From:	DMHC Licensing eFiling
Subject:	APL17-011 (OPL) Guidance Regarding AB 72 and Notice to Enrollees
Date:	Wednesday, July 12, 2017 4:00:51 PM
Attachments:	AB 72 Specialized APL.pdf

Dear Health Plan Representative,

Please find the attached All Plan Letter regarding AB 72 and Notice to Enrollees. If you have any questions regarding the letter, please contact the Office of Plan Licensing through your assigned counsel.

Thank you.

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th St., Ste. 500, Sacramento, CA 95814
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ALL PLAN LETTER

DATE: July 12, 2017

TO: All Specialized Health Plans (not including non-EAP behavioral health plans)[1]

FROM: Sarah Ream, Deputy Director
Office of Plan Licensing

SUBJECT: APL 17-011 (OPL) Guidance Regarding AB 72 and Notice to Enrollees

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Assembly Bill (AB) 72 (Stats. 2016, ch. 492) prohibits a noncontracting individual health care professional from "surprise balance billing" an enrollee when the enrollee received covered services from a contracting health facility at which, or as a result of which, the enrollee received service from the noncontracted individual health professional.[2] In such instances the enrollee shall pay no more than the same cost sharing the enrollee would pay for the same covered services received from an in-network individual health professional.[3] AB 72 addresses the issue of surprise balance billing when an enrollee receives care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the enrollee's care are not contracted with the enrollee's health plan.

AB 72's prohibition on surprise balance billing is effective **July 1, 2017**. All health plans shall implement immediately any necessary internal process change to comply with AB 72. AB 72 does not exempt or provide exceptions for specialized health care service plans; however, the DMHC understands that given the services specialized health plans provide, those plans' payment structures may not fit squarely with AB 72's filing requirements. This APL provides guidance in this regard.

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[1] The DMHC has determined AB 72 does not apply to specialized health plans operating lawfully under the laws of Mexico and licensed under Health and Safety Code section 1351.2. The DMHC also has determined that AB 72 does not apply to health plans that offer only a discount for services and are not at risk for the provision of services.

[2] Health and Safety Code section 1371.9, subdivision (a). All statutory citations in this APL refer to the California Health and Safety Code unless otherwise noted.

[3] Please note: Section 1371.9, subdivision (c), provides a narrow exception to the no-balance-billing rule when an out-of-network provider provides services to an enrollee in a product that includes coverage for out-of-network benefits, such as a PPO. This exception allows out-of-network providers to balance bill an enrollee if the noncontracted individual health professional obtained the enrollee's consent for such services in compliance with section 1371.9, subdivision (c).

A. Requests for exemption from the AB 72 average contracted rate filing requirement

In addition to prohibiting surprise balance billing, AB 72 requires health plans and their delegated entities to submit data regarding the health services "most frequently subject to Section 1371.9 in each geographic region in which the services are rendered for calendar year 2015."[4] "Services subject to Section 1371.9" generally means services provided by noncontracting individual health professionals as a result of non-emergency covered services provided to health plan enrollees at contracting health facilities.

The DMHC understands that in calendar year 2015, for reasons not based on the health plan's business model (i.e. a "closed" system), some specialized health plans, or their delegated entities, either paid no claims for services covered under section 1371.9, or did not pay a statistically significant number or dollar amount of claims for services covered under section 1371.9.

In these instances, the DMHC will consider, upon request, granting an exemption to the filing requirements contained in section 1371.31, subdivision (a)(2).[5] To request such an exemption, the health plan must submit a Notice of Material Modification to the DMHC by **August 15, 2017.**

The Notice of Material Modification must contain the exhibits and information described below.

1. **Exhibit E-1s:**

    a. Request an exemption from the filing requirement in section 1371.31, subdivision (a)(2). The DMHC will treat the Exhibit E-1 containing the request for exemption as confidential indefinitely.

    b. The request for exemption must be based on the health plan or delegated entity either having paid no claims covered under section 1371.9 in 2015 or having not paid a statistically significant number or dollar amount of claims for services covered under section 1371.9. If the request is based on the latter, the request must provide specific information regarding:

        i. The number of claims for services covered under section 1371.9 the health plan or entity paid in 2015.

        ii. The amount paid for of each of those claims and whether the amount paid was higher, lower, or equal to 125% of the amount Medicare reimburses on a fee-for-service basis. If the health

[4] Section 1371.31.
[5] Health and Safety Code section 1343, subdivision (b), allows the DMHC to exempt a health plan from compliance with the Act and regulations, or certain portions thereof, if the Director finds the action to be in the public interest and not detrimental to subscribers, enrollees, or persons regulated under the Act.

plan paid for services subject to section 1371.9, but Medicare does not cover those or or similar services, specify this in the E-1.

iii. If the health plan paid claims for services covered under section 1371.0, a detailed explanation as to why it is not a statistically significant number or dollar amount.

iv. Whether the health plan operates a closed system.

b. In a separate E-1 provide the following affirmations[6]:

i. In 2015, the health plan or entity: [select one]

a. paid no claims for services covered under section 1371.9; or,

b. paid claims for services covered under section 1371.9, but the number or dollar amount of those claims is not statistically significant.

ii. The health plan does not operate on a closed system model.

iii. If, after July 1, 2017, a health plan enrollee receives a service subject to section 1371.9, unless otherwise agreed to by the noncontracting individual health professional and the health plan, the health plan shall reimburse the provider:

a. at 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered; or,

b. for the amount of billed chargess for any services subject to 1371.9, if Medicare does not covered the same or similar services.

iv. The health plan or entity acknowledges that the provisions in AB 72, with the exception of section 1371.31, subdivision (a)(2), apply to the health plan or entity.

The DMHC will promptly review requests for exemption submitted pursuant to this APL. If the DMHC does not issue an exemption to a health plan or entity, the health plan or entity must file promptly all information required per section 1371.31, subdivision (a)(2).

[6] The DMHC will not treat the E-1 containing the affirmations as confidential.

B. Evidence of Coverage language and notice to enrollees

Regardless of whether the health plan or entity intends to file a request for exemption from the filing requirement in section 1371.31, all health plans must review their Evidences of Coverage (EOCs) and other documents to ensure they do not contain provisions that conflict with AB 72.

The DMHC will likely deem an EOC that states an enrollee is responsible for *all* out-of-network services (other than emergency services) as being noncompliant with AB 72, because an enrollee could reasonably interpret that provision as allowing for balance billing by an out-of-network provider even if the enrollee received the covered services at an in-network facility. EOCs should affirmatively advise enrollees about the consumer protections under AB 72.

While the specific language for your EOCs and other documents might vary, the DMHC has found EOC provisions similar to the following to comply with AB 72:

> **Example 1:** If you receive covered services at an in-network health facility but from a non-participating provider, you only have to pay the copayment amount in your Schedule of Benefits. An in-network "health facility" includes, but is not limited to, a licensed hospital, ambulatory surgery center, or other outpatient setting such as a lab, or a radiology or imaging center.
>
> **Example 2:** If you receive covered services at an in-network health facility at which or as a result of which you receive services provided by an out-of-network provider, you will pay no more than the same cost sharing you would pay for the same covered services received from an in-network provider.

If a health plan has EOCs in effect currently that conflict with or are silent regarding the prohibition on "surprise balance billing," the health plan must by **August 18, 2017**:

1. file a correction to the EOC with the DMHC for approval, and once approved by the DMHC, send the correction to impacted enrollees; **or,**

2. send the impacted enrollees a notice with the language contained in Attachment A hereto.

The DMHC considers the correction and notice described above to be "vital documents" that require translation and dissemination pursuant to section 1367.04 and California Code of Regulations, title 28, section 1300.67.04.

If you have questions regarding APL, please contact the Office of Plan Licensing through your assigned reviewer.

ATTACHMENT A

New Law Protects Consumers from Surprise Medical Bills

A new law created by Assembly Bill (AB) 72[i] (Bonta, Chapter 492, Statutes of 2016) protects consumers from surprise medical bills when they go to in-network facilities such as hospitals, labs or imaging centers. This new consumer protection starts July 1, 2017, and makes sure consumers only have to pay their in-network cost sharing. Providers now cannot send consumers out-of-network bills when the consumer did everything right and went to an in-network facility.

Consumer Quick Facts:

- **No Surprise Medical Bills**: Health care consumers are no longer put in the middle of billing disputes between health plans and out-of-network providers. Consumers can only be billed for their in-network cost-sharing, when they use an in-network facility.
- **Prevents Collections**: Protects consumers from having their credit hurt, wages garnished, or liens placed on their primary residence.
- **Helps Control Health Care Costs**: Health plan 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:

- A consumer had a surgery at a hospital or outpatient surgery center in their health plan network, but the anesthesiologist was not in their health plan 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 plan network for tests and the doctor who reads the results is not in their health plan network. That doctor then bills the consumer for their services creating a surprise bill for the consumer.

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 plan network, and end up with a doctor who is not in your health plan 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 only have to pay for in-network cost-sharing (co-pays, co-insurance, or deductibles). Consumers should contact their health plan if they have questions about their in-network cost-sharing.

What is a Health Plan Network?

A health plan network is the group of doctors, hospitals and other health care providers a health plan contracts with to provide health care services to its members. 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 providers."

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

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

If you received a surprise bill and already paid more than your in-network cost share (co-pay, co-insurance or deductible) file a grievance/complaint with your health plan with a copy of the bill. Your health plan will review your grievance and should tell the provider to stop billing you. If you do not agree with your health plan's response or they take more than 30 days to fix the problem, you can file a complaint with the Department of Managed Health Care, the state regulator of health plans. You can file a complaint by visiting www.HealthHelp.ca.gov or calling **1-888-466-2219**.

Does the New Law Apply to Everyone?

The law applies to people in health plans regulated by the Department of Managed Health Care or the California Department of Insurance. 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 Help Center at **1-888-466-2219** for help.

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

If you are in a health plan with an out-of-network benefit, such as a PPO, you can choose to go to an out-of-network provider. You have to give your permission by signing a form in writing at least 24 hours before you receive care. The form should inform you that you can receive care from an in-network provider if you so choose. The form should be in your language if you speak English, Spanish, Vietnamese, Cantonese, Armenian, Russian, Mandarin, Tagalog, Korean, Arabic, Hmong, Farsi, or Cambodian.

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[i] AB 72 protects consumers receiving non-emergency services at in-network facilities from being balanced billed by an out-of-network provider. California law already protects most consumers from balance billing for emergency services.