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AB 72: Stopping Surprise Bills

from Out-of-Network Doctors at In-Network Facilities

July 22, 2019

This fact sheet summarizes key provisions of California's AB 72, which took effect July 1, 2017.

Overview: Consumers are Protected from Surprise Medical Bills As Well As From Health Care Premium Increases Resulting from Surprise 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 ended up getting a surprise bill for hundreds or thousands of dollars from an anesthesiologist, radiologist, pathologist or other specialist who turned out to be out-of-network and who the patient had probably never met, did not choose, and had no control over choosing. AB 72 protects patients from surprise medical bills when they do the right thing and go to an in-network health care facility. Under AB 72, patients are only responsible for in-network cost-sharing and are protected from getting outrageous out-of-network (OON) bills from doctors they did not choose.

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 payers, and not just billed charges (sticker prices).

SCOPE OF AB 72

- Non-emergency services: AB 72 protects consumers who receive non-emergency services at in-network facilities from being balance billed by an out-of-network doctor.
- Emergency services: Prior California law already protects most consumers from balance billing for emergency services, therefore AB 72 does not include emergency services. (See Health Access fact sheet.)

CONSUMER PROTECTIONS

- 1) **Ensures those going to in-network facilities are only responsible for in-network cost-sharing.**
 - In-network cost-sharing (co-pays, co-insurance, or deductible) counts toward annual deductible and maximum out-of-pocket limits.
 - Facilities include: hospital, ambulatory surgery center or other outpatient setting, laboratory, and radiology or imaging center.
- 2) **Ends surprise bills by stopping out-of-network doctors from billing or collecting more than the in-network cost-sharing.**
 - Out-of-network 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 the communication is not a bill and that the consumer shall not pay until they are informed of any applicable in-network cost-sharing.

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- Refunds for overpayments: If the out-of-network (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 without requiring the consumer to ask for it.

- 3) **Stops and prevents collections.** Consumers are protected from having their credit adversely affected, wages garnished, or liens placed on their primary residences. These provisions are based on existing consumer protections in California law for uninsured and underinsured consumers receiving hospital care:
- Out-of-network doctors can only send to collections the in-network cost-sharing amount the consumer has failed to pay.
 - Cannot send consumers to collections or sue within 150 days of the first billing.
 - Cannot garnish wages or put liens on primary residences to collect unpaid bills.

FAIR PAYMENTS TO OUT-OF-NETWORK DOCTORS

AB 72 helps to control health care costs by basing payment to out-of-network providers on actual rates paid by public and private payers instead of billed charges (or sticker prices) sought by providers.

Out-of-network 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:

- As required by January 1, 2019, state regulators created a standardized methodology for determining average contracted rates. Stakeholders (including insurers, providers, and consumer advocates) were consulted in the development of the standards.
- Regulators have oversight over insurer compliance in determining average contracted rates.
- Data regarding average contracted rates are not subject to the public records act because these rates are negotiated and are proprietary and confidential information.

Why are payments **NOT** based on billed charges or sticker prices?

- “Billed charges,” or what the physician wishes to be paid, bears little or no resemblance to – and can be multiple times – 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/insurers. Billed charges do not determine rates paid to physicians by commercial plans/insurers because of the negotiated rates.
- AB 72 bases the payment standard on what a large public purchaser, Medicare, or what is the average rate negotiated by that health plan/insurer in the region for that service. These amounts reflect what doctors are actually paid and not what they charge as sticker prices.
- Health care costs are higher in the US than other countries due to higher sticker prices. We end up paying more for doctors, hospitals and prescription drugs, and therefore more in premiums as well.

How often do health plans pay out-of-network doctors at in-network facilities?

- In March 2019, the Department of Managed Health Care (DMHC) reported that since the passage of the law, health plans report that the percentage of in-network facilities where there were even just one claim to an out-of-network doctor ranged from 0% to 20%.¹

¹ DMHC AB72 Report, March 4, 2019: <http://www.dmhc.ca.gov/Portals/0/Docs/DO/ab72.pdf?ver=2019-03-04-154101-503>

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- For the largest four health plans in California, the percent of contracted hospitals and facilities that had at least one health plan payment to an out-of-network provider was 4% for HealthNet, to 11%-12% for Blue Cross and Kaiser Permanente and 16% for Blue Shield of California. In other words, of the four health plans that account for almost 90% of the commercial, state-regulated insurance market in California², over 80-95% of their contracted facilities yielded no billing by out-of-network doctors.

INDEPENDENT DISPUTE RESOLUTION PROCESS (IDRP)

AB 72 created an administrative appeals process for out-of-network doctors, who wish to seek higher payments over either the 125% of Medicare or the insurer's average contracted rate.

- **Contractor:** The Department of Managed Health Care and the Department of Insurance contracted with an independent third-party entity to administer the IDRP.
- **Bundling of claims:** Providers can bundle claims for the same or similar services.
- **Mandatory:** If either party appeals and requests the IDRP, the other party must participate. **The IDRP decision is binding**, but either party is still permitted to litigate the outcome.
- **Decision process:** All relevant information may be considered when determining the appropriate reimbursement, including payments 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)

Between September 1, 2017 and July 19, 2019, the DMHC received 68 applications for IDRP. Of these, 45 were withdrawn or ineligible, 20 are pending, and 3 were decided, all 3 in favor of the health plan.

VOLUNTARY USE OF OUT-OF-NETWORK BENEFITS

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

- Consumers consent 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;
- Out-of-network doctors must provide consumers 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 consumers that an in-network care provider is available for lower out-of-pocket cost;
- Consent and estimate must be translated to language spoken by consumers if it's a Medicaid threshold language; and
- Consent must inform consumers that OON costs will not count toward annual maximum out-of-pocket for in-network benefits or deductibles.

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

² California Health Care Almanac, November, 2018, www.chcf.org

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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 required 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.

As noted above, the March 2019 DMHC AB 72 report found that the proportion of out-of-network doctors at in-network facilities varied but of the four health plans that account for almost 90% of the commercial, state-regulated insurance market in California, over 80-95% of their contracted facilities yielded no billing by out-of-network doctors. While we do not have data prior to AB 72, the law does not seem to have led to health plans not contracting with doctors en masse. Ongoing monitoring by the DMHC will track if there is a trend that requires a regulator or legislative response.

The report also found that 39 claims had been submitted to IDRP but 37 of these were closed prior to a decision, half because the claim was withdrawn and half because the claim was ineligible.

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:

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