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Consumer Protection from Surprise Medical Bills

A new law created by Assembly Bill 72 (Chapter 492, Statutes of 2016) protects consumers from surprise medical bills when they go to an in-network health facility and receive care from an out-of-network provider without their consent. This new consumer protection started July 1, 2017, and makes sure consumers only have to pay their in-network cost sharing in that circumstance. Medical providers now cannot send consumers out-of-network bills when the consumer followed their health insurer's requirements and went to an in-network facility.

Consumer Quick Facts:

- **Scope of AB 72:** Consumers are protected when receiving NON-EMERGENCY services at an in-network facility by an out-of-network provider. Facilities include: hospital, ambulatory surgery center or other outpatient setting, laboratory, and radiology or imaging center.
- **No Surprise Medical Bills:** Consumers are no longer put in the middle of billing disputes between health insurers and out-of-network providers when seeking non-emergency services. Consumers can only be billed for their in-network cost-sharing (co-pays, co-insurance, or deductible), when they use an in-network facility for non-emergency care.
- **Prevents Collections:** Consumers following their health insurer's requirements are protected from having their credit hurt, wages garnished, or liens placed on their primary residence.
- **Helps Control Health Care Costs:** Health insurer payments for out-of-network services are no longer based on sticker price.

Frequently Asked Questions

What is a surprise bill, and why would I get one?

Here are some examples of when consumers have gotten surprise bills in the past:

- A consumer had a surgery at a hospital or outpatient surgery center in the health insurer network, but the anesthesiologist who provided care was not in their health insurer network. Even though the consumer did not have a choice in who their anesthesiologist was, that provider sends a bill to the consumer after the surgery. This is a surprise bill.
- A consumer goes to a lab or imaging center in their health insurer network for tests and the doctor who reads the results is not in their health insurer network. That doctor then bills the consumer for their services creating a surprise bill.

Under AB 72, consumers should no longer receive these surprise bills. This means when you go to a health care facility like a hospital or a lab in your health insurer network, and end up with a doctor who

is not in your health insurer network, they cannot charge you more than you would have to pay for an in-network doctor.

What should I pay?

Consumers who go to an in-network facility should only have to pay for in-network cost-sharing (co-pays, co-insurance, or deductibles). Consumers should contact their health insurer if they have questions about their in-network cost sharing. Any in-network cost sharing a consumer pays to an out-of-network provider at an in-network facility counts towards their in-network deductible and maximum out-of-pocket limits for the policy year.

What is a Health Insurer Network?

A health insurer network is the group of doctors, health care facilities and other health care providers a health insurer contracts with to provide health care services to its policyholders. These providers are called “network providers,” “contracted providers” or “in-network providers.” A provider who does not contract with your health plan is called an “out-of-network provider” or “non-contracted provider.”

Examples of health care facilities that are in a health insurer network include hospitals, ambulatory surgery centers or other outpatient settings, laboratories, and radiology or imaging centers.

NOTE: Emergency care is excluded from the prohibition on surprise billing contained in AB 72, though some policies already had protection from balance billing (i.e., the difference between the provider’s charge and the amount paid by an insurer) in this situation under existing law.

What if I Received a Surprise Bill? And What if I Already Paid?

If you received a surprise bill for medical services provided after July 1, 2017 and already paid more than your in-network cost share (co-pay, co-insurance or deductible) file a complaint with your health insurer with a copy of the bill. Your health insurer will review your complaint and should tell the provider to stop billing you. If you do not agree with your health insurer’s response or would like help from the California Department of Insurance to fix the problem, you can file a complaint with the Department, the state regulator of health insurers. You can file a complaint by visiting www.insurance.ca.gov or calling 1-800-927-4357.

Does the New Law Apply to Everyone?

The new law applies to people with health insurance policies or plans regulated by the California Department of Insurance or the California Department Managed Health Care that were issued, amended, or renewed on or after July 1, 2017. It does not apply to Medi-Cal plans, Medicare plans or “self-insured plans.” If you do not know what kind of plan you are in, you can call the Department of Insurance Help Center at 1-800-927-4357.

What If I Want to See a Doctor Who I Know is Out-of-Network?

If you have a health insurance policy with an out-of-network benefit, such as a PPO, you can choose to go to an out-of-network provider. If you go to an in-network facility and want to see an out-of-network provider, you have to give your permission in writing by signing a form provided by the out-of-network provider at least 24 hours before you receive care. The form must be separate from any other document used to obtain consent for any other part of the care or procedure and should inform you that you can receive care from an in-network provider if you so choose. At the time consent is provided, the out-of-network provider shall give the consumer providing consent a written estimate of the consumer’s total out-of-pocket cost of care as well as a notice that the consumer may contact their health insurer in order to receive the health service from an in-network provider at a lower out-of-pocket cost. The form should be in

your language if you speak English, Spanish, Vietnamese, Cantonese, Armenian, Russian, Mandarin, Tagalog, Korean, Arabic, Hmong, Farsi, or Cambodian.