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CLIENT ALERT

California's Surprise Medical Bill Statute: Part 2: Comparison to New York's Emergency Medical Services and Surprise Bills Law

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I. Executive Summary

On September 23, 2016, the California Legislature passed, and Governor Jerry Brown signed, Assembly Bill 72 ("the Law"), creating a new regime for the regulation of "surprise bills."[1]

To help put the Law in context, this Health Care and Life Sciences Client Alert compares the Law's provisions to New York's Emergency Medical Services and Surprise Bills Law (Financial Services Law, Article 6),[2] a recently adopted statute seeking to address the "surprise bills" issue that garnered significant national attention and was the subject of a prior Epstein Becker Green Health Care and Life Sciences Client Alert entitled "New York's 'Emergency Medical Services and Surprise Bills' Law."[3]

This Client Alert is the companion to an earlier Client Alert that summarized the key provisions of California's surprise medical bill statute.[4]

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[1] Assembly Bill No. 72, Approved by Governor Sep. 23, 2016, *available at*: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72.

[2] Emergency Medical Services and Surprise Bill. Financial Services Law Article 6, signed March 31, 2014, *available at*: http://www.dfs.ny.gov/consumer/hprotection.htm.

[3] This Client Alert is available at http://www.ebglaw.com/news/new-yorks-emergency-medical-services-and-surprise-bills-law/.

[4] The earlier Client Alert is available at http://www.ebglaw.com/news/californias-surprise-medical-bill-statute-part-1-implications-and-national-trends/.

II. Comparing the Surprise Bill Laws in California and New York

Surprise Bill Policy Element	California's Surprise Bill Law	New York's Emergency Medical Services and Surprise Bills Law
Definition of "Surprise Bill"	The Law defines "surprise bill" as charges for (i) covered services provided by an out-of-network ("OON") individual health professional at a contracted health facility where the beneficiary is receiving a covered service or (ii) services provided by an OON individual health professional "resulting from" a covered service delivered at a contracted health facility.	New York's law defines "surprise bill" as charges for (i) services from an OON physician at an in-network hospital or surgical center when a participating physician is not available, the service is rendered without the patient's knowledge, or an unforeseen service need arose; (ii) services from OON providers (including laboratory and pathology services) when resulting from a referral from an in-network physician without a signed patient form consenting to the OON status of the provider; or (iii) any physician service to an uninsured patient at any hospital or ambulatory surgery center when the patient has not received all disclosures.
Inclusion of Emergency Services	No. Existing California law requires a health plan to reimburse providers for emergency services and care provided to its enrollees and insurers to cover OON emergency services subject to in-network cost sharing.	Yes. Some emergency services are excluded from the independent dispute resolution process ("IDRP") if the bill does not exceed 120% of the usual and customary cost and the fee disputed is $631.72 (adjusted annually for inflation rates) or less after any applicable co-insurance, co-payment, and deductible.
Covered Insurers/Plans	Health care service plans are regulated by the California Department of Managed Health Care ("DMHC") and health insurers are regulated by the California Department of Insurance ("CDI"). Exclusions include Medicare Advantage plans, Medicaid managed care plans, Medicaid fee-for-service coverage, no fault, and workers' compensation coverage.	Health maintenance organizations and insurance plans are subject to New York State regulation. Exclusions include Medicare Advantage plans, Medicaid managed long-term care plans, Medicaid fee-for-service coverage, no fault, and workers' compensation coverage.

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Covered Providers	Only bills from "individual health professionals" may constitute surprise bills. An "individual health professional" includes a physician, a surgeon, and any other professional who is licensed by California to deliver or furnish health care services in California (other than dentists). The definition of "contracted health facility," where the in-network service begins and which results in the surprise bill, includes hospitals, ambulatory surgeries, "other outpatient settings," laboratories, and radiology/imaging centers.	Bills from many types of providers may constitute surprise bills, including laboratory and pathology services.
Limitations on Patient Costs	The Law requires health plans and insurers to limit beneficiary cost exposure to the copay, coinsurance, and deductible amounts provided for in-network providers.	New York's law requires providers of surprise bills to take any dispute as to the amount offered by the plan to the independent dispute resolution process. A beneficiary must be held harmless to the level of cost sharing for in-network services. For self-insured plans and the uninsured, there is no limit on the balance billing, but patients may dispute charges to the independent dispute resolution process.
Consent Safe Harbor	Providers can submit a full bill when the patient consents in writing in advance of the OON service. The consent must be collected separately from other consents to treat or share medical information. The OON health professional must furnish a written estimate of the patient's total out-of-pocket costs, and the billed charges must be limited to the estimate, absent a separate updated consent.	For OON providers receiving a referral from an in-network provider, it is not a surprise bill if the patient explicitly consented in writing that the referral was to an OON provider and that such referral may result in costs not being covered by the patient's plan.

Surprise Bill Policy Element	California's Surprise Bill Law	New York's Emergency Medical Services and Surprise Bills Law
Reimbursement Rate Provisions	Plans and insurers must reimburse such OON professional services the greater of the average contracted rate or 125% of the Medicare payment for the same service in that geographic region. In addition, the Law creates a new regime of rate oversight and regulation.	For OON physician services where a patient assigns benefits, the health plan must pay the billed amount or attempt to negotiate a different amount. If the latter fails to resolve any payment dispute, the plan must pay an amount that the plan determines is reasonable, and either party may submit the dispute to an independent dispute resolution entity. The entity will select either the plan's payment or the physician's fee. For OON physician services without an assignment of benefits, or for services provided to an uninsured patient or a beneficiary of a self-insured plan, the patient or beneficiary may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity. The entity will determine a reasonable fee.
Independent Dispute Resolution Process	The Law requires the individual health professional to exhaust any internal appeals process prior to going to the IDRP. Other details will be determined based on forthcoming DMHC and CDI rules and procedures for fees and process.	New York's law allows providers to dispute the amount offered by the plan for surprise bills through a binding independent process. For state-regulated plans, the independent resolution entity determines whether the provider's bill or the health plan's payment will be paid, and the losing party is responsible for the costs associated with the dispute.
Disclosure Obligations	The only disclosure obligations are those pursuant to the establishment of the consent safe harbor.	New York's law requires specific disclosures by hospitals, diagnostic and treatment facilities, and physicians regarding the health plans in which the provider is a participating provider and, in some cases, requires a list of standard charges and statements to patients, in public locations, to

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		check with physicians to determine whether all providers are in-network.
Network Adequacy Provisions	The Law grants additional authority to DMHC and/or CDI to promulgate additional network adequacy regulations. Also, the Law requires DMHC to annually review health plan compliance with newly developed timely access standards and to post the findings on its website.	The New York State Department of Financial Services promulgated new network adequacy regulations following the passage of the Emergency Medical Services and Surprise Bills Law that added the requirements for specific provider composition and provided time and distance standards for insurance products.
Approach to Beneficiaries of Medicare Advantage and Medicaid Managed Care Plans	Medicare Advantage is not covered because it is preempted by federal requirements; Medicaid Managed care statutorily is excluded.	Medicare Advantage is not covered because it is preempted by federal requirements; Medicaid Managed care is included, except for the managed long-term care programs.
Approach to Beneficiaries of Self-Insured Plans and Uninsured	None.	The independent dispute resolution process is available if a provider disputes OON reimbursement or the uninsured or self-insured patient disputes the charge.

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This Client Alert was authored by **Jackie Selby** *and* **Kevin J. Malone.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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