Pacific Business Group on Health

Value Promoting Policy Review
Payments to Out-Of-Network Hospitals In California

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INTRODUCTION

At the request of Pacific Business Group on Health (PBGH), Milliman, Inc. (Milliman) has developed a research paper regarding a proposal by Governor Schwarzenegger to revise the amount an insurer must pay to a hospital for healthcare services performed at a hospital outside of an insurer's hospital network. The recommendations and observations offered in this paper reflect the author's opinion and do not necessarily represent those of Milliman.

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BACKGROUND

California Governor Arnold Schwarzenegger has put forth a multi-faceted proposal to reform health care and health insurance in California in order to extend health insurance to all California residents. One aspect of the Governor's reform proposal deals with increasing affordability through enhancing insurer and hospital efficiency.

The Governor proposes to enhance insurer and hospital efficiency in part by:

> **"Revising the amount an insurer must pay a hospital when insured persons need treatment outside of their network so insurers don't need 'defensive contracting'* to protect against high daily rates from out-of-network providers."**

* The term "defensive contracting" appears on page 8 in the Governor's proposal. We have interpreted the term to mean seeking contracts with more hospitals than needed in order to avoid very high out-of-network costs.

PBGH is seeking to provide policy makers an unbiased summary of the proposal, potential ways to implement it, and its potential impact by commissioning a brief research paper. We have prepared such a paper, premised on the following assumptions:

- The change in payments for out-of-network services would be made in the context of enactment of the Governor's overall reform proposal – including in particular the requirement that all Californians have health insurance and the substantial increase in Medi-Cal provider reimbursement rates.

- Hospitals would not be permitted to bill patients for the difference between their billed charges and amounts allowed by a health plan as a basis for benefit determinations.

To the extent that these underlying assumptions are not correct, our conclusions would need to be reconsidered to reflect actual circumstances.

Part of the context for considering the proposed changes is the recent increased activity regarding "high value" provider networks. Several health plans, independently and in collaboration with major employers, have been developing relatively narrow "high value" networks, consisting of healthcare providers deemed to provide high quality, cost-effective health care, as a way to lower health benefit costs and reward cost-effective healthcare providers. Pressure on health plans to negotiate "defensive" contracts inhibits the formation of such "high value" networks.

DATA RELIANCE

In developing our research paper, we have relied on data and other information provided to us by several organizations. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. To the extent that additional and/or more recent data

regarding hospital costs and charges can be collected and made available the results presented in this report can be confirmed or amended. The data and other information that we relied upon included the following:

- The summary of the "Governor's Health Care Proposal," published in January 2007 (Attachment 1).

- Responses to a survey of major California health plans/health insurance companies (The survey instrument is Attachment 2).

- A letter dated October 3, 2006 to Mr. Kevin Donohue, Deputy Directory of Managed Health Care, State of California, from Mr. Dietmar Grellman, Senior Vice President, Managed Care and Professional Services, California Hospital Association re: Unfair Billing Patterns; Prohibition Against Billing Enrollees for Emergency Services; Independent Dispute Resolution Process **(Control No. 2006-0777)**; Claims Settlement Practices; Reasonable and Customary Criteria **(Control No. 2006-0782)** (Attachment 3). This was used primarily as the basis for Alternative #1 discussed below.

- A 5% random sample of 2005 Medicare claims data published by the Centers for Medicare and Medicaid Services (CMS).

- Reports regarding hospital costs for 2005†, submitted to the CMS Healthcare Cost Report Information System by Medicare Fiscal Intermediaries (Hospital Cost Reports).

- Data regarding services provided by California hospitals in 2005 from the California Office of the State Health Planning and Development (OSHPD) Hospital Annual Financial Data.

† The Hospital Cost reports include a small amount of information regarding 2006 claims.

- Data compiled by Milliman regarding billed charges and amounts used by health plans and insurers to compute payments to hospitals for inpatient and outpatient services for large employer self-insured employee health benefit plans (allowed amounts).

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency, and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

VARIABILITY OF RESULTS

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from estimated amounts to the extent that actual experience differs from the assumptions.

Policy Review

PROBLEM STATEMENT

Health Maintenance Organizations (HMOs) and health insurance companies arrange for or provide hospital services to their members/policyholders. HMOs and health insurance companies negotiate purchasing contracts with hospitals that define, among other things, the rates that hospitals will be paid for their services. HMOs and health insurance companies do not have such contractual agreements with all hospitals – because the parties cannot reach an agreement, because the HMO/health insurer has negotiated contracts with other hospitals sufficient to serve its members/policyholders, or because the HMO/health insurer has few members in the hospital's service area and determines that it does not need a hospital purchasing contract in that area. Hospitals with which an HMO/health insurer has a contract are generally called "network hospitals." Hospitals with which an HMO/health insurer does not have a contract are called "out-of-network hospitals."

HMOs/insurers encourage their members/policyholders to obtain necessary hospital services at network hospitals by including in their benefit plans coverage of more of the charges for such services obtained from a network hospital than from an out-of-network hospital. For in-network hospital services, insurers generally pay contractually agreed amounts, which differ in form but generally amount to 35% to 45% of a hospital's standard billed charges, and the hospital may not bill the patient for the difference between its billed charges and the amounts it has agreed to accept under its contract with the HMO/health insurer.

However, members/policyholders sometimes obtain hospital services from out-of-network hospitals – most frequently for services to treat a medical emergency. Approximately 4.3% of payments ($542 million) to California hospitals by HMOs/health insurers[1] for <u>inpatient</u> services in 2005 were to out-of-network hospitals. Approximately 8.5% of payments ($765 million) to

[1] Excludes Kaiser Foundation Health Plan (KFHP). No data regarding payments to out-of-network hospitals were available from KFHP. KFHP is unusual in that the Kaiser organization owns many of the hospitals that provide services to KFHP members.

California hospitals by HMOs/health insurers[1] for outpatient services in 2005 were to out-of-network hospitals.

HMOs/health insurers are obligated to pay for out-of-network hospital services to treat medical emergencies or for necessary hospital services not available from an in-network hospital. HMOs/health insurers may also be obligated to pay for out-of-network hospital services if the patient's health benefits cover out-of-network services. The amounts of these obligations are often matters of dispute. HMOs/health insurers may contend that their obligations are limited to the provisions of the member's/policyholder's benefit plan and pay only that amount – generally far less than the hospital's billed charges. Hospitals may contend that the payments for their services should be based on their billed charges – since they have no contract which obligates them to accept less. The insured patient may be held responsible for the difference between what was paid by the HMO/health insurer and the hospital's billed charges – which may be a very significant amount. Resolution of such disputes can be time-consuming, expensive, and contentious. They can lead to substantial financial obligations by patients who thought they had insurance to cover most of the expenses, increases in hospital "bad debt" if patients are unable or unwilling to pay, higher premium rates or more aggressive contract negotiations with network hospitals if HMOs/health insurers are obligated to pay out-of-network hospitals based on billed charges, and, in many cases, serious patient/consumer grievances.

ALTERNATIVE SOLUTIONS

All alternative solutions described below define the payment obligations of HMOs/health insurers in such a way that the patient/consumer is not left with a substantial financial obligation resulting from disputes between hospitals and HMOs/health insurers as to the appropriate basis for benefit determinations with respect to services provided by out-of-network hospitals. Note that patients may still have obligations to pay amounts prescribed by the deductible, copayment, or coinsurance provisions of their benefit plan/insurance policy. For each alternative, we state major advantages and disadvantages.

Alternative #1: The basis for benefit determination is mandated to be the out-of-network hospital's standard billed charges. HMOs/health insurers may challenge the billed charges as "unreasonable" through the courts. The term "unreasonable" would be defined to be not reasonably related to the hospital's costs for the services provided.

Alternative #1 Advantages	Alternative #1 Disadvantages
• Reflects specific circumstances of the hospital providing the services through use of hospital charges. • Relies on proven dispute resolution mechanism (i.e., civil courts). • Relies on market forces to establish prices; does not introduce setting of hospital prices by government. • Administratively simple. • Pays more to out-of-network hospitals than to network hospitals, recognizing that out-of-network hospitals do not receive other benefits of an HMO/health insurer contract, such as increased patient volume.	• Provides incentives to hospitals to increase billed charges. • Relies on expensive, protracted dispute resolution mechanism. • Does not reflect "market" value of services provided by network hospitals, since amounts paid by HMOs/health insurers are determined according to negotiated contractual agreements and are generally less than standard billed charges. • Does little to address "defensive contracting" by HMOs/health insurers or to relieve upward pressure on premium rates.

Alternative #2: The basis for benefit determination is mandated to be the amount customarily paid by the HMO/insurer to hospitals in the hospital's service area for the hospital services provided, increased by some amount to reflect the fact that the out-of-network hospital is not receiving the benefits of a contract with the HMO/health insurer, such as increased patient volume. If payments are based on amounts less than billed charges, the HMO/health insurer must provide information to show how the reasonable and customary payment was determined (without breaching confidentiality or anti-trust strictures). Hospitals may challenge the reasonable and customary determination by the HMO/insurer through the courts.

Alternative #2 Advantages	Alternative #2 Disadvantages
• Reflects market value of services provided. • Relies on proven dispute resolution mechanism (i.e., civil courts). • Does not provide incentives to hospitals to increase billed charges. • Relieves some pressures on HMO/health insurer premium rates and pressure for "defensive contracting". • Relies on market forces to establish prices; does not introduce setting of hospital prices by government. • Pays more to out-of-network hospitals, recognizing that out-of-network hospitals do not receive the benefits of an HMO/health insurer contract, such as increased patient volume. • Similar to the usual, reasonable, and customary (URC) approach commonly included in health plans for out-of-network physician services.	• Does not reflect specific circumstances of the hospital providing the services. • Relies on expensive, protracted dispute resolution mechanism. • Difficult to establish customary payments for the wide range and combinations of hospital services. Administratively complex. • May not work well in markets where the HMO/insurer has few members/policy-holders, since the HMO/insurer may not have sufficient data to establish credible customary amounts. • Rewards aggressive/restrictive contracting by HMOs/health insurers by applying the HMO's/health insurer's network contract payment rates to out-of-network hospitals.

Alternative #3: The basis for benefit determination is mandated to be a percentage of Medicare allowable amounts that reflects a reasonable relationship of out-of-network allowed amounts to hospital costs and a reasonable relationship of out-of-network allowed amounts to the amounts allowed to network hospitals in the market area (for example, allowed out-of-network margin over cost 20% greater than market average in-network margins over cost), but in no event more than 100% of billed charges. Exhibit 1 is an illustration of such a calculation for San Francisco Bay Area. In this illustration, the basis for benefit determination would be 165% of Medicare allowable amounts for inpatient services and 240% of Medicare allowable amounts for outpatient services.

The following table shows Alternative #3 payment amounts for major market areas in the state, using the 20% additional margin over cost for out-of-network services. The payment amounts in the table were developed using 2005 CMS Hospital Cost Reports, Milliman unpublished data derived from 2005 claim records, and 2005 Medicare 5% sample data (See Exhibit 1 for an illustration of how the data were used).

Alternative #3 Out-of-Network Payment Amounts – 20% Additional Margin Over Cost

	Percentage of Medicare Allowable		Approximate Percentage of Billed Charges for All Hospitals	
Region	**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
Bakersfield	159%	244%	40%	51%
Fresno	130%	238%	39%	52%
Los Angeles	175%	268%	36%	46%
Orange	182%	266%	38%	52%
Riverside/San Bernardino	163%	281%	41%	52%
Sacramento	182%	247%	34%	40%
San Diego	159%	206%	35%	48%
San Francisco Bay Area	165%	240%	35%	46%
Other	180%	289%	40%	52%
Total State Average	171%	257%	37%	48%

Alternative #3 Advantages	Alternative #3 Disadvantages
• Reflects market value of services provided, based upon actual allowed charges in commercial marketplace. • Reflects some specific circumstances of the hospital providing services through use of Medicare allowable amounts as reference points. • Does not require or rely upon HMO/health insurer determination of reasonable or customary amounts. • Pays more to out-of-network hospitals than to network hospitals, recognizing that out-of-network hospitals do not receive other benefits of an HMO/health insurer contract. • Does not provide incentive to hospitals to raise billed charges. • Does not reward unduly aggressive/ restrictive contracting by HMO/health insurer, since the HMO's/health insurer's network contract payment rates are not used as a factor in calculating out-of-network payments. • Works adequately in all markets, regardless of HMO's/health insurer's volume of business in any market area. • Does not require a dispute resolution mechanism, since formula for determining allowed amounts is set by regulations applicable to all hospitals and to all HMOs/health insurers. • Relieves some pressure on HMO/health insurer premium rates and for "defensive contracting".	• Relies on government regulations, reflecting market conditions, to set allowable amounts, rather than directly on market forces. • Depends on reliable and timely information about amounts allowed for services provided by network hospitals in each market area. Such information is hard to obtain. • Relies on Medicare allowable amounts, which may not adequately reflect specific circumstances of the hospital providing the services. • Is difficult to calculate Medicare allowable payment rates because of the complexities of Medicare payment formulas, e.g., DRG instead of per diem, outlier provisions, additional payment for medical education.

We recommend Alternative #3, which, although imperfect, appears to offer the best solution to the problem.

DESCRIPTION OF EXISTING MODELS

A review of the literature and a survey of Milliman's consultant network did not reveal successful models for addressing this problem at a state-wide level. An alternative that has been used by Maryland is to have hospital reimbursement rates for all payers (other than the federal government) set by a state regulatory agency. This approach is bureaucratically complex, and we sense little support for such an approach in California. Texas appears to have considered legislation in 2005, but none was passed.

PROJECTED FINANCIAL IMPACTS

Financial impacts of the recommended alternative would vary substantially among hospitals and among HMOs/health insurers. We estimate that the recommended payment rates (State averages of 171% of Medicare allowable for inpatient services and 257% of Medicare allowable for outpatient services, or 221% of Medicare for inpatient and outpatient services combined) would amount to approximately 43% of billed charges for out-of-network services.

For some hospitals 221% of Medicare allowable may equal or exceed their billed charges; for other hospitals 221% of Medicare allowable may be far less than their billed charges. Based on OSHPD data, we estimate that hospitals would receive for out-of-network services from HMOs/health insurers approximately 17% to 100% of billed charges under Alternative #3.

Some HMOs/health insurers base their benefit calculations on amounts billed by out-of-network hospitals for their services. Others may base their payments on fixed per diem allowances or other amounts that are less than billed charges. On average, we estimate that HMOs/health insurers would pay out-of-network hospitals approximately 49% less than they do now, or approximately $638 million per year. We estimate that, other things being equal, this would

allow for a reduction in HMO/health insurer premium rates of approximately 1.5% on average, but the reductions, if any, would vary substantially by HMO/health insurer, and the reductions would vary substantially by geographic area in the State, reflecting market conditions and hospital network characteristics in each area.

In addition there could be other premium rate reductions as a result of the recommended change in policy if the reduced pressure on health plans to enter "defensive" contracts leads to an increase in the number of relatively narrow "high value" hospital networks. We have not made any attempt to quantify these hypothetical reductions, but, under certain market conditions, such reductions could be significant.

Assuming that hospitals would not be permitted to bill patients for the difference between their billed charges and amounts allowed by a health plan as a basis for benefit determinations, we estimate that hospital revenues for out-of-network services would decrease by approximately $638 million per year. Offsetting this decrease, we anticipate that increased payments to hospitals for services to Medi-Cal beneficiaries under the Governor's reform proposal would be substantially more than the reduction in payments from HMOs/health insurers for out-of-network services, but the net results would vary substantially by hospital. If, however, there are no substantial increases in Medi-Cal reimbursement rates, then policy options that address the problems identified in the Problem Statement would need to be reconsidered in the context of the other reforms proposed or enacted.

In addition, when developing cost-containment policies in general, and policies regarding hospital costs in particular, PBGH and policy-makers should consider the implications of the fact that, according to our analysis, Medicare payments for hospital services are less than hospital costs, resulting in substantial cost shifting to private sector payers. An example of such underpayments is shown on line (5) of Exhibit 1, which indicates Medicare allowed-to-cost ratios of less than 100%. The data indicate that such ratios are below 100% in almost all California regions.

PROJECTED EFFECTS ON QUALITY OF HEALTH CARE

The payments to out-of-network hospitals under Alternative #3 include a margin over hospital costs of approximately 86% in total. Although margins over cost would vary by hospital, in our opinion, amounts paid for out-of-network hospital services would exceed costs for almost every hospital in the State. Therefore, it appears there would be little or no economic incentive for out-of-network hospitals to avoid providing services to HMO/health insurer members/policyholders. Therefore, we anticipate no significant effects on quality of health care. However, the clarification of payment responsibilities may lead to a reduction of stress to patients since some disputes regarding financial responsibilities would be avoided.

Attachment 1

Governor's Health Care Proposal

The Governor's vision for health reform is an accessible, efficient, and affordable health care system that promotes a healthier California through prevention and wellness and universality of coverage. For the Governor's vision to be realized, health care reform must reflect a "systems" approach that incorporates three essential building blocks in an integrated manner. These building blocks are:

Prevention, health promotion, and wellness
Coverage for all Californians
Affordability and cost containment

A. PREVENTION, HEALTH PROMOTION, AND WELLNESS

Preventable disease and disability have a profound impact on the health of California residents and communities as well as on the continued growth in health care costs. An increased emphasis on disease prevention, health promotion and healthy lifestyles will improve health outcomes and help contain health care costs. To promote a healthier California and achieve long term cost containment, the Governor's action steps include:

Structuring benefits and providing incentives/rewards to promote prevention, wellness and healthy lifestyles through the implementation of "Healthy Actions Incentives/Rewards" programs in both the public and private sector: Implement "Healthy Action Incentives/Rewards" programs in both the public and private sectors to encourage the adoption of healthy behaviors. Californians who take personal responsibility to increase healthy practices and behaviors, thereby reducing their risk of chronic medical conditions and the incidence of infectious diseases, will benefit from participation in this groundbreaking program. The Healthy Action Rewards/Incentives program will reward Californians for participation in evidence-based practices and behaviors that have been shown to both reduce the burden of disease and are cost-effective. Individuals in public programs, such as Medi-Cal and Healthy Families, will earn rewards that may include gym memberships or weight management programs. Participants enrolled in commercial plans, including CalPERS, will earn rewards and incentives, including premium reductions, for engaging in healthy activities. The Governor's plan includes the creation of a new insurance subsidy pool administered by MRMIB through which low income adults will be provided with subsidized coverage. The pool's coverage will also include a Healthy Action Incentive/Rewards program. All health plans and insurers will be required to offer a health benefit package(s) that includes incentives/rewards programs, including premium reduction, in the event that an employer wishes to make them available to their employees. All of the Healthy Actions programs are linked to the completion of a Health Risk Assessment and follow-up doctor visit.

Establishing a national model for the prevention and treatment of diabetes*:* Over 2 million Californians currently have diabetes, and the number of Californians with diabetes is expected to

double by 2025. Over one quarter of people with diabetes do not know they have the disease. To better prevent, target and manage this high-cost chronic condition, Medi-Cal and the California Diabetes Program, in collaboration with community organizations, will jointly develop a comprehensive statewide initiative to institute proven interventions for pre-diabetes and diabetes screening, primary prevention, and self-management to reduce the number of people with diabetes or improve the health of those with the disease while reducing costly care within California's health care system.

Preventing medical errors and health care acquired infections: Medical errors and health care acquired infections unnecessarily compromise the health status of patients, lower health care quality and significantly contribute to health care costs. Patient harm due to such lapses causes an estimated 23,000 hospital deaths and untold numbers of injuries each year in California and costs over $4 billion annually. To combat this problem and significantly improve patient safety throughout California the Governor will: (1) Require electronic prescribing by all providers and facilities by 2010 to substantially reduce adverse drug events; (2) Require new health care safety measures and reporting requirements in California's health facilities to reduce medical errors and hospital acquired infections by 10% over 4 years; (3) Call upon the leadership of California's health facilities to implement evidence-based measures to prevent harm to patients and provide state technical assistance; and (4) Create a university-based academic "re-engineering" curriculum designed to improve patient safety and streamline costs within the health care delivery system.

Reversing obesity trends through nation-leading innovative and comprehensive strategies: Obesity threatens to surpass tobacco as the leading cause of preventable death among Californians and costs the state $28.5 billion in health care costs, lost productivity and workers' compensation. California can lead the nation in tackling obesity with the same success demonstrated in the state's anti-tobacco campaign. Based on the Governor's 10-Step Vision for a Healthy California, the Governor's proposal includes a sustained media campaign to encourage healthy choices; community-based activities to increase access to healthy food and physical activity in stores, schools, and neighborhoods; employee wellness programs; and school-based strategies that engage the broader community in obesity prevention activity.

Continuing the battle against tobacco use: Smoking is the leading preventable cause of death in California. California has led the nation in effective smoking control activities, achieving the second lowest rate of smoking among adults in the nation. Still, an estimated 3.8 million adults and 200,000 youth smoke. California can maintain its leadership role in tobacco control and further reduce smoking rates by increasing access to cessation services offered through the highly effective California Smokers' Helpline and maximizing utilization of cessation benefits.

B. COVER ALL CALIFORNIANS

According to the UCLA California Health Interview Survey, 6.5 million Californians were uninsured at some point during last year, representing 20% of children and non-elderly adults. 75% of the uninsured were in working families, with the majority having no health coverage through their employers.

Addressing the "hidden tax" benefits everyone: A recent report by the New America Foundation estimated that a "hidden tax" on California health premiums has driven prices 10%

higher to help cover the costs of caring for the state's large numbers of uninsured. The study indicated that this annual "hidden tax" is $1,186 per California family and $455 for individual health insurance policies. This tax is even higher when underpayments from government purchasers such as Medi-Cal are added in.

Source: Dobson, Allen et al. (2006). The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications. Health Affairs, 25, no. 1: 22-33.

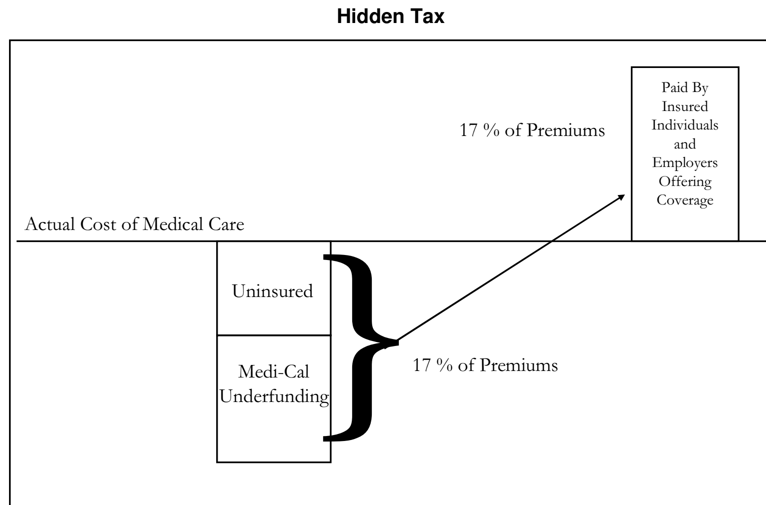

Figure 1: The effect of the hidden tax on insured individuals and employers offering coverage.

Ensuring availability of emergency rooms and trauma centers is essential: According to the Office of Statewide Health Planning and Development 65 emergency rooms (ERs) in California have closed in the last decade. In Los Angeles County, one fifth of emergency rooms have closed since 1995, leaving only 75 ERs open to the county's10 million residents. A new study by the federal Centers for Disease Control and Prevention indicates that between 40 percent and 50 percent of emergency departments experienced overcrowding during 2003 and 2004. A major source of this overcrowding, especially in metropolitan areas, is the uninsured and persons who have problems accessing physicians through government programs such as Medi-Cal, which also contributes to emergency department and trauma center closures across California. As a result, the well-being and life of many Californians is threatened by longer drives to fewer ER facilities, longer waiting times, and compromised hospital capacity to cope with a major emergency, such as a disease outbreak or earthquake.

Availability of insurance affects not only the physical but the financial health of the community: A 2002 synthesis of 25 years of research on the uninsured conducted by the Kaiser Commission on Medicaid and the Uninsured found that the uninsured receive less preventive care, are diagnosed at more advanced stages of illness, have reduced annual earnings from work and achieve reduced educational attainment. A National Institute of Medicine study indicated that the lack of insurance has resulted in a lost national economic productivity of $65 billion to $130 billion annually.

A February 2005 article in Health Affairs indicated that about half of the approximately 1.5 million American families that filed for bankruptcy in 2001 cited medical bills as the cause, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced bankruptcy due to lack of funds for medical expenses. The lack of insurance and underinsurance (less comprehensive medical policies) were major contributors to the bankruptcies for the two years

prior to 2005 as well. Numerous other articles have chronicled the sometimes catastrophic financial difficulties that individual families have encountered when facing uncovered health care costs.

To achieve coverage for all of California's uninsured, the Governor's action steps include:

Requiring all individuals to have a minimum level of coverage (individual mandate): Requiring people to carry coverage is the most effective strategy for fixing the broken health care system. The core problem for California is that those with insurance pay the cost of health care delivered to 6.5 million uninsured. Everyone must participate equally. An employer mandate will not achieve universal coverage because it fails to address the needs of part-time, seasonal and unemployed uninsured Californians.

Providing low-income individuals affordable coverage: Low-income Californians will be provided expanded access to public programs, such as Medi-Cal and Healthy Families, and lower-income working residents will be provided financial assistance to help with the cost of coverage through a new state-administered purchasing pool.

Requiring insurers to issue health insurance: Insurers will be required to guarantee coverage, with limits on how much they can charge based on age or health status, so that all individuals have access to affordable products.

Increasing Medi-Cal rates significantly: To reduce the "hidden tax" associated with low Medi-Cal reimbursement and to encourage greater provider participation in the Medi-Cal program, Medi-Cal rates for providers, hospitals and health plans will be increased.

Facilitating and enforcing the individual mandate: Systems will be established to facilitate enrollment of uninsured persons who use the health care system. Providers will play an important role in supporting enrollment by instituting such strategies as on-site enrollment at provider locations, as well as by underscoring the expectation that everyone present a coverage card at the point of service. In addition, the salary tax withholding and payment process with the Employment Development Department and the state income tax filing process will be utilized to promote compliance with the individual mandate.

Coverage Proposal Overview

6.5 million Californians are uninsured for all or part of a year; 4.8 million Californians are uninsured at any given time. Governor Arnold Schwarzenegger's health care initiative identifies sufficient funds to cover all Californians through a variety of mechanisms. Jon Gruber, Ph.D., an MIT economist and health care expert has assisted the Administration in estimating individual and employee behavior in the coverage model outlined below based upon coverage for all 4.8 million uninsured residents.

Coverage for uninsured children (approximately 750,000):

- All uninsured children below 300% of the federal poverty level (FPL), regardless of residency status, will be eligible for state-subsidized coverage. 220,000 uninsured

children below 100% of the FPL will enroll in Medi-Cal, while 250,000 uninsured children between 101-300% of the FPL will enroll in the Healthy Families Program.

- 210,000 uninsured children will enroll in employer-sponsored coverage and an additional 50,000 uninsured children above 300% of the FPL would be covered by private insurance by their parents or responsible adult. Parents of these children will be responsible for purchasing at least the minimum level of coverage for their children.

Coverage for uninsured adults (approximately 4.1 Million)

- 630,000 uninsured legal resident adults with incomes below 100% of the FPL will be eligible for and enroll in no-cost Medi-Cal. This population has little discretionary income and purchasing Medi-Cal is a cost-effective coverage option.
- Approximately 1.2 million uninsured legal resident adults with incomes between 100-250% of the FPL will be eligible for coverage through a state purchasing pool operated by the Managed Risk Medical Insurance Board. Approximately 1 million are expected to enroll with the remaining 200,000 opting for employer-sponsored coverage.
- Consistent with the principle of shared responsibility, the individual's/family's contribution toward the premium will be as follows:
  - 100-150%: 3% of gross income
  - 151-200%: 4% of gross income
  - 201-250%: 6% of gross income
- Approximately 1.1 million uninsured legal resident adults above 250% percent of the FPL will not receive a subsidy and will be required to purchase and maintain coverage under the individual mandate. Of this amount, 370,000 are expected to opt for employer-sponsored coverage and 730,000 are expected to purchase individual coverage.
- There are approximately 1 million uninsured persons without a "green card" (primarily undocumented persons and persons with temporary visas). Of this amount, approximately 40,000 are expected to opt for employer-sponsored coverage and 160,000 are expected to purchase individual coverage. The remaining 750,000 under 250% of the FPL are expected to receive health coverage provided, coordinated or arranged by county government in coordination, where applicable, with county and University of California hospitals. Counties would retain $1 billion in current funding (primarily for outpatient services) and county and UC hospitals will retain $1 billion in federal Disproportionate Share Hospital (DSH) funds and in addition, some "safety net" funds for primarily inpatient services. The state will also continue to fund emergency Medi-Cal which provides certain vital services such as prenatal care and maternity for this population.

Payment assistance will be available for low-income insured adults: In order to maintain equity for low-income persons who are already contributing towards the cost of their care, persons with individual or employer-sponsored coverage who are between 100-250% of the poverty level will be eligible for state financial assistance through the purchasing pool. Approximately 700,000 persons are expected to utilize this option. Persons with employer sponsored coverage are eligible for state financial assistance through the purchasing pool for the employee share of the premium only if the employer contributes to the cost of coverage for those employees.

Anti crowd-out provisions are included to disincentivize employers and employees from dropping current coverage. These include the 4% employer "in-lieu" fee for non-offering employers with 10 or more employees, purchasing pool premium contribution levels which are slightly higher than employee-only premium contribution levels, and a proposed provision that will be added to the Labor Code making it an unfair business practice for an employer to

differentiate the employer premium contribution by class of employee, except pursuant to a collective bargaining agreement.

In order to establish a more organized system of state-subsidized coverage that simplifies the eligibility system and maintains family unity of coverage, a "bright line" will be established between the Medi-Cal program and other subsidized programs (except for pregnant women). This would affect 680,000 children and 215,000 adult Medi-Cal enrollees above 100% of the Federal Poverty Level who would switch coverage to either the Healthy Families Program or the purchasing pool.

Source: Governor Schwarzenegger's health care team.

California's Family Health Insurance Programs

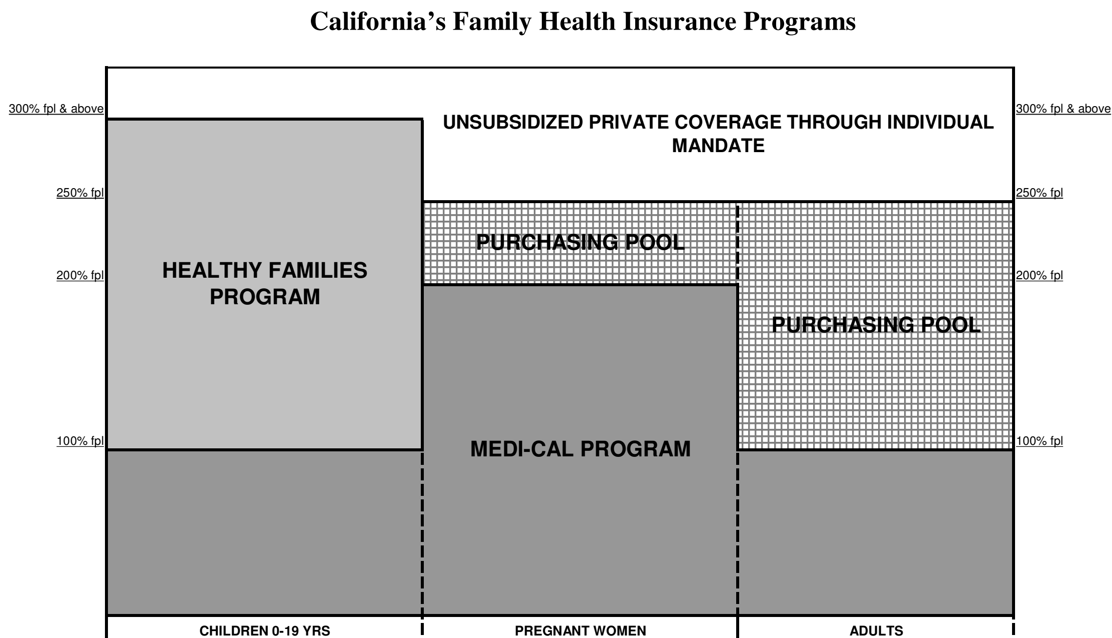

Figure 2: Proposed state coverage programs.

Everyone must maintain a minimum level of insurance:

- All Californians will be required to have health insurance coverage. Coverage must be substantial enough to protect families against catastrophic costs as well as minimize the "cost shift" that occurs when large numbers of persons are receiving care without paying the full cost of that care.
- The *minimum* health insurance benefit that must be maintained will be a $5,000 deductible plan with maximum out-of-pocket limits of $7,500 per person and $10,000 per family. For the majority of uninsured individuals, such coverage can be purchased today for $100 or less per month for an individual and $200 or less for two persons. Uninsured persons at any income level can purchase their own health coverage that meets the above requirement or, if income eligible, may obtain coverage with a state subsidy.
- Coverage through the new purchasing pool will fulfill an individual's obligation to obtain health coverage. The subsidized coverage through the purchasing pool is expected to be at the level of Knox-Keene medical benefits plus prescription drugs. Deductibles and/or co-payments that encourage the use of preventive benefits and discourage unnecessary use of emergency rooms will also be a part of the benefit package. The design of the

subsidized benefit package will be the responsibility of the Managed Risk Medical Insurance Board. Although dental and vision benefits will not be included in the subsidized benefits, the pool will also offer non-subsidized products so that members can purchase richer benefits at their own expense. Persons between 100-250% FPL will have the option to purchase this subsidized coverage through the pool.

- Medi-Cal and Healthy Families Program benefits are expected to remain the same.
- Persons not eligible for a subsidy can purchase coverage that meets the minimum requirements in the private individual market. They can also access the mandated minimum $5,000 deductible product in the purchasing pool. Individuals will also be able to take advantage of the federal pre-tax premium deductions in either place if eligible.

Under shared responsibility, financing for expanded public programs, the subsidized health plan, increased Medi-Cal rates, and programs to promote prevention, health and wellness will be achieved through the following structure:

- Employers with 10 or more employees who choose not to offer health coverage will contribute an amount equal to 4% of payroll toward the cost of employees health coverage.
- The plan will direct $10-$15 billion to hospitals and doctors, who will then return a portion of this coverage dividend associated with universal coverage; hospitals will contribute 4% of gross revenues and physicians will contribute 2% of gross revenues.
- The redirection of $2 billion in medically indigent care funding, which includes health care safety net, realignment and other funding sources.
- Additional federal reimbursements for Healthy Families Program expansion, Medi-Cal rate increases, Medi-Cal coverage of parents as well as single adults through a Medi-Cal Section 1115 Waiver.

The proceeds from these revenue sources will be deposited into a newly established Health Care Services Fund. These funds will be segregated from the state general fund and will be the source for payments for health care coverage under the initiative.

Under the proposal, counties, county and University of California hospitals, will retain $2 billion in current funding for the uninsured. The State will continue to fund emergency Medi-Cal, which provides certain vital services, including emergency care, prenatal care and maternity services for this population.

C. AFFORDABILITY AND COST CONTAINMENT

Cost and coverage must be addressed together: without short- and long-term cost containment measures, the current system of health care delivery is not sustainable for employers and employees. With health care costs rising faster than general inflation, even more employers and employees will discontinue coverage and reliance on state health care programs will increase if health care affordability is not addressed. Cost containment becomes even more important with an individual mandate so individuals can afford to purchase and maintain comprehensive benefits.

Reduction of the "Hidden Tax":

- Once more Californians have coverage, providers won't need to continue loading their insurance charges with extra funds to make up for the cost of caring for those without coverage.
- Increased Medi-Cal reimbursement will further reduce the need of providers to shift uncompensated Medi-Cal costs to other payers.
- Employers will finally see an end to the annual premium cost-spikes they are currently experiencing. Providing health coverage to their employees will be more affordable.

Enhanced tax breaks for individuals and employers for the purchase of insurance:

- Align state tax laws with federal laws by allowing persons to make pre-tax contributions to individual health care insurance Health Savings Accounts.
- Require employers to establish "Section 125" plans so that employees can make tax-sheltered contributions to health insurance and save employers additional FICA contributions.

Enhance insurer and hospital efficiency:

- Require health plans (HMO's), insurers and hospitals to spend 85% of every dollar in premium and health spending on patient care.
- Revise the amount an insurer must pay a hospital when insured persons need treatment outside of their network so insurers don't need "defensive contracting" to protect against high daily rates from out-of-network providers.

Reduce regulatory barriers to more efficient health care delivery:

- Implement a new federal classification system for hospital construction and establish a new structural performance category to adopt a "worst first" system of hospital conformity to California's seismic safety requirements.
- Implement a "24-Hour Coverage" program that combines and coordinates the health care component of workers' compensation with traditional group health coverage. The proposed five-year pilot program for Cal-PERS (state and local agency employees) will ensure that health care services are delivered by the same set of providers used in the Cal-PERS managed care/HMO program for work and non-work-related health care. The private sector will be allowed to opt into the pilot.
- Remove statutory and regulatory barriers to expansion of lower-cost models of health care delivery such as retail-based medical clinics by making scope of practice changes for "physician extenders" such as nurse practitioners and physician assistants.

Reduce cost for delivering HMO products to employers and individuals:

- Review health/plan benefit, provider and procedural mandates in order to reduce the cost of health care.
- Allow electronic submission of documents between insurers and their enrollees.
- Eliminate unnecessary health plan reporting requirements, such as the report on late grievances, antifraud and arbitration reports, which are confusing and result in incomplete and/or not useful information.
- Streamline health insurance product approval.
- Develop a technology assessment process that will promote evidence-based care.

Prevention, health promotion and wellness represent critical long-term cost containment strategies, as described above. Other key components for achieving long-term affordability include:

Health Information Technology (HIT): Health Information Technology offers great promise as one means to achieve more affordable, safe, and accessible health care for Californians while inside and outside of the state . Governor Schwarzenegger proposes the following action steps to advance the adoption of HIT throughout California:

- Providing state leadership and coordination by appointing a Deputy Secretary of HIT to lead and coordinate the state's HIT-related efforts to achieve 100 percent electronic health data exchange in the next 10 years.
- Improving patient safety through universal e-prescribing by 2010.
- Accelerating HIT by leveraging state purchasing, including support for uniform interoperability standards and HIT adoption, such as e-prescribing.
- Supporting consumer empowerment through use of standardized Personal Health Records (PHR)in the shorter-term within the public and private sectors that: are accessible via the internet and smart cards, are portable between health plan, and provide consumers with access to the core set of data in their PHR for their use and the use of their providers.
- At the county level, a pilot of an Electronic Medical Record system will be implemented, utilizing requirements under the Mental Health Services Act, creating an integrated network of care for mental health clients.
- Facilitating the use of innovative financing mechanisms, guided by a State HIT Financing Advisory Committee, to ensure the development of public/private partnerships and to meet capital needs for important HIT-related projects.
- Expanding broadband capabilities to facilitate the use of telemedicine and tele-health, particularly in underserved areas throughout the state and stimulating the adoption of e-health technologies throughout the state through engagement of early tele-health adopters, communities in which they serve, technology firms, and community stakeholders.

Leverage state purchasing power through Medi-Cal:

- Increase Medi-Cal physician, hospital outpatient and inpatient, and health plan rates to promote a stable and sizeable provider network and assure continued timely access to health care for Medi-Cal beneficiaries and the broader population.
- Link future Medi-Cal provider and plan rate increases to specific performance improvements measures, including measuring and reporting quality information, improvements in health care efficiency and safety, and health information technology adoption.
- Pursue a federal Medicaid 1115 waiver to maximize federal financing and support innovations in the financing and delivery of services through Medi-Cal. Such innovations can include the use of incentives and rewards for healthy behaviors, new strategies for diabetes prevention and management, adoption of health information technology, and strategies to rebalance the state's current system of long term care services in support of home and community-based services.

Enhance health care quality and efficiency:

- Provide a one-stop resource for information on health plan performance through the Office of the Patient Advocate website (www.opa.ca.gov) to increase the transparency of quality of care and access to other information to help inform consumers.
- Expand and strengthen the ability of the Office of Statewide Health Planning and Development to collect, integrate and distribute data on health outcomes, costs, utilization and pricing for use by providers, purchasers and consumers so that additional health care data is available to inform and drive decision-making.
- Partner with private and public sector purchasers to promote the measurement and reporting of provider performance and the aggregation of data for quality improvement, pay for performance and consumer choice.

We have a social, economic and moral imperative to fix California's broken health care system and improve health care for all. Health care reform is essential to a healthy, productive and economically competitive California. The foundation of the Governor's plan to expand health coverage and contain costs is shared responsibility. Just as society as a whole shares in the benefits of universal coverage and health care affordability, so too is there a shared responsibility to secure universal coverage and contain health care costs. Over the course of the next year, the Governor and his Administration will work collaboratively with the Legislature, employers, health care insurers and providers, and all Californians to create a national model for health care.

Source: Governor Schwarzenegger's health care team.

State Fiscal Impact Summary
(Dollars in Millions)

COSTS	STATE	LOCAL	FEDERAL	TOTAL COSTS	INDIVIDUAL TAX REDUCTION	SAFETY NET CARE POOL[1]
Increased Medi-Cal/Healthy Families Program Coverage	$1,283		$1,357	$2,638		
Subsidy for Persons 100% -250% of FPL	$1,135		$1,135	$2,270		$542
Persons w/o Green Cards Provided Coverage by Counties		$1,000	$1,000	$2,000		
Prevention and Wellness Measures	$150		$150	$300		
Section 125 Tax Treatment (State Income Tax Reduction)	$900			$900	$900	
Section 125 Tax Treatment (Federal Income Tax and FICA Reduction)					$7,500	
Medi-Cal Rate Increase	$2,208		$1,832	$4,039		$224
TOTAL COSTS	**$5,675**	**$1,000**	**$5,474**	**$12,147**	**$8,400**	**$766**

REVENUES	
Employer 4% of Social Security Wages Payroll In-Lieu Fee (employers with <10 employees excluded)	$1,000
Provider Coverage Dividend (4% Gross Revenues from Hospitals and 2% from Physicians)	$3,472
County Funds Available from Relief of County Obligations	$1,000
Savings from the elimination of State Programs[2]	$203
TOTAL REVENUES	**$5,675**

NET SURPLUS/SHORTFALL	$0

[1] Safety Net Care pool funding is included in the federal fund cost column and is split out in this column to show how these funds are being used.
[2] The Access for Infants and Mothers program, Managed Risk Medical Insurance Program and Medi-Cal Share-of-Cost will no longer be needed.

Figure 3: Fiscal impact of Governor's proposal.

Attachment 2

650 California Street, 17th Floor
San Francisco, California 94108-2702
Tel +1 415 403.1333
Fax +1 415 403.1334
www.milliman.com

April 24, 2007

RECIPIENT
TITLE
ORGANIZATION NAME
ADDRESS1
ADDRESS2

Dear RECIPIENT:

Governor Arnold Schwarzenegger's proposal for health reform in California is of keen interest to all stakeholders. Among other concepts, it contains the following element:

"Revise the amount an insurer must pay to a hospital when insured persons need treatment outside of their network so insurers don't need 'defensive contracting' to protect against high daily rates from out-of-network providers."

Consistent with its mission to promote healthcare quality and value, Pacific Business Group on Health (PBGH) seeks to inform policy-makers and its members by developing summaries of the policy implications of selected proposals by Governor Schwarzenegger or legislative leaders. Accordingly, PBGH has engaged Milliman, Inc. ("Milliman") to develop a research paper regarding alternative ways to revise payments to hospitals for out-of-network services and the potential impact of such revisions.

We would like the benefit of your expertise or perspectives about this matter. Therefore, we ask you to complete the attached questionnaire and return it to me by May 4, 2007 at the following address:

Jay.ripps@milliman.com,

Jay C. Ripps, FSA, MAAA
Milliman, Inc.
650 California Street
Floor 17
San Francisco, CA 94108
Phone Number: (415) 403-1333
Fax Number: (415) 403-1333

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Please be assured that we will keep the identity of all respondents confidential within Milliman, and will not release this information to PBGH or any outside party without your prior permission.

Thank you in advance for completing the questionnaire. If you have questions regarding the questionnaire or wish to discuss this subject, please contact me at (415) 403-1333.

Very truly yours,

Jay C. Ripps, FSA, MAAA
Consulting Actuary

HOSPITAL SERVICES FOR OUT-OF-NETWORK MEMBERS

1. In 2006, what was the total amount of claims paid by your health plans to the following categories of hospitals in California for inpatient services[1] to members enrolled in commercial HMO/PPO plans licensed in California ("California commercial members"):

    - Hospitals with which your health plan has a provider contract in effect?
    - Hospitals with which your health plan does not have a provider contract in effect?

2. In 2006, what was the total amount of claims paid by your health plans to the following categories of hospitals in California for outpatient services to California commercial members[2]:

    - Hospitals with which your health plan has a provider contract in effect?
    - Hospitals with which your health plan does not have a provider contract in effect?

---

[1] Hospital inpatient services include daily room and board and ancillary services in a short-term hospital. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs, and supplies. Costs include facilities charges billed on a UB-92 claim form only.
[2] Hospital outpatient services include services provided in an outpatient facility setting, such as emergency room, surgery, radiology and pathology services performed by a hospital outpatient department, pharmacy and blood provided in a hospital outpatient department, and physical therapy/occupational therapy/speech therapy. Costs include facilities charges billed on a UB-92 claim form only.

3. In 2006, how did your health plans pay for inpatient services to California commercial members provided by hospitals in California with which your health plan did not have a provider contract in effect (i.e., out of network)?

	Percent of Out of Network Claims (By Amount Paid)	Average Percentage of Billed Charges
(a) Full Billed Charges	_____________%	100 %
(b) Percent of Billed Charges Less than 100%	_____________ %	_____________ %
(c) Negotiated/per diem Rates (Describe)	_____________ %	_____________ %
(d) Percentage of Medicare Allowable Amounts (Describe)	_____________ %	_____________ %
(e) Other (Describe)	_____________ %	_____________ %
Total	100 %	

4. In 2006, how did your health plans pay for outpatient services for California commercial members to the hospitals with which your health plan does not have a provider contract in effect (i.e., out of network)?

	Percent of Out of Network Claims (By Amount Paid)	Average Percentage of Billed Charges
(a) Full Billed Charges	_____________%	100 %
(b) Percent of Billed Charges Less than 100%	_____________ %	_____________ %
(c) Negotiated Rates (Describe)	_____________ %	_____________ %
(d) Percentage of Medicare Allowable Amounts (Describe)	_____________ %	_____________ %
(e) Other (Describe)	_____________ %	_____________ %
Total	100 %	

5. Do you have specific concerns about potential negative implications of the Governor's proposal to revise the amount an insurer must pay to a hospital for healthcare services performed at a hospital outside of an insurer's hospital network? If so, what are your concerns?

6. What are your suggestions regarding how the Governor's proposal might be implemented? In particular, what reimbursement formula/approach do you recommend and why?

CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

Attachment 3

October 3, 2006

Kevin Donohue
Deputy Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Unfair Billing Patterns; Prohibition Against Billing Enrollees for Emergency Services; Independent Dispute Resolution Process **(Control No. 2006-0777)**; Claims Settlement Practices; Reasonable and Customary Criteria **(Control No. 2006-0782)**

Dear Mr. Donohue:

The California Hospital Association (CHA), which represents more than 400 hospitals statewide, appreciates the opportunity to comment on the Department of Managed Health Care's (DMHC) proposed regulations adopting 28 CCR §1300.71.39 and revising §1300.71.38 regarding a ban on balance billing and an independent dispute resolution process (IDRP), as well as the regulations revising §1300.71 regarding reasonable and customary criteria.

Summary

DMHC has filed two regulatory packages. The first regulatory package (Control No. 2006-0777) bans balance billing by emergency providers and establishes an independent dispute resolution process (IDRP) for resolving noncontracted provider disputes. CHA is opposed to the ban on balance billing as adopted by 28 CCR §1300.71.39 for the reasons stated below. However, we do support adoption of the IDRP as proposed by the amendments to §1300.71.38 because the IDRP is voluntary for providers, and is an additional voluntary mechanism available for resolving reimbursement disputes when appropriate. We look forward to working with the DMHC to further develop, refine and implement the IDRP and encourage providers to take advantage of this additional option to resolve disputes.

The second regulatory package (Control No. 2006-0782) adds a seventh factor to the six factors in the AB 1455 (Chapter 827, Statutes of 2000) regulations for determining what is a "prompt and fair" payment to noncontracted providers for enforcement purposes. The seventh factor is "any other relevant documentation necessary to determine reasonable and customary value." CHA is opposed to the addition of this factor as proposed in the amendments to §1300.71(a)(3)(B) for the reasons stated below.

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Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

Our comments will address each of these issues separately. However, because there are three related components in two separate regulatory packages, our comments are generally related to both regulation packages as a whole.

Ban on Balance Billing : §1300.71.39

DMHC proposes adopting §1300.71.39 to prohibit balance billing by emergency providers. DMHC does not regulate hospitals, and thus there is no authority for DMHC to regulate hospital billing practices. More specifically, there is no statutory authority for the Department to ban balance billing.

Section 1300.71.39(b) would prohibit unfair billing patterns, defined as:

> "(b) …'[u]nfair billing pattern' includes the practice, by a provider of emergency services, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan for the provision of covered services."

Section 1300.71.39(b)(2) of the proposed regulation specifically states that:

> "An emergency services provider who provides emergency services to an enrollee of a health care service plan may not collect or attempt to collect from the enrollee any amount due to the provider by the health plan, and instead must seek reimbursement directly from the health care service plan for the provision of covered services."

Existing law prohibits balance billing by ***contracted*** providers. Health & Safety Code §1379(a) provides that contracts between a health plan and provider must be in writing and must ban balance billing:

> "Every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan."

Subdivision (b) further provides that balance billing is prohibited when oral contracts exist:

> "In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan."

There is no similar provision in state law that prohibits balance billing by ***noncontracted*** providers. For this reason, proponents of a ban on balance billing have attempted for several years now to enact legislation prohibiting all balance billing. These efforts have failed. The Legislature's decision to reject proposed legislation and instead continue to allow balance billing

for ***noncontracted*** providers is further evidence there is no statutory authority for this regulation. DMHC cannot achieve any policy goal through regulation that has not been authorized by the Legislature.

DMHC incorrectly cites AB 1455 as statutory authority for its regulation to ban balance billing. AB 1455 was enacted in 2000 to ensure that *health plans* pay providers promptly and fairly. The language DMHC incorrectly relies on is found in Health & Safety Code §1371.39(b), which provides that health plans may report to DMHC instances in which the plan believes a provider is engaging in an unfair billing pattern. Section 1371.39(b) provides as follows:

> "(b) Plans may report to the department's Office of Plan and Provider Relations, either through the toll-free provider line (877-525-1295) or e-mail address (plans-providers@dmhc.ca.gov), instances in which the plan believes a provider is engaging in an unfair billing pattern."

An unfair billing pattern is defined in §1371.39(b)(1):

> "'Unfair billing pattern' means engaging in a demonstrable and unjust pattern of unbundling of claims, up-coding of claims, or other demonstrable and unjustified billing patterns, as defined by the department."

There is no statutory authority for DMHC to act on these reports, other than to *make recommendations* regarding these matters. Section 1371(b)(2) provides as follows:

> "The department shall convene appropriate state agencies to make recommendations by July 1, 2001, to the Legislature and the Governor for the purpose of developing a system for responding to unfair billing patterns as defined in this section. This section shall include a process by which information is made available to the public regarding actions taken against providers for unfair billing patterns and the activities that were the basis for the action."

The statutory construct does not mandate or authorize DMHC to begin a regulatory process regarding unfair billing practices, but to instead begin an information gathering process. The Legislature in passing AB 1455 went much further in establishing a regulatory process for unfair payment practices, but stopped short of mandating a parallel construct regarding unfair billing practices.

The Legislature, in passing AB 1455, clearly recognized the inherent complexity involved in developing a regulatory system regarding unfair billing practices. By deferring this issue, and instead placing a priority on developing a regulatory system regarding unfair payment practices, the Legislature also recognized that resolving the systemic problems regarding unfair payment practices would by its very nature address many of the payer concerns regarding allegedly unfair billing practices.

Thus, these regulations are based on a statute that directs DMHC to accept complaints from health plans, but grants no regulatory or enforcement authority. Instead, the statute cited by DMHC simply authorizes it to make recommendations for responding to unfair billing patterns. DMHC all but admits its lack of statutory authority for the regulation by using broad and conclusory language:

> "The broad authority granted the Department by Section 1371.39(b)(1) to identify demonstrable and unjustified billing patterns in addition to unbundling and up-coding *reasonably must* include the authority to address additional situations ….Based on the express and broad language of Section 1371.39, the Department has clear authority to prohibit balance billing by non-contracting emergency providers by defining the practice as a demonstrable and unjust billing pattern." (Notice of Rulemaking Action, p. 7) (Emphasis added.)

It is also possible this regulation is premature since DMHC did not issue a report to the Governor and the Legislature that may be a condition precedent to development of regulations. Health & Safety Code §1371.39 provides:

> "On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unfair billing pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption."

DMHC has not, to CHA's knowledge, implemented this section of law. DMHC held a public hearing on unfair billing patterns on October 5, 2004, but has taken no other action to develop a report or recommendations ***for legislation.*** Thus, there appears to be no authority for a regulation.

<u>Reasonable & Customary Regulation: Control #2006-0782</u>

Title 28, §1300.71(a)(3)(B) of the California Code of Regulations establishes six factors, commonly referred to as the *Gould* criteria, for determining the "reasonable and customary value" of a claim for health care services rendered by a noncontracting provider.

> "(3) 'Reimbursement of a Claim' means: . . . (B) For contracted providers without a written contract and non-contracting providers . . . the payment of the reasonable and customary value of the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the

> medical provider's practice that are relevant; and (vi) any unusual circumstances in the case."

When these regulations became effective January 1, 2004, CHA was concerned that this language might be used by health plans and DMHC to establish final reimbursement rates, rather than being used only by DMHC to determine if a plan had paid on time and exercise its enforcement authority authorized by the Knox-Keene Act. CHA sought an injunction against the implementation of §1300.71(a)(3)(B), alleging the regulations amounted to rate-setting, which exceeded the statutory authority of DMHC. The California Association of Health Plans intervened in the litigation, and thus its members and delegated providers are bound by the court's decision. In August 2004, the court upheld the validity of the regulations. However, the court also held that the initial payment established by DMHC under the "reasonable and customary value" standard is for the "purposes of applying the claims processing timelines and in determining unfair payment patterns." The court concluded that the reasonable value standard should be used only for DMHC's regulatory purposes of determining whether payments have been made on time or whether health plans have engaged in unfair payment practices, as opposed to establishing a standard that would constitute a final payment determination. (See attached, *CHA v. DMHC,* Case #03CS01643, Sacramento Superior Court (August 10, 2004)).

Thus, the law is clear that the factors in §1300.71(a)(3)(B) are not for determining how a provider must be paid (that would be rate-setting.) However, health plans and their delegated provider groups have argued for reopening §1300.71(a)(3)(B) to include additional factors *for determining the final payment amount to a noncontracted provider.* (See DMHC record on Petition by the California Association of Health Plans and California Association of Physician Groups to reopen the AB 1455 regulations – March 2006). In addition, DMHC's comments and questions made in the public hearing on this regulation on September 13 in Burbank and September 25 in San Diego also focused on "what is the right amount to pay a noncontracted emergency services provider." This is clearly beyond the scope of AB 1455. In addition, the impact of these regulations go well beyond just emergency services, but an services provided by a hospital or physician.

The seventh factor proposed by §1300.71(a)(3)(B)(vii) is "any other relevant documentation necessary to determine reasonable and customary value." Health plans and their delegated providers have been very clear in their written communications to the DMHC and in their September 13 and September 25 comments in the public hearings that this vague catch-all provision would allow them to pay final reimbursement rates to providers based on the following factors:

- Average contract rates for the service of payers and providers in the general geographic area in which the service was provided.
- Rates paid pursuant to established fee schedules by governmental payers (e.g., Medicare, Medi-Cal, Healthy Families programs) for the service.
- Average amount for the service paid to and accepted by noncontracted providers in the general geographic area in which the service was provided.

Adding Section 1300.71(a)(3)(B)(vii) is inappropriate not only because proponents intend to use it for rate-setting, but also because it eliminates the incentive and value of entering into a contractual relationship. Allowing a health plan to substitute average contract rates ***for a noncontracted*** provider ignores that hospital's unique circumstances reflected in its billed charges: payer mix, population served, labor costs, specialty services, research and education functions, infrastructure and technology costs, etc. Basing payment for noncontracted services on contracted rates is also patently unfair because the noncontracted provider does not get all the benefits of the contractual relationship (e.g. volume, streamlined billing and payment, etc.). Allowing the use of this factor eliminates the benefit and incentive of having a contract.

In addition, the seventh criteria added by §1300.71(a)(3)(B)(vii) would allow the use of government fee schedules such as Medi-Cal and Medicare. These fee schedules are budget tools for public health programs and bear little relationship to the actual cost of providing services.

Similarly, systems based on accepted amounts by noncontracted providers are inappropriate because many providers make a business decision to accept an inadequate payment because the cost of collection is too high or too time-consuming considering the amounts involved. It would be unfair to allow a health plan or its delegated provider to make an inadequate payment, and then be able to use that inadequate payment as a factor in determining future payments simply because the noncontracting provider found it cost-prohibitive to challenge the inadequate payment in the first instance.

When CHA and other providers testified in the public hearings on this regulation, the DMHC asked witnesses what alternative they would propose in determining how a noncontracted provider should be paid. Again, we note for the record that this is beyond DMHC's scope of authority. The regulations have been interpreted by the court as relevant to assisting DMHC to determine if a claim has been paid promptly and is not an unfair payment practice – not for determining the appropriate payment.

However, in response to DMHC's question in the public hearings, CHA believes the appropriate standards for determining final reimbursement to a ***noncontracted*** provider should be based on billed charges. This standard is also the appropriate standard for DMHC to use in applying §1300.71(a)(3)(B) to determine if a claim has been reimbursed timely pursuant to AB 1455. The existing regulation includes billed charges as part of its six criteria, so no further changes to the regulation are necessary.

DMHC has framed the debate on the ban on balance billing (Control No. 2006-0777) and "Reasonable & Customary Criteria" (Control No. 2006-0782) by linking the two issues. The Department's position appears to be that if there is a process to determine how a noncontracted provider should be paid, than it is possible to ban balance billing. In response to the Department's request for alternatives to its regulation, there are two ways to address the regulatory issue of an unfair payment practice for non-contracted emergency services that results in balance billing. The first is to require the plan to pay full charges for non-contracted services thereby requiring the plan to sue the hospital to recover any amount that was more than *quantum*

meruit reasonable value. The second is to allow the plan to pay less than full charges, thereby requiring the hospital to sue the plan to obtain *quantum meruit* reasonable value.

The first approach, and the approach we propose, has the benefit of being closely aligned with longstanding law defining the measurement of *quantum meruit* reasonable value as what it would cost to obtain the service from someone else in the same market. This "market approach" also creates financial incentives for plans to carefully consider whether they have sufficient grounds to prove that a hospital's full charges for non-contracted emergency services are in fact less than what those services cost in the market. ***Finally, the market approach eliminates the balance billing issue because it requires the plan to leave no unpaid balance.*** *The additional benefit of this approach is that DMHC does not exceed its statutory authority by attempting to regulate hospitals or physicians.*

We recognize that the DMHC has been concerned that a regulation requiring the plan to pay a provider's full charges unless the plan obtains declaratory relief may affect the burden of proof of the reasonable value of services. However, the regulatory approach we suggest has nothing to do with which party would have the ultimate burden of proof in a lawsuit. The determination of which party to an action challenging a provider's charges as unreasonable will be made by the courts applying common law principles, not the DMHC. In fact, if the DMHC wants to make this clear, it can simply recite that the requirement that the plan pay the full billed charges is not intended to affect the burden of proof in a suit brought to challenge the reasonableness of the provider's charges.

The second approach is the one proposed in these regulations. As described below, it is inconsistent with the legal measure of *quantum meruit* as market value. It also creates incentives for plans to pay less than the legal measure of *quantum meruit* reasonable value. For example, it forces the hospital to make the cost benefit analysis of whether to seek the underpayment, and small amounts are likely not to be pursued. Also, many small and rural hospitals are not used to using the legal process and will not pursue even larger amounts. Those hospitals that do initiate a recovery action may compromise the dispute, resulting in an after-the-fact "contract" for discounted rates for the claims in dispute. The plan obtains many of these benefits without making any initial investment in a dispute resolution process and can control its dispute resolution costs by fighting only the cases where it calculates it has a high probability of success.

This undue leverage that a plan has in supporting an underpayment strategy is lessened only by the provider's right to seek proper payment from all parties. The solution to this problem is not to remove the right to balance bill and leave the plan with undue leverage to underpay the same hospitals regarding which it made the business decision not to contract, but to return to the market approach which is aligned with a market valuation of *quantum meruit* reasonable value.

Health plans and their delegated providers have argued that the market approach allows a hospital to get more than the *quantum meruit* reasonable value of emergency services it furnished when it is paid at its full charges. They use four myths that drive this inaccurate assumption:

Myth No 1.: The reasonable value of the service should be based solely upon its cost.

In an industry where the market is allowed to set the price of goods and services, an examination of the direct and indirect costs, volume and prices is all that is necessary to identify break even points of an enterprise and from there to calculate varying levels of profitability. Cost is not the only determinative factor of a service's market value, and is most likely the least relevant factor to consider in the highly regulated healthcare industry where the market is allowed to determine the price of less than 40 percent of the services furnished.

Government payers and the uninsured make up over 60% of the "customers," all of whom pay at varying levels below the *cost* (not the price) of the goods and services they consume. Moreover, the distribution of "customers" who receive services at varying levels below cost varies greatly from hospital to hospital. Thus the "payer mix" of varying government payers, uninsured and commercial payers, as well as a hospital's bad debt, must be added to the "cost" of the goods and services to analyze the reasonable value of a service.

If retail stores in the United States had to give free food, clothes, and camping equipment to the hungry, naked and homeless who "presented" at their front door, offered a 21.5 % discount from *cost* for those on welfare and in other "special categories," offered a 16.7 % discount from *cost* to those over 65, and had the additional charity care and bad debt experience of California hospitals, the population that did not fall in these categories would pay much more than it currently does for a loaf of bread, a pair of socks, or a toothbrush.

Existing §1300.71(a)(3)(B) is consistent with a focus on market factors rather than item-by-item cost, and the seventh proposed factor is therefore unnecessary and inconsistent.

Myth No. 2: Because the vast majority of the services a hospital furnishes are paid at less than full charges, that small minority of payers who are asked to pay full charges for non-contracted emergency services are being asked to pay more than their *quantum meruit* reasonable value.

California law is clear that the *quantum meruit* reasonable value of a service is its value in the relevant market. "[T]he reasonable value of the [physician] services is . . . the reasonable value of the services *in the community where they were rendered*, *by the person who rendered them*." *Citron v. Fields*, 30 Cal. App. 2d 51, 62 (1938) (emphasis added). "The reasonable value of what it would have cost Defendant to obtain the services Plaintiff provided *from another person*." *Maglica v. Maglica*, 66 Cal. App. 4th 442, 450 (1998) (approved jury instruction at fn 6) (emphasis added).

For the under 40 percent of payers who are commercial payers, there is a market for hospital services. Emergency services are part of this market and also have a market value. Plans who contribute a volume of patients requiring a range of services obtain these services, including emergency services, at contract rates that are less than full charges. Such plans are "buying" these discounted rates by "paying" with a volume of services that contributes to the hospital's

profit margin through a larger number of patient days or encounters at a lower margin. Plans that choose not to contribute a larger volume of patients pay full charges for non-contracted emergency services and contribute at a lower number of days or encounters, but at a higher margin. This market has existed for decades.

Fundamental tenants of a market economy are that the seller sets the price of what it sells, and that the only buyers who get the benefit of a contract rate are those who bargain and trade fair value for that discount. Under *Citron* and *Maglica*, the reasonable value of what it would have cost a plan to obtain emergency services "in the community where they were rendered". . ."from another person" is either the discounted price purchased by a contract that delivered volume, or the full charges price chosen by the plan when it chose not to contract.

Existing §1300.71(a)(3)(B), on its face, is consistent with California *quantum meruit* law. Indeed, five of the six factors listed in Section 1300.71(a)(3)(B) reflect that the reasonable value of a service is measured by its value in the market: (ii) the nature of the services provided, (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case." The only factor that does not apply is "(i) the provider's training, qualifications, and length of time in practice", and then only because it applies to physicians instead of hospitals. Applied to a physician, it also reflects a measure of market value.

3. The Plan Has No Choice But To Pay The Hospital's Full Charges

A common plan argument is that it is an "unwilling" or "captive" party which has "no choice" but to pay full charges. Nothing could be further from the truth. A plan finds itself with an obligation to pay full charges for non-contracted emergency services solely as a result of the choices it made, e.g., to expand market share in the area where the services were furnished, to not trade volume for contracted discounts at the hospital where the services were furnished, to not establish or contract with emergency clinics that can service the less acute emergency needs of its members, etc. A plan is faced with a bill of full charges for non-contracted emergency services for one reason only: it has rationally decided that it was in its financial interest not to contract with that hospital for discounted rates.

4. Hospitals reap excessive profits when they are paid full charges for non-contracted emergency services

The simple fact is that many hospitals lose money from operations and most do not make enough profit to adequately fund maintenance and growth in the rapidly growing communities they serve. On the other hand, health plans report much higher profits than hospitals.

The market approach to the balance billing issue is to let the plan's own market driven choice of whether or not to contract with a hospital drive its regulatory obligation to pay the market rate of full charges for non-contracted emergency services. This eliminates the issue of balance billing

while still leaving the plan with its legal right to challenge the *quantum meruit* value of full charges in those cases where the plan believes that this is cost effective.

Our proposed solution of requiring the health plan to pay the provider's charges unless the health plan seeks relief makes practical sense as well. The health plan is in a better position to make the decision whether to challenge a provider's customary charges. The health plan knows exactly what the provider's charges are, as it receives bills from the provider. The health plan also receives bills from other providers in the same market, so the plan can compare the charges in the local market area. Finally, the health plan has direct access to hospital charges and financial data through OSHPD. Using these materials, the health plan can make an informed decision regarding whether to challenge a particular provider's charges.

On the other hand, providers have little, if any, insight into a health plan's "reasonable payment" methodology under 28 C.C.R. 1300.71(a)(3)(B). In fact, the DMHC recognized that the original filings submitted by the health plans were insufficient to explain the methodologies, and required supplemental filings. Unfortunately, the supplemental filings were no better. Most simply describe in vague terms some proprietary methodology, and the filings available to providers have key information redacted. While providers can tell that a non-contracted health plan has paid a fraction of the provider's customary charges, providers cannot fairly determine how the non-contracted health plan determined what to pay. Thus, it should be up to the health plan to decide whether to challenge a provider's customary charges. This approach avoids the need for the DMHC to rely on a presumption that all providers' charges are unfair, and also more fully aligns with the purpose of AB1455--to promote payment of providers.

Thank you for your consideration of these comments.

Sincerely,

Dietmar A. Grellmann
Senior Vice President, Managed Care and Professional Services

cc: Suzanne Chammout, Chief, Regulation Development Division
Office of Legal Services, Department of Managed Health Care

Emilie Alvarez, Regulations Coordinator
Office of Legal Services, Department of Managed Health Care

Attachments: *CHA v. DMHC,* Case #03CS01643, Sacramento Superior Court (August 10, 2004)

Exhibit 1

Calculation of Out-of-Network Payment Basis

San Francisco Bay Area

		Inpatient	Outpatient
(1)	Average cost-to-charge ratio	25%	24%
(2)	Average commercial allowed-to-charge ratio (in-network hospital services)	33%	42%
(3)	Average in-network commercial allowed-to-cost ratio = (2) / (1)	131%	176%
(4)	Average out-of-network commercial allowed-to-cost ratio = 1.2 x [(3) – 100%] + 100%	138%	191%
(5)	Average Medicare allowed-to-cost ratio	84%	80%
(6)	Average percent of Medicare allowed for out-of-network hospital services = (4) ÷ (5)	165%	240%

Notes On Sources

(1) 2005 CMS Hospital Cost Reports
(2) Milliman unpublished data derived from 2005 claim records
(3) Calculated from items (1) and (2)
(4) Calculated from item (3)
(5) 5% sample of 2005 Medicare claims
(6) Calculated from items (4) and (5)