Key Findings:

Analysis of California Assembly Bill 1611 Emergency Services

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

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

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.

CONTEXT

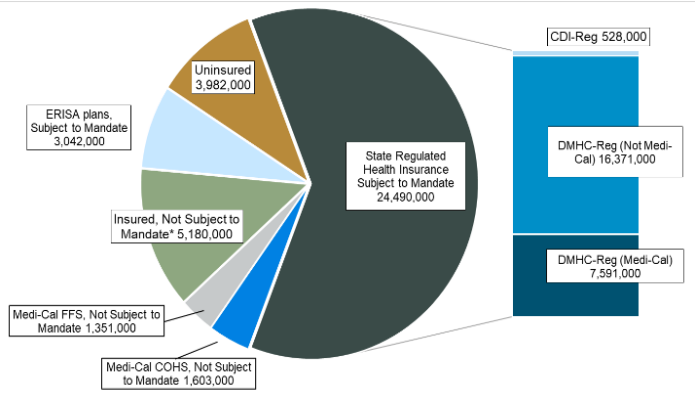
Over the last several decades, emergency departments (EDs) have become one of the main pathways through which patients are admitted to the hospital. From 1993 to 2006, the share of all inpatient stays in which patients were admitted to the hospital via an ED increased from 33.5% to 48.3%.[1] In 2016, 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.

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

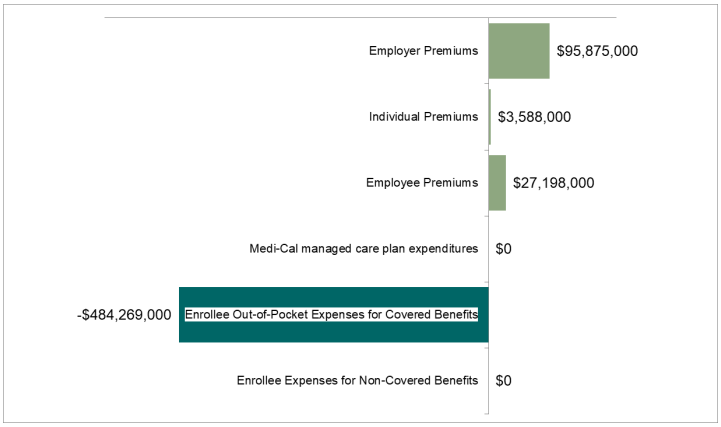
At baseline or premandate among CDI and ERISA enrollees, CHBRP estimates that there are 18,300 cases in which only an emergency room visit occurred and 6,600 cases in which both an emergency room visit and inpatient admission occurred.

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.