AB-2063 Health care coverage. (2023-2024)

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Assembly Bill No. 2063

CHAPTER 818

An act to amend Section 1343.3 of the Health and Safety Code, relating to health care coverage.

[Approved by Governor September 28, 2024. Filed with Secretary of State September 28, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2063, Maienschein. Health care coverage.

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 a health care service plan from the requirements of the act if the plan is 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.

Existing law authorizes the Director of the Department of Managed Health Care, 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 (VEBA) 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. Existing law requires the association or trust fund and each health care provider participating in each pilot program to report to the department information regarding cost savings and clinical patient outcomes compared to a fee-for-service payment model, and requires the department to report those findings to the Legislature no later than January 1, 2027. Existing law repeals these provisions on January 1, 2028.

This bill would instead authorize the director to authorize one pilot program in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a VEBA, as specified above, if certain criteria are met. The bill would extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for the pilot program to operate from December 31, 2025, to December 31, 2027. The bill would extend the deadline for the department to report the findings to the Legislature from January 1, 2027, to January 1, 2029.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1343.3 of the Health and Safety Code is amended to read:

1343.3. (a) The director, no later than May 1, 2021, may authorize 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, beginning no earlier than January 1, 2022, to December 31, 2027, 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 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.

(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 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 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 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'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 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 shall submit to the department an application consistent with paragraph (2) of subdivision (h).

(10) Each health care provider that has entered into a contract with the voluntary employees' beneficiary association 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 and a participating health care provider.

(11) (A) The voluntary employees' beneficiary association 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 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 shall appoint an ombudsperson to monitor and respond to any complaint lodged by a participating enrollee in the pilot program. 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.

(e) The participating voluntary employees' beneficiary association shall report on a quarterly basis to the department any complaint lodged by a participating enrollee in the pilot program, 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 the pilot program, and before January 1, 2029, shall submit a report to the Legislature regarding the costs and clinical patient outcomes of the pilot program 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 program described in this section.

(3) Monitoring compliance with this section.

(i) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.