2019's AB 1611 is California's Latest Attempt in Its Long, Litigious History to Eliminate Balance Billing

This has happened before.

In 2014, San Francisco General Hospital Medical Group acknowledged in a settlement with the California Department of Managed Health Care (DMHC) that it had balance billed patients with Blue Shield PPO plans for emergency services between January 2009 and March 2014. The group claimed to have balance billed these patients because it did "not realize that Blue Shield of California PPO plans were subject to DMHC jurisdiction." Because legislative and judicial authority prohibit balance billing of emergency services for enrollees that are part of a DMHC-regulated plan, the group agreed to cease balance billing these patients. While the settlement was great for some enrollees, it did not cover everyone.

Cue last month's Vox article, *A $20,243 bike crash: Zuckerberg hospital's aggressive tactics leave patients with big bills*. The medical group at the now renamed Zuckerberg San Francisco General Hospital continued to balance bill patients not covered by DMHC-regulated plans. The public outcry that stemmed from the story sparked the introduction of AB 1611 by Assemblymember Chiu and Senator Wiener and the temporary and immediate suspension of balance billing at Zuckerberg San Francisco General Hospital.[1]

The recent media coverage surrounding balance billing and the subsequent legislative actions may suggest that California does not regulate balance billing. In reality, however, California

had successfully passed several bills and fought off multiple lawsuits to protect specific types of enrollees from balance billing. AB 1611 is just another, but not the first, step in entirely eliminating the practice of balance billing. To best understand the impact of AB 1611, a survey of California's regime on regulating balance billing is necessary.

What is Balance Billing?

Balance billing, otherwise known as "surprise medical billing," occurs when (1) medical care, usually during an emergency, happens with an out-of-network physician or at an out-of-network hospital or (2) medical care happens at an in-network hospital that unwittingly or unknowingly involved an out-of-network physician.[2] In both instances, the patient's insurance does not cover the full cost of care, leaving a balance in the medical bill. Hospitals or physicians then charge that balance to the patients, holding patients, rather than the insurers, responsible for the remainder of the cost in a balance bill. As Vox and Kaiser Health News well documented, this practice of balance billing has left *insured* patients with bills like $108,951.31 for cardiac surgery or $75,346 for hip surgery – all because the patients went to a hospital that was out of network.

Regulation of Balance Billing Has Been Ongoing for More Than A Decade

2019 may be the year that balance billing captures the general public's imagination, but steps to solve balance billing had been taken long before the events at Zuckerberg Hospital. Last year, the Source's student fellow Leah Gray detailed recent state efforts and the link between the increase in balance

billing and narrow networks.[3] More recently, early this year, DMHC just adopted regulations to implement 2016's AB 72, which prohibits an enrollee or insured from owing the noncontracting individual health professional more than the in-network cost-sharing amount.

For all its successes, however, California has struggled to control balance billing in its entirety for at least fifteen years. Since 2003, at least twelve bills targeting balance billing had failed.[4] Of those twelve, three bills (SB 981 (2008), AB 2220 (2008), and AB 2593 (2018)) had been vetoed. The two 2008 bills were vetoed by Governor Schwarzenegger for not adequately solving balance billing, while Governor Brown vetoed AB 2593 in 2018 for not going through the budget process. Still, California had some successes like AB 1203 (2008) and AB 72 (2016).

The struggles to eliminate balance billing weren't for the lack of attention, either. In March 2005, the California Senate Health Committee held an informational hearing, titled "Caught in the Squeeze: Insured Patients Facing Bills and Collection Actions from Health Care Providers" to highlight the issue of balance billing.[5]

Still, California's campaign against balance billing began with an executive order and was legitimized by a court order. Successful legislative action caught up much later.

Current California Regime of Balance Billing Regulation

Statutes, regulations, court cases, and an executive order created the current California regime of balance billing regulation, which provides: (1) prohibition of balance billing for emergency services and, in certain instances,

poststabilization care, and (2) prohibition of balance billing by noncontracting individual health professional at a contracting health facility.

1. *No Balance Billing for Emergency or Subsequent Poststabilization Services Under Certain Conditions (DMHC-regulated plan enrollees only)*

California's most meaningful move against balance billing began with Governor Schwarzenegger's Executive Order S-13-06, which ordered DMHC to "take all steps necessary to protect Californians from balance billing."[6] Despite the lack of an actual statute that prohibits balance billing, on October 14, 2008, 28 CCR §1300.71.39 went into effect. The new DMHC regulation declared that balance billing for the provision of emergency services was an unfair billing pattern. Using this authority, DMHC ordered, sued, or settled with providers and physician organizations to stop balance billing for emergency services, notably against Dr. Jeannette Martello and Prime Healthcare Services.

This regulation was immediately challenged by the California Medical Association (CMA). The superior court upheld the regulation, holding that DMHC acted within its delegated authority and that "substantial evidence in the record supports DMHC's conclusion that the Balance Billing Regulation was reasonably necessary to effectuate the purposes of the Knox-Keene Act."[7]

Another court case solidified DMHC's regulations. In the seminal 2009 case, *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, the California Supreme Court unanimously held, independent from DMHC's 2008 regulations, that while "[e]mergency room doctors are entitled to reasonable payments for emergency services . . . [it] does not further entitle the doctors to bill patients for any amount in dispute."[8] The

court further opined that balance billing puts "unjustifiable pressure on the patient" and that "no reason exists to permit balance billing."[9]

To further those regulations, the California Legislature passed AB 1203 in 2008, which prohibits a noncontracting hospital from billing the patient for poststabilization care (i.e. medically necessary care after an emergency medical condition has been stabilized), except for applicable copayments, coinsurance, and deductibles. But, this prohibition is nullified under certain conditions such as the refusal of transfer by the patient to a contracting hospital or the inability of the hospital to find the contact information of the patient's health plan.

Yet, all of the above only applies to enrollees under the jurisdiction of DMHC. Enrollees who are part of PPO plans that are regulated by the California Department of Insurance are not protected. Though DMHC regulates about 90% of the individual and group insurance markets, there is still a significant amount of the population who do not benefit from existing balance billing regulations.

2. *No Balance Billing by Noncontracting Individual Health Professional at a Contracting Health Facility*

In 2016, the California Legislature passed AB 72. Unlike DMHC's 2008 regulation and AB 1203, AB 72 focuses on the non-emergency scenarios that trigger balance billing. This enacted bill mandates that an insured patient shall "pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional" if the patient is receiving nonemergency, covered services at an in-network hospital. In other words, an insured patient will not be billed out-of-network costs even if they are receiving nonemergency care from an out-of-network provider, as long as they are at an in-network hospital. DMHC uses the

following example to illustrate how AB 72 would work:

"[A]n enrollee may go to an in-network hospital for nonemergency, covered surgery. During the surgery, an anesthesiologist who is not contracted with the enrollee's health plan may provide anesthesia to the enrollee. The enrollee's health plan often does not pay the noncontracting provider's entire bill. Prior to AB 72, that noncontracting provider could balance bill the enrollee for the remainder of the bill. AB 72 protects the enrollee by prohibiting such surprise balance billing."[10]

This prohibition covers anyone with a health insurance policy regulated by the California Department of Insurance or with a health plan regulated by the DMHC that was issued, amended, or renewed on or after July 1, 2017. As such, AB 72 does not apply to a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services. Additionally, as already pointed out, AB 72 does not apply to emergency services.

Like DMHC's regulations, AB 72 was immediately challenged. The Association of American Physicians & Surgeons (AAPS) sued Governor Jerry Brown and the DMHC Director. On March 28, 2018, the United States Eastern District Court of California granted the state's motion for judgment on the pleadings but allowed AAPS to amend their complaint. With an amended complaint, the lawsuit continues. The state filed a motion to dismiss with a court hearing set for March 7, 2019. While this legal challenge continues in court, the implementation of AB 72 has not been affected.

What Does AB 1611 Contribute?

The newly introduced AB 1611 prohibits a hospital from charging insured patients more than the in-network cost-sharing amount for emergency and post-stabilization care. In this light, AB 1611 expands the *Prospect* holding (prohibiting balance billing for emergency services) and AB 1203 (prohibiting balance billing for poststabilization care) to insured patients enrolled with nearly any third party payor, such as a health maintenance organization or employer-sponsored plan.[11] If AB 1611 is passed in its current form, it would enhance consumer protection from balance billing. The chart below provides an overview of how AB 1611 compares and adds to current California law on balance billing.

Law	Date	Type of Setting			Type of Plan			Cost to Patient: in-network cost-sharing only
		Emergency	Poststabilization	Nonemergency	DMHC	CDI	Others*	
AB 1611	2019	x	x		x	x	x	x
AB 72	2016			x	x	x		x
Prospect Medical Group case	2009	x			x			
AB 1203	2008		x		x			x
1300.71.39	2008	x			x			

* *Excluding Medi-Cal managed health care service plan or any entity that enters into a contract with the State Department of Health Care Services. See footnote 11 for more details.*

Like DMHC's regulations and AB 72 before it, AB 1611 will most likely invite some litigation. However, as seen in previous iterations of balance billing legislation, the courts have endorsed the state's authority to prohibit balance billing. As such, AB 1611 will most likely survive judicial scrutiny. For now, the legislative process will be its first challenge. AB 1611 must survive committee hearings, Assembly and Senate floors, and the Governor. The bill may be entirely revised during this process and may not be enacted, if at all, until the end of the 2019-2020 session. Stay tuned!

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[1] Additionally, the San Francisco Board of Supervisors' Government Audit and Oversight Committee held a public meeting on February 21, 2019 to hear more about the temporary ban on balance billing. The presentation can be found here: https://sfgov.legistar.com/View.ashx?M=F&ID=7058946&GUID=2822AF1E-B214-4AFD-AD6D-D672D7408013. The committee moved to continue the hearing at the next committee meeting.

[2] Because of the federal Emergency Medical Treatment & Labor Act (EMTALA), a hospital must treat any individual arriving at its emergency department regardless of ability to pay. An unintended consequence of EMTALA has led insured patients to being treated at out-of-network hospitals and held responsible for the cost. Additionally, while EMTALA applies only to hospitals participating in Medicare, nearly all hospitals receive Medicare payments in some form or another. As such, one can assume that EMTALA requires virtually any hospital in the United States to accept an emergency patient regardless of their ability to pay.

[3] Leah Gray will be publishing her student note on network adequacy and balance billing in the summer of 2019 for the Hastings Law Journal.

[4] AB 2389 (2003); AB 1321 (2005); SB 417 (2005); AB 1X 1 (2007); SB 389 (2008); SB 981 (2008) (vetoed); AB 2220 (2008) (vetoed); SB 1373 (2012); SB 266 (2013) (language was revised for another topic); AB 533 (2015); SB 1252 (2016); AB 2593 (2018) (vetoed).

[5] Read the background paper for this informational hearing here.

[6] The original file for the executive order could not be found, but it was extensively covered in other sources. The text of the executive order in its entirety can be found here: https://www.csahq.org/news/research-publications/gasline-newsletter-july-2006. To ensure accuracy of the quote, the quote used here was checked with other posts covering the executive order.

[7] California Medical Association. v. Department of Managed Health Care, No. 34-2008-80000059 (Cal. Super. Ct., Sacramento County Nov. 21, 2007) (tentative ruling).

[8] Prospect Med. Grp., Inc. v. Northridge Emergency Med. Grp., 45 Cal. 4th 497, 509 (Cal. 2009).

[9] *Id.* at 508.

[10] Initial Statement of Reasons for Proposed Adoption of Section 1300.71.31 and Proposed Amendment of 1300.71, Control No. 2017-5223, at 2, https://wpso.dmhc.ca.gov/regulations/docs/regs/44/1517587857926.pdf.

[11] AB 1611 defines "third party payor" as "any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred hospital organization, a county, or an employer that by statute or contract is required to cover emergency care." However, AB 1611 would not apply to a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services. That said, DMHC does regulate Medi-Cal managed health care service plans and can prohibit balance billing for enrollees who are part of such a plan under 28 CCR §1300.71.39.