CAHP LEGISLATIVE INFORMATION

AB 290 (Wood)
Chapter 862, Statutes of 2019

As a service to our members, the California Association of Health Plans produces guidelines designed to assist in the interpretation and implementation of new laws, and to promote full compliance with those laws. This document, however, is not intended to be authoritative. Any questions about official interpretations of the law should be directed to the appropriate state regulatory agency such as the Department of Managed Health Care or the Department of Health Care Services, as well as your legal counsel.

HEALTH CARE SERVICE PLANS AND HEALTH INSURANCE: 3RD PARTY PAYMENTS

BACKGROUND

Assembly Bill 290 was introduced by the Chair of the Assembly Health Committee, Jim Wood. The bill is designed to address the issue of third party premium payments by financially interested providers. Providers in certain sectors (dialysis and substance abuse treatment centers most habitually) have been steering patients, many that qualify for public programs due to their condition, to commercial coverage in order to receive higher reimbursements rates for their services. A primary feature of AB 290 was intended to remove the financial incentive of this practice by establishing a default payment rate for the services based on Medicare.

The bill is substantially similar to SB 1156 (Leyva) of last session which was vetoed by Governor Brown for permitting health plans to refuse premium assistance payments and to choose which patients they will cover. While supporters took a different view of the bill's impact, an attempt was made in AB 290 to add language in AB 290 to explicitly address Brown's objections.

This bill was heavily opposed by the dialysis facilities like DaVita, Fresenius and the American Kidney Fund (AKF). The AKF repeatedly threated to abandon all of its premium assistance programs in California if the bill was passed. The AKF used an esoteric and highly debatable argument involving a letter from the federal Office of Inspector General (OIG) regarding the legality of charitable organizations providing premium assistance if they receive funds from private entities. The OIG indicated in 1997 that the AKF arrangement is not in violation of federal law because the contributions to AKF from dialysis providers are not made to or on behalf of beneficiaries. AKF argues that AB 290 puts them out of compliance with the OIG guidance. According to the Assembly Health Committee analysis of AB 290 "It should be noted that the 1997 OIG opinion was limited to the facts presented at that time and there is nothing in this bill that prohibits entities, like the AKF, from continuing to provide financial assistance through its existing programs."

The bill was amended to address opposition concerns by delaying the effective date of several key provisions. Despite this the AKF appears to be ready to remove all of its premium assistance programs out of California, affecting almost 4,000 patients.

Due to heavy opposition, passage of AB 290 was far from certain. Health plans joined a coalition of labor and consumer groups in support of this because it addresses and underlying cost driver by cracking down on an obvious manipulation of the individual market. Ultimately, AB 290 cleared both houses of the Legislature by slim margins.

REQUIREMENTS

AB 290 adds Sections 1210, 1367.016, and 1385.09 to the Health and Safety Code, relating to health care coverage.

Specifically, AB 290 does the following:

SEC. 2. 1210. (a) Prohibits a chronic dialysis clinic from steering, directing, or advising a patient regarding any health care service plan contract. (b) Requires a notice to be prominently posted informing patients about the Health Insurance Counseling and Advocacy Program, as specified.

SEC. 7. Makes the provisions described below operative on July 1, 2020 for financially interested entities covered by Advisory Opinion 97-1 unless one or more parties to Advisory Opinion 97-1 requests an updated opinion and notifies DMHC and CDI in writing, including a copy of the request. If the notification and request are received by DMHC and CDI prior to July 1, 2020, it makes the provisions described below operative with respect to those entities upon a finding by the United States Department of Health and Human Services Office of Inspector General that compliance does not violate the federal laws addressed by Advisory Opinion 97-1 or a successor agreement.

SEC. 3. 1367.016. (b) Requires a financially interested entity that is making third-party premium payments to comply with specified provisions, including agreement not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug or device; and not to steer, direct, or advise the patient into or away from a specific coverage program option, health care service plan contract.

SEC. 3. 1367.016. (c) Prohibits a financially interested entity from making a third-party premium payment unless the entity annually provides a statement to the health plan that it meets the requirements set forth in SEC. 3. 1367.016. (b) above; and, discloses to the health plan, prior to making the initial payment, the name of the enrollee for each health plan contract on whose behalf a third-party premium payment was made.

SEC. 3. 1367.016. (e) Requires, commencing January 1, 2022, reimbursement for covered services to a financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment to a health plan on behalf of an enrollee to be determined by the following:

(1) For a contracted provider payment for covered services reimbursement is governed by the higher of the Medicare reimbursement rate or the rate determined through the independent dispute resolution process (IDRP) pursuant SEC. 3. 1367.016. (f) below. Requires cost-sharing to be based on the amount paid by the plan under this bill, if the contract or policy imposes coinsurance. Prohibits enrollees from being billed or reimbursement from being sought, except for cost-sharing pursuant to the terms and conditions of the contract.
(2) Requires for a noncontracted provider payment for covered services reimbursement is governed by the terms and conditions of the health plan contract or the rate determined through the IDRP, whichever is lower; A claim submitted to a health plan by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health plan pursuant to existing law if the financially interested provider has not provided the information as required in SEC. 3. 1367.016. (b) and,

SEC. 3. 1367.016. (d) Exempts reimbursement for enrollees for whom a nonprofit financially interested entity was already making premium payments prior to October 1, 2019 from being subject to SEC. 3. 1367.016. (c) and SEC. 3. 1367.016. (e) above, unless the enrollee changes his or her health plan on or after March 1, 2020. Requires reimbursement to be governed by the contract or policy until January 1, 2022 if the enrollee changes his or her health plan on or after March 1, 2020.

SEC. 3. 1367.016. (f) Requires by October 1, 2021, DMHC and CDI to establish an IDRP process, as specified.

SEC. 3. 1367.016. (h) (2) Defines financially interested to include the following entities:

(A) A provider of health care services that receives direct or indirect financial benefit from a third-party premium payment;
(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities; and,
(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of large dialysis clinic organization (LDO) under the Centers for Medicare and Medicaid Services ESRD Care Model as of January 1, 2019. Exempts a chronic dialysis clinic that does not meet the definition of LDO or has no more than 10% of California's market share of licensed chronic dialysis clinics.

SEC. 3. 1367.016. (i) Requires a health plan/health insurer, if it subsequently discovers that a financially interested entity fails to provide disclosure pursuant to SEC. 3. 1367.016. (c) above:

(1) To be entitled to recover 120% of the difference between a payment made to a provider and the payment to which the provider would have been entitled pursuant to SEC. 3. 1367.016. (e) above, including interest on that difference; and,
(2) To notify DMHC/CDI of the amount by which the provider was overpaid and to remit to DMHC/CDI any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant SEC. 3. 1367.016. (e) above, including interest on that difference that was recovered pursuant to a).

SEC. 3. 1367.016. (m) States that this bill does not alter any of a health plan obligations and requirements under existing law, including the obligation to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any individual, or small employer, consistent with existing law; or, the obligations with respect to cancellation or nonrenewal as provided in existing law; and, does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SEC. 1. (i) Establishes legislative intent that this bill, to protect the sustainability of risk pools within the individual and group health insurance markets, shields patients from potential harm caused by being steered into coverage options that may not be in their best interest and to correct a market failure that has allowed large dialysis organizations to use their oligopoly power to inflate commercial reimbursement rates and unjustly drive up the cost of care; and, (j) that the delayed

implementation and conditional nature of certain provisions will allow the American Kidney Fund (AKF) to request an updated advisory opinion.

COMPLIANCE DATES

January 1, 2020 – entities that make third party premium payments for enrollees must begin providing annual statements to health care service plans under the requirements of 1367.016(c) and 1367.016 (d).

January 1, 2022 – effective date for default payment rates for contracted and non-contracted providers per 1367.016 (e) (1) and 1367.016 (e) (2). Health plans must also report to the DMHC the names of enrollees receiving third party premium assistance, the names of facilities where these enrollees received services, and the names of providers who have not disclosed third party payments per 1367.016 (j).

IMPLEMENTATION ISSUES

This law applies to all health care service plans and products, including Medicare supplemental coverage plans.

Since this law will require additional reporting from health plans to DMHC, it is very likely that the Department will develop reporting templates for health plan use.

Plans may also need to make updates to member handbooks (EOCs) to provide information to enrollees regarding special enrollment periods; plans may also need to update existing policies and procedures to reflect the special enrollment period afforded to individuals who lose coverage due to the failure of a third party to pay an enrollee's premium payment.

This law also sets forth a default payment rate for covered services beginning on January 1, 2022. The default payment for contracted providers must be the greater of Medicare reimbursement or a negotiated rate. The default payment rate for a non-contracted provider will be the lesser of either the health care service plan contract rate or a negotiated rate between the health plan and the non-contracted provider.

In addition, plans may need to amend existing claims processing procedures to include a new process for recovering up to 120% of payments made when a financially interested party fails to provide appropriate disclosures to the health plan as allowed in Section 1367.016(i)(1).