# CALIFORNIA MEDICAL ASSOCIATION

February 28, 2019

The Honorable Bill Cassidy, MD
United States Senate
520 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Tom Carper
United States Senate
513 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Michael F. Bennett
United States Senate
261 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Lisa Murkowski
United States Senate
522 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Todd Young
United States Senate
400 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Margaret Wood Hassan
United States Senate
330 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Cassidy, Bennett, Young, Carper, Murkowski, and Hassan:

On behalf of the California Medical Association (CMA) and our 44,000 physician and medical student members, I am writing in response to your request for feedback on the impacts of California's recently enacted out-of-network billing law. CMA appreciates your recognition that out-of-network billing is a complex challenge requiring engagement from physicians, health plans, patients, and other stakeholders to resolve effectively. Given that California's law has been in effect for under two years and that contracting relationships between physicians and health plans span multiple product and market types, gathering meaningful data in a way that complies with antitrust laws and contract terms is exceedingly difficult. In the absence of California data, we urge you to review the comprehensive data provided by FAIR Health which includes both charge data and allowable payments nationwide. Accordingly, CMA seeks through this response to provide information about our state's law and its impacts in a manner that addresses many of the questions posed and identifies, based on California's experience, elements of a solution to the problem of unanticipated out-of-network medical bills.

In summary, the CMA urges adoption of the New York law for the nation because it protects patients from unanticipated out-of-network medical bills while regulating insurer network adequacy with an effective dispute resolution process. It has successfully protected patients and not resulted in higher premiums or narrower networks. Unfortunately, the California law has resulted in insurers refusing to renew long-standing contracts or reducing the contracted

rates to the out-of-network standard in the new law. Moreover, the dispute resolution process is costly, administratively burdensome, and is not being used. While patients are protected from unanticipated bills, physician networks are diminishing. We are concerned that the California law will ultimately harm patient access to care as premiums continue to rise.

**California's Law on Out-of-Network Billing**

California's law has long prohibited physicians from balance billing patients enrolled in health plans with which they are contracted. In 2009, California's Supreme Court prohibited out-of-network emergency physicians from billing patients enrolled in the majority of California's fully insured, state-regulated products.[1] California law provides that for out-of-network emergency services, physicians must be reimbursed at the reasonable and customary value for the health care services taking into consideration: 1) the provider's training, qualifications, and length of time in practice; 2) the nature of the services provided; 3) the fees usually charged by the provider; 4) prevailing provider rates charged in the general geographic area in which the services were rendered; 5) other aspects of the economics of the medical provider's practice that are relevant; and 6) any unusual circumstances in the case.[2] While the criteria for out-of-network emergency service payment is reasonable in concept, CMA member physicians report that payors frequently fail to adhere to these criteria in reimbursing them for out-of-network emergency services and that regulators have failed to adequately enforce the criteria. The California law does not require the use of an independent database for emergency charges and therefore, the rates are determined by the payors. One study showed a 19 percent reduction in the percentage of charges paid from 2008-2010. [3] Moreover, the dispute resolution process, which is voluntary, has not worked. Insurers have simply refused to engage in dispute resolution and, in many cases, it has resulted in costly litigation. And overall, California premiums continue to rise.

In 2015, the California Legislature began tackling the issue of out-of-network bills for non-emergent services provided at in-network facilities. At that time, it was estimated that less than 1% of 17.1 million Californians in fully insured, state regulated insurance products would experience a surprise medical bill. For inpatient services the average of these out-of-network medical bills was $550 and for outpatient services the average bill was $200.[4]

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[1] *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.
[2] California Code of Regulations, title 28 § 1300.71(a)(3)(B).
[3] "Impact of the Balance Billing Ban on California Emergency Providers," *Western Journal of Emergency Medicine,* 2014 Jul; 15(4): 518-522.
[4] *Analysis of Assembly Bill AB 533 Out-of-Network Coverage: A Report to the 2015-2016 California State Legislature,* California Health Benefits Review (January 7,2016) at page 6.

In 2016 California enacted Assembly Bill (A.B.) 72,[5] which provides that for covered services provided by an out-of-network physician at a facility that is in-network with the patient's plan or insurer, the patient will only be responsible for the in-network cost sharing amount. The law requires health plans and insurers to reimburse out-of-network physicians the greater of 125% of Medicare or the "average contracted rate" for the same or similar services in the same geographic region. The California law further allows a physician to challenge the reimbursement amount through an independent dispute resolution process and contains provisions allowing patients to elect to receive care from an out-of-network physician.

As predicted by the California Health Benefits Review Program, "by setting the noncontracted effective rate for potentially surprise professional services," A.B. 72 has "put downward pressure on contracted rates among the specialties …that are most likely to work in non-contracted medical groups within contracted in-network facilities …".[6] It has also "reduce[d] the negotiated rates for those specialties by setting a ceiling (i.e., based on the Medicare fee schedule) for out-of-network…surprise medical bill payment."[7] Indeed, since the passage of A.B. 72 in late 2016, substantial numbers of CMA member physicians have reported difficulties in renewing contracts with health plans and insurers with which they had longstanding existing contracts for reimbursement greater than 125% of the Medicare rate and in obtaining new contracts.

Based on our experience, wherein health plans have utilized California's law on out-of-network billing as a weapon in contract negotiations, CMA has identified several elements that are critical to ensuring a comprehensive and successful solution to protect patients from surprise billing: 1) health plan accountability through enforceable network adequacy standards and provider directory requirements; 2) a reimbursement standard that incentivizes contracting; 3) a dispute resolution process that encourages settlement; and 4) universality. Each of these elements is addressed in detail.

**Health Plan Accountability: Adequate Physician Networks and Provider Directories**

While the problem Congress is seeking to address is commonly referred to as "surprise billing," one of the primary reasons that patients receive bills from non-contracted physicians while getting care at an in-network facility is that health plans and insurers fail to maintain adequate physician networks. Although California law contains specific network adequacy requirements including time and distance requirements, maximum wait times, and physician-to-patient ratios, it lacks any specific standards regarding hospital-based specialists. Plans and insurers

[5] California Health & Safety Code §§1371.30. 1371.31, 1371.9; California Insurance Code §§10112.8, 10112.81, 10112.82.
[6] *Analysis of Assembly Bill AB 533 Out-of-Network Coverage: A Report to the 2015-2016 California State Legislature,* California Health Benefits Review (January 7,2016) at page 14.
[7] Id.

must generally ensure an adequate network of physicians and specialists with privileges at the plans' contracted facilities.[8] This lack of enforceable standard for hospital-based physicians allows plans to rely on the contracts between hospitals and hospital-based physicians to ensure enrollees have access to care without having to contract with the physicians themselves. Indeed, CMA is aware of only one instance in which a regulator took action with regard to a plan's lack of contracted hospital-based anesthesiologists. **Accordingly, we urge that any legislation seeking to address this issue must include network adequacy standards that provide for adequate in-network hospital-based specialists at plans' in-network facilities.**

Another major cause of "surprise" bills is that patients are unable to accurately determine whether a physician is in-network with their plan. In 2015, following regulatory findings of significant inaccuracies in provider directories, California passed a comprehensive law requiring plans, medical groups, and physicians to take steps to ensure that the information in the directories is accurate and current.[9] This new law has paved the way for much needed transparency about plans' networks, especially with regard to hospital-based physicians, and **CMA urges that a requirement that plans maintain accurate provider directories is a critical part of a legislative solution to the "surprise billing" problem.**

**Physician Reimbursement Benchmark that Encourages Contracting and Access to Care**

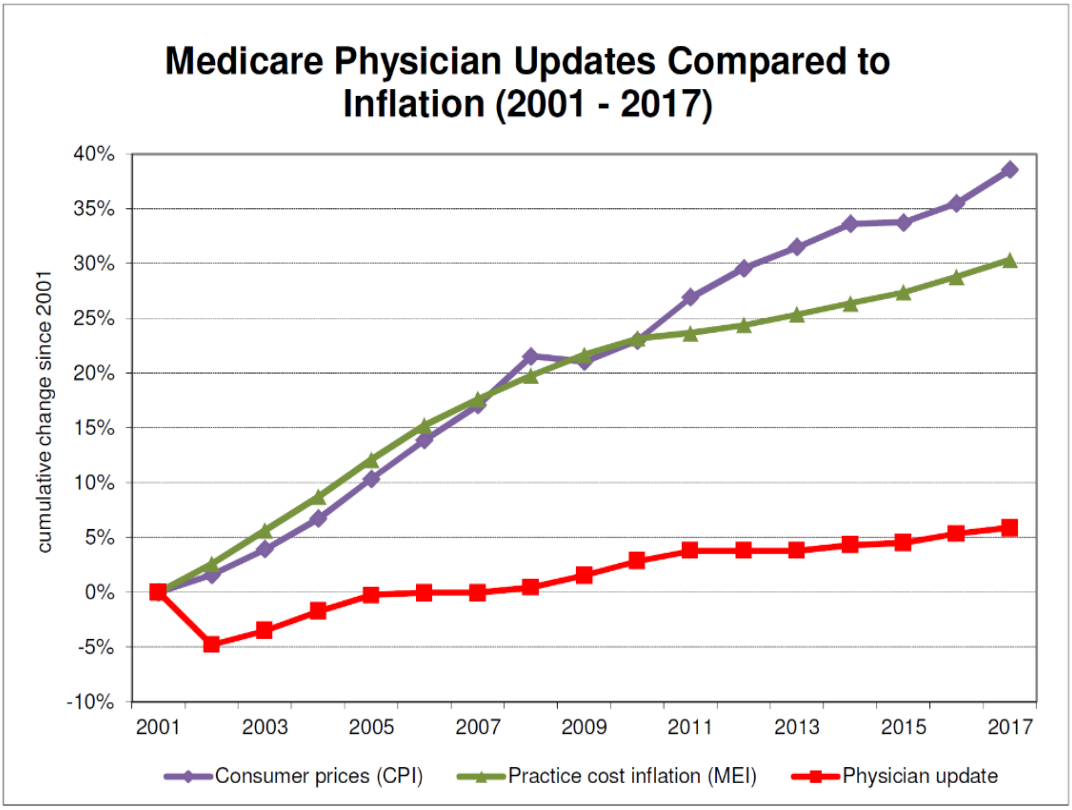
A new study, "*Competition in Health Insurance: A Comprehensive Study of U.S. Markets*," published by the AMA, shows that competition levels have again dropped for health insurers in markets across 25 states in 2017. According to the study, the majority of health insurance markets in California are highly concentrated, meaning there are only a handful of insurers in each California market. This lack of competition gives insurers an undue advantage in contracting with physicians. Absent a statutory payment standard for out-of-network services that reflects the commercial market, physicians are forced to accept contracts on terms dictated by payors. Most contracts are offered on a take-it-or-leave-it basis. In the months following the passage of California's out-of-network billing law, CMA member physicians report being offered contract renewals at severe rate reductions, being unable to negotiate any cost of living increases in contracts, and being unable to obtain new contracts with plans. In one example, following a year of negotiations, a group of 150 anesthesiologists which staffs 18 of a payor's facilities was ultimately forced to accept a 20% rate reduction in order to remain contracted with the payor. Because the problem is becoming more widespread for hospital-based physicians, the Chair of the California Assembly Health Committee has introduced legislation to address these contracting issues. Based on the California experience, any payment standard should be benchmarked to an independent database, rather than to

[8] California Code of Regulations, title 28 § 1300.51(d)(H)(iii); California Code of Regulations, title 10 § 2240.1 .
[9] California Health & Safety Code §1367.27 and California Insurance Code §10133.15.

Medicare or contracted commercial rates to encourage contracting and protect patient access to physicians.

Medicare Rates

Medicare physician payment rates fail to reflect the commercial market, as they have been stagnant since 2001 and have not kept pace with inflation. As the data collected by the Medicare Trustees' Reports and U.S. Bureau of Labor Statistics show, Medicare rates now lag more than 20% behind what it costs to operate a medical practice. Medicare rates for anesthesia services are significantly less reflective of commercial rates. A study conducted by the Government Accountability Office (GAO) found that for anesthesiology services, "Medicare payments were lower than private payments by an average of 67 percent."[10] An out-of-network payment standard benchmarked to Medicare will result in a strong disincentive for plans to enter into fair contracts with hospital-based physicians and in a marked reduction in the ability of patients to access quality care.




Sources: Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

[10] *Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Service,* Government Accountability Office Report to the Subcommittee on Health, Committee on Ways and Means, House of Representatives (July 2007), page 14.

Average Contracted Rate or Allowed Amount

CMA further urges against adopting a payment standard linked to an average contracted rate or allowed amount for out-of-network services. First, contracted or allowed amounts are based on rates negotiated between physicians and health plans during contracting. Allowing health plans to access a discounted rate without a providing the benefits of contracting -- a guaranteed volume of patients and prompt payment – in exchange disincentivizes contracting and results in even narrower networks and less patient choice. Additionally, average contracted or allowed amounts can be manipulated to the point of being meaningless if the terms are not meticulously defined. California's out-of-network billing law resulted in a protracted regulatory process which required resolution of numerous complex issues to develop a standardized methodology for plans to apply in calculating their average contracted rate.[11]

FAIR Health

To avoid the California experience and promulgating a law that disincentivizes fair contracting, is subject to manipulation by payors, and requires onerous regulatory development and oversight, CMA urges that legislation related to unanticipated out-of-network bills use the FAIR Health database as a reimbursement benchmark. The FAIR Health database is maintained by an independent non-profit company (FAIR Health), that serves as a clearinghouse for information about claims for services of health care professionals. It was created as a result of litigation and a New York Attorney General investigation that revealed that plans and their Ingenix company manipulated their provider claims and rates database they used to price out-of-network care, shortchanging the nation's patients by hundreds of millions of dollars. The settlement agreements required the insurance companies to finance an objective database of doctors' fees that patients and insurers nationally could rely on. It is updated at least twice per year using submissions from health plans about how much physicians charged and how much plans paid for a particular service in a particular location. It is regarded as one of the most clear, concise, and accurate physician charge databases and is used by a number of California plans to provide estimates to enrollees about the potential cost of out-of-network benefits.

The New York law defines the "usual and customary cost" as the 80$^{th}$ percentile of all charges for a service as reported by a benchmarking database maintained by a nonprofit organization. CMA is aware of no other nonprofit benchmarking database than FAIR Health. As we understand, the New York approach has been successful in encouraging fair contracting and in resolving billing disputes related to out-of-network claims. **Therefore, CMA urges the New York**

[11] California Code of Regulations, title 28, section 1300.71.31 and California Code of Regulations, title 10, section 2238.10-2238.12.

**approach to physician reimbursement be adopted as part of proposed unanticipated out-of-network billing legislation.**

**Dispute Resolution Mechanism that Encourages Settlement**

California's "surprise billing" law required our regulators to develop a mandatory independent dispute resolution process for physicians to use to challenge the amount of reimbursement they receive for non-emergent out-of-network services. During the regulatory implementation phase, CMA advocated for the adoption of final offer arbitration with the loser paying the cost of the arbitration. Final offer arbitration, often referred to as "baseball" arbitration, is an effective dispute resolution method that eliminates holdouts and forces the two sides to come forward with reasonable figures that lead to a negotiated solution. In the health care coverage context, the desired negotiated solution is an agreed to rate that results in a robust provider network. In baseball arbitration, each party to the dispute submits the desired reimbursement to an independent arbitrator and the arbitrator picks one figure or the other. The arbitrator cannot "split the baby" and settle on a reimbursement amount in the middle of the spread between the parties' offers. One side leaves the arbitration a winner and the other a loser, heightening risk and encouraging negotiation and settlement prior to use of the dispute resolution process.

Unfortunately, California's larger regulator adopted traditional arbitration along with a cost-prohibitive fee for participation in its dispute resolution process.[12] In the nearly two years since California's dispute resolution process has been operational, there have been zero claims adjudicated. California physicians have been disincentivized from using this dispute resolution process due to several of its key features: 1) the prohibitive cost of dispute resolution (ranging from just under $150 to just under $200 for physicians depending on the number of claims bundled and regardless of who wins); 2) impractical restrictions on how claims may be bundled; 3) a lengthy administrative process prior to the claim going to an arbiter; and 4) the significant administrative burden involved with claims submission.[13] **By contrast, the New York legislation -- which provides for an expeditious process for final offer arbitration with the loser paying the fee -- has resulted in a fair and meaningful dispute resolution process, with the decisions split evenly between plans and physicians.**

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[12] California's managed care plans (primarily HMOs) are licensed and regulated by the Department of Managed Health Care (DMHC). DMHC also licenses and regulates Blue Shield and Anthem PPO products. The Department of Insurance (CDI) licenses and regulates traditional indemnity products such as PPOs, EPOs, and POS plans. DMHC regulates insurance coverage for roughly 65% of California's population while CDI regulates the coverage of about 4% of California's population. The remainder of the population is enrolled in federally regulated products. (*California Healthcare Almanac Quick Reference Guide*, California Health Care Foundation (2017).)

[13] For the full operational guide for DMHC's dispute resolution process see *A.B. 72 Uniform Written Procedures and Guidelines*, DMHC, available at https://ab72idrp.maximus.com/idrpportal/public/docs/AB72_Uniform_Written_Procedures_and_Guidelines.pdf.

**Comprehensive Solution Addressing A Majority of Markets**

It is critical that in developing a comprehensive legislative solution to the challenges for patients and physicians caused in large part by inadequate provider networks and inaccurate provider directories, that all segments of the commercial market are included. Narrow networks, reimbursement that doesn't reflect the commercial market, lack of transparency regarding which physicians comprise the network, and onerous claims processes are all prevalent with products regulated pursuant to the Employee Retirement Income Security Act (ERISA). In California alone, nearly 6 million people receive care through self-insured insurance products, leaving them out of the state's out-of-network billing scheme. This results in confusion for patients as well as for physicians attempting to determine which set of laws apply to their care. This confusion is compounded by the fact that these self-insured products frequently lease the networks of plans that are regulated by the state, making it even more difficult to discern which rules apply. In order to provide a solution that addresses the issue of "surprise billing" in a way that protects patients, incentivizes contracting and robust physician networks, and ensures payor accountability across all plan types, **CMA urges that legislation apply to ERISA plans as well as those plans subject to the Affordable Care Act.**

We thank you for the opportunity to share our experience with surprise billing legislation in California and look forward to working with you to find a workable solution. We are also happy to share any additional information about our statutes, regulations, and physician experience or to clarify any of the information we have provided in this letter. The CMA contact is Elizabeth McNeil, Vice President of Federal Government Relations at emcneil@cmadocs.org.

Sincerely,

David H. Aizuss, MD
President

cc: The Honorable Dianne Feinstein