

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013—14 REGULAR SESSION

ASSEMBLY BILL

No. 725

Introduced by Assembly Member Wilk

February 21, 2013

An act to ~~amend Section 1367.003~~ *add Chapter 8 (commencing with Section 127670) to Part 2 of Division 107 of the Health and Safety Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 725, as amended, Wilk. ~~Health care coverage. management: health court demonstration program.~~

The federal Patient Protection and Affordable Care Act (PPACA) enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA authorizes the federal Secretary of Health and Human Services to award states with demonstration grants to develop and test alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers and organizations. States interested in receiving a grant are required to develop an alternative to current tort litigation and submit an application to the secretary.

This bill would require the Secretary of California Health and Human Services to submit an application on behalf of the state to the federal Department of Health and Human Services to receive a grant for state demonstration programs to evaluate alternatives to current medical tort litigation, as authorized by PPACA. The bill would require the secretary to write the application to design a program to create health courts based upon a no-fault process to improve the injury resolution

of liability. The bill would specify what items a patient would need to prove under the health court demonstration program.

~~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 and makes a willful violation of the act a crime. Existing law prohibits a health care service plan from expending for administrative costs, as defined, an excessive amount of the payments the plan receives for providing health care services to its subscribers and enrollees.~~

~~The federal Patient Protection and Affordable Care Act prohibits a health insurance issuer issuing health insurance coverage from establishing lifetime limits or unreasonable annual limits on the dollar value of benefits for any participant or beneficiary, as specified. The act also requires a health insurance issuer issuing health insurance coverage to comply with minimum medical loss ratios and to provide an annual rebate to each insured if the medical loss ratio of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified.~~

~~Existing law requires health care service plans and health insurers to comply with the requirements imposed under those federal provisions, as specified. Existing law authorizes the Director of the Department of Managed Health Care and the Insurance Commissioner to promulgate regulations and emergency regulations to implement requirements relating to medical loss ratios, as specified.~~

~~This bill would make technical, nonsubstantive changes to those provisions:~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes. State-mandated local program: no.

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

1 SECTION 1. Chapter 8 (commencing with Section 127670) is
2 added to Part 2 of Division 107 of the Health and Safety Code, to
3 read:

4
5 CHAPTER 8. HEALTH COURT DEMONSTRATION PROGRAM

6
7 127670. The Secretary of California Health and Human
8 Services shall submit an application on behalf of the state to the
9 United States Department of Health and Human Services to receive

1 a grant for the State Demonstration Programs to Evaluate
2 Alternatives to Current Medical Tort Litigation, as authorized by
3 Section 10607 of the federal Patient Protection and Affordable
4 Care Act (PPACA).

5 127672. (a) The secretary shall write the application described
6 in Section 127670 to design a program to create health courts
7 based upon a no-fault process to improve the resolution of liability
8 for medical injury.

9 (b) In accordance with PPACA, the application shall
10 demonstrate how the proposed alternative does all of the following:

11 (1) Makes the medical liability system more reliable by
12 increasing the availability of prompt and fair resolution of disputes.

13 (2) Encourages the efficient resolution of disputes.

14 (3) Encourages the disclosure of health care errors.

15 (4) Enhances patient safety by detecting, analyzing, and helping
16 to reduce medical errors and adverse events.

17 (5) Improves access to liability insurance.

18 (6) Fully informs patients about the differences in the alternative
19 and current tort litigation.

20 (7) Provides patients the ability to opt out of or voluntarily
21 withdraw from participating in the alternative at any time and to
22 pursue other options, including litigation, outside the alternative.

23 (8) Does not conflict with state law at the time of the application
24 in a way that prohibits the adoption of the alternative to current
25 tort litigation.

26 (9) Does not limit or curtail a patient's existing legal rights,
27 ability to file a claim in or access the legal system, or otherwise
28 abrogate a patient's ability to file a medical malpractice claim.

29 (10) Does not conflict with the Medical Injury Compensation
30 Reform Act (MICRA), including, but not limited to, Section 6146
31 of the Business and Professions Code, Sections 3333.1 and 3333.2
32 of the Civil Code, and Section 667.7 of the Code of Civil
33 Procedure.

34 (11) Does not require any party to participate in the program.

35 127674. (a) Under the health court demonstration program,
36 a patient shall be required to prove only the following:

37 (1) He or she suffered an injury.

38 (2) The injury was caused by medical care.

39 (3) The injury meets specified severity criteria.

1 (b) A patient shall not be required to show a third party acted
2 in a negligent fashion.

3 SECTION 1. Section 1367.003 of the Health and Safety Code
4 is amended to read:

5 1367.003. (a) Every health care service plan that issues, sells,
6 renews, or offers health care service plan contracts for health care
7 coverage in this state, including a grandfathered health plan, but
8 not including specialized health care service plan contracts, shall
9 provide an annual rebate to each enrollee under such coverage, on
10 a pro rata basis, if the ratio of the amount of premium revenue
11 expended by the health care service plan on the costs for
12 reimbursement for clinical services provided to enrollees under
13 such coverage and for activities that improve health care quality
14 to the total amount of premium revenue, excluding federal and
15 state taxes and licensing or regulatory fees and after accounting
16 for payments or receipts for risk adjustment, risk corridors, and
17 reinsurance, is less than the following:

18 (1) With respect to a health care service plan offering coverage
19 in the large group market, 85 percent.

20 (2) With respect to a health care service plan offering coverage
21 in the small group market or in the individual market, 80 percent.

22 (b) Every health care service plan that issues, sells, renews, or
23 offers health care service plan contracts for health care coverage
24 in this state, including a grandfathered health plan, shall comply
25 with the following minimum medical loss ratios:

26 (1) With respect to a health care service plan offering coverage
27 in the large group market, 85 percent.

28 (2) With respect to a health care service plan offering coverage
29 in the small group market or in the individual market, 80 percent.

30 (c) (1) The total amount of an annual rebate required under this
31 section shall be calculated in an amount equal to the product of
32 the following:

33 (A) The amount by which the percentage described in paragraph
34 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph
35 (1) or (2) of subdivision (a).

36 (B) The total amount of premium revenue, excluding federal
37 and state taxes and licensing or regulatory fees and after accounting
38 for payments or receipts for risk adjustment, risk corridors, and
39 reinsurance.

1 ~~(2) A health care service plan shall provide any rebate owing~~
2 ~~to an enrollee no later than August 1 of the calendar year following~~
3 ~~the year for which the ratio described in subdivision (a) was~~
4 ~~calculated.~~

5 ~~(d) (1) The director may adopt regulations in accordance with~~
6 ~~the Administrative Procedure Act (Chapter 3.5 (commencing with~~
7 ~~Section 11340) of Part 1 of Division 3 of Title 2 of the Government~~
8 ~~Code) that are necessary to implement the medical loss ratio as~~
9 ~~described under Section 2718 of the federal Public Health Service~~
10 ~~Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations~~
11 ~~issued under that section.~~

12 ~~(2) The director may also adopt emergency regulations in~~
13 ~~accordance with the Administrative Procedure Act (Chapter 3.5~~
14 ~~(commencing with Section 11340) of Part 1 of Division 3 of Title~~
15 ~~2 of the Government Code) when it is necessary to implement the~~
16 ~~applicable provisions of this section and to address specific~~
17 ~~conflicts between state and federal law that prevent implementation~~
18 ~~of federal law and guidance pursuant to Section 2718 of the federal~~
19 ~~Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial~~
20 ~~adoption of the emergency regulations shall be deemed to be an~~
21 ~~emergency and necessary for the immediate preservation of the~~
22 ~~public peace, health, safety, or general welfare.~~

23 ~~(e) The department shall consult with the Department of~~
24 ~~Insurance in adopting necessary regulations, and in taking any~~
25 ~~other action for the purpose of implementing this section.~~

26 ~~(f) This section shall be implemented to the extent required by~~
27 ~~federal law and shall comply with, and not exceed, the scope of~~
28 ~~Section 2791 of the federal Public Health Service Act (42 U.S.C.~~
29 ~~Sec. 300gg-91) and the requirements of Section 2718 of the federal~~
30 ~~Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules~~
31 ~~or regulations issued under those sections.~~

32 ~~(g) This section shall not be construed to apply to provisions of~~
33 ~~this chapter pertaining to financial statements, assets, liabilities,~~
34 ~~and other accounting items to which subdivision (s) of Section~~
35 ~~1345 applies.~~

36 ~~(h) This section shall not be construed to apply to a health care~~
37 ~~service plan contract or insurance policy issued, sold, renewed, or~~
38 ~~offered for health care services or coverage provided in the~~
39 ~~Medi-Cal program (Chapter 7 (commencing with Section 14000)~~
40 ~~of Part 3 of Division 9 of the Welfare and Institutions Code), the~~

1 ~~Healthy Families Program (Part 6.2 (commencing with Section~~
2 ~~12693) of Division 2 of the Insurance Code), the Access for Infants~~
3 ~~and Mothers Program (Part 6.3 (commencing with Section 12695)~~
4 ~~of Division 2 of the Insurance Code), the California Major Risk~~
5 ~~Medical Insurance Program (Part 6.5 (commencing with Section~~
6 ~~12700) of Division 2 of the Insurance Code), or the Federal~~
7 ~~Temporary High Risk Insurance Pool (Part 6.6 (commencing with~~
8 ~~Section 12739.5) of Division 2 of the Insurance Code), to the extent~~
9 ~~consistent with the federal Patient Protection and Affordable Care~~
10 ~~Act (Public Law 111-148).~~

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