MY BENEFIT ADVISOR

California Limits Surprise Medical Bills

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On September 23, 2016, Governor Brown signed Assembly Bill 72, California's law prohibiting surprise medical bills from out-of-network providers operating at in-network facilities. The new law takes effect for plans renewed on or after July 1, 2017 and prohibits balance billing of individuals for non-emergency services. The law establishes a reimbursement formula for out-of-network providers and requires any balance billing issues to be resolved between the carrier and service provider. The law does not apply to Medical plans, self-funded plans, fully insured plans written outside of California, or individuals that are not insured. Balance billing related to Emergency services is already prohibited in California.

Surprise medical bills result when an individual inadvertently receives services from an out-of-network provider operating inside a facility that is in-network but the individual was not able to consent to the services and did not know the provider was not actually an in-network provider. This situation frequently occurs with anesthesiologists or radiologists that work in a hospital or medical office that is contracted with an insurance network but those individual providers are not part of the same network. The ACA limitations on out-of-network cost sharing allow individuals to be held fully responsible for any balance billing.

When processing an out-of-network claim, insurance carriers will often apply a payment formula for a portion of the claim, such as 60% of the usual and customary charge. The provider, at their discretion, can then bill the individual that received the services. This could be a significant charge because an out-of-network provider is not limited as to what can be charged for services in the same way that an in-network provider agreed when they joined the network.

For example, anesthesiology provided in-network may be billed at $2,500 but discounted to $700, of which the individual may pay $140. However, the same anesthesiology services provided out-of-network may be billed at $2,500 with no discount applied. The individual would be balance billed for the amount in excess of the insurance payment. This is illustrated in the chart below:

Anesthesiology	Billed Cost	Insurance Discount	Insurance Payment	Individual Payment	Balance Bill
In-Network Provider	$2,500	-$1,800	$560	$140	$0
Out-of-Network Provider	$2,500	$0	$480	$140	$1,880

The law requires the reimbursement rate for an out-of-network provider at an in-network facility to be either the average of the health insurer's contracted rate or 125% of Medicare reimbursement for the same or similar service in the same geographic area, whichever is greater. Additionally, the out-of-network provider must accept this amount as full payment. The law further requires that any disputes as to the reimbursement would be resolved by an insurer's internal review process or, if that fails to reach a resolution, an independent dispute resolution process (IDRP). The California Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) would establish the IDRP.

Health Insurers are required to provide the DMHC and CDI with data listing their average contracted rates for their most frequently provided services by out-of-network providers, their methodology for determining their average contracted rate, and their policies used to determine their average contracted rate. The DMHC and CDI will use this information to establish an average contracted rate methodology for the IDRP by January 1, 2019.

Individuals can agree to balance billing in writing that meets the following criteria:

- Provided 24 hours in advance of the care
- In a document that is separate from any other consent required for the treatment
- Is not obtained by the facility
- Is not obtained while the individual is being prepared for the procedure
- Provides an estimate of the individual's total out of pocket cost and prohibits collecting more than the estimated amount
- Informs the individual that they may seek care form an in-network provider by contacting the insurer
- Is provided in the language spoken by the individual providing consent
- Advises that the out-of-network costs are in addition to in-network costs and may not count towards the annual deductible or out of pocket maximum.

The law also limits the collection and debt information that can be provided to a credit reporting agency.

Employers should ensure that their fully insured plans renewing on or after July 1, 2017 comply with the new law.