BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Cease and Desist Order Issued to: THE CAPELLA GROUP, INC., d/b/a CARE ENTRÉE Respondent.	DMHC No.: 04-312 OAH No.: N2005-10-0840

FILED
SEP 26 2006
DEPARTMENT OF MANAGED HEALTH CARE
By Susan Ball
Filing Clerk

DECISION

Pursuant to Government Code Section 11517 (c) (2) (C), the Department of Managed Health Care adopts the attached Proposed Decision dated June 15, 2006, issued by Administrative Law Judge, Ann E. Sarli, in the above-entitled matter as a Precedent Decision, except that the Department makes the minor changes indicated below to the Proposed Decision that do not affect the factual or legal basis of the Proposed Decision.

The parties have entered into the attached Consent Agreement dated September 25, 2006 by which they have agreed to settle the above described enforcement matter and that will be controlling in all future actions by the parties.

The Department hereby adopts all findings of fact and conclusions of law within the Proposed Decision. The "Order" portion of the Proposed Decision is revised as follows:

> Paragraph 3 b. of the Order portion of the Proposed Decision is revised to read:
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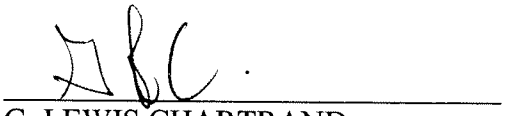
> > All funds to enrollees who have sought refunds in accordance with the terms of Care Entrée's membership agreement.
>
> Paragraph 3 c. is deleted in its entirety.

This Decision by the Department is effective immediately.

Pursuant to Government Code Section 11521(a), the Department's power to order reconsideration of this Decision expires thirty (30) days after service of the Decision or on the effective date of the Decision, whichever occurs earlier.

It is so ordered.

DEPARTMENT OF MANAGED HEALTH CARE



G. LEWIS CHARTRAND,
Chief Deputy Director

DATED: September 26, 2006

BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Cease and Desist Order Issued to: THE CAPELLA GROUP, INC. dba CARE ENTREE Respondent.	OAH No. N2005100840

PROPOSED DECISION

This matter was heard before Ann Elizabeth Sarli, Administrative Law Judge, Office of Administrative Hearings, State of California, on February 21, 2006, February 22, 2006, and on March 23, 2006.

Terry A. German and Jennifer V. Gore, Staff Counsel, represented the complainant.

Phillip R. Recht Attorney at Law and Francisco Ochoa, Attorney at Law, of Mayer, Brown, Rowe & Maw LLP., represented respondent.

Evidence was received. The matter remained open until April 24, 2006 to allow the parties to file written closing briefs. On April 21, 2006, the parties requested an extension of time in which to file closing briefs. The extension was granted. On May 5, 2006 respondent filed its closing brief, which was marked for the record as Exhibit 85. On May 5, 2006, complainant filed its closing brief which was marked for the record as Exhibit 86. On May 9, 2006 complainant filed its corrected closing brief, which was marked for the record as Exhibit 87. The matter was submitted for decision and the record was closed on May 9, 2006.

PROCEDURAL FINDINGS

1. On July 15, 2005, the Department of Managed Health Care (DMHC) filed a Cease and Desist Order (Order) [1]against The Capella [2] Group, Inc., D/B/A Care Entrée (Care Entrée). The Order alleges that Capella, through Care Entrée, is acting as a health care service plan as that term is defined by Health and Safety Code section 1345, subdivision (f)(1). The Order alleges that Capella is thus required to obtain a license under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act).[3]

2. The Order also alleges that Capella engaged in false and misleading advertising, offered consumers illusory benefits and violated other provisions of the Knox-Keene Act. The Order directs, among other things, that Capella cease and desist from operating in California without a Knox-Keene Act license, and that Capella "refund all monies to demanding members without undue delay." The DMHC stayed the Order, pending the instant appeal.

3. On February 10, 2006, the parties entered into a stipulation entitled "Joint Stipulation and [Proposed] Order Limiting the Scope of Hearing to Jurisdiction." The stipulation was made an Order of the Administrative Law Judge and states:

> The administrative hearing in this matter shall be limited to the issue of whether Capella is acting as a "health care service plan" under the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code section 1340 et seq. and is therefore subject to the jurisdiction of DMHC, and any and all issues related to the DMHC's allegations of false and misleading advertising shall be dismissed from the current proceeding without prejudice to the DMHC's ability to raise such issues after the question of jurisdiction is conclusively determined in the administrative proceedings and any litigation that may follow.

FACTUAL FINDINGS

The Care Entrée Program

1. Care Entrée is d/b/a[4] and wholly owned subsidiary of The Capella Group, Inc., a Texas Corporation. The Capella Group Inc. is licensed by the Sate of California to do business in California as a corporate entity. The Capella Group Inc. (Capella) also owns

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[1] The Cease and Desist Order was filed in accordance with Health and Safety Code sections 1349, 1360, 1386, 1391, and 1395, and California Code of Regulations, title 28, section 1300.67.4, subdivision (a) (3) (A).
[2] "Capella" is misspelled on the Cease and Desist Order as "Cappella."
[3] Health and Safety Code section 1340, et seq.
[4] The acronym "d/b/a" stands for "doing business as."

Foresight TPA a corporation. Foresight TPA provides third party administrator services to Care Entrée.[5]

2. Care Entrée, through Capella, contracts with medical providers to obtain discounted rates for medical services and supplies. Capella negotiates discount rates through contracts with a physicians' network (PHCS[6]), hospitals, dentists, pharmacists, alternative health care providers and suppliers of medical equipment. PHCS is the largest private physicians and hospitals network in the country. It charges Capella a fee for access to its network of physicians. PHCS also offers a claims management service, which Capella has declined to purchase. Many of the other medical providers Capella uses charge a fee for access to their discounted rates. Many networks and providers enter into contracts with Capella because Care Entrée "steers" a large number of patients to the providers.

3. Care Entrée markets a variety of programs to individuals and to groups such as benefit associations and employers. In 2002, Care Entrée began selling its programs in California.[7] The programs offer savings on healthcare services and products. In exchange for an enrollment fee and monthly membership payments, the Care Entrée member receives access to Care Entrée's networks of providers. The member is promised "discounted" rates on medical services and supplies in exchange for his/her enrollment fee and monthly membership fees. Care Entrée's "Total Care Program" offers the greatest network access and consequently is the most expensive. The consumer who purchases the Total Care Program pays approximately $69.95 per month per family for access to the PHCS physicians and hospital networks, dental directory services, eye care, prescriptions, hearing aids and alternative care providers. Associations and businesses which purchase Care Entrée membership for their members and employees may pay a negotiated rate for membership in Care Entrée.

4. The Total Care Program includes all of the services Care Entrée offered in California at the time DMHC issued its Order. Total Care members have full access to all Care Entrée's networks of medical services and ancillary services. Members are provided a membership card and lists of participating providers. With the membership card and referral lists, members may directly access many services, such as eye care and dental services. The member contacts the medical provider directly, sets an appointment or orders the product, and pays the provider the discounted rate Capella has contracted for with the provider. The member often must contact Care Entrée's Customer Service Department to locate a particular provider, confirm that the provider is still a member of the network, or to ascertain the discounted rate. At times, the provider may contact Care Entrée's Customer Service Department to verify a member is eligible for the discount or to ascertain the discounted rate. The member at times pays for the product or service at the time of the service or receipt of the product. However, with physician and hospital services, the provider typically sends the

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[5] Foresight TPA is involved in other business activities not relevant here.
[6] Private Health Care Systems.
[7] The programs are sold primarily through multi-level marketing arrangements with sales agents who work as independent contractors and who do not hold licenses to sell insurance.

bill to Care Entrée with its customary charges and Care Entrée "reprices" the bill to reflect the negotiated discount. Repricing of member bills is described below.

5. A Total Care member may not access PHCS physicians and hospitals unless the member has established and funded a personal medical account (PMA) with Foresight TPA (Foresight). The purpose of a funded PMA is to assure the PHCS network providers that they will be paid for their services. The member is required to have enough money in his or her PMA to cover physician or hospital charges before the member receives these services. If there are insufficient funds in the PMA at the time services are provided, the member may not get the discounted rate and may be required to pay the provider his or her full rate.

6. Foresight acts as Care Entrée's third party administrator, by maintaining members' PMA accounts and by processing and paying bills from PHCS physicians and hospitals. Care Entrée and PHCS regard Foresight as the "Payor of health claims"[8] on behalf of Care Entrée members. Although Foresight pays the PHCS providers, Foresight pays providers with the members' PMA funds. Care Entrée and Foresight collect PMA deposits from Care Entrée members through automatic monthly debits to their credit cards or bank accounts.[9] The debited funds are placed in a single trust account. Foresight pays interest to individual members for those days in which the member's balance reaches or exceeds $1,500. Foresight provides members with periodic statements detailing the activity on their accounts. A member may close an account, but must wait 30 days for a refund so that Foresight can pay any pending claims. The member must also agree, when setting up the PMA, that any delinquent membership fees will be paid to Care Entrée out of the PMA.

7. When a Care Entrée member seeks physician services, the physician's office may call Foresight to determine if there are sufficient funds in the member's PMA to cover the services. If there are sufficient funds, the physician sends the bill to Foresight and Foresight drafts the funds directly from the member's PMA. If there are insufficient funds in the PMA at the time services are provided, the member may not get the discounted rate and may be required to pay the provider the full rate. Care Entrée discourages the member from paying a PHCS physician directly, rather than through the Foresight claims process, because Care Entrée does not want PHCS to view the program as a "discount card," where discounts are given to members, but rather as a program which guarantees payment of negotiated rates.[10]

8. In order to assure its PHCS hospitals and other facilities that the member has sufficient funds in his or her PMA to fund an anticipated service or procedure, Foresight requires the member to get pre-certification for hospital or facility services. A pre-authorization form must be completed by the member's physician's office. Foresight

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[8] Care Entrée member publication "Understanding Personal Medical Accounts and the Pre-Authorization Process When Using Your Foresight TPA Card." Form - Understanding PMA 02/05

[9] Foresight recommends an initial deposit of $100 followed by monthly deposits of at least $25.

[10] Care Entrée member publication "Understanding Personal Medical Accounts and the Pre-Authorization Process When Using Your Foresight TPA Card." Form - Understanding PMA 02/05

receives the completed form and investigates the costs of network hospitals and facilities.[11] The member chooses a hospital and Care Entrée issues a pre-certification number to the hospital. The pre-certification number has the effect of "locking" the estimated medical charges in the member's PMA account so that Foresight can guarantee the provider that Foresight controls the funds necessary to pay the bill.[12] If a member is admitted to a hospital in an emergency, the hospital obtains a pre-certification from Foresight.

9. In order to adjust a member's bill to the negotiated rate, Care Entrée and Foresight maintain a proprietary software system. The system contains data on providers' customary charges for products and services and data on the negotiated discounts. The software program calculates the discounted charge and "reprices" the member's bill to conform to the negotiated charge. Foresight provides the member and the provider with copies of the repriced bill. If the member is paying a bill directly, for instance, when the member purchases medical supplies, the member pays the repriced amount directly to the provider. If Foresight is paying the bill from the member's PMA, Foresight forwards the repriced amount to the medical provider. Foresight provides the member and the medical provider with an Explanation of Benefits form which sets forth the customary charges for the services and reflects the application of the discount and resulting balance.[13]

10 Care Entrée provides its Total Care members with additional services. A 24-hour "Health Hotline" called "Optum Nurse Line" is staffed by registered nurses who provide information to callers about symptoms, treatment options and general information about an injury or illness. The Optum Nurse Line also has a library of tape recorded messages concerning health issues. The registered nurse can assist the member in making a decision about whether certain medical treatments are needed and where to secure them. Care Entrée also provides its Total Care members with a $2,000 insurance policy for excess accidental medical coverage; payment of three months of membership fees upon involuntary unemployment; and an emergency medical card which electronically stores a member's health information.

11. The PMA was a vital part of the Care Entrée program and in March of 2005, Capella held $ 5,349,000 in its trust fund account. Capella initiated the PMA procedure to ensure that PHCS network providers were paid. Subsequently, Capella experienced a reduction in memberships, and attributed that reduction in large part to imposition of the

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[11] The Care Entrée member information form entitled "Special Procedures for the Use of Hospitals, Doctors and other Medical Services" reads "utilizing the information on this [pre-certification] form, we will investigate the costs at the appropriate hospitals and help you determine the one that best suits your needs."

[12] PHCS and other networks generally contract with an entity which guarantees payment, such as an employer, an HMO, or an insurance company. In these situations, PHCS views the business entity, HMO or insurance company as the guarantor of payment, and the pre-certification process as a guarantee that the entity has agreed to pay for a particular service. With the Care Entrée's program, the Foresight TPA account and the pre-certification process were designed to provide assurances that Foresight has the money in hand and reserved for payment of the authorized procedure or service.

[13] PHCS's contracts with Capella and Foresight require that Foresight provide an Explanation of Benefits for each medical service billed.

PMA. At the time of the hearing of this matter, Capella represented that it had discontinued use of the PMAs.[14]

DISCUSSION AND LEGAL CONCLUSIONS

1. The California Legislature enacted the Knox-Keen Health Care Service Plan Act of 1975, (Knox-Keene) which is embodied in Chapter 2.2 of the Health and Safety Code, section 1340 et seq.[15] Subject to exceptions and exclusions not applicable here, section 1349 makes it unlawful for any health care service plan to engage in business in the State of California without having first obtained a license from the Director of DMHC. Section 1341, subdivision (a), charges the DMHC with "execution of the laws of the state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees."

2. As set forth in Procedural Finding 3, the issue here is whether the Care Entrée Program is a health care service plan, as that term is defined in Knox-Keene. Section 1345 defines terms used within Knox-Keene. Section 1345, subdivision (f), states; "'Health care service plan' or 'specialized health care service plan' means either of the following:

> (1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.
>
> (2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.[16]

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[14] Capella has not introduced evidence of practices or procedures currently in place to assure PHCS providers of payment. There is some question about the ability of Capella to continue to contract with PHCS, without the guarantee of payment PMAs provided.

[15] Subsequent statutory references are to the Health and Safety Code, unless otherwise indicated.

[16] Additional pertinent definitions are included in Health and Safety Code section 1345, subdivisions:
[¶]...[¶]

(c) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan.

(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) "Person" means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) "Service area" means a geographical area designated by the plan within which a plan shall provide health care services.

(o) "Specialized health care service plan contract" means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any

Section 1345, subdivision (n), states; "Solicitor firm" means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (l).

3. Complainant maintains that the language of section 1345, subdivision (f)(1), is clear and unambiguous on its face and that Care Entrée's Program squarely fits within that section's definition of "health care service plan." Simply put, complainant maintains that Care Entrée "undertakes to arrange for the provision of health care services" to Care Entrée's enrollees.[17]

4. Capella maintains that the Care Entrée's Program does not fit within the section's definition of health care service plan. Capella contends that Care Entrée does not arrange for the provision of health care services: it arranges only for the provision of discounted prices on health care services.

5. Knox-Keene does not define "undertake to arrange" for the provision of health care services.[18] There is no controlling or persuasive case law interpreting the relevant language of section 1345, subdivision (f)(1).[19] "Under settled canons of statutory construction, in construing a statute we ascertain the Legislature's intent in order to effectuate

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part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(p) "Subscriber" means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, "plan" refers to health care service plans and specialized health care service plans.

(r) "Plan contract" means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

[17] There is no dispute between the parties that Care Entrée is a "person" to whom the statute applies, or that Care Entrée's services are provided "in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees."

[18] There is no dispute as to what "health care services" are. The phrase is defined in section 1345, as follows:

As used in this chapter:

[¶] ... [¶]

(b) "Basic health care services" means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

(7) Hospice care pursuant to Section 1368.2.

[19] The parties have thoroughly and articulately briefed the issues in this case and have presented no persuasive authority.

the law's purpose. Because the statutory language is generally the most reliable indicator of legislative intent, the words of the statute themselves must be examined, giving them their usual and ordinary meaning and construing them in context." (*Eisberg v. Union Oil Company* (2002) 28 Cal 4th 262, 268-26.) Under the accepted rules of statutory construction, the usual and ordinary meaning of words apply. (*State Farm Mutual Automobile Ins. Co. v. Garamendi* (2004) 32 Cal. 4th 1029, 1043)

6. Complainant has urged the definition of "arrange" found in Merriam – Webster Dictionary (1999) p.64: "to make preparations for" or "to bring about an agreement or understanding concerning." Complainant argues that entering into contracts with health care providers to provide health care services to members qualifies as making preparations for or bringing about an agreement or understanding concerning provision of health care services to members. Further, complainant argues that Capella is more involved in providing of health care services than simply contracting with networks of providers.

7. Capella advances alternative definitions of the word "arrange;"[20] to " plan or provide for; cause to occur, settle beforehand and order the manner of, take measures, form plans, give instructions, to put in order beforehand; plan." Capella argues that under these constructions, a plan must provide health care services directly, rather than simply facilitating network discounts. Capella argues that if it "arranges" for anything, it is for the provision of health discounts, not health care services.

8. As the cited definitions illustrate, the common meaning of the term "arrange" encompasses a broad range of activities. The activities contemplated by the broad language of the statute are those activities involved in providing medical services to members or subscribers. Under the plain meaning of the statute, an entity is a health care service plan when it, among other things: engages in making preparations for provision of health care services; plans for provision of health care services; brings about agreements or contracts for provision of health care services; takes measures for provision of health care services; or gives instructions for provision of health care services.

9. "The statute's plain meaning controls the court's interpretation unless its words are ambiguous. If the plain language of a statute is unambiguous, no court need, or should, go beyond that pure expression of legislative intent." (*Kosbzoff v. Los Angeles County Harbor/UCLA Med. Ctr.* (1998) 19 Cal. 4th 851, 861.) When statutory language is clear and unambiguous, there is no need for construction and courts should not indulge in it. (*People v. Benson* (1998) 18 Cal.4th 24, 30.)

The legislature, by using the broad term "arrange for the provision of health care services," expressed its intention to regulate the nascent field of businesses offering alternatives to traditional health insurance plans. The legislature, by using a broad definition of health care service plan, intended to cast a wide net, capturing all activity related to

[20] Capella's definitions are derived from Concise Oxford Dictionary 68 (9th Ed. 1995) and Webster's Third New International Dictionary 120 (1986).

provision of health care. Capella has been extensively involved in arranging for the provision of health care services for its members. As set forth in the Factual Findings, Capella not only enters into service contracts with health care providers and maintains those contracts, Capella enrolls members, provides referrals to network providers, assists members with obtaining appointments, assists providers in verifying member eligibility for discounts, requires members to deposit funds in PMAs, controls the large sums of money aggregated into the PMA trust fund, verifies the ability of the member to pay through the PMA, reprices bills, reviews, reprices and pays claims, and provides medical information through the nurse help line. This panoply of activity constitutes "arranging for the provision of medical services" within the meaning of sections 1345 and 1349. The nurse help line constitutes direct provision of medical services.

10. Capella represents that it no longer offers a nurse help-line to California members. Assuming this is the case, Care Entrée no longer provides direct medical care to members. Capella also represents that it no longer requires or permits its California membership to maintain PMAs. Assuming this is the case, Capella, through Foresight, is no longer the guarantor of payment to network providers, and no longer is responsible for paying members' medical bills. By taking these actions, Capella has curtailed its activities in "arranging for the provision of health care services."

11. But, although Capella may now be less involved in "arranging for the provision of health care services" for its California members, Capella continues to arrange for these services within the meaning of sections 1345 and 1349 of Knox-Keene. Establishing a network of medical providers who offer services to plan members is arranging for the provision of health care services. Maintaining that network, referring members to providers, handling inquiries and disputes between network providers and members, repricing bills and providing explanations of benefits are all activities which arrange for provision of health care services to members.

12. Capella raises several arguments to support its position that its programs should not be regulated by Knox-Keene. It argues that it does not arrange for the provision of health care services, but only for the provision of discounts on health care services. On the surface, this appears to be an important distinction. However, the core of Capella's "discount health card" business remains health care service. Capella offers its members continuing access to medical care, at a discounted price, in exchange for periodic membership fees. Consumers who purchase Capella's services purchase the assurance that they will have health care available to them at affordable prices. Consumers who purchase health insurance, HMO[21] membership, PPO[22] membership, or membership in the many other health care service plans currently marketed, purchase the assurance that they will have health care available to them either without additional charge or with reduced charges. All of these plans, including Capella's, connect the member to the participating provider. All of

[21] Health maintenance organization.
[22] Preferred provider organization.

these plans provide "discounts" in the sense that by participating in the plan, the members do not pay the full price of medical services that would otherwise be imposed upon them.

13. Capella also raises the argument that the legislature intended Knox- Keene to protect members of HMOs and similar plans which assume the risk of payment for medical services. Capella points to sections of Knox Keene which indicate that the legislature was concerned with the solvency of health care service plans. As tempting as it is to examine indicia of legislative intent in this matter, the statutory language is clear and unambiguous. Thus, there is no need for construction and the temptation should not be indulged. (*People v. Benson* (1998) 18 Cal.4th 24, 30.) Moreover, section 1345, subdivision (f)(1), makes no mention of assuming the risk of payment for health care services. If the legislature had intended to limit the reach of Knox-Keene to "risk bearing" entities, it could have done so. Even if it was necessary to examine these sections to determine legislative intent, it is clear that Capella's insolvency would endanger the public as much as would the insolvency of other health care entities. Capella holds millions of dollars belonging to its members in an erroneously named "escrow" account, over which Capella and Foresight have complete control. An insolvent Capella or Foresight could fail to pay the members' medical bills or could divert members' assets. Capella's insolvency would also cost its members in that they would no longer be able to access the discounts they have paid for. These losses can be as substantial as the loss to members of a "risk bearing" entity which fails to pay the members' medical bills.

14. Capella argues that its business model simply does not fit the model of a health care service plan contemplated by Knox-Keene. Capella would not be able to meet many of the requirements of Knox-Keene, for instance regulations regarding financial reserves and regulations regarding quality of care. In essence, Capella and programs similar to those offered by Capella would be unable to do business in California in their present forms. Capella argues that the services it offers are much needed and provide an alternative for families unable to afford the more traditional health care plans and policies. This may very well be the case, and the time may have come for recognition and regulation of so-called "discount health care cards." But, Capella is bound by existing legislation. Capella and similar programs are subject to Knox-Keene because they arrange for the provision of health care services. Only the Legislature may modify or extend the existing law.[23] (*Kosbzoff v. Los Angeles County Harbor/UCLA Med. Ctr.* (1998) 19 Cal. 4th 851, 863.)

15. Finally, Capella argues that if it is ordered to cease operations in California, it should not also be ordered to refund all membership and enrollment fees paid by California

[23] The director of DMHC also has the discretion to create exemptions under Knox-Keene. Section 1343, provides in pertinent part;

(a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (n) of Section 1345.

(b) The director may by the adoption of rules or the issuance of orders deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

members. The Cease and Desist Order in this matter orders Capella to cease operations, disclose that it does not do business in California, and orders that "respondent shall refund all monies to demanding members without undue delay." Capella may certainly be required to refund to California members all monies held in trust or in "escrow" in personal medical accounts as well as interest due. Capella may also be ordered to refund enrollment fees paid by members since July 15, 2005, when the Cease and Desist Order was filed. The rationale for this is that Capella may not enrich itself with membership fees at the expense of members enrolled since July 15, 2005, who were in jeopardy of losing the value of the membership fee if the Cease and Desist Order was upheld. Likewise, all periodic payments which cover periods of time subsequent to the effective date of this decision must be refunded, as Capella will no longer be providing the services the member has paid for.

Capella argues that forcing it to disgorge any other monies to members constitutes a penalty or liability. Capella argues that it cannot be penalized in this manner because it relied on the "Zingale Opinion" when it began operating in California. The DMHC and the California Department of Corporations[24] have issued Director's/Commissioner's Opinions[25] addressing the issue of whether a particular entity would be deemed a health care service plan under Knox-Keene. Pursuant to section 1344,[26] the DMHC director may issue interpretive opinions.

16. Director's Opinion 01/1 (Zingale opinion) was issued in June of 2001, by then Director Daniel Zingale. The Zingale opinion discussed generally the "so-called discount membership entities" that had "proliferated in the years following the prior Commissioner's opinion" in July 1983, (NBA opinion- No. 4614H). The Zingale opinion explained the workings of discount plans; "Many of these entities market discount health services to employers, insurers, health care service plans, and individual members of the public...." "Some discount membership programs contract individually with providers to obtain contractual discounts for their members. Others contract with networks of providers. Some

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[24] When Knox-Keene was enacted, responsibility for its enforcement was vested in the California Department of Corporations.

[25] Pursuant to section 1344, the Director of DMHC has the discretion to issue interpretive opinions resolving questions of law that arise under Knox-Keene. Prior to July 1, 2000, the authority to issue interpretive opinions regarding Knox-Keene was vested in the Commissioner of Corporations.

[26] Health and Safety Code section 1344, provides:

(a) The director may from time to time adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of this chapter. For the purpose of rules and forms, the director may classify persons and matters within the director's jurisdiction, and may prescribe different requirements for different classes. The director may waive any requirement of any rule or form in situations where in the director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. The director may adopt rules consistent with federal regulations and statutes to regulate health care coverage supplementing Medicare.

(b) The director may honor requests from interested parties for interpretive opinions.

(c) No provision of this chapter imposing any liability applies to any act done or omitted in good faith in conformity with any rule, form, order, or written interpretive opinion of the director, or any such opinion of the Attorney General, notwithstanding that the rule, form, order, or written interpretive opinion may later be amended or rescinded or be determined by judicial or other authority to be invalid for any reason.

discount programs offer discounts on a single type of health care services, such as dental and some offer discounts on a multiplicity of medical services and products."

The Zingale opinion set forth the "common attributes of these discount membership programs." They "(1) charge fixed – rate periodic membership fees, generally monthly or annual, without regard to the volume of health care services, if any, accessed by the member; (2) arrange for members to receive discounts on health care services received from providers; (3) provide their members with lists of participating plan providers; and (4) are not involved in the member's decision to access providers or the provision of health care services. The programs typically promise only that members will receive a discount on the fees charged by participating providers for any services the member may choose to seek."

The Zingale opinion concluded that "discount membership programs are not engaged in 'arranging for the provision of health care services' when and to the extent they contract to obtain fee discounts on services their members choose to receive from participating program providers." The Zingale opinion ordered the recission of Commissioner's order no. 4614 H (the NBA opinion). The NBA opinion found that discount health plans did arrange for the provision of health care services.[27] The Zingale opinion was rescinded by DMHC on December 14, 2005, pursuant to section 1344, subdivision (c), and the NBA opinion was reinstated.

17. Section 1344, subdivision (c), provides that; "No provision of this chapter imposing any liability applies to any act done or omitted in good faith in conformity with any rule, form, order, or written interpretive opinion of the director, or any such opinion of the Attorney General, notwithstanding that the rule, form, order, or written interpretive opinion may later be amended or rescinded or be determined by judicial or other authority to be invalid for any reason." Capella argues that it relied upon the Zingale opinion in determining that it could legally sell its discount health plans in California. Complainant counters that

[27] On June 9, 1983, the Commissioner issued Commissioner's Opinion No. OP 4614H, regarding National Benefits Association (NBA opinion). NBO was established to provide its members with multiple buying services at discounted rates. In exchange for an annual membership fee, members of NBA were entitled to receive discounts of up to 50% of the normal retail price for consumer goods and services. NBA proposed to contract with health care providers who were willing to offer NBA members a specified percentage discount off their reasonable and customary fees for vision, dental, medical and prescription services and products. A list of the providers willing to offer discounts would be provided to NBA members. NBA planned to package its discount program to avoid running afoul of section 1345, subdivision (f). Specifically, NBA avoided linking its discounted health care services to the annual membership fee; so that the discount health services would not be provided "in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." NBA worded the contract with health care providers so that the discount available to NBA members was called a "courtesy" discount. It worded the consumer offerings so that the consumer acknowledged that s/he was paying annual fees for the discount consumer opportunities, and not the medical services. In essence, NBA created a fiction that the medical discount was free when the member purchased the consumer discounts service.
Thus, the commissioner addressed the issue of whether this strategy could legally be employed to remove NBA from the ambit of section 1345, subdivision (f). It was assumed that provision of the medical discounts NBA intended to offer constituted arrangement of medical services and would fall within this section if the member paid for the discount through membership fees. The NBA opinion held that the NBA plan provided medical services which had been paid for through membership fees, and thus NBA could not offer its plan in Californian without obtaining a Knox-Keene license.

Capella was not entitled to rely on Zingale, as that opinion was not applicable to Capella. California Code of Regulations, title 10, section 250.12, provides in pertinent part: "each interpretive opinion ...is applicable only to the transaction identified in the request therefore, and may not be relied upon in any other transaction." However, the Zingale opinion did not identify whether a specific entity had requested the opinion, and discusses discount programs generally. It addresses "so-called discount membership entities."

Complainant also argues that the program described in the Zingale opinion is not the same program Capella operates, and thus Capella could not rely upon the Zingale opinion. Capella's program does differ from the "generic" program described in Zingale. It has operational variants not present in the basic design the Zingale opinion identified. However, the core of the Capella program, access to discounted health care, is the core of the programs Zingale opinion described, and Capella reasonably and in good faith relied upon the language of Zingale in determining that its programs were exempted from Knox-Keen licensing requirements. The fact that Capella's reliance was misplaced, and the Zingale decision was ultimately rescinded does not change the fact that Capella acted in good faith and in conformity with a written interpretive opinion of the director. Thus, under section 1344, subdivision (c), liability cannot be imposed. Complainant in not seeking imposition of penalties or fines in the traditional sense. However, forcing the return of member funds actually earned by Capella, as identified above, operates as a penalty or liability and cannot stand.[28]

18 Complainant has established that Capella violated Health and Safety Code section 1349, by unlawfully engaging in business as a health care service plan in the State of California and by receiving periodic consideration in connection with the plan from persons in this state, without having first secured a license from the director of DMHC.

ORDER

The Cease and Desist Order issued July 15, 2005, is upheld in part and modified in part. Paragraph 1, with subparts a. through e., is upheld. Paragraph 2 is upheld. Paragraph 3 ("Respondent shall refund all monies to demanding members without undue delay.") is modified to read as follows:

3) Respondent shall refund to California members without undue delay:

a. Monies held in members' personal medical accounts with interest as calculated pursuant to the personal medical account agreement entered into between the member and Capella/Foresight.

[28] Capella had argued in pre-trial motions that complainant was estopped from taking any actions against Capella, including enforcement of the Cease and Desist Order, due to Capella's reliance on Zingale and the application of section 1344, subdivision (c). This argument is completely devoid of merit and was not considered herein.

b. Enrollment fees paid by members since July 15, 2005.

c. Members' periodic payments which cover periods of time subsequent to the effective date of this decision.

Dated: June 15, 2006

ANN ELIZABETH SARLI
Administrative Law Judge
Office of Administrative Hearings