CalPERS

Pension & Health Benefits Committee

California Public Employees' Retirement System

Agenda Item 5b

May 19, 2015

ITEM NAME: Assembly Bill 533 (Bonta) – Balance Billing by Individual Health Professionals

As Amended April 23, 2015

Sponsor: Health Access

PROGRAM: Legislation

ITEM TYPE: Action

RECOMMENDATION

Adopt a **Support** position on Assembly Bill (AB) 533 because this bill protects members from negative financial consequences when they unknowingly receive care from an out-of-network health professional at an in-network health facility.

EXECUTIVE SUMMARY

AB 533, among other things, requires health plan contracts and insurance policies issued, amended, or renewed on or after January 1, 2016, to provide that patients only owe in-network cost sharing when they receive care from a non-contracting health professional at an in-network health facility. It also requires in-network cost-sharing amounts paid to a non-contracting health professional to count toward annual deductibles and out-of-pocket limits, and allows a patient to voluntary consent to use an out-of-network health professional and pay any amounts beyond the in-network rate, as specified.

The California Public Employees' Retirement System (CalPERS) Board of Administration's Legislative and Policy Engagement Guidelines do not specifically address the issues raised by this bill. However, this bill provides an important consumer protection by removing CalPERS members enrolled in CalPERS health maintenance organization (HMO) plans that use in-network health facilities from being balance billed by out-of-network health professionals especially when members sought in-network care but were seen by an out-of-network health professional through no fault of their own.

STRATEGIC PLAN

This item supports CalPERS 2012-17 Strategic Plan Goal A to improve long-term pension and health benefit sustainability by ensuring high-quality, accessible, and affordable health benefits.

BACKGROUND

Balance Billing

Balance billing occurs when a health care provider charges a patient the difference between what the patient's health plan reimburses for a service and what the provider charges. For example, a health plan may pay $400 for a specific procedure for which the physician regularly charges $600. If the physician accepts the health plan's payment and bills the patient $200 to make up the difference, the physician has balance-billed the patient.

Current law prohibits medical providers contracting with health plans and insurers from seeking any payment from patients, other than agreed upon co-payments or deductibles, for services covered by the health plan. Under the health plan or insurer contract, the provider has agreed to accept a discounted reimbursement rate as payment in full for all covered services provided to enrollees and insureds of that health plan or insurer. The physician, therefore, has no recourse to seek additional compensation for those services from the patient through balance billing. Any disputes regarding reimbursement must be addressed with the health plan or insurer.

Except for emergency services provided to individuals enrolled in plans regulated by the California Department of Managed Health Care (DMHC), current law does not prevent balance billing by medical providers who have not entered into a contract with a health plan or insurer.

Balance Billing by Individual Health Professionals

When a health facility, that is part of a health plan or insurer's network, admits a patient, it is reasonable for the patient to assume that his or her health plan or insurer will pay for services provided in the health facility. Nevertheless, even though a health facility has contracted with a health plan or insurer, there may be a physician or surgeon within the health facility delivering services to that patient who has not contracted with the plan or insurer, typically referred to as a non-contracting physician. The patient, therefore, may be subject to balance billing for whatever amount the non-contracting physician charges above the health plan or insurer's reimbursement amount.

For certain specialties such as anesthesiology, the health facility may only have one anesthesiologist on duty. Once admitted, a patient has no way of knowing whether the anesthesiologist is a contracted physician. The patient also has no option to select a different anesthesiologist.

As an example, a CalPERS member enrolled in an HMO could receive prior authorization from the health plan for a surgical procedure at a contracted health facility. After the surgery, the member learns that the surgeon selected an assistant and an anesthesiologist who did not have a contractual relationship with the member's health plan. As a result, the member could receive a bill for services performed by the assistant and the anesthesiologist, even though the member complied with the health plan protocols and was unaware that the assistant and the anesthesiologist were non-contracting physicians.

Alternatives to Balance Billing in Specific Settings
According to the Assembly Health Committee analysis of AB 533, non-contracting emergency service physicians may balance bill if a patient is enrolled in a plan regulated by the California Department of Insurance (CDI); however, pursuant to Executive Order S-13-06 signed by Governor Schwarzenegger in 2006, they may not balance bill patients enrolled in DMHC-regulated plans. The resulting DMHC regulations have been reviewed by the courts, including a 2009 Supreme Court ruling in *Prospect Medical Group, Inc. vs. Northridge Emergency Medical Group*, which held that billing disputes over emergency medical care must be resolved solely between the emergency room doctors and the managed care plan, and that emergency room doctors may not bill a patient for the disputed amount.

California law requires health plans regulated by the DMHC to pay non-contracting providers reasonable and customary rates for their services. If the provider is unsatisfied with the payment from the health plan, the provider may use the health plan's dispute resolution procedures, lodge a complaint with the DMHC, or file a lawsuit. For example, the DMHC's current Independent Dispute Resolution Process (IDRP) is nonbinding and does not allow for compromise on a rate, rather, it requires the arbitrator apply six criteria to determine the reasonable and customary value of the services rendered by a non-contracting emergency room provider, and then decide which rate, the payer's paid amount or the provider's billed amount, best represents that value. The IDRP also allows a hospital provider to reduce his or her billed amount prior to a determination by the arbitrator.

ANALYSIS

1. <u>Proposed Changes</u>
   Specifically, AB 533:
   - Defines "individual health professional" as a physician or surgeon or other professional who is licensed by California to deliver or furnish health care services.
   - Requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, to provide that if an enrollee or insured obtains care from a contracting health facility at which, or as a result of which, the enrollee or insured receives covered services from a non-contracting individual health professional, he or she is required to pay the non-contracting individual health professional no more than the cost-sharing amount they would have paid to a contracting individual health professional.
   - Requires a health plan or insurer to inform the non-contracting individual health professional of the in-network cost-sharing amount of the enrollee or insured at time of payment by the plan or insurer.

- Specifies that a non-contracting individual health professional who accepts reimbursement from a health plan or insurer is not entitled to collect from an enrollee or insured any more than his or her in-network cost-sharing amount.
- Requires a non-contracting individual health professional to refund any amount collected from an enrollee or insured that is greater than his or her in-network cost-sharing amount within 30 working days of being informed by the plan or insurer of that amount, and requires any refundable amount to accrue interest at an annual rate of 15 percent from the end of the 30-day period to the time the refund is made. The refundable amount must include all accrued interest without requiring the enrollee or insured to submit a request for the interest amount.
- Prohibits a health plan or insurer from paying a non-contracting individual health professional for services rendered if he or she has referred an enrollee or insured to the collections process for non-payment prior to payment by the plan or insurer. A non-contracting individual health professional may, however, advance to collections any in-network cost sharing an enrollee or insured fails to pay after the health plan or insurer informs the non-contracting individual health professional of the amount owed by the enrollee or insured.
- Requires any in-network cost-sharing amounts paid by the enrollee or insured for services rendered by a non-contracting individual health professional shall count toward the annual out-of-pocket expenses limit and the enrollee or insured's deductible.
- Allows an enrollee or insured to voluntary consent to use an out-of-network individual health professional and pay the additional costs of care beyond the in-network rate, if he or she receives an estimate of the cost of services, notification that payments above the in-network rate may not be counted toward his or her annual deductible or out-of-pocket expenses, and provides written consent at least 24 hours prior to receiving services.

2. <u>Arguments in Support</u>

According to the author, "California consumers who go to an in-network hospital or other in-network health facility are too often surprised when they get a bill from a doctor they never met or did not choose. Sometimes it is an anesthesiologist who administers anesthesia, a radiologist who the patient never meets and who reads an X-ray or other image, or a pathologist who works on test results. The consumer needs care and goes to an in-network facility but gets surprise bills from providers that are out of network."

"These surprise bills are often for tens of thousands of dollars, and media reports have detailed surprise bills in excess of $100,000. Furthermore, because the consumer went out of network, albeit inadvertently, these charges do not count toward the annual out of pocket maximum of $6,600."

3. Arguments in Opposition
According to the Assembly Health Committee analysis of AB 533, several specialty provider group associations opposing the bill argue that it provides health plans and insurers additional opportunities to collect premiums from patients, not provide patients agreed to care, and allows them to pay arbitrary amounts to non-contracting providers for their services. The analysis also indicates that opponents argue the bill undermines existing law that requires health plans and insurers maintain adequate provider networks because it creates disincentives for them to negotiate fair payment arrangements and establish robust networks. They believe that that patients and providers can be protected by establishing reimbursement standards for health plans and insurers, determined by an independent non-profit entity, or by establishing a dispute resolution system that allows the parties to appeal payment amounts.

4. Protects Patients from High Charges for Out-Of-Network Care
If individuals want to receive care at a hospital or facility within their health plan or insurer's contracted network, their choice involves selecting a network hospital or facility. Once an individual is admitted to a hospital or facility for care, there is usually little or no choice of which health professional will provide the required services. When consumers have made every appropriate decision to obtain medical services through a contracted health professional or facility with their health plan, it would appear unreasonable to subject these individuals to balance billing practices. AB 533 prohibits members enrolled in CalPERS HMO plans and other consumers that use in-network health facilities from being balance billed by out-of-network health professionals providing care at these facilities.

BUDGET AND FISCAL IMPACTS

1. Benefit Costs
The impact on premiums is unknown. The bill does not change the existing processes by which health plans and non-contracting providers determine the reasonable and customary rates of reimbursement for services rendered, and there is no similar process under the Insurance Code that applies to billing disputes between health insurers and non-contracting providers. Any additional costs would be based on whether the rates of reimbursement health plans and insurers have to pay individual health professionals increase as a result of eliminating balance billing.

2. Administrative Costs
None.

BENEFITS/RISKS

1. Benefits of Bill Becoming Law
   - Protects CalPERS members enrolled in CalPERS HMO plans that use in-network facilities from being balance billed by out-of-network individual health professionals providing care at in-network facilities.

- May encourage non-contracting individual health professionals to enter into contracts with health plans and insurers.

2. Risks of Bill Becoming Law
   - While the bill removes consumers from billing conflicts and disputes between out-of-network individual health professionals and health plans and insurers, it could potentially impact future access and quality of care if non-contracting individual health professionals and health plans and insurers cannot agree on a fair payment amount.

ATTACHMENTS
Attachment 1 – Legislative History
Attachment 2 – List of Support and Opposition

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