Date of Hearing: May 18, 2020

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2157 (Wood) – As Introduced February 10, 2020

SUBJECT: Health care coverage: independent dispute resolution process.

SUMMARY: Makes changes to existing law enacted under AB 72 (Bonta), Chapter 942, Statutes of 2016, that requires the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to establish an independent dispute resolution process (IDRP) for claims and claim disputes related to covered services provided at a contracted health facility by a noncontracting individual health care professional. Specifically, **this bill**:

1) Requires the IDRP established by DMHC and CDI, for claims and claim disputes related to covered services provided at a contracted health facility by a noncontracting individual health care professional, to include a process for each party to submit confidential evidence information in order to preserve the confidentiality of the source contract.

2) Requires the IDRP organization to conduct a de novo review of the claim dispute, based solely on the information and documents timely submitted into evidence by the parties.

3) Requires the IDRP organization to assign reviewers to each case based on their relevant education, background, and medical claims payment and clinical experience.

EXISTING LAW:

1) Establishes the DMHC to regulate health plans and the CDI to regulate health insurers.

2) Requires contracts between providers and health plans to be in writing and prohibits, except for applicable copayments and deductibles, a contracted provider from invoicing or balance billing a health plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the health plan or the health plan's capitated provider for any covered benefit.

3) Prohibits a provider, in the event that a contract has not been reduced to writing, or does not contain the prohibition above, from collecting or attempting to collect from the subscriber or enrollee sums owed by the health plan. Prohibits a contracting provider, agent, trustee or assignee from taking action at law against a subscriber or enrollee to collect sums owed by the health plan.

5) Establishes a payment rate, which is the greater of the average of a health plan or health insurer's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services; and, an IDRP for claims and claim disputes related to covered services provided at a contracted health facility by a non-contracting individual health care professional for health plan contracts and health policies issued, amended, or renewed on or after July 1, 2017. Limits enrollee and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, the IDRP for surprise balance billing health insurance claims has been in place for a couple of years now and this bill addresses some of the concerns raised by the providers impacted by recent legislation.

2) **BACKGROUND.**

   a) **Surprise Balance Billing.** AB 72 is a consumer protection measure that ensures health plan enrollees only have to pay their in-network cost sharing (co-pays, co-insurance, or deductibles) when faced with surprise balance billing scenarios in which a patient seeks services (for example, surgery) from a contracted hospital, however, receives services (for example, anesthesia) from a non-contracted provider. Providers cannot bill consumers more than their in-network cost sharing. AB 72 establishes a payment rate, which is the greater of the average of a health plan or health insurer's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services. AB 72 also establishes an IDRP for claims and claim disputes related to covered services provided at a contracted health facility by a non-contracting individual health care professional. AB 72 limits enrollee and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

   b) **AB 72 IDRP.** AB 72 authorizes the DMHC and CDI to contract with one or more independent organizations to conduct the AB 72 IDRP. The decision of the IDRP organization is binding on the parties, however after completing the AB 72 IDRP, a dissatisfied party may pursue any right, remedy, or penalty established under any other applicable law.

      According to the DMHC, the IDRP organization reviewing each AB 72 IDRP claim(s) dispute will have a maximum of 30 calendar days following receipt of payment to provide the DMHC with an AB 72 IDRP Decision Letter. The IDRP organization's decision regarding the appropriate reimbursement amount for the claim(s) dispute is based on all relevant information as submitted by the parties to the AB 72 IDRP. The AB 72 IDRP decision drafted by the IDRP organization will provide a written explanation of the appropriate reimbursement amount decision, and will include a list of appropriate reimbursement amounts by relevant billing code. The IDRP organization is not limited to the suggested appropriate reimbursement amounts offered by each party when making its decision.

      On September 1, 2017, the DMHC implemented an IDRP for claims payment disputes between payors and non-contracting individual health professionals for specified services rendered at contracting facilities. As part of the implementation process, the DMHC developed an online IDRP submission website in partnership with an IDRP vendor.

      As of December 31, 2018, the DMHC has received 39 IDRP applications. Of those, 37 were closed prior to a reimbursement decision and two applications are pending.

      i) Seventeen, or 46% of the closed applications, were withdrawn by the applicant;

ii) Thirteen, or 35%, were ineligible for the IDRP, primarily because the facility was not a contracting facility;
iii) Five, or 14%, were non-jurisdictional, meaning the disputed claims concerned enrollees of a health plan product not licensed by the DMHC; and,
iv) Two, or 5%, were incomplete applications.

c) DMHC response to IDRP concerns. In December 2019, the California Society of Anesthesiologists (CSA), sponsor of this bill, drafted a letter detailing provider concerns as it relates to the AB 72 IDRP process.

In response to CSA's concerns, as well as the concerns of other stakeholder groups, the DMHC drafted a letter committing to make a few changes to the AB 72 Written Procedures and Guidelines (Guidelines). These changes include the following:

i) The DMHC will add a provision stating the IDRP portal shall allow each party to submit information that will be kept confidential from the other party. This change is in response to CSA's statement that providers are at a disadvantage because they cannot submit documents due to confidentiality concerns. The DMHC will work with the IDRP organization to make appropriate system changes to the IDRP portal.
ii) The DMHC will also add a provision stating reviewers shall be assigned to disputes based on their relevant education, background, and medical claims payment and clinical experience. This language is already part of the DMHC's contract with the IDRP organization, but the DMHC will clarify this in the Guidelines.
iii) The DMHC will add a provision stating the review shall be "de novo" and "true arbitration." This is not a departure from current practice, but the DMHC will clarify this in the Guidelines to ensure the parties understand the IDRP landscape.

3) SUPPORT. CSA, the sponsor of this bill, states that some payors and delegated entities have taken advantage of the law and paid providers, anesthesiologists in particular, far lower average contracted rates than many providers would consider their true fair average in that region. Compounding this is the fact that the physician groups that contract with health plans and provide anesthesia services do not know the average contracted rates for that region, since anti-trust laws prohibit physician groups and health plans from discussing payments and incentives with their competitor. However, health plans contract with multiple providers and have a much better vantage point of the local price ranges. According to CSA, this bill codifies recent changes to DMHC's IDRP sought by physician groups to ensure fairness in certain billing disputes**.**

4) SUPPORT IF AMENDED. Health Access, has a support if amended position and seeks the following amendment, to ensure that the IDRP is conducted in a manner that takes into account all aspects of the claim:

(5) *(A)* In deciding the dispute, the independent organization shall conduct a de novo review and base its decision regarding the appropriate reimbursement **on all relevant information solely on including** the information and documents timely submitted into evidence by the parties to the dispute.

5) RELATED LEGISLATION. AB 1611 (Chiu) of 2019 limits the cost-sharing required of a patient receiving covered emergency services at a hospital that does not have a contract with

the patient's health plan, insurer, or other third-party payor to no more than the same cost-sharing that the patient would pay for the same covered emergency services received from a contracting hospital. Establishes as the rate of payment for those services, the reasonable and customary value of the hospital services or the average contracted rate for the same or similar hospital services in the general geographic region in which the services where rendered. AB 1611 was made a two year bill and is pending in Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) AB 1174 (Wood) of 2019 would have required a health plan, its delegated entity, or a health insurer to notify the DMHC or CDI before the expiration or plan-, entity-, or insurer-initiated termination of a contract pursuant to which anesthesia services are provided. AB 1174 was held in the Assembly Appropriations Committee.

b) AB 72 establishes a payment rate, which is the greater of the average of a health plan or health insurer's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services; and an IDRP for claims and claim disputes related to covered services provided at a contracted health facility by a non-contracting individual health care professional for health plan contracts and health policies issued, amended, or renewed on or after July 1, 2017. Limits enrollee and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

c) SB 1252 (Stone) of 2016 would have required a general acute care hospital, surgical clinic, and an attending physician, as applicable, to notify the patient, in writing, of the net costs to the patient for the medical procedure being done, as provided, when a medical procedure is scheduled to be performed on a patient; and, would have required disclosure, in writing, if any of the physicians providing medical services to the patient are not contracted with the patient's health plan or health insurer and the costs for which the patient would be responsible as a result. SB 1252 was set for hearing in the Senate Health Committee, but not heard per the request of the author.

d) AB 533 (Bonta) of 2015 would have required DMHC and CDI to establish a binding IDRP for claims for non-emergency covered services provided at contracted health facilities by a non-contracting health care professional. AB 533 would have limited enrollee and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional; and, required the plan or insurer to base reimbursement for covered services on the amount the individual health professional would have been reimbursed by Medicare for the same or similar services in the geographic area in which the services were rendered. AB 533 failed passage on the Assembly Floor.

e) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data, as specified, to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

REGISTERED SUPPORT / OPPOSITION:

Support

California Society of Anesthesiologists (sponsor)
Allied Anesthesia Medical Group
California Chiropractic Association
California Orthopedic Association
California Society of Anesthesiologists
Vaprnet Anesthesiology Network
Numerous providers

Opposition

None on file.

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