Date of Hearing: August 30, 2016

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 72 (Bonta) – As Amended August 25, 2016

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

**SUMMARY**: Establishes a payment rate, which is the greater of the average of a health care service plan (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 (IDRP) for claims and claim disputes related to covered services provided at a contracted health facility by a noncontracting 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.

**The Senate amendments** delete the Assembly-approved version of this bill, and instead:

***IDRP***

1) Requires the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to establish an IDRP, by September 1, 2017, for the purpose of processing and resolving a claim dispute between a health plan or health insurer and a noncontracting individual health professional for covered services from a contracted health facility by a noncontracting individual health professional, as specified.

2) Requires the noncontracting individual health professional to complete the health plan or health insurer's internal process prior to initiating IDRP.

3) Requires DMHC and CDI to establish uniform written procedures and other guidelines, and reasonable and necessary fees to be paid by both parties. Permits the bundling of claims submitted to the same health plan or health insurer or the same delegated entity for the same or similar services by the same noncontracting individual health professional. Permits a physician group, independent practice association (IPA), or other entity authorized to act on behalf of a professional to initiate and participate in the IDRP. Requires DMHC and CDI to contract with one or more independent organization to conduct the proceedings. Requires DMHC and CDI to establish conflict-of-interest standards consistent with this bill and existing law. Permits DMHC and CDI to contract with the same independent organization.

4) Requires DMHC and CDI to provide, upon request of an interested person, a copy of all nonproprietary information, as specified, and permits DMHC or CDI to charge a nominal fee to cover the costs of providing a copy.

5) Exempts IDRP contracts from the Public Contract Code, as specified.

6) Requires the IDRP decision to be binding on both parties and requires the health plan or health insurer to implement the IDRP determination. Permits a dissatisfied party to pursue any right, remedy, or penalty established under any other applicable law.

7) Exempts Medi-Cal managed care health plans or any entity that contracts with the Department of Health Care Services (DHCS) from this bill.

8) Requires delegated entities, including medical groups and IPAs, as specified, to comply with this bill.

9) Exempts emergency services and care, as defined, from this bill.

10) Specifies that this bill does not alter the health plan or health insurer's obligation of timely authorization of post-stabilization services and time for reimbursement of claims consistent with existing law.

11) Permits DMHC and CDI to implement and interpret the IDRP process without taking regulatory action, until regulations are adopted.

12) Requires DMHC and CDI to report, in a manner and format specified by the Legislature, data and information provided in the IDRP to the Governor and Legislature by January 1, 2019.

***Reimbursement Rate***

13) Requires, effective July 1, 2017, the health plan and health insurer to reimburse the greater of the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service (FFS) basis for the same or similar services in the general geographic region in which the services specified in this bill are provided, unless otherwise agreed to by the health plan or health insurer and noncontracting individual health professional. Defines average contracted rate as the average of the contracted commercial rates paid by the health plan or health insurer or delegated entity for the same or similar services in the geographic region.

14) Requires each health plan or health insurer and its delegated entities to provide to DMHC or CDI by July 1, 2017, all of the following:

    a) Data listing its average contracted rate for services most frequently provided in contracted facilities by noncontracting individual health professionals, as specified, in each geographic region in which the services are rendered for the calendar year 2015;
    b) Its methodology for determining the average contracted rate for services provided in contracted facilities by noncontracting individual health professionals. Requires the average contracted rate methodology to include the highest and lowest contracted rates for the calendar year 2015; and,
    c) The policies and procedures used to determine the average contracted rates.

15) Requires the health plan or health insurer and the delegated entities, to adjust the rate initially submitted in this bill by the Consumer Price Index (CPI) for Medical Care Services, as published by the United States Bureau of Labor Statistics, for each calendar year after the health plan and health insurer's initial submission and until DMHC and CDI specify an average contracted methodology.

16) Requires DMHC and CDI to specify an average contracted rate methodology by January 1, 2019. Requires the methodology to take into account, at a minimum, information from IDRP, the individual health professional's specialty, and the geographic region in which the

services are rendered. Requires the methodology to include the highest and lowest contracted rates. Requires health plans and health insurers to provide its policies and procedures to DMHC or CDI.

17) Permits a health plan that does not pay a statistically significant number or dollar amount of claims for services covered under this bill, to demonstrate to DMHC that it has access and will use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region.

18) Requires DMHC or CDI to audit the accuracy of the filed information and to keep the average contracted rate data confidential and not subject to disclosure under the Public Records Act.

19) Requires DMHC or CDI to consult with interested parties in the development of the standardized methodology described in 16) above and to hold its first stakeholder meeting no later than July 1, 2017.

20) Requires health plans or health insurers, in its network data reporting submissions, to include the number of payments made to noncontracting individual health professionals for services described in this bill, as well as other data sufficient to determine the proportion of noncontracting individual health professionals to contracting individual health professionals at contracting health facilities, as defined. Requires DMHC and CDI to include a summary of this information and its findings regarding the impact of this bill on health plan contracting and network adequacy in its January 1, 2019 report, as described in 12) above.

21) Requires health plans and health insurers to meet existing network adequacy requirements, including but not limited to, inpatient hospital and specialist physician services, and requires DMHC or CDI to adopt additional regulations related to those services, if necessary. Specifies that this bill does not limit the director or commissioner's authority.

22) Defines, for purposes of Medicare FFS reimbursement, geographic regions as those specified for physician reimbursement for Medicare FFS by the United States Department of Health and Human Services.

23) Requires a health plan or health insurer to authorize and permit assignment of the enrollee or insured's right, if any, to any reimbursement for health care services covered under the health plan or health policy to a noncontracting individual health professional who furnishes the health care services at a contracted facility.

24) Requires a noncontracting individual health professional, health plan, or health insurer, or a delegated entity who disputes the claims reimbursement to utilize IDRP.

25) Provides that the amount paid by the health plan or health insurer for nonemergency services provided by a noncontracting individual health professional to enrollees or insureds who voluntarily choose to use his or her out-of-network benefit for services covered by a health plan or health policy that includes out-of-network benefits, be the amount set forth in the enrollee or insured's evidence of coverage or policy, unless otherwise agreed to by the health plan or health insurer and the noncontracting individual health professional, and prohibits the payment from the IDRP as described in this bill.

26) Requires the payment made by the health plan or health insurer to the noncontracting health care professional for nonemergency services as described in this bill, in addition to the applicable cost sharing owed by the enrollee or insured, to be payment in full for nonemergency services rendered unless either party uses the IDRP or other lawful means pursuant to this bill.

27) Prohibits the amount paid by the health plan or health insurer for services pursuant to this bill from constituting the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual health professional.

***Patient Obligations and Protections***

28) Refers to the in-network cost sharing amount, for health plan contracts or health policies issued, amended, or renewed on or after July 1, 2017, as the amount no more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting individual health professional. Limits enrollee or insured payment to no more than the in-network cost sharing amount for services pursuant to this bill. Requires the health plan or health insurer to inform the noncontracting individual health professional of the in-network cost sharing owed by the enrollee or insured at the time of payment by the health plan or health insurer. Prohibits the noncontracting individual health professional from billing or collecting any amount from the enrollee or insured for services subject to this bill, except the in-network cost sharing amount. Requires any communication from the noncontracting individual health professional to the enrollee or insured prior to the receipt of information about the in-network cost sharing include a notice in 12-point bold type stating that the communication is not a bill and informing the enrollee or insured that the enrollee or insured will not pay until the enrollee or insured is informed of any applicable cost sharing.

29) Requires the noncontracting individual health professional to refund any overpayment to the enrollee or insured within 30 calendar days of receiving payment from the enrollee, otherwise interest will accrue at the rate of 15% per annum beginning with the date payment was received from the enrollee.

30) Requires cost sharing paid by the enrollee or insured to count toward the limit on annual out-of-pocket expenses and any deductible, as specified.

31) Permits a noncontracting individual health professional to bill or collect from the enrollee or insured with out-of-network coverage, the out-of-network cost sharing, if applicable, only when the enrollee or insured consents in writing and that written consent satisfies all the following criteria:

    a) At least 24 hours in advance of care, the enrollee or insured consents in writing to receive services from the identified noncontracting individual health professional;
    b) The consent is obtained by the noncontracting individual health professional in a document that is separate from the document used to obtain the consent for any other part of the care or procedure, and not obtained by the facility or its representative, at the same time as admission or at any time when the enrollee or insured is being prepared for surgery or any other procedure;
    c) At the time of consent, a written estimate of the enrollee or insured's total out-of-pocket cost of care is provided and based on the noncontracting individual health professional's

billed charges, and prohibits the noncontracting individual health professional from attempting to collect more than the estimate amount without receiving separate written consent from the enrollee or insured or authorized representative unless circumstances arise during the delivery of services that was unforeseen at the time the estimate was given that would require the provider to change the estimate;

d) The consent must advise the enrollee or insured that he or she may elect to seek care from a contracted provider or may contact the health plan or health insurer in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs;
e) The consent and estimate will be provided to the enrollee or insured in the language spoken by the enrollee or insured if the language is a Medi-Cal threshold language as defined in existing law; and,
f) The consent will also advise the enrollee or insured that any costs incurred as a result of the out-of-network benefit will be in addition to in-network cost sharing amount and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

32) Provides that a professional who fails to comply with 31) above has not obtained written consent and therefore other provisions of this bill applies.

33) Permits the noncontracting individual health professional to advance to collections only the in-network cost sharing amount or the out-of-network cost sharing amount described in 31) above, that the enrollee or insured failed to pay. Prohibits the noncontracting individual health professional, or any entity acting on his or her behalf, including any assignee of debt, from reporting adverse information to a consumer credit reporting agency or commencing civil action against the enrollee or insured for 150 days after the initial billing regarding amounts owed by the enrollee or using wage garnishments or liens on primary residences as a means of collecting unpaid bills.

***Other Provisions and Definitions***

34) Defines a contracting health facility as a health facility that is contracted with the enrollee or insured's health plan or health insurer to provide services under the health plan or health policy. Includes, but is not limited to, the following providers:

a) A licensed hospital;
b) An ambulatory surgery or other outpatient setting, as described;
c) A laboratory; or,
d) A radiology or imaging center.

35) Defines cost sharing as any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee or insured other than premium or share of premium.

36) Defines an individual health professional as a physician and surgeon or other professional who is California licensed to deliver or furnish health care services and does not include a dentist, licensed pursuant to the Dental Practice Act. Defines noncontracting individual health professional as an individual health professional not contracted with the enrollee or insured's health plan or health insurer.

37) Defines in-network cost sharing amount as an amount no more than the same cost sharing the enrollee or insured would pay for the same covered service received from a contracting health professional. Specifies the in-network cost sharing amount for enrollee's or insured's with coinsurance to be the amount paid by the health plan or health insurer pursuant to 13) above.

38) Provides that this bill shall not be construed to exempt a health plan or health insurer or provider from the requirements under existing law, nor abrogate the holding in Prospect Medical Group, Inc. v. Northridge Emergency Medical Group (2009) 45 Cal.4th 497.

**EXISTING LAW**:

1) Provides for the regulation of health plans by DMHC under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and for health insurers by 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 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.

4) Establishes, pursuant to regulations, requirements that health plans must implement in their claims settlement practice, including the meaning of "reimbursement of a claim," such that providers with a contract receive the contract rate. Claims for contracted providers without a written contract and non-contracted providers require payment of the reasonable and customary value for the health care services rendered based upon "statistically credible information" that is updated at least annually and takes into consideration the following:

   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.

5) Allows a noncontracted 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 health plan's mandated provider dispute resolution process.

6) Requires health plans to pay for medically necessary services provided in a licensed acute care hospital, if the services were related to authorized services and provided after the health

plan's normal business hours, unless the health plan has a system whereby it can respond to authorization requests within 30 minutes.

7) Prohibits a health plan from engaging in an unfair payment pattern, defined as, engaging in a demonstrable and unjust pattern, of reviewing or processing complete and accurate claims that results in payment delays; engaging in a demonstrable and unjust pattern of reducing the amount of payment or denying complete and accurate claims; failing on a repeated basis to pay the uncontested portions of a claim within specified timeframes; and, failing on a repeated basis to automatically include the interest due on claims, as specified.

8) 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 non-participation in a contract with that insurer, hospital service plan, or health plan.

9) Defines emergency services and care as medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility; and to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

10) Requires a health plan, or its contracting medical providers, to provide 24-hour access for enrollees and providers, including, but not limited to, non-contracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services, and is stabilized, but the treating provider believes that the enrollee may not be discharged safely. Establishes additional requirements associated with treatment or transfer post stabilization.

11) Requires a health plan to annually report 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 with existing requirements.

12) Requires DMHC to annually review health plan compliance with timely access standards and to post its final findings from the review, and any waivers or alternative standards approved by DMHC, on its Website.

13) Authorizes DMHC to develop, and requires health plans to use, standardized methodologies for timely access reporting.

**FISCAL EFFECT**: 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 IDRP that DMHC would convene to settle a dispute between a provider and a health plan (Managed Care Fund).

3) One-time costs of about $600,000 for the development of regulations and review of plan filings by the CDI (Insurance Fund).

4) Ongoing costs of $1 million per year for the IDRP that CDI would convene to settle a dispute between a provider and a health insurer (Insurance Fund).

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the authors, this bill protects patients from surprise medical bills when they follow the rules of their health plan by going to an in-network hospital, lab, imaging center, or other health care facility. Patients would only be responsible for their in-network cost sharing and would be prohibited from getting outrageous out-of-network bills from doctors they did not choose. Surprise medical bills wreak havoc on people's finances and their ability to pay for basic necessities.

This bill also provides certainty for doctors and insurers and keeps our health care costs under control. Insurers must reimburse doctors a fair rate for their services, and doctors are assured a minimum payment in statute. The Patient Protection and Affordable Care Act requires all consumers to have health coverage, and it is the state's responsibility to ensure patients are safeguarded from hidden costs unfairly imposed upon them when they have followed their insurers' rules.

**2) BACKGROUND**. A March 2016 Kaiser Family Foundation Issue Brief (Brief) defined "surprise medical bill" as a term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient's care are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In some cases, entire departments within an in-network facility may be operated by subcontractors who don't participate in the same network. In these non-emergency situations, too, the in-network provider or facility generally arranges for the other treating providers, not the patient. The Brief reported that a Kaiser Family Foundation survey found that among insured, non-elderly adults struggling with medical bill problems, charges from out-of-network providers were a contributing factor about one-third of the time. Further, nearly seven in 10 of individuals with unaffordable out-of-network medical bills did not know the health care provider was not in their health plan's network at the time they received care.

In 2011, the New York Department of Financial Services studied more than 2,000 complaints involving surprise medical bills, and found the average out-of-network emergency bill was $7,006. Insurers paid an average of $3,228 leaving consumers, on average, "to pay $3,778 for an emergency in which they had no choice." The same New York study found that 90% of surprise medical bills were not for emergency services, but for other in-hospital care. The specialty areas of physicians most often submitting such bills were anesthesiology, lab

services, surgery, and radiology. Out-of-network assistant surgeons, who often were called in without the patient's knowledge, on average billed $13,914, while insurers paid $1,794 on average. Surprise bills by out-of-network radiologists averaged $5,406, of which insurers paid $2,497 on average.

According to the National Academy for State Health Policy, 49 states have enacted some consumer protections against balance billing for managed care enrollees. Of these, 27 states apply protections against out-of-network providers in PPO plans and 13 apply them for HMO plans. Usually protections relate to care delivered in emergency settings. Other state legislation is aimed at enabling independent legal resolution between providers and providers without involving the consumer, as in Illinois, and laws that empower consumers to dispute billing issues, like in Texas. New York's law, enacted in April 2015, includes some of the most comprehensive protections to date. The New York law protects consumers from owing more than their in-network copayment, coinsurance, or deductible when receiving emergency care even from out-of-network providers. It also enables consumers to sign an "assignment of benefits form" that allows providers to pursue payment directly from insurers in the case of a dispute.

Several states are considering actions to address surprise billing. Proposals range from improving the processes by which patients are notified about the receipt of out-of-network services to setting cost limits on charges assessed for out-of-network care. Florida recently passed legislation that will exempt patients from having to pay balance bills from out-of-network providers in certain situations. The Florida legislation will apply to patients who go to a healthcare facility in their health plan network and inadvertently receive services from a noncontracted provider. Patients would only be responsible for paying their usual in-network cost-sharing. Plans and noncontracted providers would have to work out payment for those services through a state-arranged, voluntary dispute resolution process, with a penalty assessed to the party that refused to accept an offer that was close to the final arbitration order. The negotiation would be based on the usual and customary rate for the particular geographic area. Disputes could be taken to court. Florida's law would only apply to PPO-type plans, since it already bars balance-billing patients in HMOs.

3) **DMHC LETTER**. In a letter dated August 25, 2016, the DMHC provided its understanding with respect to the CPI and network adequacy provisions in this bill and how these provisions would impact the Director's authority under the Knox-Keene Act. DMHC states the following:

> Proposed Health & Safety Code section 1371.31(a)(2)(B) provides the following:
>
> *For each calendar year after the plan's initial submission of the average contracted rate as specified in subparagraph (A) and until the standardized methodology under paragraph (3) is specified,* a *health care service plan and the plan's delegated entities shall adjust the rate initially established pursuant to this subdivision by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.*

DMHC interprets this proposed language to require health plans and their delegated entities, for the calendar year after the initial submission, to adjust their 2015 average contracted rates for the services subject to this bill, by the CPI for Medical Care Services, as published by the United States Bureau of Labor Statistics for the 2017 calendar year.

Proposed Health & Safety Code section 1371.31(a)(5) provides the following:

*A health care service plan that provides services subject to Section 1371.9 shall meet the network adequacy requirements set forth in this chapter, including, but not limited to, in subdivisions (d) and (e) of Section 1367 of this code and in Exhibits (H) and (I) of subdivision (d) of Section 1300.51 of, and Section*

*1300.67.2 and 1300.67.2.1 of, Title 28 of the California Code of Regulations, including, but not limited to, inpatient hospital services and specialist physician services, and if necessary, the department may adopt additional regulations related to those services. This section shall not be construed to limit the director's authority under this chapter.*

DMHC interprets this proposed language to reaffirm the DMHC's existing authority to require health plans to have an adequate provider network, including adequate geographic access and timely acess, and clarify that this bill neither relieves health plans of their existing obligations under the Knox-Keene Act to maintain an adequate provider network nor in any way constrains DMHC's existing authority with respect to any other provision of the Knox-Keene Act and its implementing regulations.

**4) RELATED LEGISLATION**.

a) 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 noncontracting 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.

b) SB 1252 (Stone) of 2016 would have required the general acute care hospital, surgical clinic, and the 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.

**5) SUPPORT.** Health Access California writes that patients know they have to follow their health plan or health insurer's rules and go to in-network providers and facilities to keep their out-of-pocket costs low. Unfortunately, many patients end up getting a surprise medical bill for hundreds or thousands of dollars from an anesthesiologist, radiologist, pathologist or other specialist who turns out to be out-of-network. The California Labor Federation indicates patients may not even be able to rely on their hospitals to tell them if they will be

treated by an out-of-network doctor, since doctors are not direct employees of most hospitals, they are independent contractors and not all necessarily in the same network as the hospital. Surprise bills threaten to undo that work by subjecting patients to astronomically high bills they were not expecting. Consumers Union writes health insurance coverage should provide protection against overwhelming medical bills and debt. Consumers should not pay the price for the complicated relationships between doctors, facilities and health plans. Anthem Blue Cross (Anthem) writes that while there are provisions of this bill that are still of concern, Anthem supports this bill as it protects consumers from balance billing by noncontracting providers. Anthem states that balance billing is the largest grievance Anthem receives from its enrollees.

6) **NEUTRAL.** The California Medical Association's position on this bill is neutral and states that it still has serious concerns about how this legislation will affect access to specialty care and incentivize health plans to carry narrow provider networks.

7) **CONCERNS.** The America's Health Insurance Plans, Association of California Life and Health Insurance Companies, and California Association of Health Plans, write that while they laud the authors' efforts to protect consumers from balance billing, they believe some provisions of this bill may increase costs for families and employers through higher premiums and cost-sharing. Specifically, they state that adjusting the annual contracted rate formula using the CPI no longer reflects average contracted rates and distorts real market prices. Additionally, they state that current provisions, including the IDRP language, may increase litigation between providers and health plans and health insurers, and drive up costs in the system.

8) **OPPOSITION.** The California Chapter of the American College of Cardiology (CA-ACC) states that while they agree with this bill's intent to protect patients from surprise balance billing, the average contracted rate methodology is largely undefined and empowers the health plans and health insurers to ratchet down existing contract rates with physicians. CA-ACC is concerned that health plans and health insurers will offer low ball contract rates and that physician networks will continue to narrow making it more difficult for patients to find in-network physicians to obtain quality care. The American College of Surgeons writes that mandating payment incentivizes health insurers to drive down contracting rates, making it less likely that physicians will contract with them to be participating providers in the network.

This bill was substantially amended in the Senate and the Assembly-approved version of this bill was deleted. This bill, as amended in the Senate, is inconsistent with Assembly actions and the provisions of this bill, as amended by the Senate, have not been heard in an Assembly policy committee.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Labor Federation (co-sponsor)
Health Access California (co-sponsor)
American Cancer Society - Cancer Action Network
Americans for Democratic Action, Southern California
Anthem Blue Cross
Blue Shield of California
California Alliance for Retired Americans
California Association of Health Underwriters
California Black Health Network
California Coverage & Health Initiatives
California Pan-Ethnic Health Network
California Professional Firefighters
CALPIRG
Children's Partnership
Congress of California Seniors
Consumers Union
National Health Law Program
National MS Society CA Action Network
SEIU California
Western Center on Law & Poverty

**Opposition**

American College of Cardiology - California Chapter
American College of Surgeons
American College of Physicians - California Chapters
American Congress of Obstetricians and Gynecologists, District IX
American Society of Plastic Surgeons
California Academy of Eye Physicians and Surgeons
California Association of Neurological Surgeons
California Chapter of the American College of Cardiology
California Neurology Society
California Orthopaedic Association
California Otolaryngology Society
California Society of Facial Plastic Surgery
California Society of Physical Medicine & Rehabilitation
California Society of Plastic Surgeons
California Thoracic Society
California Urological Association
Medical Oncology Association of Southern California
The Plastic Surgery Foundation

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