Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 533
Author: Bonta (D)
Amended: 9/4/15 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 6-2, 7/15/15
AYES: Hernandez, Hall, Mitchell, Monning, Roth, Wolk
NOES: Nguyen, Nielsen
NO VOTE RECORDED: Pan

SENATE APPROPRIATIONS COMMITTEE: 5-2, 8/27/15
AYES: Lara, Beall, Hill, Leyva, Mendoza
NOES: Bates, Nielsen

SENATE HEALTH COMMITTEE: 7-1, 9/9/15 (pursuant to Senate Rule 29.10)
AYES: Hernandez, Hall, Mitchell, Monning, Nielsen, Roth, Wolk
NOES: Pan
NO VOTE RECORDED: Nguyen

ASSEMBLY FLOOR: 74-1, 6/2/15 - See last page for vote

SUBJECT: Health care coverage: out-of-network coverage

SOURCE: Health Access California

DIGEST: This bill requires the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to establish a binding independent dispute resolution process (IDRP) for claims for non-emergency covered services provided at contracted health facilities by a non-contracting health care professional. This bill 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.

Senate Floor Amendments of 9/4/15 1) delete the requirement that the DMHC and CDI jointly establish written procedure, 2) delete the provision which would have required the plan or insurer to base reimbursement of non-contracted claims, as specified, on the average rates based on the statistically credible information, as specified. Instead, requires reimbursement to be based on the amount the individual health professional would have been reimbursed by Medicare for the same or similar services in the general geographic area in which services were rendered, 3) delete a requirement that plans maintain statistically credible information, 4) delay until July 1, 2016, the implementation of the provisions to limit an enrollee or insureds cost sharing to in-network cost sharing, as specified, 5) revise the provision which allows an enrollee or insured to voluntarily agree to charges of a noncontracting provider that are more than the in-network cost sharing, specifically by requiring the enrollee or insured to consent in writing at least three business days in advance of care (instead of 24 hours), 6) delete a disclosure that the cost of the services will not accrue to the limit on annual out-of-pocket expense or the enrollee's or insured's deductible, and 7) make other clarifying changes to the bill.

ANALYSIS:

Existing law:

1) Provides for the regulation of health plans by the DMHC under the Knox-Keene Act and for health insurers by the CDI under the Insurance Code.

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

4) Allows a non-contracted provider to dispute the appropriateness of a health plan's computation of the reasonable and customary value and requires the health plan to respond to the dispute through the plan's mandated provider

dispute resolution process.

5) Prohibits a hospital which contracts with an insurer, nonprofit hospital service plan, or health plan from determining or conditioning medical staff membership or clinical privileges upon the basis of a physician and surgeon's or podiatrist's participation or nonparticipation in a contract with that insurer, hospital service plan or health plan.

This bill:

1) Requires DMHC and CDI to each establish an IDRP for the purpose of processing and resolving a claim dispute between a health plan or insurer and a non-contracting individual health professional for non-emergency services provided at a contracting health facility. Makes the determination obtained through IDRP binding on both parties.

2) Requires both parties to participate in the IDRP if initiated by either party.

3) Permits DMHC and CDI to contract with one or more independent organizations for the IDRP and requires the departments to establish additional requirements, including conflict-of-interest standards.

4) Requires, unless otherwise provided in this bill or otherwise agreed by the non-contracting health professional and the plan or insurer, 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.

5) Requires, if non-emergency services are provided by a noncontracting individual health professional to an enrollee who has voluntarily chosen to use his or her out-of-network benefit for services covered by a preferred provider organization or a point of service plan, unless otherwise agreed to by the plan and the health professional, the amount paid shall be the amount set forth in the enrollee's evidence of coverage.

6) Limits enrollee or insured cost sharing under a health plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2016, when an enrollee or insured obtains care from a contracting health facility at which, or as a result of which, the enrollee or insured receives services provided by a non-contracting health professional, to the same cost sharing that the enrollee

or insured would pay for the same covered benefits received from a contracting health professional.

7) Requires the plan or insurer to inform the non-contracting health professional of the in-network cost sharing owed by the enrollee or insured. Requires the non-contracting health professional to refund any overpayment within 30 working days of receiving the in-network cost sharing amount. Requires, if overpayment is not refunded within 30 working days, interest to accrue at the rate of 15% per annum beginning with the first calendar day after the 30-working day period and the health professional to automatically include the interest with the refund.

8) Prohibits payment of a non-contracting health professional if any amount owed by the enrollee or insured has advanced to collections. Requires a non-contracting health professional to affirm in writing that he or she has not advanced to collections any payment owed by the enrollee or insured when submitting a claim to the plan or insurer. Permits any in-network cost sharing to advance to collections after payment by the plan or insurer if the enrollee or insured fails to pay the amount owed.

9) Requires enrollee or insured cost sharing arising from services received by a non-contracting health professional at a contracting facility to be counted toward any limit on annual out-of-pocket expenses and any deductible in the same manner as cost sharing would be attributed to a contracting health professional.

10) Defines "contracted health facility" as a health facility that is contracted to provide services under the enrollee's health plan contract or insured's health insurance policy and includes: hospital, skilled nursing facility, ambulatory services or other outpatient settings, as specified, laboratory, radiology or imaging, facilities providing mental health or substance abuse treatment, and any other provider as the DMHC or CDI may by regulation define as a health facility for purpose of this bill.

11) Defines "individual health professional" as a California licensed physician or surgeon.

12) Permits an enrollee or insured to voluntarily consent to the use of a non-contracting individual health professional if, in at least three business days in advance of the receipt of services, the enrollee or insured is provided a written

estimate of the cost of care and consents in writing to both the use of a non-contracting individual health professional and payment of the estimated additional cost.

Comments

1) *Author's statement*. According to the author, this bill will protect patients who do the right thing by seeking care in an in-network facility, only to later receive a surprise bill from an out-of-network provider that had been called in to provide service. Surprise bills cost consumers substantial sums of money, placing an undeserved and unreasonable financial burden upon them. Consumers should not be placed in the middle of billing conflicts and disputes between out-of-network providers and plans or insurers, particularly when they sought in-network care but were seen by an out-of-network provider through no fault of their own. While California has been at the forefront of the federal Patient Protection and Affordable Care Act implementation, the state needs to catch up to other states that have taken the lead in fully protecting consumers from surprise bills. It is the state's responsibility to ensure full consumer protection for all of our patients, and this bill is a critical measure to ensure patients are safeguarded from hidden costs unfairly imposed upon them when they have followed the rules.

2) *Out-of-network services and surprise bills*. A recent survey commissioned by the Consumer Reports National Research Center found that nearly one third of privately insured Americans received a surprise medical bill where their health plan paid less than expected in the past two years. Among the 2,200 adult U.S. respondents, nearly one out of four got a bill from a doctor they did not expect to get a bill from. Survey findings also suggest that consumers overall seem largely confused when it comes to their rights to fight surprise bills. Based on the California respondents to this survey, one in four privately insured Californians faced surprise medical bills. One quarter of Californians who had hospital visits or surgery in the past two years were charged an out-of-network rate when they thought the provider was in-network. Sixty-three percent assume doctors at an in-network hospital are also in-network.

3) *Unfair claims practices*. AB 1455 (Scott, Chapter 1827, Statutes of 2000) prohibits unfair claims practices, and the resulting regulations detailed requirements health plans must meet in processing and paying claims for both contracting and non-contracting providers. The AB 1455 regulations define reimbursement of a claim for non-contracting providers as the "reasonable and

customary value," based on statistically credible information that is updated at least annually, and that takes into consideration the following specified criteria: 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. These regulations codified the factors for determining non-contracted provider reimbursement as outlined in *Gould v. Workers' Compensation Appeals Board, City of Los Angeles*, (1992) 4 Cal.App.4th 1059, 1071. Consequently, the AB 1455 regulations are often referred to as requiring payments for non-contracting providers according to the "Gould criteria." More recently in *Children's Hospital Central California v. Blue Cross of California et.al*, (2014) 226 Cal.App4th 1260, 172. the appellate court determined that the Gould criteria includes more than the charges billed by the provider. Charges are just one data point and payments and rates accepted by other payors could also be considered. Because of this decision, the criteria proposed in this bill are slightly modified from the Gould criteria in that they include "prevailing provider rates charged *or paid* in the general geographic area in which the services were rendered."

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

According to the Senate Appropriations Committee:

1) One-time costs of about $500,000 for the development of regulations and review of plan filings by DMHC (Managed Care Fund).
2) Annual costs of $1.5 million to $3 million per year for the IDRP that DMHC convenes to settle a dispute between a provider and a health plan (Managed Care Fund).
3) One-time costs of about $550,000 for the development of regulations and review of plan filings by CDI (Insurance Fund).
4) Annual costs of $900,000 per year for the IDRP that CDI convenes to settle a dispute between a provider and a health plan (Insurance Fund).

SUPPORT: (Verified 9/9/15)

Health Access California (source)
AARP

America's Health Insurance Plans
American Cancer Society Cancer Action Network
American Federation of State, County and Municipal Employees
Anthem Blue Cross
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Association of Health Underwriters
California Association of Physician Groups
California Black Health Network
California Chamber of Commerce
California Labor Federation
California Pan-Ethnic Health Network
California Primary Care Association
California Professional Firefighters
California Public Employees Retirement System Board of Administration
California School Employees Association
California State Council of the Service Employees International Union
California Teachers Association
CALPIRG
Children Now
Children's Defense Fund California
Cigna
City of Oakland
Community Clinic Association of Los Angeles County
Consumers Union
International Alliance of Theatrical Stage Employees Local 80
Leukemia & Lymphoma Society
LIUNA Local 777
LIUNA Local 792
NAMI California
National Health Law Program
National Multiple Sclerosis Society – California Action Network
SEIU California
The Children's Partnership
Western Center on Law and Poverty

OPPOSITION: (Verified 9/4/15)

California Chapter of the American College of Cardiology
California Chapter of the American College of Emergency Physicians
California Medical Association

California Orthopaedic Association
California Radiological Society
California Society of Anesthesiologists
California Society of Pathologists
California Society of Plastic Surgeons
Osteopathic Physicians and Surgeons of California

ARGUMENTS IN SUPPORT: According to Health Access California, even the most careful consumers can end up being treated by an out-of-network provider and then receiving a surprise bill for the difference between the provider's charge and what the health plan is willing to pay. The difference can be hundreds and sometimes thousands of dollars. A consumer who goes to an in-network imaging center, only to discover that a non-contracting radiologist the consumer never met and did not select was responsible for reviewing the consumer's imaging or a consumer who selects an in-network surgeon for surgery at an in-network hospital or surgery center but discovers that the anesthesiologist is a non-contracting provider only when they get the bill from the anesthesiologist. This bill holds consumers harmless for surprise bills from out-of-network charges that were outside of their control. Consumers should not get stuck in the middle of business disputes between health plans and providers. The California Association of Health Underwriters writes that agents and brokers act as advocates for policyholders when disputes arise and supports a strict prohibition on balance billing. CalPERS believes this bill provides an important consumer protection by preventing CalPERS members and other insured Californians that use in-network health facilities from being balance billed by out-of-network health professionals.

ARGUMENTS IN OPPOSITION: The California Orthopaedic Association writes that the issue of patients who unknowingly receive care which will not be paid for by their health plan needs to be addressed on the front end. Insurers and plans must maintain adequate networks of providers, and pay rates that are adequate to sustain those networks. This bill will penalize those providers who cannot accept inadequate rates and will provide no incentive for plans to negotiate fair contracts. The California Radiological Society and California Society of Pathologists indicate that they would prefer to contract with plans and insurers but the absence of contracts may be due to plans that provide contract terms on a "take it or leave it" attitude. They do not oppose protections on patient cost exposure but would suggest that plans be required to create a process to treat this similarly to an out-of-network referral for medically necessary services. The California Chapter of the American College of Emergency Physicians writes even if emergency physicians are exempt, they remain opposed because it is bad policy to adopt a framework that hands all the power to insurers and leaves providers at their mercy

for payment. The California Medical Association (CMA) prefers an approach focused on reducing or eliminating surprise billing in the first place, as well as ensuring a process for fair compensation for physician services. According to CMA, this bill will hinder PPO beneficiaries' ability to use those products' out-of-network benefits and change contracting dynamics, creating significant uncertainty in the relationships among payors and providers.

ASSEMBLY FLOOR: 74-1, 6/2/15
AYES: Achadjian, Alejo, Baker, Bigelow, Bloom, Bonilla, Bonta, Brough, Brown, Burke, Calderon, Campos, Chang, Chau, Chiu, Chu, Cooley, Cooper, Dababneh, Dahle, Daly, Dodd, Eggman, Frazier, Gallagher, Cristina Garcia, Eduardo Garcia, Gatto, Gipson, Gomez, Gonzalez, Gordon, Gray, Grove, Hadley, Harper, Roger Hernández, Holden, Irwin, Jones, Jones-Sawyer, Kim, Lackey, Levine, Linder, Lopez, Low, Mathis, Mayes, McCarty, Medina, Melendez, Mullin, Nazarian, Obernolte, O'Donnell, Olsen, Patterson, Perea, Quirk, Rendon, Ridley-Thomas, Rodriguez, Salas, Santiago, Steinorth, Mark Stone, Thurmond, Ting, Wagner, Waldron, Weber, Wilk, Atkins
NOES: Travis Allen
NO VOTE RECORDED: Chávez, Beth Gaines, Maienschein, Williams, Wood

Prepared by: Teri Boughton / HEALTH /
9/9/15 15:37:38

****** END ******