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Analysis of California Assembly Bill 1611: Emergency Services

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California Health Benefits Review Program

Limited/Fiscal Impact Analysis of California Assembly Bill 1611 Emergency Services

A Report to the 2019-2020 California State Legislature

April 17, 2019



Key Findings:

Analysis of California Assembly Bill 1611 Emergency Services

Summary to the 2019–2020 California State Legislature, April 17, 2019



CONTEXT

Over the last several decades, emergency departments (EDs) have become one of the main pathways through which patients are admitted to the hospital. From 1993 to 2006, the share of all inpatient stays in which patients were admitted to the hospital via an ED increased from 33.5% to 48.3%.¹ In 2016, 334 hospitals in California operated EDs, handling 14.6 million visits between them. A “surprise medical bill” is a bill from an out-of-network provider that was not expected by the patient or that came from an out-of-network provider not chosen by the patient. California already has protections in place against surprise billing by individual doctors that are not chosen by consumers but are out-of-network, like anesthesiologists. However, the law does not currently apply to entire hospitals that are out-of-network. The federal Affordable Care Act (ACA) does require health plans to cover out-of-network hospital emergency care at usual and customary rates (UCR), however, there are no specific standards as to what usual and customary should be.

BILL SUMMARY

AB 1611 would prohibit a hospital from billing a patient over and above his or her regular copay or deductible charges. AB 1611 also limits the amount that out-of-network hospitals could charge health plans for their fees to 150% of Medicare rates or the “average contracted rate” in the geographic area, whichever is higher. The patient would be financially obligated to pay the in-network benefit cost sharing. DMHC-regulated health policies already have such protections in place due to a State Supreme Court ruling. CDI-regulated policies and ERISA plans would be impacted as a result of AB 1611. Figure A notes how many Californians have health insurance that would be subject to AB 1611 and those with insurance that would be impacted by AB 1611.

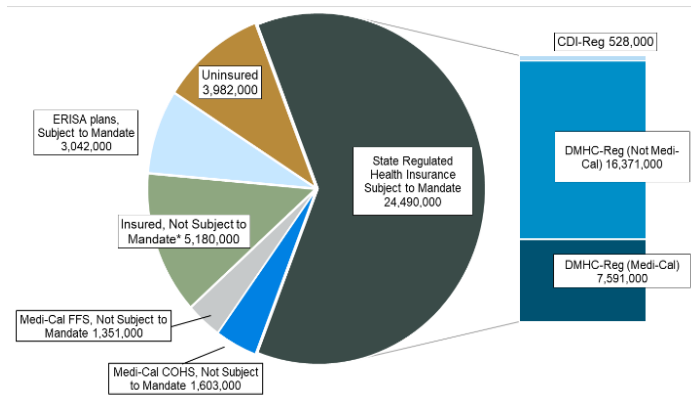
¹ Refer to CHBRP’s full report for full citations and references.

AT A GLANCE

California Assembly Bill (AB) 1611 would prohibit a hospital from billing a patient over and above regular copay or deductible charges and limits the amount that out-of-network hospitals could charge for their fees to 150% of Medicare rates or the “average contracted rate” in the geographic area, whichever is higher. The bill’s impacts apply to policies regulated by the California Department of Insurance (CDI) and plans regulated by the Employee Retirement Income Security Act (ERISA).

1. Currently, there are 24,490,000 enrollees with health insurance subject to state-level benefit mandates. 3,570,000 enrollees have health insurance subject to AB 1611’s provision on emergency services and post-stabilization care, and of these, 3,042,000 enrollees have health insurance through a self-funded employer or ERISA plan.
2. **Benefit coverage.** Postmandate, 100% of enrollees would continue to have health insurance that is fully compliant with AB 1611. There is no change in benefit coverage.
3. **Utilization.** No change in utilization is expected. At baseline, CHBRP estimates 18,300 cases in which only an emergency room visit occurred and 6,600 cases in which both an emergency room visit and inpatient admission occurred. The average cost for an enrollee who visits an emergency department and has inpatient admission is \$82,459 (\$13,474 from the plan share, \$59,281 from total member share, and \$9,704 from member/hospital negotiation).
4. **Expenditures.** AB 1611 would decrease total net annual expenditures by \$357,608,000 or 0.1921% for enrollees with CDI-regulated policies.
5. **Long-term impacts.** The bill is likely to prevent medical debt for a number of patients. AB 1611 may alter hospital and health plan contracting practices, potentially generating long-term savings on health plan premiums. CHBRP is unable to estimate potential service or financial impacts to hospitals.

Figure A. Health Insurance in CA and AB 1611



Source: California Health Benefits Review Program, 2019.

Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Benefit Coverage, Utilization, and Cost

Milliman’s Commercial Consolidated Health Cost Guidelines Sources Database (CHSD) claims and enrollment data for California in 2016 were used to quantify the number of visits, utilization, and costs associated with ED visits and admissions. There is no change in benefit coverage. However, unit costs (hospital charges would drop) and enrollee out-of-pocket costs would decrease.

Benefit Coverage

Currently, there are 24,490,000 enrollees with health insurance subject to state-level benefit mandates. AB 1611, however, is expected to impact ERISA plans, as well as state-regulated plans. 3,570,000 enrollees have health insurance subject to AB 1611’s provision on emergency services and post-stabilization care (CDI and ERISA), and of these, 3,042,000 enrollees have health insurance through a self-funded employer or ERISA plan.

Utilization

At baseline or premandate among CDI and ERISA enrollees, CHBRP estimates that there are 18,300 cases

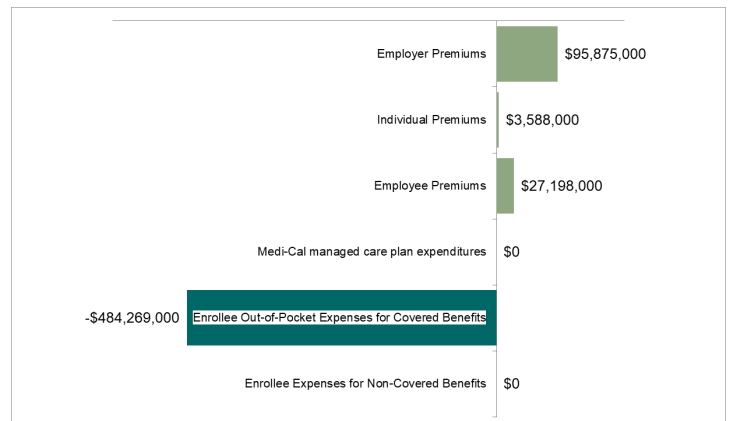
in which only an emergency room visit occurred and 6,600 cases in which both an emergency room visit and inpatient admission occurred.

Expenditures

The average cost for an enrollee who only visits an ED is \$9,551 (\$1,108 from the plan share, \$7,183 from total member share, and \$1,260 from member/hospital negotiation). The average cost for an enrollee who visits an ED and has inpatient admission is \$82,459 (\$13,474 from the plan share, \$59,281 from total member share, and \$9,704 from member/hospital negotiation). Postmandate, CHBRP estimates that costs would decrease to \$3,226 and \$28,351, respectively.

AB 1611 would decrease total net annual expenditures by \$357,608,000 or 0.1921% for enrollees with ERISA-regulated plans and CDI-regulated policies. This is due to a change in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a decrease in enrollee expenses for covered benefits. Table 1 shows the projected impact for all state-regulated enrollees as well as ERISA Plans.

Figure B. Expenditure Impacts of AB 1611



Source: California Health Benefits Review Program, 2019.

DMHC-Regulated Plans

CHBRP projects no impact to DMHC due to a unanimous State Supreme Court ruling, the Court held that non-contracting ER physicians — and, by implication, certain other non-contracting emergency services providers — may not balance bill HMO beneficiaries. Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, 45 Cal. 4th 497, 502 (2009).

Medi-Cal

CHBRP projects no impact to Medi-Cal.

CalPERS

No impact to CalPERS HMO Plans is projected. Total self-funded premium expense increase includes \$1,262,000 for CalPERS self-insured enrollees. Total reduction in enrollee expenses includes a \$22,472,000 decrease for CalPERS self-insured enrollees.

Number of Uninsured in California

No measureable impact projected.

Public Health

Because a public health impacts analysis was not requested by the Legislature, estimating how these long-term effects could potentially impact public health (including economic loss, increased mortality, racial and ethnic disparities, and gender disparities) is beyond the scope of this report. However, in previous reports, CHBRP has identified literature that clearly shows cost sharing and financial barriers can have the unintended impact of delaying necessary care.

Long-Term Impacts

Debt is clearly an increasingly important category of socioeconomic experience (Seifer, 2004). The bill is likely to prevent potential indebtedness to a number of patients.

In addition to regular medical debt, surprise billing has resulted in a number of Americans experiencing high debt. This may have public health implications. Health care providers are increasingly relying on collection agencies to recoup charges associated with medical care. Little is known about the prevalence of this practice in low-income communities and what effect it has on health-seeking behavior.

A recent study suggests that hospitals currently use high out-of-network emergency service prices to pressure health plans in contracting efforts. Hospitals set high out-of-network prices for emergency services, knowing that they will care for (because of geography) a substantial number of a health plan's enrollees accessing care through admission from the ER. This gives hospitals leverage with health plans to include them in a network, even if prices for their other hospital services are not as competitive as alternatives in a local market. This, along with other practices, such as requiring plans to contract with all or none of the hospitals in a chain, may undermine the ability of health plans to use selective contracting with health care facilities. To the extent that AB 1611 may alter such practices, this legislation may offer savings over the long term on health plan premiums in California.

CHBRP is unable to measure the impact on hospitals service offerings or contracting strategies in light of revenues being shifted away from hospitals by AB 1611.

A Report to the California State Legislature

Limited/Fiscal Impact Analysis California Assembly Bill 1611
Emergency Services

April 17, 2019

California Health Benefits Review Program
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ABOUT CHBRP

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

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses 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. 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, authorizing statute, as well as all CHBRP reports and other publications are available at www.chbrp.org.

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Table 1. AB 1611 Impacts on Benefit Coverage, Utilization, and Cost, 2020

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Benefit coverage				
Total enrollees with health insurance subject to AB 1611	27,532,000	27,532,000	0	0%
Total enrollees with health insurance subject to state-level benefit mandates (a)	24,490,000	24,490,000	0	0%
Total enrollees with health insurance subject to state-level benefit mandates impacted by AB 1611 (CDI plans)	528,000	528,000	0	0%
Total enrollees with health insurance through a self-funded employer or ERISA plan impacted by AB 1611	3,042,000	3,042,000	0	0%
Total enrollees with health insurance impacted by AB 1611	3,570,000	3,570,000	0	0%
Utilization and unit cost				
Number of out-of-network emergency department visits				
Emergency department visits only	18,300	18,300	0	0%
Emergency department visit with inpatient admission	6,600	6,600	0	0%
Average cost per enrollee using services				
Emergency department visits only (b)	\$9,551	\$3,226	-\$6,325	-66%
Plan share	\$1,108	\$2,938	\$1,830	165%
Total member share	\$7,183	\$288	-\$6,895	-96%
Member cost share (deductibles, copays, coinsurance, etc.)	\$109	\$288	\$179	164%
Balance billing	\$7,074	\$0	-\$7,074	-100%
Emergency department visit with inpatient admission (b)				
Emergency department visit with inpatient admission (b)	\$82,459	\$28,351	-\$54,108	-66%
Plan share	\$13,474	\$25,821	\$12,347	92%
Total member share	\$59,281	\$2,531	-\$56,750	-96%
Member cost share (deductibles, copays, coinsurance, etc.)	\$1,321	\$2,531	\$1,210	92%
Balance billing	\$57,960	\$0	-\$57,960	-100%

Expenditures				
<u>Premium expenditures by payer</u>				
Private employers for group insurance – fully insured	\$86,438,375,000	\$86,448,949,000	\$10,574,000	0.0122%
CalPERS HMO employer expenditures (d)	\$3,098,551,000	\$3,098,551,000	\$0	0.0000%
Medi-Cal Managed Care Plan expenditures (e)	\$28,492,273,000	\$28,492,273,000	\$0	0.0000%
Enrollees for individually purchased insurance	\$12,045,324,000	\$12,048,912,000	\$3,588,000	0.0298%
Individually purchased – outside exchange	\$2,486,222,000	\$2,487,729,000	\$1,507,000	0.0606%
Individually purchased – Covered California	\$9,559,102,000	\$9,561,183,000	\$2,081,000	0.0218%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (c)	\$14,476,394,000	\$14,480,328,000	\$3,934,000	0.0272%
Private employers for group insurance – self-funded (g)	\$19,403,096,000	\$19,488,397,000	\$85,301,000	0.4396%
Enrollees with group insurance – self-funded (g)	\$5,291,983,000	\$5,315,247,000	\$23,264,000	0.4396%
<u>Enrollee expenses</u>				
Enrollee out-of-pocket expenses for covered benefits (deductibles, copayments, etc.)	\$16,900,836,000	\$16,416,567,000	-\$484,269,000	-2.8654%
Enrollee expenses for noncovered benefits (f)	\$0	\$0	\$0	0.00%
Total expenditures	\$186,146,832,000	\$185,789,224,000	-\$357,608,000	-0.1921%

Source: California Health Benefits Review Program, 2019.

Notes: (a) This population includes persons with privately funded 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 employment-sponsored insurance.

(b) Is not equal to the total of plan share and member cost share due to assumed negotiations from balance billing.

(c) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(d) Of the increase in CalPERS employer expenditures, about 55.1% or \$696,000 would be state expenditures for CalPERS members who are state employees or their dependents. It should be noted that should CalPERS choose to make similar adjustments for consistency to the benefit coverage of enrollees associated with CalPERS' self-insured products, the fiscal impact on CalPERS could be greater.

(e) Does not include enrollees in COHS.

(f) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. In addition, this only includes those expenses that would be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance

(g) Self-funded employer plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA) and are not subject to state-level benefit mandates. For AB 1611, CHBRP does believe ERISA-plans would be subject due to provisions on hospitals.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations;

CDI = California Department of Insurance; DMHC = Department of Managed Health; COHS = County Operated Health Systems;

ERISA = Employee Retirement Income Security Act of 1974

POLICY CONTEXT & BACKGROUND

On February 25, 2019, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct an evidence-based fiscal assessment of the impacts of Assembly Bill (AB) 1611: Emergency Services. Per the Committee's request, CHBRP focused on fiscal and policy analysis and thus did not conduct a medical effectiveness or public health analysis. AB 1611 would prohibit a hospital from billing a patient over and above his or her regular copay or deductible charges and also limits the amount that out-of-network hospitals could charge for their fees to 150% of Medicare rates or the "average contracted rate" in the geographic area, whichever is higher. For the purposes of this section, "average contracted rate"² means the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. AB 1611 would prohibit hospitals from balance billing the patient for charges in excess of the mandated rate. The patient would be financially obligated to pay the in-network benefit cost sharing. DMHC-regulated health policies already have such protections in place. CDI-regulated policies and Employee Retirement Income Security Act of 1974 (ERISA) plans would be impacted by AB 1611.

Background

From the 1970s through the 1990s, care in hospital-based emergency departments (EDs) in the United States shifted from being provided on an ad hoc basis by community physicians to being delivered, round-the-clock, by doctors who often completed emergency medicine residencies and obtained board-certification in the specialty (IOM, 2006). Over the last several decades, EDs have become one of the main pathways through which patients are admitted to the hospital (Morganti et al., 2013). From 1993 to 2006, the share of all inpatient stays in which patients were admitted to the hospital via an ED increased from 33.5% to 48.3% (Schuur and Venkatesh, 2012).

In the aggregate, ED care is profitable for hospitals. Wilson and Cutler (2014) estimated that average ED profit margins are approximately 7.8% per patient. However, the profit margins that hospitals face for ED care vary significantly depending on how a patient's care is funded and based on whether a patient is admitted to the hospital. Wilson and Cutler (2014) found that hospitals had profit margins of 39.6% for privately insured patients treated in EDs, whereas the profit margin for patients covered by Medicare and Medicaid and those uninsured was -15.6%, -35.9%, and -54.4%, respectively. They also found that patients who were admitted to the hospital were significantly more profitable than those who were not. In addition, hospital profitability varies by visit acuity. Henneman et al. (2014) found that commercial insurance pays 1,256% more for level 5 visits than level 1 (\$1,281 versus \$102).

In 2016, 334 hospitals in California operated EDs, handling 14.6 million visits between them (CHCF, 2018).

Because a public health impacts analysis was not requested by the Legislature, estimating how these long-term effects could potentially impact public health (including economic loss, increased mortality, racial and ethnic disparities, and gender disparities) is beyond the scope of this report. However, in previous reports, CHBRP has identified literature that clearly show cost sharing and financial barriers can have the unintended impact of delaying necessary care (CHBRP, 2012, 2014).

² The "Average Contracted Rate" is a defined calculation in both the Health & Safety Code and Insurance Code: Health & Safety Code: A shortened url was created to provide the link: <http://tinyurl.com/yyxc9gsf>. The Insurance Code calculation may be found at: <http://tinyurl.com/y2lo2o26>.

According to a recent study from the Kaiser Family Foundation, more than a quarter of adults in the United States report that, within the past year, they or someone in their household have had challenges paying medical debt. This includes 20% of individuals under the age of 65 who are insured. Notably, 51% of insured individuals reported owing sums over \$5,000 (Hamel et al., 2016).

In addition to regular medical debt, surprise billing has resulted in a number of Americans experiencing high debt (Hamel et al., 2016). This may have public health implications. One recent study examined associations between foregone medical care and debt using a population-based sample of 914 southeastern Michigan residents surveyed in the wake of the late-2000s recession. Overall debt and ratios of debt to income and debt to assets were positively associated with foregoing medical or dental care in the past 12 months, even after adjusting for the poorer socioeconomic and health characteristics of those foregoing care and for respondents' household incomes and net worth. These overall associations were driven largely by credit card and medical debt, while housing debt and automobile and student loans were not associated with foregoing care (Kalousova et al., 2013). Foregoing necessary care may lead to higher health care costs and reduced health status (Chen et al., 2011).

Health care providers are increasingly relying on collection agencies to recoup charges associated with medical care. Little is known about the prevalence of this practice in low-income communities and what effect it has on health-seeking behavior (O'Toole et al., 2004). O'Toole et al. (2004) also found that aggressive debt retrieval for medical care appears to be indiscriminately applied with a negative effect on subsequent health-seeking behavior among those least capable of navigating the health system.

Outcomes for Seeing Out-of-Network Emergency Departments

When an insured patient sees an out-of-network ED, there are two potential outcomes:

- First, the insurer may pay the hospital's out-of-network bill in its entirety. This will protect the patient, but ultimately insurers will pass the cost of these higher payment rates on to all beneficiaries in the form of higher premiums. In addition, patients generally face higher co-insurance rates when they see an out-of-network provider. As a result, even if their insurer pays the hospital's charge, the patient may still face substantial cost sharing.
- Second, when an out-of-network hospital's billed charge is more than the noncontracted effective rate (what the plan/insurer will pay an out-of-network hospital, a payment based on negotiation or internal-to-the-plan/insurer benchmarks), the hospital may seek the difference, or balance of the bill, from the enrollee. This practice is called "balance billing" (Fedor, 2006; Pao et al., 2014).

Surprise Medical Bills

A "surprise medical bill" is a bill from an out-of-network provider or facility that was not expected by the patient or that came from an out-of-network provider not chosen by the patient (Garmon and Chartock, 2017). Surprise medical bills cause financial anxiety and have been linked to unavoidable medical debt (Hamel et al., 2017). California already has protections in place against surprise billing by individual doctors that are not chosen by consumers but are out-of-network, like anesthesiologists. However, the law does not currently apply to entire hospitals that are out-of-network. CHBRP provided analysis of AB 533, which contained many similar elements as AB 72, enacted in 2016.³

³ AB 72 was enacted into law in 2016. That same year, CHBRP analyzed a related bill, AB 533. AB 533 (Bonta) would have required DMHC and CDI to establish a binding Independent Dispute Review Process (IDRP) for claims

Existing Patient Protections in California

Though the federal Affordable Care Act (ACA) does require health plans to cover out-of-network hospital emergency care at usual and customary rates (UCR), there are no specific standards as to what usual and customary should be. Often plans set their UCR much lower than what a hospital charges leaving patients open to liability for the remainder of the charges.

For most enrollees in DMHC-regulated plans and CDI-regulated policies (as well as ERISA Plans), health professionals and facilities are categorized as in-network or out-of-network. 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).

In January 8, 2009, the California Supreme Court (Court) issued its decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et al.* This case raised the issue of whether emergency room (ER) physicians who have not contracted with a health maintenance organization (HMO) may bill the HMO's members for the balance of the physicians' billed charges that were not paid by the HMO. This practice is known as "balance billing." In a unanimous ruling, the Court held that non-contracting ER physicians — and, by implication, certain other non-contracting emergency services providers — may **not** balance bill HMO beneficiaries. *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497, 502 (2009). This ruling is why CHBRP assumes that AB 1611 would not impact DMHC-regulated plans.

Under the Knox-Keene Health Care Service Plan Act of 1975 ("Act"), insured individuals are only responsible for costs equal to what they would pay if they received the service from an in-network provider.⁴ Further, out-of-network providers are prohibited from billing or collecting any amount from the enrollee for their services except for the in-network cost-sharing amount.⁵

However, there are carve-outs. The billing limitations do not apply if the enrollee has a healthcare service plan that pays for out-of-network services.⁶ Moreover, the Act does not extend protections to all services provided by out-of-network providers. For example, healthcare service plans do not need to cover services that are not required by the plan or by law.⁷ Additionally, the provisions do not apply to Medi-Cal managed healthcare service plans, to certain contracts with the State Department of Health Care

for non-emergency covered services provided at contracted health facilities by a non-contracting health care professional. AB 533 would have limited enrollee and insured cost sharing for these covered services to no more than the cost sharing required, had the services been provided by a contracting health professional. AB 533 also would have required the plan or insurer to 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 geographic area in which the services were rendered. The most significant difference between AB 533 and AB 72 was the payment standard. AB 533 would have set the payment standard at the Medicare payment rate. AB 72 set it at the greater of 125% of Medicare or average contracted rates of each health plan based on a single benchmark year with an annual adjustment equal to the consumer price index for medical care services. In addition to this higher payment standard, AB 72 allows non-contracted individual health professionals to receive assignment of benefits, which requires the health plan or insurer to make payment directly to the provider rather than issuing payment to the patient who in turn pays the provider. AB 72 allows either party to pursue legal remedies if dissatisfied with the Independent Dispute Review process (IDRP). AB 533 failed passage on the Assembly Floor.

⁴ Cal. Health & Safety Code § 1371.9(a)(1).

⁵ Cal. Health & Safety Code § 1371.9(a)(3).

⁶ Cal. Health & Safety Code § 1371.9(c).

⁷ Cal. Health & Safety Code § 1371.9(g).

Services for public social services, or to emergency services and care.⁸ To ensure that patient services are not compromised, however, the Act does require health plans to meet existing network adequacy requirements, including but not limited to inpatient hospital and specialist physician services.⁹

In 2016, California also passed legislation protecting commercially insured patients from balance billing by out-of-network clinicians furnishing nonemergency services at an in-network facility or having to pay their health plan any more for that service than they would have paid for an in-network clinician for the same service. Unlike the California law governing out-of-network emergency services, this legislation (AB 72), which became effective on January 1, 2017, specifies that out-of-network clinicians furnishing *nonemergency* services can bill insurers the greater of either the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services are provided.

California already has protections in place against surprise billing by individual doctors that are not chosen by consumers but out-of-network, like anesthesiologists. However, the law does not currently apply to emergency care at entire hospitals that are out-of-network. Surprise medical bills cause financial anxiety and have been linked to unavoidable medical debt (Hamel et al., 2016).

Self-Funded Health Insurance

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. ERISA requires plans to provide participants with plan information including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty.¹⁰

In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers' compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans. Large employers often self-insure. In addition, smaller and midsize firms have increasingly chosen to self-insure (SHRM 2016)¹¹, which means the health insurance they offer employees and retirees (as well as dependents) is subject only to federal law.¹² 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

⁸ Cal. Health & Safety Code § 1371.9(j)(k).

⁹ Cal. Health & Safety Code § 1371.31(a)(5).

¹⁰ There have been a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries. One important amendment, the Consolidated Omnibus Budget Reconciliation Act (COBRA), provides some workers and their families with the right to continue their health coverage for a limited time after certain events, such as the loss of a job. Another amendment to ERISA is the Health Insurance Portability and Accountability Act (HIPAA) which provides important protections for working Americans and their families who might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health. Other important amendments include the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, the Women's Health and Cancer Rights Act, the Affordable Care Act, and the Mental Health Parity and Addiction Equity Act.

¹¹ Further information on employer self-insurance trends may be accessed at: <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/self-insurance-aca.aspx>.

¹² Employee Retirement Income Security Act of 1974 (ERISA).

regulations setting rates and cost sharing, and prohibiting balance billing when an out-of-network professional is involved with an in-network facility encounter. As of 2015, the DOL has not enacted any prohibitions regarding balance billing (Silas and Bell, 2015). A few other states have enacted Legislation related to surprise medical bills, but none of these state laws protect individuals who are in self-insured plans, which are regulated under ERISA.

Similar requirements in other states

Most states do not have laws that directly protect consumers from balance billing by an out-of-network provider for care delivered in an ED or in-network hospital. Of the 25 states offering protections, only nine have a comprehensive approach to safeguarding consumers in both settings, and gaps remain even in these states (Hoadley et al., 2019).

State laws also vary in their approach to restricting balance billing. Some *prohibit balance billing by providers*, others *require insurers to hold enrollees harmless* from balance-billing charges by paying the entire charge if necessary, and some do both. In states that have adopted both approaches, out-of-network providers are directly prohibited from balance billing consumers for additional charges beyond what the health plan pays. In addition, insurers must guarantee that the consumer is held harmless from, and is not liable for, balance-billing charges (Lucia et al., 2017).

Some laws include *payment standards* to ensure that providers are compensated fairly. Certain states, for example, require insurers to pay out-of-network providers at a set percentage of Medicare rates or at “usual and customary rates.” Other states require providers and insurers to engage in a *dispute resolution process* for settling payment rate issues, with some requiring that the enrollee be held harmless. Most states that include dispute resolution processes find they are rarely used, though an incentive may be offered for parties to negotiate. Some state laws provide further protections:

Federal Requirements

In addition to the ACA requirements described above, 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 1611.

Potential Federal Activity

There appears to be bipartisan interest in the surprise billing issues in Congress, offering potential for federal action. States are limited in their inability to address all insurance plans. States without laws have often faced opposition from stakeholder groups, even when there is a consensus around protecting consumers. A federal solution may offer a more comprehensive approach, while giving states appropriate flexibility to seek an approach fitting their particular market environments (Hoadley et al., 2019).

The U.S. House of Representatives held a hearing on the issue of surprise medical billing on April 2, 2019. The hearing explored the scope of the problem and what types of policy solutions would be best to fix it. The hearing was convened by a subcommittee of Education and Labor, which has jurisdiction over some of the key laws that regulate surprise medical bills.

During the 115th Congress, proposals were released by Senator Bill Cassidy (R-La.)¹³, Senator Maggie

¹³ [https://www.cassidy.senate.gov/imo/media/doc/Discussion Draft- Protecting Patients from Surprise Medical Bills Act.pdf](https://www.cassidy.senate.gov/imo/media/doc/Discussion+Draft+-+Protecting+Patients+from+Surprise+Medical+Bills+Act.pdf). The draft legislation includes three important components that would jointly protect consumers from surprise medical bills:

Hassan (D–N.H.)¹⁴, Representative Lloyd Doggett (D–Texas)¹⁵, and Representative Michelle Lujan Grisham (D–N.M.)¹⁶. The Cassidy proposal has bipartisan support, with three Democrats and two other Republicans as cosponsors.¹⁷

Federal approaches vary along some of the same lines as state laws. For example, the Hassan bill relies most heavily on a dispute-resolution approach. By contrast, the Cassidy proposal relies on a payment standard that is the greater of a) the median in-network rate paid by the insurer or b) 125% of the average allowed amount across payers. Several federal proposals make protections contingent on failure of providers to notify the consumer that they could be billed by an out-of-network provider. States that have enacted protections have mostly viewed such contingent protections as an insufficient means of protecting consumers. Federal proposals also vary in the degree to which they allow a state role in implementing protections.

Some federal proposals, like some state laws, have potential gaps. For example, some address balance bills only from hospital-based physicians such as anesthesiologists and radiologists. Also, state laws and federal proposals mostly do not address ground or air emergency transport providers.¹⁸

Limiting patient cost sharing to the amount they would owe to an in-network provider; Setting a payment standard regarding what insurers owe providers in these situations; and, prohibiting providers from balance billing patients. The legislation would address the two main situations in which surprise out-of-network bills frequently arise:

Out-of-network emergency care; and out-of-network care, typically from ancillary physicians, delivered at an in-network facility (e.g., a hospital or ambulatory surgical center). Additionally, once a patient is stabilized following emergency care at an out-of-network facility, the patient must be notified about the potential for higher cost-sharing if they remain at the current facility and provided the option to transfer to an in-network facility. Critically, the bill's protections would automatically kick in when either of these two situations occur, without the patient having to take any action. The patient would be required only to pay the standard amount they would have owed if the service in question was performed by an in-network physician and balance billing would be prohibited. The patient's health plan, then, would have to pay the provider an amount determined by the state (or locality) in which the service was performed. If a state does not elect a payment methodology, then the federal default would require the health plan to pay (less the patient cost-sharing amount) the greater of: The median in-network contracted rate for the service in a specified geographic area (the draft legislation does not specify from which data this median rate would be calculated); or 125% of the average allowed amount for the service in a specified geographic area, as determined by the most recent year of data available from a "statistically significant benchmarking database maintained by a nonprofit organization," such as FAIR Health, Health Care Cost Institute, or a state's all-payer claims database if administered by a nonprofit.

¹⁴ <https://www.congress.gov/bill/115th-congress/senate-bill/3592>

¹⁵ <https://www.congress.gov/bill/115th-congress/house-bill/817>

¹⁶ <https://www.congress.gov/bill/115th-congress/house-bill/3877>

¹⁷ <https://www.healthaffairs.org/doi/10.1377/hblog20190221.859328/full/>

¹⁸ CHBRP has completed a 2019 analysis of AB 651 (Grayson), Air Ambulances, as introduced on February 15, 2019. Available at http://chbrp.org/completed_analyses/index.php.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 1611 would prohibit hospitals from charging payers out of network the greater of 150% of Medicare or the average contracted rate paid by the health plan for out-of-network emergency services and post-stabilization care. Hospitals would not be allowed to balance bill the patient for charges in excess of the mandated rate. The patient would be financially obligated to pay the in-network benefit cost sharing. DMHC-regulated health plans already have similar protections in place. CDI-regulated policies and ERISA policies would be impacted as a result of this mandate.

This section reports the estimated incremental impacts of AB 1611 on emergency services benefit coverage, utilization, and overall cost. For the purposes of describing AB 1611's impact, CHBRP has used the following terms and definitions:

- **Billed charge:** The amount billed for services by providers. Health plans have contracts with in-network providers to pay an agreed upon "allowed charge" which is usually lower than the billed charge. Health plans generally only pay out-of-network providers a portion of their billed charges. Billed charges are typically higher than in-network rates, out-of-network effective rates, or local Medicare rates.
- **In-network rate:** The total amount paid for a service by a plan/insurer and a patient (cost sharing) to in-network providers. The amount is based on contracts between the provider and the health plan/insurer and dictates the plan/policy requirements regarding enrollee cost sharing.
- **Out-of-network effective rate:** The total amount the plan/insurer defines to be appropriate for the out-of-network service. The amount is then shared between the plan's payment and the enrollee cost sharing. There is no contract with these providers. The plan pays a specified amount. The enrollee is responsible for the out-of-network cost sharing and any amounts balance billed by the provider.
- **Balance bill:** This term refers to the practice of providers billing enrollees for the difference between the billed charge and the amount paid by the health plan or the amount paid as cost sharing. This is the amount a provider may send as a bill directly to a patient. Balance billing is typically not allowed for in-network providers.
- **Medicare rate:** The total amount paid for a service according to the Medicare Fee Schedule, which is set by the federal government. Local Medicare rates can vary by region due to geographic and overhead factors.

Emergency department (ED) and stabilization care services were identified for the California commercial population in Milliman Consolidated Health Cost Guidelines™ Sources Database (CHSD). The Milliman research category "Outpatient Facility – Emergency Room" was used to identify ED visits. ED visits with stabilization care were also identified using the "Inpatient Facility" Milliman research categories that had an emergency room revenue code. CHBRP included the cost of professional or physician services in the total ED visit. Based on the current bill language, it is unclear whether or emergency transport is subject to the provisions in this bill.¹⁹ CHBRP did not include emergency transport in this analysis.

The ED visits were summarized separately by in-network and out-of-network at the Metropolitan Statistical Area (MSA) level of detail. In the baseline calculations, CHBRP assumed that the average total cost of out-of-network emergency services is the total billed charge. CHBRP assumed the out-of-network

¹⁹ This was also the opinion of DMHC. Personal Communication, M Karshtedt, DMHC, April 2019.

effective rate is the average allowed amount for out-of-network services. The out-of-network effective rate includes both the payer and patient cost sharing. The difference between the average billed charge and the average allowed is the balance bill amount in the baseline calculation. CHBRP assumed that one-third of enrollees with a balance bill charge will negotiate their balance bill and will be financially responsible for a rate of 50% of the total balance bill. This assumption is applied multiplicatively to the average balance bill charge. The remaining two thirds of enrollees are assumed to be financially responsible for the full balance bill amount.

As discussed in the Policy Context and Background section, a significant percentage of enrollees may have difficulty paying medical bills and debts. This analysis estimates the patient payment responsibility. Given limited sources of reliable or comparable data, CHBRP did not attempt to model the amounts collected by the provider or the number of enrollees declaring bankruptcy resulting from an out-of-network balance bill. The enrollee out of pocket expenses presented in this analysis are the patient payment responsibility if the patient were able to pay the amount charged by their emergency services provider.

In the postmandate calculation, the total cost of emergency room services is assumed to be the in-network average allowed charge by MSA weighted by the out-of-network utilization by MSA. CHBRP applied the greater of the average contracted rate or 150% of Medicare. The allowed charges were calculated as a percentage of Medicare basis applied multiplicatively to the state average to adjust for the regional severity variation.

CHBRP did not assume any change in the utilization of out-of-network ED services between the baseline and postmandate periods. Patients would continue to seek emergency care from in-network facilities whenever possible to ensure that their visit does not receive scrutiny over whether their condition necessitated an emergency. AB 1611 requires hospitals to charge no more than the in-network rate for emergency services. CHBRP did not assume that the in-network rate would increase or decrease as a result of the mandate.

It is possible that the hospital revenue lost from AB 1611 would be shifted to other facility services. It is also possible that hospitals would lose negotiating leverage on other facility services since the price of emergency services would be the in-network rate, causing a reduction in-network rates for all facility services (Melnick et al., 2018). Due to the complexity of network contracts, CHBRP did not assume cost shifting to or a reduction of the rates of other facility services that may occur as a result of AB 1611.

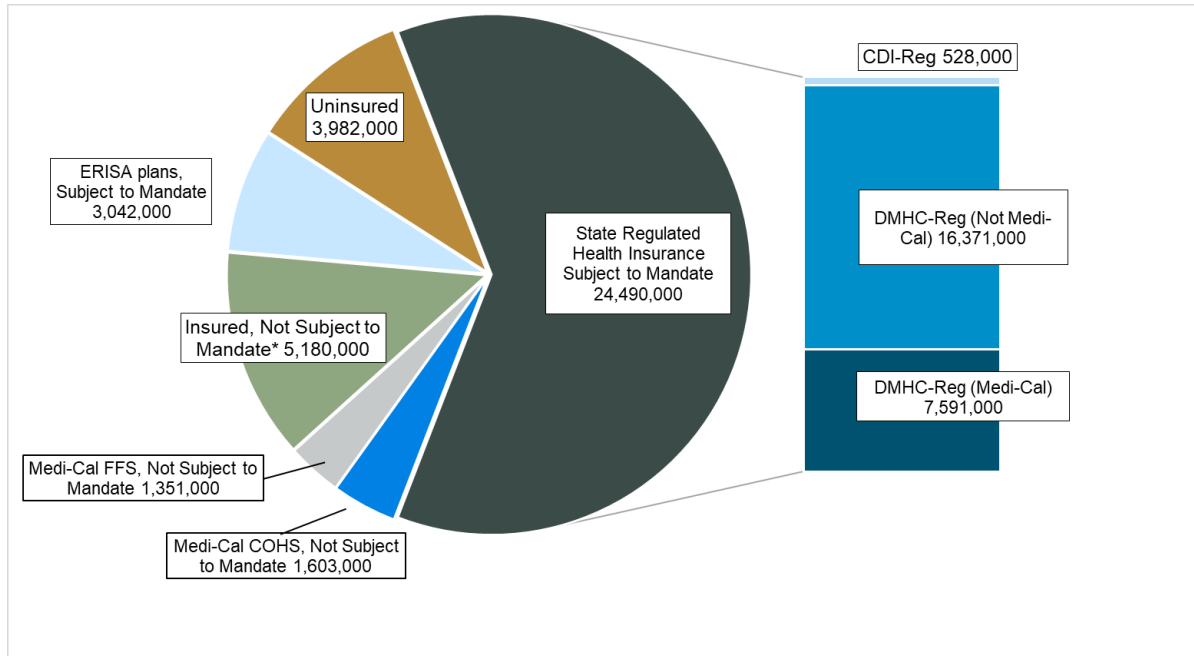
This section reports the potential incremental impacts of AB 1611 on estimated baseline benefit coverage, utilization, and overall cost. For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

Baseline and Postmandate Benefit Coverage

Currently, there are 24,490,000 enrollees with health insurance subject to state-level benefit mandates. There are an additional 3,042,000 enrollees that have health insurance through a self-funded or ERISA plan. Combining these two populations, there are a total of 27,532,000 enrollees with health insurance subject to AB 1611. Because DMHC plans already have emergency services balance billing protections in place and Medi-Cal is exempt, only CDI and ERISA plans are impacted by AB 1611. In total, there are 3,570,000 enrollees in CDI and ERISA plans impacted by AB 1611.

All enrollees have coverage for ED services in the baseline and postmandate periods. There are 3,570,000 enrollees who would no longer be subject to balance billing postmandate.

Figure 1. Health Insurance in CA and AB 1611



Source: California Health Benefits Review Program, 2019.

Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

Baseline and Postmandate Utilization

CHSD claims and enrollment data for California in 2016 were used to quantify the number of visits, utilization, and costs associated with ED visits and admissions. In 2020, CHBRP estimates 18,300 out-of-network ED visits followed by discharge and 6,600 visits followed by hospitalizations in California for the populations impacted by AB 1611. There would be no change in the utilization of emergency room services postmandate due to AB 1611.

Baseline and Postmandate Per-Unit Cost

Baseline costs per enrollee were estimated using CHSD claims and enrollment data for California in 2016. The average billed charge for an out-of-network ED visit followed by discharge is \$9,551. CHBRP estimates the out-of-network effective rate is \$1,217. Of this amount, \$1,108 will be paid by the plan and \$109 will be paid by the enrollee in the form of deductibles, copays, and coinsurances. The enrollee will also be charged, on average, an additional \$7,074 for balance billing. This results in the total member cost share of \$7,183. It is important to note that the plan share and the member share of cost does not fully recoup the cost of the ED visits because CHBRP assumed one-third of enrollees will be able to negotiate the balance bill to 50% of the balance bill charge.

The average billed charge for an out-of-network ED visit followed by an admission is \$82,459. CHBRP estimates the out-of-network effective rate is \$14,795. Of this amount, \$13,474 will be paid by the plan and \$1,321 will be paid by the enrollee in the form of deductibles, copays, and coinsurances. The enrollee will also be charged, on average, an additional \$57,960 for balance billing. This results in the total member cost share of \$59,281. Similar to the ED visit followed by discharge, the plan share and the

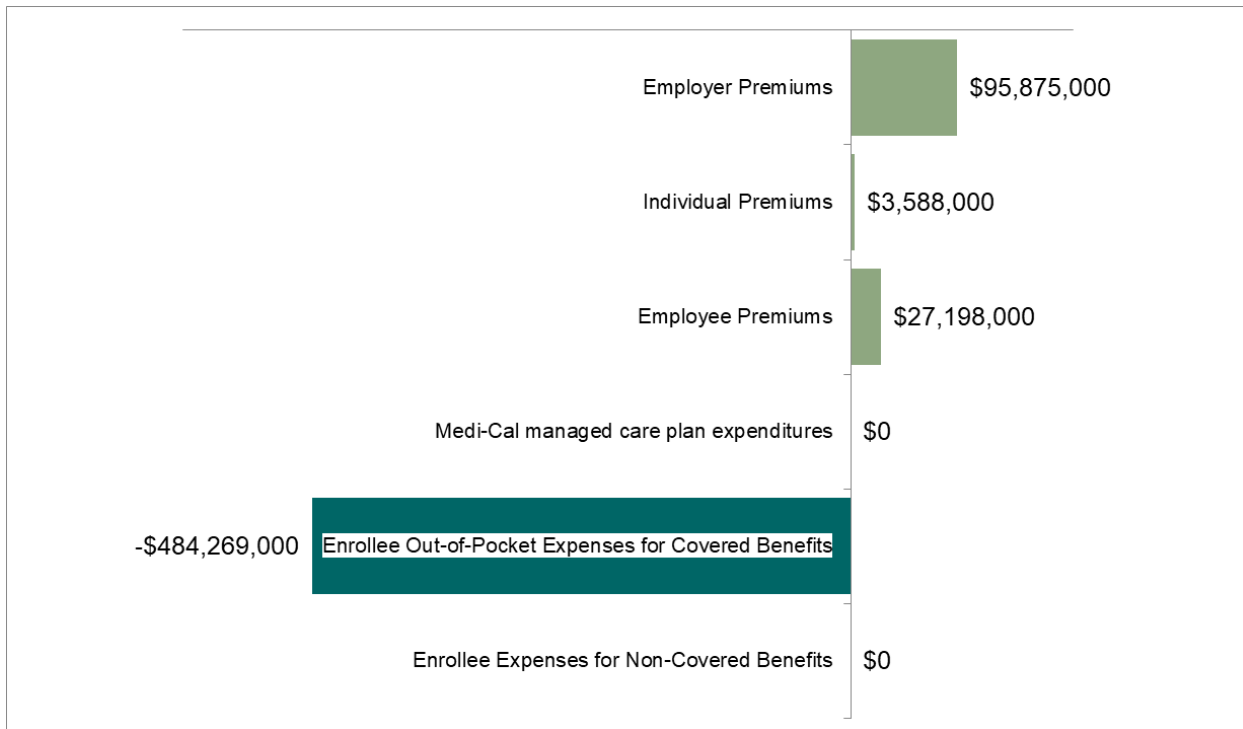
member share of cost does not fully recoup the cost of the ED visits because CHBRP assumed one-third of enrollees will be able to negotiate the balance bill to 50% of the balance bill charge.

Postmandate per-unit costs for ED visits with discharge and with admission would be \$3,226 (66% reduction) and \$28,351 (66% reduction), respectively. The per-unit costs postmandate would be equal to the average in-network rate. The plan cost share for the ED with discharge visits would increase 165% to an average of \$2,938 and the enrollee cost share due to deductibles, copays, coinsurance would increase 164% to \$288. These charges would increase because plans typically pay more for in-network contracts than the out-of-network effective rate to incentivize hospitals to join the network. The balance billing amount postmandate would be \$0, resulting in a total member cost share reduction of 96%. The plan cost share for the ED visits with admission is projected to increase 92% to an average of \$25,821 and the enrollee cost share due to deductibles, copays, coinsurance is projected to increase 92% to \$2,531. Due to the elimination of balance billing, the projected reduction in total enrollee cost share is 96%.

Baseline and Postmandate Expenditures

AB 1611 would decrease total net annual expenditures by \$357,608,000 or 0.1921% for enrollees with CDI-regulated policies and ERISA plans. This is due to an \$126,661,000 increase in total premiums in total health insurance premiums paid by employers and enrollees for out-of-network ED services becoming reimbursed at in-network average charges and a \$484,269,000 or 2.8654% decrease in enrollee expenses for out-of-network ED services.

Figure 2. Expenditures by Category Postmandate, AB 1611



Source: California Health Benefits Review Program, 2019.

Premiums

Changes in premiums as a result of AB 1611 would vary by market segment. Note that such changes are related to the number of enrollees with health insurance that would be impacted by AB 1611.

Among publicly funded DMHC-regulated health plans, there is no impact for DMHC-regulated enrollees associated with Medi-Cal Managed Care and with CalPERS.

Enrollee Expenses

AB 1611-related changes in enrollee expenses for covered benefits (deductibles, copays, etc.) and enrollee expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees with health insurance that would be subject to AB 1611 during the year after enactment. CHBRP estimates that the 3,570,000 CDI and ERISA regulated enrollees impacted by AB 1611 would see a reduction of \$484,269,000 or 2.8654% in expenses including deductibles, copayments, coinsurance, and the elimination of balance billing.

Out-of-Pocket Spending for Covered and Noncovered Expenses

Out-of-network ED services are a covered benefit in the baseline period. There is no change in the expenses of noncovered benefits.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons²⁰

Because the change in average premiums does not exceed 1% for any market segment (see Table 1) CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1611.

Changes in Public Program Enrollment

CHBRP estimates that there would be no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 1611.

²⁰ See also CHBRP's [Uninsured: Criteria and Methods for Estimating the Impact of Mandates on the Number of Individuals Who Become Uninsured in Response to Premium Increases \(December 2015\)](http://chbrp.com/analysis_methodology/cost_impact_analysis.php), available at http://chbrp.com/analysis_methodology/cost_impact_analysis.php.

LONG-TERM IMPACTS

Despite the growing significance of indebtedness in the economic lives of Americans and debt being an increasingly important category of socioeconomic experience, financial debt is largely neglected in research on social and economic determinants of health. The bill is likely to prevent potential indebtedness for a number of patients.

A recent study (Melnick et al., 2018) suggests that hospitals currently use high out-of-network emergency service prices to pressure health plans in contracting efforts. Hospitals set extremely high out-of-network prices for emergency services, knowing that they will care for (because of geography) a substantial number of a health plan's enrollees. This gives hospitals leverage with health plans to include them in a network, even if prices for their other hospital services are not as competitive as alternatives in a local market. This, along with other practices, such as requiring plans to contract with all or none of the hospitals in a chain, may undermine the ability of health plans to use selective contracting with health care facilities. To the extent that AB 1611 may alter such practices, this legislation may offer savings over the long term on health plan premiums in California. However, contracting dynamics and the fiscal health of hospitals is a complex equation involving many complex variables beyond the scope of this legislation, making this bill's potential impacts on health plan and hospital contracting difficult to project.

APPENDIX A TEXT OF BILL ANALYZED

On February 25, 2019, the California Assembly Committee on Health requested that CHBRP analyze AB 1611.

ASSEMBLY BILL

No. 1611

**Introduced by Assembly Member Chiu
(Principal coauthor: Senator Wiener)**

February 22, 2019

An act to amend Section 1317.2a of, and to add Sections 1317.11, 1317.12, 1371.6, 1371.7, and 1385.035 to, the Health and Safety Code, and to add Sections 10112.91, 10112.92, and 10181.35 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1611, as introduced, Chiu. Emergency hospital services: costs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or health insurer offering a contract or policy to provide coverage for emergency services. Existing law prohibits a hospital from transferring a person needing emergency services and care to another hospital for any nonmedical reason unless prescribed conditions are met and makes a willful violation of this requirement a crime.

This bill would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment. The bill would require health care service plans and insurers

to document cost savings pursuant to these provisions. By expanding the duties of health care services plans and hospitals, this bill would expand existing crimes, thereby imposing a state-mandated local program.

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.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Section 1317.11 is added to the Health and Safety Code, to read:

1317.11 (a) A hospital that has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred hospital organization, a county, or an employer to provide emergency care or poststabilization care as defined in Section 1317.1 for a patient, shall not charge more than the greater of the average contracted rate or 150 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, “average contracted rate” means the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region.

(b) Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance Commissioner or the Director of the Department of Managed Health Care and has a contractual obligation to provide or indemnify emergency medical services under a contract which covers a subscriber or an enrollee shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(c) A third-party payor shall not be liable for payment for emergency services if the third-party payor reasonably determines that the emergency services and care were never performed, provided that a third-party payor may deny reimbursement to a hospital for a medical screening examination in cases in which the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist.

SEC. 2.

Section 1317.12 is added to the Health and Safety Code, to read:

1317.12. (a) (1) A hospital that provides care subject to Section 1317.1 or 1317.2 shall provide that if a patient receives covered services consistent with Section 1317.1 or 1317.2, the patient shall pay no more than the same cost sharing that the patient would pay for the same covered services received from a contracting hospital. This amount shall be referred to as the “in-network cost-sharing amount.”

(2) An enrollee shall not owe a hospital that provides emergency or other services consistent with Section 1317.1 or 1317.2 more than the in-network cost-sharing amount for services subject to this section. The hospital shall be provided information on the amount of the in-network cost sharing by the third-party payor.

(3) A hospital shall not bill or collect any amount from the patient for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting hospital to the patient shall include a notice in 12-point bold type stating that the communication is not a bill and informing the patient that the patient shall not pay until the patient is informed by the patient’s third-party payor of any applicable cost sharing.

(4) (A) If the hospital has received more than the in-network cost-sharing amount from the patient for services subject to this section, the noncontracting hospital shall refund any overpayment to the patient within 30 calendar days after receiving payment from the patient.

(B) If the hospital does not refund any overpayment to the patient within 30 calendar days after being informed of the patient’s in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the enrollee.

(C) A hospital shall automatically include in the refund to the patient all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount.

(b) If a patient does not have a third-party payor and a hospital determines, consistent with Article 1 (commencing with Section 127400) of Chapter 2.5 of Part 2 of Division 107, that a patient is participating in the charity care or discount payment policy provisions of that article, then this section shall not apply to that patient. If a patient does not have a third-party payor and has not yet begun to participate in either the charity care or discount payment policy provisions of Article 1 (commencing with Section 127400) of Chapter 2.5 of Part 2 of Division 107, then the hospital shall, consistent with subdivision (b) of Section 127420, provide information on the hospital’s charity care and discount payment policies, as well as information on how to apply for Medi-Cal and any other applicable coverage.

(c) (1) A hospital may advance to collections only the in-network cost-sharing amount, as determined by the third-party payor pursuant to subdivision (a), that the enrollee has failed to pay.

(2) The hospital, or any entity acting on its behalf, including any assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for a minimum of 150 days after the initial billing regarding amounts owed by the enrollee under subdivision (a) or (b).

(3) With respect to a patient subject to this section, the noncontracting hospital, or any entity acting on its behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

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

(1) “Contracting hospital” means a hospital that is contracted with the patient’s third-party payor to provide services under the patient’s contract.

(2) “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.

(3) “In-network cost-sharing amount” means an amount no more than the same cost sharing the enrollee would pay for the same covered service received from a contracting health professional.

(4) “Third-party payor” means any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred hospital organization, a county, or an employer that by statute or contract is required to cover emergency care.

(e) This section shall not be construed to require a third-party payor to cover services not required by law or by the terms and conditions of the third-party contract.

(f) This section shall not be construed to exempt a plan or hospital from the requirements under Section 1371.4 or 1373.96, nor abrogate the holding in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

(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), Chapter 8 (commencing with Section 14200), and

Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3.

Section 1317.2a of the Health and Safety Code is amended to read:

1317.2A. (a) A hospital ~~which~~ *that* has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2 and who is determined by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county hospital is unable to accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements as set forth in this subdivision does not mandate a level of service or payment, modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, create a cause of action, or limit a county's flexibility to manage county health systems within available resources. However, the county's flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440).

(c) The receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, or employer ~~which~~ *that* has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation to the patient, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for uncovered services, or any deductible or copayment obligation. *Reasonable charges shall not exceed the greater of the average contracted rate or*

150 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, “average contracted rate” means the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. Notwithstanding this section, the liability of a third-party payor ~~which that~~ has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance Commissioner or the Director of the Department of Managed Health Care and has a contractual obligation to provide or indemnify emergency medical services under a contract ~~which that~~ covers a subscriber or an enrollee shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital ~~which that~~ has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a to the extent of its legal obligation, imposed by statute or by contract to the extent of that contractual obligation, which does not accept transfers of, or make other appropriate arrangements for, medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physicians for providing services and care ~~which that~~ should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Institutions Code.

(g) Nothing in this section shall be interpreted to require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal obligation to provide care.

SEC. 4.

Section 1371.6 is added to the Health and Safety Code, to read:

1371.6. (a) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that if an enrollee receives covered services consistent with Section 1371.4 or 1371.5 from a noncontracting hospital, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting hospital. This amount shall be referred to as the “in-network cost-sharing amount.”

(2) An enrollee shall not owe a noncontracting hospital that provides emergency or other services consistent with Section 1371.4 or 1371.5 more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting hospital, the plan shall inform the enrollee and the noncontracting hospital of the in-network cost-sharing amount owed by the enrollee.

(3) A noncontracting hospital shall not bill or collect any amount from the enrollee for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting hospital to the enrollee prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the enrollee that the enrollee shall not pay until the enrollee is informed by the enrollee's health care service plan of any applicable cost sharing.

(4) (A) If the noncontracting hospital has received more than the in-network cost-sharing amount from the enrollee for services subject to this section, the noncontracting hospital shall refund any overpayment to the enrollee within 30 calendar days after receiving payment from the enrollee.

(B) If the noncontracting hospital does not refund any overpayment to the enrollee within 30 calendar days after being informed of the enrollee's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the enrollee.

(C) A noncontracting hospital shall automatically include in the 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.

(b) The following shall apply:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting hospital.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service and shall constitute "applicable cost sharing owed by the enrollee."

(c) (1) A noncontracting hospital may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a) that the enrollee has failed to pay.

(2) The noncontracting hospital, or any entity acting on its behalf, including any assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for a minimum of 150 days after the initial billing regarding amounts owed by the enrollee under subdivision (a) or (b).

(3) With respect to an enrollee, the noncontracting hospital, or any entity acting on its behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

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

(1) “Contracting hospital” means a hospital that is contracted with the enrollee’s health care service plan to provide services under the enrollee’s plan contract.

(2) “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.

(3) “In-network cost-sharing amount” means an amount no more than the same cost sharing the enrollee would pay for the same covered service received from a contracting health professional. The in-network cost-sharing amount with respect to an enrollee with coinsurance shall be based on the amount paid by the plan pursuant to paragraph (1) of subdivision (a) of Section 1371.31.

(e) This section shall not be construed to require a health care service plan to cover services not required by law or by the terms and conditions of the health care service plan contract.

(f) This section shall not be construed to exempt a plan, hospital, any other individual or any other entity from the requirements under Section 1371.4 or 1373.96, nor abrogate the holding in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

(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), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 5.

Section 1371.7 is added to the Health and Safety Code, to read:

1371.7. A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that:

(a) (1) A noncontracting health facility subject to Section 1371.6 shall be paid the greater of the average contracted rate or 150 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, “average contracted rate” means the average of the

contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region.

(2) To determine the “average contracted rate,” the department shall use the standardized methodology as provided in paragraphs (2) and (3) of subdivision (a) of Section 1371.31.

(b) (1) A noncontracting health facility providing emergency services subject to Section 1371.4 may use the independent dispute resolution process established under Section 1371.30. If the noncontracting health facility participates in the independent dispute resolution process, the health care service plan shall also participate.

(2) The decision obtained through the department’s independent dispute resolution process shall be binding on both parties. The plan shall implement the decision obtained through the independent dispute resolution process.

(c) If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

SEC. 6.

Section 1385.035 is added to the Health and Safety Code, to read:

1385.035. (a) For a plan contract subject to Section 1385.03, the plan shall file a separate schedule documenting the cost savings associated with Section 1371.7 and the impact on rates.

(b) For a plan contract subject to Section 1385.04, the plan shall file a separate schedule documenting cost savings associated with Section 1371.7 and the impact on rates.

SEC. 7.

Section 10112.91 is added to the Insurance Code, to read:

10112.91. (a) (1) A health insurance policy issued, amended, or renewed on or after January 1, 2020, shall provide that if an insured receives covered services consistent with Section 1371.4 or 1371.5 of the Health and Safety Code from a noncontracting hospital, the insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from a contracting hospital. This amount shall be referred to as the “in-network cost-sharing amount.”

(2) An insured shall not owe a noncontracting hospital that provides emergency or other services consistent with Section 1371.4 or 1371.5 of the Health and Safety Code more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting hospital, the insurer shall inform the insured and the noncontracting hospital of the in-network cost-sharing amount owed by the insured.

(3) A noncontracting hospital shall not bill or collect any amount from the insured for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting hospital to the insured prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the insured that the insured shall not pay until the insured is informed by the insured's health insurance policy of any applicable cost sharing.

(4) (A) If the noncontracting hospital has received more than the in-network cost-sharing amount from the insured for services subject to this section, the noncontracting hospital shall refund any overpayment to the insured within 30 calendar days after receiving payment from the insured.

(B) If the noncontracting hospital does not refund any overpayment to the insured within 30 calendar days after being informed of the insured's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the insured.

(C) A noncontracting hospital shall automatically include in the 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.

(b) The following shall apply:

(1) Any cost sharing paid by the insured for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting hospital.

(3) The cost sharing paid by the insured pursuant to this section shall satisfy the insured's obligation to pay cost sharing for the health service and shall constitute "applicable cost sharing owed by the insured."

(c) (1) A noncontracting hospital may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a) that the insured has failed to pay.

(2) The noncontracting hospital, or any entity acting on its behalf, including any assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for a minimum of 150 days after the initial billing regarding amounts owed by the insured under subdivision (a) or (b).

(3) With respect to an insured, the noncontracting hospital, or any entity acting on its behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

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

(1) “Contracting hospital” means a hospital that is contracted with the insured’s health insurance policy to provide services under the insured’s plan contract.

(2) “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.

(3) “In-network cost-sharing amount” means an amount no more than the same cost sharing the insured would pay for the same covered service received from a contracting health professional. The in-network cost-sharing amount with respect to an insured with coinsurance shall be based on the amount paid by the plan pursuant to paragraph (1) of subdivision (a) of Section 10112.82.

(e) This section shall not be construed to require a health insurance policy to cover services not required by law or by the terms and conditions of the health insurance policy contract.

(f) This section shall not be construed to exempt a health care service plan, hospital, any other individual, or any other entity from the requirements under Section 1371.4 or 1373.96 of the Health and Safety Code, nor abrogate the holding in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

(g) If a health insurance policy 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.

SEC. 8.

Section 10112.92 is added to the Insurance Code, to read:

10112.92. A health insurance policy issued, amended, or renewed on or after January 1, 2020, shall provide that:

(a) (1) A noncontracting health facility subject to Section 10112.91 shall be paid the greater of the average contracted rate or 150 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, “average contracted rate” means the average of the contracted commercial rates paid by the insurer or delegated entity for the same or similar services in the geographic region.

(2) To determine the “average contracted rate,” the department shall use the standardized methodology as provided in paragraphs (2) and (3) of subdivision (a) of Section 10112.82.

(b) (1) A noncontracting health facility providing emergency services subject to Section 1371.4 of the Health and Safety Code may use the independent dispute resolution process established under Section 10112.81. If the noncontracting health facility participates in the independent dispute resolution process, the insurer shall also participate.

(2) The decision obtained through the department's independent dispute resolution process shall be binding on both parties. The insurer shall implement the decision obtained through the independent dispute resolution process.

(c) If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

SEC. 9.

Section 10181.35 is added to the Insurance Code, to read:

10181.35. (a) For a policy subject to Section 10181.3, the insurer shall file a separate schedule documenting the cost savings associated with Section 10112.91 and the impact on rates.

(b) For a policy contract subject to Section 10181.4, the insurer shall file a separate schedule documenting cost savings associated with Section 10112.92 and the impact on rates.

SEC. 10.

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

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. (Milliman).

Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.

This appendix describes any analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis Specific Caveats and Assumptions

This subsection discusses the caveats and assumptions relevant specifically to an analysis of AB 1611.

AB 1611 is a regulatory action rather than a benefit mandate. This means that it would apply to ALL commercially insured plans instead of just state-regulated plans subject to benefit mandates.

Under the provisions of AB 1611, hospitals may charge the maximum of 150% Medicare or the "average contracted rate" (the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region) for emergency services and post-stabilization care. Hospitals would be required to accept in-network charges as payment in full from patient and would not be allowed to balance bill.

DMHC currently has protections in place, so this bill is expected to only impact ERISA (self-funded large-group) plans and CDI-regulated policies.

CHBRP projects that AB 1611:

- Would have no impact on the utilization of emergency hospital services.
- Would eliminate balance billing for emergency hospital services provided out-of-network.
- May result in increased cost of other facility services to offset the lost revenue from balance billing. It is also possible that it would result in reduced charges for emergency hospital services due to facilities having a weaker negotiating position with payers. Because of the uncertainty on the impact AB 1611 on the cost of services, it is assumed that the cost of in-network emergency services would remain unchanged. Impacts on the cost of non-emergency services were not modeled.

The following is a description of methodology and assumptions used to develop the estimates of cost impacts.

Identification and Categorization of Emergency Services

CHBRP relied upon the 2016 Milliman Consolidated Health Cost Guidelines™ Sources Database (CHSD) to identify commercial out-of-network emergency hospital services in the state of California. These visits were classified into two categories:

- ED Only: Emergency department services with the visit followed by discharge. These services were identified by the “Outpatient Facility – Emergency Room” category by the Milliman Grouper software.
- ED Service + Admission: Instances in which the ED visit and the inpatient visit are not split and the full cost of the visit is in the inpatient. To identify these visits, CHBRP used emergency room revenue codes ("0450", "0451", "0452", "0459").

For the categories above, all charges attributable to the same case were included to account for all professional services and lab tests performed during the visit. A visit and all services were considered in-network or out-of-network based on the indicator of the qualifying claim as identified above. Claims not adjudicated to a percentage of Medicare were adjudicated to Medicare by applying the average billed as a percentage of Medicare within the same metropolitan statistical area (MSA). Billed charges were used for consistency between in-network and out-of-network. Billed, allowed, and Medicare-adjudicated claims (including those imputed as described above) were summarized by MSA and facility in-network/out-of-network. Each unique case was counted as a single visit.

Baseline Utilization

The total ED visits per 1,000 were calculated as the sum of the case counts divided by California member months, multiplied by 12,000. Utilization was trended to 2020 using 1% trend based on the outpatient trend recommended in Milliman’s Health Cost Guidelines (HCGs). The percent of ED visits out-of-network is the total visits out of network divided by total ED visits. The percentage of ED-only visits is the percentage of total out-of-network visits with no associated inpatient admit as classified above. The percentage of ED visits associated with an inpatient admission admit is 1 minus the percentage of ED-only visits.

Baseline Cost

CHBRP used the 2016 CHSD average out-of-network billed charges. Billed charges were trended to 2020 using 7% trend based on the outpatient trend recommended in Milliman’s HCGs.

Baseline Payer and Patient Cost Sharing

CHBRP used 2016 CHSD average out-of-network allowed charges to estimate cost-sharing charges. Allowed charges were trended to 2020 using 2% trend, based on the medical component of the 2018 Consumer Price Index. The cost sharing was adjusted to reflect out-of-pocket maximums associated with the distribution of plan designs in each market segment. The payer share is calculated as the difference between the average out-of-network allowed charges and the patient cost sharing.

Balance Billed Amount

The balance billed amount is the difference between billed charges (baseline cost) and the payer share of the allowed amount, described above. CHBRP assumed one-third of patients negotiate a balance bill. Those who negotiate receive an average 50% reduction in billed charges. The billed charge reduction was applied multiplicatively to the average balance bill charge.

Postmandate Utilization

CHBRP assumed the same utilization as baseline.

Postmandate Cost

CHBRP used 2016 CHSD average in-network allowed charges by MSA, and repriced as a percentage of Medicare. The greater of the MSA-specific percentage of Medicare or 150% of Medicare was multiplicatively applied to the California average allowed charge repriced to Medicare to calculate a severity-adjusted average allowed charge by MSA. The severity adjusted allowed amount was re-weighted using out-of-network utilization to calculate the average severity adjusted allowed charge. These amounts were trended to 2020 using 2% trend.

AB 72, which eliminated balance billing of out-of-network professional services performed at an in-network ED, went into effect January 1, 2017. Approximately 7% of in-network ER claims have an out-of-network professional component. These claims were removed from the cost analysis.

Postmandate Payer and Patient Cost Sharing

The patient cost sharing was applied to the postmandate cost. Cost sharing was adjusted to reflect out-of-pocket maximums associated with the distribution of plan designs in each market segment. The payer share is calculated as the difference between the postmandate cost and the patient cost sharing.

Postmandate Balance Billing

The balance billed amount is assumed to be \$0 postmandate as AB 1611 eliminates balance billing.

Modeling Self-Funded (ERISA) plans

With the exception of population counts, self-funded plans are not in the standard CHBRP cost model, so CHBRP needed to develop assumptions for this analysis. CHBRP relied upon the Kaiser Family Foundation Employer Health Benefits Survey, 2018, for the average annual premium and average employer contribution (KFF, 2018). The national premium was adjusted to reflect California premiums by applying the ratio of the California average PPO premium to the national average PPO premium reported by the California Health Care Foundation. CHBRP weighted the single and family premiums and employer contributions together to calculate an average rate. CHBRP assumed a carrier administrative load of 10%. CHBRP assumed the ERISA plans have the same cost sharing and maximum out-of-pocket cost as DMHC large-group nongrandfathered plans.

REFERENCES

- California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1800: Health Care Coverage*. Report to Calif. State Legislature. Oakland, CA; 2012.
- California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 1917: Outpatient Prescription Drugs, Cost Sharing*. Report to Calif. State Legislature. Oakland, CA; 2014.
- California Health Care Foundation (CHCF). California Emergency Departments: Use grows as coverage expands. *California Health Care Almanac*. 2018. Available at: <https://www.chcf.org/publication/2018-edition-california-emergency-departments-use-grows-coverage-expands/>. Accessed April 3, 2019.
- Chen J, Rizzo JA, Rodriguez HP. The Health Effects of Cost-Related Treatment Delays. *American Journal of Medical Quality*. 2011;26(4):261–271.
- Fedor F. The balancing role of balance billing. *Healthcare Financial Management*. 2006;60:46-50.
- Garmon C, Chartock B. One in five inpatient emergency department cases may lead to surprise bills. *Health Affairs (Millwood)*. 2017;36:177-181.
- Hamel L, Norton M, Pollitz K, Levitt L, Claxton G, Brodie M. The Burden of Medical Debt: Results from The Kaiser Family Foundation/New York Times Medical Bill Survey (Henry J. Kaiser Family Foundation, Jan. 2016). Available at: <https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey>. Accessed April 5, 2019.
- P.L. Henneman, B.H. Nathanson, H. Li, et al. Is outpatient emergency department care profitable? Hourly contribution margins by insurance for patients discharged from an emergency department. *Ann Emerg Med*, 63 (2014), pp. 404-411.
- Hoadley J, Lucia K, Kona M. *State Efforts to Protect Consumers from Balance Billing Continue, While Momentum Builds for Federal Action, To the Point* (blog), Commonwealth Fund. Jan. 18, 2019. Available at: <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>.
- Institute of Medicine (IOM). 2006. *Hospital-Based Emergency Care: At the Breaking Point*. Washington, DC: The National Academies Press.
- Kaiser Family Foundation (KFF). *2018 Employer Health Benefits Survey*. Henry J. Kaiser Family Foundation, San Francisco, California. 2018. Available at: <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>.
- Kalousova L, Burgard SA. Debt and Foregone Medical Care. *Journal of Health and Social Behavior*. 2013;54:204–20.
- Lucia K, Hoadley J, Williams A. *Balance Billing by Health Care Providers: Assessing Consumer Protections Across States*. Issue Brief, Commonwealth Fund. June 13, 2017. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer>. Accessed April 6, 2019.

- Melnick GA, Fonkych K, Zwanziger J. The California Competitive Model: How Has It Fared, And What's Next? *Health Affairs (Millwood)*. 2018;37(9):1417-1424
- Morganti KG, Bauhoff S, Blanchard JC, et al. *The Evolving Role of Emergency Departments in the United States*. Santa Monica, CA: RAND Corporation, 2013. Available at: https://www.rand.org/pubs/research_reports/RR280.html. Also available in print form.
- O'Toole TP, Arbelaez JJ, Lawrence RS, et al. Medical debt and aggressive debt restitution practices: predatory billing among the urban poor. *Journal of General Internal Medicine*. 2004;19:772.
- Pao B, Riner M, Chan T. Impact of the balance billing ban on California emergency providers. *Western Journal of Emergency Medicine*. 2014;15:518-552
- Seifert RW. The demand side of financial exploitation: The case of medical debt. *Housing Policy Debate*. 2004;15:3:785-803.
- Schuur JD, Venkatesh AK. The growing role of emergency departments in hospital admissions. *N Engl J Med*. 2012;367(5):391-393.
- Silas J, Bell C. *Getting Started on Surprise Medical Bills: An Advocate's Guide*. 2015. Consumers Union. Available at: <http://consumersunion.org/research/getting-started-on-surprise-medical-bills-an-advocates-guide/>. Accessed December 29, 2015.
- Society for Human Resource Management (SHRM). *More Small and Midsize Firms Choose to Self-Insure*. Available at: <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/self-insurance-aca.aspx>. Accessed April 9, 2019.
- Wilson M, Cutler D. Emergency department profits are likely to continue as the Affordable Care Act expands coverage. *Health Affairs (Millwood)*. 2014;33:792-799.

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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 researchers and analysts who are **Task Force 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**, 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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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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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org