SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: AB 2157
AUTHOR: Wood
VERSION: February 10, 2020
HEARING DATE: August 1, 2020
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Due to the COVID-19 Pandemic and the unprecedented nature of the 2020 Legislative Session, all Senate Policy Committees are working under a compressed timeline. This timeline does not allow this bill to be referred and heard by more than one committee as a typical timeline would allow. In order to fully vet the contents of this measure for the benefit of Senators and the public, this analysis includes information from the Senate Judiciary Committee.

SUBJECT: Health care coverage: independent dispute resolution process

SUMMARY: Requires the Department of Managed Health Care and the California Department of Insurance to include confidential information as part of the independent dispute resolution process (IDRP) created for processing and resolving claims disputes between health plans/health insurers and noncontracting health professionals, and requires the IDRP organization to conduct a de novo review, and assign reviewers with relevant background and experience.

Existing law:
1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance. [HSC §1340, et seq. and INS §106, et seq.]

2) Establishes a payment rate for covered services provided by noncontracting health professionals at contracting facilities, 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. [HSC §1371.31 and INS §10112.8]

3) Requires DMHC and CDI to establish an IDRP for processing and resolving a claim dispute between a health plan/health insurer and a noncontracting individual health professional related to covered services provided at a contracted health facility, as specified. Requires DMHC and CDI to establish uniform written procedures and guidelines. [HSC §1371.30 and INS §10112.81]

4) Requires the IDRP organization to be independent and to base its decision regarding appropriate reimbursement on all relevant information. [HSC §1371.30 and INS §10112.81]

This bill:
1) Requires DMHC and CDI to include in the IDRP process a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract.

2) Requires the IDRP organization to conduct a de novo review and base its decision solely on the information and documents timely submitted into evidence by the parties to the dispute.

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

FISCAL EFFECT: According to the Assembly Appropriations Committee analysis, costs to DMHC are minor and absorbable (Managed Care Fund), and $120,000 in staff costs to CDI if regulations are necessary to incorporate these new requirements into existing processes (Insurance Fund).

PRIOR VOTES:

Assembly Floor:	76 - 0
Assembly Appropriations Committee:	18 - 0
Assembly Health Committee:	15 - 0

COMMENTS:

1) *Author's statement.* 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 this recent legislation.

2) *Surprise bills.* Surprise bills can arise when a patient receives planned care at an in-network facility but later finds out that an out-of-network provider (i.e., anesthesiologist, pathologist, or radiologist) provided treatment. This practice is called "surprise balance billing" when it happens at an in-network facility because most consumers cannot distinguish or control when an out-of-network provider is providing services at an in-network facility. To stop this practice and remove consumers from the middle of these billing disputes AB 72 (Bonta, Chapter 492, Statutes of 2016) was enacted, which prohibits providers from surprise balance billing consumers, and also created a default reimbursement rate (125% of Medicare or the average contracted rate for that region, whichever is greater) for out-of-network or non-contracted providers to resolve payment disputes with health plans/insurers and not involve consumers. In compliance with AB 72, both CDI and DMHC each launched an IDRP in 2017 as a mechanism for non-contracted providers, health plans and health insurers to dispute the default reimbursement amount. According to DMHC's annual report, in 2019, DMHC received 32 IDRP applications. Of those, nine were ineligible, nonjurisdictional or withdrawn, and 22 completed the process and a determination letter was issued. One IDRP was pending as of December 31, 2019. According to DMHC, in 2019, one determination letter awarded additional reimbursement to the provider and 21 determination letters found that the payor's reimbursement was appropriate. In March 2020, DMHC's IDRP guidelines and submission portal were updated to allow parties to submit information about contracted rate information confidentially (visible only to DMHC and the external reviewer). One recent (July 2020) IDRP determination letter where the provider used the new portal capabilities to submit confidential evidence of its commercial contracted rates resulted in the external reviewer finding that the payor's reimbursement for the claim was too low. DMHC has observed that majority of the submissions are from anesthesiologists. According to CDI, there have been no submissions to IDRP.

3) *IDRP process.* According to the DMHC website, once a noncontracting provider or payor submits an AB 72 IDRP application, the opposing party is required by law to participate. AB 72 authorizes DMHC to contract with one or more independent organizations to conduct the AB 72 IDRP. The decision of the independent organization is binding on the parties, but after completing the AB 72 IDRP, a dissatisfied party may pursue any right, remedy, or penalty

established under any other applicable law. The AB 72 IDRP is conducted electronically through a web-based portal that is managed by MAXIMUS Federal Services, Inc., (MAXIMUS), the independent organization currently conducting the AB 72 IDRP. Noncontracting providers and payors may request independent review through the AB 72 IDRP for an individual claim or multiple claims (up to 50) involving the same or similar services, same noncontracting provider and the same health care service plan. A provider in which these parameters do not apply may be eligible for DMHC's Emergency Services IDRP, or can file a complaint against a plan. AB 72 does not apply to emergency services and care, dental providers, or to Medi-Cal managed care plans.

Eligible claim disputes are those disputes that are subject to DMHC jurisdiction and meet specified criteria such as:

- The disputed claim must be for services rendered on or after July 1, 2017.
- The disputed claim must be for non-emergency services. If there is an unresolved dispute as to whether the health care service(s) at issue is non-emergent, the claim does not qualify for the AB 72 IDRP.
- The disputed claim must be for covered services provided at a contracting health facility, or provided as a result of covered services at a contracting health facility, by a noncontracting individual health professional.
- The noncontracting provider has completed the health plan or payor's Provider Dispute Resolution (PDR) process within the last 365 days.

Claim disputes that do not meet the criteria listed above, including disputes concerning claims that have not been submitted to (and completed) the health plan or payor's PDR process, are ineligible for the AB 72 IDRP. This includes claim disputes that are not subject to DMHC jurisdiction, late payment disputes, disputes regarding claims that do not involve covered benefits, and claims denied on the basis that the services were not medically necessary or were experimental/investigational in nature.

Upon submission of a complete application through the web-based portal, DMHC will review the submission and then, if the submitter is a noncontracting provider, contact the health plan to confirm DMHC jurisdiction and identify the responsible payor. Once DMHC jurisdiction is confirmed and both parties to the AB 72 IDRP are clearly identified, the opposing party will have a full opportunity to submit any information and/or documents relevant to the reimbursement amount for the claim(s) at issue. After DMHC confirms that the claim(s) dispute meets the requirements for the AB72 IDRP, the claim(s) dispute will be forwarded to MAXIMUS for review. A claim form and PDR determination letter, and Explanation(s) of Benefits or Remittance Advice must be included with an IDRP application in order for it to be processed by DMHC. It is each participant's responsibility to redact all proprietary, confidential, or protected health information that should not be viewed by DMHC, MAXIMUS, or parties to the AB 72 IDRP. Additionally, it is each AB 72 IDRP participant's responsibility to redact all identifying information relating to patient claims that are not in dispute from documents uploaded to the AB 72 IDRP portal.

5) *IDRP decisions.* MAXIMUS has a maximum of 30 calendar days following receipt of payment from the parties to provide DMHC with an AB 72 IDRP Decision Letter. MAXIMUS' decision regarding the appropriate reimbursement amount for the claim(s)

dispute is based on all relevant information as submitted by the parties. This information includes, but is not limited to, information regarding the following factors:

a) The provider's training, qualifications, and length of time in practice;
b) The nature of the services provided;
c) The fees usually charged by the provider;
d) Prevailing provider rates charged in the general geographic area in which the services were rendered;
e) Other aspects of the economics of the medical provider's practice that are relevant; and,
f) Any unusual circumstances in the case.

The AB 72 IDRP decision provides a written explanation of the appropriate reimbursement amount decision, and includes a list of appropriate reimbursement amounts by relevant billing code. MAXIMUS is not limited to the suggested appropriate reimbursement amounts offered by each party when making its decision.

6) *Complaints about the IDRP process.* According to background information provided by proponents, a number of anesthesia providers have submitted reimbursement disputes through DMHC AB 72 IDRP. The final determination letters from MAXIMUS have rejected most or all evidence submitted by the providers. MAXIMUS ruled for the payor in each instance. The objections raised by MAXIMUS related to documentary evidence (or the lack of such evidence) and a failure to explain the evidence submitted. Related to the most recent July 2020 determination letter, although MAXIMUS ruled for the provider for the first time, it appears to continue to employ a "baseball" arbitration approach rather than independently determining the appropriate rate. That is, it decides whether the payor or the providers proposed rate is more reasonable. Also, MAXIMUS has continued to reject out of hand information the provider has submitted consistent with DMHC guidance.

7) *Related legislation.* AB 1611 (Chiu), pending in the Senate Health Committee, 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.

8) *Prior legislation.* 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 independent dispute resolution process for claims and claim disputes related to covered services provided at a contracted health facility by a noncontracting individual health care professional. 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.

9) *Support*. The California Society of Anesthesiologists, (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.

10) *Support if amended*. Health Access California requests an amendment to allow all relevant information to be considered as part of the IDRP process. As an example, Health Access California suggests the Health Care Payments Database may have relevant data that may not be submitted by either party in the process but should be considered by the IDRP reviewer.

11) *Policy comment*. According to the Senate Judiciary Committee, this bill touches on various issues within the jurisdiction of the Senate Judiciary Committee, most prominently the issues of arbitration and the interplay between due process and confidentiality of evidence. According to the author, this bill addresses certain concerns with IDRP for surprise balance billing health insurance claims that has been in place for a couple of years. According to the author, while the independent review has always been in the form of a "de novo" arbitration from the health plan's internal dispute process, this bill clarifies the procedure as such. While there is significant controversy over the use of arbitration in lieu of litigation, particularly in situations where one party is at a significant disadvantage (such as consumer and employment contracts), the procedure contemplated here is in the nature of an administrative appeal, and many of the bill's supporters are physicians who participate in the dispute resolution process and believe this bill will provide better balance between physicians and health plans/and or insurers in disputes over payment. With respect to the provision requiring a provision for the submission of evidence on a confidential basis, the procedures established by DMHC and CDI will need to ensure that the procedures for confidential evidence provide sufficient protections for the party against whom the confidential evidence is offered.

SUPPORT AND OPPOSITION:

Support: California Society of Anesthesiologists (sponsor)
Allied Anesthesia Medical Group
California Chiropractic Association
California Orthopaedic Association
VaPRNet Anesthesiology Network
Ventana Anesthesia Associates

Oppose: None received

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