Assembly Bill No. 1124

CHAPTER 266

An act to add and repeal Section 1343.3 of the Health and Safety Code, relating to health care service plans.

[Approved by Governor September 29, 2020. Filed with Secretary of State September 29, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1124, Maienschein. Health care service plans: regulations: exemptions.

Existing federal law defines a voluntary employees' beneficiary association as an organization composed of a voluntary association of employees that provides for the payment of life, sick, accident, or similar benefits to members, their dependents, or designated beneficiaries. Existing federal law defines a welfare plan as any plan, fund, or program established or maintained by an employer or employee organization, or both, for the purpose of providing participants or their beneficiaries specified benefits, such as medical, surgical, or hospital care or benefits. Existing law further defines a multiemployer plan as a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that meets other specified requirements.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law exempts specified persons or plans from the requirements of the act and authorizes the Director of the Department of Managed Health Care (director) to exempt additional specified persons or plans if the director finds, among other things, that the exemption is in the public interest. Under existing law, upon the request of the Director of Health Care Services, the director must exempt a county-operated pilot program contracting with the State Department of Health Care Services, and may exempt a non-county-operated pilot program, subject to any conditions the Director of Health Care Services deems appropriate. Existing law also exempts a health care service plan operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies certain criteria, including that the plan requires providers to be reimbursed solely on a fee-for-service basis.

This bill would authorize the director, no later than May 1, 2021, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement described above, or a trust fund that is a

welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if certain criteria are met, including that each risk-bearing provider is registered with the department as a risk-based organization and holds or will obtain a limited or restricted license, as applicable. The bill would require the association or trust fund and each health care provider participating in each pilot program to be responsible for providing certain services, as specified, to report to the department information regarding cost savings and clinical patient outcomes compared to a fee-for-service payment model, and would require the department to report those findings to the Legislature no later than January 1, 2027. The bill would require pilot program participants to reimburse the department for reasonable regulatory costs of up to $500,000. The bill would repeal these provisions on January 1, 2028.

The people of the State of California do enact as follows:

SECTION 1. Section 1343.3 is added to the Health and Safety Code, to read:

1343.3. (a) The director, no later than May 1, 2021, may authorize one pilot program in northern California, and one pilot program in southern California, whereby providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association, as defined in Section 501(c)(9) of Title 26 of the United States Code or in Section 1349.2, notwithstanding paragraph (3) of subdivision (a) of Section 1349.2, with enrollment of greater than 100,000 lives, or a trust fund that is a welfare plan, as defined in Section 1002(1) of Title 29 of the United States Code, and a multiemployer plan, as defined in Section 1002(37) of Title 29 of the United States Code, with enrollment of greater than 25,000 lives, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if all of the following criteria are met:

(1) The purpose of the pilot program is to demonstrate the control of costs for health care services and the improvement of health outcomes and quality of service when compared against a sole fee-for-service provider reimbursement model.

(2) The voluntary employees' beneficiary association 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 voluntary employees' beneficiary association or trust fund.

(3) Each risk-bearing provider is registered as a risk-bearing organization pursuant to Section 1375.4 and applicable department regulations if the provider accepts professional capitation and is delegated the responsibility for the processing and payment of claims.

(4) Each global risk-bearing provider holds or will obtain in conjunction with the pilot program application a limited or restricted license pursuant

to Section 1349 or 1351, or Section 1300.49 of Title 28 of the California Code of Regulations.

(5) Each risk-bearing provider continues to comply with applicable financial solvency standards and audit requirements under this chapter, including, but not limited to, financial reporting on a quarterly basis, during the term of the pilot program.

(6) The voluntary employees' beneficiary association or trust fund shall be responsible for providing all of the following:

(A) Basic health care services.

(B) Prescription drug benefits.

(C) Continuity of care.

(D) Standards for network adequacy and timely access to care, including, but not limited to, access to specialty care.

(E) Language assistance programs.

(F) A process for filing and resolving consumer grievances and appeals, including, but not limited to, independent medical review.

(G) Prohibitions against deceptive marketing.

(H) Member documents that include a description of the benefit coverage, any applicable copays, how to access services, and how to submit a grievance.

(I) Mechanisms for resolving provider disputes, including an appeals process.

(7) The contract between the voluntary employees' beneficiary association or trust fund and each health care provider shall include all of the following:

(A) Provisions dividing financial responsibility between the parties and defining which party is financially responsible for services rendered, including arrangements for member care should a global or risk-bearing provider become insolvent.

(B) A delegation agreement.

(C) Requirements regarding utilization review or utilization management.

(D) Provisions stating the risk-based organization, limited licensee, or restricted licensee, as applicable, has the organizational and administrative capacity to provide services to covered employees, and that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management, including the disclosure of the percentage of risk assumed in relation to its total risk-based business.

(E) Requirements regarding the submission of claims by providers and the timely processing of provider claims, including a guarantee that the voluntary employees' beneficiary association or trust fund will indemnify any outstanding unpaid provider claim in the event of the insolvency of a participating provider to the pilot program.

(F) Require the health care provider to comply with the voluntary employees' beneficiary association or trust fund's requirements for all of the following:

(i) Continuity of care.

(ii) Language assistance.

(iii) Consumer grievances and appeals, including, but not limited to, independent medical review.

(8) The term of each contract between the voluntary employees' beneficiary association or trust fund and a health care provider does not exceed the period of the pilot program.

(9) To participate in the pilot program, each voluntary employees' beneficiary association or trust fund shall submit to the department an application consistent with paragraph (2) of subdivision (h). The department may select up to two qualified participants for the pilot program.

(10) Each health care provider that has entered into a contract with the voluntary employees' beneficiary association or trust fund is a party to the pilot program application submitted to the department. The application shall include a copy of each contract between the voluntary employees' beneficiary association or trust fund and a participating health care provider.

(11) (A) The voluntary employees' beneficiary association or trust fund and each health care provider participating in the pilot program agree to collect and report to the department, in each year of the pilot program, in a manner and frequency determined by the department, information regarding the comparative cost savings when compared to fee-for-service payment, performance measurements for clinical patient outcomes, and enrollee satisfaction. The department may require additional information be reported. Any additional reporting requirements shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.)

(B) The department may authorize a public or private agency to receive the information specified in this paragraph and monitor the pilot program under the data standard currently used by the Integrated Healthcare Association's "Align. Measure. Perform." (AMP) program and the California Regional Health Care Cost & Quality Atlas.

(b) This section does not exempt a health care provider that contracts with a voluntary employees' beneficiary association or trust fund as part of a pilot program authorized by subdivision (a) from the financial solvency requirements of Section 1375.4 and related department regulations, Section 1349 or 1351, or Section 1300.49 of Title 28 of the California Code of Regulations, as applicable, or any other provision of this chapter required by the department as part of the pilot program.

(c) Notwithstanding paragraph (3) of subdivision (a), this section does not exempt a voluntary employees' beneficiary association participating in a program authorized by subdivision (a) of Section 1349.2 from the requirement to reimburse providers on a fee-for-service basis.

(d) The participating voluntary employees' beneficiary association or trust fund shall each appoint an ombudsperson to monitor and respond to any complaint lodged by a participating enrollee in their respective pilot programs. If the enrollee is not satisfied with the result, the ombudsperson shall refer the enrollee to the department's grievance and appeal process as established pursuant to Section 1368. Determinations made by the

department pursuant to the grievance and appeal process shall be binding upon the voluntary employee's beneficiary association or trust fund.

(e) The participating voluntary employees' beneficiary association or trust fund shall report on a quarterly basis to the department any complaint lodged by a participating enrollee in their respective pilot programs, along with a description of the response and resolution.

(f) The global and risk-bearing providers participating in a pilot program authorized by subdivision (a) shall be approved by the department. The department shall retain the right to disapprove any pilot program application for any reason consistent with this chapter, including, but not limited to, failure to demonstrate to the department's satisfaction adequate enrollee protection and compliance with all criteria and requirements in this section.

(g) The department, after the termination of both pilot programs, and before January 1, 2027, shall submit a report to the Legislature regarding the costs and clinical patient outcomes of the pilot programs compared to fee-for-service payment models, including data on enrollee satisfaction, consumer and provider grievances, appeals, and independent medical reviews. The department may authorize a public or private agency in subparagraph (B) of paragraph (11) of subdivision (a) to prepare the report on behalf of the department. This report shall be submitted in compliance with Section 9795 of the Government Code.

(h) The pilot program participants shall reimburse the department for reasonable regulatory costs of up to five hundred thousand dollars ($500,000) for all of the following:

(1) Commissioning the report described in subdivision (g).

(2) Developing an application process for the pilot programs described in this section.

(3) Monitoring compliance with this section.

(i) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

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