



PATIENTS PROTECTED, PROVIDERS PAID: Data From Three Years of California's Compromise to Stop Surprise Medical Bills

Federal Action Needed to Protect Many More in CA & US

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Three years ago, on September 26th, 2016, California Governor Jerry Brown signed into law AB 72, a measure to prevent “surprise medical bills” when a patient goes to an in-network hospital or other facility and is seen by an out-of-network physician and charged the out-of-network price. AB 72, co-authored by Assemblymembers Bonta (D), Bonilla (D), Dahle (R), Gonzalez (D), Maienschein (R), Santiago (D), and Wood (D), was a hard-fought bipartisan compromise resulting from intense negotiation, advocacy and lobbying which ultimately led to a fair resolution between stakeholders and multiple legislators of both political parties.¹

AB 72 took effect on July 1, 2017, and now, over two years later, the data is clear: The law is working as intended by consumer advocates, protecting patients from physician balance billing, while ensuring a fair payment to providers (a key focus of negotiations) where the compromise benchmark payment is based on the average contracted rate. **California's health system protects patients while continuing to provide access to needed care without any empirical evidence of negative impacts from AB 72.**

Highlighting the most recent data from state regulators, this paper shows:

- **Patients are being protected** from surprise medical bills from out-of-network physicians.
- **All but a handful of physicians are accepting the “average contracted rate” benchmark as payment in full**, rather than appealing and making their case for higher payment.
- According to state regulators and health plans, **insurers have broadened their networks, and contracting continues to be widespread** such that 80%-100% of their hospitals and other facilities have no out-of-network billing from the physicians practicing within.

Key lessons can be learned from California to inform federal action. California's experience also highlights the need for federal action to fully hold consumers harmless, protecting them from surprise bills and medical debt, regardless of their insurance plan.

Key Consumer Protections in AB 72

- No surprise medical bills, period. Consumers are only billed for their in-network cost-sharing, and no more than that, when they select an in-network facility for their care. They cannot be sent to collections, wages garnished, or lose their house for more than the in-network cost-sharing.
- Fair provider reimbursement to control health care costs. Payment for out-of-network services is based on rates paid by public and private payers, and not billed charges or sticker prices. Providers can dispute the benchmark rate—of 125% of Medicare or average contracted rate—through an independent dispute resolution process.

Scope of AB 72

- Non-emergency physician services: AB 72 protects consumers who receive non-emergency services at in-network facilities from being balance billed by an out-of-network doctor.
- Emergency services mostly covered by other California laws: A 2009 California Supreme Court decision, *Prospect*, already protects most consumers from balance billing for emergency services, therefore AB72 was silent on emergency services.

FEDERAL LOOPHOLES NEED FEDERAL ACTION: The biggest caveat to the success of AB 72 is that patients in federally regulated plans (those under ERISA) are largely exempt from the law’s protections, as evidenced by continued surprise bills from health claims data from large employers that tend to be self-insured under ERISA.²

AB 72 did not address emergency care due to a 2009 California Supreme Court decision that dealt with most, but not all, surprise hospital bills from out-of-network emergency rooms.³ A follow-up bill to cover many of the remaining California consumers without surprise bill protections for emergency services, AB1611 (Chiu), is pending for next year. However, surprise bills from out-of-network providers and emergency rooms would be best dealt with **federal patient protection legislation which would extend protections and peace of mind to around seven million Californians.**

Federal Proposals Align with California’s Compromise

Patient Protection: Federal proposals can look to California’s approach as a model, as one of the most comprehensive consumer protections compared to those in other states:⁴ AB 72 protects patients from being held responsible for cost-sharing beyond in-network co-payments, coinsurance, and deductibles.⁵ Current federal proposals mirror these patient protections.

Provider Reimbursement: Leading bipartisan proposals (from Senators Alexander and Murray of the Senate Health, Education, Labor and Pensions Committee, and Representatives Pallone and Walden of the House Energy and Commerce Committee, as amended by Representatives Ruiz and Buschon) set a benchmark for paying out-of-network providers at a “median in-network rate,” which is very similar to California’s “average contracted rate” benchmark in AB 72.

The “average contracted rate” set in AB 72 was a compromise position after much negotiation. The initial position from the sponsors of the legislation, Health Access California, the statewide health care consumer advocacy coalition, and the California Labor Federation, was that payment should be set at Medicare rates, which many providers take as payment in full. However, some providers wanted their payment to be based on billed charges, or to create an arbitration process that would allow them to reference these billed charges, or “sticker prices,” which are often multiple times what most insurers and public programs actually pay.

Ultimately, the compromise in California’s law was the greater of 125% of Medicare or “average contracted rate.” The “average contracted rate” is a commercial rate determined by the market where physicians and insurers negotiate. Some providers have significant leverage, approaching a functional monopoly in an emergency situation, and are able to charge a very high price (sometimes 500% of Medicare or even more), and thus the “average contracted rate” would align with that very high market price set when the insurers and providers negotiated. The “average contracted rate” benchmark in AB 72 allows providers to collect something close to their current high price, but it prevents providers from using their monopoly position to further inflate their payments, both in and out of network.

Appeals Process: AB 72 also created an independent resolution process, or IDR, for insurers or for out-of-network doctors who wish to seek higher payments in excess of either the 125% of Medicare or the insurer’s average contracted rate. This allows providers to make their case for even higher payments.

- **Contractor:** The Department of Managed Health Care and the Department of Insurance contracted with an independent third-party entity to administer the IDR. The contractor must be independent of insurers or providers.
- **Bundling of claims:** Providers can bundle claims for the same or similar services when appealing.
- **Mandatory:** If either party appeals and requests the IDR, the other party must participate.
- **Decision Process:** All relevant information may be considered when determining appropriate reimbursement, including payments made by public and private payers, including Medicaid, Medicare, and other insurers.
- **Funding IDR:** State regulators can collect reasonable and necessary fees from both parties.

Three Years of Experience Shows Success for Patients and Providers

After three years, the data shows that most patients in California are protected from physician surprise bills, and California's health system continues to provide access to care with adequate networks without any empirical evidence that suggests negative impacts. Despite some anecdotes by self-interested providers, including statements rated as "false" by Kaiser Health News and Politifact Healthcheck⁶, the data actually point toward widespread acceptance of the benchmark rate and more provider contracting.

The Law is Working, Protecting Patients: Consumer groups, after years of hearing from patients about surprise medical bills, report that balance billing from out-of-network physicians has largely been quelled, at least for those in plans covered by AB 72, a sentiment echoed by California regulators. A RAND survey of stakeholder interviews of both supporters and opponents of the law was predictable in presenting conflicting views on payment issues (which are all anecdotal without actual data), but the consensus opinion even with opponents was that "AB 72 is effectively protecting patients from surprise medical bills."⁷

Insurers Continue Widespread Contracting with Physicians: One argument raised against AB 72 by physicians was that a benchmark rate would cause insurers to drop their contracts, under the theory that insurers would dump their networks and pay all their providers the out-of-network benchmark rate. Anticipating this, AB 72 required that state insurance regulators report on the status of networks in California after the law's implementation, in addition to the annual review of network adequacy and timely access to care standards that state law imposes on insurers. We now have the data to analyze the outcomes of the law.

- In March 2019, California's Department of Managed Health Care (DMHC) reported that since passage of AB 72, insurers contracting with physicians is still so widespread that **over 80% of the hospitals reported *zero* claims from out-of-network physicians practicing at their facilities.**
- To put it another way, the health plans report that the percentage of in-network facilities where there was even just *one* claim by an out-of-network doctor ranged from 0% to 20%, depending on the health plan.⁸ For the big four health plans in California, the percent of contracted hospitals and facilities that had at least one health plan payment to an out-of-network provider was 4% for HealthNet; 11%-12% for Blue Cross and Kaiser Permanente; and 16% for Blue Shield of California.
- Of the four health plans, which account for almost 90% of the commercial, state-regulated insurance market in California⁹, **around 85-95% of their contracted facilities yielded no billing by out-of-network doctors.** While we do not have data prior to AB 72, this clearly shows that the law does not seem to have led health plans to stop contracting with doctors. Insurers did not dump their networks in favor of relying on the benchmark.
- Ongoing monitoring by the DMHC will track if there is a trend that requires a regulator or legislative response. AB 72 reiterates an insurer's obligation to comply with existing network adequacy requirements as well as a regulators' existing authority to adopt additional regulations if needed. Federal legislation could have a similar monitoring provision.

Insurer Data Indicates Networks Have Expanded Since AB 72: This DMHC data aligns with reports from insurers, which indicate contracting actually increased during the two years since AB 72 has been in effect.

- A study by America's Health Insurance Plans (AHIP) indicates that in July 2019, **the networks of major health plans in California actually increased to 116% of the size of networks two years earlier**, in July 2017.
- These increases are reported for the specialties most likely to engage in surprise medical billing, including:
 - general surgery (110%),
 - emergency medicine (110%),
 - anesthesiology (118%), and
 - diagnostic radiology (126%).¹⁰

Most Providers Accept Benchmark Rate, With Very Few Appeals: California’s law allows providers or insurers to appeal if the average contracted rate is unacceptable. **In two years, in the entire state of California, nearly all providers accepted the payment based on the benchmark rate, and a very small number of providers appealed the rate.**

Between September 2017 and July 2019, the DMHC received not thousands or even hundreds of appeals, but **just 68 applications for the independent dispute resolution process (IDRP).**

- The appeals were mostly from one specialty, with 49 of those appeals coming from anesthesiologists.
- Of the 68 appeals, 44 were withdrawn, non-jurisdictional, incomplete or ineligible (often because the provider was in fact contracted, in Medi-Cal or another plan not covered by AB 72).
- Just 23 are pending appeals, with just one decided by mid-2019, in favor of the health plan. The California Medical Association contracted with a consultant to help physicians with appeals, **yet only 24 relevant claims were appealed out of the hundreds of thousands of claims in California a year.**¹¹

CONCLUSION: No patient should end up getting a surprise bill for hundreds or thousands of dollars from an anesthesiologist, radiologist, pathologist or other specialist who turns out to be out-of-network and who the patient had no control over choosing. No doctor, hospital, or other provider should be able to leverage a functional monopoly arising from a patient’s emergency, hospital stay, or surgery to demand whatever they want as payment.

AB 72 established a fair compromise for compensation, an “average contracted rate” benchmark. The vast majority of providers accepted these rates as payment in full, and all indications are that insurers have continued to contract and negotiate with providers—if not expanded their networks to bring in more physicians. Given this positive experience backed up by hard data, California’s compromise is a worthy construct to consider in developing federal legislation, which is urgently needed to protect millions of Californians and Americans.

Endnotes

- 1 AB 72 text and legislative analyses: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72
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- 3 Health Access factsheet: “Surprise ER Bills: A California Perspective.” August 2019. https://health-access.org/wp-content/uploads/2019/07/Surprise-ER-Bills-A-CA-Perspective_7.22.19.pdf
- 4 Hoadley, Jack, Kevin Lucia, and Maanasa Kona, “State Efforts to Protect Consumers from Balance Billing.” Commonwealth Fund, January 18, 2019. <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>
- 5 Health Access & California Labor Federation Fact Sheet. https://health-access.org/wp-content/uploads/2019/07/AB-72-Fact-Sheet_updated-7.22.19.pdf
- 6 Bluth, Rachel. “Doctors Argue Plans to Remedy Surprise Medical Bills Will Shred Safety Net.” False Rating by Kaiser Health News & PolitiFact HealthCheck. August 7, 2019. <https://khn.org/news/doctors-argue-plans-to-remedy-surprise-medical-bills-will-shred-the-safety-net/>
- 7 Duffy, Erin. RAND, “California Rules to Limit Surprise Medical Bills Are Working, But Influence Insurer-Provider Bargaining.” <https://www.rand.org/news/press/2019/08/12.html>
- 8 California Department of Managed Health Care. “Assembly Bill 72 Report,” March 4, 2019: <https://www.dmhc.ca.gov/Portals/0/Docs/DO/ab72.pdf>
- 9 California Health Care Almanac, November, 2018, www.chcf.org
- 10 Thornton, Jeanette. America’s Health Insurance Plans. “Can We Stop Surprise Medical Bills and Strengthen Provider Networks? California Did.” American Journal of Managed Care, August 22, 2019 <https://www.ajmc.com/contributor/america-s-health-insurance-plans/2019/08/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did>
- 11 California Department of Managed Health Care. “Quarterly Report Regarding the AB 72 Independent Dispute Resolution Process.” September 2019. http://dmhc.ca.gov/Portals/0/Docs/HCP/AB%2072%20IDRP%20Quarterly%20Report%20through%20nd%20Q%202019_1.pdf?ver=2019-09-24-075358-030