Influence of Out-of-Network Payment Standards on Insurer–Provider Bargaining: California's Experience

Erin L. Duffy, PhD, MPH

ABSTRACT

OBJECTIVES: To examine the early effects of California's recent policy addressing surprise medical billing (AB-72) on the dynamics among physician, hospital, and insurer stakeholders and to identify the influences of the policy's novel out-of-network (OON) payment standard on provider–payer bargaining. This study can inform current policy formation, given that current federal proposals include a payment standard like that in AB-72.

STUDY DESIGN: Case study of the implementation of AB-72 and stakeholders' perspectives, experiences, and responses in the first 6 to 12 months after policy implementation.

METHODS: Semistructured interviews were conducted with 28 individuals representing policy experts, representatives of advocacy organizations and state-level professional associations, and current executives of physician practice groups, hospitals, and health benefits companies. Related documentation was collected and analyzed, including bill text, rulemaking guidance, testimony before the California Senate Committee on Health, and advocacy letters. Qualitative analysis techniques, such as process tracing and explanation building, were employed to identify key themes.

RESULTS: AB-72 is effectively protecting patients from surprise medical bills. However, stakeholders report that an OON payment standard set at payer-specific local average commercial negotiated rates has changed the negotiation dynamics between hospital-based physicians and payers. Interviewees report that leverage has shifted in favor of payers, and payers have an incentive to lower or cancel contracts with rates higher than their average as a means of suppressing OON prices. Physicians reported that this experience of decreased leverage is exacerbating provider consolidation.

CONCLUSIONS: California's experience demonstrates that OON payment standards can influence the payer–provider bargaining landscape, affecting network breadth and negotiated rates.

Am J Manag Care. 2019;25(8):e243-e246

There is growing bipartisan drive to address the widespread consumer protection issue of surprise medical billing, with several federal proposals currently under consideration.[1-4] Such bills occur when patients involuntarily receive services from out-of-network (OON) providers, typically in emergencies or when treated by an OON physician at an in-network hospital without the opportunity to choose an alternative in-network physician.[5] In these cases, the provider bills the patient's insurer at usual and customary rates (or charges), which can be substantially higher than in-network rates.[6] If the insurer does not pay these full charges, then the provider can bill the patient for the remaining balance. Several studies estimate that patients are at risk of receiving these bills for as many as 1 in 10 elective hospital admissions and 1 in 5 emergency department visits.[7,8] Although some patients have success in negotiating down the owed amount, these bills are widely viewed as unfair by patients and are a significant source of medical debt.[9-11]

There are 4 federal proposals to address surprise medical billing: separate bills from the Senate Health, Education, Labor and Pensions Committee and the House Energy and Commerce Committee; a bill from a bipartisan Senate working group led by Senator Bill Cassidy (R-LA); and a bipartisan House bill introduced by Representative Raul Ruiz (D-CA).[1-4] All 4 protect patients from cost sharing above in-network levels and establish arbitration processes or set an OON payment standard dictating the amount that insurers must pay providers for services. Standards that incorporate commercial contracted rates are prominent among the options described in the current federal proposals. Although several states have policies in place to address surprise medical billing, California is one of few states with experience employing an OON payment standard based on commercial rates.[12] Federal and state policy makers can gain insights into the influence of this type of OON payment standard on the healthcare market from California's experience.

California's Approach to Addressing Surprise Medical Billing

California implemented a comprehensive policy (AB-72) addressing surprise medical billing for OON nonemergency physician services

TAKEAWAY POINTS

California's 2017 policy to address surprise medical billing (AB-72) includes a novel out-of-network (OON) payment standard. Current federal proposals employ similar standards, and California's experience can inform this policy making:

- California's OON payment standard, which is based on payer-specific local average contracted rates, decreased physician leverage and created an incentive for insurers and health plans to reduce or cancel contracts with above-average rates.
- As a secondary effect, physicians facing lower rates consolidated to regain leverage.
- OON payment standards influence payer–provider contracting dynamics. Policy makers can use OON payment standards like AB-72 to place downward pressure on prices or use a modified approach to decrease market disruption.

at in-network hospitals in 2017, expanding existing protections in emergency scenarios.[13,14] AB-72 limits patients' cost sharing to in-network levels for all nonemergency physician services at in-network hospitals, unless patients provide written consent to billing 24 hours in advance of services.

Insurers and health plans pay OON physicians at in-network hospitals the greater of the payer's local average contracted rate (ACR) or 125% of Medicare's fee-for-service reimbursement rate. ACR rulemaking is conducted separately for health insurers and health plans by the California Department of Insurance (DOI) and the Department of Managed Health Care (DMHC), respectively. From July 2017 through December 2018, a legislated interim ACR was in effect using inflation-adjusted 2015 rates that were self-reported by each payer.[13] As of January 2019, the DMHC is updating ACRs annually with a 2-year lookback whereas the DOI continues to use the inflation-adjusted 2015 rates.[15,16] AB-72 also establishes a binding independent dispute resolution process to enable physicians to challenge payments from insurers and health plans.

Notably, state insurance regulations only apply to fully insured plans because employers' self-funded plans are subject to the Employee Retirement Income Security Act of 1974 preemption.[17] The current federal proposals would expand states' authority to regulate both fully insured and self-funded plan types.

Negotiation Dynamics Underlying Surprise Medical Billing

Surprise medical bills are a symptom of physicians and payers (ie, insurers and health plans) failing to contract with one another; thus, one must consider the dynamics between physicians and payers to understand the potential effects of policies that address surprise medical billing. Physicians and payers negotiate contracted rates, and the resulting rates reflect the relative leverage of each entity.[18,19] Payers' leverage in negotiations with physicians can be influenced by market share and state regulations, such as California's provider to enrollee ratios, maximum travel times, and maximum appointment wait times.[20] Such network adequacy requirements can be a source of leverage for physicians in remote or highly consolidated provider markets. Physicians and hospitals also garner leverage through greater market share and a reputation that drives patient demand.

Physicians and payers will reach a contract if they can agree on a rate that is amenable to both parties; if not, physicians will bill the payer and/or patient their charges. When an OON payment standard is imposed, charges are replaced by the new standard as the physician's price for OON services. An OON payment standard higher than existing negotiated rates creates an incentive for physicians to go OON. In turn, an OON payment standard below negotiated rates discourages payers from contracting and pressures providers to accept lower rates.[21] Such effects have been observed within the Medicare Advantage market, in which participating providers are prohibited from billing OON Medicare Advantage patients higher than traditional Medicare rates; thus, provider reimbursement by Medicare Advantage plans tracks traditional Medicare rates closely.[22-24]

METHODS

Data Collection

In this case study, semistructured interviews were conducted with 28 stakeholders 6 to 12 months after AB-72 implementation. Interviewees included representatives of advocacy organizations and state-level professional associations, as well as current executives of physician practice groups, hospitals, and health benefits companies. They were asked open-ended questions about 3 domains: (1) the effects of AB-72 on physician, hospital, and health benefits company stakeholders; (2) the effects of AB-72 on relationships and contracting dynamics among these stakeholders; and (3) the role of stakeholders in the legislative process. Potential interviewees were initially identified from among those who testified about AB-72 before the California Senate Committee on Health, authors of editorials and advocacy documents, and experts quoted in newspaper articles.[13] Those who were interviewed were asked to recommend other individuals with relevant expertise or experience; 16 interviewees were identified by the author and 12 were referrals. This referral sampling process was repeated to obtain a sample reflecting a balance of stakeholder perspectives.

Legislative, regulatory, and media materials related to AB-72 were collected, including bill text, analysis, rulemaking guidance, video and transcripts of testimony before the Senate Committee on Health, floor announcements, letters of support and opposition from stakeholders, news articles, and editorials.

Analysis

Interview transcripts, hearing transcripts, and other documents were analyzed using process-tracing, pattern-matching, and explanation-building techniques with computer-based qualitative analysis software (Dedoose version 8.0.35 [SocioCultural Research Consultants, LLC; Los Angeles, California]).[25] Triangulation among

these interview and document data was used to identify stakeholders' perspectives on and early responses to AB-72.

RESULTS

Provider, payer, and consumer advocate stakeholders agreed that it is important to protect patients from surprise medical bills and that the policy provides effective consumer protection. However, the OON payment standard has been disruptive to the contracting landscape.

Contracting Between Hospital-Based Physicians and Payers

Although the payment standard in AB-72 applies only to OON providers, stakeholders report that it is having substantial effects on hospital-based physicians who historically contracted with payers. When hospital-based physician groups and payers negotiated contracts prior to AB-72, the physicians' leverage was that they could walk away and bill the payers and patients their charges. Hospital-based physician groups with contracted rates above the new payment standard have lost that leverage because they would now face lower payments as OON providers.

Applying the payer-reported local ACR as the OON payment standard has incentivized payers to lower or cancel contracts above their local ACR. One hospital-based interviewee expressed fear that over time "health plans could selectively terminate hospital-based physician contracts for those receiving the higher reimbursement level…bringing the average rate down." Physicians in anesthesiology, radiology, and orthopedic practices reported unprecedented decreases in payers' offered rates and less interest in contracting since AB-72 was passed into law. The use of historical rates to compute ACR in the DOI rulemaking may mitigate this.

Insurer and health plan representatives asserted that their leverage in each market is primarily determined by the level of provider consolidation and state network adequacy requirements that mandate that networks include a sufficient number of physicians within a reasonable travel distance. In consolidated physician markets, payers perceive that they are underleveraged in negotiations because they must reach a contract agreement with the only provider group in the area. From their perspective, they gained a small amount of leverage under AB-72, and it corrected an existing imbalance.

Consolidation Among Hospital-Based Specialists

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.

Workforce Stability and Access to Care

Some physicians experienced revenue decreases under the AB-72 OON payment standard, and many raised concerns about long-term pay stagnation. One anesthesiologist expressed fears about the uncertain future of their practice if "rates are insufficient for me to recruit and retain the caliber of physicians that our hospital and surgery center clients expect." Another anesthesiologist contemplated leaving California to attain a higher standard of living in a state without OON payment regulations.

AB-72 applies to nonemergency on-call consultations by neurologists, cardiologists, orthopedic surgeons, and other specialists. These physicians were accustomed to billing full charges for OON services, and the AB-72 payment standard is lower than what some are willing to accept for their labor. One physician observed that "we've had a number of surgeons just drop off the call list" under the new OON payment standard. Another explained that specialists are now unwilling to be on call for undesirable shifts: "All night long, holidays, weekends, etc—they're not going to work."

This response could be especially problematic in safety net hospitals where physicians may rely on high commercial payments to cross-subsidize relatively low Medi-Cal rates. Several stakeholders reported that hospital-based specialist shortages are a longstanding issue for publicly insured patients and they expect only marginal impact from AB-72. However, in the words of one hospital stakeholder, marginal losses matter: "I think every loss of an important specialty is a problem when you're a Medi-Cal patient who needs care."

DISCUSSION

AB-72 successfully protects patients in fully insured plans from surprise medical bills. This study demonstrates that OON payment standards influence negotiating leverage between payers and providers. In the initial implementation of AB-72, employing a payer's own current ACR in the calculation of its future OON payment standard created a mechanism for insurers and health plans to lower their future payments to physicians. This incentivized payers to cancel or reduce the higher-priced contracts in their portfolio.

Beginning in January 2019, DMHC applies contemporary contracted rates to calculate ACR, which may drive a continuation of the in-network price suppression reported by interviewees. Physician and hospital stakeholders interviewed for this study identified several negative aspects of this market disruption, but advocates for cost control may applaud these policy impacts. Policy makers seeking to contain healthcare costs through lower prices could use OON payment standards as a policy lever to place downward pressure on in-network rates. In contrast, DOI continues to compute ACR by projecting forward individual payers' 2015 contracted rates adjusted for inflation based on the Consumer Price Index for Medical Care Services. This approach preserves rates that reflect the relative pre-existing leverage of physicians and insurers. Therefore, it seems less apt to affect in-network rates or trigger the physician consolidation and workforce instability that interviewees reported in this study.

Limitations

There are several limitations to this study. The sample is not representative of all local markets across California; thus, this study may not capture the heterogeneity in policy effects by local population density, market concentration, and geography. Findings may not be directly generalizable to states with markedly different regulatory and market contexts. The timing of this study enables a close look at stakeholders' early experiences, but it does not permit comprehensive empirical study of long-term impacts.

CONCLUSIONS

It is early in the implementation process of AB-72, and there may be long-term effects yet to be observed, but California offers a rare example of an OON payment standard based on commercial rates. Thus, California's experience can inform stakeholders and policy makers as they seek to address surprise medical billing nationally and across states. This study's findings demonstrate that an OON payment standard incorporating contracted rates influenced the bargaining landscape for insurers and providers, affecting network breadth and in-network rates. Policies modeled on AB-72 can potentially effectively protect consumers in fully insured plans from surprise medical bills and offer a policy lever to influence contracted rates.

Author Affiliation: RAND Corporation and Pardee RAND Graduate School, Santa Monica, CA.

Source of Funding: The Anne and James Rothenberg Dissertation Award.

Author Disclosures: The author reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design; acquisition of data; analysis and interpretation of data; drafting of the manuscript; and obtaining funding.

Address Correspondence to: Erin L. Duffy, PhD, MPH, RAND Corporation, 1776 Main St, PO Box 2138, Santa Monica, CA 90407. Email: eduffy@rand.org.

REFERENCES

1. Adler L, Ginsburg PB, Hall M, Trish E. Analyzing the House E&C Committee's bipartisan surprise out-of-network billing proposal. *Health Affairs* Blog website. healthaffairs.org/do/10.1377/hblog20190514.695693/full. Published May 14, 2019. Accessed July 10, 2019.
2. Adler L, Ginsburg PB, Hall M, Trish E. Breaking down the bipartisan Senate group's new proposal to address surprise billing. *Health Affairs* Blog website. healthaffairs.org/do/10.1377/hblog20190521.144063/full. Published May 21, 2019. Accessed July 10, 2019.
3. Reps. Ruiz, Roe release outline of bipartisan legislation with Reps. Morelle, Taylor, Bera, Bucshon, Shalala, and Wenstrup to protect patients, prevent surprise medical bills [news release]. Washington, DC: Office of Representative Raul Ruiz; May 23, 2019. ruiz.house.gov/media-center/press-releases/reps-ruiz-roe-release-outline-bipartisan-legislation-reps-morelle-taylor. Accessed July 10, 2019.
4. Bluth R. Senate panel makes surprisingly fast work of 'surprise medical bills' package. Kaiser Health News website. khn.org/news/senate-panel-makes-surprisingly-fast-work-of-surprise-medical-bills-package. Published June 26, 2019. Accessed July 10, 2019.
5. Hoadley J, Ahn S, Lucia K. Balance billing: how are states protecting consumers from unexpected charges? Robert Wood Johnson Foundation website. rwjf.org/en/library/research/2015/06/balance-billing--how-are-states-protecting-consumers-from-unexpe.html. Published June 15, 2015. Accessed November 14, 2018.
6. Bai G, Anderson GF. Variation in the ratio of physician charges to Medicare payments by specialty and region. *JAMA*. 2017;317(3):315-318. doi: 10.1001/jama.2016.16230.
7. Garmon C, Chartock B. One in five inpatient emergency department cases may lead to surprise bills. *Health Aff (Millwood)*. 2017;36(1):177-181. doi: 10.1377/hlthaff.2016.0970.
8. Claxton G, Rae M, Cox C, Levitt L. An analysis of out-of-network claims in large employer health plans. Peterson-Kaiser Health System Tracker website. healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#. Published August 13, 2018. Accessed July 11, 2019.
9. Hamel L, Norton M, Pollitz K, Levitt L, Claxton G, Brodie M. The burden of medical debt: results from the Kaiser Family Foundation/*New York Times* medical bills survey. Kaiser Family Foundation website. kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey. Published January 5, 2016. Accessed November 14, 2018.
10. Kyanko KA, Pong DD, Bahan K, Curry LA. Patient experiences with involuntary out-of-network charges. *Health Serv Res*. 2013;48(5):1704-1718. doi: 10.1111/1475-6773.12071.
11. Kyanko KA, Busch SH. Patients' success in negotiating out-of-network bills. *Am J Manag Care*. 2016;22(10):647-652.
12. Lucia K, Hoadley J, Williams A. Balance billing by health care providers: assessing consumer protections across states. The Commonwealth Fund website. commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer. Published June 13, 2017. Accessed November 14, 2018.
13. AB-72 Health care coverage: out-of-network coverage. California Legislative Information website. leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72. Updated 2016. Accessed November 14, 2018.
14. Mitchel L. Balanced billing in California: update regarding 2016's A.B. 72 and an overview of newly introduced bill A.B. 1611. The National Law Review website. natlawreview.com/article/balanced-billing-california-update-regarding-2016-s-ab-72-and-overview-newly. Published March 21, 2019. Accessed July 10, 2019.
15. State of California Department of Insurance. Average contracted rate methodology (AB 72). Eversheds Sutherland website. us.eversheds-sutherland.com/portalresource/nr003-18AverageContracted-Rate01-03-18.pdf. Published December 24, 2018. Accessed July 10, 2019.
16. § 1300.71.31. Methodology for determining average contracted rate; default reimbursement rate: 28 CA ADC § 1300.71.31. Barclays Official California Code of Regulations website. govt.westlaw.com/calregs/Document/I5AC58B2B18314FFCA0C4F201DEF9118E?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default). Updated September 13, 2018. Accessed July 10, 2019.
17. Pierron W, Fronstin P. ERISA pre-emption: implications for health reform and coverage. *EBRI Issue Brief*. 2008;(314):1-14.
18. Berenson RA, Ginsburg PB, Christianson JB, Yee T. The growing power of some providers to win steep payment increases from insurers suggests policy remedies may be needed. *Health Aff (Millwood)*. 2012;31(5):973-981. doi: 10.1377/hlthaff.2011.0920.
19. Trish EE, Herring BJ. How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums? *J Health Econ*. 2015;42:104-114. doi: 10.1016/j.jhealeco.2015.03.009.
20. Hall M, Ginsburg PB. A better approach to regulating provider network adequacy. The Brookings Institution website. brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy. Published September 14, 2017. Accessed November 14, 2018.
21. Mattke S, White C, Hanson MA, Kotzias V. Evaluating the impact of policies to regulate involuntary out-of-network charges on New Jersey hospitals. RAND Corporation website. rand.org/pubs/research_reports/RR1809.html. Published 2016. Accessed November 14, 2018.
22. Trish E, Ginsburg P, Gascue L, Joyce G. Physician reimbursement in Medicare Advantage compared with traditional Medicare and commercial health insurance. *JAMA Intern Med*. 2017;177(9):1287-1295. doi: 10.1001/jamainternmed.2017.2679.
23. Berenson RA, Sunshine JH, Helms D, Lawton E. Why Medicare Advantage plans pay hospitals traditional Medicare prices. *Health Aff (Millwood)*. 2015;34(8):1289-1295. doi: 10.1377/hlthaff.2014.1427.
24. Chen JL, Hicks AL, Chernew ME. Prices for physician services in Medicare Advantage versus traditional Medicare. *Am J Manag Care*. 2018;24(7):341-344.
25. Yin RK. *Case Study Research: Design and Methods*. 5th ed. London, United Kingdom: SAGE Publications, Inc; 2014.