PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

# ISSUE BRIEF

# The Menace of Medical Rate Setting: The Case of California's AB 72

Wayne Winegarden

AUGUST 2020

A Pacific Research Institute Publication

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Pacific Research Institute
PO Box 60485
Pasadena, CA 91116
Tel: 415-989-0833
www.pacificresearch.org

# Contents

# Introduction

Surprise medical billing continues to plague the U.S. healthcare system. The problem occurs when patients seek treatment at healthcare facilities that are officially in their insurance network but receive some of their care from out-of-network doctors and healthcare practitioners. Often, patients are unaware that any of the doctors who treated them, such as their anesthesiologist, are not part of their insurance network. Since these practitioners are not in-network, insurers will typically cover a small portion of these large out-of-network fees. The patient is then invoiced to pay the remaining out-of-network charges, which are often distressingly large and a surprise to the patients who were unaware that any of their doctors were out-of-network.

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California was the first state to try to address the surprise billing problem by passing Assembly Bill 72, which has been in effect since July 2017. This law mandates that, if patients are using in-network hospitals or healthcare facilities, physicians must accept the average insurance reimbursement rate for their services (based on their location) or 125 percent of the Medicare reimbursement rate. The intention of AB 72 is to protect patients from the adverse consequences from surprise-billing. Unfortunately, it relies on price controls to achieve this goal.

Price controls, wherever they have been used, inevitably make a bad situation worse. Rent control policies are an excellent example of good intentions gone awry. Legislatures pass rent controls in order to increase the supply of affordable housing in a high-cost area or region – like San Francisco or New York City. However, a 2019 study in the *American Economic Review* found, “while rent control prevents displacement of incumbent renters in the short run, the lost rental housing supply likely drove up market rents in the long run, ultimately undermining the goals of the law.”[1] In other words, due to the responses of market participants, rent control policies wind up increasing average rents. Beyond the impact on prices, the empirical literature has also found that rent control policies undermine the quality of the housing supply in the regions where they are implemented.[2]

Similar to rent control, AB 72’s price controls are having significant and adverse impacts on California’s healthcare market. The rate cap *protects* patients from the problem of surprise billing just as rent controls *benefit* those renters lucky enough to procure a rent-controlled apartment. However, the same downsides of worsening quality and rising cost pressures are emerging in California.

# AB 72 Incentivizes Lower Quality Healthcare Services

As a government price control, AB 72 mandates arbitrary limits on a doctor practice’s revenue. The system’s advocates assume that the doctors impacted by the law will not change their behavior and provide patients with the same amount of healthcare services in the exact same manner. Thus, the advocates assume that AB 72’s price controls will reduce the cost of healthcare without impacting its quality. After three-years of implementation, this assumption is proving false.

The evidence to date is showing that AB 72 is narrowing patients' provider networks and incenting an acceleration in provider consolidation. Both of these trends threaten to decrease the quality of healthcare and increase its costs. Several surveys of California healthcare professionals demonstrate these adverse consequences are occurring.

For example, Duffy (2019) interviewed 28 policy experts regarding the impact from the new law. Those interviewed include the leadership of advocacy organizations, state-level professional associations, physician practice groups, hospitals, and health benefits companies.[3] These stakeholders noted that, in response to AB 72, doctors are "dropping off" on-call lists and specialists are unwilling to be on call during undesirable shifts (e.g. weekends, holidays, and late at night). These impacts exacerbate doctor shortages, particularly for key specialists at crucial times where doctor availability is the most limited.

A November 2019 survey by the California Medical Association (CMA) confirm the results from Duffy (2019).[4] This survey interviewed "855 physician practices representing thousands of physicians" that "represent a broad range of practice sizes and medical specialties from 52 counties in the state, representing urban, suburban and rural areas".[5]

A vast majority of the respondents (79 percent) stated that AB 72 reduced the availability of emergency and on call physicians.[6] In addition, most interviewees confirmed that the new law has created contracting difficulties (94 percent), reduced the size of physician networks (88 percent), and created access issues for their patients (62 percent).[7]

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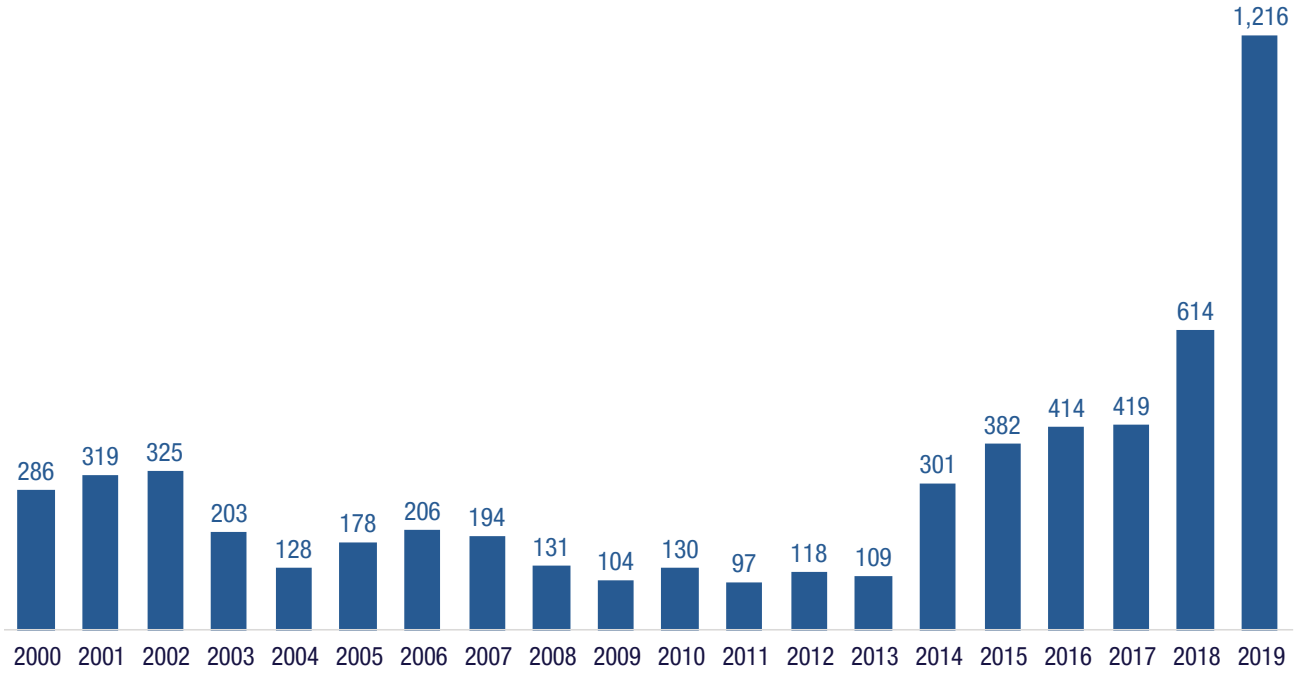
Patients seem to concur that access issues have worsened in California following the enactment of AB 72. One measure of these concerns is the data maintained by the California Department of Managed Health Care (DMHC).[8] The DMHC "resolves complaints from California health plan enrollees on issues such as billing, access, cancellation of coverage, and provider attitude."[9]

The number of patients complaining about access to care spiked in 2018, and then rose even further in 2019 (see Figure 1). These spikes are unprecedented in size and demonstrate a large disruption in the overall trend in complaints tracked by the DMHC. While the DMHC data does not state that these complaints are due to AB 72, the rise in complaints is consistent with both theory and the concerns raised by the healthcare professionals.

**Figure 1** Number of Access Issue Complaints Reported to the Department of Managed Health Care, 2000 - 2019




*Source: DMHC*

Undoubtedly, the rising problems of access, shrinking networks, and fewer on-call physicians threaten the quality of healthcare for patients throughout California.

## AB 72 Accelerates Healthcare Cost Pressures

Beyond these quality issues, AB 72 creates additional cost pressures that worsen California's healthcare affordability problem. To understand how AB 72 is generating these cost pressures, it is important to understand the problems that arise when policies *force* independent practices to consolidate with hospital systems.

Practice consolidation was a large and growing problem in California even before AB 72 was passed. A *Health Affairs* study by Scheffler, Arnold, and Whaley (2018), found that in California, "the percentage of physicians in practices owned by a hospital increased from about 25 percent in 2010 to more than 40 percent in 2016."[10] Practice consolidation reduces patient choice with respect to the type of healthcare they receive – those patients who prefer seeing doctors associated with an independent practice rather than a larger hospital system lose this option. There are also adverse cost implications. Scheffler, Arnold, and Whaley (2018) found that the practice consolidations between 2013 and 2016 was "associated with a 12 percent increase in marketplace premiums. For physician outpatient services, the increase in vertical integration was also associated with a 9 percent increase in specialist prices and a 5 percent increase in primary care prices."[11]

Other studies confirm the link between consolidation and higher prices. A review of studies by the National Council on Compensation Insurance (NCCI) confirmed that provider and hospital consolidations lead to higher healthcare costs.[12] Specifically, the NCCI study concluded that hospital mergers increased prices between 6 percent and 18 percent.[13] A 2015 Government Accountability Office (GAO) study examined the relative costs of charges in hospital settings compared to physician offices. The GAO analysis found that the Medicare payment rates were between 56 percent and 230 percent more expensive in the hospital setting.[14] In light of these pricing disparities, policies like AB 72 that further incentivize practice consolidation reduce competition and increase prices.

"Although consolidating smaller practices with larger hospital systems is an effective means to rebalance negotiation power, it is also increasing overall healthcare costs. Consequently, these dynamic responses to AB 72's price controls ultimately harm the patients that the legislation is designed to help.

AB 72 encourages additional practice consolidation because its price controls disadvantage smaller practices in their negotiations with insurers. Now, insurers can play hardball during negotiations with smaller practices knowing that the insurer can always fall back on the 125 percent of Medicare reimbursement rate if no agreement is reached. As a consequence, independent practices are finding it more difficult to remain financially viable. Under the status quo, an effective way for smaller independent practices to improve their negotiating leverage, and remain financially viable, is to combine with hospital systems in the state.

Essentially, by changing the balance of power during the negotiations, AB 72 further increased the incentive for independent practices to combine and affiliate with hospital systems. According to the aforementioned Duffy (2019) survey,

> hospital-based physicians are seeking to regain their leverage in negotiations with payers, and one approach is accelerating consolidation and exclusive contracting with facilities. Their logic follows that if only 1 practice exists in the local area serving all the local facilities, then payers will have to contract with them on their terms to fulfill network adequacy requirements. Although consolidation is an ongoing trend, several interviewees reported that AB-72 was "what clearly put it over the edge" for their practice. Physicians described engaging in mergers between practices and hiring independently practicing physicians in their area.[15]

Although consolidating smaller practices with larger hospital systems is an effective means to rebalance negotiation power, it is also increasing overall healthcare costs. Consequently, these dynamic responses to AB 72's price controls ultimately harm the patients that the legislation is designed to help.

## Transparency Not Price Controls

Having been in effect for three years, AB 72 has created unintended consequences that simultaneously increase the costs of healthcare and reduce its quality. Worse, it is likely that the current adjustments are just the beginning, and AB 72's adverse impact on the quality and cost of care will increase further over time.

Fortunately, the surprise billing problem can be resolved without imposing AB 72's burdens. For example, Badger and Blase (2019) propose policy reforms that would impose truth-in-advertising requirements on insurers and healthcare facilities.[16] The truth-in-advertising requirement "would hold insurers and facilities accountable for the information they provide consumers" by enforcing the common sense definition of an in-network facility.[17] Under this definition, a facility could only be considered in-network if all of a patient's charges reflect the in-network rates. This reform would create protections for patients and empower fair negotiations between insurers, doctors, and healthcare facilities to determine each party's appropriate compensation. The approach suggested by Badger and Blase addresses the surprise billing problem without resorting to price controls and the large costs that they inevitably create.

California's failed experiment with price controls should serve as a warning for other states and members of Congress, who are considering similar proposals for surprise medical bills at the federal level. The existence of alternative policy approaches demonstrates that the large costs created by price controls are not justifiable. Instead, reforms are possible that would control the surprise billing problem while enhancing the efficiency of the healthcare system. These reform ideas, not California's AB 72, should form the model for future policies geared toward resolving the problem of surprise billing.

# Endnotes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15 Duffy E L "Influence of Out-of-Network Payment Standards on Insurer–Provider Bargaining: California's Experience" *AJMC* August 5, 2019, https://www.ajmc.com/view/janssens-wild-gust-breaks-down-bispecific-antibodies-in-development-for-nonsmall-cell-lung-cancer-and-multiple-myeloma.

16 Badger D and Blase B "A Targeted Approach to Surprise Medical Billing" Galen Institute December 2019, https://galen.org/assets/A_Targeted_Approach_To_Surprise_Medical_Billing.pdf. The study also addresses the surprise billing problems that arise when patients seek care at an out-of-network facility during a medical emergency. To protect patients, the study suggests that balance billing on patients during emergency situations should be prohibited.

17 Badger D and Blase B "A Targeted Approach to Surprise Medical Billing" Galen Institute December 2019, https://galen.org/assets/A_Targeted_Approach_To_Surprise_Medical_Billing.pdf.

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SAN FRANCISCO HEADQUARTERS
Tel 415-989-0833

SACRAMENTO OFFICE
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