

California Health Benefits Review Program

Analysis of California Assembly Bill AB 533 Out-of-Network Coverage

A Report to the 2015–2016 California State Legislature

January 7, 2016



Key Findings:

Analysis of California Assembly Bill (AB) 533 Out-of-Network Coverage

Summary to the 2015–2016 California State Legislature



CONTEXT

AT A GLANCE

“Surprise medical bills,” as defined and addressed by AB 533 (as amended September 4, 2015), may occur when an enrollee receives care from an out-of-network (OON) health professional for services accompanying an in-network health facility encounter. The OON professional may expect the enrollee to pay either the full billed charge or the billed charge less what the enrollee’s plan/insurer paid and less any cost sharing collected by the OON professional. The second possibility is “balance billing.” Note: AB 533 does not address all surprises or prohibit all balance billing.

- **Enrollees.** In 2016, 17.1 million Californians will have state-regulated health insurance that would be subject to AB 533.
- **EHBs.** AB 533, which addresses cost sharing and plan/insurer payments to professionals, would not exceed essential health benefits (EHBs).
- **Benefit coverage.** For surprise medical bills relevant to AB 533, AB 533 would alter benefit coverage in two ways. AB 533 would require that only in-network cost sharing (generally less than OON cost sharing) be applicable. AB 533 would prohibit related balance billing by OON professionals.
- **Unit costs.** For surprise medical bills relevant to AB 533, AB 533 would establish local Medicare rates as the default plan/insurer payments (unit costs). Medicare rates are generally lower than the noncontracted effective rates plans/insurers would have paid.
- **Expenditures.** Lower unit costs would reduce both premiums and directly related cost sharing (e.g., coinsurance). Making only in-network cost sharing applicable would also reduce enrollee cost sharing. In addition to reducing enrollee expenses related to cost sharing, the prohibition on balance billing would eliminate additional enrollee expenses for surprise medical bills. In all, AB 533 would be expected to decrease expenditures (premiums and enrollee expenses) by as much as \$252 million (0.18%).

The surprise medical bills AB 533 would define and address occur among enrollees in plans regulated by the California Department of Managed Health Care (DMHC) as well as among enrollees in policies regulated by the California Department of Insurance (CDI). Surprise medical bills occur even for enrollees in plans with closed networks or panels of providers, such as health maintenance organizations (HMOs) and exclusive provider organizations (EPOs). For Medi-Cal beneficiaries, including those enrolled in DMHC-regulated plans, all balance billing is prohibited, including balance bills related to surprise medical bills.

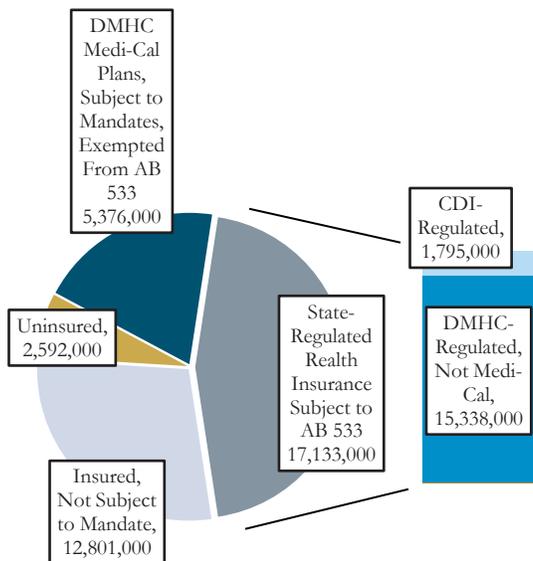
Without the passage of AB 533, for 2016, CHBRP estimates:

- Approximately 0.63% of enrollees could see a surprise medical bill related to use of an inpatient admit at an in-network facility. On average, these enrollees would be balance billed \$550.
- Approximately 0.20% of enrollees could see a surprise medical bill related to an outpatient visit at an in-network facility. On average, these enrollees would be balance billed \$200.

Types of professionals/services frequently associated with surprise medical bills include: internal medicine, family practice, chiropractic, diagnostic radiology, anesthesiology, clinical laboratory, and psychiatry.

BILL SUMMARY

As noted in Figure 1, AB 533 would be relevant for the health insurance of enrollees in policies regulated by the California Department of Insurance (CDI) and enrollees in plans regulated by the California Department of Managed Health Care (DMHC), but would exempt from compliance the health insurance of Medi-Cal beneficiaries. Balance billing Medi-Cal beneficiaries is already prohibited.

Figure 1. Health Insurance in CA and AB 533

*Neither = Federally regulated health insurance, such as Medicare, veterans, or self-insured plans.

Source: California Health Benefit Review Program, 2016

For surprise medical bills, AB 533 would:

- Set local Medicare rates as the default unit cost (plan/insurer payment to OON professionals);
- Require both DMHC and CDI to establish independent dispute resolution (IDR) processes through which OON professionals could challenge the appropriateness of plan/insurer payments;
- Prohibit OON professionals (in the absence of prior, written agreement) from collecting more than in-network cost sharing from enrollees; and
- Require plans/insurers to count collected cost sharing towards any applicable limit on enrollee cost sharing.

AB 533 defines “health facility” as inclusive of but not limited to licensed hospitals, ambulatory surgery and other outpatient settings, laboratories, radiology or imaging centers, and facilities providing mental health or substance abuse treatment. AB 533 defines “health

professional” as licensed by the state to deliver or furnish health care services.

IMPACT OF AB 533

For surprise medical bills, AB 533 would alter benefit coverage and unit costs, which would reduce total expenditures (premiums and enrollee expenses).

Benefit Coverage

AB 533 would not add new benefit coverage, but would require in-network cost-sharing (rather than OON cost sharing) be applicable for surprise medical bills. AB 533 would also prohibit related balanced billing.

All enrollees in DMHC-regulated plans and CDI-regulated policies have benefit coverage for surprise medical bills. For 95% of these enrollees, in-network cost-sharing requirements are applicable, and they are protected by their plans/insurers from related balance billing. Their benefit coverage is effectively compliant with AB 533. Postmandate, the remaining 5% of enrollees would also have AB 533 compliant benefit coverage. They would be expected to pay only in-network cost sharing, and AB 533 would prohibit OON professionals from related balance billing.

Utilization

By definition, AB 533 relates to situations that are surprises to enrollees, who expected in-network professionals to be associated with in-network facility encounters. Postmandate, when enrollee financial responsibility would align with enrollee expectations regarding services at in-network facilities, CHBRP expects no change in utilization of professional services related to in-network facility encounters.

Unit Cost

For enrollees with relevant benefit coverage, AB 533 would establish local Medicare rates as the default unit costs (plan/insurer payments to OON professionals for surprise medical bills).

Medicare rates are generally lower than what a plan or insurer would pay either an in-network professional (the contracted rate) or an OON professional (the noncontracted effective rate). In 2016, CHBRP estimates

the typical noncontracted effective rates for surprise medical bills to be:

- 253% of the Medicare rate for outpatient services; and
- 260% of the Medicare rate for inpatient services.

Postmandate, CHBRP would expect AB 533 to prompt some (25%) of OON professionals to begin contracting with plans/insurers — becoming in-network professionals — so as to receive contracted rates, which are generally higher than Medicare rates. In addition, some OON professionals would use the AB 533 required independent dispute resolution process to obtain higher-than-Medicare rates. Still, AB 533 would lower average unit costs. Postmandate, CHBRP estimates that average plan/insurer payments would be:

- 109% of the Medicare rate for both inpatient and outpatient services.

Expenditures

This estimated reduction in unit costs would cause a reduction in premiums of approximately \$153 million relative to predicted premiums in 2016, a 0.13% reduction in total premiums for enrollees associated with DMHC-regulated plans and CDI-regulated policies.

Enrollee cost sharing would also be reduced, both due to only in-network cost sharing being applicable for all enrollees and due to decreased unit costs reducing some cost sharing (e.g., coinsurance). In combination, the reduction would be approximately \$43 million (a 0.28% reduction in enrollee cost sharing).

The prohibition on balance billing would reduce additional enrollees out-of-pocket expenses related to surprise medical billing. The reduction could be as much as \$56 million, but this figure is a calculation based on claims paid by plans/insurers. It is unclear what portion of this figure professionals would balance bill or what portion of those amount enrollees would pay (or negotiate into smaller figures).

In total, AB 533 would reduce expenditures (premiums and enrollee expenses) by as much as \$252 million (which would be a 0.18% reduction).

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Out-of-Network Coverage

January 7, 2016

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002 to provide the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals, per its authorizing statute. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff in the University of California's Office of the President supports a task force of faculty and research staff from several campuses of the University of California to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact, and content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, as well as all CHBRP reports and publications, are available at www.chbrp.org.

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Table 1. Impacts on Benefit Coverage, Utilization, and Cost, 2016

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Benefit coverage				
Total enrollees with health insurance subject to state benefit mandates (a)	24,557,000	24,557,000	0	0%
Total enrollees with health insurance subject to AB 533	17,133,000	17,133,000	0	0%
Number of enrollees by their current coverage for AB 533 relevant “surprise medical bills”				
Covered, in-network cost sharing only	16,259,740	17,133,000	873,260	5%
Covered, OON cost sharing, potential balance billing	873,260	—	-873,260	-100%
No coverage	—	—	—	0.0%
Percentage of enrollees by their current coverage for AB 533 relevant “surprise medical bills”				
Covered, in-network cost sharing only	95%	100%	5%	5%
Covered, OON cost sharing, potential balance billing	5%	0%	-5%	-100%
No coverage	0%	0%	0%	0.000%
Utilization and cost				
Inpatient admits — in-network facilities				
Annual admits per 1,000 enrollees	43.4	43.4	0%	0.000%
Annual admits with surprise medical bills* per 1,000 enrollees (b)	6.3	6.3	0%	0.000%
Average unit cost (*) for inpatient surprise medical bills	\$830	\$349	-\$482	-58%
Percent of admits with surprise medical bills (b)	15%	15%	0%	0.000%
Annual admits per 1000 enrollees; enrollee pays in-network cost sharing	6.0	6.3	0.3	5%
Annual admits per 1000 enrollees; enrollee pays OON cost sharing, potential balance billing	0.3	—	-0.3	-100%
Annual admits per 1000 enrollees; enrollee pays full cost of service	—	—	—	0.000%
Outpatient visits — in-network facilities				

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Annual visits per 1,000 enrollees	832.7	832.7	0%	0.000%
Annual visits with surprise medical bills per 1,000 enrollees (e)	20.7	20.7	0%	0.000%
Average unit cost (*) for outpatient surprise medical bills	\$290	\$125	-\$165	-57%
Percent of visits with surprise medical bills (b)	2%	2%	0%	0.000%
Annual visits per 1000 enrollees; enrollee pays in-network cost sharing	19.7	20.7	1.1	5%
Annual visits per 1000 enrollees, enrollee pays OON cost sharing, potential balance billing	1.1	—	-1.1	-100%
Annual visits per 1000 enrollees, enrollee pays full cost of service	—	—	—	0.000%
Expenditures				
<u>Premium expenditures by payer</u>				
Private employers for group insurance	\$58,393,205,000	\$58,322,077,000	-\$71,128,000	-0.12%
CalPERS HMO employer expenditures (c)	\$4,391,552,000	\$4,388,176,000	-\$3,376,000	-0.08%
Medi-Cal Managed Care Plan expenditures	\$17,667,731,000	\$17,667,731,000	\$0	0.00%
Enrollees for individually purchased insurance	\$21,319,735,000	\$21,264,315,000	-\$55,420,000	-0.26%
Individually purchased — outside exchange	\$8,581,274,000	\$8,555,753,000	-\$25,521,000	-0.30%
Individually purchased — Covered California	\$12,738,461,000	\$12,708,562,000	-\$29,899,000	-0.23%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (d)	\$18,703,917,000	\$18,681,236,000	-\$22,681,000	-0.12%
<u>Enrollee expenses</u>				
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$15,510,004,000	\$15,467,282,000	-\$42,722,000	-0.28%

	Premandate	Postmandate	Increase/ Decrease	Change Postmandate
Additional enrollee out-of-pocket expenses for AB 533 surprise medical bills (e)	\$56,159,000	\$0	-\$56,159,000	-100.00%
Total expenditures	\$136,042,303,000	\$135,790,817,000	-\$251,486,000	-0.18%

Source: California Health Benefits Review Program, 2016.

Notes: (*) Unit cost is the plan/insurer payment to the professional. (a) This population includes persons with privately funded (including Covered California) and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employer-sponsored health insurance.

(b) AB 533 is not expected to impact utilization but will reduce payments from both plans/insurers and enrollees to professionals.

(c) Enrollee premium expenditures include contributions to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(d) Of The decrease in CalPERS employer expenditures, about 55.4%, or \$1,870,000, would be a decrease in state expenditures for CalPERS members who are state employees, state retirees, or their dependents. This percentage reflects the share of enrollees in CalPERS HMOs as of 2013. For this analysis, CHBRP assumes the same ratio in 2016.

(e) Includes only payments (other than cost sharing) that may be made by enrollees to OON professionals for services related to surprise medical bills as a result of balance billing.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; OON = out-of-network.

POLICY CONTEXT

On October 12, 2015, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)¹ conduct an evidence-based assessment of the impacts of AB 533 Out-of-Network Coverage.

If enacted, AB 533 would affect the health insurance of approximately 17.1 million enrollees (45% of all Californians). This represents 70% of the 24.6 million Californians who will have health insurance regulated by the state² that may be subject to any state health insurance law.^{3,4} Specifically, health care service plans regulated by the Department of Managed Health Care (DMHC) and health insurance policies regulated by the California Department of Insurance (CDI), would be subject to AB 533. AB 533 would exempt plans enrolling Medi-Cal beneficiaries.

Bill-Specific Analysis of AB 533, Out-of-Network Coverage

For most enrollees in DMHC-regulated plans and CDI-regulated policies, health professionals and facilities are categorized as in-network or out-of-network (OON). An in-network professional has a contract with a plan or insurer that defines plan/insurer payment for services (the “contracted rate”). The in-network contracted rate generally represents a discount from what would be an OON professional’s billed charge for the service. It is important to note, however, that network participation is both facility specific and professional specific; a hospital (or other facility) may be in-network for an enrollee, but the group of professionals associated with a particular in-network hospital admit might be a mix of in-network professionals and OON professionals.

When an OON professional’s billed charge is more than the noncontracted effective rate (what the plan/insurer will pay an OON provider, a payment based on negotiation or internal-to-the-plan/insurer benchmarks), the professional may seek the difference, or balance of the bill, from the enrollee. This practice is called “balance billing” (Fedor, 2006; Pao et al., 2014).

In the past, such situations could arise when an enrollee received *emergency* services from an OON professional practicing in an in-network hospital, but the California Supreme Court has ruled⁵ that balance bills are not allowed for *emergency* services provided by OON professionals or facilities.

However, balance billing can still occur in nonemergency scenarios. AB 533 would address medical bills for services delivered by OON professionals to enrollees seeking care at an in-network facility. These are commonly referred to as “surprise” medical bills (Silas and Bell, 2015) and this term will be used in the remainder of the report for the purposes of describing the potential impact of AB 533. A surprise medical bill would occur if an enrollee is treated at an in-network hospital, and a professional involved is OON for

¹ CHBRP is authorized to review legislation affecting health insurance regulated by the state. CHBRP’s authorizing statute is available at www.chbrp.org/docs/authorizing_statute.pdf.

² State benefit mandates apply to a subset of health insurance in California, those regulated by one of California’s two health insurance regulators: the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

³ CHBRP’s estimates of the source of health insurance available at: www.chbrp.org/other_publications/index.php.

⁴ Of the rest of the state’s population, a portion will be uninsured (and therefore will have no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

⁵ Prospect Medical Group, Inc. v. Northridge Emergency Medical Group — 45 CAL. 4th 497, 138 P.3D 86, 87 CAL. RPTR. 3D 299.

the enrollee's plan/insurer. The OON professional may then submit bill (generally referred to as a "billed charge") for services rendered to the enrollee's plan/insurer. If the plan/insurer does not pay the full amount of the OON professional's billed charge (an amount of which is not constrained by a contract between the professional and the plan/insurer), the OON professional may balance bill the enrollee for the billed charge less the plan/insurer payment and less any cost sharing⁶ collected from the enrollee.

Some enrollees have benefit coverage for medically necessary nonemergency services delivered by an OON professional. OON cost-sharing requirements are generally higher than in-network cost sharing requirements. When an enrollee has no OON benefit coverage, his or her plan/insurer might expect the enrollee to pay either in-network cost sharing or the full cost of the service received.

Bill Language

The full text of AB 533 can be found in Appendix A.

AB 533 addresses some (but not all) circumstances in which an enrollee in a DMHC-regulated plan or CDI-regulated policy might face a "surprise" regarding a medical bill. AB 533 specifically addresses surprise medical billing due to an enrollee's use of nonemergency covered services at an in-network health facility that were provided by an OON health professional.

AB 533 addresses plan/insurer payments and enrollee expenses related to what, in terms of AB 533, would be "surprise medical billing." AB 533 would also prohibit OON professionals from balance billing the enrollee in such situations.

For surprise medical bills:

- AB 533 would set local Medicare rates as the default payment owed by the plan/insurer to the OON professional who submitted a bill charge (the "billed charge") related to a surprise medical bill.
- AB 533 would require the regulators, DMHC and CDI, to establish independent dispute resolution processes for such circumstances. Such disputes might include an OON professional disputing whether the local Medicare rate is an appropriate payment for services rendered.
- AB 533 would prohibit balance billing due related to what AB 533 defines as surprise medical bills and would establish an enrollee's in-network cost-sharing requirements as the full extent of the enrollee's financial responsibility.
 - AB 533 would prohibit the OON professional (in the absence of prior, written agreement) from collecting more than in-network cost sharing from the enrollee.
 - AB 533 would require the enrollee's plan/insurer to count collected cost sharing towards any applicable limits on out-of-pocket expenses and/or deductibles.⁷

AB 533 defines "health facility" as inclusive of, but not limited to, licensed hospitals, ambulatory surgery and other outpatient settings, laboratories, radiology or imaging centers, and facilities providing mental health or substance abuse treatment.

⁶ For a further discussion of cost sharing, see CHBRP's resource *What Is Cost Sharing in Health Insurance?* Available at http://chbrp.org/other_publications/index.php.

⁷ Typically, plans/insurers do not count enrollee payments towards amounts toward out-of-pocket maximums or deductibles.

AB 533 defines “health professional” as licensed by the state to deliver or furnish health care services.

Analytic Approach and Key Assumptions

It is important to note that CHBRP’s analyses address the incremental effects of proposed legislation

For this analysis, CHBRP has assumed that AB 533 would be applicable to the health insurance of enrollees with and without OON benefit coverage.

CHBRP has also assumed that AB 533, which would alter California’s Insurance Code and Health & Safety Code, would be applicable to health professionals (as well as to DMHC-regulated plans and CDI-regulated insurers).

AB 533 would require both regulators, DMHC and CDI, to establish independent dispute resolution (IDR) processes for professionals disputing the appropriateness of plan/insurer payments related to what AB 533 defines as surprise medical bills. Operation of IDRs would be an expense for each regulator. Estimates of their expenses are included in the August 24, 2015, Senate Appropriations Analysis of AB 533.⁸ However, CHBRP has not included regulators’ expenses into the impacts CHBRP is projecting for AB 533, because it is unclear how such costs would impact expenditures (premiums and enrollee expenses).

Interaction With Existing Requirements

Proposed legislation can interact with state and federal requirements. When possible, CHBRP indicates possible overlaps or interactions.

State Requirements

California law and regulations

For enrollees in DMHC-regulated plans (not associated with Medi-Cal) or CDI-regulated policies, CHBRP is unaware of California laws or regulations that address what AB 533 defines as surprise medical bills.⁹ Although not directly relevant to AB 533, laws related to other forms of health insurance are further discussed in the *Additional Laws* section of this report.

Similar requirements in other states

Laws prohibiting balance billing for health care services are present in at least 14 states, but these prohibitions vary widely in their applicability and requirements (CHCF, 2009; Hoadley et al., 2015; KFF, 2013). Many of these laws focus on *emergency* services (where AB 533 addresses nonemergency services) and few address what AB 533 defines as surprise medical bills. The variations are significant enough to make comparisons difficult and to make it unclear how closely the results of AB 533, were it passed into law, would resemble the results of balance billing laws in other states.

⁸ Available at www.leginfo.ca.gov.

⁹ As previously noted, balance billing connected to *emergency* services is prohibited in California — but AB 533 addresses nonemergency services.

CHBRP is aware of only two states, Maryland and New York, that have passed laws that prohibit balance billing and address plan/insurer payments to providers for situations similar to what AB 533 defines as surprise medical bills. However, these state laws are distinctly different from AB 533, and it is unclear how closely the results of AB 533, were it passed into law, would resemble the results of either law. Further discussion of the Maryland and New York laws is included in the *Additional Laws* section of this document.

Federal Requirements

For enrollees in DMHC-regulated plans (not associated with Medi-Cal) or CDI-regulated policies not associated with Medi-Cal, CHBRP is unaware of Federal laws or regulations that overlap or align with AB 533.

Essential health benefits and AB 533

The requirements in AB 533, related to enrollee expenses and plan/insurer payments, appear not to exceed the essential health benefits (EHBs) requirements of the Affordable Care Act (ACA), and so would not trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans (QHPs).¹⁰

¹⁰ In California, QHPs are nongrandfathered, small-group and individual market DMHC-regulated plans and CDI-regulated policies sold in Covered California, the state's online marketplace.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

This section reports the incremental impact of AB 533 on benefit coverage, utilization, and cost. For further details on the underlying data sources and methods, see Appendix B.

AB 533 would address “surprise medical bills,” which AB 533 would define as resulting from noncontracted, or out-of-network (OON), professional services associated with an in-network facility encounters. OON professionals requesting billed charges can result in plan/insurer payments, cost sharing from the enrollee,¹¹ and additional payments by enrollee (e.g., “balance billing” for part or all of the difference between the billed charge, the plan/insurer payment, and any cost sharing collected by the OON professional).

For the purposes of describing AB 533’s impact and the surprise billing process, CHBRP has adopted the following terms and definitions:

- **Contracted Rate** — The total amount paid for a service by a plans/ insurer and an enrollee (cost sharing) to in-network professionals. The amount is based on contracts between the health plan/insurer and enrollee cost sharing.
- **Noncontracted Effective Rate** — The total amount the plan defines to be appropriate for the service. The amount is then split between the plan’s payment and the enrollee cost sharing.
- **Medicare Rate** — The total amount paid for a service by a Medicare and enrollee cost sharing. The amount is based on the Medicare Fee Schedule, which is set by the federal government, local Medicare rate varies by region due to geographic and overhead factors.
- **Billed Charge** — The amount billed for services by OON professionals. Billed charges are typically higher than contracted rates, noncontracted effective rates, or local Medicare rates.
- **Balance Bill** — This term refers to the practice of billing enrollees for the difference between the billed charge and the noncontracted effective rate. This is the amount a professional may send as a bill directly to an enrollee without expectation that the enrollee’s plan/insurer will pay any part of the bill.
- **Surprise Medical Bill** — As relevant to AB 533, these are billed charges from an OON professional for services associated with an in-network facility encounter (which may result in the professionals balance billing the enrollee).

AB 533 would address the issue of surprise medical bills within existing covered benefits. For this reason, CHBRP did not need to estimate utilization or costs of services associated with new benefits, but had to estimate the prevalence, utilization, and costs associated with the surprise medical bills. To do so, CHBRP analyzed a database of paid nonemergency claims in California to identify surprise medical bills (see Appendix B for additional details).

Prevalence and Magnitude of Surprise Medical Bills

The surprise medical bills relevant to AB 533 occur for enrollees in DMHC-regulated plans and CDI-regulated policies.

¹¹ For a further discussion of cost sharing, see CHBRP’s resource *What Is Cost Sharing in Health Insurance?* Available at http://chbrp.org/other_publications/index.php.

In 2016, CHBRP estimates that 15% of nonemergency inpatient admits and 2% of nonemergency outpatient visits among enrollees in health insurance that would be subject to AB 533 will result in a surprise medical bill relevant to AB 533. As a percentage of charges paid, the difference is not as pronounced between inpatient and outpatient care. Surprise medical bills for inpatient care represented 3% of the charges paid, whereas surprise medical bills for outpatient care represented 2%. Some surprise medical bills relate to repeat visits by an enrollee, and so CHBRP's estimates that, of the 17.1 million enrollees with health insurance that would be subject to AB 533:

- 0.63% would have a surprise medical bill for inpatient services, and
- 0.20% would have a surprise medical bill for outpatient services.

The types of professionals/services most likely to be involved in a surprise medical bill are internal medicine, family practice, chiropractic, diagnostic radiology, anesthesiology, clinical laboratory, and psychiatry. Other types of professionals may also be involved in surprise medical bills related to their specific domains of practice.

CHBRP estimates(see Table 1) that the additional enrollee out-of-pocket expenses for surprise medical bills (expenses beyond any cost sharing) could be as high as \$56 million among the 5% of enrollees who may be exposed to balance billing due to surprise medical bills. On average, enrollees who are exposed to surprise medical bills are balanced billed \$550 for inpatient services and \$200 for outpatient services. The total figure could be higher than the actual amount paid by enrollees, as not every OON professional would have balance billed, and some enrollees who received a balance bill may have negotiated a lower payment or may not have paid at all.

Potential Impact of AB 533

AB 533 would alter the situation in several ways. AB 533 would establish local Medicare rates as plan/insurer default payments (unit costs) for surprise medical bills. AB 533 would also allow OON professionals to file a claim through an independent dispute resolution process to recover additional payment if the default payment is not satisfactory or was made in error. In addition, some professionals might become in-network in order to receive contracted rate payments (generally higher than Medicare rates). Still, AB 533 would decrease average plans/insurers payments for surprise medical bills. Because of the reduced unit costs (plan/insurer payments) and because AB 533 would also establish in-network cost sharing as applicable for all enrollees and prohibit related balance billing, CHBRP anticipates a reduction in the total amount paid for surprise medical bills.

Discussion of the premandate situation and estimates of postmandate impacts on benefit coverage, utilization, and cost follow.

Benefit Coverage

Current coverage for surprise medical bills was determined by a survey of the seven largest (by enrollment) providers of health insurance in California. Responses to this survey represent:

- 68% of enrollees in the privately funded market subject to state mandates.

CHBRP recognizes the limitations of this survey. However, based on survey responses and database analysis, CHBRP was able to estimate the magnitude and frequency of surprise medical bills (see Appendix B).

Premandate (Baseline) Benefit Coverage

Although all the health insurance of all enrollees in DMHC-regulated plans (except Medi-Cal beneficiaries) and all enrollees in CDI-regulated policies would be subject to AB 533, data gathered by CHBRP indicate that 95% have benefit coverage that is effectively already compliant with AB 533. If these enrollees receive a surprise medical bill, they pay in-network cost sharing and can expect their plan/insurer to settle the surprise medical bill with the OON professional. These enrollees are not required to pay any balance bill from the OON professional even if their plan typically did not cover OON services (in non-surprise situations).

Premandate, if the other 5% of these enrollees receives a surprise medical bill, these enrollees are expected to meet OON cost-sharing requirements. In addition, although these enrollees' plans/insurers pay the OON professional the noncontracted effective rate, the enrollees might be subject to balance billing for the professional's billed charge, less what the plan/insurer paid and less any cost sharing already collected by the OON professional from the enrollee.

Postmandate Benefit Coverage

Postmandate, 100% of enrollees would pay in-network cost sharing for any surprise medical bill and could expect such cost sharing to be counted by the plan/insurer towards any applicable limits on cost sharing and/or towards any applicable deductible. In addition, AB 533's prohibition on professionals balance billing would mean that none of these enrollees would pay additional out-of-pocket expenses (due to a balance bill related an AB 533–relevant surprise medical bill).

Utilization

Premandate (Baseline) Utilization

As noted in the prior discussion of the prevalence of surprise medical bills, of the total annual nonemergency admits to in-network inpatient facilities (43.4 per 1,000 enrollees), 15% (6.3 per 1,000 enrollees) are associated with surprise medical bills. Because it is fairly rare to have a hospital admission in a given year (4.34% of all enrollees), and 15% of those admissions had a surprise medical bill component and some people had more than one admission in a given year, only 0.63% of enrollees had a surprise medical bill. The presence of surprise medical bills varies by type of insurance product, with exclusive provider organizations (EPOs) and health maintenance organizations (HMOs) associated with fewer, and preferred provider organizations (PPOs) and points of service (POS) associated with more.

Of the total annual nonemergency outpatient visits to in-network facilities (832.7 per 1,000 enrollees), 2.5% (20.7 per 1,000 enrollees) are associated with surprise medical bills. As with inpatient admits, the presence of surprise medical bill also varies by type of insurance product for outpatient visits, with EPOs and HMOs associated with fewer, and PPOs and POS associated with more. Despite the higher number of outpatient visits (higher than the number of inpatient admits), surprise medical bills associated with outpatient visits only affected 0.20% of enrollees.

Postmandate Utilization

The utilization of professional services associated with surprise medical bills is unlikely to change due to AB 533. Because OON professional services associated with in-network facilities encounters are not planned for by enrollees and represent a "surprise," CHBRP does not anticipate utilization of services changing due to AB 533, which would bring enrollee expenses in line with what enrollees expected before

AB 533. In addition, in-network facilities will have to fill the need for professionals to deliver needed services without regard for whether the medical group or professional they work with is in specific insurance networks. Although AB 533 is unlikely to change the actual number of services performed by professionals in health care facilities, it will change the way in which those surprise medical bills are handled by plans/insurers, facilities and professionals, and enrollees.

Per-Unit Cost

Premandate (Baseline) and Postmandate Per-Unit Cost

Although utilization will not change, AB 533's establishment of local Medicare rates as default plan/insurer payments to OON professionals for surprise medical bills would decrease unit costs. The impacts expected are presented in Table 2.

Table 2. Impact of AB 533 on Average Unit Costs

Plan/Insurer Payments to OON Professionals for Surprise Medical Bills	Premandate (Baseline)		Postmandate*	
	Unit Cost	As % of Medicare	Unit Cost	As % of Medicare
Average inpatient unit cost (per admit) for OON professional charges associated with an in-network facility	\$830	260%	\$349	109%
Average outpatient unit cost (per visit) for OON professional charges associated with in-network facility	\$290	253%	\$125	109%

Source: California Health Benefits Review Program, 2016.

Notes: * Postmandate figures are based on CHBRP's estimates that 75% of professionals associated with surprise medical bills remain OON and are paid 100% of Medicare by plans/insurers (excepting those that successfully dispute the payment through IDR), whereas the other 25% of professionals contract with plans/insurers to become in-network and be paid 140% of Medicare.

Key: IRD = independent dispute resolution process; OON = out-of-network.

The postmandate unit costs would be slightly above Medicare rates because CHBRP estimates that 25% of OON professionals would, postmandate, contract with plan/insurers to become in-network professionals for specific insurers/plans in order to receive contracted rates (generally higher than Medicare) or would engage in the dispute process to obtain additional payments above the Medicare rate. Becoming in-network professionals would remove the ability to surprise bill and doing so would mean agreeing to a contracted rate (generally lower than either billed charges or the premandate noncontracted effective rates paid by plans/insurers). For the purpose of this analysis, CHBRP has assumed the contracted rates for such newly in-network professionals would average 140% of Medicare.

For enrollees, the decrease in average unit costs would also mean a decrease in cost sharing directly related to unit costs (e.g., coinsurance).

Expenditures (Premiums and Enrollee Expenses)

Premandate (Baseline) Expenditures

As presented in Table 3, total per member per month (PMPM) expenditures by market segment are as follows for DMHC-regulated plans and CDI-regulated policies, respectively:

- Large group: \$574.65 and \$752.16;
- Small group: \$541.10 and \$726.27; and
- Individual market: \$563.87 and \$440.26.

Total current annual expenditures for all DMHC-regulated plans and CDI-regulated policies are \$136,042,303,000.

Postmandate Expenditures

As noted in Table 4, AB 533 would decrease PMPM expenditures. Postmandate PMPM decreases by market segment for DMHC-regulated plans and CDI-regulated policies would be, respectively:

- Large group: -0.12% and -1.34%;
- Small group: -0.15% and -0.51%; and
- Individual market: -0.20% and -0.36%.

Changes in total expenditures

AB 533 would reduce net annual expenditures by \$251 million for enrollees in DMHC-regulated plans and CDI-regulated policies. This is due to decreases in: (1) unit costs paid by plans/insurers for professional services related to surprise medical bills, which would result in an overall decrease in premiums; (2) cost sharing related to unit costs (e.g.; coinsurance) and any cost sharing that had been OON; and (3) enrollee out-of-pocket expenses related to balance billing for surprise medical bills would be eliminated. Approximately \$153 million of the total \$251 million reduction would be related to the decreases in premiums. The remaining \$98 million reduction would be reductions in enrollee expenses (cost sharing and other out-of-pocket expenses).

Postmandate premium expenditures and PMPM amounts per category of payer

Decreases in insurance premiums as a result of AB 533 would vary by market segment. Note that the total population in Table 4 reflects the full 17.1 million enrollees in DMHC-regulated plans and CDI-regulated policies that would be subject to AB 533.

Because plans and policies with an OON coverage component were most impacted by surprise medical bills, the premium PMPM changes were highest in those market segments.

Among publicly funded DMHC-regulated health plans, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would be unchanged, because AB 533 explicitly exempts Medi-Cal

Managed Care. However, a broader prohibition against balance billing is already in effect for all beneficiaries associated Medi-Cal.¹²

Postmandate administrative expenses and other expenses

CHBRP estimates that the decrease in administrative costs for DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the decrease in premiums. CHBRP assumes that if health care costs decrease as a result of changes in unit costs, there will be a corresponding and proportional decrease in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Related Considerations for Policymakers

Cost of Exceeding Essential Health Benefits

As explained in the *Policy Context* section, AB 533 would not be expected to exceed the Affordable Care Act's essential health benefits (EHBs).

Postmandate Changes in Uninsured and Public Program Enrollment

Changes in the number of uninsured persons

There is no expected change in the number of uninsured because the estimated premium reduction is less than 1%.

Changes in public program enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs or on utilization of covered benefits in the publicly funded insurance market.

How Lack of Coverage Results in Cost Shifts to Other Payers

AB 533 would not result in a shift in payment or service delivery to public payers.

¹² Welfare & Institutions Code 14019.4.

Table 3. Baseline (Premandate) Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2016

	DMHC-Regulated						CDI-Regulated			TOTAL
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,651,000	2,094,000	3,757,000	836,000	6,891,000	533,000	534,000	690,000	571,000	24,557,000
Total enrollees in plans/policies subject to AB 533	8,651,000	2,094,000	3,757,000	836,000	—	—	534,000	690,000	571,000	17,133,000
Premium costs										
Average portion of premium paid by employer	\$423.58	\$304.59	\$0.00	\$437.75	\$179.24	\$445.00	\$511.84	\$421.06	\$0.00	\$80,452,488,000
Average portion of premium paid by employee	\$114.05	\$147.22	\$422.03	\$109.44	\$0.76	\$0.00	\$134.80	\$137.71	\$334.65	\$40,023,653,000
Total premium	\$537.63	\$451.81	\$422.03	\$547.19	\$180.00	\$445.00	\$646.64	\$558.76	\$334.65	\$120,476,140,000
Enrollee expenses										
Enrollee expenses for covered benefits (deductibles, copays, etc.)	\$36.95	\$89.15	\$141.84	\$29.78	\$0.00	\$0.00	\$99.91	\$166.51	\$105.38	\$15,510,004,000
Enrollee expenses for benefits not covered (e)	\$0.07	\$0.13	\$0.00	\$0.00	\$0.00	\$0.00	\$5.61	\$1.00	\$0.22	\$56,159,000
Total expenditures	\$574.65	\$541.10	\$563.87	\$576.98	\$180.00	\$445.00	\$752.16	\$726.27	\$440.26	\$136,042,303,000

Source: California Health Benefits Review Program, 2016

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance, inside and outside the exchange.

(b) As of September 30, 2013, 57.5%, or 462,580, CalPERS members were state retirees, state employees, or their dependents. CHBRP assumes the same ratio for 2016.

(c) Includes children formerly in Health Families, which was moved into Medi-Cal Managed Care in 2013 as part of the 2012–13 state budget.

(d) Medi-Cal Managed Care Plan expenditures for members over age 65 include those who also have Medicare coverage.

(e) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 4. Postmandate Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2016

	DMHC-Regulated						CDI-Regulated			TOTAL
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,651,000	2,094,000	3,757,000	836,000	6,891,000	533,000	534,000	690,000	571,000	24,557,000
Total enrollees in plans/policies subject to AB 533	8,651,000	2,094,000	3,757,000	836,000	—	—	534,000	690,000	571,000	17,133,000
Premium costs										
Average portion of premium paid by employer	-\$0.40	-\$0.37	\$0.00	-\$0.34	\$0.00	\$0.00	-\$1.15	-\$1.51	\$0.00	-\$74,504,000
Average portion of premium paid by employee	-\$0.11	-\$0.18	-\$1.06	-\$0.08	\$0.00	\$0.00	-\$0.30	-\$0.49	-\$1.14	-\$78,101,000
Total premium	-\$0.51	-\$0.55	-\$1.06	-\$0.42	\$0.00	\$0.00	-\$1.46	-\$2.00	-\$1.14	-\$152,605,000
Enrollee expenses										
Enrollee expenses for covered benefits (deductibles, copays, etc.)	-\$0.08	-\$0.12	-\$0.09	-\$0.04	\$0.00	\$0.00	-\$3.00	-\$0.69	-\$0.22	-\$42,722,000
Enrollee expenses for benefits not covered (e)	-\$0.07	-\$0.13	\$0.00	\$0.00	\$0.00	\$0.00	-\$5.61	-\$1.00	-\$0.22	-\$56,159,000
Total expenditures	-\$0.66	-\$0.81	-\$1.15	-\$0.46	\$0.00	\$0.00	-\$10.07	-\$3.69	-\$1.57	-\$251,486,000
Postmandate percent change										
Percent change insured premiums	-0.0952%	-0.1225%	-0.2504%	-0.0769%	0.0000%	0.0000%	-0.2256%	-0.3585%	-0.3392%	-0.1267%
Percent change total expenditures	-0.1155%	-0.1488%	-0.2041%	-0.0798%	0.0000%	0.0000%	-1.3387%	-0.5078%	-0.3577%	-0.1849%

Source: California Health Benefits Review Program, 2016.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance, inside and outside the exchange.

(b) As of September 30, 2013, 57.5%, or 462,580 CalPERS members were state retirees, state employees, or their dependents. CHBRP assumes the same ratio for 2015.

(c) Includes children formerly in Health Families, which was moved into Medi-Cal Managed Care in 2013 as part of the 2012–13 state budget.

(d) Medi-Cal Managed Care Plan expenditures for members over age 65 include those who also have Medicare coverage.

(e) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

LONG-TERM IMPACT OF AB 533

In this section, CHBRP estimates the long-term impact of AB 533, defined as impacts occurring beyond the first 12 months of implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

In the long term, the number of Californians enrolled in DMHC-regulated plans or CDI-regulated policies subject to AB 533 would grow commensurate with the size of the state-regulated insurance market. As described below, by setting the noncontracted effective rate for potentially surprise professional services, AB 533 will put downward pressure on contracted rates among the specialties (radiology, pathology, anesthesia, etc.) that are most likely to work in noncontracted medical groups within contracted in-network facilities that are likely to incur surprise medical bills. That could reduce the negotiated rates for those specialties by setting a ceiling (i.e., based on the Medicare fee schedule) for out-of-network (OON) surprise medical bill payment even if insurers do not have a contract in place. AB 533 could also reduce the ability of providers to negotiate higher payment as an OON provider with the insurer directly. Currently, that ceiling is set at 109% of Medicare¹³ for the 12-month CHBRP estimate, but it could change over time due to market pressure, availability of professionals, and insurer and/or professional consolidation.

Long-Term Utilization and Cost Impacts

Utilization Impacts

In the 12 months following enactment, CHBRP estimates that there will be no change in health care use due to AB 533. In the long term, it is unlikely that AB 533 would change health care usage by creating new demand for services or limiting supply. Because the legislation applies to “surprise” medical bills, there is no reason to assume that more use will occur over time. However, as expressed in the CHBRP cost estimates, it is likely that a portion (25%) of previously OON professionals will become in-network professionals for specific insurers/plans to avoid the relatively lower Medicare rates AB 533 would set as the default noncontracted effective rates. This will not change the actual volume or use of services, but will limit circumstances where surprise medical bills currently occur. Facilities will continue to arrange access to professionals to meet patient needs, and despite the price control placed upon OON surprise medical bills, are unlikely to reduce the volume of services provided.

Cost Impacts

Long-term impacts on premiums and enrollee expenses are not possible to quantify, and will be largely determined by local and regional market conditions, provider consolidation, plan/insurer competition, and other factors for which data and research are not readily available. Because Medicare will serve as the default plan/insurer payment for surprise medical bills, OON professionals could have a weakened negotiating position that will put downward pressure on negotiated rates. Therefore, CHBRP expects that premium and enrollee expenses related to surprise medical bills will decrease. DMHC-regulated plans and CDI-regulated insurers still have incentives to contract with professionals that were previously OON

¹³ The 109% figure is based upon 75% professionals remaining OON and being paid 100% of Medicare (excepting some portion that use the IDR to successfully challenge the payment) while the other 25% of professionals contract to become in-network to be paid 140% of Medicare.

to help control utilization, to meet network adequacy requirements related to plan/insurer licensure, and to better coordinate care with facilities and other professionals. We do not expect contracting between certain specialists and insurance carriers to stop, but we do anticipate that there will be less need from the plan/insurer perspective to contract with facility-based specialists involved in care delivered through in-network facilities, because AB 533 will set the default payment at Medicare (which is lower than the negotiated rates currently paid for in-network hospital-based professionals and to OON professionals).

Future Developments

Recently proposed federal regulations¹⁴ would require that Qualified Health Plans (QHPs) sold through Covered California or in the individual insurance market outside of Covered California (i.e., mirrored plans) to provide some protection to enrollees who incurred surprise medical bills. Although the proposed regulation does not set the noncontracted effective rate for surprise medical bills, it would require plans/insurers to count cost sharing from surprise medical bills toward the enrollees' cost-sharing limits (i.e., deductible, out-of-pocket maximum). Because the regulation has not been finalized, does not do quite what AB 533 would do, and would affect the health insurance of less than 10% of enrollees in the commercial markets, CHBRP has not modeled its potential impact in this analysis. It is unlikely to have a significant impact throughout the state although it will partially address enrollee out-of-pocket spending for a portion of the individual insurance market in California.

¹⁴ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-29884.pdf>.

ADDITIONAL LAWS RELEVANT TO AB 533

For most enrollees in DMHC-regulated plans and CDI-regulated policies, health professionals and facilities are categorized as in-network or out-of-network (OON). In-network health facilities and professionals have a contract with the enrollee's plan or insurer that defines a contracted rate for payment for services. When a provider's billed charge is more than the plan/insurer will pay, the provider may then seek to recoup the difference, or balance bill, directly from the enrollee (Fedor, 2006). AB 533 is intended to address balance billing in a specifically defined scenario: in cases where an enrollee receives services at an in-network facility from an OON professional. To inform the understanding of the potential impact of AB 533, this section reviews laws, in California and elsewhere, some of which address balance billing, although not in ways identical to those proposed by AB 533.

As noted in the *Policy Context* section, except for enrollees associated with Medi-Cal, CHBRP is unaware of California or federal laws that address, for enrollees in DMHC-regulated plans and CDI-regulated policies, balance billing for nonemergency OON professional services associated with an in-network facility encounter.¹⁵ However, CHBRP is aware of laws that are relevant to Medi-Cal beneficiaries and to enrollees of some other (not state-regulated) forms of health insurance present in California. Both are discussed in this section.

As also noted in the *Policy Context* section, though CHBRP is aware of balance billing laws in a number of states, the complexity of these laws makes direct comparison difficult and suggests that the results of these various laws may not be identical. However, laws in Maryland and New York, which include guidance around plan/insurer payments to OON professionals, are discussed in this section.

Other Health Insurance

For enrollees in DMHC-regulated plans (not associated with Medi-Cal) or CDI-regulated policies, CHBRP is unaware of California laws or regulations that address balance billing for *nonemergency* OON professional charges associated with an in-network facility encounter.

However, as discussed below, CHBRP is aware of laws and regulations relevant to other health insurance present in California that address the same circumstance.

Medi-Cal

AB 533 would exempt from compliance the DMHC-regulated plans that currently enroll Medi-Cal beneficiaries. However, a broad prohibition on balance billing is already in place for Medi-Cal beneficiaries in both the fee-for-service (FFS) and managed care Medi-Cal.¹⁶

Medicare

Federal law disallows balance billing for Medicare beneficiaries when the provider "accepts assignment," and also prohibits Medicare providers from "balance billing" Medicare beneficiaries who have secondary coverage under a state Medicaid plan.¹⁷

¹⁵ Also as noted in the Policy Context section, balance billing connected to emergency services is prohibited in California — but AB 533 addresses only nonemergency services.

¹⁶ California Welfare & Institutions Code 14019.4.

Self-Funded Health Insurance

Large employers may self-insure, which means the health insurance they offer employees and retirees (as well as dependents) is subject only to federal law.¹⁸ Self-insured health insurance is regulated by the U.S. Department of Labor (DOL). For enrollees in self-insured products, CHBRP is unaware of laws or regulations setting rates and cost sharing, and prohibiting balance billing when an OON professional is involved with an in-network facility encounter. A recent brief on the subject (Silas and Bell, 2015) also indicates that the DOL has not enacted any prohibitions regarding balance billing.

Laws in Other States

As noted in the *Policy Context* section, CHBRP is aware of similar, but different, balance billing laws in at least 14 states, but the laws are quite varied in terms of applicability and requirements (CHCF, 2009; Hoadley et al., 2015; KFF, 2013). Laws and regulations addressing balance billing are often known as “enrollee hold harmless” language, and some prohibition against balance billing is the common aspect of many of these laws.

However, CHBRP is unaware of a balance billing law in another state that sets local Medicare rates as the default plan/insurer payment for nonemergency OON professional services delivered in conjunction with an in-network facility encounter.

CHBRP is aware of laws in two states that address plan and/or insurer payments to OON professionals, although not in ways identical to what AB 533 proposes. Comparison and discussion follow.

¹⁷ Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997.

¹⁸ Employee Retirement Income Security Act of 1974 (ERISA).

Table 5. Balance Billing Laws Comparison

AB 533 ¹⁹	New York ²⁰	Maryland - HMO ²¹	Maryland - PPO and POS ²²
Applies to			
DMHC-regulated plans (includes HMOs) and insurers subject to California law Exempts plans enrolling Medi-Cal beneficiaries. ²³	HMOs and insurers subject to New York law	HMOs subject to Maryland law	PPO and POS insurance products subject to Maryland law
Balance billing			
Prohibits balance billing for covered services provided by an OON professional at an in-network facility	Prohibits balance billing for <ul style="list-style-type: none"> • covered services provided by an OON professional at an in-network facility • covered services provided by an OON professional or facility to which the enrollee was referred by an in-network professional • covered services provided by an OON laboratory that was selected by the in-network professional 	Prohibits balance billing for a covered service by an OON professional or facility	Prohibits balance billing by hospital-based and on-call physicians, but not by all other non-preferred physicians
Plan (HMO) or insurer payments			
Would set at local Medicare rate as the default payment.	The insurer may pay the billed charge, or attempt to negotiate a rate, or initiate a dispute through the IDR; the provider may accept the rate, or initiate a dispute through the IDR	Requires HMOs to make payments to OON professionals and facilities whichever is higher: <ul style="list-style-type: none"> • 140% of the local Medicare rates or • 125% of the HMOs usual and customary rate (noncontracted effective rate) 	Requires PPOs/POS to pay either <ul style="list-style-type: none"> • 140% of the average rate the insurer paid for the previous calendar year or • the final allowed amount for the same covered service in 2009 inflated by the Medicare Economic Index to the current year
Independent Dispute Resolution (IDR) Process			
Requires DMHC and CDI to establish IDR processes Requires professionals disputing payment to utilize the IDR IDR decision binding	State has an established IDR process that uses a standard reference point (80th percentile) from an independent database maintained by a nonprofit organization (currently FAIR Health). IDR decision binding Also dictates who must pay the fee for the IDR	Does not establish a relevant IDR	Does not establish a relevant IDR

Source: California Health Benefits Review Program, 2015.

Key: HMO = health maintenance organization; CDI = California Department of Insurance; DMHC = California Department of Managed Health Care; IDR = independent dispute resolution process; OON = out-of-network; POS = point of service product; PPO = preferred provider organization.

¹⁹ See Appendix A for the full text of AB 533.

²⁰ New York Financial Services Law § 603(h).

²¹ Maryland Statute 19-710.1 of the Health-General Article.

²² Maryland Statutes 14-201, 14-205, and 15-304 of the Health-General Article.

²³ As previously noted, balance billing is already prohibited for Medi-Cal beneficiaries.

New York

The New York balance billing law is similar to AB 533 in some ways, but not comparable in all aspects. They are similar in that both apply to similar insurance products, and are narrowly focused on specific situations, though the New York law applies to additional scenarios where AB 533 addresses only OON professional services delivered in conjunction with an in-network facility encounter. New York law addresses services from both OON professionals and OON facilities (as part of an encounter, an in-network hospital might use an OON laboratory) (NYDFS, 2015). Both states require IDR processes for disputed payments. The New York law does not establish local Medicare rates as the default plan/insurer payment. Instead, the New York law references an independent party (currently FAIR Health), which is to establish current “usual and customary rates” and to use that information to set plan/insurer payments. The New York law is too new for results to be clear. However, because the scope of the New York law is broader, and because it would not use local Medicare rates to set default plan/insurer payments, it is unclear how similar the results of the New York law and AB 533 would be.

Maryland

Maryland has multiple laws that impact balance billing, and the laws governing HMOs differ from those governing PPO and POS products. All of the laws differ from AB 533.

Like AB 533, the Maryland law governing HMOs does reference Medicare rates. However, AB 533 links plan/insurer payments to local Medicare rates whereas the Maryland law requires the higher of either a payment based on the higher of two figures: 125% of currently applicable Medicare reimbursement rates or 140% of the average rate the HMO paid for a similar service in the same geographic area (the usual and customary rate). As the usual and customary rate is generally higher, the Medicare rates would rarely come into effect.

Maryland’s PPO and POS product balance billing law differs from its’ HMO law. The PPO and POS law addresses OON physician services (not other OON professionals or OON facilities). Like AB 533, the law references Medicare, but does not use local Medicare rates to establish default insurer payments. Hospital-based physicians and on-call physicians who accept an assignment of benefits (AOB) from an enrollee will be paid the higher of two figures: 140% of the average rate the insurer paid for the previous calendar year or the final allowed amount for the same covered service in 2009 inflated by the Medicare Economic Index to the current year. All other physicians who elect to receive an AOB will not be limited in the amount of their bill.

A review of the impacts of the Maryland law governing HMOs (MHCC, 2002) is available, but no similar review is available for the Maryland law governing PPOs and POS products. However, because the laws both differ from AB 533, it is unclear how similar the results of either Maryland law and AB 533 would be.

APPENDIX A TEXT OF BILL ANALYZED

On October 12, 2015 the California Assembly Committee on Health requested that CHBRP analyze AB 533.

ASSEMBLY BILL

No. 533

AMENDED IN SENATE SEPTEMBER 4, 2015

AMENDED IN SENATE AUGUST 18, 2015

AMENDED IN SENATE JULY 7, 2015

AMENDED IN ASSEMBLY APRIL 23, 2015

AMENDED IN ASSEMBLY APRIL 15, 2015

Introduced by Assembly Member Bonta

February 23, 2015

An act to add Sections 1371.30, 1371.31, and 1371.9 to the Health and Safety Code, and to add Sections 10112.8, 10112.81, and 10112.82 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 533, as amended, Bonta. Health care coverage: out-of-network coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law requires a health care service plan to reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee. Existing law prohibits a *health care service* plan from requiring a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical care, as specified.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires a health insurance policy issued, amended, or renewed on or after January 1, 2014, that provides or covers benefits with respect to services in an emergency department of a hospital to cover emergency services without the need for prior authorization, regardless of whether the provider is a participating provider, and subject to the same cost sharing required if the services were provided by a participating provider, as specified.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after ~~January~~ *July* 1, 2016, to provide that if an enrollee or insured ~~obtains care~~ *receives covered services* from a contracting health facility, as defined, at which, or as a result of which, the enrollee or insured receives covered services provided by a noncontracting individual health professional, as defined, the enrollee or insured ~~is~~ *would be* required to pay the noncontracting individual health professional only the same cost sharing required if the services were provided by a contracting individual health professional. The bill would prohibit an enrollee or insured from owing the noncontracting individual health professional at the contracting health facility more than the in-network ~~cost-sharing~~ *cost-sharing* amount if the noncontracting individual health professional receives reimbursement for services provided to the enrollee or insured at a contracting health facility from the *health care service plan* or health insurer. *However, the bill would make an exception from this prohibition if the enrollee or insured provides written consent that satisfies specified criteria.* The bill would require a noncontracting individual health professional who collects more than the in-network cost-sharing amount from the enrollee or insured to refund any overpayment to the enrollee or insured, as specified, and would provide that interest on any amount overpaid by, and not refunded to, the enrollee or insured shall accrue at 15% per annum, as specified.

Existing law requires a contract between a health care service plan and a provider, or a contract between an insurer and a provider, to contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan or insurer. Existing law requires that dispute resolution mechanism also be made accessible to a noncontracting provider for the purpose of resolving billing and claims disputes.

This bill would require the department and the commissioner to each establish an independent dispute resolution process that would allow a noncontracting individual health professional who rendered services at a contracting health ~~facility~~ *facility, or a plan or insurer,* to appeal a claim payment ~~dispute with a plan or insurer, dispute,~~ as specified. The bill would authorize the department and the commissioner to contract with one or more independent dispute resolution organizations to conduct the independent dispute resolution process, as specified. The bill would provide that the decision of the organization would be binding on the parties. ~~The bill would require a health care service plan to base reimbursement of a claim by a noncontracting individual health professional on~~

~~statistically credible information with regard to the amount paid to contracted individual health professionals who provide similar services, are not capitated, and practice in the same or a similar geographic region, as specified. The bill would require an a plan or insurer to base reimbursement of a claim by a noncontracting health professional on statistically credible information with regard to the amount paid to contracted individual health professionals who provide similar services and practice in the same or a similar geographic region, as specified. for covered services on the amount the individual health professional would have been reimbursed by Medicare for the same or similar services in the general geographic area in which the services were rendered. The bill would require a noncontracting individual health professional who disputes that claim reimbursement to utilize the independent dispute resolution process. The bill would provide that these provisions do not apply to emergency services and care, as defined.~~

Because a willful violation of the bill's provisions relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.

~~Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.~~

~~This bill would make legislative findings to that effect.~~

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1371.30 is added to the Health and Safety Code, immediately following Section 1371.3, to read:

1371.30. (a) (1) The department shall establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health care service plan and a noncontracting individual health professional for services subject to Section 1371.9.

(2) If either the noncontracting individual health professional or the plan appeals a claim to the department's independent dispute resolution process, the other party shall participate in the appeal process as described in this section.

(b) ~~The department and the Department of Insurance shall jointly~~ *shall* establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this ~~section—section and any other guidelines for implementing this article.~~

(c) The department may contract with one or more independent organizations ~~that specialize in dispute resolution~~ to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute. The department shall establish conflict-of-interest standards, consistent with the purposes of this section, that an organization shall meet in order to qualify for participation in the independent dispute resolution program. The department may contract with the same independent organization or organizations as the Department of Insurance.

(d) The determination obtained through the department's independent dispute resolution process shall be binding on both parties.

(e) This section shall not apply to a Medi-Cal managed health care service plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, and Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(f) If a health care service plan delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, then the delegated entity shall comply with this section.

(g) This section shall not apply to emergency services and care, as defined in Section 1317.1.

SEC. 2. Section 1371.31 is added to the Health and Safety Code, immediately following Section 1371.30, to read:

~~1371.31. (a) (1) The health care service plan shall maintain statistically credible information, updated at least annually, regarding rates paid to currently contracting individual health professionals or a group of professionals who provide similar services, are not capitated, and are practicing in the same or a similar geographic area as the noncontracting individual health professional.~~

~~(2) If, based on the health care service plan's model or payment arrangements, a health care service plan does not pay a statistically significant number or dollar amount of claims for covered services in order to maintain the statistically credible information required by paragraph (1), the health care service plan shall demonstrate to the department that it has access to a statistically credible database reflecting reasonable rates paid to providers for services provided in the same or similar geographic area.~~

~~(3) The statistically credible information required by paragraphs (1) and (2) shall be confidential and exempt from public disclosure.~~

~~(b) (1) Unless otherwise provided in this section or otherwise agreed by the noncontracting individual health professional and the plan, the plan shall base reimbursement of noncontracted claims for services rendered according to Section 1371.9 on the average rates based on the statistically credible information with regard to the amount paid to contracted individual health professionals who are providing similar services, are not capitated, and practicing in the same or similar geographic area.~~

1371.31. (a) For services rendered subject to Section 1371.9, unless otherwise agreed to by the noncontracting individual health professional and the plan, the plan shall base reimbursement for covered services on the amount the individual health professional would have been reimbursed by Medicare for the same or similar services in the general geographic area in which the services were rendered.

~~(2)~~

(b) If nonemergency services are provided by a noncontracting individual health professional pursuant to subdivision (d) of Section 1371.9, to an enrollee who has voluntarily chosen to use his or her out-of-network benefit for services covered by a preferred provider

organization or a point of service plan, unless otherwise agreed to by the plan and the noncontracting individual health professional, the amount paid shall be the amount set forth in the enrollee's evidence of coverage.

~~(3)~~

(c) A noncontracting individual health professional who disputes the claim reimbursement shall utilize the independent dispute resolution process described in Section 1371.30.

13 ~~(e)~~

(d) If a health care service plan delegates by written contract the responsibility for payment of claims to a contracted entity, including, but not limited to, a medical group or independent practice association, then the entity to which that responsibility is delegated shall comply with the requirements of this section.

~~(d)~~

(e) A payment made by the health care service plan to the noncontracting health care professional for nonemergency services as required by Section 1371.9 and this section, in addition to the applicable cost sharing owed by the enrollee, shall constitute payment in full for nonemergency services rendered.

~~(e)~~

(f) This section shall 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 pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, and Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

~~(f)~~

(g) This section shall not apply to emergency services and care, as defined in Section 1317.1.

SEC. 3. Section 1371.9 is added to the Health and Safety Code, to read:

1371.9. (a) (1) A health care service plan contract issued, amended, or renewed on or after ~~January~~ July 1, 2016, shall provide ~~that~~ *that, except as provided in subdivision (d), if an enrollee*

~~obtains care~~ *receives covered services* from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional, the enrollee shall pay the noncontracting individual

health professional no more than the same cost sharing that the enrollee would ~~have paid—pay~~ for the same covered ~~benefits services~~ received from a contracting individual health professional. This amount shall be referred to as the “in-network cost sharing.”

(2) At the time of payment by the plan to the noncontracting individual health professional, the plan shall inform the noncontracting individual health professional of the in-network cost sharing owed by the enrollee. ~~If~~

(3) ~~Except as provided in subdivision (d), if~~ a noncontracting individual health professional receives reimbursement for services provided to the enrollee at a contracting health facility from the plan, an enrollee shall not owe the noncontracting individual health professional at the contracting health facility more than the in-network ~~cost sharing—cost-sharing amount~~.

~~(3) Except as provided in subdivision (d), if the noncontracting individual health professional collects more than the in-network cost sharing from the enrollee, the noncontracting individual health professional shall refund any overpayment to the enrollee within 30 working days of receiving notice from the plan of the in-network cost sharing amount owed by the enrollee pursuant to paragraph (2). If the noncontracting individual health professional does not refund any overpayment within 30 working days after being informed of the enrollee’s in-network cost sharing, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period. A noncontracting individual health professional shall automatically include in his or her refund of the overpayment all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount.~~

~~(4) If the noncontracting individual health professional has advanced to collections any amount owed by the enrollee, the plan shall not reimburse the noncontracting individual health professional for services provided to the enrollee by the noncontracting individual health professional at a contracting health facility. In submitting a claim to the plan, the noncontracting individual health professional at a contracting health facility shall~~

~~affirm in writing that he or she has not advanced to collections any payment owed by the enrollee. A noncontracting individual health professional shall not attempt to collect more than the in-network cost sharing from the enrollee after receiving payment from the plan. Once the noncontracting individual health professional receives payment from the plan, the noncontracting individual health professional may advance to collections any in-network cost sharing owed by the enrollee if the enrollee fails to pay the in-network cost sharing after the plan has informed the noncontracting individual health professional of the amount owed~~

~~by the enrollee pursuant to paragraph (2).~~

(4) Except as provided in subdivision (d), a noncontracting individual health professional shall not bill or collect any amount from the enrollee except the in-network cost-sharing amount.

(5) A noncontracting individual health professional shall not bill or collect any amount from the enrollee until the noncontracting individual health professional is informed of the in-network cost-sharing amount pursuant to paragraph (2).

(6) In submitting a claim to the plan, the noncontracting individual health professional at a contracting health facility shall affirm in writing that he or she has not attempted to collect any payment other than in-network cost sharing owed by the enrollee.

(7) (A) If the noncontracting individual health professional has collected more from the enrollee than the in-network cost sharing, the noncontracting individual health professional shall refund any overpayment to the enrollee within 30 business days of receiving notice from the plan of the in-network cost-sharing amount owed by the enrollee pursuant to paragraph (2).

(B) If the noncontracting individual health professional does not refund an overpayment to the enrollee within 30 business days after being informed of the enrollee's in-network cost sharing, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-business day period.

(C) A noncontracting individual health professional shall automatically include in his or her overpayment refund to the enrollee all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount.

(8) A noncontracting individual health professional may advance to collections only the in-network cost sharing, as determined by the plan pursuant to paragraph (2), that the enrollee has failed to pay.

(b) (1) Any cost sharing paid by the enrollee for the services provided by a noncontracting individual health professional at the contracting health facility shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services received by a noncontracting individual health professional at a contracting health facility shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

(c) For purposes of this section, the following definitions shall apply:

(1) “Cost sharing” includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee other than premium or share of premium.

(2) ~~“Health facility”~~ *“Contracting health facility”* means a health facility ~~provider who is licensed by this state to deliver or furnish health care services. A health facility shall include that is contracted with the enrollee’s health care service plan to provide services under the enrollee’s plan contract. A contracting health care facility includes, but is not be limited to,~~ the following providers:

- (A) Licensed hospital.
- (B) Skilled nursing facility.
- (C) Ambulatory ~~surgery~~ *surgery or other outpatient setting, as described in Section 1248.1.*
- (D) Laboratory.
- (E) Radiology or imaging.
- (F) Facilities providing mental health or substance abuse treatment.
- (G) Any other provider as the department may by regulation define as a health facility for purposes of this section.

(3) “Individual health professional” means a physician or surgeon or other professional who is licensed by this state to deliver or furnish health care services.

~~(d) An enrollee may voluntarily consent to the use of a noncontracting individual health professional. For purposes of this section, consent shall be voluntary if at least 24 hours in advance of the receipt of services, the enrollee is provided a written estimate of the cost of care by the noncontracting individual health professional and the enrollee consents in writing to both the use of a noncontracting individual health professional and payment of the estimated additional cost for the services to be provided by the noncontracting individual health professional. The consent shall inform the enrollee that the cost of the services of the noncontracting individual health professional will not accrue to the limit on annual out of pocket expenses or the enrollee’s deductible, if any.~~

(4) “Noncontracting individual health professional” means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the enrollee’s health care service plan.

(d) A noncontracting individual health professional may bill or

collect from an enrollee the out of network cost sharing, if applicable, or more than the in-network cost sharing for nonemergency health services provided in a contracting health facility only when the enrollee consents in writing and the written consent demonstrates satisfaction of all of the following criteria:

(1) The enrollee initiated the request for the identified nonemergency health services from the identified noncontracting individual provider.

(2) At least three business days in advance of care, the enrollee consented in writing consistent with this subdivision to the use of the identified noncontracting individual health professional.

(3) At the time of consent under this subdivision, the noncontracting individual health professional gave the enrollee a written estimate of the enrollee's total out-of-pocket cost of care.

(4) The written consent under this subdivision advises the enrollee that he or she may contact the enrollee's health care service plan in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.

(5) The written consent and estimate are provided to the enrollee in the language spoken by the enrollee.

(e) This section shall not be construed to require a plan to cover services ~~or provide benefits that are not otherwise covered under that are not required by law or by the terms and conditions of the plan contract.~~

(f) This section shall not be construed to exempt a plan or provider from the requirements under Section 1371.4 or 1373.96 nor abrogate the holding in *Prospect Medical Group v. Northridge Emergency Medical Group et al.*, (2009) 45 Cal.4th 497, that an emergency room physician is prohibited from billing an enrollee of a health care service plan directly for sums that the health care service plan has failed to pay for the enrollee's emergency room treatment.

(g) If a health care service plan delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(h) This section shall 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 pursuant to Chapter 7 (commencing with Section ~~14000~~ *of, 14000*), Chapter 8 (commencing with Section ~~14200~~ *of, 14200*), and Chapter 8.75

(commencing with Section 14591) Part 3 of Division 9 of the Welfare and Institutions Code.

(i) This section shall not apply to emergency services and care, as defined in Section 1317.1.

SEC. 4. Section 10112.8 is added to the Insurance Code, to read:

10112.8. (a) (1) A health insurance policy issued, amended, or renewed on or after ~~January~~ July 1, 2016, shall provide ~~that~~ *that, except as provided in subdivision (d),* if an insured obtains care from a contracting health facility at which, or as a result of which, the insured receives services provided by a noncontracting individual health professional, the insured shall pay the noncontracting individual health professional no more than the same cost sharing that the insured would ~~have paid~~ pay for the same covered ~~benefits~~ services received from a contracting individual health professional. This amount shall be referred to as the “in-network cost sharing.”

(2) At the time of payment by the health insurer to the noncontracting individual health professional, the health insurer shall inform the noncontracting individual health professional of the in-network cost sharing owed by the insured. ~~If~~

(3) *Except as provided in subdivision (d), if* a noncontracting individual health professional receives reimbursement for services provided to the insured at a contracting health facility from the health insurer, an insured shall not owe the noncontracting individual health professional at the contracting health facility more than the in-network ~~cost sharing~~ cost-sharing amount.

~~(3) Except as provided in subdivision (d), if the noncontracting individual health professional collects more than the in-network cost sharing from the insured, the noncontracting individual health professional shall refund any overpayment to the insured within 30 working days of receiving notice from the health insurer of the in-network cost sharing amount owed by the insured pursuant to paragraph (2). If the noncontracting individual health professional does not refund any overpayment within 30 working days after being informed of the insured’s in-network cost sharing, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period. A noncontracting individual health professional shall automatically include in his or her refund of the overpayment all interest that has accrued pursuant to this section without requiring the insured to submit a request for the interest amount.~~

~~(4) If the noncontracting individual health professional has advanced to collections any amount owed by the insured, the health insurer shall not reimburse the noncontracting individual health~~

~~professional for services provided to the insured by the noncontracting individual health professional at a contracting health facility. In submitting a claim to the health insurer, the noncontracting individual health professional at a contracting health facility shall affirm in writing that he or she has not advanced to collections any payment owed by the insured. A noncontracting individual health professional shall not attempt to collect more than the in-network cost sharing from the insured after receiving payment from the health insurer. Once the noncontracting individual health professional receives payment from the health insurer, the noncontracting individual health professional may advance to collections any in-network cost sharing owed by the insured if the insured fails to pay the in-network cost sharing after the health insurer has informed the noncontracting individual health professional of the amount owed by the insured pursuant to paragraph (2).~~

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(4) This section shall only apply to a health insurer that enters into a contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 2 10133.

(5) Except as provided in subdivision (d), a noncontracting individual health professional shall not bill or collect any amount from the insured except the in-network cost-sharing amount.

(6) A noncontracting individual health professional shall not bill or collect any amount from the insured until the noncontracting individual health professional is informed of the in-network cost-sharing amount pursuant to paragraph (2).

(7) In submitting a claim to the insurer, the noncontracting individual health professional at a contracting health facility shall affirm in writing that he or she has not attempted to collect any payment other than in-network cost sharing owed by the insured.

(8) (A) If the noncontracting individual health professional has collected more from the insured than the in-network cost sharing, the noncontracting individual health professional shall refund any overpayment to the insured within 30 business days of receiving notice from the plan of the in-network cost-sharing amount owed by the insured pursuant to paragraph (2).

(B) If the noncontracting individual health professional does not refund an overpayment to the insured within 30 business days after being informed of the insured's in-network cost sharing, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-business day period.

(C) A noncontracting individual health professional shall automatically include in his or her overpayment refund to the insured all interest that has accrued pursuant to this section without requiring the insured to submit a request for the interest amount.

(9) A noncontracting individual health professional may advance to collections only the in-network cost sharing, as determined by the plan pursuant to paragraph (2), that the insured has failed to pay.

(b) (1) Any cost sharing paid by the insured for the services provided by a noncontracting individual health professional at the contracting health facility shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services received by a noncontracting individual health professional at a contracting health facility shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

(c) For purposes of this section, the following definitions shall apply:

(1) “Cost sharing” includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

(2) ~~“Health facility”~~ “Contracting health facility” means a health facility ~~provider who is licensed by this state to deliver or furnish health care services. A health facility shall include that is~~ contracted with the insured’s health insurer to provide services under the insured’s policy. A contracting health facility includes, but is not limited to, the following providers:

- (A) Licensed hospital.
- (B) Skilled nursing facility.
- (C) Ambulatory ~~surgery~~-surgery or other outpatient setting, as described in Section 1248.1 of the Health and Safety Code.
- (D) Laboratory.
- (E) Radiology or imaging.
- (F) Facilities providing mental health or substance abuse treatment.
- (G) Any other provider as the commissioner may by regulation define as a health facility for purposes of this section.

(3) “Individual health professional” means a physician ~~or~~ and surgeon or other professional who is licensed by this state to deliver or furnish health care services.

~~(d) An insured may voluntarily consent to the use of a noncontracting individual health professional. For purposes of this section, consent shall be voluntary if at least 24 hours in advance of the receipt of services, the insured is provided a written estimate of the cost of care by the noncontracting individual health professional and the insured consents in writing to both the use of a noncontracting individual health professional and payment of the estimated additional cost for the services to be provided by the noncontracting individual health professional. The consent shall inform the insured that the cost of the services of the noncontracting individual health professional will not accrue to the limit on annual out of pocket expenses or the insured's deductible, if any.~~

(4) "Noncontracting individual health professional" means a physician or surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the insured's health insurer.

(d) A noncontracting individual health professional may bill or collect from an insurer the out of network cost sharing, if applicable, or more than the in-network cost sharing for nonemergency health services provided in a contracting health facility only when the insured consents in writing and the written consent demonstrates satisfaction of all of the following criteria:

(1) The insured initiated the request for the identified nonemergency health services from the identified noncontracting individual provider.

(2) At least three business days in advance of care, the insured consented in writing consistent with this subdivision to the use of the identified noncontracting individual health professional.

(3) At the time of consent under this subdivision, the noncontracting individual health professional gave the insured a written estimate of the enrollee's total out-of-pocket cost of care.

(4) The written consent under this subdivision advises the insured that he or she may contact the insured's health care service plan in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.

(5) The written consent and estimate are provided to the insured in the language spoken by the insured.

~~(e) This section shall not be construed to require an insurer to cover services or provide benefits that are not otherwise covered under not required by law or by the terms and conditions of the~~

policy.

(f) This section shall not be construed to exempt a health insurer from the requirements under Section 10112.7 or Section 10133.56.

(g) This section shall not apply to emergency services and care, as defined in Section 1317.1.

SEC. 5. Section 10112.81 is added to the Insurance Code, to read:

10112.81. (a) (1) The commissioner shall establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between an insurer and a noncontracting individual health professional for services subject to Section 10112.8.

(2) If either the noncontracting individual health professional or the insurer appeals a claim to the department's independent dispute resolution process, the other party shall participate in the appeal process as described in this section.

(b) The commissioner ~~and the Department of Managed Health Care shall jointly~~ shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this ~~section~~ section, and any other guideline for implementing this article.

(c) The commissioner may contract with one or more independent organizations ~~that specialize in dispute resolution~~ to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute. The commissioner shall establish conflict-of-interest standards, consistent with the purposes of this section, that an organization shall meet in order to qualify for participation in the independent dispute resolution program. The commissioner may contract with the same independent organization or organizations as the Department of Managed Health Care.

(d) The determination obtained through the independent dispute resolution process shall be binding on both parties.

(e) This section shall not apply to emergency services and care, as defined in Section 1317.1 of the Health and Safety Code.

SEC. 6. Section 10112.82 is added to the Insurance Code, to read:

~~10112.82. (a) (1) A health insurer shall maintain statistically credible information, updated at least annually, regarding rates paid to currently contracting individual health professionals or a~~

~~group of professionals who provide similar services and are practicing in the same or a similar geographic area as the noncontracting individual health professional.~~

~~(2) If a health insurer does not pay a statistically significant number or dollar amount of claims for covered services in order to maintain the statistically credible information required by paragraph (1), the health insurer shall demonstrate to the department that it has access to a statistically credible database reflecting reasonable rates paid to providers for services provided in the same or a similar geographic area.~~

~~(3) The statistically credible information required by paragraphs (1) and (2) shall be confidential and shall be exempt from public disclosure.~~

~~(b) (1) Unless otherwise provided in this section or otherwise agreed to by the noncontracting individual health professional and the insurer, the insurer shall base reimbursement of noncontracted claims for services rendered according to Section 10112.81 on the average rates based on the statistically credible information with regard to the amount paid to contracted individual health professionals who are providing similar services and practicing in the same or similar geographic area.~~

10112.82. (a) For services rendered subject to Section 10112.8, unless otherwise agreed to by the noncontracting individual health professional and the insurer, the insurer shall base reimbursement for covered services on the amount the individual health professional would have been reimbursed by Medicare for the same or similar services in the general geographic area in which the services were rendered.

~~(2)~~

(b) If nonemergency services are provided by a noncontracting individual health ~~professional~~ professional, pursuant to subdivision

(d) of Section 10112.8, to an insured who has voluntarily chosen to use his or her out-of-network benefit for services covered by a preferred provider organization or a point-of-service plan, unless otherwise agreed to by the insurer and the noncontracting individual health professional, the amount paid shall be the amount set forth in the insured's evidence of coverage.

~~(3)~~

(c) A noncontracting individual health professional who disputes the claim reimbursement shall utilize the independent dispute resolution process described in Section 10112.81.

~~(e)~~

(d) A payment made by a health insurer to a noncontracting health care professional for nonemergency services as required by Section 10112.81 and this section, in addition to the applicable

cost sharing owed by the insured, shall constitute payment in full for the nonemergency services rendered.

~~(d)~~

~~(e)~~ This section shall not apply to a Medicare plan or a Medicare supplemental plan.

~~(e)~~

~~(f)~~ This section shall not apply to emergency services and care, as defined in Section 1317.1 of the Health and Safety Code.

~~SEC. 7. The Legislature finds and declares that Sections 2 and 6 of this act, which add Section 1371.31 to the Health and Safety Code and Section 10112.82 to the Insurance Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:~~

~~In order to protect confidential and proprietary information, it is necessary for that information to remain confidential.~~

~~SEC. 8.~~

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

This appendix describes data sources, estimation methodology, as well as general and mandate-specific caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP website at: www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

The cost analysis in this report was prepared by the members of the cost team, which consists of CHBRP task force members and contributors from the University of California, Los Angeles, and the University of California, Davis, as well as the contracted actuarial firm Milliman, Inc.²⁴

Data Sources

This subsection discusses the variety of data sources CHBRP uses. Key sources and data items are listed below, in Table B-1.

Table B-1. Data for 2016 Projections

Data Source	Items
California Department of Health Care Services (DHCS) administrative data for the Medi-Cal program, data available as of end of December 2014	Distribution of enrollees by managed care or FFS distribution by age: 0–17; 18–64; 65+ Medi-Cal Managed Care premiums
California Department of Managed Health Care (DMHC) data from the interactive website “Health Plan Financial Summary Report,” August–October, 2014	Distribution of DMHC-regulated plans by market segment*
California Department of Insurance (CDI) Statistical Analysis Division data; data as of December 31, 2014	Distribution of CDI-regulated policies by market segment
California Health Benefits Review Program (CHBRP) Annual Enrollment and Premium Survey of California’s largest (by enrollment) health care service plans and health insurers; data as of September 30, 2014; responders’ data represent approximately 97.4% of persons not associated with CalPERS or Medi-Cal with health insurance subject to state mandates — 97.8% of full-service (nonspecialty) DMHC-regulated plan enrollees and 95.9% of full-service (nonspecialty) CDI-regulated policy enrollees.	Enrollment by: <ul style="list-style-type: none"> • Size of firm (2–50 as small group and 51+ as large group) • DMHC vs. CDI regulated • Grandfathered vs. nongrandfathered Premiums for individual policies by: <ul style="list-style-type: none"> • DMHC vs. CDI regulated • Grandfathered vs. nongrandfathered

²⁴ CHBRP’s authorizing legislation requires that CHBRP use a certified actuary or “other person with relevant knowledge and expertise” to determine financial impact (www.chbrp.org/docs/authorizing_statute.pdf).

Data Source	Items
California Employer Health Benefits Survey, 2014 (conducted by NORC and funded by CHCF)	Enrollment by HMO/POS, PPO/indemnity self-insured, fully insured Premiums (not self-insured) by: <ul style="list-style-type: none"> • Size of firm (3–25 as small group and 25+ as large group) • Family vs. single • HMO/POS vs. PPO/indemnity vs. HDHP employer vs. employer premium share
California Health Interview Survey (CHIS) 2012/2013/T7 (“T7” representing the first 6 months of 2014)	Uninsured, age: 65+ Medi-Cal (non-Medicare), age: 65+ Other public, age: 65+ Employer-sponsored insurance, age: 65+
California Public Employees’ Retirement System (CalPERS) data, enrollment as of October 1, 2014	CalPERS HMO and PPO enrollment <ul style="list-style-type: none"> • Age: 0–17; 18–64; 65+ HMO premiums
California Simulation of Insurance Markets (CalSIM) Version 1.9.1 (projections for 2016)	Uninsured, age: 0–17; 18–64 Medi-Cal (non-Medicare) (a), age: 0–17; 18–64 Other public (b), age: 0–64 Individual market, age: 0–17; 18–64 Small group, age: 0–17; 18–64 Large group, age: 0–17; 18–64
Centers for Medicare and Medicaid (CMS) administrative data for the Medicare program, annually (if available) as of end of September	HMO vs. FFS distribution for those 65+ (noninstitutionalized)
Milliman estimate	Medical trend influencing annual premium increases

Notes: * CHBRP assumes DMHC-regulated PPO group enrollees and POS enrollees are in the large-group segment. *Key:* CDI = California Department of Insurance; CHCF = California HealthCare Foundation; CHIS = California Health Interview Survey; CMS = Centers for Medicare & Medicaid Services; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care; FFS = fee-for-service; HDHP = high deductible health plan; HMO = health maintenance organization; NORC = National Opinion Research Center; POS = point of service; PPO = preferred provider organization.

Further discussion of external and internal data follows.

Internal data

- CHBRP’s Annual Enrollment and Premium Survey collects data from the seven largest providers of health insurance in California (including Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and United Healthcare/Pacificare) to obtain estimates of enrollment not associated with CalPERS or Medi-Cal by purchaser (i.e., large and small group and individual), state regulator (DMHC or CDI), grandfathered and nongrandfathered status, and average premiums. CalSIM and market trends were applied to project 2016 health insurance enrollment in DMHC-regulated plans and CDI-regulated policies.
- CHBRP’s other surveys of the largest plans/insurers collect information on benefit coverage relevant to proposed benefit mandates CHBRP has been asked to analyze. In each report, CHBRP indicates the proportion of enrollees — statewide and by market segment — represented by responses to CHBRP’s bill-specific coverage surveys. The proportions are derived from data provided by CDI and DMHC.

External sources

- California Department of Health Care Services (DHCS) data are used to estimate enrollment in Medi-Cal Managed Care (beneficiaries enrolled in Two-Plan Model, Geographic Managed Care, and County Operated Health System plans), which may be subject to state benefit mandates, as well as enrollment in Medi-Cal Fee For Service (FFS), which is not. The data are available at: www.dhcs.ca.gov/dataandstats/statistics/Pages/Monthly_Trend_Report.aspx. Medi-Cal enrollment is projected to 2016 based on CalSIM's estimate of the continuing impact of the Medi-Cal expansion implemented in 2014.
- California Employer Health Benefits Survey data are used to make a number of estimates, including: premiums for employment-based enrollment in DMHC-regulated health care service plans (primarily health maintenance organizations [HMOs] and point of service [POS] plans) and premiums for employment-based enrollment in CDI-regulated health insurance policies regulated by the (primarily preferred provider organizations [PPOs]). Premiums for fee-for-service (FFS) policies are no longer available due to scarcity of these policies in California. This annual survey is currently released by the California Health Care Foundation/National Opinion Research Center (CHCF/NORC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Health Research and Educational Trust. More information on the CHCF/NORC data is available at: www.chcf.org/publications/2014/01/employer-health-benefits.
- California Health Interview Survey (CHIS) data are used to estimate the number of Californians aged 65 and older, and the number of Californians dually eligible for both Medi-Cal and Medicare coverage. CHIS data are also used to determine the number of Californians with incomes below 400% of the federal poverty level. CHIS is a continuous survey that provides detailed information on demographics, health insurance coverage, health status, and access to care. More information on CHIS is available at: www.chis.ucla.edu.
- California Public Employees Retirement System (CalPERS) data are used to estimate premiums and enrollment in DMHC-regulated plans, which may be subject to state benefit mandates, as well as enrollment in CalPERS' self-insured plans, which is not. CalPERS does not currently offer enrollment in CDI-regulated policies. Data are provided for DMHC-regulated plans enrolling non-Medicare beneficiaries. In addition, CHBRP obtains information on current scope of benefits from evidence of coverage (EOC) documents publicly available at: www.calpers.ca.gov. CHBRP assumes CalPERS's enrollment in 2016 will not be affected by continuing shifts in the health insurance market as a result of the ACA.
- California Simulation of Insurance Markets (CalSIM) estimates are used to project health insurance status of Californians aged 64 and under. CalSIM is a microsimulation model that projects the effects of the Affordable Care Act on firms and individuals. More information on CalSIM is available at: <http://healthpolicy.ucla.edu/programs/health-economics/projects/CalSIM/Pages/default.aspx>.
- Milliman data sources are relied on to estimate the premium impact of mandates. Milliman's projections derive from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by many of the major health plans in the United States. Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed health care plans, generally those characterized as PPO plans. More information on the Milliman HCGs is available at: <http://us.milliman.com/Solutions/Products/Resources/Health-Cost-Guidelines/Health-Cost-Guidelines---Commercial/>.

- The MarketScan databases, which reflect the health care claims experience of employees and dependents covered by the health benefit programs of large employers. These claims data are collected from insurance companies, Blue Cross Blue Shield plans, and third party administrators. These data represent the medical experience of insured employees and their dependents for active employees, early retirees, individuals with COBRA continuation coverage, and Medicare-eligible retirees with employer-provided Medicare Supplemental plans. No Medicaid or Workers Compensation data are included.
- Ingenix MDR Charge Payment System, which includes information about professional fees paid for health care services, based upon claims from commercial insurance companies, HMOs, and self-insured health plans.

Projecting 2016

This subsection discusses adjustments made to CHBRP's Cost and Coverage Model to project 2016, the period when legislation proposed in 2015 would, if enacted, generally take effect. It is important to emphasize that CHBRP's analysis of specific mandate bills typically addresses the incremental effects of a mandate — specifically, how the proposed mandate would impact benefit coverage, utilization, costs, and public health, *holding all other factors constant*. CHBRP's estimates of these incremental effects are presented in the *Benefit Coverage, Utilization, and Cost Impacts* section of this report.

Baseline premium rate development methodology

The key components of the baseline model for utilization and expenditures are estimates of the per member per month (PMPM) values for each of the following:

- Insurance premiums PMPM;
- Gross claims costs PMPM;
- Member cost sharing PMPM; and
- Health care costs paid by the health plan or insurer.

For each market segment, we first obtained an estimate of the insurance premium PMPM by taking the 2014 reported premium from the abovementioned data sources and trending that value to 2016. CHBRP uses trend rates published in the Milliman HCGs to estimate the health care costs for each market segment in 2016.

The large-group market segments for each regulator (CDI and DMHC) are split into grandfathered and nongrandfathered status. For the small-group and individual markets, further splits are made to indicate association with Covered California, the state's health insurance marketplace. Doing so allows CHBRP to separately calculate the impact of ACA and of specific mandates, both of which may apply differently among these subgroups. The premium rate data received from the CHCF/NORC California Employer Health Benefits survey did not split the premiums based on grandfathered or exchange status. However, CHBRP's Annual Enrollment and Premium (AEP) survey asked California's largest health care service plans and health insurers to provide their average premium rates separately for grandfathered and nongrandfathered plans. The ratios from the CHBRP survey data were then applied to the CHCF/NORC aggregate premium rates for large and small group, to estimate premium rates for grandfathered and nongrandfathered plans that were consistent with the NORC results. For the individual market, the premium rates received from CHBRP's AEP survey were used directly.

The remaining three values were then estimated by the following formulas:

- Health care costs paid by the health plan = insurance premiums PMPM × (1 – profit/administration load);
- Gross claims costs PMPM = health care costs paid by the health plan ÷ percentage paid by health plan; and
- Member cost sharing PMPM = gross claims costs × (1 – percentage paid by health plan).

In the above formulas, the quantity “profit/administration load” is the assumed percentage of a typical premium that is allocated to the health plan/insurer’s administration and profit. These values vary by insurance category, and under the ACA, are limited by the minimum medical loss ratio requirement. CHBRP estimated these values based on actuarial expertise at Milliman, and their associated expertise in health care.

In the above formulas, the quantity “percentage paid by health plan” is the assumed percentage of gross health care costs that are paid by the health plan, as opposed to the amount paid by member cost sharing (deductibles, copays, etc.). In ACA terminology, this quantity is known as the plan’s “actuarial value.” These values vary by insurance category. For each insurance category, Milliman estimated the member cost sharing for the average or typical plan in that category. Milliman then priced these plans using the Milliman Health Cost Guidelines to estimate the percentage of gross health care costs that are paid by the carrier.

General Caveats and Assumptions

This subsection discusses the general caveats and assumptions relevant to all CHBRP reports. The projected costs are estimates of costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated benefits (and, therefore, the services covered by the benefit) before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

Additional assumptions that underlie the cost estimates presented in this report are:

- Cost impacts are shown only for plans and policies subject to state benefit mandate laws.
- Cost impacts are only for the first year after enactment of the proposed mandate.
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of the premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.
- For state-sponsored programs for the uninsured, the state share will continue to be equal to the absolute dollar amount of funds dedicated to the program.

- When cost savings are estimated, they reflect savings realized for 1 year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for estimating long-term impacts, please see: www.chbrp.org/analysis_methodology/docs/longterm_impacts08.pdf.
- Several studies have examined the effect of private insurance premium increases on the number of uninsured (Chernew et al., 2005; Glied and Jack, 2003; Hadley, 2006). Chernew et al. (2005) estimate that a 10% increase in private premiums results in a 0.74 to 0.92 percentage point decrease in the number of insured, whereas Hadley (2006) and Glied and Jack (2003) estimate that a 10% increase in private premiums produces a 0.88 and a 0.84 percentage point decrease in the number of insured, respectively. Because each of these studies reported results for the large-group, small-group, and individual insurance markets combined, CHBRP employs the simplifying assumption that the elasticity is the same across different types of markets. For more information on CHBRP's criteria for estimating impacts on the uninsured, please see: www.chbrp.org/analysis_methodology/docs/Uninsured_paper_Final_120815.pdf.

There are other variables that may affect costs, but which CHBRP did not consider in the estimates presented in this report. Such variables include, but are not limited to:

- Population shifts by type of health insurance: If a mandate increases health insurance costs, some employer groups and individuals may elect to drop their health insurance. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefits: To help offset the premium increase resulting from a mandate, deductibles or copayments may be increased. Such changes would have a direct impact on the distribution of costs between health plans/insurers and enrollees, and may also result in utilization reductions (i.e., high levels of cost sharing result in lower utilization of health care services). CHBRP did not include the effects of such potential benefit changes in its analysis.
- Adverse selection: Theoretically, persons or employer groups who had previously foregone health insurance may elect, postmandate, to enroll in a health plan or policy because they perceive that it is now to their economic benefit to do so.
- Medical management: Health plans/insurers may react to the mandate by tightening medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan/policy types that previously had the least effective medical management (i.e., PPO plans).
- Geographic and delivery systems variation: Variation exists in existing utilization and costs, and in the impact of the mandate, by geographic area and by delivery system models. Even within the health insurance plan/policy types CHBRP modeled (HMO, including HMO and POS plans, and non-HMO, including PPO and FFS policies), there are likely variations in utilization and costs. Utilization also differs within California due to differences in the health status of the local population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between providers and health plans/insurers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.

- Compliance with the mandate: For estimating the postmandate impacts, CHBRP typically assumes that plans and policies subject to the mandate will be in compliance with the benefit coverage requirements of the bill. Therefore, the typical postmandate coverage rates for persons enrolled in health insurance plans/policies subject to the mandate are assumed to be 100%.

Analysis Specific Caveats and Assumptions

This subsection discusses the caveats and assumptions relevant specifically to an analysis of AB 533.

In order to identify the presence, prevalence, and magnitude of what AB 533 defines as “surprise medical bills,” claims data summaries were prepared using Truven Health Analytics MarketScan[®] Databases. The data summaries utilized 2013 claims data from California.

AB 533 addresses out-of-network (OON) professional charges incurred during an in-network facility encounter. In-network facilities are associated with inpatient admits and outpatient visits. For this reason, CHBRP identified and then separated claims associated with:

- In-network inpatient admits; and
- in-network outpatient facility visits.

CHBRP then identified which of these inpatient admits and outpatient visits had claims identified as OON professional services as a component of the in-network admit or visit.²⁵

AB 533 does not affect all OON professional charges for services performed at an in-network facility, only those that are deemed to be a “surprise” for the member. If AB 533 is enacted, OON professionals may be required to submit additional information so that carriers can identify what AB 533 defines as surprise medical bills and so determine AB 533 compliant enrollee cost sharing and the plan/insurer payments. CHBRP’s claims analysis was based on historical data that do not identify which OON claims would have been deemed a “surprise” within the intent of AB 533.

To estimate the subset of historical OON professional charges associated with in-network inpatient admits and outpatient visits, CHBRP removed several types of claims assumed unlikely to not be surprises, or otherwise not subject to AB 533. For example, admits or visits that included a surgery, if the primary surgeon was an OON physician, were omitted. CHBRP assumed that the member would select or be referred to a physician, who would then define the inpatient or outpatient facility where they would perform the needed service. If this primary physician was OON, the member would or should know that before agreeing to the service. Therefore, CHBRP assumed that any professional charges from that physician would not be a surprise to the enrollee. We identified the primary surgeon using modifier codes in the claims data. We assumed that the enrollee would be a patient of the primary surgeon, or have been referred to that surgeon in advance of the nonemergency admission or visit, and therefore have had the opportunity to determine the network status of the surgeon.

The data summaries allowed CHBRP to estimate average OON professionals’ billed charges and average plan/insurer payments (noncontracted effective rates) as well as associated enrollee cost

²⁵ Were plans/insurers to refuse some such OON professional charges, some portion of OON professional charges would be absent from the claims data. However, based on the data summaries and plans/insurer responses to CHBRP’s survey, CHBRP believes that the claims data is reasonably complete for the enrollees whose health insurance would be subject to AB 533.

sharing. The billed charge, less plan/insurer payments and less cost sharing, was used to calculate the potential balance bill.

The claims analysis described above was the primary source for CHBRP's estimate of the percentage of the total claims dollars for an insured population that are associated with these surprise claims. Because it is difficult to identify claims as being "surprises" in a retrospective claim review, CHBRP also asked the surveyed carriers for their estimates of this percentage. Although the carriers were asked to base their estimate on their recent claims experience, CHBRP understands that they faced the same challenge as with the MarketScan analysis because carrier claims data would not identify specific claims as meeting the AB 533 criteria. Although some of the carrier responses were of the same magnitude as the MarketScan analysis, others were materially different and could have been due to a different interpretation of the survey question than intended. As a result, CHBRP was unable to use the weighted average of the carrier responses to inform this particular assumption. CHBRP notes that the primary purpose of the carrier survey is to assess the level of coverage premandate. Survey questions occasionally cover other aspects of the premandate insurance market, such as utilization and unit cost levels, but these assumptions are primarily based on data not provided directly by the carriers.

CHBRP's overall assumption was that these surprise claims represent about 1.5% of total allowed claims for plans with an OON benefit and 0.4% of total allowed claims for plans without an OON benefit. The 1.5% assumption for plans with an OON benefit was consistent with the average carrier response for this type of plan, and higher than the 0.7% value suggested by the MarketScan data analysis.

For plans without an OON benefit, the MarketScan data analysis suggested an assumption of 0.2%. The average carrier response for this type of plan was significantly higher than this, and also much higher than the carrier estimate of plans with OON benefits. CHBRP used a conservative 0.4% estimate in the data analysis.

The relationship between the average in-network and OON effective payments and the Medicare allowed payments was estimated using the MarketScan data. MarketScan data does not include billed amounts, so did not allow a direct estimate of the relationship between OON effective payments and billed amounts. CHBRP estimated this relationship based on an analysis of Milliman's Health Cost Guidelines Contributor claims database.

Average premandate and postmandate plan/insurer payments were then compared with Medicare rates to establish the effective "percent of Medicare" the payments would represent (see Table 2).

Determining Public Demand for the Proposed Mandate

This subsection discusses public demand for the benefits AB 533 would mandate. Considering the criteria specified by CHBRP's authorizing statute, CHBRP reviews public demand for benefits relevant to a proposed mandate in two ways. CHBRP:

- Considers the bargaining history of organized labor; and
- Compares the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

On the basis of conversations with the largest collective bargaining agents in California, CHBRP concluded that unions currently do not include prohibitions against balance billing or standardized rates for OON professionals associated with an in-network facility encounter in their health insurance

negotiations. In general, unions negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and broad coinsurance levels.

Among publicly funded self-insured health insurance policies, the PPO plans offered by CalPERS currently have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask carriers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

COMMITTEES AND STAFF

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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Please direct any questions concerning this document to:

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP Faculty Task Force comprises rotating representatives from six University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis.

CHBRP staff coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature.

CHBRP is also grateful for the valuable assistance of its National Advisory Council, who provide expert reviews of draft analyses and offer general guidance on the program. CHBRP is administered by the UC Health Division of the University of California, Office of the President, a division led by John D. Stobo, MD, Executive Vice President.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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