SENATE RULES COMMITTEE AB 2157
Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: AB 2157
Author: Wood (D)
Introduced: 2/10/20
Vote: 21

SENATE HEALTH COMMITTEE: 8-0, 8/1/20
AYES: Pan, Lena Gonzalez, Grove, Hurtado, Leyva, Mitchell, Monning, Rubio
NO VOTE RECORDED: Melendez

SENATE APPROPRIATIONS COMMITTEE: 7-0, 8/13/20
AYES: Portantino, Bates, Bradford, Hill, Jones, Leyva, Wieckowski

ASSEMBLY FLOOR: 76-0, 6/8/20 (Consent) - See last page for vote

SUBJECT: Health care coverage: independent dispute resolution process

SOURCE: California Society of Anesthesiologists

DIGEST: This bill requires the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) 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.

ANALYSIS:

Existing law:

1) Establishes the DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the 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 claims 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.

Comments

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.

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.

IDRP process. The AB 72 IDRP is conducted electronically through a web-based portal that is managed by MAXIMUS Federal Services, Inc., (MAXIMUS), which is 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. 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:

1) The provider's training, qualifications, and length of time in practice;

2) The nature of the services provided;

3) The fees usually charged by the provider;

4) Prevailing provider rates charged in the general geographic area in which the services were rendered;

5) Other aspects of the economics of the medical provider's practice that are relevant; and,

6) 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.

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.

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.

Related/Prior Legislation

AB 72 (Bonta, Chapter 492, Statutes of 2016) established 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. 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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Senate Appropriations Committee:

- *CDI*. The department reports one-time costs of $120,000 (Insurance Fund) for 0.67 FTE to promulgate regulations (approximately 1,191 hours). However, staff notes this figure may be lower to the extent regulations do not need to be promulgated, but need only to be analyzed, in a similar approach as DMHC, and adjusted in a minor way.

- *DMHC*. The department's Office of Legal Services anticipates one-time $33,000 (Managed Care Fund) and 0.2 PY in FY 2020-21 to clarify this bill's requirements with the existing process.

SUPPORT: (Verified 8/14/20)

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

OPPOSITION: (Verified 8/14/20)

None received

ARGUMENTS IN 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.

ASSEMBLY FLOOR: 76-0, 6/8/20
AYES: Aguiar-Curry, Arambula, Bauer-Kahan, Berman, Bigelow, Bloom, Boerner Horvath, Bonta, Brough, Burke, Calderon, Carrillo, Cervantes, Chau, Chen, Chiu, Choi, Chu, Cooley, Cooper, Cunningham, Megan Dahle, Daly, Diep, Eggman, Flora, Fong, Frazier, Friedman, Gabriel, Gallagher, Cristina Garcia, Eduardo Garcia, Gipson, Gloria, Gonzalez, Gray, Grayson, Holden, Irwin, Jones-Sawyer, Kalra, Kamlager, Kiley, Lackey, Levine, Limón, Maienschein, Mathis, Mayes, McCarty, Medina, Mullin, Nazarian, Obernolte, O'Donnell, Patterson, Petrie-Norris, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Salas, Santiago, Smith, Mark Stone, Ting, Voepel, Waldron, Weber, Wicks, Wood, Rendon
NO VOTE RECORDED: Low, Muratsuchi, Quirk

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
8/19/20 14:12:12

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