vida's worsening financial condition.[9] While La Vida was clearly experiencing financial problems at various times

[9] Appellants' (Centinela) Complaint, page 10, paragraphs 48 – 49 (1AA41.).

in 2007 and 2008, La Vida's collapse was not certain at the time. To avoid the significant disruption of care for the large number of members assigned to La Vida by the multiple Health Plans, the DMHC continued its efforts to facilitate the CAP approval process.

Unfortunately, despite efforts by the Health Plans, La Vida, and the DMHC, the La Vida CAP was never finalized and financial solvency could not be restored. As alleged in Centinela's complaint, in October 2009, La Vida advised the Health Plans that its lender filed bankruptcy and withdrew $4 million from its account, and that – in that time of historic financial crisis – La Vida was unable to obtain money from the contracting capital markets.[10]

In the interest of protecting the Health Plans' members, the DMHC issued Cease and Desist Orders (December Orders) to the Health Plans on December 2, 2009, ordering the Health Plans to immediately cease and desist from assigning or adding any additional members to La Vida.[11] The December Orders were based on the DMHC's findings that La Vida was functionally insolvent and that permitting any expansion of delegation might cause injury to the Health Plans' members. In the months that

[10] Appellants' (Centinela) Complaint, page 11, paragraph 51 (1AA42.).
[11] See, e.g., Matter of Health Net of California, Inc. (Cal. Dept. of Managed Health Care, December 2, 2009, No. 09-468) <http://wpso.dmhc.ca.gov/enfactions/docs/941/1456442686237.pdf>; The December Orders for the other Health Plans are substantially identical and are also on the DMHC website, each with the December 2, 2009 date.

followed, the DMHC continued to engage with La Vida and the Health Plans in an attempt to secure a viable CAP that could turn La Vida around. However, despite the DMHC's best efforts to secure an appropriate CAP from the parties in order to avoid the disruption to members that reassignment of risk or failure would cause, the DMHC could never approve a CAP as viable because La Vida's situation, combined with the economic climate at the time, placed La Vida beyond rescue. In the interests of the Health Plans' members, on May 19, 2010, the DMHC issued Amended Cease and Desist Orders to the remaining Health Plans, ordering them to stop assigning claims payment risk to La Vida and to cease and desist from entering into any new risk contracts with La Vida. [12]

There are lessons that health plans, RBOs and the DMHC have learned from the La Vida experience. La Vida's failure demonstrates the delicate balance inherent in the delegated model when weighing the goal of restoring RBO financial solvency against the potential disruption to health plan members. Although La Vida's reporting showed in 2007 that it was beginning to have financial trouble, it was by no means certain that La Vida

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[12] See, e.g., *Matter of Health Net of California, Inc.* (Cal. Dept. of Managed Health Care, May 19, 2010, No. 09-468) <http://wpso.dmhc.ca.gov/enfactions/docs/941/1456442580886.pdf>; The Orders for the other Health Plans are substantially identical and are also on the DMHC website, each with the May 19, 2010 date.

would not regain its financial footing after the concerted efforts of both the Health Plans and the DMHC. Certainly, one could argue that the Health Plans could have terminated their delegation agreements with La Vida earlier, or transferred members sooner; or the DMHC could have ordered a prohibition on assignment (or mandated the transfer) of members in the earlier stages of La Vida's financial distress. But none of these possible courses of action would have guaranteed that La Vida would have regained financial solvency, or that member care would not have been disrupted, or even that provider claims, including claims from non-contracted emergency providers, would have been paid.

On the other hand, if health plans terminate delegation contracts, transfer members to new and unfamiliar medical providers, or reassume risk too soon at the first signs of RBO financial trouble, such actions could very well result in the earlier demise of an RBO, or cause its demise, when that RBO could have otherwise been restored to financial solvency and performed its delegated responsibilities without disruption of care for its members.

The La Vida facts impart lessons learned for all. If a similar situation occurred today, the DMHC would ensure that the health plan and RBO determine at an earlier stage whether it is feasible and worthwhile to freeze enrollment, transfer members, re-negotiate capitation rates, or obtain additional lender funding. The DMHC would also focus early scrutiny on

the likelihood that the RBO could again reach financial solvency, taking prompt action as soon as it becomes clear that solvency is not possible.

The unusual circumstances in La Vida do not necessarily lead to the conclusion that statutory and regulatory process for initial delegation, continued monitoring, or the CAP process should be supplemented with recognition of new tort causes of action. Indeed, La Vida was an exception. Allowing tort causes of action for negligent delegation or negligent continued delegation, even for the narrow circumstance of unpaid non-contracted emergency providers, could negatively impact the existing comprehensive health care delivery framework by discouraging delegation, causing or hastening an RBO's financial failure, and ultimately disrupting and potentially harming consumers.

B. RBO Failures Were Infrequent in the Past and, With Revisions to the Statutory and Regulatory Framework Since the Late 1990s, Should be Less Frequent in the Future

Experience has shown that, in most cases, the inherent incentive of all parties to prevent RBO failure, along with DMHC's financial solvency oversight of the delegated arrangements between health plans and RBOs – even for those RBOs in some degree of financial distress – has worked well, and that DMHC-approved CAPs have been largely successful. This is in part why California continues to be a leader in managed care. The last ten years have included the worst domestic economic downturn since the

Great Depression. Yet since 2005, only a small number of RBOs, approximately 18, have lost their RBO status because of financial difficulties. The current total number of active RBOs is 178.[13] And while the California Medical Association rightly notes in its amicus curiae brief, at pages 8-10, that several RBOs became financially insolvent in the late 1990s, the heightened statutory and regulatory requirements enacted since then (as described above)[14] have helped to significantly curtail RBO financial problems.[15]

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[13] *Licensing and Reporting/Risk Bearing Organizations* (Cal. Dept. of Managed Health Care) <http://www.dmhc.ca.gov/licensingreporting/riskbearingorganizations.aspx#.vsayte0uwic>

[14] The relevant regulations took effect on September 9, 2005. (Cal.Reg. Notice Register, No. 32.) They were prompted by specific legislation addressing, inter alia, the financial solvency of RBOs, and requiring the promulgation of regulations on that subject. As a result, they are sometimes referred to in the industry, as the SB 260 regulations. They outline requirements for data collection, disclosure language, grading/reviewing and corrective action for RBOs. (Regs §§ 1300.75.4 through 1300.75.4.8) By these statutes and regulations, the DMHC exercises its direct authority over health plan conduct, and consequently, by virtue of delegated arrangements, the DMHC mandates financial reporting and disclosure by RBOs. The DMHC collects and analyzes the financial statements of RBOs on a quarterly and annual basis, which enables the DMHC to closely monitor the financial solvency of RBOs to keep this important component of the managed care system strong. The DMHC public website contains a summary explanation of the SB 260 regulations: <https://www.dmhc.ca.gov/LicensingReporting/RiskBearingOrganizations/SB260Regulation.aspx#.VuijPSz2aMM>

[15] The operative facts in *California Emergency Physicians Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127 and *Ochs v. PacifiCare* (2004) 115 Cal.App.4th 782, pertaining to the failure of the RBO known as Family Health Network, occurred before the SB 260

Additionally, since La Vida went out of business, the DMHC has taken an even more active role in monitoring RBO financial solvency and has taken additional steps to correct problems before they become more serious. In the eight years that have passed since La Vida's financial distress first arose, the DMHC has issued cease and desist orders in multiple cases, prohibiting new assignments to financially insolvent RBOs.[16] These RBOs came into compliance and the DMHC lifted the orders.[17] The DMHC has also issued orders against health plans for their RBOs' failures to comply with financial reporting and inspection requirements.[18] This proactive regulatory approach is in the best interest of consumers because it helps both health plans and RBOs to take careful and appropriate action when an RBO either falls below financial Grading

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regulations became effective and the current regulatory structure came into place.

[16] *E.g.: Matter of DCHS Medical Foundation* (Cal. Dept. of Managed Health Care, March 24, 2015, No. 15-170) <http://otis/apps/enfactions/docs/2285/1429719329214.pdf>; *Matter of Health Net of California, Inc.* (Cal. Dept. of Managed Health Care, February 1, 2012, No. 11-468) <http://otis/apps/enfactions/docs/1870/1345496773433.pdf>

[17] *Matter of DCHS Medical Foundation* (Cal. Dept. of Managed Health Care, March 24, 2015, No. 15-170) <http://otis/apps/enfactions/docs/2285/1438985437002.pdf>

[18] *Matter of Arta Medicare Health Plan, Inc.* (Cal. Dept. of Managed Health Care, July 1, 2011, No. 11-361) <http://otis/apps/enfactions/docs/1738/1311794506794.pdf>; *Matter of California Physicians' Service, et al.* (Cal. Dept. of Managed Health Care, August 8, 2013, No. 13-277) <http://otis/apps/enfactions/docs/1996/1376345873636.pdf>

Criteria or fails to meet reporting requirements. It provides an opportunity for RBOs to restore financial solvency and continue performance of their delegated duties, without unnecessary and potentially harmful consequences to consumers.

C. A Tort Cause of Action for Negligent Delegation is Likely to Discourage Delegation and Negatively Impact Consumers

The specific scope of the questions before the Court is important. If the Court is inclined to create the contemplated causes of action, it would be best for consumers if they were defined as narrowly as possible – limited to just reimbursement of non-contracted emergency physicians – to minimize the disruption that tort causes of action could have on the benefits that the calibrated delegated model provides to California's health care consumers.

When health plans enter into delegation contracts with RBOs, they must assess the costs associated with member care, including potentially expensive claims for unforeseen emergency care. While the health plans do not always know the exact make-up of their member population before open enrollment is complete, they do perform sophisticated actuarial analyses related to health care costs in order to set capitation rates. The cost of all care, including emergency care, is included in their forecasts and factored into the capitation rate. Therefore, health plans are essentially

paying for the cost of member emergency care, up front, to their delegated RBO, before such costs are actually incurred.

Tort liability for the claims in this case would impose on health plans the additional risk of having to pay twice – initially with capitation payments and subsequently in tort damages to non-contracted emergency providers whom the RBO should have paid. This risk may discourage plans from utilizing the delegated model altogether. If a health plan determines that it cannot delegate emergency risk, it may not be willing to delegate any risk to an RBO. This is because the health plan may not be willing to create incentives for the RBO to avoid the responsibility of paying for expensive care by steering it to the emergency setting, for which the plan could remain responsible. Even if the risks do not discourage health plans from entering into delegation contracts altogether, such risk may at least curtail them. Further, the health plans' increased emergency risk costs will be passed on to consumers in the form of higher premiums. Therefore, California's delegated model could be disrupted by way of retraction or increased cost to account for this additional litigation risk. Neither the retraction of delegation nor increased cost are in the members' best interests.

CONCLUSION

The Knox-Keene Act and the DMHC's implementing regulations do not expressly preempt a cause of action by unreimbursed non-contracted

emergency providers against a health plan for negligent delegation or negligent continued delegation to an RBO. Yet, based on the DMHC's experience with distressed RBOs, the DMHC believes that the potential value of such torts is outweighed by the dampening effect these torts could have on the delegated model and the benefits delegation offers to consumers. Existing laws impose significant statutory and regulatory obligations on health plans to safeguard against an RBO's financial insolvency. Under this legal structure, the DMHC holds health plans accountable, requiring them to: (i) demonstrate adequate administrative and financial capacity and that its risk arrangements are financially sound; (ii) include financial reporting requirements in its delegation contracts; (iii) report quickly to the DMHC about any threats to the RBO's financial solvency, and (iv) engage in the CAP approval process when an RBO is at risk.

The delegated model of managed care, and the inherent risks associated with costly emergency care, are well known to health plans, RBOs, and emergency providers. All must weigh the risks and proceed accordingly. Burdening this carefully crafted and balanced statutory and regulatory framework – which has proven predominantly successful and which continues to encourage the delegated model – with tort causes of action is not likely to achieve better outcomes for consumers, who already bear the expense of premiums and often costly co-pays and deductibles for

emergency care received from non-contracted providers. With the additional risk of tort liability, health plans would be more likely to raise premiums, co-pays, and deductibles to alleviate the additional lawsuit risk, and might be disinclined to delegate to an RBO, or act too quickly to terminate delegation, which would disrupt member care.

Therefore, the DMHC respectfully urges the Court not to introduce the unpredictability of new tort causes of action into the delegated health care delivery system.

Dated: March 18, 2016

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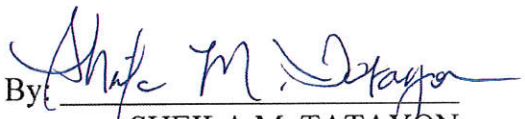
By: 
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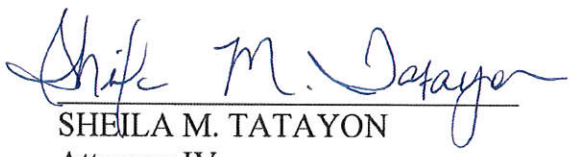
CERTIFICATION OF WORD COUNT

Pursuant to Rule 8.520(c) of the California Rules of Court, I certify that this Amicus Curiae Brief uses a 13 point Times New Roman font and contains 6,622 words, as calculated by the computer program (Microsoft Word 2010) used to prepare this brief.

March 18, 2016



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PROOF OF SERVICE

I am employed in the County of Sacramento, State of California. I am over the age of 18 years and not a party to the within action. My business address is 980 9th Street, Suite 500, Sacramento, California 95814. On March 18, 2016, I served the foregoing document described as:

AMICUS CURIAE BRIEF OF THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE IN RESPONSE TO THE SUPREME COURT'S INVITATION

on all persons named on the attached list, by the method of service indicated, as follows:

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

Executed on March 18, 2016, at Sacramento, California.

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