CAHP LEGISLATIVE INFORMATION

AB 1124 (Maienschein)
Chapter 266, Statutes of 2020

As a service to our members, the California Association of Health Plans produces guidelines designed to assist in the interpretation and implementation of new laws, and to promote full compliance with those laws. This document, however, is not intended to be authoritative. Any questions about official interpretations of the law should be directed to the appropriate state regulatory agency such as the Department of Managed Health Care or the Department of Health Care Services, as well as your legal counsel.

HEALTH CARE SERVICE PLANS: REGULATIONS: EXEMPTIONS

BACKGROUND

Assembly Bill 1124 was introduced by Assemblymember Brian Maienschein (D-San Diego) and sponsored by the California Health Care Coalition, a membership organization of private and public sector employers, unions and health and welfare trust funds in California. The strongest support for the measure came from America's Physician Groups and an array of labor unions.

AB 1124 authorizes the Department of Managed Health Care (DMHC) to permit two pilot programs (one in Southern California and one in Northern California) that allow health care providers to undertake risk-bearing arrangements with a voluntary employees' beneficiary association (VEBA) or a trust fund that is a welfare plan, and a multiemployer plan. The bill permits these specified entities to undertake risk-bearing arrangements with providers, without the involvement of a fully state-licensed health plan. CAHP opposed this bill because this arrangement sets a dangerous precedent and does not provide the important consumer protections that licensed health plans must extend to their enrollees under the Knox-Keene Health Care Service Plan Act. The DMHC was also opposed to this bill for many of the same reasons.

A substantially similar bill, AB 1249 (Maienschein), was vetoed last year by Governor Newsom. In his veto message he stated that AB 1249 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." A major concern is the tenuous financial solvency of many provider groups. It bears noting that the Department of Managed Health Care (DMHC) promulgated regulations in October 2019 to address concerns about the financial solvency of risk-bearing organizations. As of 2020 Q1, there were 17 risk-bearing organizations that were on Corrective Action Plans for failure to meet financial solvency requirements.[1]

Supporters of AB 1124 attempt to address the Governor's veto of AB 1249 with amendments that try to protect consumers from financial risk should the risk-bearing organizations created by this bill face serious solvency issues. Specifically an amendment was added requiring the VEBA or trust to

[1] DMHC Financial Solvency Services Board (FSSB) Meeting:
https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSB%20August2020/AgendaItem9_ProviderSolvencyQuarterlyUpdate(Handout).pdf?ver=2020-08-18-102151-570

indemnify their members by directly paying for medical claims should the participating provider group become insolvent. This amendment, however, does not necessarily provide a viable guarantee for consumers against financial exposure. The bill also creates an unfair advantage as fully licensed health plans are required to comply with strict financial solvency requirements and may not subrogate the responsibility to pay claims to an employer group or to the consumer.

Despite the foundational policy flaws with AB 1124 and the opposition from the DMHC, the bill was popular in the Legislature and received strong bipartisan support.

<u>REQUIREMENTS</u>
AB 1124 adds and repeals Section 1343.3 of the Health and Safety Code, relating to health care service plans.

Specifically, AB 1124 does the following:

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) 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.

2) Requires the contract between the VEBA or trust fund and each health care provider to include requirements regarding the submission of claims by providers and the timely processing of provider

claims, including a guarantee that the VEBA or trust fund will indemnify any outstanding unpaid provider claim in the event of the insolvency of a participating provider to the pilot program.

3) 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.

4) 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. Sunsets this bill on January 1, 2028.