HEALTH ACCESS
California's Health Consumer Advocacy Coalition

Patients Protected, Providers Paid: CA's Experience to Stop Surprise Medical Bills

Five Years of California Data Points to Success for the Federal "No Surprises Act" and Qualifying Payment Amount

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In 2022, the federal "No Surprises Act" went into effect preventing patients across the country from getting unfair and unexpected out-of-network medical bills, which can be hundreds or thousands of dollars, and in some cases, even more. This national law will protect millions of consumers, even in states that had previously had strong state-level protections; for example, over six million Californians in federally-regulated plans that were exempt from state laws will now get these protections.

California's state law on surprise medical bills is directly relevant to the new federal law in another way, to provide real data about the projected implementation of the No Surprises Act. While a major bipartisan achievement, the rules put out by Secretary Xavier Becerra and the U.S. Health and Human Services Department are opposed by some providers, who are making claims about the impact of this surprise bill solution, especially the benchmark for payment to providers, called the "Qualifying Payment Amount". This standard is similar to what was adopted in California law in 2017, and the experience in our state is relevant as an indication of what may or may not happen nationally.

Lessons from AB 72: The campaign to pass the state law ended in September 26th, 2016, when 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) (now Attorney General Bonta), Bonilla (D), Dahle (R), Gonzalez (D), Maienschein (R), Santiago (D), and Wood (D) (now Assembly Health Committee chair), 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.[i]

AB 72 took effect on July 1, 2017, and now, 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 state negotiations was the compromise benchmark payment based on the average contracted rate. This is similar to the median contracted rate or "Qualifying Payment Amount" in the federal No Surprises Act.

California's AB 72 protects patients while continuing to provide access to needed care without any empirical evidence of negative impacts. Highlighting the most recent data from state regulators, data 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. Out of the millions of claims by non-contracting physicians at in-network hospitals, ambulatory surgeries, labs and imaging centers in California, between September 2017 and September 2021, only 40 disputes proceeded through the independent dispute resolution process.
- According to state regulators and independent studies, **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 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 the house for more than the in-network cost-sharing.
- **Fair provider reimbursement to control health care costs.** Payment for out-of-network services is the greater of 125% of Medicare or average contracted rate, not billed charges or sticker prices.

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.

The biggest caveat to the success of AB 72 was that patients in federally regulated plans (those under ERISA) were 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.[ii] **The federal No Surprises Act closes that loophole.**

AB 72 also 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.[iii] In these instances, the federal rule for the use of the qualifying benchmark payment will apply.

THE FEDERAL INTERIM FINAL RULES FOR THE NO SURPRISES ACT ALIGN WITH CALIFORNIA'S COMPROMISE

Patient protection: The Federal interim final rules look to California's approach as a model, as one of the most comprehensive state-level consumer protections.[iv] AB 72 protects patients from being held responsible for cost-sharing beyond in-network co-payments, coinsurance, and deductibles.[v] The federal law provides substantially similar patient protections from surprise medical bills, applying to both providers and health plans.

Provider Reimbursement: The reliance on the "qualifying payment amount" in the interim final rule sets 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" in AB 72 was a compromise 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, providers wanted their payment to be based on billed charges, or to create an arbitration process that would allow them to submit these billed charges, or "sticker prices." Billed charges are often multiple times what most insurers and public programs actually pay. This mirrors the debate at the federal level.

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.

The continued effort on the part of providers to obtain higher, above market rates by altering the federal interim final rule would continue to drive up health care costs. Consumers would be caught in the middle between providers and health plans—and whether it is a surprise medical bill or an inflated premium, the consumer is the one who pays the ultimate price.

Appeals Process: AB 72 also created an independent resolution process (IDRP) 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, in a mandatory process.

- **Contractor**: The Department of Managed Health Care and the Department of Insurance contracted with an independent third-party entity to administer the IDRP. The contractor must be independent of insurers or providers.
- **Bundled claims**: Providers can bundle claims for the same or similar services when appealing.
- **Mandatory**: If either party appeals by requesting the IDRP, the other party must participate.
- **Decision D**: 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 IDRP**: State regulators can collect reasonable and necessary fees from both parties.

YEARS OF EXPERIENCE IN CALIFORNIA SHOWS SUCCESS FOR PATIENTS AND PROVIDERS

After more than four 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 Healthcheck[vi], 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 was largely 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."[vii]

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.**
- Independent studies found that *networks have grown in California:*
    - A 2019 analysis from USC-Brookings Schaeffer Initiative for Health Policy found that compared with the period before the law was enacted, the percentage of anesthesiologists, pathologists, assistant surgeons, radiologists, and neonatalists included in-network had increased by an average of 17 percent.[viii]
    - A second analysis published in the American Journal of Managed Care found that the state saw a 16 percent increase in the total number of physicians participating in health plan networks, with increases across a range of specialties (10% growth in emergency medicine, 1% in pathology, 18% in anesthesiology; 26% in diagnostic radiology).[ix]

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.[x] 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 California[xi], **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.

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 September 2021, the DMHC received not thousands or even hundreds of appeals, but **just 124 applications for the independent dispute resolution process (IDRP)**.

- The appeals were mostly from one specialty, with 85 of those appeals coming from anesthesiologists.
- Of the 124 appeals, 108 were withdrawn, non-jurisdictional, or ineligible (often because the provider was in fact contracted, in Medi-Cal or other plan not covered by AB 72).

- Only 40 disputes have been determined, out of the millions of claims filed by 13.5 million Californians with coverage regulated by the California Department of Managed Health Care for care at in-network hospitals, ambulatory surgery centers, labs and imaging. About half the disputes were favorable to the provider and about half to the health insurer.
- The California Medical Association contracted with a consultant to help physicians with appeals, but yet **only 40 relevant claims were appealed out of the millions of claims in California over the last four years.** [xii]

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.

The new federal rules align with AB 72. The state law established a fair compromise for compensation, an "average contracted rate" benchmark—a model that the federal government largely adopted. The No Surprise Act regulations thus protected patients from surprise medical bills, but also for overcharging. 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 in California backed up by hard data, we expect the federal experience will be similar: patients protected, providers paid, without negative impacts on networks or access to care.

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[iii] 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

[iv] 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

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[vi] 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/

[vii] 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

[viii] Loren Adler, Erin Duffy, Bich Ly and Erin Trish. "California saw reduction in out-of-network care from affected specialties after the 2017 surprise billing law." USC-Brookings Schaeffer Initiative for Health Policy. Sept. 2019.

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[xi] California Health Care Almanac, November, 2018, www.chcf.org

[xii] California Department of Managed Health Care. "Quarterly Report Regarding the AB 72 Independent Dispute Resolution Process." September 2019. http://www.dmhc.ca.gov/