HB

193

<TARGET><BILL>HB 193</BILL><SUBJECT>HB 193</SUBJECT><COMM>HHSS30</COMM></TARGET>

ALASKA STATE LEGISLATURE

Session
State Capitol, Rm. 418
Juneau, AK 99801
(907) 465-3892
Fax: (907) 465-6595

Interim
1500 W. Benson Blvd.
Anchorage, AK 99503
(907) 269-0234
Fax: (907) 269-0238

Rep.Jason.Grenn@akleg.gov

House Finance Committee

Dept. of Law
Finance Subcommittee
Chairman

Dept. of Administration
Finance Subcommittee
Chairman

REPRESENTATIVE JASON GRENN

SPONSOR STATEMENT
House Bill 193

House Bill 193 is focused on protecting Alaskans in emergency situations from being surprised with unexpected medical bills. The most common occurrence for balance billing is during emergency situations where patients are left without the option or wherewithal to ensure they are treated by an in-network provider. As a result, they find themselves on the hook for hefty medical bills, despite having proper health insurance. HB 193 would help Alaskans already dealing with the turmoil of a medical emergency by removing them from the billing side of the equation. When a patient is already in a dire situation, they should not be punished for the inability of an in-network provider to respond to their crisis.

HB 193 bans the practice of medical providers from balance billing in emergency situations and requires insurance providers to hold harmless their clients. This covers emergency situations inside and outside of hospitals. If a patient was transported to a hospital, or an emergency situation arose during a medical procedure requiring an out-of-network provider, this legislation mandates the insurance and medical providers to develop a fair and equitable payment agreement. Instead of being left to handle the labyrinth of medical billing on their own, the patient will be held harmless in these situations.

Medical costs are a major concern in Alaska. HB 193 is a part of a national movement to protect consumers from unexpected costs in an already difficult situation. Twenty-one states have a ban of some kind on balance billing and more states are looking are into the issue. Unexpected and excessive medical bills from out-of-network providers contribute to the growing problem of consumer medical debt, which continues to be a significant cause of personal bankruptcy. The goal of this legislation is to hold a patient harmless while the medical and insurance providers come to an agreement for the services rendered.

I urge your consideration and support of House Bill 193.

HB 193 Definitions

Sec. 47.32.900. Definitions. In this chapter,

(1) **"ambulatory surgical center"** means a facility that

(A) is not a part of a hospital or a physician's general medical practice; and

(B) operates primarily for the purpose of providing surgical services to patients who do not require hospitalization;

Sec. 21.07.250. Definitions. In this chapter,

(1) *[Repealed, Sec. 65 ch 41 SLA 2016].*

(2) *[Repealed, Sec. 65 ch 41 SLA 2016].*

(3) **"emergency medical condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent person who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious impairment of bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(4) **"emergency services"** means medical care services or items furnished or required to evaluate and treat an emergency medical condition;

(6) **"health care provider"** means a person licensed in this state or another state of the United States to provide medical care services;

Sec. 21.54.500. Definitions.

(15) **"health care insurance plan"** means a health care insurance policy or contract but does not include an excepted benefits policy or contract;

(16) **"health care insurer"** means a person transacting the business of health care insurance, including an insurance company licensed under AS 21.09, a hospital or medical service corporation licensed under AS 21.87, a fraternal benefit society licensed under AS 21.84, a health maintenance organization licensed under AS 21.86, a multiple employer welfare arrangement, a church plan, and a governmental plan, except for a nonfederal governmental plan that elects to be excluded under 42 U.S.C. 300gg-21(b)(2) (Health Insurance Portability and Accountability Act of 1996);

30-LS0466\T
Wallace
3/6/18

CS FOR HOUSE BILL NO. 193( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE GRENN

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance trade practices and frauds; relating to services rendered by and payments made to non-network health care providers in certain circumstances; relating to the duty of health care insurers to hold covered persons harmless for covered services provided by non-network health care providers in certain circumstances; relating to group health insurance policies covering employees of a participating governmental unit; relating to balance billing by a health care provider or health care facility; and making certain acts violations of the Alaska Unfair Trade Practices and Consumer Protection Act."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 21.36 is amended by adding new sections to read:

Sec. 21.36.512. Services rendered by non-network health care providers; payment. (a) Except as provided in (d) of this section, a health care insurer that offers,

issues for delivery, delivers, or renews in this state a health care insurance plan shall pay a non-network health care provider in accordance with (b) of this section if the non-network health care provider renders to a covered person

(1) emergency services or treats an emergency medical condition;

(2) services at an in-network hospital or ambulatory surgical center; or

(3) services for which a referral was made by an in-network health care provider to the non-network health care provider without explicit written consent of the covered person acknowledging that the in-network health care provider is referring the covered person to a non-network health care provider and that the referral may result in costs not covered by the health care insurance plan.

(b) If a non-network health care provider renders services to a covered person under (a) of this section,

(1) the covered person may only be required to pay the copayment, deductible, or coinsurance amounts or other out-of-pocket expenses that would be imposed under the health care insurance plan of the covered person for those services if those services were rendered by an in-network health care provider;

(2) the health care insurer shall apply the amount paid by the covered person under (1) of this subsection toward the in-network deductible of the covered person; and

(3) the health care insurer shall pay the non-network health care provider, based on a calculation that excludes the in-network copayment, deductible, or coinsurance amount imposed on the covered person, the greater of the amount

(A) of the median negotiated contract rate generated using the in-network health care providers for the service provided;

(B) that is equal to the 80th percentile of charges for the service calculated using a method that establishes a statistically credible profile that reflects the general cost differences between the geographical area where the service was performed and the other geographical areas when performed by a health care provider in the same or similar specialty; or

(C) that is at least 350 percent of the amount reimbursed by Medicare for the service provided.

(c) A non-network health care provider that renders services to a covered person under (a) of this section shall submit all bills or invoices for covered services to the covered person's health care insurer to be paid in accordance with (b) of this section. A non-network health care provider that renders services to a covered person under (a) of this section may not send a bill or invoice to the covered person for covered services, except for a copayment, deductible, or coinsurance amount owed under (b) of this section.

(d) A health care insurer is not required to pay a non-network health care provider under (a) or (b) of this section if an in-network health care provider is available to render services to a covered person and the covered person knowingly elects to obtain those services from the non-network health care provider.

(e) In this section,

(1) "ambulatory surgical center" has the meaning given in AS 47.32.900;

(2) "emergency medical condition" has the meaning given in AS 21.07.250;

(3) "emergency services" has the meaning given in AS 21.07.250;

(4) "health care insurance plan" has the meaning given in AS 21.54.500;

(5) "health care insurer" has the meaning given in AS 21.54.500;

(6) "health care provider" has the meaning given in AS 21.07.250.

Sec. 21.36.513. Health care insurers; hold harmless. (a) A health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall hold a covered person harmless for any covered services provided by a non-network health care provider under AS 21.36.512(a) and ensure that the covered person does not incur greater out-of-pocket costs, including copayment, deductible, or coinsurance amounts, for services rendered from a non-network health care provider under AS 21.36.512(a) than the covered person would have incurred from a health care provider that furnishes those services through a network of health care providers that have entered into a contract with the health care insurer.

(b) In this section,

(1) "health care insurance plan" has the meaning given in AS 21.54.500;

(2) "health care insurer" has the meaning given in AS 21.54.500;

(3) "health care provider" has the meaning given in AS 21.07.250.

*** Sec. 2.** AS 39.30 is amended by adding a new section to read:

Sec. 39.30.093. Services rendered by non-network health care providers. Notwithstanding the definition of health care insurer in AS 21.36.512, 21.36.513, and AS 21.54.500, or its application to the state, a health care insurance plan obtained under AS 39.30.090 or provided under AS 39.30.091 is subject to the requirements of AS 21.36.512 and 21.36.513 for services rendered by a non-network health care provider, as that term is defined in AS 21.07.250.

*** Sec. 3.** AS 45.45 is amended by adding a new section to read:

Sec. 45.45.915. Balance billing by health care provider or health care facility. (a) A health care provider or health care facility that provides services under the circumstances described in AS 21.36.512(a)

(1) may not balance bill a covered person for those services in a manner that results in the covered person's incurring greater out-of-pocket costs, including copayment, deductible, or coinsurance amounts, from a non-network health care provider than would be imposed for those services if those services were rendered by an in-network health care provider; and

(2) shall be paid in accordance with AS 21.36.512(b).

(b) In this section,

(1) "health care facility" includes a hospital emergency room or stand-alone emergency service facility;

(2) "health care insurer" has the meaning given in AS 21.54.500;

(3) "health care provider" has the meaning given in AS 21.07.250.

*** Sec. 4.** AS 45.50.471(b) is amended by adding a new paragraph to read:

(58) violating AS 45.45.915 (balance billing by health care provider or health care facility).

ALASKA STATE LEGISLATURE

Session
State Capitol, Rm. 418
Juneau, AK 99801
(907) 465-3892
Fax: (907) 465-6595

Interim
1500 W. Benson Blvd.
Anchorage, AK 99503
(907) 269-0234
Fax: (907) 269-0238

Rep.Jason.Grenn@akleg.gov

House Finance Committee

Dept. of Law
Finance Subcommittee
Chairman

Dept. of Administration
Finance Subcommittee
Chairman

REPRESENTATIVE JASON GRENN

SECTIONAL ANALYSIS
House Bill 193 ver T

Section 1: Establishes a "Hold Harmless" standard for insurance providers in the situation where a covered person receives medical care from an out-of-network medical provider in an emergency situation. An insurance provider will hold a covered person harmless to ensure that the covered person only pay what would have been paid if the medical provider was an in-network provider.

Outlines the standards to establish the situations where a medical provider cannot balance bill a covered person. An insurance provider shall pay a non-network health care provider if the health care provider renders to a covered person;

- emergency services or treats an emergency medical condition
- services at an in-network facility
- services for which a referral was made by an in-network health care provider to an out-of-network health care provider without the explicit written consent of the covered person.

The covered person is still required to pay the in-network rates for the deductible, coinsurance and copayment. The amount paid by the covered person is required to be counted towards the covered persons deductible.

The final payment determined for the medical provider will subtract any amount paid by the covered person.

The insurance provider is to pay the greater of three possible amounts;

- the median negotiated contract rate generated using the in-network health care providers for the service provided;
- That is equal to the 80th percentile of charges for the services calculated using a method that establishes a statistically credible profile that reflects the general cost differences between the geographical area where the service was preformed and the other geographical areas when performed by a health care provider in the same or similar specialty; or
- That would be paid under Medicare for the service provided.

ALASKA STATE LEGISLATURE

Session
State Capitol, Rm. 418
Juneau, AK 99801
(907) 465-3892
Fax: (907) 465-6595

Interim
1500 W. Benson Blvd.
Anchorage, AK 99503
(907) 269-0234
Fax: (907) 269-0238

Rep.Jason.Grenn@akleg.gov

House Finance Committee

Dept. of Law
Finance Subcommittee
Chairman

Dept. of Administration
Finance Subcommittee
Chairman

REPRESENTATIVE JASON GRENN

Medical providers are required to send all bills to the insurance provider, except for the deductible, coinsurance and copayment.

Contains a clause that if a covered person knowingly elects to use an out-of-network medical provider then they can be balanced billed for the services.

Section 2: Health care insurance plans obtained under AS 39.30.090 or provided under AS 39.30.091 will be subject to the requirements of secs. 21.36.512 and 21.36.513.

Section 3: Bans the practice of "Balance Billing" by a medical provider under the criteria of section 1 of the bill. Stipulates that the medical provider can still bill for the deductible, coinsurance and copayment.

States that a medical provider will be paid according to section 1 of the bill.

Section 4: Establishes the punishment for medical providers under the Unfair Trade Practices and Consumer Protection.

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version: HB 193
Fiscal Note Number:
() Publish Date:

Identifier: HB193-DCCED-DOI-03-02-18
Title: HEALTH CARE; BALANCE BILLING
Sponsor: GRENN
Requester: (H) Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2019**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version/comments:

Not applicable, initial version.

Prepared By: Lori Wing-Heier, Director — Phone: (907)465-2560
Division: Division of Insurance — Date: 03/02/2018
Approved By: Catherine Reardon, Director — Date: 03/02/18
Agency: Division of Administrative Services, DCCED

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** HB 193
2018 LEGISLATIVE SESSION

Analysis

HB193 requires insurers to provide the in-network level of benefits for services in certain circumstances. The bill ensures that insurers will provide in-network cost sharing levels for emergency services and when a covered person has no control over out-of-network provider services. The bill also provides that the insurer is not obligated to pay a non-network health care provider at the in-network rate if an in-network provider is available to render services and the covered person knowingly chooses to obtain services from a non-network health care provider. The bill includes a provision that the insurer shall pay non-network providers the in-network rate under the health care insurance plan as payment in full unless the insurer and provider agree otherwise.

The bill prohibits an insurer from balance billing, but identifies the term to mean the differences in the covered person's "out of pocket costs, including copayment, deductible, or coinsurance" between in-network versus non-network providers under the plan agreement which may or may not include amounts in excess of the allowed amount.

The Division of Insurance does not anticipate a fiscal impact from this legislation.

Policy Implications of Legislating AlaskaCare Benefits

White Paper | Department of Administration

A number of different bills introduced in the 2018 legislative session seek to mandate certain private industry health insurance provisions under Title 21 and apply them to State of Alaska's Health Plans. The State's self-funded employee and retiree health benefit plans, called AlaskaCare, are not health insurance plans regulated under Title 21. Instead, they are statutorily authorized under AS 39.30.090 and AS 39.30.091 managed by the Commissioner of Administration (through the Division of Retirement and Benefits) with input from certain advisory committees, and subject to federal regulations.

Why aren't the AlaskaCare plans under Title 21?

Title 21 regulates insurance. It does not apply to the state's AlaskaCare plans because the state does not provide insurance.

What is insurance?

Insurance is the transfer of risk. An entity (person or company) pays premiums to an insurance company in exchange for the insurance company accepting the potential risk of having to pay additional money on the entity's behalf later. An insurance plan is the transfer of risk from the entity, the insured, to the insurer in exchange for premium payments.

Why are the state health plans not insurance?

The AlaskaCare plans are not insurance because there is no contractual transfer of risk. The state self-funds the health benefits so it retains the risk entirely. State employees contribute to the cost of health benefits, but they do not enter into an insurance contract.

Why are the AlaskaCare plans managed differently than a typical insurance plan?

The benefits of having the Commissioner of Administration manage the State's AlaskaCare plans, and therefore the plan's "risk", rather than through statutory mandates are outlined below:

- **Flexibility.** The Division can make changes or clarifications to AlaskaCare benefits without needing a legislative vehicle or regulatory provisions. In an environment that changes rapidly on multiple fronts (fiscal, technological, business, etc.), the Division can nimbly manage the plan to address issues as they arise.
- **Stability.** The Division relies on professionals with specialized expertise to inform benefit and administrative changes. All AlaskaCare and/or administrative changes are contemplated comprehensively taking into account timing, existing contracts, fiscal impacts, and long-term goals and objectives.
- **Constitutional diminishment and unfunded liability.** Administration of the AlaskaCare retiree plan is complex, subject to certain constitutional protections

and impacting the funding ratio of the state's retirement system liability. Minor changes, even those which appear administrative in nature, must undergo heavy scrutiny to ensure they do not create unintended consequences.

- **Fiscal impact.** The AlaskaCare plans are funded, in part or in whole, with state general fund dollars, so it is important to thoroughly evaluate and understand the impacts of any benefit or administrative change. These changes include the impact to the rate setting process for both the employer and employee, and the unfunded liability of the retirement systems as a whole.
- **Collective bargaining.** Currently, changes to the AlaskaCare benefit design or plan administration occur in an agreed upon process that involves feedback from the union-represented employee bargaining groups that participate in the State's AlaskaCare plans. A statute mandating changes will disrupt this process.

Other considerations: Certain State employee unions have opted out of the State's Health Plan and instead provide health coverage through union health trusts. These employees would not be affected by any mandated change to the State's Health Plans made through amendments to AS 39.30.090 and AS 39.30.091.

Important considerations when considering including AlaskaCare plans in statutory requirements:

In reviewing proposed legislation, the Division notes three categories of legislation:

1) Bills that would legislate processes or benefit changes that the AlaskaCare plans already provide;
2) Bills that would legislate processes or benefits that AlaskasCare does, or can do without the need for legislation; and,
3) Bills that would pose an administrative challenge to AlaskaCare plans or which are prohibitively expensive to implement.

General questions specific to AlaskaCare a bill sponsor may want to consider are below:

1) Is there actually an identified problem specific to AlaskaCare?
2) Are the AlaskaCare plans already compliant with the proposed bill?
3) Could AlaskaCare become compliant without legislation by working with the department? If not, why?
4) Will this bill create additional costs to the AlaskaCare health plan that must be communicated in a fiscal note?

Contact: Minta Montalbo, Department of Administration | 465-2200

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

March 16, 2018

The Honorable Representative Ivy Spohnholz
Chair, House Health and Social Services Committee
State House
Alaska State Capitol
Juneau, AK 99801-1182

Re: HB 193 – Balance Billing

Dear Representative Spohnholz,

I write today on behalf of America's Health Insurance Plans (AHIP) to express our concerns with HB 193, which takes the important step of banning balance billing by out-of-network providers but establishes a troublesome reimbursement mechanism.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Health plans develop provider networks to offer consumers and employers access to affordable, high-quality care. Health plan networks have been demonstrated as an effective means of containing costs and limiting patient out-of-pocket costs. When providers contract with carriers, patients benefit. Enrollees who receive services from a facility participating in their plan's network have a reasonable expectation that their providers at that facility will also be in-network. Unfortunately, patients may still be seen by an out-of-network provider because some interactions that patients have in a facility could be with ancillary service providers (e.g. anesthesia, radiology, and pathology) who do not have a contract with the health plan to provide covered services at in-network rates. Sometimes these providers, especially emergency room providers, refuse to contract with the facilities or insurers. We appreciate the sponsor's efforts to ban surprise balance bills and share his goals to provide that important consumer protection.

AHIP previously submitted comments to the Division of Insurance, agreeing with the Alaska Health Care Commission that the Division's current reimbursement mechanism based on out-of-network providers' billed charges is increasing costs. We are concerned the methodology being proposed here may also result in difficulties for carriers to contract with providers and develop robust networks.

The rate of payment to out-of-network providers should be set at a level that does not destabilize provider contracts in the state and instead continues to encourage health plans and providers to enter into mutually beneficial contracts.

Reimbursement to out-of-network providers should not be based on a methodology that uses billed charges – instead we strongly support a reasonable reimbursement based on what the market is already paying for those services (i.e. accepted rates, contracted rates, or government payment fee schedules). Billed charges are generally higher than the amount paid to providers under negotiated health plan contracts, or Medicare or Medicaid payment rates.

A study using Alaska-specific data from FAIR Health has shown average billed charges at up to 1617.4% of Medicare reimbursement rates.[1] The Alaska data shows a general trend of much higher billed charges that the national average. We believe that this data confirms the findings of the Alaska Health Care Commission that providers with high market share are pricing their services to ensure that they are below the 80th percentile and receive payment for their full billed charge, while artificially inflating costs for consumers across the entire health care system. [2]

The proposed approach harms insurers' efforts to build strong networks, hospitals' efforts to contract with providers, and consumers by increasing their costs, since cost-sharing is a percentage of the allowed amount. When providers can be virtually assured that they will receive their full billed charge by not contracting with health plans, this type of reimbursement methodology provides no incentive for providers to join networks, restricts the ability of carriers to manage costs through contracting with providers, and encourages already-contracting providers to remove themselves from networks. Using billed charges as a reimbursement rate would also create greater challenges for hospitals working to find and contract with providers of hospital-based services who will agree to participate in the same health insurance plans' networks as the hospital. Finally, requiring reimbursement at the billed charges amount would leave consumers open to higher cost sharing and charges that they should not have to incur.

Regarding a reimbursement mechanism based on what the market is currently paying for services, we appreciate that this bill provides other possible reimbursement amounts. However, the proposed reimbursement at 350% of Medicare is higher than anywhere else in the country. The Medicare reimbursement rates are already higher in Alaska than the rest of the country, in recognition of the increased costs of care. Requiring private plans to pay over three times what the government has already establishes as a fair payment amount is untenable. We believe that a reimbursement amount that high will have the same effects as discussed above for a billed-

---

[1] *Charges Billed by Out-of-Network Providers: Implications for Affordability*. Page 13. America's Health Insurance Plans. September 2015. Available at https://www.ahip.org/wp-content/uploads/2015/09/OON_Report_11.3.16.pdf.
[2] *Findings and Recommendations 2009-2013. Alaska Health Care Commission*. Available at http://dhss.alaska.gov/ahcc/Documents/AHCC-Findings-Recommendations2009-2013.pdf.

charges based reimbursement – raising costs and destabilizing provider networks. We thus recommend that the benchmark specified should be significantly lower than the proposed 350% of the Medicare reimbursement rate.

We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue.

Sincerely,

Sara Orrange
Regional Director, State Affairs

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Administration

LESLIE RIDLE, Commissioner

10th Fl. State Office Building
PO Box 110200
Juneau, AK 99311-0200
Main: 907.465.2200
Fax: 907.465.2135
www.doa.alaska.gov

March 27, 2018

The Honorable Ivy Spohnholz, Co-Chair
Health & Human Services Committee
Capitol Room 421

RE: CSHB 193 Health Care; Balance Billing

Dear Representative Spohnholz:

During the House Health and Social Services committee hearing on March 8, questions were raised about the impacts of the Committee Substitute for HB 193, which includes language attempting to apply this legislation to State public employee health plans. We are providing the following information in response.

It is the position of the Department of Administration (DOA) that CSHB 193 does not apply to the state employee or retiree health plans administered by our department; ie, the AlaskaCare plans. Section 2 references "a health insurance plan obtained under AS 39.30.090 or 091." The AlaskaCare employee, defined benefit retiree, and defined contribution retirement health plans are provided under a self-funded arrangement in accordance to the statute. These arrangements are not insurance, nor does the state enter into an insurance contract. Therefore, the bill as written does not apply to plans administered by DOA.

As a self-insured plan, we do not fall under Title 21, which regulates commercial insurance plans and is overseen by the Department of Commerce and Economic Development (DCCED). DCCED does not have authority over plans administered by DOA; rather, the Commissioner of DOA is the Plan Administrator. Please see the attached "Policy Implications" white paper for more information.

The plan sponsor has indicated the bill should only apply to emergency services or for treatment of an emergency medical condition. However, we read the draft CS as written to have broader implications.

DOA does not oppose the balance billing concepts put forward by HB 193. The AlaskaCare plans cover balance bills received in an emergency setting at 100% of billed charges, and do not subject members to different cost share provisions (i.e. deductible and out-of-pocket maximums).

We balance member protection from balance billing with retaining incentives for providers to participate in the plan network. The network savings received by the health plans are tremendous. In 2014, when the state switched from HealthSmart to Aetna, the difference in network discounts was around $40 million.

Were the section 1 provisions of this bill applied to the AlaskaCare plans, we would expect to see increased costs, as 350% of Medicare is substantially higher than our non-network reimbursement policies, and substantially higher than many providers currently bill. This could encourage providers to leave the networks and could result in a long-term growth in the cost of services.

DOA has taken active steps to use steerage to negotiate better rates with providers and reduce the cost of care, especially in the employee plan. CSHB 193 could erode those gains. Furthermore, including the retiree plan will increase the unfunded liability on the plan and impact the associated state assistance payments. Additionally, the provisions could be protected in perpetuity.

We have discussed our concerns at length with the bill sponsor, and have requested section 2 be deleted from the CS. We would be happy to meet with you for further discussion.

Thank you for your consideration of DOA's concerns.

Sincerely,

Leslie D Ridle

Leslie Ridle, Commissioner

CC: Darwin Peterson
Rep. Jason Grenn

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

7700 East First Place Denver, CO 80230
ph (303) 364-7700 fax (303) 364-7800
www.ncsl.org

Balance and Surprise Bill Legsilation
January 2017

Ashley A. Noble, JD

- **36 bills introduced in 14 states:** Delaware (1), Georgia (1), Illinois (1), Massachusetts (6), Minnesota (2), Montana (2), New Hampshire (1), New Jersey (10), New York (2), Oregon (1), Pennsylvania (2), Rhode Island (5), Texas (1), and Washington (1).
  - **2 laws enacted in 2 states:** Delaware (1) and New York (1).
  - **20 bills pending in 10 states:** Georgia (1), Illinois (1), Minnesota (2), Montana (2), New Hampshire (1), New Jersey (9), Oregon (1), Rhode Island (1), Texas (1), and Washington (1).
  - **14 bills failed in 4 states:** Massachusetts (6), New Jersey (1), New York (1), Pennsylvania (2), and Rhode Island (4).

(2015) DE H 439

Sponsor:	Short B (D)
Title:	Health Insurance
Introduced:	06/21/2016
Enacted:	07/29/2016
Disposition:	Enacted
Effective Date:	01/01/2017
Location:	Chaptered
Chapter:	339
Summary:	Provides for network disclosure and transparency for insured individuals who may be provided non-emergency health care services from an out-of-network provider; states that an insured must be notified that a provider or facility is an out-of-network and given notice that the services may not be covered; requires health insurance companies maintain up to date and comprehensive provider directories.
Status:	07/29/2016 Signed by GOVERNOR. 07/29/2016 Chapter Number 339 [Effective Rule]
Text Hits:	

(3) A facility-based provider or a health care provider may not balance bill a covered person for health care services not covered by an insured's health insurance contract, if the facility-based provider or health care provider:

(2) Regulations requiring health insurers and out-of-network providers to inform covered persons of their rights with respect to payment of balance bills.

The regulations adopted and arbitrations authorized pursuant to this section shall reflect the objectives of protecting consumers from surprise bills and not creating incentives for providers to be out-of-network.

(3) A facility-based provider or a health care provider may not balance bill a covered person for health care services not covered by an insured's health insurance contract, if the facility-based provider or health care provider:

(2) Regulations requiring health insurers and out-of-network providers to inform covered persons of their rights with respect to payment of balance bills.

The regulations adopted and arbitrations authorized pursuant to this section shall reflect the objectives of protecting consumers from surprise bills and not creating incentives for providers to be out-of-network.

GA S 8

Author:	Unterman (R)
Title:	Amends Title 33 of the Official Code of Georgia
Introduced:	01/09/2017
Disposition:	Pending
Location:	SENATE
Summary:	Relates to insurance; provides for consumer protections regarding health insurance; provides for definitions; provides for disclosure requirements or providers, hospitals and insurers; provides for related matters; repeals conflicting laws; provides for other purposes.
Status:	01/09/2017 INTRODUCED.
Text Hits:	insurance; to provide for definitions; to provide for disclosure requirements of providers, hospitals, and insurers; to provide for billing and reimbursement of out-of-network services; to provide for procedures for dispute resolution for surprise bills for nonemergency services; to provide for payment of emergency services; to provide for an out-of-network reimbursement rate workgroup; to provide for related matters; to repeal conflicting laws; and for other purposes. This Act shall be known and may be referred to as the "Surprise Billing and Consumer Protection Act." (14) 'Surprise bill' means a bill for health care services, other than emergency services, received by:

physician is unavailable or a nonparticipating physician renders services without the insured's knowledge or when unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a nonparticipating physician;

(a) The Commissioner shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The Commissioner shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process.

When an insured assigns benefits for a surprise bill in writing to a nonparticipating physician who knows that the insured is insured under a health care plan, the nonparticipating physician shall not bill the insured except for any applicable copayment, coinsurance, or deductible that would be owed if the

(d) Either the health care plan or the nonparticipating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity; provided, however, that the health care plan may not submit the dispute unless it has complied with the requirements of subsections (a), (b), and (c) of this Code section.

(g) An insured who does not assign benefits under subsection (a) of this Code section or a patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

(2015) IL S 2364

Sponsor:	Haine (D)
Title:	Comprehensive Health Insurance Plan Act
Introduced:	01/28/2016
Last Amend:	04/06/2016
Disposition:	Pending
Location:	House Rules Committee
Summary:	Amends the Department of Insurance Law and the Comprehensive Health Insurance Plan Act; transfers powers, duties, rights, and responsibilities of the Comprehensive Health Insurance Plan and the Board; requires the Board to develop a dissolution plan; discontinues new enrollment and policy renewals and the insurance operations of the Plan; provides for claims, the transfer of contracts, causes of action, and pending business.
Status:	05/13/2016 Rereferred to HOUSE Committee on RULES.
Text Hits:	(f) Balance billing by a health care provider that is not a member of the provider network used by the Plan is prohibited.

(2015) MA H 1014

DOCKET	1579

Author:	Michlewitz (D)
Title:	Payments to Out of Network Health Care Providers
Introduced:	03/11/2015
Disposition:	Failed - Adjourned
Location:	House Study Order
Summary:	Relates to payments to out-of-network health care providers for services rendered to persons covered under contracts with risk-bearing provider organizations.
Status:	09/21/2016 From JOINT Committee on HEALTH CARE FINANCING: Accompanied Study Order H 4635.
Text Hits:	covered services as an out-of-network health care provider to any person covered under a contract with a Risk-Bearing Provider Organization must provide such service to any such person as a condition of their licensure, and must accept payment at the statutory reimbursement rate, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles.

(2015) MA H 1026

DOCKET	1151
Author:	Sannicandro (D)
Title:	Single Payer Health Insurance Trust Fund
Introduced:	03/11/2015
Disposition:	Failed - Adjourned
Location:	House Study Order
Summary:	Establishes a single-payer health insurance trust fund.
Status:	09/21/2016 From JOINT Committee on HEALTH CARE FINANCING: Accompanied Study Order H 4635.
Text Hits:	(c) no balance billing or out-of-pocket charges will be made for covered services unless otherwise provided in this chapter; and

(2015) MA H 848

DOCKET	489
Author:	Finn (D)
Title:	Health Care Insurance Rate Equity and Cost Savings
Introduced:	03/11/2015
Disposition:	Failed - Adjourned
Location:	House Study Order
Summary:	Ensures health care insurance rate equity and cost savings.
Status:	03/21/2016 From JOINT Committee on FINANCIAL SERVICES: Accompanied Study Order H 4111.
Text Hits:	(a) Every health care provider which provides covered services to a person must provide such services to any such person as a condition of their licensure, and must

accept payment by a carrier consistent with the provisions of this section, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles. Any health care provider that participates in a carrier's network or any health benefit plan shall not

Nothing in this subsection shall prohibit a carrier from denying payment for unapproved services conducted by a non-network provider. Every out-of-network health care provider must accept payment by a carrier consistent with the provisions of this section, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section for such covered out-of-network services, other than applicable co-payments, co-insurance and deductibles.

(2015) MA S 528

DOCKET	458
Author:	Moore M (D)
Title:	Affordable Health Plan
Introduced:	04/15/2015
Disposition:	Failed - Adjourned
Location:	Senate Study Order
Summary:	Relates to an affordable health plan.
Status:	06/06/2016 From JOINT Committee on FINANCIAL SERVICES: Accompanied Study Order S 2318.
Text Hits:	amount equal to the actuarial equivalent of the statutory reimbursement rate, or the applicable contract rate with the carrier for the carrier's product offering with the lowest level benefit plan available to the general public within the connector, other than the young adult plan, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles.

(2015) MA S 574

DOCKET	1150
New Draft see:	(2015) MA H 4348
Author:	Downing (D)
Title:	Equitable Health Care Pricing
Introduced:	04/15/2015
Last Amend:	05/26/2016
Disposition:	Failed - Adjourned
Location:	Replaced by New Draft
Summary:	Relates to equitable health care pricing.

Status: 05/26/2016 From JOINT Committee on HEALTH CARE FINANCING: Amended by substitution of New Draft. For further action see H 4348.

Text Hits: (a) Every health care provider must accept payment by a carrier consistent with the provisions of this section, and may not balance bill the recipient of services for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles. Any health care provider that participates in a carrier's network or any health

(2015) MA H 3931

Author: Initiative Petition of Jerald N. Fishbein

Title: Fair Health Care Pricing Act

Introduced: 01/07/2016

Disposition: Failed - Adjourned

Location: Joint Committee on Health Care Financing

Summary: (Initiative Petition) Submits an initiative petition of Jerald N. Fishbein and others for the passage of an act known as the Massachusetts Fair Health Care Pricing Act.

Status: 03/08/2016 In JOINT Committee on HEALTH CARE FINANCING: Heard. Eligible for Executive Session.

Text Hits: (a) Every health care provider that provides covered benefits to a person must provide such covered benefits to any such person as a condition of their licensure, must accept payment by a carrier consistent with the provisions of this section, and may not balance bill the recipient of services for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles. Any health care provider that participates in a carrier's network or any health benefit plan

(j) Nothing in this section shall prohibit a carrier from denying payment for unapproved services conducted by a non-network provider. Every out-of-network health care provider must accept payment by a carrier consistent with the provisions of this section and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section for such covered out-of-network services, other than applicable co-payments, co-insurance and deductibles.

MN H 99

Author: Schomacker (R)

Title: Health Maintenance Organizations

Introduced: 01/09/2017

Disposition: Pending

Location: House Ways and Means Committee

Summary: Relates to health; modifies requirements for health maintenance organizations; modifies provisions governing health insurance; appropriates money.

Status: 01/11/2017 From HOUSE Committee on HEALTH AND HUMAN SERVICES REFORM: Do pass.

01/11/2017 Rereferred to HOUSE Committee on WAYS AND MEANS.

Text Hits: Sec. 10. [62Q.557] BALANCE BILLING PROHIBITED.

MN H 1

Companion: MN S 1
Author: Hoppe (R)
Title: Health Care Coverage
Introduced: 01/05/2017
Last Amend: 01/11/2017
Disposition: Pending
Location: House Second Reading
Summary: Relates to health care coverage; provides a temporary program to help pay for health insurance premiums; modifies requirements for health maintenance organizations; modifies provisions governing health insurance; requires reports; appropriates money.
Status: 01/12/2017 From HOUSE Committee on WAYS AND MEANS: Do pass.
01/12/2017 In HOUSE. Second Reading.
Full Status
Text Hits: Sec. 12. [62Q.557] BALANCE BILLING PROHIBITED.

MT D 379

Author: Economic Affairs Interim Committee
Title: Balance Billing by Air Ambulance
Prefiled: 08/30/2016
Disposition: Pending
Location: SENATE
Summary: Provides process to hold patients harmless from balance billing by air ambulance; relates to health care services; relates to insurance.
Status: 12/13/2016 Assigned SENATE Bill No. 44
Text Hits: WHEREAS, these gaps have resulted in some air ambulance patients receiving crippling balance bills and in the proliferation of air ambulance subscription programs; and

MT S 44

Author: Vance (R)
Title: Balance Billing By Air Ambulance
Introduced: 01/02/2017
Disposition: Pending
Location: Senate Business, Labor and Economic Affairs Committee
Summary: Provides process to hold patients harmless from balance billing by air ambulance; relates to health care services; relates to insurance; relates to rule making.

Status:	01/02/2017 INTRODUCED. 01/02/2017 Filed as Draft 379 01/02/2017 To SENATE Committee on BUSINESS, LABOR AND ECONOMIC AFFAIRS.
Text Hits:	WHEREAS, these gaps have resulted in some air ambulance patients receiving crippling balance bills and in the proliferation of air ambulance subscription programs; and

NH H 329

Author:	Luneau (I)
Title:	Committee to Study Balance Billing
Introduced:	01/04/2017
Disposition:	Pending
Location:	House Commerce and Consumer Affairs Committee
Summary:	Establishes a committee to study balance billing.
Status:	01/11/2017 Public Hearing: 01/19/2017.
Text Hits:	AN ACT establishing a committee to study balance billing. This bill establishes a committee to study balance billing by health care providers. AN ACT establishing a committee to study balance billing. 1 Committee Established. There is established a committee to study balance billing by health care providers. 3 Duties. The committee shall study the practice of balance billing by health care providers for services received by an insured person at an in-network health care facility.

NJ S 277

Sponsor:	Vitale (D)
Title:	Out of Network Consumer Protection
Introduced:	01/12/2016
Disposition:	Failed
Location:	Withdrawn
Summary:	The Out of Network Consumer Protection, Transparency, Cost Containment and Accountability Act.
Status:	02/04/2016 Withdrawn from further consideration.
Text Hits:	b. Despite existing State and federal laws and regulations to protect against certain surprise out-of-network charges, these charges continue to pose a problem for health care consumers in New Jersey. Many consumers find themselves with surprise bills for hospital emergency room procedures or for charges by providers that the consumer had no choice in selecting;

d. Health insurers and consumers continue to report exorbitant charges by certain health care professionals and facilities for out-of-network services, including balance billing, and in certain cases, consumers' bills are referred to collections, which contributes to the increasing costs of health care services and insurance and imposes hardships on health care consumers;

NJ A 1933

Identical:	NJ S 1261
Sponsor:	Coughlin (D)
Title:	Managed Care Plans
Introduced:	01/27/2016
Disposition:	Pending
Location:	Senate Budget and Appropriations Committee
Summary:	Requires managed care plans, State Health Benefits Program to provide for accommodation in accessing providers for persons with physical disabilities.
Status:	06/16/2016 From SENATE Committee on HEALTH, HUMAN SERVICES AND SENIOR CITIZENS. 06/16/2016 To SENATE Committee on BUDGET AND APPROPRIATIONS.
Text Hits:	reimburse the accessible out-of-network provider for the covered service at the same rate as that which the carrier would pay to an in-network provider for the same service. The out-of-network provider shall accept the payment by the carrier as payment in full for the covered service and shall not balance bill the covered person for any amount in excess of the payment made by the carrier plus any required copayment or coinsurance. accessible out-of-network provider for the covered service at the same rate as that which the carrier would pay to an in-network provider for the same service. The out-of-network provider shall accept the payment by the carrier as payment in full for the covered service and shall not balance bill the covered person for any amount in excess of the payment made by the carrier plus any required copayment or coinsurance. reimbursed for the covered service at the same rate as that which would be paid to an in-network provider for the same service. The out-of-network provider shall accept the payment pursuant to the contract as payment in full for the covered service and shall not balance bill the covered person for any amount in excess of the payment made pursuant to the contract plus any required copayment or coinsurance. reimbursed for the covered service at the same rate as that which would be paid to an in-network provider for the same service. The out-of-network provider shall accept the payment pursuant to the contract as payment in full for the covered service and shall not balance bill the covered person for any amount in excess of the payment made pursuant to the contract plus any required copayment or coinsurance.

NJ S 1261

Identical:	NJ A 1933

Sponsor: Vitale (D)
Title: Health Benefits Program
Introduced: 02/08/2016
Disposition: Pending
Location: Senate Budget and Appropriations Committee
Summary: Requires managed care plans, State Health Benefits Program and School Employees' Health Benefits Program; provides for reasonable accommodation in accessing providers for persons with physical disabilities.

Status:
06/16/2016 From SENATE Committee on HEALTH, HUMAN SERVICES AND SENIOR CITIZENS.
06/16/2016 To SENATE Committee on BUDGET AND APPROPRIATIONS.

Text Hits:
at the same rate as that which the carrier would pay to an in-network provider for the same service. The out-of-network provider will be required to accept the payment by the carrier as payment in full for the covered service and will not be permitted to balance bill the covered person for any amount in excess of the payment made by the carrier plus any required copayment or coinsurance.

accessible out-of-network provider for the covered service at the same rate as that which the carrier would pay to an in-network provider for the same service. The out-of-network provider shall accept the payment by the carrier as payment in full for the covered service and shall not balance bill the covered person for any amount in excess of the payment made by the carrier plus any required copayment or coinsurance.

reimbursed for the covered service at the same rate as that which would be paid to an in-network provider for the same service. The out-of-network provider shall accept the payment pursuant to the contract as payment in full for the covered service and shall not balance bill the covered person for any amount in excess of the payment made pursuant to the contract plus any required copayment or coinsurance.

reimbursed for the covered service at the same rate as that which would be paid to an in-network provider for the same service. The out-of-network provider shall accept the payment pursuant to the contract as payment in full for the covered service and shall not balance bill the covered person for any amount in excess of the payment made pursuant to the contract plus any required copayment or coinsurance.

NJ S 1285
Identical: NJ A 1952
Sponsor: Vitale (D)
Title: Consumer Protection
Introduced: 02/08/2016
Disposition: Pending
Location: Senate Budget and Appropriations Committee
Summary: Relates to Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.

Status: 06/20/2016 Transferred to SENATE Committee on BUDGET AND APPROPRIATIONS.

Text Hits: b. Despite existing State and federal laws and regulations to protect against certain surprise out-of-network charges, these charges continue to pose a problem for health care consumers in New Jersey. Many consumers find themselves with surprise bills for hospital emergency room procedures or for charges by providers that the consumer had no choice in selecting;

the same method the plan generally uses to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the emergency service, patients continue to face out-of-network charges for surprise bills;

e. Carriers and consumers continue to report exorbitant charges by certain health care professionals and facilities for out-of-network services, including balance billing, and in certain cases, consumers' bills are referred to collection, which contributes to the increasing costs of health care services and insurance and imposes hardships on health care consumers;

NJ A 2935

Sponsor: Gusciora (D)

Title: Out-of-Network Health Care Patient Notification

Introduced: 02/16/2016

Disposition: Pending

Location: Assembly Health and Senior Services Committee

Summary: Requires in-network hospitals to notify patients of out-of-network health care professionals who provide services in hospital.

Status: 02/16/2016 INTRODUCED.

02/16/2016 To ASSEMBLY Committee on HEALTH AND SENIOR SERVICES.

Text Hits: the hospital, such as emergency room care, radiology, and anesthesia, by physicians who are not participating providers in that patient's health insurance plan. The patients usually are made aware of this situation and the fact that they may be liable for unanticipated balance billing by the physician after they have received the services. The purpose of this bill, therefore, is to provide patients with information, in advance of receiving services whenever practicable, about the insurance participation of health care professionals who

NJ S 2434

Identical: NJ A 4178

Sponsor: Cardinale (R)

Title: Health Care Consumers Out-of-Network

Introduced: 06/27/2016

Disposition: Pending

Location: Senate Commerce Committee

Summary: Concerns the Health Care Consumer's Out-of-Network Protection, Transparency, Cost Containment and Accountability Act.

Status: 06/27/2016 INTRODUCED.

06/27/2016 To SENATE Committee on COMMERCE.

Text Hits: regarding any other physician or group of physicians whose ancillary services are to be utilized by the attending physician, as well as information as to how the patient can determine whether the ancillary physician or physicians are in the patient's network, thus avoiding what has been called "surprise" balance billing. The same requirements would apply to hospitals, which would have to inform patients that their facility-based physicians, including staff physicians, radiologists, and anesthesiologists who bill separately, may not be in the patient's health benefits plan network.

In the event that a patient or insurer or third party administrator receives a balance bill from a physician or facility, the bill provides two peer review mechanisms - one for physicians and one for health care facilities. The physicians' peer review panel, established in the Physicians' Medical Bill Dispute Resolution Review Program and located in the State Board of Medical

the same method the plan generally uses to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the emergency service, patients continue to face out-of-network charges for surprise bills;

d. Carriers and consumers continue to report exorbitant charges by certain health care professionals and facilities for out-of-network services, including balance billing, and in certain cases, consumers' bills are referred to collection, which contributes to the increasing costs of health care services, insurance, and self-insured employers costs, and imposes hardships on health care consumers;

13. a. There is established a Physicians' Medical Bill Dispute Resolution Review Program in the State Board of Medical Examiners for the purpose of reviewing and settling disputes regarding balance billing by non-participating physicians and non-participating facility-based physicians. The Physicians' Medical Bill Dispute Resolution Review Program shall be comprised of 21 physicians licensed by the State Board of Medical Examiners. The physicians on

15. a. There is established a Health Care Facilities Medical Bill Dispute Resolution Program for the purpose of reviewing and settling disputes regarding the balance billing of covered persons who utilize a non-network facility on a non-emergency basis pursuant to section 12 of this act. The program shall be comprised of a board of 11 members representing health care facilities located in this State, who shall be appointed by the Governor, in consultation with the

NJ A 4178

Identical: NJ S 2434

Sponsor: Auth (R)

Title: Health Care Consumer Out-of-Network Protection

Introduced: 09/19/2016

Disposition: Pending

Location: Assembly Financial Institutions and Insurance Committee

Summary: Concerns the Health Care Consumer's Out-of-Network Protection, Transparency, Cost Containment and Accountability Act; provides remedies for individuals who are treated by physicians and treated in facilities that do not belong to a provider network used by the individual's health benefits plan and who are consequently billed for the balance of charges that are not paid for by their health benefits plan.

Status: 09/19/2016 INTRODUCED.

09/19/2016 To ASSEMBLY Committee on FINANCIAL INSTITUTIONS AND INSURANCE.

Text Hits: regarding any other physician or group of physicians whose ancillary services are to be utilized by the attending physician, as well as information as to how the patient can determine whether the ancillary physician or physicians are in the patient's network, thus avoiding what has been called "surprise" balance billing. The same requirements would apply to hospitals, which would have to inform patients that their facility-based physicians, including staff physicians, radiologists, and anesthesiologists who bill separately, may not be in the patient's health benefits plan network.

In the event that a patient or insurer or third party administrator receives a balance bill from a physician or facility, the bill provides two peer review mechanisms - one for physicians and one for health care facilities. The physicians' peer review panel, established in the Physicians' Medical Bill Dispute Resolution Review Program and located in the State Board of Medical

the same method the plan generally uses to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the emergency service, patients continue to face out-of-network charges for surprise bills;

d. Carriers and consumers continue to report exorbitant charges by certain health care professionals and facilities for out-of-network services, including balance billing, and in certain cases, consumers' bills are referred to collection, which contributes to the increasing costs of health care services, insurance, and self-insured employers costs, and imposes hardships on health care consumers;

13. a. There is established a Physicians' Medical Bill Dispute Resolution Review Program in the State Board of Medical Examiners for the purpose of reviewing and settling disputes regarding balance billing by non-participating physicians and non-participating facility-based physicians. The Physicians' Medical Bill Dispute Resolution Review Program shall be comprised of 21 physicians licensed by the State Board of Medical Examiners. The physicians on

15. a. There is established a Health Care Facilities Medical Bill Dispute Resolution Program for the purpose of reviewing and settling disputes regarding the balance billing of covered persons who utilize a non-network facility on a non-emergency basis pursuant to section 12 of this act. The program shall be comprised of a board of 11

members representing health care facilities located in this State, who shall be appointed by the Governor, in consultation with the

NJ A 4228

Identical:	NJ S 2674
Sponsor:	Mukherji (D)
Title:	Health Care Costs Disclosure
Introduced:	10/06/2016
Disposition:	Pending
Location:	Assembly Financial Institutions and Insurance Committee
Summary:	Requires certain disclosures to consumers regarding health care costs.
Status:	10/06/2016 INTRODUCED. 10/06/2016 To ASSEMBLY Committee on FINANCIAL INSTITUTIONS AND INSURANCE.
Text Hits:	programs shall be created and funded by carriers and administered by community based organizations for the purpose of providing education and counseling to employers and employees on their health care benefits in order to prevent surprise billing to the consumer.

NJ S 2674

Identical:	NJ A 4228
Sponsor:	Vitale (D)
Title:	Health Care Consumer Disclosures
Introduced:	10/13/2016
Disposition:	Pending
Location:	Senate Health, Human Services and Senior Citizens Committee
Summary:	Requires certain disclosures to consumers regarding health care costs.
Status:	10/13/2016 INTRODUCED. 10/13/2016 To SENATE Committee on HEALTH, HUMAN SERVICES AND SENIOR CITIZENS.
Text Hits:	programs shall be created and funded by carriers and administered by community based organizations for the purpose of providing education and counseling to employers and employees on their health care benefits in order to prevent surprise billing to the consumer.

NJ A 1952

Identical:	NJ S 1285
Sponsor:	Coughlin (D)
Title:	Out of Network Consumer Protection Act
Introduced:	01/27/2016
Last Amend:	10/27/2016

Disposition: Pending

Location: ASSEMBLY

Summary: Relates to the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act; relates to health care insurers and health care providers; provides for a system to enhance consumer protections; requires confirmation if health care providers are in-network or out of network; relates to arbitration.

Status: 10/27/2016 From ASSEMBLY Committee on APPROPRIATIONS as amended.

Text Hits: b. Despite existing State and federal laws and regulations to protect against certain surprise out-of-network charges, these charges continue to pose a problem for health care consumers in New Jersey. Many consumers find themselves with surprise bills for hospital emergency room procedures or for charges by providers that the consumer had no choice in selecting;

the same method the plan generally uses to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the emergency service, patients continue to face out-of-network charges for surprise bills;

e. Carriers and consumers continue to report exorbitant charges by certain health care professionals and facilities for out-of-network services, including balance billing, and in certain cases, consumers' bills are referred to collection, which contributes to the increasing costs of health care services and insurance and imposes hardships on health care consumers;

(2015) NY S 6347

Sponsor: Hannon (R)

Title: Hospital Patient Bill of Rights

Introduced: 01/06/2016

Last Amend: 05/16/2016

Disposition: Failed - Adjourned

Location: SENATE

Summary: Amends the Public Health Law; requires each hospital patient bill of rights and responsibilities to include a statement of the availability of a list of standard charges, participating health plans, the right to be held harmless from surprise bills, and to designate a caregiver.

Status: 06/07/2016 Substituted by A9188B

Full Status

Text Hits: (k) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to choose to submit surprise bills or bills for emergency services to the independent dispute process established in article six of the financial services law, and informing the patient of his or her right to view a list of the hospital's standard charges and the health plans the hospital participates with consistent with

(2015) NY A 9188

Sponsor:	Gunther (D)
Title:	Hospital Statements of Rights and Responsibilities
Introduced:	02/02/2016
Enacted:	08/18/2016
Disposition:	Enacted
Effective Date:	02/14/2017 [code impact]
Location:	Chaptered
Chapter:	241
Summary:	Relates to hospital statements of the rights and responsibilities of patients; includes provisions informing the patient of the right to choose to submit surprise bills or bills for emergency services to the independent dispute process, and informing the patient of his or her right to view a list of the hospital's standard charges and the hospital's health plans; provides for a patient's right to choose a caregiver for inclusion in discussions on patient care after discharge.
Status:	08/18/2016 Signed by GOVERNOR. 08/18/2016 Chapter No. 241 [Effective Rule]
Text Hits:	(k) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to choose to submit surprise bills or bills for emergency services to the independent dispute process established in article six of the financial services law, and informing the patient of his or her right to view a list of the hospital's standard charges and the health plans the hospital participates with consistent with

OR H 2339

Author:	Office of the Governor
Title:	Health Care Provider
Prefiled:	01/09/2017
Disposition:	Pending
Location:	HOUSE
Summary:	Prohibits health care provider or participating health care facility from balance billing patient covered by health benefit plan or health care service contract for services provided at participating health care facility; requires insurer and health care service contractor to reimburse nonparticipating provider at rate that is reasonable and customary; requires insurer and health care service contractor to have process to resolve dispute regarding reimbursement paid to nonparticipating provider; declares/.
Status:	01/09/2017 PREFILED Full Status
Text Hits:	Prohibits health care provider or participating health care facility from balance billing patient covered by health benefit plan or health care service contract for services provided at participating health care facility. Requires insurer and health care service

contractor to reimburse nonparticipating provider at rate that is reasonable and customary. Requires insurer and health

(2015) PA H 1688

PN	2506
Author:	DeLissio (D)
Title:	Statewide Comprehensive Health Care System
Introduced:	11/09/2015
Disposition:	Failed - Adjourned
Location:	House Health Committee
Summary:	Provides for a Statewide comprehensive health care system; establishes the Pennsylvania Health Care Plan; provides for eligibility, services, coverages, subrogation, participating and nonparticipating providers, cost containment, quality assurance, transitional support and training; establishes the Pennsylvania Health Care Board, the Pennsylvania Health Care Agency, the Office of Health Care Ombudsman and the Pennsylvania Health Care Trust Fund; imposes a payroll tax and an additional personal income tax.
Status:	11/09/2015 INTRODUCED. 11/09/2015 To HOUSE Committee on HEALTH.
Text Hits:	(c) Copayments, deductibles and other charges.--Participants are not subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package and shall not be directly billed nor balance billed by participating providers for covered benefits provided to the participant. If a participant has directly paid for nonemergency services of a nonparticipating provider, the participant may submit a claim for reimbursement from the plan for the amount the plan would have paid a participating provider

(2015) PA S 1158

PN	1643
Author:	Schwank (D)
Title:	Emergency Medical and Health Care Services Billing
Introduced:	03/22/2016
Disposition:	Failed - Adjourned
Location:	Senate Banking and Insurance Committee
Summary:	Prohibits emergency medical and health care services surprise billing.
Status:	03/22/2016 FILED. 03/22/2016 INTRODUCED. 03/22/2016 To SENATE Committee on BANKING AND INSURANCE.

(2015) RI H 5597

Author:	McKiernan (D)
Title:	Health Benefit Plan Network Access and Adequacy Act

Introduced:	02/25/2015
Disposition:	Failed - Adjourned
Location:	House Corporations Committee
Summary:	Would establish criteria by which the office of the health insurance commissioner shall review and regulate the adequacy of health plan networks. This act would take effect on January 1, 2016.
Status:	03/31/2015 In HOUSE Committee on CORPORATIONS: Committee recommends measure to be held for further study.
Text Hits:	(1) "Balance billing" means the practice of a (non-participating) provider billing for the difference between the provider's charge and the health carrier's allowed amount.

(2015) RI S 382

Author:	Goldin (D)
Title:	Health Benefit Plan Network Access
Introduced:	02/25/2015
Disposition:	Failed - Adjourned
Location:	Senate Health and Human Services Committee
Summary:	Would establish criteria by which the office of the health insurance commissioner shall review and regulate the adequacy of health plan networks. This act would take effect on January 1, 2016.
Status:	04/28/2015 In SENATE Committee on HEALTH AND HUMAN SERVICES: Committee recommends measure to be held for further study.
Text Hits:	(1) "Balance billing" means the practice of a (non-participating) provider billing for the difference between the provider's charge and the health carrier's allowed amount.

(2015) RI H 8004

Author:	Craven (D)
Title:	Medical Service Billing
Introduced:	03/25/2016
Disposition:	Failed - Adjourned
Location:	House Corporations Committee
Summary:	Would provide for a dispute resolution process for emergency services and surprise bills for medical services performed by nonparticipating (out-of-network) health care providers. This act would take effect upon passage.
Status:	04/12/2016 In HOUSE Committee on CORPORATIONS: Committee recommends measure to be held for further study.
Text Hits:	RELATED TO INSURANCE - SURPRISE BILLS FOR MEDICAL SERVICES This act would provide for a dispute resolution process for emergency services and surprise bills for medical services performed by nonparticipating (out-of-network) health care providers.

RELATED TO INSURANCE - SURPRISE BILLS FOR MEDICAL SERVICES

SURPRISE BILLS FOR MEDICAL SERVICES

27-81-1. Dispute resolution process established. -- The health insurance commissioner ("commissioner") shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The commissioner shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The commissioner shall promulgate rules and

(10)(i) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider at an in-network facility, during a service or

(ii) "Surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of- network.

(d) With respect to a surprise bill:

27-81-7. Hold harmless and assignment of benefits for surprise bills for insureds. -- When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, the non-participating physician shall not bill the insured except for any applicable co-payment, co-insurance or deductible that

27-81-8. Dispute resolution for surprise bills. -- (a) Surprise bill received by an insured who assigns benefits:

(4) Either the health care plan or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity, provided however, the health care plan may not submit the dispute unless it has complied with the requirements of subsections (a)(1) through (a)(3) of this section.

(b) Surprise bill received by an insured who does not assign benefits or by a patient who is not an insured:

(1) An insured who does not assign benefits in accordance with subsection (a) of this section or a patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

(2015) RI S 2462

Author: Archambault (D)

Title:	Medical Services and Surprise Bills
Introduced:	02/11/2016
Last Amend:	06/15/2016
Disposition:	Failed - Adjourned
Location:	HOUSE
Summary:	Provides a dispute resolution process for emergency services and surprise bills for medical services performed by nonparticipating out-of-network health care providers when the insured did not knowingly elect to obtain such services from an out-of-network provider; relates to emergency medical services billed under American Medical Association current procedural terminology (CPT) codes; provides that no health carrier shall require prior authorization for rendering emergency services to an insured.
Status:	06/16/2016 Placed on Senate Calendar 06/16/2016. 06/16/2016 Passed SENATE. *****To HOUSE.
Text Hits:	RELATED TO INSURANCE - SURPRISE BILLS FOR MEDICAL SERVICES

This act would provide for a dispute resolution process for emergency services and surprise bills for medical services performed by nonparticipating (out-of-network) health care providers.

RELATED TO INSURANCE - SURPRISE BILLS FOR MEDICAL SERVICES

SURPRISE BILLS FOR MEDICAL SERVICES

27-81-1. Dispute resolution process established. -- The health insurance commissioner ("commissioner") shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The commissioner shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The commissioner shall promulgate rules and

(8)(i) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider at an in-network facility, during a service or

(ii) "Surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of- network.

(d) With respect to a surprise bill:

27-81-7. Hold harmless and assignment of benefits for surprise bills for insureds. -- When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, the non-participating physician shall not bill the insured except for any applicable co-payment, co-insurance or deductible that

27-81-8. Dispute resolution for surprise bills. -- (a) Surprise bill received by an insured who assigns benefits.

(4) Either the health care plan or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity, provided however, the health care plan may not submit the dispute unless it has complied with the requirements of subsections (a)(1) through (a)(3) of this section.

(b) Surprise bill received by an insured who does not assign benefits or by a patient who is not an insured.

(1) An insured who does not assign benefits in accordance with subsection (a) of this section or a patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

RI H 5012

Author:	Craven (D)
Title:	Medical Services Surprise Bills
Introduced:	01/05/2017
Disposition:	Pending
Location:	House Corporations Committee
Summary:	Relates to insurance; relates to surprise bills for medical services; provides for a dispute resolution process for emergency services and surprise bills for medical services performed by nonparticipating out-of-network health care providers.
Status:	01/05/2017 INTRODUCED. 01/05/2017 To HOUSE Committee on CORPORATIONS.

TX H 307

Author:	Burrows (R)
Title:	Health Care Costs Disclosure
Introduced:	01/10/2017
Disposition:	Pending
Location:	HOUSE
Summary:	Relates to disclosure of certain health care costs and shared savings between certain health benefit plans and enrollees.
Status:	01/10/2017 INTRODUCED.

	Full Status
Text Hits:	(2) subject to Chapter 185, Health and Safety Code, a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan.

WA H 1117

Author:	Cody (D)
Title:	Health Care Services Balance Billing
Introduced:	01/11/2017
Disposition:	Pending
Location:	House Health Care and Wellness Committee
Summary:	Addresses health care services balance billing.
Status:	01/11/2017 INTRODUCED. 01/11/2017 To HOUSE Committee on HEALTH CARE AND WELLNESS.

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

7700 East First Place Denver, CO 80230
ph (303) 364-7700 fax (303) 364-7800
www.ncsl.org

Balanced Billing and Surprise Bill Legislation
June 2015

Ashley A. Noble, JD

Summary

- 5 bills introduced in 4 states: Connecticut (2), Michigan (1), and New Jersey (2).
  - All bills remain pending in state legislatures.

CT S 808

Introducer:	Looney (D)
Title:	Surprise Billing
Introduced:	01/28/2015
Last Amend:	04/02/2015
Disposition:	Pending
Location:	Joint Committee on Insurance and Real Estate
Summary:	Concerns the establishment of a dispute resolution process for surprise bills and bills for emergency services.
Status:	05/27/2015 To JOINT Committee on INSURANCE AND REAL ESTATE.

CT S 811

Introducer:	Looney (D)
Title:	Parity in Hospital Sales Oversight
Introduced:	01/28/2015
Last Amend:	05/30/2015
Disposition:	To Governor
Location:	Eligible for Governor
Summary:	Concerns parity in hospital sales oversight; establishes a consistent and fair process for hospital sale oversight by treating all sales equally; relates to the Department of Public Health; prohibits a hospital from entering into an agreement to transfer a material

amount of its assets or operations or a change in control of operations to any person without first having received approval of the agreement by the commissioner and the Attorney General; relates to transacting parties.

Status: 06/01/2015 SENATE concurred in HOUSE amendments.
06/01/2015 Eligible for GOVERNOR'S desk.

MI SCR 5

Sponsor: Colbeck (R)
Title: Consumer Opportunity Resolution
Introduced: 03/04/2015
Disposition: Pending
Location: House Health Policy Committee
Summary: Requests the United States Congress to enact legislation and the U.S. Department of Health and Human Services to promulgate rules that would promote the opportunity for consumers to choose Direct Primary Care Services as an integral part of their health care plan.
Status: 04/16/2015 To HOUSE Committee on HEALTH POLICY.

NJ S 20

Identical: NJ A 4444
Sponsor: Vitale (D)
Title: Consumer Protection
Introduced: 05/14/2015
Disposition: Pending
Location: SENATE
Summary: The Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.
Status: 05/14/2015 FILED.
05/14/2015 INTRODUCED.
05/14/2015 Received in the SENATE without Reference.

NJ A 4444

Identical: NJ S 20
Sponsor: Coughlin (D)
Title: Medical Insurance
Introduced: 06/01/2015
Disposition: Pending
Location: Assembly Financial Institutions and Insurance Committee
Summary: The Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act.

Status: **06/01/2015 INTRODUCED.**

06/01/2015 To ASSEMBLY Committee on FINANCIAL INSTITUTIONS AND INSURANCE.

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

7700 East First Place Denver, CO 80230
ph (303) 364-7700 fax (303) 364-7800
www.ncsl.org

In Network Rates and Surprise Bill Legislation
June 2015

Ashley A. Noble, JD

Summary:

- **7 bills introduced in 5 states: Colorado (1), Connecticut (2), New Jersey (1), Pennsylvania (1), and Tennessee (2).**
  - **1 law enacted in 1 state: Tennessee (1).**
  - **5 bills pending in 5 states: Colorado (1), Connecticut (1), New Jersey (1), Pennsylvania (1), and Tennessee (1).**
  - **1 bill failed in 1 state: Connecticut (1).**

CO S 259

Sponsor:	**Aguilar (D)**
Title:	**Out of Network Health Care Provider Charges**
Introduced:	**04/02/2015**
Disposition:	**Pending**
Location:	**Postponed Indefinitely**
Summary:	**Concerns out-of-network health care provider charges.**
Status:	**04/20/2015 From SENATE Committee on BUSINESS, LABOR, & TECHNOLOGY: Postponed indefinitely.**

CT S 808

Introducer:	**Looney (D)**
Title:	**Surprise Billing**
Introduced:	**01/28/2015**
Last Amend:	**04/02/2015**
Disposition:	**Failed - Adjourned**
Location:	**Joint Committee on Insurance and Real Estate**

Summary:	Concerns the establishment of a dispute resolution process for surprise bills and bills for emergency services.
Status:	05/27/2015 To JOINT Committee on INSURANCE AND REAL ESTATE.

CT S 811

Introducer:	Looney (D)
Title:	Parity in Hospital Sales Oversight
Introduced:	01/28/2015
Last Amend:	05/30/2015
Disposition:	To Governor
Location:	Eligible for Governor
Summary:	Concerns parity in hospital sales oversight; establishes a consistent and fair process for hospital sale oversight by treating all sales equally; relates to the Department of Public Health; prohibits a hospital from entering into an agreement to transfer a material amount of its assets or operations or a change in control of operations to any person without first having received approval of the agreement by the commissioner and the Attorney General; relates to transacting parties.
Status:	06/01/2015 SENATE concurred in HOUSE amendments. 06/01/2015 Eligible for GOVERNOR'S desk.

NJ A 1956

Sponsor:	Riley (D)
Title:	Health Care Professionals Requirements
Introduced:	01/16/2014
Disposition:	Pending - Carryover
Location:	Assembly Health and Senior Services Committee
Summary:	Requires health care professionals to notify patients of end of health benefits coverage during course of treatment in certain circumstances.
Status:	01/16/2014 INTRODUCED. 01/16/2014 To ASSEMBLY Committee on HEALTH AND SENIOR SERVICES.

PA H 1172

PN	1541
Author:	DeLuca (D)
Title:	Powers and Duties on the Insurance Department
Introduced:	05/12/2015
Disposition:	Pending
Location:	House Insurance Committee
Summary:	Provides for the additional regulation and oversight of integrated delivery networks; confers powers and imposing duties on the Insurance Department.

Status:	05/12/2015 INTRODUCED. 05/12/2015 To HOUSE Committee on INSURANCE.

TN S 284

Same as:	TN H 440
Author:	Briggs (R)
Title:	Physician Credentialing
Introduced:	01/29/2015
Enacted:	05/08/2015
Disposition:	Enacted
Location:	Chaptered
Chapter #:	386
Summary:	Relates to physician credentialing; provides that an insurance entity shall provide to any medical group practice with which the entity has an existing contract a list of all information and supporting documentation required for a credentialing application of a new provider applicant to be considered complete; requires notice in writing to the new provider; provides that a new provider shall not submit any claims for reimbursement while such application is pending.
Status:	05/14/2015 Public Chaptered. Chapter No. 386 [Effective Rule]

TN H 440

Same as:	TN S 284
Author:	Byrd (R)
Title:	Physicians and Surgeons
Introduced:	02/05/2015
Disposition:	Pending
Location:	HOUSE
Summary:	Relates to Physicians and Surgeons; establishes a process for reimbursing physicians for services rendered during the pendency of a credentialing application before a health insurance entity.
Status:	04/20/2015 In HOUSE. Substituted on HOUSE floor by S 284

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

7700 East First Place Denver, CO 80230
ph (303) 364-7700 fax (303) 364-7800
www.ncsl.org

Balance Billing in Health Care
March 19, 2013/ reviewed Feb 2, 2015

Richard Cauchi

I. What is Balance Billing?

Balance Billing:. The practice of medical care providers (such as doctors, hospital, or other medical practitioner) billing the insurer for full costs, then billing the insured for the portion of the bill which was not paid. Many Managed Care plans prohibit the use of balanced billing and may use sanctions against providers who balance the bill."
"Specific deductible is the point at which the stop-loss insurance carrier begins to reimburse the employer based upon the individual's total of claims paid within a policy year
According to the National Association of Health Underwriters, http://www.nahu.org/.

Several states have insurance laws that prohibit, restrict or require disclosures related to balance billing. *[2/2/15]*

II. Current Statute

Arkansas
Title 11. Labor and Industrial Relations - Chapter 9. Workers' Compensation (Refs & Annos), Subchapter 5. Accidental Injury or Death (Refs & Annos) **§ 11-9-508. Medical, etc., services--Employer's liability**

(a) The employer shall promptly provide for an injured employee such medical, surgical, hospital, chiropractic, optometric, podiatric, and nursing services and medicine, crutches, ambulatory devices, artificial limbs, eyeglasses, contact lenses, hearing aids, and other apparatus as may be reasonably necessary in connection with the injury received by the employee.

(b) If the employer fails to provide the medical services set out in subsection (a) of this section within a reasonable time after knowledge of the injury, the Workers' Compensation Commission may direct that the injured employee obtain the medical service at the expense of the employer, and any emergency treatment afforded the injured employee shall be at the expense of the employer. In no circumstance may an employee, his or her family, or dependents, be billed or charged for any portion of the cost of providing the benefits to which he or she is entitled under this chapter.

(c) In order to help control the cost of medical benefits, the commission, on or before July 1, 1994, following a public hearing and with the assistance and cooperation of the State Insurance Department, is authorized and directed to establish appropriate rules and regulations to establish and implement a system of managed health care for the State of Arkansas.

(d) For the purpose of establishing and implementing a system of managed health care, the commission is authorized to:

(1) Develop rules and regulations for the certification of managed care entities to provide managed care to injured workers;

(2) Develop regulations for peer review, service utilization, and resolution of medical disputes;

(3) Prohibit "balance billing" from the employee, employer, or carrier;

(4)(A) Establish fees for medical services as provided in Workers' Compensation Commission Rule 30 and its amendments.

(B) The commission shall make no distinction in approving fees from different classes of medical service providers or health care providers for provision of the same or essentially similar medical services or health care services as specified in this section; and

(5)(A) Give the employer the right to choose the initial treating physician, with the injured employee having the right to petition the commission for a one-time only change of physician to one who is associated with a managed care entity certified by the commission or is the regular treating physician of the employee who maintains the employee's medical records and with whom the employee has a bona fide doctor-patient relationship demonstrated by a history of regular treatment prior to the onset of the compensable injury, but only if the primary care physician agrees to refer the employee to a certified managed care entity for any specialized treatment, including

physical therapy, and only if such primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer.

(B) A petition for change of physician shall be expedited by the commission.

(e) Any section or subsection of this chapter notwithstanding, the injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission.

(f) The commission is authorized to promulgate any other rules or regulations as may be necessary to carry out the provisions of this section and its purpose of controlling medical costs through the establishment of a managed care system.

CREDIT(S)

Acts of 1948, Initiated Act 4, § 11. Acts of 1949, p. 1420; Acts of 1975, Act 330, § 1; Acts of 1979, Act 253, § 3; Acts of 1981, Act 290, § 3; Acts of 1983, Act 444, § 2; Acts of 1993, Act 796, § 19, eff. July 1, 1993; Acts of 2003, Act 1473, § 23, eff. July 1, 2003; Acts of 2009, Act 653, § 1, eff. July 31, 2009.

Idaho

Worker's Compensation and Related Laws--Industrial Commission - Chapter 4. Benefits § 72-432. Medical services, appliances and supplies--Reports

(1) Subject to the provisions of section 72-706, Idaho Code, the employer shall provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital services, medicines, crutches and apparatus, as may be reasonably required by the employee's physician or needed immediately after an injury or manifestation of an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer.

(2) The employer shall also furnish necessary replacements or repairs of appliances and prostheses, unless the need therefor is due to lack of proper care by the employee. If the appliance or prosthesis is damaged or destroyed in an industrial accident, the employer, for whom the employee was working at the time of accident, will be liable for replacement or repair, but not for any subsequent replacement or repair not directly resulting from the accident.

(3) In addition to the income benefits otherwise payable, the employee who is entitled to income benefits shall be paid an additional sum in an amount as may be determined by the commission as by it deemed necessary, as a medical service, when the constant service of an attendant is necessary by reason of total blindness of the employee or the loss of both hands or both feet or the loss of use thereof, or by reason of being paralyzed and unable to walk, or by reason of other disability resulting from the injury or disease actually rendering him so helpless as to require constant attendance. The commission shall have authority to determine the necessity, character and sufficiency of any medical services furnished or to be furnished and shall have authority to order a change of physician, hospital or rehabilitation facility when in its judgment such change is desirable or necessary.

(4)(a) The employee upon reasonable grounds, may petition the commission for a change of physician to be provided by the employer; however, the employee must give written notice to the employer or surety of the employee's request for a change of physicians to afford the employer the opportunity to fulfill its obligations under this section. If proper notice is not given, the employer shall not be obligated to pay for the services obtained. Nothing in this section shall limit the attending physician from arranging for consultation, referral or specialized care without permission of the employer. Upon receiving such written notice, the employer shall render its written decision on the claimant's request within fourteen (14) days. If any dispute arises over the issue of a request for change of physician, the industrial commission shall conduct an expedited hearing to determine whether or not the request for change of physician should be granted, and shall render a decision within fourteen (14) days after the filing of the response by the employer.

(b) The industrial commission shall, no later than December 31, 1997, promulgate a rule for the expeditious handling of a petition for change of physician pursuant to this section. Nothing herein shall prevent the commission from making periodic amendments, as may become necessary, to any rule for a petition for change of physician.

(5) Any employee who seeks medical care in a manner not provided for in this section, or as ordered by the industrial commission pursuant to this section, shall not be entitled to reimbursement for costs of such care.

(6) No provider shall engage in balance billing as defined in section 72-102, Idaho Code.

(7) An employee shall not be responsible for charges of physicians, hospitals or other providers of medical services to whom he has been referred for treatment of his injury or occupational disease by an employer designated physician or by the commission, except for charges for personal items or extended services which the employee has requested for his convenience and which are not required for treatment of his injury or occupational disease.

(8) The employer or surety shall not be subject to tort liability to any health care provider for complying with the provisions of this law.

(9) Nothing in this chapter shall be construed to require a workman who in good faith relies on Christian Science treatment by a duly accredited Christian Science practitioner to undergo any medical or surgical treatment, providing that neither he nor his dependents shall be entitled to income benefits of any kind beyond those reasonably expected to have been paid had he undergone medical or surgical treatment, and the employer or insurance carrier may pay for such spiritual treatment.

(10) The commission shall promulgate rules requiring physicians and other practitioners providing treatment to make regular reports to the commission containing such information as may be required by the commission. The commission shall promulgate such rules with the counsel, advice, cooperation and expertise of representatives of industry, labor, sureties and the legal and medical professions as well as institutions, hospitals and clinics having physical rehabilitation facilities.

(11) All medical information relevant to or bearing upon a particular injury or occupational disease shall be provided to the employer, surety, manager of the industrial special indemnity fund, or their attorneys or authorized representatives, the claimant, the claimant's attorneys or authorized representatives, or the commission without liability on the part of the physician, hospital or other provider of medical services and information developed in connection with treatment or examination for an injury or disease for which compensation is sought shall not be privileged communication. When a physician or hospital willfully fails to make a report required under this section, after written notice by the commission that such report is due, the commission may order forfeiture of all or part of payments due for services rendered in connection with the particular case. An attorney representing the employer, surety, claimant or industrial special indemnity fund shall have the right to confer with any health care provider without the presence of the opposing attorney, representative or party, except for a health care provider who is retained only as an expert witness.

(12) Physicians or others providing services under this section shall assist in the rehabilitation program provided in section 72-501A, Idaho Code. They shall cooperate with specialists from the commission's rehabilitation staff and with employer rehabilitation personnel in furthering the physical or vocational rehabilitation of the employee. The extension of total temporary disability benefits during retraining as authorized by section 72-450, Idaho Code, shall be the responsibility of the commission, however, the physician shall inform the commission as soon as it is medically apparent that the employee may be unable to return to the job in which he sustained injury or occupational disease following treatment and maximum recovery.

(13) An injured employee shall be reimbursed for his expenses of necessary travel in obtaining medical care under this section. Reimbursement for transportation expenses, if the employee utilizes a private vehicle, shall be at the mileage rate allowed by the state board of examiners for state employees; provided however, that the employee shall not be reimbursed for the first fifteen (15) miles of any round trip, nor for traveling any round trip of fifteen (15) miles or less. Such distance shall be calculated by the shortest practical route of travel.

(14) An employee who leaves the locality where employed at the time of the industrial accident, or manifestation of an occupational disease, or the locality in which the employee is currently receiving medical treatment for the injury, shall give timely notice to the employer and surety of the employee's leaving the locality. The employer or surety may require the claimant to report to the treating physician for examination prior to leaving the locality, if practical. If an examination by the treating physician is not practical prior to leaving the locality, the employer or surety may assist in arranging an examination by an appropriate physician in the new locality. After receiving notice of relocation, the employer or surety shall have the same responsibility to furnish care as set forth in subsection (1) of this section.

CREDIT(S)

S.L. 1971, ch. 124, § 3; S.L. 1971, ch. 297, § 1; S.L. 1974, ch. 132, § 4; S.L. 1978, ch. 264, § 12; S.L. 1997, ch. 274, § 9; S.L. 2005, ch. 161, § 1; S.L. 2006, ch. 206, § 2, eff. July 1, 2006.

Louisiana

Louisiana Revised Statutes - Title 22. Insurance Code (Refs & Annos) - Chapter 6. Payment of Claims (Refs & Annos), Part II. Health and Accident Insurance Claims Payments, Subpart D. Health Care Consumer Billing and Disclosure Protection Act, § 1880. Balance billing disclosure

A. Definitions. As used in this Section, the following terms shall be defined as follows:

(1) "Balance billing" means any written or electronic communication by a non-contracted health care provider that appears to attempt to collect from an enrollee or insured any amount for covered, non-covered, and out-of-network health care services received by the enrollee or insured from the non-contracted health care provider that is not fully paid by the enrollee or insured, or the health insurance issuer.

(2) "Enrollee or insured liability" means the financial liability of an enrollee or insured for covered, non-covered, and out-of-network health care services pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer.

(a) In the case of a contracted health care provider, "enrollee or insured liability" is the amount due for coinsurance, co-payments, deductibles, non-covered services, or any other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the enrollee or insured is liable for the covered or non-covered service.

(b) In the case of a non-contracted health care provider, "enrollee or insured liability" is the amount as determined pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer for covered and non-covered, out-of-network health care services, including but not limited to the enrollee's or insured's contractual deductible, coinsurance, or co-payment amount.

B. (1) Health insurance issuer disclosure requirements. Each health insurance issuer shall provide the following balance billing disclosure notice:

"NOTICE

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN".

(2) The balance billing disclosure notice shall be disclosed in all of the following methods:

(a) To the potential policyholder prior to the time the health benefit plan is purchased. The disclosure notice may be provided directly by the health insurance issuer or through an authorized insurance producer. If the health insurance issuer provides the disclosure notice to the producer, then the producer shall provide that disclosure notice to the potential policyholder.

(b) To the policyholder and enrollees, at the time the insurance policy or other proof of coverage is issued, as follows:

(i) For a group benefit plan, to the policyholder and employees at the time the insurance policy or other proof of insurance coverage is issued.

(ii) For an individual benefit plan, to the policyholder at the time the insurance policy or other proof of insurance coverage is issued.

(c) To the policyholder and enrollees at least once a year as follows:

(i) For a group benefit plan, to the policyholder and employees.

(ii) For an individual benefit plan, to the policyholder.

(d) On the health insurance issuer's website.

C. Facility disclosure requirements. Each health care facility shall:

(1) Provide a written notice to an enrollee or insured at the first registration contact with the enrollee or insured at the health care facility regarding nonemergency services disclosing the following items:

(a) Confirmation as to whether the facility is a participating provider contracted with the enrollee's or insured's health insurance issuer on the date services are to be rendered, based on the information received from the enrollee or insured at the time the confirmation is provided.

(b) The following balance billing disclosure notice:

"NOTICE

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN".

(2) Provide a list upon request from an enrollee or insured that contains the name and contact information for each individual or group of hospital-contracted anesthesiologists, pathologists, radiologists, hospitalists, intensivists, and neonatologists who provide services at that facility and inform the enrollee or insured that the enrollee or insured may request information from their health insurance issuer as to whether those physicians are contracted with the health insurance issuer and under what circumstances the enrollee or insured may be responsible for payment of any amounts not paid by the health insurance issuer.

(3) If the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, post on the facility's website a list that contains the name and contact information for each facility-based physician or facility-based physician group that has been granted medical staff privileges to provide medical services at the facility, and an update of the list within thirty days of any changes.

D. Facility-based physician disclosure requirements. Whenever a facility-based physician bills a patient who has health insurance coverage issued by a health insurance issuer that does not have a contract with the facility-based physician, the facility-based physician shall send a bill that includes all of the following items:

(1) An itemized listing of the services and supplies provided by the facility-based physician along with the dates such services and supplies were provided.

(2) The amount that is owed by the enrollee or insured and language conspicuously displayed on the front of such bill:

"NOTICE: THIS IS A BILL BASED UPON INFORMATION FROM YOUR HEALTH PLAN. YOU OWE THE AMOUNT SHOWN".

(3) A telephone number to call to discuss the statement.

CREDIT(S)

Added by Acts 2010, No. 453, § 1. Amended by Acts 2012, No. 271, § 1.

Ohio

R.C. T. XLVII, Ch. 4769, Refs & Annos

LAW REVIEW AND JOURNAL COMMENTARIES
Health Law--Federal Preemption of State Medicare Balance Billing Regulations, Pennsylvania Medical Society v Marconis, Comment. 37 Vill L Rev 1064 (1992).

Health Law--Provider Challenge to State Medicaid Reimbursement Plan, Temple University v White, Comment. 37 Vill L Rev 1081 (1992).

R.C. T. XLVII, Ch. 4769, Refs & Annos, OH ST T. XLVII, Ch. 4769, Refs & Annos

Current through all 2012 laws and statewide issues of the 129th GA (2011-2012).

Ohio Revised Code Annotated - Title XLVII. Occupations--Professions (Refs & Annos), Chapter 4769. Health Care Practitioner Balance Billing (Refs & Annos), 4769.01 Definitions

As used in this chapter:

(A) "Medicare" means the program established by Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

(B) "Balance billing" means charging or collecting from a medicare beneficiary an amount in excess of the medicare reimbursement rate for medicare-covered services or supplies provided to a medicare beneficiary, except when medicare is the secondary insurer. When medicare is the secondary insurer, the health care practitioner may pursue full reimbursement under the terms and conditions of the primary coverage and, if applicable, the charge allowed under the terms and conditions of the appropriate provider contract, from the primary insurer, but the medicare beneficiary cannot be balance billed above the medicare reimbursement rate for a medicare-covered service or supply. "Balance billing" does not include charging or collecting deductibles or coinsurance required by the program.

(C) "Health care practitioner" means all of the following:

(1) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;

(2) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(3) An optometrist licensed under Chapter 4725. of the Revised Code;

(4) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code;

(5) A pharmacist licensed under Chapter 4729. of the Revised Code;

(6) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry;

(7) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;

(8) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;

(9) A psychologist licensed under Chapter 4732. of the Revised Code;

(10) A chiropractor licensed under Chapter 4734. of the Revised Code;

(11) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;

(12) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;

(13) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;

(14) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

(15) A professional clinical counselor, professional counselor, social worker, or independent social worker licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code;

(16) A dietitian licensed under Chapter 4759. of the Revised Code;

(17) A respiratory care professional licensed under Chapter 4761. of the Revised Code;

(18) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.

CREDIT(S)

(1996 S 223, eff. 3-18-97; 1995 S 143, eff. 3-5-96; 1995 S 150, eff. 11-24-95; 1992 H 478, eff. 1-14-93)
CROSS REFERENCES
Health and hospitalization insurance, open enrollment, health care practitioner defined, see 3923.58

NOTES OF DECISIONS
Balance billing, defined 1

1. Balance billing, defined

Attempt by helicopter ambulance service to recover, from surviving spouse of patient, portion of expense of transporting patient to hospital, that was not reimbursed by Medicare, did not constitute prohibited "balance billing," which was defined as charging or collecting from Medicare beneficiary amount in excess of Medicare reimbursement rate for Medicare-covered services or supplies provided to beneficiary; Medicare covered only cost of transporting patient to nearest hospital that provided level of care required by patient, so difference between cost of transporting patient to nearest qualified medical facility, and more distant hospital selected by patient's physician, was not "Medicare-covered" service or supply. Med Flight, Inc. v. Whites (Ohio App. 3 Dist., Crawford, 08-02-2004) No. 3-04-08, 2004-Ohio-4005, 2004 WL 1717644, Unreported. Health 535(4)

R.C. § 4769.01, OH ST § 4769.01

Ohio Revised Code Annotated - Title XLVII. Occupations--Professions (Refs & Annos), Chapter 4769. Health Care Practitioner Balance Billing (Refs & Annos), 4769.02 Balance billing prohibited

No health care practitioner, and no person that employs any health care practitioner, shall balance bill for any supplies or service provided to a medicare beneficiary.

CREDIT(S)

(1995 S 150, eff. 11-24-95; 1992 H 478, eff. 1-14-93)

Texas

Vernon's Texas Statutes and Codes Annotated - Insurance Code - Title 8. Health Insurance and Other Health Coverages (Refs & Annos),Subtitle F. Physicians and Health Care Providers, Chapter 1456. Disclosure of Provider Status, § 1456.001. Definitions

(1) "Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

(2) "Enrollee" means an individual who is eligible to receive health care services through a health benefit plan.

(3) "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:

(A) to whom the facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(4) "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing health care services.

(5) "Health care practitioner" means an individual who is licensed to provide and provides health care services.

(6) "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan. The term includes a network operated by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) another entity that issues a health benefit plan, including an insurance company.

CREDIT(S)

Added by Acts 2007, 80th Leg., ch. 997, § 11, eff. Sept. 1, 2007.

Utah

U.C.A. 1953 § 31A-26-301.5 - West's Utah Code Annotated - Title 31A. Insurance Code, Chapter 26. Insurance Adjusters (Refs & Annos), Part 3. Claim Practices, § 31A-26-301.5. Health care claims practices

(1) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for paying for health care services the insured receives. If a service is covered by one or more individual or group health insurance policies, all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies.

(2)(a) Except as provided in Section 31A-22-610.1, a health care provider may bill and collect for any deductible, copayment, or uncovered service.

(b) A health care provider may bill an insured for services covered by health insurance policies or may otherwise notify the insured of the expenses covered by the policies. However, a provider may not make any report to a credit bureau, use the services of a collection agency, or use methods other than routine billing or notification until the later of:

(i) the expiration of the time afforded to an insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim without penalty; or

(ii) in the case of medicare beneficiaries or retirees 65 years of age or older, 60 days from the date medicare determines its liability for the claim.

(c) Beginning October 31, 1992, all insurers covering the insured shall notify the insured of payment and the amount of payment made to the provider.

(3) The commissioner shall make rules consistent with this chapter governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process. These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:

(a) a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed; and

(b) a prohibition against an implication that the provider is charging excessively if the provider is:

(i) a participating provider; and

(ii) prohibited from balance billing.

CREDIT(S)

Laws 1992, c. 291, § 1; Laws 1996, c. 181, § 1, eff. April 29, 1996; Laws 2000, c. 198, § 2, eff. May 1, 2000; Laws 2001, c. 240, § 1, eff. Sept. 1, 2001.

Virginia

West's Annotated Code of Virginia - Title 32.1. Health, Chapter 5. Regulation of Medical Care Facilities and Services (Refs & Annos), Article 1.1. Certificate of Quality Assurance of Managed Care Health Insurance Plan Licensees (Refs & Annos), **§ 32.1-137.1. Definitions**

As used in this and the following article, unless the context indicates otherwise:

"Agent" or "insurance agent," when used without qualification, means an individual, partnership, limited liability company, or corporation that solicits, negotiates, procures or effects contracts of insurance or annuity in this Commonwealth.

"Bureau of Insurance" means the State Corporation Commission acting pursuant to Title 38.2.

"Complaint" means any written communication from a covered person primarily expressing a grievance.

"Covered person" means an individual residing in the Commonwealth, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan under Title 38.2.

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Managed care health insurance plan licensee" means a health carrier subject to licensure by the Bureau of Insurance under Title 38.2 who is responsible for a managed care health insurance plan in accordance with Chapter 58 (§ 38.2-5801 et seq.) of Title 38.2.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, other organization, partnership, receiver, reciprocal or inter-insurance exchange, trustee or society.

CREDIT(S)

Acts 1998, c. 891.

Washington

West's Revised Code of Washington Annotated - Title 70. Public Health and Safety (Refs & Annos), Chapter 70.47. Basic Health Plan--Health Care Access Act (Refs & Annos), **70.47.230. Payments to nonparticipating providers *(Expires July 1, 2016)***

*(1) For services provided to plan enrollees on or after August 24, 2011, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under RCW 70.47.100(2) in addition to any deductible, coinsurance, or copayment that is due from the enrollee under the terms and conditions set forth in the managed health care system contract with the *administrator. A plan enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract with the *administrator.*

(2) This section expires July 1, 2016.

CREDIT(S)

[2011 1st sp.s. c 9 § 5, eff. Aug. 24, 2011.]
HISTORICAL AND STATUTORY NOTES

***Reviser's note:** The definition of "administrator" was changed to "director" in RCW 70.47.020 by 2011 1st sp.s. c 15 § 83.*

***Findings--Intent--2011 1st sp.s. c 9:** See note following RCW 70.47.020.*

2011 Legislation

Laws 2011, 1st Sp.Sess. ch. 9, § 1, provides:

"(1) The legislature finds that:

"(a) There is an increasing level of dispute and uncertainty regarding the amount of payment nonparticipating providers may receive for health care services provided to enrollees of state purchased health care programs designed to serve low-income individuals and families, such as basic health and the medicaid managed care programs;

"(b) The dispute has resulted in litigation, including a recent Washington superior court ruling that determined nonparticipating providers were entitled to receive billed charges from a managed health care system for services provided to medicaid and basic health plan enrollees. The decision would allow a nonparticipating provider to demand and receive payment in an amount exceeding the payment managed health care system network providers receive for the same services. Similar provider lawsuits have now been filed in other jurisdictions in the state;

"(c) In the biennial operating budget, the legislature has previously indicated its intent that payment to nonparticipating providers for services provided to medicaid managed care enrollees should be limited to amounts paid to medicaid fee-for-service providers. The duration of these provisions is limited to the period during which the operating budget is in effect. A more permanent resolution of these issues is needed; and

"(d) Continued failure to resolve this dispute will have adverse impacts on state purchased health care programs serving low-income enrollees, including: (i) Diminished ability for the state to negotiate cost-effective contracts with managed health care systems; (ii) a potential for significant reduction in the willingness of providers to participate in managed health care system provider networks; (iii) a reduction in providers participating in the managed health care systems; and (iv) increased exposure for program enrollees to balance billing practices by nonparticipating providers. Ultimately, fewer eligible people will get the care they need as state purchased health care programs will operate with less efficiency and reduced access to cost-effective and quality health care coverage for program enrollees.

"(2) It is the intent of the legislature to create a legislative solution that reduces the cost borne by the state to provide public health care coverage to low-income enrollees in managed health care systems, protects enrollees and state purchased health care programs from balance billing by nonparticipating providers, provides appropriate payment to health care providers for services provided to enrollees of state purchased health care programs, and limits the risk for managed health care systems that contract with the state programs."

West's RCWA 70.47.230, WA ST 70.47.230

Current with all 2012 Legislation and Chapters 1, 2, and 3 from the 2013 Regular Session

West Virginia

West's Annotated Code of West Virginia - Chapter 16. Public Health, Article 29D. State Health Care, **§ 16-29D-4. Prohibition on balance billing; exceptions**

(a) Except in instances involving the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency, the agreement by a health care provider to deliver services to a beneficiary of any department or division of the state which participates in a plan or plans developed under section three of this article shall be considered to also include an agreement by that health care provider:

(1) To accept the assignment by the beneficiary of any rights the beneficiary may have to bill such division or department for, and to receive payment under such plan or plans on account of, such services; and

(2) To accept as payment in full for the delivery of such services the amount specified in plan or plans or as determined by the plan or plans. In such instances, the health care provider shall bill the division or department, or such other person specified in the plan or plans, directly for the services. The health care provider shall not bill the beneficiary or any other person on behalf of the beneficiary and, except for deductibles or other payments specified in the applicable plan or plans, the beneficiary shall not be personally liable for any of the charges, including any balance claimed by the provider to be owed as being the difference between that provider's charge or charges and the amount payable by the applicable department or divisions. The plan or plans may specify what sums are deductibles, copayments or are otherwise payable by the beneficiary and the sums for which the health care provider may bill the beneficiary: In addition, any health care service which is not subject to payment by the plan or plans shall be the responsibility of the beneficiary and for those health care services which are not covered by the plans, there shall be no prohibition against billing the beneficiary directly.

(b) The prohibitions and limitations stated in subsection (a) of this section do not apply to the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency. However, once the patient is stabilized, then the delivery of any further health care services shall be subject to subsection (a) of this section for those latter services only.

(c) The exceptions provided in this section for the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency shall not apply to health care providers under contract with a department or division plan or plans.

CREDIT(S)

Acts 1989, c. 87; Acts 1991, c. 134.
LIBRARY REFERENCES
Health 487.
Westlaw Topic No. 198H.
C.J.S. Social Security and Public Welfare §§ 264, 267.

Department of Health and Human Resources (DHHR) was required to provide supportive therapeutic services of specialist in attachment disorders for children whose parental rights were terminated, but specialist was not entitled to payment for her services in excess of Medicaid rate, as specialist was working out of offices of Medicaid provider. State ex rel. Aaron M. v. West Virginia Department of Health and Human Resorces, 2001, 571 S.E.2d 142, 212 W.Va. 323. Health 476; Health 487(2)

A Medicaid provider cannot bill another source for the difference between the allowable Medicaid rate and the provider's customary rate. State ex rel. Aaron M. v. West Virginia Department of Health and Human Resorces, 2001, 571 S.E.2d 142, 212 W.Va. 323. Health 487(2)

W. Va. Code, § 16-29D-4, WV ST § 16-29D-4

Current through End of the 2012 First Extraordinary Session

West's Annotated Code of West Virginia - Chapter 33. Insurance, Article 48. Model Health Plan for Uninsurable Individuals Act, § 33-48-6. Plan administrator

(a) The board shall select a plan administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The plan administrator's proven ability to handle health insurance coverage to individuals;

(2) The efficiency and timeliness of the plan administrator's claim processing procedures;

(3) An estimate of total charges for administering the plan;

(4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and

(5) The financial condition and stability of the plan administrator.

(b)(1) The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator subject to removal for cause and subject to any terms, conditions and limitations of the contract between the plan and the plan administrator.

(2) At least one year prior to the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator to submit bids to serve as the plan administrator. Selection of the plan administrator for the succeeding period shall be made at least six months prior to the end of the current period.

(c) The plan administrator shall perform such functions relating to the plan as may be assigned to it, including:

(1) Determination of eligibility;

(2) Payment of claims;

(3) Establishment of a premium billing procedure for collection of premium from persons covered under the plan; and

(4) Other necessary functions to assure timely payment of benefits to covered persons under the plan.

(d) The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be specified in the contract between the board and the plan administrator.

(e) Following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board and the commission on a form prescribed by the commissioner.

(f) Notwithstanding any other provision in this section to the contrary, the board may elect to designate the public employees insurance agency as the plan administrator. If so designated, the public employees insurance agency shall provide the services set forth in subsection (c) of this section and shall be subject to the reporting requirements of subsections (d) and (e) of this section. The plan shall, if the public employees insurance agency is designated by the board as the plan administrator, reimburse health care providers at the same health care reimbursement rates then in effect for the West Virginia public employees insurance agency and health care providers are subject to the same prohibition against balance billing of plan participants as set forth in section four, article twenty-nine-d, chapter sixteen of this code.

CREDIT(S)

Acts 2004, c. 148, eff. July 1, 2004; Acts 2004, 3rd Ex. Sess., c. 12, eff. Nov. 16, 2004.

HISTORICAL AND STATUTORY NOTES

Acts 2004, 3rd Ex. Sess., c. 12, rewrote this section, which formerly read:

"(a) The board shall select a plan administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

"(1) The plan administrator's proven ability to handle health insurance coverage to individuals;

"(2) The efficiency and timeliness of the plan administrator's claim processing procedures;

"(3) An estimate of total charges for administering the plan;

"(4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and

"(5) The financial condition and stability of the plan administrator.

"(b)(1) The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator subject to removal for cause and subject to any terms, conditions and limitations of the contract between the plan and the plan administrator.

"(2) At least one year prior to the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator to submit bids to serve as the plan administrator. Selection of the plan administrator for the succeeding period shall be made at least six months prior to the end of the current period.

"(c) The plan administrator shall perform such functions relating to the plan as may be assigned to it, including:

"(1) Determination of eligibility;

"(2) Payment of claims;

"(3) Establishment of a premium billing procedure for collection of premium from persons covered under the plan; and

"(4) Other necessary functions to assure timely payment of benefits to covered persons under the plan.

"(d) The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be specified in the contract between the board and the plan administrator.

"(e) Following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board and the commission on a form prescribed by the commissioner.

"(f) Notwithstanding any other provision in this section to the contrary, the board may elect to designate the public employees insurance agency as the plan administrator. If so designated, the public employees insurance agency shall provide the services set forth in subsection (c) of this section and shall be subject to the reporting requirements of subsections (d) and (e) of this section. The plan shall, if the public employees insurance agency is designated by the board as the plan administrator, reimburse health care providers at the same health care reimbursement rates then in effect for the West Virginia public employees insurance agency."

Current statute search courtesy of West Law

III. Pending Legislation (2013-14 sessions)

Illinois
IL S 1716 (Pending) *similar to IL H 2933 (pending) and IL S 34 (pending)*

Amends the Illinois Health Benefits Exchange Law. Provides that except as otherwise provided in the provision concerning the dissolution of the Comprehensive Health Insurance Plan, the insurance operations of the Comprehensive Health Insurance Plan (the Plan) authorized by the Comprehensive Health Insurance Plan Act shall cease on January 1, 2014 (and makes conforming changes in the Comprehensive Health Insurance Plan Act). Sets forth provisions concerning service provided after January 1, 2014, grievances, balance billing, the plan of dissolution, actions by or against the Plan Board, and General Revenue Fund funds and insurer assessments in the Plan on the date of final dissolution. Provides for the repeal of the Comprehensive Health Insurance Plan Act on January 1, 2015. Effective immediately.

(e) Balance billing under this Section by a health care provider that is not a member of the provider network arrangement used by the Plan is prohibited.

Indiana
IN H 1319 (Pending) *similar to IN S 551 (pending)*

SECTION 9. IC 27-8-10-0.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Sec. 0.5. (a) Except as provided in this section, the insurance operations of the association cease on the later of:
(1) the date on which a health benefit exchange (as defined in IC 27-19-2-8) begins operating in Indiana; or
(2) December 31, 2013.
(b) A claim for payment under an association policy must be made to the association not later than the later of:
(1) sixty (60) days after the date on which the insurance operations cease under subsection (a); or
(2) March 1, 2014.
(c) An appeal or grievance under this chapter must be resolved not later than ninety (90) days after the date on which the insurance operations cease under subsection (a).
(d) Balance billing under this chapter by a health care provider that is not a member of a health care provider network arrangement used by the association is prohibited after the later of:
(1) ninety (90) days after the date on which the insurance operations cease under subsection (a); or
(2) March 30, 2014.

Massachusetts
MA S 515 (Pending)
A bill to establish Medicare for all in MA;
(b) the provider or facility will comply with all state and federal laws regarding the confidentiality of patient records and information; (c) no balance billing or out-of-pocket charges will be made for covered services unless otherwise provided in this chapter; and

MA H 1035 (Pending)
A bill to establish a single-payer health insurance trust fund;
c) no balance billing or out-of-pocket charges will be made for covered services unless otherwise provided in this chapter; and

Minnesota
MN H 779 (Pending)
Sec. 11. [62K.11] BALANCE BILLING PROHIBITED.
(a) A network provider is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the provider as total payment for the health care service.

New Jersey
NJ A 3158 (Pending)

Be It Enacted by the Senate and General Assembly of the State of New Jersey:
1. A hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) that is a participating provider under a patient's health insurance plan shall notify the patient or patient's representative, in writing, as soon as practicable, if physicians or other health care professionals who are under contract to, or have another arrangement with, the hospital to provide health care services to patients at the facility are not participating providers under the patient's health insurance plan.
The notification, which shall be signed by the patient or patient's representative and included in the patient's medical record, shall provide the names of the health care professionals from whom the patient is most likely to receive services at the hospital, the type or

category of health care services they provide at the hospital, and the unit or department of the hospital in or through which they provide services.

2. This act shall take effect on the first day of the third month next following the date of enactment.

STATEMENT

This bill requires a hospital, which is a participating provider under a patient's health insurance plan, to notify a patient or the patient's representative, in writing, as soon as practicable, if physicians or other health care professionals who are under contract to, or have another arrangement with, the hospital to provide health care services to patients at the facility are not participating providers under that patient's health insurance plan. The notification, which is to be signed by the patient or the patient's representative and included in the patient's medical record, is to provide the names of the health care professionals from whom the patient is most likely to receive services at the hospital, the type or category of health care services they provide at the hospital, and the unit or department of the hospital in or through which they provide services.

Increasingly, insured patients who seek care at a hospital that is in the provider network of their health insurance plan receive health care services at the hospital, such as emergency room care, radiology, and anesthesia, by physicians who are not participating providers in that patient's health insurance plan. The patients usually are made aware of this situation and the fact that they may be liable for unanticipated balance billing by the physician after they have received the services. The purpose of this bill, therefore, is to provide patients with information, in advance of receiving services whenever practicable, about the insurance participation of health care professionals who will render services at the hospital, so as to enable patients to make informed decisions about the providers who treat them.

Oklahoma

OK S 485 (Pending)

Prohibit "balance billing" from the employee, employer, or carrier;

Oregon

OR D 1312 (Pending, filed as draft) *similar to OR S 165*

(2) "Cost-sharing" does not include premiums, balance billing amounts for non-network providers or costs of services not covered by the health insurance policy or certificate.

Texas

TX H 3270 (Pending)

(4) procedures that the insurer will implement to assist insureds in obtaining medically necessary services if a preferred provider is not reasonably available, including procedures to coordinate care to avoid balance billing;

Virginia

VA H 357 (Failed) *similar to VA H 402 (failed) and VA S 383 (failed) and VA S 615 (failed) and VA H 2160 (failed)*

"Cost sharing" means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for noncovered services.

Bill search courtesy of StateNet

IV. Resources

A. Balance billing: the patients' perspective, By **Mathias Kifmann**[1*] and **Florian Scheuer**[2], September 17, 2011. Universität Hamburg, Fakultät Wirtschafts-und Sozialwissenschaften, Von-Melle-Park 5, 20146 Hamburg, Germany and Stanford University, Department of Economics, Stanford, CA 94305, USA. © 2011 Kifmann and Scheuer; licensee Springer.

Health Economics Review 2011, 1:14 doi:10.1186/2191-1991-1-14

Abstract
"We study the effects of 'balance billing', i.e., allowing physicians to charge a fee from patients in addition to the fee paid by Medicare. First, we show that on pure efficiency grounds the optimal Medicare fee under balance billing is zero. An active Medicare policy thus can only be justified when distributional concerns are accounted for. Extending the analysis by Glazer and McGuire, we therefore analyze the optimal policy from the patients' point of view. We demonstrate that, from the patients' perspective, a positive fee can be superior under balance billing. Furthermore, patient welfare can be lower if balance billing is prohibited. In particular, this is the case if the administrative costs of Medicare are large. However, we cannot rule out that prohibiting balance billing may be superior. Finally, we show that payer fee discrimination increases patient welfare if Medicare's administrative costs are high or if Medicare's optimal fee under balance billing implies lower quality for fee-only patients.

Introduction

The US Medicare program allows doctors to 'balance bill' patients, i.e., to charge them a price in addition to the Medicare payment. In the late 80s and early 90s, state and federal legislation was introduced to restrict this practice. Additional prices are now limited to about 10% of the Medicare fee.(endnote a) In a theoretical study, Glazer and McGuire have shown that these restrictions on balance billing come at a price as doctors have an incentive to reduce the quality of their services [1]. Strikingly, prohibiting balance billing reduces quality for all patients, regardless of whether they pay a balance bill. From an efficiency point of view, they demonstrate that allowing balance billing always leads to superior results if the Medicare fee is set appropriately.

A limitation of the analysis by Glazer and McGuire is that they focus exclusively on the efficiency aspects of balance billing. An important concern, however, is that patients are worse off if physicians are allowed to balance bill. In particular, previous work by Paringer, Mitchell and Cromwell as well as Zuckerman and Holahan has shown that allowing physicians to charge extra fees may only increase the rents of physicians at the expense of patients [2-4]. These papers, however, do not consider effects on quality. Taking into account efficiency gains from balance billing, this raises the question on how these gains are shared between patients and physicians.

In this paper, we take the analysis of Glazer and McGuire further and focus on the welfare of patients. We analyze the optimal Medicare fee both from a pure efficiency perspective and from the patients' point of view. Furthermore, we reexamine the case for prohibiting balance billing and consider the effects on patient welfare if Medicare discriminates the fee depending on whether the physician treats the patient at the fee only or charges a balance bill.

The paper proceeds as follows. In Section 2, we discuss the literature. Section 3 reviews the analysis by Glazer and McGuire. In Section 4, we determine the optimal Medicare fee under balance billing using the social surplus function of Glazer and McGuire. Section 5 analyzes the implications of Medicare's policy on patient welfare. Section 6 concludes the paper.

2 Review of the literature

Most of the theoretical studies on balance billing assume a monopolistic physician who faces a downward-sloping demand curve [2]-[4]. Within this framework, the effects on the quantity of services supplied by the physician has been explored. The physician is able to price discriminate, requiring patients with a high willingness to pay a balance bill. If the physician also accepts fee-only patients under balance billing, then prohibiting balance billing leaves the quantity of supply unchanged since only inframarginal patients are balance billed. Only the physician's rent is reduced. However, if doctors refuse to treat fee-only patients under balance billing, then prohibiting balance billing reduces the number of patients treated.

How Medicare's balance billing policy affects the incentives for a monopolistic physician to set quality of treatment is analyzed by Feldman and Sloan as well as Wedig, Mitchell and Cromwell [5,6]. Both papers assume that the physician is not able to price or quality discriminate. Feldman and Sloan show that it is uncertain whether price controls, i.e., prohibiting balance billing, increase welfare. Wedig et al., however, find a case for price controls if health insurance shifts the demand curve to the right and physicians react by increasing quantity and quality beyond the social optimum.

All the models presented do not include competition among physicians. Furthermore, neither Feldman and Sloan nor Wedig et al. consider price and quality discrimination. However, these factors are highly relevant in the context of balance billing. First, Medicare's fee policy affects the degree of competition between physicians. Second, balance billed patients are likely to receive higher quality than fee-only patients. Both factors are incorporated in the model by Glazer and McGuire. They show that physicians have an incentive to save costs by reducing quality for Medicare patients. To patients who pay a balance bill, however, they will provide the efficient quality level. Their main result is that by setting fees correctly, efficiency is higher if balance billing is allowed.

An empirical study of the effects of Medicare restrictions on balance billing in late 80s and early 90s has been performed by McKnight [7]. She finds that these reduced out-of-pocket medical expenditure of Medicare beneficiaries by 9%. With the exception of a significant fall in the number of follow-up telephone calls, her study shows little evidence that physicians changed their behavior in response to the balance billing restrictions."

B. New York Times, **Avoiding Surprise Bills With Homework and Negotiation**
By WALECIA KONRAD Published: April 30, 2010.

"Ms. Cornford would soon become very familiar with the phenomenon known as balance billing. It is a controversial and sometimes illegal practice: doctors and other health care providers receive a discounted payment from the insurance company — an amount less than the fee they want to be paid — and then they bill the patient for the rest. Most states, including Illinois, have passed laws making balance billing illegal within an insurer's medical network. And federal law prohibits balance billing by providers paid under Medicare.

But balance billing in these cases can still happen. If you receive a bill from an in-network provider that you are not expecting, call your insurer immediately. "Your insurance company is the best enforcer, if you will, of these laws," said Jane Cooper, chief executive of Patient Care, a Milwaukee patient advocate firm.

Most cases occur when patients who are part of H.M.O.'s, P.P.O.'s and other network health care plans use an out-of-network doctor, lab hospital or other provider. H.M.O.'s, as a rule, will

not cover any out-of-network fees unless for an emergency or for a pre-approved treatment so specialized that no one in the network can provide it. P.P.O.'s generally cover some percentage of out-of-network fees, usually 70 or 80 percent of so-called usual and customary charges."

C. American Bar Association, California Ends Budget Billing, By Angela M. Lai and M. Dylan McClelland, California Department of Managed Health Care, Sacramento, CA.

"The practice of "balance billing" by emergency room doctors is part of a contentious issue that has plagued the managed care industry, providers, and health care consumers for many years. On January 8, 2009, in a unanimous decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, the California Supreme Court declared balance billing unlawful in the context of emergency medical care. Where a health plan (i.e., an "HMO") does not pay, in whole or in part, the amount charged by emergency room doctors, the doctors now must resolve billing disputes solely with the health plans. The providers may seek dispute resolution, or even sue the health plans if they wish, but they may no longer bill patients with a health plan for the disputed amount."

D. Heartland.org; Inpatient Balance Billing is an Unfair Medical Practice, May 9, 2011

E. Medicare Balance Billing Restrictions: Impacts on Physicians and Beneficiaries, By Robin McKnight, University of Oregon and NBER, September 2004.

F. CONSUMER WIN AGAINST BALANCE BILLING: State Regulator Secures Hospital Settlement on Balance Billing Practices Statement from California Association of Health Plans President Patrick Johnston, 2010.

G. Fiercehealthcare.com, Patient Sues Over Balance Billing, By Sandra Yin, January 11, 2011.

"At issue is the common practice of "balance billing," where health providers charge patients the difference between their own [the doctor's] fee and what the insurer reimburses. Out-of-network providers resort to this kind of billing when an insurer's payment does not cover the whole fee for a service. By contrast, if both the patient and provider are part of the payer's network, the provider by contract will be okay accepting less than the regular fee for seeing patients in the network.

From a consumer's standpoint, it looks like the provider is charging different fees depending on who is responsible for the bill.

The suit alleges that balance billing, which is common among state healthcare providers and banned in some states, violates the Missouri Merchandising Practices Act, which forbids unfair or deceptive practices. It says that Washington University and other providers charged high prices to patients for "out-of-network" care, not fully covered by their insurance policies."

*- Original research updated by Kara Hinkley, 3/2013

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

7700 East First Place Denver, CO 80230
ph (303) 364-7700 fax (303) 364-7800
www.ncsl.org

Non-Network Provider Insurance Coverage and Billing Legislation
October 2014

Ashley A. Noble, JD

Summary:

- 30 bills introduced in 8 states: Alaska (1), Louisiana (1), Massachusetts (2), Minnesota (4), Missouri (2), New Jersey (10), New York (9), and Virginia (1).
  - 3 laws enacted in 3 states: Minnesota (1), New York (1), and Virginia (1)
  - 19 bills pending in 3 states: Massachusetts (2), New Jersey (10), and New York (7).
  - 8 bills failed in 5 states: Alaska (1), Louisiana (1), Minnesota (3), Missouri (2), and New York (1).

Alaska
AK H 203

Author:	Keller (R)
Title:	Reimbursement Of Health Insurance Claims
Introduced:	04/10/2013
Disposition:	Failed - Adjourned
Location:	House Labor and Commerce Committee
Summary:	Relates to payment or reimbursement of health care insurance claims.
Status:	04/10/2013 INTRODUCED. 04/10/2013 To HOUSE Committee on LABOR AND COMMERCE. 04/10/2013 To HOUSE Committee on FINANCE.
Text Hits:	covered services rendered by an out-of-network provider by check made out to both the provider and the covered person as joint payees requiring endorsement by both the provider and the covered person DIRECTLY TO THE PROVIDER OF MEDICAL CARE SERVICES . A health insurance policy may not contain a —— Next Hit in Bill —— an out-of-network provider in the single name of the provider. IF A HEALTH CARE INSURER MAKES A CLAIM PAYMENT TO THE COVERED PERSON AFTER THE COVERED PERSON HAS GIVEN WRITTEN NOTICE ELECTING DIRECT PAYMENT TO THE PROVIDER OF THE

SERVICE, THE HEALTH CARE INSURER SHALL ALSO PAY THAT AMOUNT TO THE

Louisiana
LA H 895

Author: Fannin (R)
Title: Insurance and Health
Introduced: 03/10/2014
Disposition: Failed - Adjourned
Location: House Insurance Committee
Summary: Provides relative to balance billing.
Status: 03/10/2014 INTRODUCED.
03/10/2014 To HOUSE Committee on INSURANCE.

Text Hits: HOUSE BILL NO. 895

—— Next Hit in Bill ——
directly from the health insurance issuer payment of the same amount the out-of-network provider would have received if in network may not seek payment of remaining balance from the patient.

—— Next Hit in Bill ——
Proposed law provides that if a health insurance issuer pays the in-network amount for services provided to an insured to an out-of-network healthcare provider, the provider may not seek payment of the remaining balance from the insured.

—— Next Hit in Bill ——
To enact R.S. 22:1827, relative to payment of claims for services provided by noncontracted healthcare providers; to provide for definitions; to provide for exemptions, and to provide for related matters.

—— Next Hit in Bill ——
Section 1827. Payment of claims for services provided by noncontracted health care providers

—— Next Hit in Bill ——
rendered, the health insurance issuer shall directly pay the claim by the noncontracted provider in the amount as determined pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer, less any amount representing coinsurance, copayments, deductibles,

—— Next Hit in Bill ——
insured or enrollee is liable. Payment of such claim by the health insurance issuer shall in no circumstances be made directly to the patient, insured, or enrollee.

—— Next Hit in Bill ——
the services were provided to seek payment from the health insurance issuer of the recipient of the services provided.

—— Next Hit in Bill ——
(b) If the provider receives a lesser amount in payment directly from the issuer for the services rendered than the provider would have received had the provider contracted with the issuer, the provider may seek payment of the remainder of the amount from the recipient of the services.

—— Next Hit in Bill ——
(4) If the healthcare provider does not seek payment from the health insurance issuer for the services rendered, the provider may seek full payment for the services rendered from the recipient of the services provided.

Massachusetts
MA H 1020

DOCKET	403
Author:	Donato (D)
Title:	Health Care Rates
Introduced:	02/18/2013
Disposition:	Pending
Location:	House Second Reading
Summary:	Provides that certain health care providers not included in a managed care organization's network accept rates equal to the rate paid by Medicaid for the same or similar services.
Status:	06/27/2014 From JOINT Committee on HEALTH CARE FINANCING: Accompanied Study Order H 4234.

MA S 547

DOCKET	11
Author:	Moore M (D)
Title:	Equitable Reimbursement Rates for Health Care
Introduced:	02/15/2013
Disposition:	Pending
Location:	Senate Second Reading
Summary:	Relates to equitable reimbursement rates for health care.
Status:	05/21/2014 From JOINT Committee on HEALTH CARE FINANCING: Accompanied Study Order S 2148.

Minnesota
MN S 761

Author:	Lourey T (DFL)
Title:	Health Plan Regulation
Introduced:	02/22/2013
Disposition:	Failed - Adjourned
Location:	Senate Commerce Committee
Summary:	Relates to health plan regulation; regulates policy and contract coverages; conforms state law to federal requirements.
Status:	02/25/2013 To SENATE Committee on COMMERCE.

MN H 978

Author:	Huntley (DFL)
Title:	Health Plan Regulation
Introduced:	02/28/2013
Last Amend:	03/20/2013
Disposition:	Failed - Adjourned
Location:	House Second Reading
Summary:	Relates to health plan regulation; regulates policy and contract coverages; conforms state law to federal requirements.
Status:	04/08/2013 From HOUSE Committee on RULES AND LEGISLATIVE ADMINISTRATION: Do pass. 04/08/2013 In HOUSE. Second Reading.

MN S 662

Author.	Lourey T (DFL)
Title:	Health Plan Regulation
Introduced:	02/20/2013
Last Amend:	04/02/2013
Disposition:	Failed - Adjourned
Location:	Senate Finance Committee
Summary.	Relates to health plan regulation; regulates policy and contract coverages; conforms state law to federal requirements; establishes health plan market rules.
Status	04/02/2013 From SENATE Committee on STATE AND LOCAL GOVERNMENT: Do pass as amended. 04/02/2013 Rereferred to SENATE Committee on FINANCE.

MN H 779

Author:	Atkins (DFL)
Title	Health Insurance Exchange Market Rules
Introduced:	02/21/2013
Enacted	05/24/2013
Disposition:	Enacted
Location:	Chaptered
Chapter #:	2013-84
Summary:	Deals with the market rules that will apply to health carriers and health plans in connection with health coverage in Minnesota sold inside and outside of the exchange; involves Minnesota laws, federal laws under the Affordable Care Act; specifies how they will be coordinated; requires carriers to offer individual and small group plans in service areas that are at least as large as a county, unless a smaller area

is necessary, nondiscriminatory, and in the best interests of enrollees.

Status: 05/24/2013 Signed by GOVERNOR.
05/24/2013 Filed with Secretary of State. Chapter No. 2013-84 [Effective Rule]

Missouri
MO H 1662

Sponsor: Richardson (R)
Title: Current Population HealthNet Managed Care Statewide
Introduced: 01/29/2014
Disposition: Failed - Adjourned
Location: HOUSE
Summary: Extends Missouri HealthNet managed care statewide for only the current managed care populations.
Status: 04/03/2014 In HOUSE Committee on RULES: Voted do pass.
04/03/2014 From HOUSE Committee on RULES: Reported do pass.
Text Hits: access to out-of-network providers if necessary to meet the health needs of enrollees in accordance with standards developed by the department of social services and included in the managed care contracts.

MO H 1901

Sponsor: Torpey (R)
Title: Health Care Coverage
Introduced: 02/18/2014
Disposition: Failed - Adjourned
Location: HOUSE
Summary: Changes the laws regarding health care coverage.
Status: 04/14/2014 Public Hearing scheduled: Bill not heard.

New Jersey
NJ S 860

Sponsor: Vitale (D)
Title: Health Care Transparency and Disclosure Act
Introduced: 01/14/2014
Disposition: Pending
Location: Senate Commerce Committee
Summary: Relates to Health Care Transparency and Disclosure Act.
Status: 01/14/2014 INTRODUCED.
01/14/2014 To SENATE Committee on COMMERCE.

NJ S 869

Sponsor: Vitale (D)
Title: Healthcare Disclosure and Transparency Act
Introduced: 01/14/2014
Disposition: Pending
Location: Senate Commerce Committee
Summary: Relates to Healthcare Disclosure and Transparency Act.
Status: 01/14/2014 INTRODUCED.
01/14/2014 To SENATE Committee on COMMERCE.

NJ A 1045

Sponsor: Schaer (D)
Title: Patient Referrals
Introduced: 01/16/2014
Disposition: Pending
Location: Assembly Health and Senior Services Committee
Summary: Requires practitioners to disclose business relationship with out-of-state facilities when making patient referrals to those facilities.
Status: 01/16/2014 INTRODUCED.
01/16/2014 To ASSEMBLY Committee on HEALTH AND SENIOR SERVICES.

NJ A 1069

Sponsor: Schaer (D)
Title: Healthcare Disclosure and Transparency Act
Introduced: 01/16/2014
Disposition: Pending
Location: Assembly Financial Institutions and Insurance Committee
Summary: Creates Healthcare Disclosure and Transparency Act.
Status: 01/16/2014 INTRODUCED.
01/16/2014 To ASSEMBLY Committee on FINANCIAL INSTITUTIONS AND INSURANCE.

NJ A 2112

Sponsor: Gusciora (D)
Title: Out of Network Healthcare Professionals
Introduced: 01/16/2014
Disposition: Pending
Location: Assembly Health and Senior Services Committee
Summary: Requires in network hospitals to notify patients of out of network health care

professionals who provide services in hospital.

Status: 01/16/2014 INTRODUCED.
01/16/2014 To ASSEMBLY Committee on HEALTH AND SENIOR SERVICES.

Text Hits: out-of-network providers and supplementing Title 26 of the Revised Statutes.

NJ A 952

Identical: NJ S 1216
Sponsor: Singleton (D)
Title: New Jersey All Payer Claims Database Act
Introduced: 01/16/2014
Disposition: Pending
Location: Assembly Financial Institutions and Insurance Committee
Summary: Relates to the New Jersey All-Payer Claims Database Act; establishes New Jersey All-Payer Claims Database and arbitration process for reimbursing out-of-network health care providers.
Status: 01/16/2014 INTRODUCED.
01/16/2014 To ASSEMBLY Committee on FINANCIAL INSTITUTIONS AND INSURANCE.

NJ A 2238

Identical: NJ S 970
Sponsor: Gove (R)
Title: Breanns Law
Introduced: 01/27/2014
Disposition: Pending
Location: Assembly Financial Institutions and Insurance Committee
Summary: Creates Breann's Law; requires health insurers, the State Health Benefits Program and NJ FamilyCare to provide "out of network" coverage for children with catastrophic illnesses.
Status: 01/27/2014 INTRODUCED.
01/27/2014 To ASSEMBLY Committee on FINANCIAL INSTITUTIONS AND INSURANCE.

NJ S 970

Identical: NJ A 2238
Sponsor: Connors C (R)
Title: Coverage for Children with Catastrophic Illnesses
Introduced: 01/27/2014
Disposition: Pending

Location:	Senate Commerce Committee
Summary:	Creates Breann's Law; requires health insurers, the State Health Benefits Program and New Jersey FamilyCare to provide out of network coverage for children with catastrophic illnesses.
Status:	01/27/2014 INTRODUCED. 01/27/2014 To SENATE Committee on COMMERCE.

NJ S 1216

Identical:	NJ A 952
Sponsor:	Vitale (D)
Title:	All-Payer Claims Database Act
Introduced:	01/30/2014
Disposition:	Pending
Location:	Senate Commerce Committee
Summary:	Creates the New Jersey All-Payer Claims Database Act; establishes New Jersey All-Payer Claims Database and arbitration process for reimbursing out-of-network health care providers.
Status:	01/30/2014 INTRODUCED. 01/30/2014 To SENATE Committee on COMMERCE.

NJ S 2099

Sponsor:	Singer (R)
Title:	Reimbursement Rates for Health Care Providers
Introduced:	05/19/2014
Disposition:	Pending
Location:	Senate Commerce Committee
Summary:	Requires health insurance carriers that offer a managed care plan that provides for both in-network and out-of-network benefits to reimburse out-of-network health care providers using the same reimbursement structure that was used and at the same rates that were provided to those health care providers.
Status:	05/19/2014 INTRODUCED. 05/19/2014 To SENATE Committee on COMMERCE.

New York
NY A 636

Sponsor:	Weprin D (D)
Title:	Reimbursement of Certain Clinical Laboratories
Introduced:	01/09/2013
Disposition:	Pending
Location:	Assembly Insurance Committee

Summary: Relates to the reimbursement of out-of-network providers of clinical laboratory services.

Status: 01/08/2014 To ASSEMBLY Committee on INSURANCE.

NY S 1083

Sponsor: Maziarz (R)

Title: Reimbursement of Certain Clinical Laboratories

Introduced: 01/09/2013

Disposition: Pending

Location: Senate Health Committee

Summary: Relates to the reimbursement of out-of-network providers of clinical laboratory services.

Status: 01/08/2014 To SENATE Committee on HEALTH.

Text Hits: the reimbursement of out-of-network providers of clinical laboratory services by organizations providing or offering comprehensive health services plans

NY A 2783

Sponsor: O'Donnell (D)

Title: Insurance Reimbursement for Early Intervention Services

Introduced: 01/18/2013

Disposition: Pending

Location: Assembly Insurance Committee

Summary: Relates to insurance reimbursement for early intervention services for infants and toddlers with disabilities; provides that insurers and health plans shall not deny claims for such services due to lack of prior approval or out of network providers where such services are furnished pursuant to an early intervention individual family service plan.

Status: 01/08/2014 To ASSEMBLY Committee on INSURANCE.

NY S 2551

Sponsor: Hannon (R)

Title: Protections To Prevent Surprise Medical Bills

Introduced: 01/18/2013

Disposition: Pending

Location: Senate Insurance Committee

Summary: Establishes protections to prevent surprise medical Bills including network adequacy requirements, claim submission requirements, adequacy of and access to out-of-network care and prohibition of excessive emergency charges.

Status: 01/08/2014 Recalled from ASSEMBLY. *****Returned to SENATE.
01/08/2014 To SENATE Committee on INSURANCE.

NY A 4546

Sponsor:	DenDekker (D)
Title:	Insurance Coverage for Clinical Laboratory Services
Introduced:	02/06/2013
Disposition:	Pending
Location:	Assembly Insurance Committee
Summary:	Amends the Insurance Law; requires health insurance coverage for clinical laboratory services if a covered health care provider directs a specimen to be sent to an out-of-network laboratory or refers a patient to an out-of-network laboratory for clinical laboratory services.
Status:	01/08/2014 To ASSEMBLY Committee on INSURANCE.

NY A 7253

Sponsor:	Montesano (R)
Title:	Protections To Prevent Surprise Medical Bills
Introduced:	05/08/2013
Disposition:	Pending
Location:	Assembly Insurance Committee
Summary:	Establishes protections to prevent surprise medical bills including network adequacy requirements, claim submission requirements, adequacy of and access to out-of-network care and prohibition of excessive emergency charges.
Status:	01/08/2014 To ASSEMBLY Committee on INSURANCE.

NY A 7813

Sponsor:	Gottfried (D)
Title:	Excessive Charges for Emergency Services
Introduced:	06/05/2013
Disposition:	Failed
Location:	Assembly Insurance Committee
Summary:	Prohibits excessive charges for emergency services; requires certain disclosures relating to payment schedules and network coverage, provides certain appeal rights for coverage denials.
Status:	04/01/2014 Enacting clause stricken.

NY A 9205

Sponsor:	
Title:	State Health and Mental Hygiene
Introduced:	03/29/2014
Disposition:	Pending

Location: Assembly Ways and Means Committee

Summary: Enacts into law major components of legislation necessary to implement the state health and mental hygiene budget for the 2014-2015 state fiscal year.

Status: 03/29/2014 INTRODUCED.
03/29/2014 To ASSEMBLY Committee on WAYS AND MEANS.
03/31/2014 From ASSEMBLY Committee on WAYS AND MEANS.
03/31/2014 To ASSEMBLY Committee on RULES.
03/31/2014 From ASSEMBLY Committee on RULES.
03/31/2014 Substituted by S 6914.

NY S 6914

Sponsor:

Title: State Health and Mental Hygiene

Introduced: 03/29/2014

Enacted 03/31/2014

Disposition: Enacted

Location: Chaptered

Chapter: 60

Summary: Enacts major components of legislation necessary to implement the state health and mental hygiene budget for the 2014-2015 fiscal year to include prenatal care, disease reports, breast cancer research fund, Alzheimer's disease fund, patient handling, long term care and facilities, Medicaid prescription drug coverage, general hospital payments, personal care services, professional medical misconduct, behavioral health care, development disabilities care, foster care children, and community mental health.

Status: 03/31/2014 Signed by GOVERNOR.
03/31/2014 Chapter No. 60 [Effective Rule]

Virginia
VA H 5002 a

Author: Jones (R)

Title: Budget Bill

Introduced: 03/24/2014

Enacted 06/23/2014

Disposition: Enacted

Location: Chaptered

Chapter: 2

Summary: Relates to appropriations of the Budget submitted by the Governor providing a portion of revenues for the two years ending respectively on the thirtieth day of June, 2015, and the thirtieth day of June, 2016.

Status: 06/23/2014 Line Item Veto sustained by SENATE.
06/23/2014 Acts of Assembly. Chapter No. 2 [Effective Rule]

Text Hits: organizations and out-of-network providers for emergency or otherwise authorized treatment shall be considered payment in full. In the absence of rates negotiated between the managed care organization and the out-of-network provider, these services shall be reimbursed at the Virginia Medicaid fees and/or rates and shall be considered payment in full. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

7700 East First Place Denver, CO 80230
ph (303) 364-7700 fax (303) 364-7800
www.ncsl.org

Surprise Medical Billing Legislation
June 2015

Ashley A. Noble, JD

MT D 1611

Author:	Williams K (D)
Title:	Consumer Opt Out Provisions from Surprise Medical Bills
Prefiled:	12/05/2014
Disposition:	Pending
Location:	Draft
Summary:	Provides for consumer opt-out provisions from surprise medical Bills; relates to health care services; relates to insurance.
Status:	02/13/2015 Assigned HOUSE Bill No. 498.

MT H 498

Author:	Williams K (D)
Title:	Consumer Opt Out Provisions for Medical Bill Prevention
Introduced:	02/13/2015
Disposition:	Failed
Location:	Tabled
Summary:	Provides for consumer opt-out provisions to prevent surprise medical Bills; relates to health care services; relates to insurance.
Status:	02/27/2015 Missed Deadline for General Bill Transmittal.

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas
7700 East First Place, Denver CO 80230 υ Tel.: (303) 364-7700

DATE: overview updated January 2013
From: Richard Cauchi, NCSL Health Program
Re: STATE STATUTES AND PRACTICES RELATED TO "BALANCE BILLING" IN HEALTH CARE

Balance billing is the practice of hospitals, clinics, doctors offices and other medical facilities billing patients for the balance between what they want to charge their patients for services and what the insurance company has already reimbursed them.

The practice of balance billing is illegal for all Medicare patients. It also can be illegal in up to 47 states when patients with private insurance seek care from doctors and facilities that are under contract or "in-network" with their insurers. The issues can be financially and legally complex for two reasons -- 1) it can be difficult for outside parties or patients to determine exactly what the contract between insurer and provider does specify, and 2) some arrangements like PPOs (preferred provider organizations) and tiered provider arrangements are designed to have more than one rate structure and may be designed to allow a form of 'balance billing.'

There also are two broad exceptions to balance billing prohibitions or restrictions:

1. Out-of-network providers usually are permitted to use balance billing, and such managed care insurance contracts should spell out those billing terms.
2. If a provider tells the patient ahead of time that a service probably won't be covered by the insurance / payer, then balance billing can take place, whether or not the payer actually does reimburse any of the total amount due to the provider for the service.

Some aspects of restricting balance billing are covered under general consumer protection contract law and may not be specific to health.

An Archive of Examples of State Laws

Based on a 50-state statute search conducted in 2008-2010, the following are state laws with specific reference to "balance billing" as it applies to health care services. This summary excludes references solely to worker's compensation The states included are: **Arkansas (2001), California (2006), Connecticut, Delaware, Maine, Maryland, Mississippi (2003), Ohio (1996), Pennsylvania, Utah (1991, 2001), Vermont and Virginia.** Note that Ohio, Pennsylvania, Utah and Vermont all make specific reference to Medicare beneficiaries.

=======

CALIFORNIA
EXECUTIVE ORDER 113. Signed and filed JULY 25, 2006 with Secretary of State.
Directs the Department of Managed Health Care to **take all steps necessary to protect Californians from balance billing,** re-double efforts to enforce the Know-Keene Health Care Service Plan Act of 1975's provisions relating to the fair and prompt payment of non-contracted provider claims, and conduct a review of the current criteria used to

determine the reasonable and customary value of non- contracted emergency services to ensure that it results in fair reimbursement for the provider.,

Cal Civ Code § 3040, (2008)
Hospital Lien Act and "Balance Billing": Protecting Innocent Patients'
Cal Ins Code § 12693.55, (2008), INSURANCE CODE, Division 2.
(f) The practice of balance billing Medicare and Medi-Cal
Cal Ins Code § 12698.26, (2008), INSURANCE CODE, Division 2
Health care provider limited in seeking reimbursement for covered services provided to subscriber; Exception.

Connecticut. Gen. Stat. § 20-7f, TITLE 20 Unfair billing practices.
Conn. Gen. Stat. § 42-110b, for billing them for the balance not paid by the ...
... in that practice, known as "balance billing;" the trial court's findings were ...
... 3. Doctor violated the balance billing prohibition set forth ...
... Conn. Gen. Stat. § 42-110b, for billing them for the balance not paid by the ...
... in that practice, known as "balance billing;" the trial court's findings were

DELAWARE CODE ANNOTATED
TITLE 18. INSURANCE CODE ; PART I. INSURANCE ; CHAPTER 1. GENERAL DEFINITIONS AND PROVISIONS ; 18 Del. C. § 102 (2002)

§ 102. Definitions
As used in this part:
(10) An "authorized" insurer is one duly authorized to transact insurance in this State by a subsisting certificate of authority issued by the Commissioner.
(11) " **Balance billing** " means a health care provider's demand that a patient pay a greater amount for a given service than the amount the individual's insurer, managed care organization or health service corporation has paid or will pay for the service.

REVISOR'S NOTE. --Section 1 of 73 Del. Laws, c. 96 provides: "This act shall be referred to as the "Delaware Patient's Bill of Rights."'
Section 13 of 73 Del. Laws, c. 315, provides: "Sections 1 through 9 and sections 11 and 12 shall take effect July 1, 2002."
§ 332. Arbitration of disputes involving health insurance coverage

---

MAINE REVISED STATUTES
TITLE 24-A. MAINE INSURANCE CODE
CHAPTER 56-A. HEALTH PLAN IMPROVEMENT ACT
SUBCHAPTER I. HEALTH PLAN REQUIREMENTS
24-A M.R.S. § 4303 (2003)

§ 4303. Plan requirements

A carrier offering a health plan in this State must meet the following requirements.
.....
8. MAXIMUM ALLOWABLE CHARGES. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to **balance billing** when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

1) Clearly disclose that the insured or enrollee may be subject to **balance billing** as a result of claims adjustment; and

2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service.

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service.

Md. HEALTH-GENERAL Code Ann. § 19-710.1 (2009), HEALTH - GENERAL, TITLE 19. HEALTH CARE FACILITIES, SUBTITLE 7. HEALTH MAINTENANCE ORGANIZATIONS , § 19-710.1. Payment to health care provider not under written contract
Section 3, ch. 275, Acts 2000, provides that "the Health Services Cost Review ...
... in consultation with the Maryland Health Care Commission, the Maryland Insurance Administration, health care providers, and health maintenance organizations, shall ...
... a prohibition against the balance billing of health maintenance organization subscribers

==========

MISSISSIPPI 2003 REGULAR SESSION

2003 Miss. S.B. 2628

SECTION 1. This act may be cited as the "Medical Malpractice Insurance Availability Act."

SECTION 2. The purpose of this act is to provide a temporary market of last resort to make necessary medical malpractice insurance available for hospitals, institutions for the aged or infirm, or other health care facilities licensed by the State of Mississippi, physicians, nurses and any other personnel who are duly licensed to practice in a hospital or other health care facility licensed by the State of Mississippi. It is not intended that the insurance plan authorized by this act shall become a permanent facility.

.....

(5) Policies may be underwritten based on participant history. All rates applicable to the coverage provided herein shall be on an actuarially sound basis and calculated to be self-supporting.

(6) Every participant in the plan shall:

(a) File with the board a written agreement, the form and substance of which shall be determined by the board, signed by a duly authorized representative of the participant, that the participant will provide services to (i) Medicaid recipients, (ii) State and School Employees Health Insurance Plan participants, and (iii) Children's Health Insurance Program participants. The agreement must provide, among other things, that the participant will provide services to Medicaid recipients, State and School Employees Health Insurance Plan participants, and Children's Health Insurance Program participants in a manner that is comparable to the services provided to all other patients and shall be made without **balance billing** to the patient; and

(b) Pay all assessments and premiums established by the board.

==========

OHIO

TITLE XLVII [47] OCCUPATIONS -- PROFESSIONS
CHAPTER 4769: **BALANCE BILLING** OF MEDICARE BENEFICIARIES

ORC Ann. 4769.01 (Anderson 2002)

§ 4769.01 Definitions.

As used in this chapter:

(A) "Medicare" means the program established by Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), *42 U.S.C.A. 301*, as amended.

(B) " **Balance billing** " means charging or collecting from a Medicare beneficiary an amount in excess of the Medicare reimbursement rate for Medicare-covered services or supplies provided to a Medicare beneficiary, except when Medicare is the secondary insurer. When Medicare is the secondary insurer, the health care practitioner may pursue full reimbursement under the terms and conditions of the primary coverage and, if applicable, the charge allowed under the terms and conditions of the appropriate provider contract, from the primary insurer, but the medicare beneficiary cannot be balance billed above the medicare reimbursement rate for a medicare-covered service or supply. " **Balance billing** " does not include charging or collecting deductibles or coinsurance required by the program.

CASE NOTES AND OAG

1. (1996) Ohio statutes prohibiting the balance billing of Medicare beneficiaries are not preempted by the Medicare Act: *Downhour v. Somani, 85 F3d 261* (6th Cir.).

==========

PENNSYLVANIA STATUTES,
TITLE 35. HEALTH AND SAFETY ; CHAPTER 1F. HEALTH CARE PRACTITIONERS MEDICARE FEE CONTROL ACT
35 P.S. § 449.33 (2002)

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

" **Balance billing.** " To charge or collect from a beneficiary of health insurance under Title XVIII of the Social Security Act (Public Law 74-271, *42 U.S.C. § 301* et seq.), known as the Medicare Program, an amount in excess of the reasonable charge for the service provided, as determined by the United States Secretary of Health and Human Services.

.....

§ 449.36. Notice to Medicare beneficiaries

(a) PRACTITIONER'S DUTY.--A SIGN WHICH SETS FORTH THE FOLLOWING SHALL BE POSTED BY LICENSED HEALTH CARE PRACTITIONERS WHO TREAT MEDICARE BENEFICIARIES:

(1) The rights of Medicare patients under this act.

(2) The identification of the Department of State as the proper State agency to receive patients' complaints relating to **balance billing** prohibited under this act.

(3) The address and telephone number of the Department of State.

§ 449.36. Notice to Medicare beneficiaries

(a) PRACTITIONER'S DUTY.--A SIGN WHICH SETS FORTH THE FOLLOWING SHALL BE POSTED BY LICENSED HEALTH CARE PRACTITIONERS WHO TREAT MEDICARE BENEFICIARIES:

(1) The rights of Medicare patients under this act.

(2) The identification of the Department of State as the proper State agency to receive patients' complaints relating to **balance billing** prohibited under this act.

==========

UTAH CODE ANNOTATED
TITLE 31A. INSURANCE CODE ; CHAPTER 26. INSURANCE ADJUSTERS; PART 3. CLAIM PRACTICES
Utah Code Ann. § 31A-26-301.5 (2003)

§ 31A-26-301.5. Health care claims practices

(1) Except as provided in Section 31A-8-407, an insured retains ultimate responsibility for paying for health care services the insured receives. If a service is covered by one or more individual or group health insurance policies, all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies.

(2) (a) Except as provided in Section 31A-22-610.1, a health care provider may bill and collect for any deductible, copayment, or uncovered service.

(b) A health care provider may bill an insured for services covered by health insurance policies or may otherwise notify the insured of the expenses covered by the policies. However, a provider may not make any report to a credit bureau, use the services of a collection agency, or use methods other than routine billing or notification until the later of:

(i) the expiration of the time afforded to an insurer under Section 31A-26-301.6 to determine its obligation to pay or deny the claim without penalty; or

(ii) in the case of medicare beneficiaries or retirees 65 years of age or older, 60 days from the date medicare determines its liability for the claim.

(c) Beginning October 31, 1992, all insurers covering the insured shall notify the insured of payment and the amount of payment made to the provider.

(3) The commissioner shall make rules consistent with this chapter governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process. These rules shall be limited to the form and content of the disclosures on the explanation of benefits, and shall include:

(a) a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed; and

(b) a prohibition against an implication that the provider is charging excessively if the provider is:

(i) a participating provider; and

(ii) prohibited from **balance billing.**

HISTORY: C. 1953, 31A-26-301.5, enacted by L. 1992, ch. 291, § 12000, ch. 198, § 2; 2001, ch. 240, § 1.

==========

VERMONT STATUTES ANNOTATED
TITLE THIRTY-THREE. HUMAN SERVICES; PART 5. PROGRAMS AND SERVICES FOR VULNERABLE ADULTS; CHAPTER 65. MEDICARE AND GENERAL ASSISTANCE BENEFICIARIES; **BALANCE BILLING**
33 V.S.A. § 6508 (2003)

§ 6508. Report required

On or before January 15 of each year up to and including 1992, the department of aging and disabilities shall evaluate the effect of this chapter and report its findings to the chairpersons of the senate and house health and welfare committees. At a minimum, the report shall address the following: inquiries or complaints received by the department of aging and disabilities concerning physician **balance billing** practices, changes in actual billing of Medicare beneficiaries for physician services, issues relating to access to physician services for beneficiaries, and any other information necessary to enable the committees to assess the effect of this chapter on physicians and beneficiaries. In compiling its report, the department of aging and disabilities shall consult with the secretary of state, the carrier for Medicare physician services for Vermont, and the professional societies of professions affected by this chapter.

HISTORY: Added 1987, No. 51, § 1; amended 1989, No. 219 (Adj. Sess.), § 9(a).

==========

CODE OF VIRGINIA
TITLE 32.1. HEALTH; CHAPTER 5. REGULATION OF MEDICAL CARE FACILITIES AND SERVICES
ARTICLE 1.1. CERTIFICATE OF QUALITY ASSURANCE OF MANAGED CARE HEALTH INSURANCEPLAN LICENSEES
Va. Code Ann. § 32.1-137.1 (2003)

§ 32.1-137.1. Definitions

As used in this and the following article, unless the context indicates otherwise:

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any

credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. For the purposes of this definition, the prohibition of **balance billing** by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

.....

§ 38.2-5800. Definitions

As used in this chapter:

"Managed care health insurance plan" or "MCHIP" means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of **balance billing** by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

Virginia H.B. 1044, 2006 SESSION, Enacted - Final, March 31, 2006, An Act to amend and reenact Sections 38.2-4300, 38.2-4307.1, and 38.2-5800 of the Code of Virginia, relating to the regulation of health maintenance organizations.

OTHER LAWS WITH NARROW FOCUS OR CIRCUMSTANCES

Arkansas also enacted a law. A.C.A. § 11-9-118 (2003), in April 2001 to prohibit providers from balance billing health insurance consumers in the event of the financial difficulty or insolvency of an HMO. One new law prohibits health care providers from attempting to collect from an enrollee for covered services that fall under the payment liability of an HMO. It includes an emergency clause because legislators felt that compliance with contractual terms by the providers was failing. The provisions in the act impose a penalty of not less than $150 or more than $1,500 for violations subject to the provisions.

Additional resources:

---

[1] A definition of balance billing - published by answers.com

80th Percentile Benchmark for Biling Codes in an Area (Emergency)

CPT Code 99285 : Emergency department visit, Problem with Significant Threat to Life or Function

In Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$455.00	$199.74	228%
WA (Spokane)	$480.00	$190.89	251%
AK	$404.00	$266.59	152%
VT	$257.00	$184.21	140%
OR (Eugene)	$370.00	$187.10	198%
OR (Portland)	$350.00	$192.51	182%
ID	$317.00	$177.23	179%
ND	$146.00	$182.88	80%
MT	$310.00	$195.53	159%
WY	$474.00	$188.18	252%
DE	$263.00	$195.52	135%
		Average	**178%**

Out-of-Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$1,177.00	$199.74	589%
WA (Spokane)	$1,874.00	$190.89	982%
AK	$1,057.00	$266.59	396%
VT	$614.00	$184.21	333%
OR (Eugene)	$1,241.00	$187.10	663%
OR (Portland)	$909.00	$192.51	472%
ID	$667.00	$177.23	376%
ND	$376.00	$182.88	206%
MT	$785.00	$195.53	401%
WY	$1,262.00	$188.18	671%
DE	$651.00	$195.52	333%
		Average	**493%**

Information from FairHealth and CMS

CPT Code 99284: Emergency department visit, Problem of High Severity

In Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$278.00	$135.71	205%
WA (Spokane)	$479.00	$190.89	251%
AK	$276.00	$180.71	153%
VT	$174.00	$125.11	139%
OR (Eugene)	$235.00	$127.02	185%
OR (Portland)	$235.00	$130.74	180%
ID	$167.00	$120.29	139%
ND	$129.00	$124.20	104%
MT	$197.00	$132.76	148%
WY	$304.00	$127.78	238%
DE	$242.00	$132.75	182%

Average	175%

Out-of-Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$599.00	$135.71	441%
WA (Spokane)	$1,269.00	$190.89	665%
AK	$725.00	$180.71	401%
VT	$416.00	$125.11	333%
OR (Eugene)	$595.00	$127.02	468%
OR (Portland)	$626.00	$130.74	479%
ID	$242.00	$120.29	201%
ND	$345.00	$124.20	278%
MT	$368.00	$132.76	277%
WY	$769.00	$127.78	602%
DE	$445.00	$132.75	335%

Average	407%

Information from FairHealth and CMS

CPT Code 99283 Emergency department visit, moderately severe problem

In Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$157.00	$71.59	219%
WA (Spokane)	$251.00	$68.33	367%
AK	$206.00	$69.97	294%
VT	$92.00	$65.98	139%
OR (Eugene)	$171.00	$66.95	255%
OR (Portland)	$158.00	$68.95	229%
ID	$135.00	$63.40	213%
ND	$63.00	$65.50	96%
MT	$113.00	$69.96	162%
WY	$213.00	$67.36	316%
DE	$105.00	$69.97	150%

Average	222%

Out-of-Network	Primary Medical Procedure	Medicare Facility Limiting Charge	% of Medicare
WA (King County)	$378.00	$71.59	528%
WA (Spokane)	$669.00	$68.33	979%
AK	$693.00	$69.97	990%
VT	$219.00	$65.98	332%
OR (Eugene)	$447.00	$66.95	668%
OR (Portland)	$400.00	$68.95	580%
ID	$296.00	$63.40	467%
ND	$185.00	$65.50	282%
MT	$299.00	$69.96	427%
WY	$478.00	$67.36	710%
DE	$266.00	$69.97	380%

Average	577%

Information from FairHealth and CMS

The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Robert Wood Johnson Foundation

JUNE 2015

Balance Bill (n): An unexpected bill sent by a hospital, doctor, or clinic for an amount beyond that paid by the patient's insurance.

Balance Billing: How Are States Protecting Consumers from Unexpected Charges?

How seven states—California, Colorado, Florida, Maryland, New Mexico, New York, and Texas—have approached protecting consumers from certain types of balance billing.

By Jack Hoadley, Sandy Ahn, and Kevin Lucia

Support for this report was provided by a grant from the Robert Wood Johnson Foundation.

Authors

Jack Hoadley, Ph.D.
Research Professor
Georgetown University Health Policy Institute

Sandy Ahn, J.D.
Research Fellow
Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Kevin Lucia, J.D.
Senior Research Fellow
Center on Health Insurance Reforms
Georgetown University Health Policy Institute

The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Introduction

Large bills from an out-of-network health care provider can be an unexpected surprise to consumers who did not knowingly decide to obtain health care outside the plan's provider network. As health plans embrace tighter networks as a tool for improving quality or reducing premiums, the potential for such bills may grow. Although insurers may protect their plan members in some cases, there is no broad protection from these types of bills in federal law or in most states. Several states have acted to protect consumers from the need to pay balance bills, at least in emergency situations. New York started implementation of expanded protections in April, providing a test of what may be the most comprehensive state approach to date. But even these states have struggled with how to implement protections while balancing legitimate interests of health plans and health care providers. This issue brief summarizes and compares seven state approaches to protecting consumers from balance billing.

What is a Balance Bill?

Americans purchase health insurance to protect themselves against the cost of care for a significant illness or health condition. In doing so, they hope to protect themselves against large and unaffordable bills from health care providers. Yet even with insurance, some consumers face bills for the difference between an insurer's payment to the provider and the provider's charges, often referred to as balance bills or surprise bills.[1] These bills occur most often when consumers receive covered services from out-of-network providers.[2] Large balance bills are often stressful for consumers and are a significant source of medical debt.[3]

Most health insurance plans for working-age Americans today involve a provider network.[4] Networks can take the form of a closed network in many health maintenance organizations (HMOs) or exclusive provider organizations (EPOs), in which the plan normally pays only for care delivered by a network provider. Under an open network, such as a preferred provider organization (PPO) or other point-of-service plans, the plan typically covers out-of-network care, but imposes higher cost sharing or a higher deductible when using out-of-network providers. PPOs are the most common insurance choice, at least for those with employer-based coverage.[5] Some consumers elect to enroll in plans with more restricted networks, most often when these plans are available at lower premiums. For other consumers, especially those who value their existing relationships with providers, easier access to providers outside the network may be preferable.

Typically, when a consumer uses a network provider, the consumer is held harmless; in other words, the consumer does not have to pay the difference between the insurer's coverage and the provider's billed charges. This assurance is based on the network contract between the plan and the provider and on state laws regulating these relationships. But when a consumer uses a non-network provider, there is often no contractual relationship to prevent the provider from balance billing the consumer regardless of whether the health plan makes no payment (e.g., closed-network HMO) or partial payment (e.g., open-network PPO).

Provider networks involve a set of agreements among the plan, the health care provider, and the plan enrollee. Network providers agree to accept a payment rate that may be less than they would charge on the open market, but in return they expect to get a higher share of business from the plan's enrollees. The plan selects providers based on providers' willingness to accept these lower rates, the plan's need to have adequate providers to serve their policyholders, and the goal of maintaining high-quality care. Consumers, in selecting a plan, may consider the tradeoffs between broader networks and lower premiums. But in selecting a plan, they should understand the financial consequences of obtaining care outside the network. Network negotiations and thus the ultimate costs—premiums and other cost sharing—borne by plan enrollees are influenced by factors such as the market concentration of providers and health plans.

Scenarios for Balance Billing

Consumers receive care from non-network providers in a variety of scenarios. Depending on the scenario, the legal and financial consequences differ.

- *Scenario 1: Informed Use of Non-Network Providers.* In the simplest and probably most common scenario, the consumer makes a voluntary, informed decision to go out of network for a particular service. For example, he or she may want to receive a surgical procedure from a particular surgeon who does not participate in the plan's network. The consumer is aware that he or she will be responsible either for the entire bill (if enrolled in a closed-network plan) or will pay both higher cost sharing and a balance bill for the amount by which the provider's charge exceeds the health plan's payment for out-of-network care.
- *Scenario 2: Emergency Settings.* In this scenario, the consumer has some type of medical emergency and is taken to a hospital for emergency care.[6] Even if the consumer makes sure to go to a network hospital, there is no certainty that the emergency department (ED) is staffed by network providers. In these situations, the consumer has little or no ability to choose a network or non-network provider. Most consumers probably assume that the network hospital is staffed by network physicians and other health professionals. In reality, this is not always the case. Data are not widely available to track how often these situations arise. But a recent study of networks for the three largest insurers in Texas found that at least one of five in-network hospitals had no in-network emergency department physicians (for one of these insurers, over half of the network hospitals had no in-network ED physicians).[7] In some emergency situations in which the consumer is treated by a non-network provider, the health plan may agree to reimburse the provider at a certain level, but a provider can balance bill the consumer for any additional charges since there is no contractual obligation to accept the health plan's payment as payment in full.
- *Scenario 3: Surprise Billing Situations in a Network Hospital.* Beyond the emergency context, consumers may still find themselves in scenarios in which they are treated unexpectedly by a non-network provider. One common situation occurs when the consumer makes sure to identify an in-network hospital and providers to perform a procedure or service, but still encounters non-network providers in other roles. This could occur when a woman arranges to have her baby delivered by a network obstetrician and hospital, but the anesthesiologist is not part of her health plan's network. Or it could occur when an individual arranges for knee replacement surgery with a network surgeon but the assistant surgeon or surgical assistant helping with the surgery and the radiologist performing the MRI are not in network. Another scenario arises following an emergency department encounter when the patient is stabilized and no longer in emergency care. Follow-up care during the hospital stay may be provided by an out-of-network cardiologist, infectious disease specialist, or physical therapist. The non-network providers in these situations can bill the patient, and there is no guarantee how much the insurer will pay (if at all) for coverage for these types of "surprise bills."
- *Scenario 4: Consultations or Services Outside the Network.* While the above scenarios are the most common, situations may also arise in which the consumer needs a consultation with or services from a specialist not in a health plan's network. This could occur when there are gaps in the plan's network or when network directories are inaccurate. In theory, this situation allows all parties involved more time to identify the possibility of an uncovered charge than in emergency or surprise bill scenarios.

There are few sources of data that document how frequently these situations occur, although a study of 2004 claims data found that out-of-network care represented 10 percent to 13 percent of charges in PPOs or similar plans.[8] According to a survey-based analysis conducted in 2011, 8 percent of consumers used an out-of-network physician, most frequently in the emergency department. About 40 percent of those consumers (3 percent of the overall sample) went out of network involuntarily at least once over a 12-month period—more frequently in inpatient or ED settings.[9] Decisions by health plans to offer narrower networks could increase the potential for balance billing.[10]

Protecting Consumers

Federal law does not currently protect consumers from balance billing or surprise billing in these scenarios. The Affordable Care Act (ACA) only guarantees that the health plan must provide coverage for emergency services even if the providers are out of network (Scenario 2).[11] Specifically, the plan must pay these out-of-network providers the greatest of the plan's median payment amount for in-network providers, a payment based on the methods the plan generally uses to determine payments for other out-of-network services (e.g., a percentage of usual and customary fees), or the amount that Medicare would pay for the service.[12] When providers are paid adequately, they are less likely to balance bill. But some providers may not consider these amounts adequate, and the ACA neither prohibits balance billing nor requires the plan to hold the consumer harmless. Furthermore, ACA rules do not apply to situations in which a consumer unknowingly receives care from an out-of-network provider (Scenario 3) or in which in-network providers are unavailable (Scenario 4).

States take various approaches to protecting consumers from balance billing. Nearly all states require HMO contracts to hold consumers harmless when they go to in-network providers; a smaller share apply the same protections for PPOs.[13] Thus providers participating in a health plan's network are obligated under their contracts with insurers to hold consumers harmless by forgoing balance bills.

Although most states have no provisions that address billing for care received from out-of-network providers, about one-fourth of states have elected to protect consumers against bills from non-network providers in at least some circumstances.[14] Some of these state laws have a very narrow scope (e.g., one law applies only to ambulance services). Most state laws apply to emergency services received from non-network providers (Scenario 2) and less frequently in surprise billing situations (Scenario 3). Some states have limited these protections to a subset of insurance products; for example, more states apply protections to HMOs than to PPOs.[15]

Under federal law, employer-sponsored plans that are self-funded by the employer are generally exempt from state regulation.[16] Thus, consumers with self-funded employer health plans must use network providers to avoid receiving balance bills. In practice, employer-sponsored plans may elect to take a similar approach as that offered by some states and protect policyholders from some balance bills.

In the absence of legal protections, consumers do not always face balance bills. Even if the plan design is a closed network, a plan may elect to provide coverage for selected services delivered by non-network providers. As noted above, health plan contracts may protect members who receive emergency services or when the network cannot meet a particular need. Plans may seek to negotiate a rate with providers in these situations, but often pay the full billed charges to ensure that their members are "kept out of the middle" and protected from a balance bill.[17] These situations could be limited to requests by members or their providers, but in some cases plans may elect to use their discretion more broadly.

Alternatively, some providers elect to write off the unpaid amounts after insurers make a payment, either by not sending a balance bill or not making active efforts to collect payment from the patient. Providers may do so to preserve a good doctor-patient relationship. Some hospitals have sought to make sure that facility-based

What Should Consumers Do To Prevent Unexpected Charges?

- When possible, use provider directories and other plan-provided information to locate in-network providers.
- When possible, ask providers whether they are in the plan's network. If providers are not in network, ask whether they will accept the plan's payment as payment in full.
- In cases where a provider sends a balance bill, review the health plan's explanation of benefits and any notices about consumer rights.
- Before paying a balance bill, contact both the health plan and the provider. Ask whether the plan is willing to pay the bill. If not, ask whether the provider will accept a lesser amount.
- Contact the state insurance department to see if any remedy is available under the state's laws.

physicians participate in the same networks that include the hospital. But narrower networks have made this more difficult, especially when excluded providers respond with high charges. For example, United Healthcare in Missouri recently decided to stop paying the full charges of non-network emergency department physicians.[18]

Purpose of Study and Methodology

To protect consumers from balance billing, some states focus narrowly on making consumers aware of the potential financial consequences when going out of network. Other states focus on removing the consumer from payment disputes by regulating the amount of payments from the insurer to the out-of-network provider.

In an effort to determine how states are protecting consumers from balance billing, we analyzed the legal framework in seven states: California, Colorado, Florida, Maryland, New Mexico, New York, and Texas. We chose these states because they represent a range of state approaches to balance billing protections. In addition to analyzing state laws, we conducted 19 interviews with state regulators, insurers, providers, and consumer advocates from our study states to gain a comprehensive understanding of how state laws are affecting consumers' experiences with surprise bills.

Specific Elements of Consumer Protection

Four key elements are highlighted in state approaches to protecting consumers from balance billing. The states in this study use a variety of these elements in different combinations, as described in the next section.

Disclosure and Transparency. Several states have taken steps to help make consumers aware that they may face balance bills in situations where they are unable to use network providers in emergencies (Scenario 2) or encounter out-of-network providers as part of a care team when they use network providers (Scenario 3). It is the standard in many states to require insurers to have language in notices and plan summaries about the financial consequences of going out of network. Some states go beyond that to require notices to consumers at the point of service describing the potential for seeing a non-network provider and receiving a balance bill. Other state provisions are aimed more broadly at bringing greater transparency to networks and medical bills by providing consumers with information on the composition of the plan's network, such as accurate provider directories. In addition, some states seek to make public specific information on the cost of using a non-network provider and summary information on how often network hospitals have non-network providers delivering care (e.g., non-network emergency physicians in a network hospital).

Balance Billing Prohibitions. Several states protect consumers more directly by prohibiting non-network providers from billing patients, beyond any allowed cost sharing, in certain situations. States are more likely to address the emergency setting (Scenario 2), but some states have also sought to address surprise billing (Scenario 3). In some states, the ban applies only if the non-network provider accepts payment for the claim directly from the insurer based on an assignment of benefits. Assignment of a claim means that the consumer transfers the right to reimbursement to the provider, who becomes entitled to direct payment from the insurer (even though there is no network relationship between the plan and provider). In states taking this approach, providers agree to accept the plan's payment as payment in full, and the consumer is liable only for applicable cost sharing. Physician groups often advocate for assignment in these situations, since it is easier to collect payments from insurers than from patients.

Hold Harmless Provisions. An alternative to a ban on balance billing is to require that insurers hold plan members harmless by paying providers their billed charges (or some lower amount that is acceptable to the provider) in situations such as emergency care. From the consumer's perspective, either a ban on balance billing or a hold harmless rule yields the same result, although practical matters may complicate the effectiveness of

both approaches. For example, hold harmless rules could require the consumer to be aware of their ability to pass the bill to the insurer rather than pay the billed amount. Also, the costs incurred by insurers will eventually be passed to consumers through higher premiums.

Adequate Payment. Although both balance billing prohibitions and hold harmless provisions achieve the goal of protecting the consumer, they may leave health plans and providers in conflict over the question of adequate payment. Some states have specific rules to set payment rates for these situations, for example requiring that insurers pay non-network providers at the usual and customary rates they pay to network providers. Other states, instead of setting a specific rate, refer providers and insurers to an independent mediation or dispute resolution process to settle on a fair rate of payment. These mechanisms help to protect consumers because they allow both providers and health plans to know what they will pay or be paid, which in turn helps to address the conflicts over payment.

How States Use Elements of Consumer Protection

California takes a direct approach to protect consumers by prohibiting physicians from balance billing in emergency cases (Scenario 2). The policy, established by the Department of Managed Health Care (DMHC), treats all emergency department services as in network and applies only to plans under the jurisdiction of the DMHC, not the Department of Insurance.[19] Generally HMOs and PPOs fall under DMHC jurisdiction, representing most of the market.[20, 21]

As part of the rules, California requires that plans pay providers a "reasonable and customary" payment rate. It goes beyond "usual and customary" in that payment must be based on "statistically credible information that is updated at least annually" and must take into account factors such as the provider's training and experience, the nature of the service provided, and fees usually charged by a provider.[22] As one stakeholder reports, the provider and the plan "have to work it out," but "no one thinks the standard is completely clear." If providers are unhappy with the plan's payment, they can use the state's voluntary, non-binding independent dispute resolution process (IDRP).[23] Although disputes between plans and providers are common, respondents indicate that use of this voluntary process is limited.[24]

California has no disclosure requirements beyond the standard information required at the point of service regarding the use of out-of-network providers. In the view of one stakeholder, disclosure may be valuable in principle, but it does not provide the type of consumer protection achieved by a state's prohibition on balance billing.

Colorado takes a policy approach that differs from that used in California. The state treats covered services by non-network providers at a network facility as if they are in network and requires health plans to hold their members harmless in both emergency and surprise billing situations (Scenarios 2 and 3) when patients are treated in network facilities, as well as for referrals when the plan's network is deemed inadequate (Scenario 4).[25]

The Colorado approach thus puts the burden on health plans to pay the provider's billed charge or some other amount that is agreeable to the provider. Nevertheless, one insurer reports that the consumer protections are working well, although acknowledging that health plans typically must pay the provider's full billed charges and rarely are able to negotiate rates. Another stakeholder suggests there is a gap in the protections for consumers with high-deductible health plans, in which the plan cannot pay if the member has not met the deductible.[26] In these situations, the member must challenge the provider on the amount billed in order to avoid paying full billed charges.

Florida has a statute that takes the same general approach as California by prohibiting balance billing for emergency services (Scenario 2), but only for HMO products. In these situations, plans are required to pay the lesser of the provider's charges, the usual and customary charges for similar services in the community, or a charge mutually agreed to by the plan and the provider.[27] Florida also prohibits out-of-network providers from balance billing HMO patients for covered services that are authorized by the HMO.[28] Regulators interpret the statute as prohibiting balance billing for any ancillary services provided to a patient in an in-network hospital if admitted by an in-network physician, including services by non-network providers.

If disputes arise, the state has an independent dispute resolutions (IDR) process administered by a third party.[29] The IDR process is rarely used, in part because providers perceive that decisions tend to favor insurers or because providers would have to pay for the cost of the IDR if they are unsuccessful.

Maryland protections originally applied only to consumers enrolled in HMOs, and some balance billing protections were expanded in 2010 to PPO enrollees. Maryland prohibits providers from balance billing HMO consumers for covered services including but not limited to emergency services (Scenarios 2 and 3). HMOs must hold consumers harmless for covered services provided by out-of-network providers and pay at prescribed rates; for example, provider rates for emergency services are based on Medicare reimbursement rates.[30] The PPO law grants the protection against balance billing to patients who assign benefits to their physicians.[31] For physicians who are not hospital-based or on-call, however, the prohibition on balance billing applies only if the patient assigns benefits to the physician and the out-of-network physician fails to disclose certain information to consumers prior to providing health care services, including an estimate of the cost of services and a statement that the physician can balance bill for covered services.[32]

Stakeholders generally believe that the state's laws are working well for consumers, and a 2015 report by the Maryland Health Care Commission on the extension to PPOs concluded that "the law, generally, achieved its intended purpose."[33] One stakeholder characterizes the PPO law this way: "We are still seeing balance billing occur, but it's not as prevalent as it used to be." There are gaps, however. Several stakeholders note that there is currently no balance billing protection for costly air ambulance services and for services of non-physician providers (e.g., hospital-based surgical assistants).

Maryland's approach is distinctive in two respects. First, it does not incorporate a dispute resolution process. Second, Maryland has specific requirements for payment levels that must be met by health plans for different types of health services and different types of physicians.[34] For example, for services other than evaluation and management, an HMO must pay at least 125 percent of the average rate it paid during the previous calendar year.[35] A PPO must pay 140 percent of the average rate paid the previous year or the average rate paid in 2010 to an on-call physician.[36]

New Mexico was included in this study to illustrate what happens in a state that has no specific state legislation to address balance billing by out-of-network providers. Because we focused on a single state in this situation, we cannot say whether it is representative of other states without legislation. A stakeholder in New Mexico reports that the state has relatively few providers, and so health plans tend to have contracts with most providers in the state. As a result, legislation to protect consumers from balance billing situations has not been necessary because balance billing occurs infrequently. One stakeholder notes that at least one health plan often holds their members harmless when non-network providers are used, despite the absence of any requirement to do so. This includes paying the full-billed charges to protect their members if they cannot work out a lower payment with the provider. If the providers in these situations are unwilling to negotiate, the health plan apparently chooses to pay full billed charges to protect their members.

New York is the only state to combine various elements of consumer protection for Scenarios 2 and 3, including disclosure, transparency, and a process to resolve payment disputes. The new law, enacted in April 2014, went into effect starting April 1, 2015 for any new insurance contract or contracts renewed after March 31, 2015.[37] The law builds on some existing protections that applied to HMOs but not to other insured products. The stakeholders we interviewed generally agree with the principles enshrined in the law, and since enactment, the state has consulted closely with stakeholders to work through implementation details and guidance.

Under the new law, the state bans balance billing by providers in emergency situations. It extends that protection to surprise billing and other situations, as long as the consumer assigns the provider's claim to the insurer.[38] Thus, in surprise billing situations where assignment is in place, no balance bill can be charged to the consumer. The link to assignment may have helped garner support from physician groups, because it makes it easier for them to collect payments.

New York requires plans to establish a reasonable payment amount, and plans must disclose their methodology and how it compares to usual and customary rates, which are defined as the 80th percentile of the amounts made available by Fair Health, an independent entity created in 2009 to maintain a database of charges for medical procedures.[39] If the provider is not satisfied with the amount paid, the state has created an independent dispute resolution process. The IDR process uses licensed physicians in active practice; they can choose either the provider's original billed charge or the plan's original

payment—as opposed to any amount in the middle. In making a decision, the IDR must consider the patient's characteristics, the doctor's training and experience, and the usual and customary rate based on the Fair Health data. As an alternative, the parties can negotiate a settlement on their own and notify the IDR. The IDR can also direct the parties to negotiate a settlement.[40] The IDR system is designed to create incentives for providers and plans to set their charges and payments at more reasonable levels. Stakeholders express cautious optimism for the IDR process, although they will wait for some actual experience with the process before making any final assessments. Some issues remain. One insurer is concerned that physicians could distort the Fair Health data by increasing their charges, while a physician stakeholder worries that the IDR could be complex for smaller physician practices to navigate successfully.

In the new law, New York includes a more extensive set of disclosure requirements for health plans, hospitals, physicians, and other providers.[41] The goal is to make it easier for consumers to look at out-of-network benefits when doing comparison shopping prior to selecting a plan and to understand the potential charges prior to using services from an out-of-network provider. One stakeholder describes the new rules as: "Each party will be responsible for disclosing the information about which it has knowledge." For example, plans are required to maintain accurate and regularly updated provider directories, provide clear statements of how bills are calculated, and provide examples of out-of-pocket costs for frequently billed services.[42] Hospitals are required to provide lists of their standard charges, the insurance plans with which they participate, and whether their employed or contracted physician groups participate in these insurance plans.[43] Physicians are required to make available their participation status with health plans and their "reasonably anticipated charges" (on request).[44] Also, if a doctor is scheduling a hospital service and that particular doctor knows who else is going to be providing additional services or "be in the room," he or she must disclose whether those doctors participate with the patient's insurance.[45]

Texas provides varying protections for each of three product types. For HMOs, regulators interpret the law to hold consumers harmless for emergency services (Scenario 2) and when medically necessary covered services are not reasonably available from in-network providers, including some situations in Scenario 3. Some stakeholders report that the HMO law is confusing for consumers; regulators indicate that their current interpretation and practice will be more clearly articulated in upcoming regulations.[46] Regulators believe that their current approach has resulted in few balance billing issues for HMO enrollees, but other stakeholders are concerned that the protections "may not always translate into practice."[47] Similarly, Texas rules require EPOs to hold consumers harmless when they cannot reasonably use a preferred provider, including emergencies; regulators indicate that this approach also includes surprise billing situations.[48]

For PPOs, its most popular product, Texas relies primarily on disclosure and mediation to help consumers, but does not guarantee that consumers are protected from balance billing. Pursuant to 2013 rules, PPO plans in Texas must provide up-to-date provider directories. Directories must identify hospitals that have agreed to facilitate the use of preferred providers and must disclose the percentage of out-of-network claims filed by providers at each contracted hospital, by provider type.[49] Directories must also identify all contracted providers at network facilities and specify those facilities without any contracts with a particular type of provider.[50] In order for a network to be adequate, at least one hospital must be available where all types of facility-based physicians are available in network. If there is a sudden decrease in the availability of a type of facility-based provider, plans must post this on their website.[51]

The state also requires that PPOs provide general disclosures informing consumers that they may receive care from out-of-network providers, but one stakeholder points out that consumers "have to know to ask" which providers are in network. PPO and EPO consumers can also receive information about their right to get estimates of the amounts the plan will pay, if they request this information from their health plan.[52] In addition, the state collects information from insurers on frequently used services, including charges and actual paid amounts in and out of network. The state then publishes the information on a website that identifies costs for out-of-network care. One stakeholder, however, told us that there have been problems with inconsistencies in the cost data that are reported, resulting in a recent proposal by the department of insurance to refine its data collection. Another believes the state is "making progress," but found it "not so clear that [state efforts have] made a difference." On the other hand, regulators believe improvements will be seen as the recent rules begin to have an impact.

When out-of-network services are provided in an emergency or inadequate network situation, Texas law requires that PPOs pay at least the usual and customary rate for the services in the area. It has also established

a mediation process and allows consumers to initiate mediation if the balance bill from a single out-of-network provider based at a facility exceeds $1,000 (bills from multiple providers involved in one service may not be combined).[54] Providers must inform consumers of their right to mediation when balance billing, and insurers must do so in the explanation of benefits. The mediation evaluates whether the provider's charge is excessive and whether the amount the insurer paid meets the usual and customary standard. Stakeholders report that few consumers use the process; many cases never go to mediation because the parties settle on a payment amount (some suggest that insurers often pay the full charges). Of the 900 cases filed in 2014, only one went to actual mediation, which regulators indicate was the first case for mediation. Other stakeholders suggest that the $1,000 threshold limits the availability of mediation, and that consumers (despite being notified) may not be aware of their right. A bill to decrease the threshold to $500 has passed the legislature and is awaiting action by the governor.

Summary of State Approaches

Our seven study state approaches are summarized in Table 1.

Table 1. Summary of Laws and Regulations Affecting Out-of-Network Balance Billing in Study States

	California	Colorado	Florida	Maryland	New Mexico	New York	Texas
Hold harmless or provider prohibition on balance billing in emergency situations (Scenario 2)	Yes, for HMOs and some PPOs	Yes	Yes, for HMO plans	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes	Yes, for HMOs and EPOs[f]
Hold harmless or provider prohibition on balance billing in surprise bills (Scenario 3)	No	Yes	Yes, for HMOs[b]	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes, tied to assignment[d]	Yes, for HMOs and EPOs[f]
Hold harmless or provider prohibition on balance billing in other situations (Scenario 4)	No[a]	Yes	No	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes, tied to assignment[d]	Yes, for HMOs and EPOs[g]
State mediation or dispute resolution process	Yes, not much used	No	Yes, not much used	No	No	Yes	Yes, if more than $1,000
Disclosure rules beyond standard notices	No	No	No	Yes[e]	No	Yes	Yes

Sources: Cal. Code Regs. tit. 28, § 1300.71.39; Colo. Rev. Stat. § 10-16-704 (3)(a)(I); Fla. Stat. Ann. § 641.513; Fla. Stat. Ann. § 641.3154; Fla. Admin. Code r. 59A-12.030; MD. Code Ann. Health-Gen. §§ 19-710(p), 19-710.1 and 19-712.5; MD. Code Ann. Insurance §§ 14-205.2 and 14-205.3; N.Y. Fin. Services Law §§ 601 to 608; N.Y. Comp. Codes R. & Regs. tit. 23 § 200; N.Y. Pub. Health Law § 24 and Insur. Law § 3217-a; Tex. Insur. Code Ann. §§ 1271.055, 1271.155, 1467.051; 28 Tex. Admin. Code §§ 3.3725; 3.3705; 3.3708; 22 Tex. Admin. Code §§ 187.85 to 187.89; proposed regulation 28 Tex. Admin. Code § 11.1611(e).

[a] Per California's Knox-Keene Act, regulators indicate that if there is a network gap for medically necessary treatment, plan members may be protected. See Ca. Health & Safety Code § 1367 and 1367.03. Also, regulators indicate that if consumers relied upon an inaccurate provider directory, he/she can appeal to the Department of Managed Health Care's Help Center.

[b] Under Fl. Stat. Ann. § 641.3154, out-of-network providers are prohibited from balance billing for ancillary services when the HMO has authorized the covered service. Regulators also interpret the statute as prohibiting balance billing for ancillary services when an in-network physician admits the patients to an in-network hospital.

[c] For PPOs, protection against balance billing does not apply for physicians other than hospital-based or on-call if these other physicians disclose, prior to delivering services, information on estimated costs and the fact that a balance bill is possible.

[d] Assignment means that the consumer transfers the right to reimbursement from the health plan directly to the provider so that the health plan can pay the provider directly.

[e] Maryland's pre-disclosure requirements do not apply to hospital-based or on-call physicians and only apply to other out-of-network physicians prior to providing a service if they want to balance bill.

[f] Texas regulators indicate that their current interpretation requires HMOs to hold consumers harmless when they receive ER services or when in-network providers are unavailable for medically necessary covered services; proposed HMO regulations reflect this interpretation. Tex. Insur. Code §§ 1271.055 and 1271.155; see proposed regulation 28 Tex. Admin. Code § 11.1611(e). For EPOs, Texas rules require the EPO to hold the enrollee harmless when an insured cannot reasonably use a preferred provider; regulators interpret this to include surprise billing situations. 28 Tex. Admin. Code § 3.3725.

[g] Texas requires PPOs and EPOs to have a disclosure stating that consumers may be entitled to have their services paid at in-network rates if their reliance on an inaccurate provider directory causes them to go out of network. For EPOs, the disclosure statement states that if a consumer goes out of network because an in-network provider is unavailable or the consumer received out-of-network ER care, "the insurer, must, in most cases resolve the non preferred provider's bill." Tex. Admin. Code § 3.3705 (f)(1) and (f)(2). Texas rules further require the EPO to hold the enrollee harmless when an insured cannot reasonably use a preferred provider. 28 Tex. Admin. Code § 3.3725.

Cross-Cutting Issues

Several issues arise out of the experiences observed in the seven study states. These provide potential lessons for other states that may be considering regulatory approaches.

Protecting Consumers. Other than in Texas, stakeholders report that state balance billing legislation has been reasonably effective in keeping consumers out of the middle of disputes between non-network providers and health plans over the correct level of payments. While protections exist in Texas, there has been disagreement among stakeholders over the effectiveness of the protection. Also because Texas law has neither a ban on balance billing nor a hold harmless provision for PPOs, it does not offer consumers the same degree of protection as provided in other states. By contrast, in New Mexico, which lacks a balance billing statute, consumers have been protected because of market dynamics that have generally encouraged broad networks and insurer practices that include paying full billed charges when necessary. The steps taken recently by United Healthcare in Missouri, however, show the limits of private actions to protect consumers.[55]

Even in the states with laws in place, however, there are noteworthy gaps. As noted, some states have segments of the insurance market (e.g., PPOs in Florida or some PPOs in California) in which the rules do not apply. And no state has the ability to address coverage that is self-funded by employers or unions because these insurance arrangements are regulated exclusively under federal law.

Emergency Versus Surprise Billing Settings. There appears to be a greater consensus about protecting consumers from balance bills in emergency situations (Scenario 2) than for other surprise billing situations (Scenario 3). This result is not unexpected since consumers have the least control in medical emergencies. Even if the consumer goes to the emergency department of a network hospital,[56] he or she has essentially no control over whether the physicians or other providers who provide treatment in the emergency department are in the plan's network. The surprise bill settings identified in Scenario 3, however, are starting to attract more attention from policymakers. Legislation in New York specifically addresses surprise billing situations, and California legislators are considering an extension of protections to these situations.[57]

Both Maryland and New York have created a linkage between assignment of insurance benefits and restrictions on balance billing (applying to any surprise billing situations in New York and to some PPO billing disputes in Maryland). In part, this was a political compromise whereby physicians obtained an easier means of payment through assignment in exchange for agreeing not to balance bill, while insurers consented to assignment to help protect their members from getting caught in the middle of a billing dispute. Maryland stakeholders are generally satisfied with how this limited protection has worked to date, and New York stakeholders seem cautiously optimistic.

Balancing Interests of Insurers and Providers. The difference between a direct ban on balance billing by providers and requirements on insurers to hold their plan members harmless mainly revolves around which stakeholders are at financial risk. Under hold harmless rules, the insurer is at risk for paying whatever the provider charges. Under balance billing bans, the provider is at risk for accepting an amount less than the amount billed—or even an amount the provider considers reasonable. To the extent that either stakeholder is dissatisfied with the process, there is a greater chance that consumers can get caught in the middle despite the protections built into law.

To balance the interests of all stakeholders, several states have either incorporated stronger approaches to setting rates or included a dispute resolution process. A state requirement that plans pay based on their own usual and customary rates, without more specific rules, leaves the insurers with greater leverage. The Maryland approach provides enough specificity so that most stakeholders believe that the system works well enough. Providers had previously raised concerns that insurers sometimes took advantage of loopholes to keep payments low, but they have been alleviated somewhat by statutory adjustments to the payment formula. Maryland's reliance in part on historical payment rates may sometimes disadvantage certain insurers, but these situations seem uncommon.

One Maryland insurer reports a clear preference for having a set rate for payment rather than the uncertainty that may occur under New York's greater reliance on dispute resolution. But New York stakeholders believe that their approach will work for them. One physician stakeholder emphasizes that a formula fails to recognize

that physicians have different abilities and charge histories. Although New York does not require that payments be based on the usual and customary rates calculated by an independent entity (Fair Health), those rates could become something of a "safe harbor" in practice, especially if the IDR process relies heavily on this standard.

The Role of Mediation and Dispute Resolution. Mediation or dispute resolution processes have a mixed record to date in California and Florida. Regulators in Florida indicate that the potential cost to participate for providers is a barrier, particularly if they are unsuccessful. In California, regulators reported that insurers have little incentive to participate because balance billing is already prohibited for emergency services.

While the IDR process in New York became effective in April 2015,[58] some stakeholders hope that the threat of its use and the procedure for selecting the amount ultimately paid to the provider will convince both providers and insurers to charge or pay at more reasonable levels. They suggest the IDR will be a success if health plans and providers use the process infrequently. One stakeholder compared the IDR to the binding arbitration model that Major League Baseball uses today, which succeeds by encouraging "bids" that are close enough together to encourage voluntary settlements in advance of arbitration.

By contrast, stakeholders in Texas suggest that requiring consumers to initiate the dispute resolution process poses an overly high barrier to its use, even if the current $1,000 threshold were lowered. Overall, the success of a mediation or dispute resolution process appears to depend both on who initiates the process and the cost of using the process. Low use of a dispute resolution process may signal success if it creates an incentive for health plans and providers to negotiate or accept rates that are viewed as reasonable.

Disclosure and Transparency. Most of our study states have made some provisions to improve consumer disclosures. Disclosure provisions may be used in lieu of more direct protections (PPOs in Texas) or to complement other measures (New York). But it remains an open question how much value consumers derive from disclosure rules. One consumer advocate suggests that disclosure rules can yield good information, especially if it means more accurate and easy-to-use provider directories; however, she thinks that disclosure does little to protect consumers from balance billing. At best it helps a small subset of consumers who take an active role in reviewing their disclosures. At worst and more likely, as some respondents note, it is one more piece of paper that consumers receive when they have a health care encounter, without improving their understanding of the financial implications of receiving in- versus out-of-network care. At the same time, transparency provisions in Texas have encouraged data disclosures that have proved valuable for advocates and journalists who use the data to identify and highlight problem areas.

Plans have an interest in making sure their members know which providers are in the network, but insurers' track record of providing this information has been mixed at best.[59] Some insurers report taking steps to improve how they provide information. One health plan highlights its efforts to use care managers to alert members which specialists are in network when they schedule care—information that is useful because it arrives at a time when the member is seeking out new providers.

Impact on the Market. The market environment is critical because it creates a context for how states approach consumer protection relative to balance billing. The design of provider networks vary, in part because the supply, distribution, and expertise of providers vary from state to state, as do the concentration and market leverage of health insurers. In New Mexico, one stakeholder suggests that the need for state protections is minimal because there are few non-contracted providers in the state. In other words, most plans have contracts with most providers. But in many states, this is not the case.

The presence of non-network physicians and other providers in network hospitals has been documented in Texas, but occurs in other states as well. In some markets, insurers may have the leverage to encourage or require participating hospitals to guarantee that all of their clinicians contract with the network. But in many markets, physicians or other providers have enough market power to block these efforts. In our stakeholder interviews, we heard about specialist physicians (e.g., anesthesiologists) and other providers (e.g., surgical assistants) who frequently avoid contracting with insurer networks. Some stakeholders express concerns that balance billing restrictions might interfere with negotiations over networks. For example, a hold harmless provision might encourage providers to stay outside the network since they would likely get paid at higher rates (i.e., their full charges or a regulated rate) if they decline to participate in a plan's network.

Narrow Networks. In recent years, insurers have changed the designs of their provider networks, and many are offering narrower networks.[60] These changes may lead

more people to use out-of-network providers and thus may increase the likelihood of balance billing. While most respondents indicate that there were no documented trends in that direction, there have been anecdotal reports linking balance billing to narrower networks. The trend could increase the likelihood of surprise billing situations, in which non-network providers are delivering services in network hospitals or in which patients are referred to non-network specialists. It could also lead to more situations in which network providers are unavailable (either because of gaps in a network or because network providers are not taking new patients). Furthermore, the use of narrower networks could influence the willingness of health plans and providers to protect consumers in the absence of legal remedies.

Politics of Balance Billing Legislation. Passing meaningful consumer protection legislation can be challenging, particularly since legislators must balance the interests of insurers, providers, and consumers. Although all stakeholders may agree that consumers should not be caught in the middle of payment disputes between insurers and providers, they tend to disagree on how to implement that protection. Both the degree of market concentration and the political clout of providers and health plans can influence the ability of states to pass legislation to protect consumers. Some stakeholders suggest that the political clout of Texas physicians has been a factor in the more modest approach taken there. Similarly, in the 2015 Florida legislative session, a subcommittee of the Florida House of Representatives reported out a bill that would have extended the prohibition on balance billing in emergency settings to PPOs. The bill would have also modified the payment standard to the greater of the negotiated amount, the in-network amount, or the Medicare allowable amount.[61] The bill, however, was not enacted. Although supported by the insurance industry it was opposed by the Florida Medical Association. The Colorado Medical Society was also instrumental in convincing a state Senate Committee to postpone legislation that would prohibit out-of-network providers at in-network facilities from balance billing.[63]

The comprehensive approach taken in New York, which tried to balance all stakeholder interests, will be tested as implementation proceeds. Accompanying issues, such as the desire of physicians to be paid on assignment when out of network or the desire of health plans to take their plan members out of the crossfire, can encourage agreement on legislation initiatives. Similarly, publicity over the growth of narrow networks and a push to address network adequacy in legislation may raise the related issue of balance billing.

Conclusion

Only a few states have acted through regulations or legislation to protect consumers against the unexpected charges that result when providers send balance bills to their patients. Even those states enacting protections typically limit their scope to scenarios in which consumers have limited control: in hospital emergency departments and when treated by a non-network provider while in an in-network facility. The states studied for this report took varied approaches but shared the goal of ensuring that consumers are not liable for charges that are mostly outside their control. But the approaches have different levels of effectiveness. The most effective protections appear to share two common elements. First, they do not require active intervention by the consumer. Second, they have a mechanism, acceptable to both plans and providers, for determining the amount of payment. Many consider New York's new law to be the most comprehensive approach in this domain; it will thus be important to monitor its impact.

The necessity of state remedies may be mitigated when the market environment encourages plans and providers to resolve bills from non-network providers without involving the consumer. But publicity over surprise balance bills can place this issue squarely on the political agenda and put pressure on stakeholders to find some common ground. Once a law or regulation is in place, states often return to the issue to address gaps or solve unresolved issues. Most states in this study with laws or regulations on the books (California, Colorado, Florida, and Texas) are or were considering bills in the 2015 legislative session to expand existing protections.[64] As seen from these examples, it may be easier to enact additional incremental measures after taking some initial steps, although this does not always guarantee success as seen recently in Florida and Colorado.

The evolution of provider networks may increase pressures on states to address balance billing. Colorado includes network inadequacy as one trigger for requiring plans to hold consumers harmless when using a non-network provider in a network hospital; other states may consider such approaches in the future. Conversely, state efforts to address network adequacy can help to reduce opportunities for unexpected bills. If there are a greater number of situations in which network providers are unavailable to provide care in emergency departments at network hospitals or in which patients must obtain needed care out of network, more consumers could feel the financial sting of surprise balance bills. The financial harm they may face is exacerbated because the amounts they pay for balance bills are not typically counted toward either deductibles or annual out-of-pocket maximums.[65] The promise of financial security in the Affordable Care Act could be called into to question if we see large increases in balance billing.

Endnotes

1 A balance bill is in addition to amounts owed by the patient in cost sharing under the terms of the insurance contract.

2 We looked at this issue previously in a 2009 policy brief; this brief draws on that earlier effort. Hoadley J, Lucia K, and Schwartz S, *Unexpected Charges: What States Are Doing about Balance Billing*, California HealthCare Foundation, April 2009.

3 Rosenthal E, *After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know,* New York Times, September 20, 2014; Pollitz K, et al., *Medical Debt among People with Health Insurance,* Kaiser Family Foundation, January 2014.

4 Traditional Medicare does not involve a provider network. In addition, Medicare has provisions that prohibit balance billing in most situations. In the few cases in which balance bills are permitted, they are limited to a small share of the amount paid by Medicare.

5 Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey,* September 10, 2014. Available at http://kff.org/report-section/ehbs-2014-section-five-market-shares-of-health-plans/.

6 Ambulance services may also fall under this scenario.

7 Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans,* Center for Public Policy Priorities, September 15, 2014.

8 McDevitt R., et al., *Financial Protection Afforded by Employer-Sponsored Health Insurance: Current Plan Designs and High-Deductible Health Plans,* Medical Care Research and Review 64(2):212-228, April 2007.

9 Also, about half of consumers with out-of-network encounters reported a lack of cost transparency (they reported they did not know how much they would have to pay for the service). Kyanko K, et al., *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?* Health Services Research 48(3):1154–1172, June 2013.

10 Corlette S, et al., *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care,* Robert Wood Johnson Foundation, May 2014; Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy,* Robert Wood Johnson Foundation, September 2014.

11 The Public Health Service Act (PHS Act) section 2719A, amended by the Affordable Care Act, generally provides, among other things, that if a group health plan or individual health plan provides benefits for emergency services, an insurer must provide coverage for such emergency services without regard to whether the health care provider is in-network. Insurers generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. The statute, however, does not require insurers to cover amounts that out-of-network providers may "balance bill." Current regulations at 29 C.F.R. §2590.715-2719A; 45 C.F.R. § 147.138 set forth minimum payment standards to ensure that a plan does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient. See also Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight, *Affordable Care Act Implementation FAQs – Set 1.* Available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.

12 29 C.F.R. §2590.715-2719A (b)(3)(i)(A) to (C) and 45 C.F.R. § 147.138 (b)(3)(i)(A) to (C).

13 Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees.* Available at http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/.

14 In this project, we did not conduct a 50-state survey of state laws. Two available sources for state laws are American Health Lawyers Association, 3 Health L. Prac. Guide Appendix B-2: State Law Charts (2014) and Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees.* Available at http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/. These sources are not fully consistent on interpretations of state laws.

15 *See* Kaiser Family Foundation, *State Restriction Against Providers Balance Billing Managed Care Enrollees.* Available at http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/.

16 Employee Retirement Income Security Act, § 514.

17 Some plans participate in a Multiplan agreement that acts like a supplemental provider network. Participating providers agree to accept amounts from a network fee schedule as payment in full and do not send balance bills. Plans agree to base their payments on the network fee schedule, which may be higher than fees paid to providers in their own network.

18 Shapiro J, *Policy Shift by Nation's Largest Insurer Could Leave Some with Unexpected Bills,* St. Louis Post-Dispatch, March 30, 2015.

19 Cal. Code Regs. tit. 28, § 1300.71.39 (2014). The policy was established through a regulatory interpretation of the Knox-Keene Act by the California Department of Managed Health Care (DMHC). It was challenged in court by providers, but was affirmed unanimously by the California Supreme Court. Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, 45 Cal. 4th 497 (Cal.), Jan. 8, 2009.

20 Wilson K, *California Health Insurers: Brink of Change,* California Healthcare Foundation, February 2015. Available at http://www.chcf.org/publications/2015/02/california-health-plans-insurers.

21 DMHC also has the authority to enforce its regulations. *See* Cal. Code. Regs. tit. 28 § 1341. Recently, the agency reached a settlement with a group of emergency department physicians for sending illegal balance bills to 324 patients. *See* California Healthline, *DMHC Issues Fines Against Several Health Care Organizations,* March 26, 2015. Available at http://www.californiahealthline.org/articles/2015/3/26/dmhc-issues-fines-against-several-health-care-organizations.

22 Cal. Code Regs. tit. 28, § 1300.71 (2015).

23 California DMHC, *Independent Dispute Resolution Process (IDRP)*. Available at https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/IndependentDisputeResolutionProcess.aspx#.VW-Ces9Viko.

24 One area of complaints has been hospital-based specialists.

25 Colo. Rev. Stat. § 10-16-704 (3)(a)(I). Colorado also requires insurers to allow members to assign benefits to out-of-network providers. Colo. Rev. Stat. § 10-16-106.7.

26 By federal law, high-deductible plans (HDHP) under health savings accounts (HSAs) cannot have deductibles less than $1,300 for self-coverage and $2,600 for family coverage. Insurers are not permitted to start paying for covered benefits unless the consumer has met the deductible for the plan year (excludes preventive services). *See* IRS Publication 969, *Health Savings Account and Other Tax-Favored Health Plans*, 2014.

27 Fla. Stat. Ann. § 641.513 (West 2014).

28 Fla. Stat. Ann. § 641.3154 (West 2014).

29 Fla. Admin. Code r. 59A-12.030 (2014).

30 MD. Code Ann. Health-Gen. §§ 19-710(p); 19-710.1 and 19-712.5.

31 MD. Code Ann. Insurance §§ 14-205.2 and 14-205.3.

32 MD. Code Ann. Insurance § 14-205.3. This provision does not apply to hospital-based or on-call physicians.

33 The bill was scheduled to sunset in 2015, but a measure removing the sunset date became law on April 14, 2015.

34 MD. Code Ann., Health-Gen. § 19-710.1, MD. Code Ann. Ins.-Gen. § 14-205.2 (West 2015).

35 MD. Code Ann., Health-Gen. § 19-710.1 (West 2015).

36 MD. Code Ann. Insurance § 14-205.3 (West 2015).

37 N.Y. Fin. Services Law §§ 601 to 608 (McKinney 2015); N.Y. Comp. Codes R. & Regs. tit. 23 § 200 (2014). Since the cycle for many insurance contracts is January to January, the effective date of the new policies for many consumers will be January 1, 2016.

38 N.Y. Fin. Services Law §§ 603 and 606 (McKinney 2015).

39 N.Y. Fin. Services Law § 607 (McKinney 2015). FAIR Health was created after the state's attorney general uncovered potential conflicts of interest in the methods that health insurers were using to determine reimbursements to patients who received care from providers outside their health plans' networks. Settlement agreements with New York insurers focused on bringing fairness and transparency to the out-of-network reimbursement system. FAIR Health maintains a database of charge data for medical procedures and website designed to help consumers estimate charges for health care services. Insurers use the data to help determine reimbursement rates for out-of-network claims.

40 N.Y. Fin. Services Law § 607 (McKinney 2015).

41 N.Y. Pub. Health Law § 24 and Insur. Law § 3217-a (McKinney 2015).

42 N.Y. Insur. Law § 3217-a (McKinney 2015).

43 N.Y. Pub. Health Law § 24 (6) and (7) (McKinney 2015).

44 N.Y. Pub. Health Law § 24 (1) and (2) (McKinney 2015).

45 N.Y. Pub. Health Law § 24 (4) (McKinney 2015).

46 Tex. Insur. Code § 1271.00 and 1271.155 (2015); proposed regulation 28 Tex. Admin. Code § 11.1611. The language in the proposed regulation covers "circumstances where an enrollee cannot reasonably reach a network provider, including circumstances where an enrollee is not given a choice between network and non-network providers when receiving care at a network facility." *See* Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans*, Center for Public Policy Priorities, September 15, 2014, noting confusion about the Texas HMO law.

47 Pogue S and Randall M, *Surprise Medical Bills Take Advantage of Texans*, Center for Public Policy Priorities, September 15, 2014.

48 28 Tex. Admin. Code § 3.3725.

49 28 Tex. Admin. Code § 3.3705 (2015).

50 28 Tex. Admin. Code § 3.3705 (2015).

51 28 Tex. Admin. Code § 3.3705 (2015).

52 28 Tex. Admin. Code § 3.3705 (2015).

53 28 Tex. Admin. Code § 3.3708 (2015).

54 Tex. Ins. Code Ann. § 1467.051 (West 2015); 22 Tex. Admin. Code §§ 187.85 to 187.89.

55 Shapiro J, *Policy Shift by Nation's Largest Insurer Could Leave Some with Unexpected Bills*, St. Louis Post-Dispatch, March 30, 2015

56 In the event that a patient arrives at a hospital that is not in the insurer's network, stakeholders report that the insurer typically negotiates a rate with the hospital for its services. Historically, these situations arise less often than encounters with out-of-network physicians and other providers. But as narrower networks are employed by insurers, they may arise more often in the future.

57 *See* A.B. 533 (Bonta), 2015-2016 Gen. Assembly, Reg. Sess. (Ca. 2015).

58 Because the law became effective mid-year, it will only applies immediately to consumers with new health plans or health plans that renew on or after April 1, 2015. The majority of consumers will have to wait until their health plans renew, i.e., January 1, 2016.

59 *See* Tahir S, *Why Can't Insurers Publish Accurate Provider Directories?* Modern Healthcare, December 13, 2014. Available at http://www.modernhealthcare.com/article/20141213/MAGAZINE/312139963; Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy*, Robert Wood Johnson Foundation, September 2014.

60 Corlette S, et al., *Implementation of the Affordable Care Act: Cross-Cutting Issues: Six-State Case Study on Network Adequacy*, Robert Wood Johnson Foundation, September 2014.

61 H.B. 681, 2015 Leg. Sess. (Fl. 2015).

62 Sexton C, *House Panel OKs Balance Billing Ban, Sponsor Says Unlikely to Pass this Year*, Saint Petersburg Blog, April 9, 2015. Available at http://www.saintpetersblog.com/archives/225230.

63 Colorado Medical Society, *SB 259 Provider Out-of-Network Legislation Defeated*, April 21, 2015. Available at http://www.cms.org/communications/sb-259-provider-out-of-network-legislation-defeated.

64 A.B. 533 (Bonta), 2015-2016 Leg. Sess. (Ca. 2015); S.B. 15-259, 2015 Gen. Assembly, Reg. Sess. (Co. 2015); H.B. 681, 2015 Leg. Session (Fl. 2015); H.B. 3102, 84th Leg., Reg. Sess. (Tx. 2015); H.B. 1638, 84th Leg., Reg. Sess. (Tx. 2015); S.B. 481, 84th Leg., Reg. Sess. (Tx. 2015).

65 One law professor has argued that network adequacy rules under the Affordable Care Act could be used to require exchange plans to contract with emergency department physicians at all network hospitals or that state insurance commissioners could apply such a policy for plans under their jurisdictions. Bagley N, *What Should the Law Do about Out-of-Network ER Docs?* The Incidental Economist, September 29, 2014. Available at http://theincidentaleconomist.com/wordpress/what-should-the-law-do-about-out-of-network-er-docs/.

Acknowledgements

The authors would like to thank the various stakeholders interviewed for this project and are especially appreciative of the generous help provided by the state regulators who detailed the legislative and regulatory environment in their states. Thanks also to Sabrina Corlette for her thoughtful review and suggestions and to Mason Weber for his research support.

The Center on
Health Insurance Reforms
Georgetown University Health Policy Institute

Georgetown University Health Policy Institute
3300 Whitehaven Street, N.W., Suite 5000
Box 571444
Washington, DC 20057
Telephone (202) 687-0880
http://chir.georgetown.edu/