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Balanced Billing in California: Update Regarding 2016's A.B. 72 and an Overview of Newly Introduced Bill A.B. 1611

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Balanced billing or "surprise billing" has been getting increased attention at both the federal and state level. Balance bills arise when a payor covers out-of-network care, but the provider bills the patient for amounts beyond what the payor covers and beyond cost-sharing amounts. California has been tackling this issue for over a decade. This article provides an update regarding two pieces of California legislation – A.B. 72, effective in 2017 and A.B. 1611, newly proposed – which concern balance billing.

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A.B. 72 – Out of Network Coverage

In 2009, the California Supreme Court held, in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, that billing disputes over emergency medical care must be resolved solely between the emergency department physicians and the HMO; emergency department physicians may not bill the HMO enrollee for any disputed. The California Supreme Court determined that the Knox-Keene Act, which governs HMOs in California, evidenced a legislative intent to prohibit balance billing *in this context* based on the following factors: (1) an intent in the Knox-Keene Act to transfer the financial risk of health care from patients to providers, (2) the statutory requirement that requires emergency care patients to either agree to pay for the services *or* to supply insurance information, (3) the statutory requirement that HMOs pay doctors for emergency services rendered to their subscribers, (4) the statutory prohibition on balance billing when the HMO, and not the patient, is contractually required to pay, (5) the statutory requirement that HMOs adopt mechanisms to resolve billing disputes between emergency room (i.e., non-contracting) doctors and HMOs, and (6) *Bell v. Blue Cross of California* (2005), wherein the Court of Appeal interpreted the Knox-Keene Act to permit emergency room physicians to sue the HMO directly for the reasonable value of the emergency services.

Prospect Medical Group left open the issue of whether the Knox-Keene Act evidenced a legislative intent to prohibit balance billing for *non-emergency services*, which is where Assembly Bill (A.B.) 72, Stats. 2016, ch. 492, steps in. A.B. 72 became effective on July 1, 2017 and requires an HMO contract issued, amended, or renewed on or after the effective date to provide that if an enrollee receives covered services from a contracting health facility at which the enrollee also receives covered services provided by a noncontracting individual health professional, then the enrollee is only required to pay the contracting individual health professional the same cost-sharing required as if the services were provided by a contracting professional. There is an exception if the enrollee provides written consent that satisfies specified criteria.

A.B. 72 requires HMOs to reimburse an out-of-network individual health professional (typically hospital-based specialists such as pathologists, radiologists and anesthesiologists) at an "average contracted rate" or 125% of the amount that Medicare reimburses on a fee-for-service basis for the same or similar services in the geographic region in which the services were rendered. A.B. 72 required that by September 1, 2017, the California Department of Managed Health Care (Department) establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between an HMO and a noncontracting individual health professional.

A.B. 72 also required that by January 1, 2019, the Department specify a methodology that HMOs and their delegated entities use to determine the average contracted rates for services based upon, at minimum, (1)

information from the independent dispute resolution process, (2) the specialty of the individual health professional, and (3) the geographic region in which the services are rendered. New Section 1300.71.31 of Title 28 of the California Code of Regulations sets forth the methodology for determining the average contracted rate, which utilizes a claims volume-based mean adjusted at the time of reimbursement by applicable payment modifiers. Payors must include the highest and lowest contracted rates for a health care service, even if the payor paid zero claims at those rates. Payors are also required to take into consideration several factors, at minimum, including: (1) the health care service code, (2) geographic region, (3) provider type and specialty, and (4) facility type. Several claims are excluded from this calculation, including, but not limited to, case rates, bundled payments, claims paid pursuant to capitation and risk-sharing arrangements. HMOs are now required to file their policies and procedures used to determine the average contracted rates by August 15, 2019, and thereafter when the policies and procedures are modified.

Currently, A.B. 72 is being challenged by The Association of American Physicians & Surgeons (APPS) in the United States Eastern District Court of California. A hearing to consider the Department's motion to dismiss has been scheduled for March 21, 2019.

A.B. 1611 Emergency Hospital Services: Costs

Balance billing regulation has been going on in California for well over a decade. The newly introduced A.B. 1611 is the California Legislature's latest attempt – this bill would prohibit a hospital from charging insured individuals more than the in-network cost-sharing amount for emergency and post-stabilization care. It would expand the holding in *Prospect Medical Group* to insured patients enrolled with nearly any third-party payor, including an employer-sponsored plan. Assemblyman David Chiu, the sponsor of A.B. 1611, has stated that he became aware of this issue due to media reports involving Zuckerberg San Francisco General Hospital (ZSFG), the city's only trauma center, which does not enter into contracts with any private insurance companies. The hospital, which is operated by the San Francisco Department of Public Health, announced on February 1, 2019 that it will develop a comprehensive plan for improvements to improve billing practices at ZSFG, including a temporary halt to the practice of balance billing.

The California Hospital Association has stated in a press release that its hospitals support the intent of A.B. 1611 – "[w]hile California is a leader in protecting patients from unexpected bills, this proposal enhances current safeguards, and hospitals look forward to working with the authors and sponsor in the weeks ahead."

We will continue to monitor and report on developments regarding A.B. 72 and A.B. 1611.

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