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California Clamps Down On Surprise Out-Of-Network Bills

By: Carol K. Lucas

On September 23, 2016, Governor Brown signed AB 72, California's surprise out-of-network law. The bill protects patients who seek care at an in-network facility from balance billing by individual health care providers who are out of network. A common scenario is as follows: patient undergoes surgery at an in-network hospital; the surgery is performed by an in-network surgeon, but the anesthesiologist is not contracted with the patient's plan. The anesthesiologist bills the patient and the patient's insurance carrier pays its out-of-network amount, leaving an unexpectedly large balance to be paid by the patient. The patient was not aware that the anesthesiologist was out-of-network and is stuck with the bill.

AB 72 provides that insured patients who receive care from an individual non-contracted provider at a contracting health care facility are required to pay no more for the service than they would pay if the service were provided by a contracting provider (the "in-network cost-sharing amount"). Contracting health care facilities include hospitals as well as ambulatory surgery centers, laboratories and imaging centers. The bill requires an individual non-contracting provider who collects more than the in-network cost-sharing amount to refund any such overpayment and sets a statutory interest rate of 15% per annum if the refund is not made within 30 days of receipt. In addition, the bill imposes collection protections prohibiting wage garnishment and liens on primary residences as well as adverse credit reports.

Patients with out-of-network benefits may voluntarily agree in writing to pay the charges of an out-of-network provider based on a written estimate provided by the out-of-network provider at least 24 hours in advance of the services. The patient's consent must be in a document separate from any other consent the provider obtains and may not be obtained by the facility on behalf of the provider. Nor may the consent be obtained at the time of admission or at a time when the patient is being prepared for surgery or any other procedure. The consent document must advise the patient that he or she may elect to seek care from a contracted provider, which care may be at lower cost to the patient. (AB 72 does not address how this would work if the facility has an exclusive agreement with a non-contracted group).

Under AB 72, non-contracting providers at in-network facilities are entitled to be reimbursed by the patient's health insurer at the greater of 125% of the Medicare rate for the service or the payor's average contracted rate for similar services in the same geographic area. The provider can appeal the amount paid through a binding independent dispute resolution process to be established by the Department of Managed Health Care and the Department of Insurance by September 1, 2017 (even though the law itself will apply to coverage issued on or after July 1, 2017).

For providers and payors (including delegated groups) the most contentious issue may prove to be the determination of average contract rate. In order to determine the average contract rate, each plan and its delegated groups must provide to the DMHC (or Department of Insurance for plans regulated by the DOI) (i) its average contracted rates in each geographic region in which services were rendered for 2015 (which will be treated confidentially); (ii) its methodology for determining the average contracted rate (which must include the highest and lowest contracted rates for 2015); and (iii) the policies and procedures used to determine the average contracted rates.

By January 1, 2019, the Department (or the DOI) must specify a methodology for plans and delegated groups to use to determine average contracted rates. The methodology is to take into account information from the dispute resolution process, the specialty of the provider and the geographic region in which the services are rendered. The plan must include the highest and lowest contracted rates. If a plan does not have a sufficient number of claims to determine an average contracted rate, the plan may instead use a statistically credible database reflecting rates paid to non-contracting providers in the geographic area. In developing the standardized methodology the Department is required to consult with interested parties, including health plans, insurers, providers, hospitals, consumer advocates and "other stakeholders it deems appropriate." The first stakeholder meeting is to be held no later than July 1, 2017.

Opponents of AB 72 argued that the bill strengthens the hand of payors in contract negotiations with physicians. While AB 72 does specifically require plans to satisfy network adequacy requirements, which may be a contracting benefit to providers, the cap on payments to non-contracting providers in contracted facilities may make an out-of-network strategy less feasible or desirable for physicians. Notwithstanding the opposition, however, AB 72 was viewed as a major piece of consumer protection legislation. A recent survey conducted by Consumers Union found that one-quarter of Californians who had hospital visits or surgery in the past two years received out-of-network bills when they thought they were obtaining their care in-network.

California now joins New York and Florida in protecting patients from surprise out-of-network bills. Many other states are currently considering legislation in the area.

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