

New Law Protects Consumers from Surprise Medical Bills

A new law created by Assembly Bill (AB) 72¹ (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.

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.

Frequently Asked Questions:

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 DMHC 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.

¹ AB 72 protects consumers receiving non-emergency services at in-network facilities from being balance billed by an out-of-network provider. California law already protects most consumers from balance billing for emergency services.