



AB 72: Stop Surprise Medical Bills from Out-of-Network Doctors at In-Network Facilities

September 29, 2016

Note: This document summarizes key provisions of California's AB 72, which takes effect July 1, 2017. In the coming months, Health Access California will pen a policy brief detailing how we won the fight to stop surprise medical bills.

OVERVIEW: CONSUMERS NEED PROTECTION FROM SURPRISE MEDICAL BILLS

Patients know they have to follow their insurers' rules and go to an in-network hospital, lab or other facility to keep their out-of-pocket costs low. Unfortunately, many patients end up getting a surprise bill for hundreds or thousands of dollars from an anesthesiologist, radiologist, pathologist or other specialist who turns out to be out-of-network, one the patient probably never met, did not choose, and have no control over. AB 72 protects patients from surprise medical bills when they do the right thing 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.

CONSUMER PROTECTIONS

KEY CONSUMER PROTECTIONS IN AB 72

- No surprise medical bills, period. Consumers are only billed for their in-network cost-sharing, and no more than that, when they select an in-network facility for their care.
- Control health care costs. Payment for out-of-network services is based on rates paid by public and private payors, not billed charges (sticker price).

SCOPE OF AB 72

- Non-emergency services: AB 72 protects consumers receiving non-emergency services at in-network facilities from being balance billed by an out-of-network (OON) doctor.
- Emergency services: Prior California law already protects most consumers from balance billing for emergency services so AB72 is silent on emergency services.

- 1) **Consumers who go to an in-network facility are only responsible for in-network cost-sharing.**
 - In-network cost-sharing (co-pays, co-insurance, or deductible) counts toward deductible and maximum out-of-pocket limit.
 - Facilities included: hospital, ambulatory surgery center or other outpatient setting, laboratory, and radiology or imaging center.
- 2) **Ending surprise bills by stopping out-of-network doctors from billing or collecting more than the in-network cost-sharing.**
 - OON doctor cannot bill consumer until health insurer tells OON doctor what the applicable in-network cost-sharing is.
 - This is not a bill! If the OON doctor sends any communication to the consumer before getting the in-network cost-sharing information from the insurer, the OON doctor must include a notice in 12-point bold type stating that the communication is not a bill and that

the consumer shall not pay until they are informed of any applicable in-network cost-sharing.

- Refunds for overpayments: If the OON doctor has collected more than the in-network cost-sharing from the consumer, the OON doctor must refund the overpayment to the consumer within 30 days of receiving payment. If the OON doctor does not refund within 30 days, then interest shall accrue at the rate of 15% per annum beginning with the date payment was received from the consumer. Interest must be included in the refund without requiring the consumer to ask for it.

3) Stopping & preventing collections. Protects consumers from having their credit adversely affected, wages garnished, or liens placed on their primary residence. These provisions are based on existing consumer protections in CA law for uninsured and underinsured consumers receiving hospital care:

- OON doctors can only send to collections the in-network cost-sharing amount the consumer has failed to pay.
- Cannot send consumer to collections or sue within 150 days of the first billing.
- Cannot garnish wages or put liens on primary residences to collect unpaid bills.

PAYMENTS TO OUT-OF-NETWORK DOCTORS

AB 72 helps to control health care costs by basing payment to OON providers on rates paid by public and private payers rather than the billed charges or sticker price sought by providers.

OON doctors are reimbursed the greater of:

- 125% of Medicare, **OR**
- average contracted rate
(paid by the particular health insurer for same or similar services in the same geographic area)

Determining average contracted rates:

- State regulators will create a standardized methodology for determining average contracted rates by January 1, 2019. Stakeholders (including insurers, providers, and consumer advocates) will be consulted in the development of the standards.
- Between July 1, 2017 and when the standardized methodology is established, the average contracted rates will be based on rates paid in 2015.
- Regulators have oversight over insurer compliance in determining average contracted rates.
- Data regarding average contracted rates not subject to public records act.

Why payments are not based on sticker price or billed charges:

- "Billed charges", or what the physician wishes to be paid, bears little or no resemblance to the prices paid by public payers such as Medicare or Medicaid or private payers such as commercial health plans.
- Only the uninsured and those unwittingly out-of-network pay billed charges.
- Most commercial coverage in California relies on negotiated rates between providers and health plans: billed charges do not determine rates paid to physicians by commercial plans.
- AB 72 bases the payment standard on what a large public purchaser, Medicare, or the average rate negotiated by that health insurer in the region for that service. These amounts reflect what doctors are actually paid, not their billed charges.
- Health care costs are higher in the US than other countries- we pay more for doctors, hospitals and prescription drugs.

INDEPENDENT DISPUTE RESOLUTION PROCESS (IDRP)

AB 72 creates an administrative appeal process for OON doctors who wish to seek higher payment than 125% of Medicare or the insurer's average contracted rate.

- Contractor: The Department of Managed Health Care and the Department of Insurance can contract with an independent third-party entity to administer IDRP.
- Bundling of claims: Providers can bundle claims for the same or similar services.
- Mandatory & binding: If either party appeals to IDRP, the other party must participate. The IDRP decision is binding. Either party is permitted to litigate the outcome.
- Decision process: All relevant information may be considered when determining appropriate reimbursement, including payment sought by OON doctor, and payments made by public and private payers, including Medicaid, Medicare, and other insurers.
- Funding IDRP: State regulators can collect reasonable and necessary fees from both parties.
- Conflict of interest standards: Same as for independent medical review (independent of insurers and physicians)

VOLUNTARY USE OF OUT-OF-NETWORK BENEFITS

Most California consumers have coverage through HMO products, which do not cover out-of-network services. About 20% of consumers with commercial coverage have PPOs with an out-of-network benefit. This subset of consumers may voluntarily and explicitly agree to receive and pay for out-of-network charges if:

- Consumer consents in writing at least 24 hours before receiving care;
- Consent is obtained by the OON doctor separate from other documents used to obtain consent for the care. The consent cannot be obtained by the facility. The consent cannot be obtained at the time of admission or when the consumer is being prepared for the procedure;
- OON doctor must provide consumer with a written estimate of the consumer's total out-of-pocket cost of care at the time the consent is provided, and cannot collect more than the estimated amount without authorization, unless unforeseeable circumstances arise;
- Consent must tell consumer they can get care from an in-network provider for lower out-of-pocket costs;
- Consent and estimate must be translated to language spoken by consumer if it's a Medicaid threshold language; and
- Consent must inform consumer that OON costs will not count toward annual maximum out-of-pocket for in-network benefits or deductibles.

If an OON doctor fails to obtain proper consent, the consumer is not responsible for OON charges and other requirements of AB 72 apply.

MONITORING THE IMPACT OF AB 72

California has strong network adequacy protections, which are embodied in the Knox-Keene Act, the Insurance Code, and implementing regulations. These protections are intended to assure that a consumer receives the care they need when they need it. AB 72 reiterates an insurer's obligation to comply with existing network adequacy requirements and reiterates regulators' existing authority to adopt additional regulations if needed.

AB 72 requires state regulators to collect and report the following information to the Governor and the Legislature by January 1, 2019:

1. **Impact on insurer contracting and network adequacy:**
Summarize data collected from insurers regarding:
 - the number of payments made to OON doctors at in-network facilities
 - the proportion of OON doctors to in-network doctors at in-network facilities
2. **IDRP:** Provide a report on the data and information provided in the IDRP process.

AB 72 SUPPORT AND OPPOSITION

- **Sponsors:** Health Access California & California Labor Federation.
- **Bi-Partisan Authors:** Assemblymembers Bonta (D), Bonilla (D), Dahle (R), Gonzalez (D), Maienschein (R), Santiago (D), and Wood (D).
- **Supporters:** Consumer, health, and patient advocacy organizations, labor unions, and health insurers including Anthem Blue Cross and Blue Shield of California.
- **Neutral:** California Medical Association, California Hospital Association, health insurer trade organizations, and some specialists (radiologists & pathologists).
- **Opposition:** Some specialists (anesthesiologists, surgeons, cardiologists, plastic surgeons, etc).

FOR MORE INFORMATION, PLEASE CONTACT:

Health Access California

Tam Ma: tma@health-access.org

Beth Capell: bcapell@jps.net

California Labor Federation

Sara Flocks: SFlocks@calaborfed.org