

Key Findings:

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

Summary to the 2015–2016 California State Legislature



CONTEXT

AT A GLANCE

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

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

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

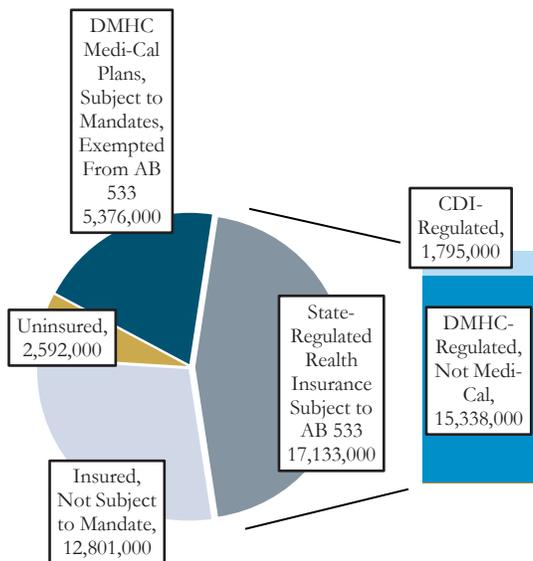
Without the passage of AB 533, for 2016, CHBRP estimates:

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

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

BILL SUMMARY

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

Figure 1. Health Insurance in CA and AB 533

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

Source: California Health Benefit Review Program, 2016

For surprise medical bills, AB 533 would:

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

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

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

IMPACT OF AB 533

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

Benefit Coverage

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

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

Utilization

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

Unit Cost

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

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

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

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

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

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

Expenditures

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

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

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

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