



Agenda Item 5c

June 12, 2012

ITEM NAME: Senate Bill 1285 (Hernandez) – Hospital Emergency Services and Care

As Amended on May 9, 2012

PROGRAM: Legislation

ITEM TYPE: Action

RECOMMENDATION

Adopt a **Support, with Suggested Amendments** position on Senate Bill (SB) 1285 to clarify that its provisions apply to health benefit plans offered by CalPERS. This bill will protect CalPERS health plan participants from medical billing disputes between CalPERS health plan providers and non-contracting hospitals that exceed specific utilization rate thresholds for emergency services and care.

EXECUTIVE SUMMARY

SB 1285 would require hospitals with an out-of-network emergency utilization rate of greater than 50 percent to adjust charges for out-of-network emergency care so that the expected reimbursement does not exceed the greater of the amount the hospital could reasonably expect Medicare to pay for the care, or a good faith and reasonable estimate of the actual cost of providing necessary pre-stabilization care.

BACKGROUND

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) and State law requires hospitals to provide emergency care to anyone who enters an emergency room requiring treatment, regardless of their ability to pay. The costs of such emergency care may have been negotiated in advance if the patient's health plan contracts with the hospital that provided the emergency care. However, if there is no contract, the amount billed by the hospital and its emergency room physicians may be more than the health plan deems reasonable. The health plan is required by law to pay a non-contracting hospital the "reasonable and customary value" for the emergency care provided to its enrollees. If a hospital feels that payment from a Health Maintenance Organization (HMO) is not "reasonable and customary" for the services provided, it can elect to enter into a voluntary arbitration process set up by the Department of Managed Health Care (DMHC), or it may take legal action against the HMO. While existing law also prohibits out-of-network health care providers from billing patients enrolled in HMO plans that are regulated by the DMHC, in the case of a dispute with a Preferred Provider Organization (PPO), the hospital may attempt to bill the patient or take legal action against the PPO.

According to the author, "Current law governing payment rates for out-of network emergency hospital care has created unintended incentives that raise the cost of health care and reduce the appropriate coordination of patient care. Pursuing these incentives as part of their business practice, a small but growing number of hospitals now refuse to contract with most insurers and demand excessive payments for out-of-network emergency care."

This February, the State Senate and Assembly Health Committees held a joint hearing on hospital reimbursement mechanisms. During this hearing, a number of witnesses expressed concern with the practices of hospitals that operate largely without insurance contracts and who appear to maximize the diagnostic services and treatments provided to out-of-network patients before they are deemed stabilized for discharge or transfer, and subsequently seek reimbursement at their "full-charge" rates.

ANALYSIS

1. Proposed Changes

Specifically, SB 1285:

- Requires a hospital with an out-of-network emergency utilization rate of 50 percent or greater (*defined as the percentage of emergency department encounters whose costs exceed \$2,000, as adjusted for inflation, that are out-of-network for local, privately insured patients*), to adjust its total billed charges for emergency services and care provided to an out-of-network patient prior to stabilization, as specified.
- Requires the adjustment to any billed charges to be such that the hospital's total expected payment does not exceed the amount of payment the hospital reasonably could expect to receive from Medicare for providing the same care, or, if the Medicare amount is less than the actual cost to the hospital, the adjustment shall not exceed a good faith and reasonable estimate of the actual cost of providing the care.
- Excludes charges billed by an emergency physician from the adjustment to the hospital's total billed charges.
- Excludes adjustments for care provided pursuant to a contract between a health plan or insurer and the hospital.
- Excludes medical care provided to a patient that is compensable for purposes of workers' compensation.
- Excludes medical care provided to a patient for whom Medicare, Medi-Cal, or any other government program of health benefits is the primary payer.

However, public employee benefit plans and plan participants are subject to the bill's provisions and the definition of "privately insured patient."

- Requires, if federal law mandates payment from a health plan or health insurer in an amount greater than would be called for under its provisions, the hospital to adjust its charges so that the total expected payment is the minimum amount required under federal law.
 - Specifies its provisions do not require a hospital to modify its uniform schedule of charges or published rates or preclude the recognition of its established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital's rates or chargers under the Medi-Cal program, the Medicare Program, workers' compensation, or other federal, state, or local public program of health benefits.
 - Requires a hospital to provide reimbursement for any amount actually paid in excess of the amount due under the provisions of this bill, including interest, as specified, unless the amount due is less than \$5.
2. Protects Patients From High Charges For Out-Of-Network Emergency Care
Currently, when a CalPERS member enrolled in a PPO health plan accesses emergency care in a hospital outside of the PPO plan's network, the member can incur some out-of-pocket cost if their health plan were not to agree to the hospital's charges. By limiting how much a hospital may charge for out-of-network emergency care, this bill protects both CalPERS health plans and members enrolled in PPO plans from unreasonable medical costs. It may also discourage hospitals from employing such practices by limiting the amount they can charge for out-of-network emergency care to the amount the hospital reasonably could expect to receive from Medicare, which are usually lower than payments from commercial health insurers.
3. Legislative Policy Standards
The CalPERS Board of Administration's Legislative Policy Standards do not specifically address the issues raised by this bill. However, its 2009-10 Health Policy Priorities for State Legislation suggest a support position on proposals that seek to protect patients from undue pressures during provider-plan contract negotiations or network disruptions. This bill provides an important consumer protection in payment disputes between health plans and hospitals for emergency services and care provided outside a plan's contracted network.

4. Costs

Program Costs

We anticipate some savings would be achieved if this bill becomes law.

Administrative Costs

None

BENEFITS/RISKS

Benefits

- According to the Senate Floor Analysis of SB 1285, SEIU California, a supporter of the bill, states that: "Ontario-based Prime Healthcare is a case study on why this bill is necessary, arguing that Prime refuses to contract with most managed care organizations and even refuses to coordinate with the HMO physicians that have access to members' medical records when HMO members turn up at Prime-operated hospitals...SEIU states that this bill would discourage Prime and its imitators from employing these predatory practices, which will reduce costs and improve access to care for thousands of Californians."
- If this bill were enacted, it could serve as an incentive for hospitals subject to its provisions to enter into contracts with health plans. If this were to happen, CalPERS members enrolled in PPO plans accessing those hospitals for emergency care and services would not be billed for such services, other than applicable co-pays, co-insurance and/or deductibles.

Risks

- According to the California Hospital Association, "This bill harms those communities in which the local hospital is unable to obtain contracts with certain health plans. The statutory default rate reduces access to care because it does not provide sufficient funds to invest in new technology, patient safety and quality initiatives such as electronic medical records, seismic safety and other capital improvements and community services that are not reimbursed."
- Limiting the amount that health plans must pay specified non-contracting hospitals for emergency services may result in cost shifting for remaining in-network hospital procedures and services.
- Placing a limit on what one segment of the health care delivery system can charge for services tendered could serve as a precedent for regulating what other segments can charge.

ATTACHMENTS

Attachment 1 – Legislative History

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