Are You Ready for AB 72?

Carol K. Lucas and Anne N. McKenzie

To protect patients from receiving an unexpected surprise bill when they seek care at in-network facilities from out-of-network providers, Governor Brown signed AB 72: California's surprise out-of-network law. The new law limits the amount out-of-network providers may bill patients who receive services at an in-network facility. Nonetheless, in certain circumstances, patients may consent to pay out-of-network rates.

Effective July 1, 2017, providers that render certain services at a contracting health facility may be limited to billing patients for the in-network cost-sharing amount. Upon the effective date, any issued, amended, or renewed managed care contracts and health insurance policies must include provisions that provide that if (i) an enrollee or insured receives covered services (ii) at a contracting health facility (iii) from a noncontracting individual health professional, then (iv) the enrollee or insured is required to pay only the in-network cost-sharing amount.

Under the new law, an "individual health professional" means a physician, surgeon or other health care provider (dentists are excluded). A "health facility" is a hospital, ASC or other outpatient center, laboratory, or radiology or other imaging center. "Covered services" do not include Medi-Cal covered services or emergency services. And the "in-network cost-sharing amount" is the same amount that the enrollee or insured would have paid had the services been provided by a contracting provider.

Noncontracting individual health professionals are prohibited from billing or collecting any amount above the in-network cost-sharing amount from enrollees or insureds. Any such overpayments received must be refunded. From the carriers, noncontracting providers will be paid the greater of (1) the payor's average contracted rate or (2) 125% of the then-current Medicare physician fee schedule based on the geographic region where the services were rendered. Disputes related to such payments must be resolved pursuant to a dispute resolution process under regulations to be promulgated by California Department of Managed Health Care and the California Insurance Commissioner by September 1, 2017.

But noncontracting individual health professionals may opt-out of in-network rates in certain circumstances. First, the enrollee or insured must have a health care service plan or insurance policy that includes coverage for out-of-network benefits. Second, the enrollee or insured must consent in writing. Effective consent is subject to the following six requirements pursuant to Health and Safety Code section 1371.9(c) and Insurance Code section 10112.8(c):

1. At least 24 hours in advance of care, the enrollee or insured must consent in writing to receive services from the identified noncontracting individual health professional.

2. The consent shall be 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. The consent may not be obtained by the facility or any representative of the facility on the physician's behalf. The consent may also not be obtained at the time of admission or at any time when the enrollee or insured is being prepared for surgery or any other procedure.

3. At the time consent is provided, the noncontracting individual health professional must give the enrollee or insured a written estimate of the enrollee's total out-of-pocket cost of care. The written estimate is to be based on the professional's billed charges for the service to be provided. The noncontracting individual health professional may not attempt to collect more than the estimated amount without receiving separate written consent from the enrollee or the enrollee's or insured's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given, which would require the provider to change the estimate.

4. 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 enrollee's or insured's health care service plan or insurance policy (respectively) in order to arrange to receive the health care service from a contracted provider for lower out-of-pocket costs. (It is not clear how this requirement would work in the case of a noncontracted provider with an exclusive agreement to provide services at a contracted facility.)

5. The consent and cost estimate must 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.

6. The consent must also advise the enrollee or insured that any costs incurred as a result of the enrollee's or insured's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

If the enrollee's or insured's plan or policy covers out-of-network benefits, and if the six above-referenced conditions are met, then a noncontracting provider may bill and collect the out-of-network cost-sharing amount from the enrollee or insured. In addition, the payor must pay the noncontracting provider the amount provided in the health care service plan contract or insurance policy. Notably, such

payment will not be subject to the independent dispute resolution processes.

All noncontracting individual health professionals should presume that their patients' HMO and other private insurance policies are subject to AB 72. Should noncontracting individual health professionals wish to retain their current out-of-network rates, they may obtain patient consent – subject to above-referenced requirements. Further, we recommend that ASCs communicate with the physicians on their medical staffs about (1) which health plans and insurers the ASC is contracted with and (2) compliance with AB 72. For questions and concerns regarding compliance with AB 72, ASCs and individual health professionals should contact their Buchalter counsel for guidance.

Carol K. Lucas is a Shareholder in the Firm's Los Angeles office. She can be reached at 213.891.0700 or clucas@buchalter.com.

Anne N. McKenzie is an Attorney in the Firm's Los Angeles office. She can be reached at 213.891. 5049 or amckenzie@buchalter.com.