Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 1124
Author: Maienschein (D)
Amended: 8/25/20 in Senate
Vote: 21

PRIOR VOTES NOT RELEVANT

SENATE HEALTH COMMITTEE: 7-0, 8/10/20 (Pursuant to Senate Rule 29.10)
AYES: Pan, Lena Gonzalez, Hurtado, Leyva, Mitchell, Monning, Rubio
NO VOTE RECORDED: Grove, Melendez

SENATE APPROPRIATIONS COMMITTEE: 5-2, 8/20/20
AYES: Portantino, Bradford, Hill, Leyva, Wieckowski
NOES: Bates, Jones

SUBJECT: Health care service plans: regulations: exemptions

SOURCE: America's Physician Groups
California Schools Voluntary Employee Benefits Association

DIGEST: This bill authorizes the Department of Managed Health Care to authorize two pilot programs that allow health care providers to undertake risk-bearing arrangements with a voluntary employees' beneficiary association, as defined under federal and state law with enrollment of greater than 100,000 lives, or a trust fund that is a welfare plan, and a multiemployer plan, as defined in federal law, with enrollment greater than 25,000 lives.

Senate Floor Amendments of 8/25/20 (1) change the date by which the Department of Managed Health Care (DMHC) director would authorize the pilot from no later than March 1, 2021, to, no later than May 1, 2021, and change the pilot period from July 1, 2021, to December 31, 2022, inclusive, to independent periods of time beginning no earlier than January 1, 2022 to December 31, 2025, inclusive; (2) delete the prohibition on a participating provider from agreeing to accept financial risk greater than 10% of its existing contracted risk-based business; (3) add to information the voluntary employees' beneficiary association (VEBA) or trust fund

and each participating health care provider must agree to collect and report to DMHC, enrollee satisfaction, and authorize DMHC to require additional information to be reported, and not subject to the Administrative Procedures Act; (4) add that if an enrollee is not satisfied with the result of internal ombudsperson, the enrollee should be referred to DMHC's grievance and appeals process and that the results are binding on the VEBA or trust fund; (5) require DMHC to retain the right to disapprove any pilot program application for any reason consistent with the Knox-Keene Act; (6) change the date of the required DMHC report from June 1, 2027 to January 1, 2027, and allow DMHC to authorize a public or private agency to prepare the report, as specified; (8) sunset the bill on January 1, 2028; and, (9) delete the urgency clause.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act (Knox-Keene Act). [HSC §1340, et seq.]

2) Permits the DMHC director to exempt from the Knox-Keene Act any class of persons or plan contracts if the DMHC director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under the Knox-Keene Act, and that the regulation of the persons or plan contracts is not essential to the purposes of the Knox-Keene Act. [HSC §1343]

This bill:

1) Authorizes the DMHC director no later than May 1, 2021, to authorize one pilot program in northern California and one pilot program in southern California, whereby providers approved by DMHC may undertake risk-bearing arrangements with a VEBA, as defined under federal and state law, with enrollment of greater than 100,000 lives, or a trust fund that is a welfare plan, as defined in federal law, and a multiemployer plan, as defined in federal law, with enrollment of greater than 25,000 lives for the independent periods of January 1, 2022, to December 31, 2025, inclusive, if specified criteria are met, including, in part:

a) The VEBA or trust fund has entered into a contract with one or more health care providers under which each provider agrees to accept risk-based or global risk payment from the VEBA or trust fund;
b) Each risk-bearing provider is registered as a risk-bearing organization pursuant to existing law, and applicable DMHC regulations if the provider accepts professional capitation and is delegated the responsibility for processing and payment of claims;
c) Each global risk-bearing provider holds or will obtain in conjunction with the pilot program application a limited or restricted license, pursuant to existing law and regulations;
d) Each risk-bearing provider continues to comply with applicable financial solvency standards and audit requirements, including financial reporting on a quarterly basis, during the pilot;
e) The VEBA or trust is responsible for providing basic health care services, prescription drug benefits, continuity of care, network adequacy and timely access to care, as well as other requirements;
f) Submit an application for DMHC to select up to two qualified participants for the pilot program;
g) The contract of each health care provider that has entered into a contract under the pilot, included in the pilot application; and,
h) The VEBA or trust fund and each participating health care provider agree to collect and report to DMHC, in each year of the pilot, in a manner and frequency determined by DMHC, information regarding the comparative cost savings when compared to fee-for-service payment, performance measurements for clinical patient outcomes, and enrollee satisfaction. Authorizes DMHC to require additional information required by DMHC.

2) Requires the participating VEBA or trust fund to appoint an ombudsperson, and if the enrollee is not satisfied with the result refer the enrollee to DMHC grievance and appeal process, which is binding on the VEBA or trust fund.

3) Requires the global and risk-bearing providers participating in the pilot to be approved by DMHC. Requires DMHC to retain the right to disapprove any pilot program at any time, as specified.

4) Sunsets this bill on January 1, 2028.

Comments

Author's statement. According to the author, labor union trusts cannot utilize value-based payment mechanisms with the provider networks in their self-funded

plan networks. This results in higher health care costs that could be avoided. Independent, impartial research on health care cost drivers and delivery system reform conducted by the U.C. Berkeley School of Public Health and the Integrated Healthcare Association consistently show that the solution to rising health care costs is to increase the percentage of health care that is delivered through clinically integrated providers that share the financial risk with health plans, government and employer payers. To date, this kind of health care financing and delivery model has been used in the fully-insured employer-sponsored HMO, Medicare Advantage and Medi-Cal Managed Care market segments.

DMHC. The DMHC licenses and regulates the full scope of managed care models, assesses and monitors health plan networks and delivery systems for compliance with the Knox-Keene Act, and evaluates compliance through onsite surveys (audits) of health plan operations performed every three years. DMHC reviews health plan financial statements and filings, and analyzes health plan reserves, financial management systems, and administrative arrangements. DMHC does not license provider organizations, but it monitors the financial solvency of risk-bearing organizations. Risk-bearing organizations are provider groups that, in their contracts with health plans, pay claims and assume financial risk for the cost of all health care services (inpatient and outpatient) by accepting a fixed monthly payment for each enrolled person assigned to the risk-bearing organization. This arrangement is typically referred to as "capitation." Risk-bearing organizations are subject to financial reserve requirements and regular financial reporting. DMHC monitors the financial stability of risk-bearing organizations by analyzing financial filings, conducting financial examinations, reviewing claims payment practices and developing and monitoring corrective action plans. DMHC conducted financial examinations on 24 risk-bearing organizations in 2019. As a result, all 24 risk-bearing organizations were required to remediate underpaid claims. In total, the risk-bearing organizations paid an additional $762,000 in payment, interest and penalties to providers.

Related/Prior Legislation

AB 1249 (Maienschein, 2019) would have allowed DMHC to authorize for five years similar pilots as authorized under this bill. AB 1249 was vetoed by Governor Newsom. The Governor's veto message stated:

> This bill would authorize a pilot program that would exempt risk-bearing provider groups taking on global risk from full licensure under the Knox-Keene Act. This proposed pilot project would undermine the fundamental purpose of the Knox-Keene Act by permitting such entities to operate in the

State without providing the strong consumer protections guaranteed under the Act.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Senate Appropriations Committee:

- DMHC estimates $221,000 and 1.0 PY in FY 2020-21, $375,000 and 1.1 PY in FY 2021-22, $379,000 and 1.2 PY in FY 2022-23 through FY 2026-27, and $398,000 MCF and 0.8 PY in FY 2027-28. (*Managed Care Fund).

  The bill would require the pilot participants reimburse the DMHC for regulatory costs up to $500,000.

SUPPORT: (Verified 8/25/20)

America's Physician Groups (co-source)
California Schools Voluntary Employees Benefits Association (co-source)
American Federation of State, County and Municipal Employees
Breathe California
California Environmental Justice Alliance
California Health Care Coalition
California Immigrant Policy Center
California Labor Federation
California State Association of Electrical Workers
California State Pipe Trades Council
California Teachers Association
Coalition of California Utility Employees
Heritage Provider Network
IBEW Local 18 Health and Welfare Trust
IBEW Local 234
IBEW Local 302
IBEW Local 332
IBEW Local 413
IBEW Local 440
IBEW Local 47
IBEW Local 617
IBEW Local Union 6
International Association of Sheet Metal, Air, Rail and Transportation Workers, Local 104
International Union of Elevator Constructors

Plumbers and Pipefitters Local 447
Plumbers and Pipefitters Local Union 442
Plumbers and Pipefitters UA Local 364
Plumbers and Steamfitters Local 230
Plumbers and Steamfitters UA Local 343
Plumbers and Steamfitters UA Local 398
Plumbers, Steamfitters and Refrigeration Fitters Local Union 467
Plumbers, Steamfitters, Pipefitters and HVAC/R Service Technicians UA Local Union 393
Scripps Health
Sharp Rees-Stealy Medical Group
Southern California Edison
Steam, Refrigerator, Air Conditioning, Pipe Fitters, Welders and Apprentices of the United Association Local Union 250
UA Plumbers Local 78
United Association of Plumbers and Pipefitters Local 761
United Association of Plumbers Pipe and Refrigerator Fitters Local No. 246
United Food and Commercial Workers
Western States Council of Sheet Metal, Air, Rail and Transportation

OPPOSITION: (Verified 8/25/20)

Association of California Life and Health Insurance Companies
California Association of Health Plans
California Association of Joint Powers Authorities
Department of Managed Health Care

ARGUMENTS IN SUPPORT: According to America's Physician Groups (APG), there is a growing movement to pair self-funded health benefit plans with organized, integrated providers in a more aligned relationship to produce better care at lower cost. The trust and its contracted network providers can partner to address the specific issues in the employee population – setting performance targets and exchanging relevant data on progress. Many payers complain that they cannot get access to critical performance and cost data in the current health insurance marketplace. APG writes Integrated Healthcare Association data shows that for 2013, 2015, and 2017, provider systems that share financial risk for outcomes with their payer partners score higher on ten clinical performance metrics, deliver lower total cost of care, and lower per-capita cost of care than their fee-for-service paid counterparts. In these pilots, providers and payers will directly share data on cost, outcomes, and performance measures back and forth so that gaps in care can be addressed, and priorities continuously monitored. APG states

that its' California members operate under risk-based models seven days a week and have done so for the past 20 years. The quality scores delivered by these provider organizations could not be sustained if they were not financially and operationally stable – as they have been for the past 20 years. The California Health Care Coalition, a membership organization of private and public sector employers, unions and health and welfare trust funds in California, writes that employer plan sponsors would like to use more advanced value-based payment models in a direct relationship with provider organizations that have a proven public track record of delivering care that is more timely, higher quality, and more accountable for cost. International Association of Sheet Metal, Air, Rail and Transportation Workers, Local 104 writes that this bill would address a major shortcoming in California's existing law by empowering Taft-Hartley Health and Welfare Trust Funds to by-pass HMOs and contract directly with health care providers today on a fee-for-service basis. California law (the Knox-Keene Act) is in essence a de-facto restriction on their trust funds by prohibiting providers from contracting on a capitated basis with any organization that does not hold a limited Knox-Keene license.

ARGUMENTS IN OPPOSITION: DMHC has strong concerns that allowing restricted health care service plans to contract with a VEBA or a trust fund without the involvement of a fully-licensed health care service plan, that provides both the consumer and financial protections guaranteed in the Knox-Keene Act, would negatively impact consumers. DMHC writes that currently, restricted health care service plans are permitted to contract only with fully-licensed health care service plans that act as a "parent plan." The parent plan provides any of the Knox-Keene Act's protections not provided by the restricted health care service plan, thus ensuring that together the restricted health care service plan and parent plan meet *all* the requirements of the Knox-Keene Act. If the director were to authorize the pilot and permit a VEBA or trust fund to contract directly with a restricted health care service plan, without a parent plan included in the contractual arrangement, the proposed pilot would circumvent the important consumer protections guaranteed in the Knox-Keene Act to enrollees of all licensed health care service plans. Additionally, this bill's exemption process is unnecessary because the DMHC director has authority to exempt any class, person, or plan contract from requirements of the Knox-Keene Act, when doing so is in the public interest. The director's discretion in granting such exemptions is important, as the director considers exemption requests in light of the particular circumstances of the contract arrangements as well as the impact to enrollees and the health care market. As stated in meetings with bill sponsors earlier this year on January 28 and more recently on July 20, the DMHC encourages interested parties to work with the DMHC and seek an appropriate exemption from the Knox-Keene Act, which

would allow sponsors to accomplish their goals while ensuring the DMHC has oversight over the important consumer protections in the Knox-Keene Act.

The California Association of Health Plans and the Association of California Life and Health Insurance Companies write that these exemptions from the Knox-Keene Act create unfair competitive advantages and will leave consumers without important consumer protections. The California Association of Joint Powers Authorities (CAJPA) writes that CAJPA is concerned about public entity workers that rely on stability in their long-term healthcare benefits and believes the provisions of the Knox-Keene Act are too important to allow certain groups seeking competitive advantages in the market to have an exemption at the risk of consumers being left without important protections. CAJPA members have seen firsthand the impacts of local provider networks going out of business; they're ugly and have detrimentally impacted both consumers and providers. During this global healthcare pandemic, there is already too much confusion among consumers about access to medical care and this pilot may confuse them even more. Additionally, there is also confusion among medical providers in the current medical system with networks/non-networks, billings, authorizations, and processes in the dozens and dozens of health plans that they participate in.

ASSEMBLY FLOOR: 66-0, 5/6/19
AYES: Aguiar-Curry, Bauer-Kahan, Berman, Bloom, Boerner Horvath, Bonta, Burke, Calderon, Carrillo, Cervantes, Chau, Chiu, Chu, Cooley, Cooper, Cunningham, Daly, Diep, Eggman, Flora, Frazier, Friedman, Gabriel, Cristina Garcia, Eduardo Garcia, Gipson, Gloria, Gonzalez, Gray, Grayson, Holden, Irwin, Jones-Sawyer, Kalra, Kamlager-Dove, Lackey, Levine, Limón, Low, Maienschein, Mayes, McCarty, Medina, Mullin, Muratsuchi, Nazarian, O'Donnell, Petrie-Norris, Quirk, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Santiago, Smith, Mark Stone, Ting, Voepel, Waldron, Weber, Wicks, Wood, Rendon
NO VOTE RECORDED: Arambula, Bigelow, Brough, Chen, Choi, Dahle, Fong, Gallagher, Kiley, Mathis, Melendez, Obernolte, Patterson, Salas

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8/26/20 14:31:05

****** END *****