**Memorandum**

**To:** Board of Directors

Council Officers

**From:** Michael A. Granovsky, MD, CPC, FACEP

Chair, Reimbursement Committee

Alison Haddock, MD, FACEP

Chair, State Legislative/Regulatory Committee

**Date:** April 1, 2016

**Subj:** Assisting chapters in effectively addressing balance billing prohibition legislation

**Recommendation**

That the Board of Directors approve “Strategies to Address Balance Billing and Out of Network (OON) Benefits for Professional Emergency Care Services” (Attachment A) and “Situation Report: Balance Billing Legislation” (Attachment B).

**Background**

The Reimbursement Committee and State Legislative/Regulatory Committee submit these documents for the Board’s consideration as part of their objectives to work together to assist chapters in advocating for legislative solutions to address fair payment and restrictions on balance billing.

The Reimbursement Committee, working in concert with the Joint Task Force with EDPMA, developed “Strategies to Address Balance Billing and Out of Network (OON) Benefits for Professional Emergency Care Services,” which is intended to provide chapters with strategies to help them enact favorable legislative language related to out-of-network payments. The EDPMA Executive Committee met via conference call on March 9th and recommended adoption of this document by the full EDPMA Board of Directors during its April 30th meeting.

The State Legislative/Regulatory Committee developed “Situation Report: Balance Billing Legislation” to provide an overview of state legislation related to out-of-network billing. The report includes background information on balance billing legislation along with details of current relevant laws and pending legislation in numerous states. The report is intended as a living document, and is currently being reviewed and updated by chapter executives and chapter presidents. The report will then be updated by staff periodically.

The Reimbursement Committee and the State Legislative/Regulatory Committee will continue to work together on this issue. In conjunction with the Joint Task Force, additional resources are being developed to include in a “toolkit” that will further equip chapters dealing with legislative efforts related to out-of-network payments. These two documents are the initial pieces of that toolkit. Upon approval by the Board, and upon receiving and incorporating chapter feedback to the state legislative report, the documents will be distributed to the chapters.

**Prior Board Action**

None.

**Fiscal Impact**

None beyond budgeted funds for development and distribution.

1. **Purpose:** to assist and inform ACEP, ACEP state chapter and EDPMA leadership regarding OON reimbursement challenges and threats, and to assist state leaders who may propose or may need to respond to proposed balance billing / OON benefit legislation in 2016 and beyond.
2. **Role of ACEP and EDPMA, state chapters, and local “boots on the ground”.**When faced with proposed legislation or regulations to address balance billing in a particular state, the importance of boots on the ground advocacy at the ACEP chapter level cannot be overstated.  Advocacy by individual members and by chapter-sponsored legislative advocates and consultants, if available, especially when built on established relationships with legislators and regulators, is the key to either killing or modifying or proposing legislation or regulation addressing balance billing, just as it is for most other issues important to local emergency care providers.  This document and other ‘tools’ provided by ACEP and EDPMA to address balance billing can be used by local chapter leadership and advocates to assist in developing and implementing strategies, public information campaigns, and legislative or regulatory language, either in response to efforts to restrict balance billing or to take advantage of opportunities to propose solutions to the balance billing / fair payment issue.  There are risks to engaging in either type of strategy, and discussions around these issues should not be undertaken lightly and without careful planning and thorough investigation.  Some state chapters, like California, have even established advocacy funds to support these efforts. Given what appears to be a national campaign by health insurance companies to restrict balance billing and undermine fair payment for emergency care services, the ‘ostrich defense’ is probably not an effective strategy.  Though each Chapter must ultimately decide how to achieve the best outcome for their membership, we can learn from those who came before and from their experiences in addressing these issues—what did they do, what might they have done differently and where they ended up are critically important for all who face these issues this year and beyond.  Material provided in this document and others in the toolkit provide a wide window on these prior experiences in other states, and ACEP and EDPMA can also assist Chapters in identifying national experts on these issues who may be able to provide further assistance.
3. **Recommendations and Strategy**: that critical terms be defined in legislation and/or any regulatory language to avoid confusion. Critical terms to be defined:
   1. **Provider’s Usual and Customary Charge**: the charges that ED and ED on-call specialty physicians and advanced practice providers (APPs) (collectively, “Providers”) routinely bill for their services regardless of payor involved and before any discounts that could apply pursuant to charity or indigent patient charge policies or health plan contracting discounts; also sometimes referred to as the Provider’s Actual Charge. Absent other considerations (e.g., in network services) the usual and customary charge constitutes the Provider’s total expected payment for a service. Note: avoid the terms “usual, customary and reasonable charges or amounts”: also known as the “UCR”, this concepts dates back to when Medicare reimbursed physicians (in the pre-physician fee schedule days) on a percentage of their UCR. Health plans like to include the word “reasonable” to the “usual and customary” term to permit them to determine, in their sole discretion, if the charges are reasonable or not. As was stated recently in the CCIIO explanation for the final rule, the health plans would like to move the definitions away from “usual and customary charges” to “usual and customary amounts”. By shifting the focus away from what Providers charge to all patients and payers regardless of health plan or status—their “usual” and “customary” charges—the health plans again introduce unilateral judgment over how the “usual and customary amount” for a particular service should be determined. In short, Providers do not know the “amounts” for other providers—only the health plans know the amounts for other providers—and the substitution of “amounts” for “charges” reflects that the health plans seek that determination of “reasonable amounts”.
   2. **In network services:** services provided to ED patients where the ED and ED on-call Providers have contracted with the health plan, usually at a discount to their usual and customary charges, if a discount is applicable then the Provider’s now reduced usual and customary charge is sometimes referred to as the Provider’s Allowed Charge and/or constitutes the Provider’s contractually adjusted total expected payment for a service.
   3. **“Guarantor”:** the person who is financially responsible for the professional services rendered to the Patient; while the guarantor is usually the Patient, when the Patient is a minor, the Guarantor is the minor’s parent or guardian; for ease of discussion, we will assume here that the Patient and Guarantor are one in the same.
   4. **Patient Deductible:** the patient’s financial responsibility for the ED Provider’s charges that is applied to the usual and customary charges before applying either co-insurance or co-payments; for example, a $1000 charge with a $700 allowable and $500 deductible would result in $500 of the charges applied to the deductible (patient responsibility), $140 applied to co-insurance ( presuming 20% of $700) (patient responsibility), $60 paid by the plan, and the $300 remainder would be billed to the patient as a “balance bill” if the provider was OON and balance billing of the claim was not restricted by state law. The deductible amounts are defined in the patient’s insurance agreement with his/her respective health care plan.
   5. **Patient co-insurance:** the percentage of the charge that enrollees are financially responsible for paying to the ED Providers; for example, in Medicare Part B, the patient’s co-insurance, after applying the deductible, is 20% of the Medicare allowable, e.g. $1000 charge, $800 Medicare allowable and the patient’s co-insurance is $160, or 20% of the $800. Co-insurance terms are defined in the patient’s insurance agreement with his/her respective health care plan.
   6. **Patient co-payments:** co-payments are also the patient’s responsibility for professional services received from the ED Providers and may be stated as a percentage, as in the case of co-insurance, or may be stated as a flat rate for ED services on the patient’s insurance card, e.g. $50 co-pay for ED services. Co-payments are sometimes paid to and collected by the facility at the time of service. Co-payment terms are defined in the patient’s insurance agreement with his/her respective health care plan.
   7. **Patient Cost Sharing:** this term is used in the Affordable Care Act (ACA) to generally describe the combination of the patient deductible, co-insurance and co-payments or those amounts that are the responsibility of the patient for ED services. This term is usually not applied to an “OON balance bill”. (see below)
   8. **In Network Billing of Patient Cost Sharing:** the amount of the patient financial responsibility that is provided for in the contract between the ED Providers and the health plan that may include the patient deductible, co-insurance and/or co-payments.
   9. **Out of network (OON) services:** ED professional services provided to patients where the ED Providers are out of network or non-contracted with the patient’s health plan. Pursuant to the patient’s health insurance policy, the co-insurance percentage for elective OON services is generally greater than for in network services, but per the ACA, patient cost-sharing for emergency care must be the same for in- and out of network services. Some health plans specify different benefit amounts for in network and OON services. If the benefit amount is less, the patient in turn is responsible for a greater portion of the unpaid balance after the OON allowable is applied. Some states restrict the right of the ED Providers to bill the patient for the remaining balance of the charges after the OON allowable and patient cost sharing are applied.
   10. **Health Plan OON Allowable**:  the benefit amount that the health plan believes is the ‘reasonable value' of the service rendered by an out-of-network provider.  This benefit amount may be less than the benefit that the health plan will allow for in network service.  Some plans may use this lower OON benefit as an incentive for patients to utilize in network providers.  In certain OON circumstances, health plans may refuse to recognize the patient’s signed “assignment of benefits” to the provider, and send the OON allowable benefit amount (less coinsurance and deductible payments) to the patient instead of directly to the provider.  Plans may use both tactics to try to coerce providers to contract with the plan.  Plans should honor assignment of benefits, and base their OON benefits on providers' usual and customary charges for these services.  Since contracted providers discount their services to the plan in exchange for contract considerations, like faster payment; plans should be paying a higher, not a lower, benefit for OON services.
   11. **OON Balance Billing:** the amount of the ED Provider’s actual charge that remains after the health plan determines the OON allowable and patient cost sharing. For example, assume a Provider’s $1000 actual charge and the health plan’s OON allowable is $450. The patient would be responsible for paying the “balance bill” or a total of $550. If the patient’s co-insurance payment for the ED provider’s services is 20% of $450 or $90, and the plan pays $360 ($450 OON allowable less the $90 co-insurance). Then the Actual Charge ($1000) minus the Patient’s cost sharing (co-insurance of $90) leaves $640 ($1000 charge less the OON allowable of $360) as the OON balance billing amount. Although the $90 co-insurance payment can be billed, certain states restrict the right of the ED Providers to bill the $550 balance and would require that this balance be written off. If the same facts above but the patient was in network, the issue of OON balance billing usually doesn’t arise due to prospective contractual adjustment arrangements between the health plan and the Provider.
   12. **Alternative Dispute Resolution (ADR)** Sometimes referred to as Independent Claims Dispute (IDR): generally refers to mediation or arbitration of claims disputes that are generally conducted outside of a formal court process but may be in conjunction with the courts; mediation is generally per an agreement of the parties, e.g. by contract, and is non-binding; arbitration, in contrast, is subject to more formal rules and is generally binding and enforceable by contract and maybe in the courts.
   13. **Medicare Physician Fee Schedule (MPFS):** the fee schedule modified and published annually by CMS for ED professional services that are subject to multiple federal statutes and regulations and budgetary constraints that have an impact on the changes in the fee schedule year to year.
4. **Legislative Provisions:** If there is a likelihood of legislation that would impact balance billing, the following are provisions that should be common to all OON legislation for ED services:
5. State laws should define an acceptable minimum (or interim) benefit standard (MBS) for OON ED Provider services.
   * 1. The MBS issue should be addressed in any future potential legislation that a state may consider in limiting OON balance billing: for example, NY’s law provides that the health plan may reimburse the OON ED providers at whatever the health plan determines to be reasonable. Whereas effective June 1, 2016, the new CT law requires an MBS of 80th percentile of charges *“…as reported in a benchmarking data base maintained by a nonprofit organization specified by the Insurance Commissioner.*” In exchange for the MBS at the 80th percentile of charges, CT has essentially banned OON balance billing for ED services by the group or their revenue cycle management (RCM) partner.
     2. **CT’s MBS is good, but with an Important Caveat on the CT law:** If one were writing on a blank slate in a state where there is no OON balance billing limitation, there are features of the CT law that should be avoided. CT law also has the following provisions which are potentially a hidden trap for groups doing their own billing and for RCM companies; while this is not a criticism of CT leaders or providers who may have had to negotiate the favorable “80th percentile” provisions above in exchange for the following, other states should not lead or offer the following provisions unless required to do so to obtain the favorable “80th percentile” provisions;
     3. CT law makes billing the OON patient for anything other than the patient’s cost sharing for OON services an “unfair trade practice”; as such, under most state laws, treble damages, attorney fees and/or possible class action status could result if a claim mistakenly was billed for the OON balance bill;
     4. Likewise, CT law makes it an unfair trade practice to report a patient to the credit bureau for their failure to pay an OON balance bill.
     5. Alternatively, a Bill that contains some form of penalty for violation of a balance billing prohibition may have more credibility for legislators, and something like the following might be acceptable: “A guarantor (e.g. enrollee) who is billed by a hospital-based physician in violation of this section may report receipt of the bill to the Plan and the Department of Insurance. A Plan that becomes aware that one of its enrollees has been billed in violation of this section shall also report that violation to the Department. The Department shall review all such reports, and forward those that are determined to be violations of this statute to the Medical Board of (State), which have sole authority to enforce this section. The Medical Board shall take appropriate action against a hospital-based physician upon a determination that the physician has violated this section, up to and including the issuance of a written warning, a cease and desist order, or other actions as the Board deems appropriate.
     6. While the suggestion above creates a downside for non-compliance by the physicians, it avoids the “I got you” aspects of the CT law around the “unfair trade practice” issues that could trigger significant legal costs and unwarranted contingent legal exposures.
     7. ED providers should advocate **for the MBS to be the lesser of:**
   1. the provider’s usual and customary charges, or
   2. The 80th percentile of Fair Health (FH) or the 80th percentile of the usual and customary charges derived from ED claims submitted to the state Medicaid program, POS 23, with an annual inflation index update.
   3. The Association of Health Insurance Plans (AHIP) estimates that the average ED provider charges for CPT 99285 is approximately 552% of Medicare based on their analysis of the FH database of claims.
   4. Legislation or regulations that link OON reimbursement to the MPFS or a percentage of the Medicare fee schedule should be avoided and rejected for non-Medicare patients.
6. ADR should be conducted by qualified professionals with healthcare claims experience and resolved in no less than 30 days after submission of the dispute for ADR.
   * 1. The issue is the financial burden to a small to medium sized group who could have significant numbers of claims tied up in ADR.
     2. Claim presenting common issues of fact and/or law can be bundled together and adjudicated in one ADR process, e.g. CPT 99285 chest pain cases claiming that the OON reimbursements by the health plans are unfair and/or unreasonable. The presumption in the law should be for bundling of all similarly situated claims into one ADR process.
     3. Also the ADR process should be “per CPT code” and not “per ED visit or encounter”. Both TX ($500) and NY ($600) have dollar thresholds where the patient, plan or provider may request ADR; if the ADR process is tied to “per visit” then lower level E/Ms with procedures, e.g. Level III with a head laceration repair, could be swept up into the ADR process and impact a larger percentage of small groups accounts receivable.
     4. If adjudication takes additional time, there should be a mechanism for the ED group to file for interim payment subject to a true up based on the ADR findings.
     5. Terms such as “baseball styled” ADR may have common meaning for some but do not assume such terms are understood to mean the same thing to all parties. Define how the ADR is to proceed in rule-making with an emphasis on “non-lawyer” dominated ADR—having lawyers drive the ADR process will slow it down and cost more. Examples of a lawyer dominated ADR could include the MAXIMUS ADR process in Florida that has existed for a couple of decades or more—providers and regulators agree that MAXIMUS process is counter-productive and broken.
     6. ADR should be based on the “British Rule”: the loser can be ordered to pay the attorney’s fees, if any, and costs of the ADR based on discretion of the adjudicator. Requiring a minimum or interim benefit standard ensures that the risk of having to pay for ADR does not fall more heavily on either the plan or the provider.
     7. ADR may also be needed to address issues of code bundling and down-coding which plans may use to recoup losses from having to pay a MBS.
7. Health plans should be prevented in state legislation (if not currently existing) from including false, misleading and/or confusing information in their explanation of benefits (EOBs) to patients, and must be held accountable for responding in a timely fashion to claims payment disputes.
   * 1. The issue is that health plans have in the past used misleading statements in their EOBs to patients for OON reimbursements, claiming that they have paid “XX%” of Medicare and have paid the providers fairly or the “usual, customary and reasonable” payment.
     2. The plans have instructed patients to involve the plans if the patients are in turn sent an OON balance bill and that the plans will address issues with the providers.
     3. When providers attempt to engage health plans, the plans indicated that providers are OON and the plans will not communicate with the providers or their representatives.
     4. ACEP has, with the support of an ED group, challenged and successfully settled disputes with the health plans over misleading EOBs, through the “compliance dispute” process established by the Thomas/Love class action cases filed by the AMA and select state medical societies.
8. Health plans should be required to pay ED providers directly, rather than paying the benefit to the patient, if the patient assigns the benefit to the provider.
9. **Alternative Approaches to Balance Billing Prohibitions** that address removing the patient from the middle of a dispute between the provider and health plan:
   1. **Alternative 1**: Accepting a prohibition against balance billing of OON ED provider claims for a MBS at the 80th percentile of usual and customary charges and a provision requiring plans to pay these providers directly under assignment of benefits
      1. An ADR would still be required to address down coded and bundled claims payments, and to allow plans or providers to dispute for a ‘reasonable value’ amount that was greater than or less than the MBS based on unusual circumstances
   2. **Alternative 2**: Using a dollar threshold to define when an OON claim must be paid in full or is subject to ADR, e.g. TX’s $500, for health plans, patients or providers to utilize ADR. This threshold should be clearly defined to be **after** determination by the plan of the OON allowable or MBS, the patient’s deductible, co-insurance and/or co-payments (i.e. a threshold for adjudicating a balance bill). The issues are as follows:
      1. Patients present to an in network hospital ED not knowing that the ED providers are OON;
      2. Legislatures perceive the patients to be “in the middle” of the reimbursement disputes between the health plans and providers; ADR is seen as a method to remove the patient from the dispute. The ADR should not be seen as a mechanism for determining the MBS.
      3. The dollar threshold for triggering ADR should be per CPT code, and not per ED visit (see above).
      4. If the threshold is per ED visit, lower level ED E/M services plus procedures, e.g. 99283 MVA with a head laceration, will be included in the ADR;
      5. Analysis of the ADR dollar threshold and the number of ED E/Ms potentially impacted by ADR could be misleading if the $600 threshold for NY, for example, is per ED visit and not per CPT code;
      6. If per visit, the greater proportion of ED E/Ms will be potentially swept up into ADR and cause significant financial burden on fee for service ED groups.
      7. Some legislative language may prohibit balance billing for services above the ADR dollar threshold, others require the patient to submit the balance bill to the plan to resolve the dispute
   3. **Alternative 3**: Using the ‘greatest of three’ standard in the ACA, with a clear definition for the second standard (what the plan usually pays for OON benefits) as being based on the lesser of the provider’s charge or the 80th percentile of usual and customary charges,
      1. This approach under the PPACA allows for balance billing, but reduces the amount of the unpaid balance by specifying a U&C charge based standard for the minimum benefit
      2. This approach can also be used in variations of #1 and #2 above.
   4. **Alternative 4**: Perhaps as a national strategy or a state whose legislative leaders are willing to consider strategies that are simple and yet protect the patient, one could argue that ED services should not be subject to the deductible as “essential healthcare benefits” under ACA and in furtherance of the healthcare safety net. One of the more simple and direct concepts advanced by several leaders in EM is that the ED provider stakeholders should proactively request Congress and/or CMS to define ED services as not subject to the Patient’s deductible **and** reimbursable at an MBS:
      1. The ACA defines the “essential healthcare benefits” to include mandatory health plan coverage for emergency services;
      2. Certain other preventative and primary care services are covered at or near 100% under the ACA and not subject to the patient’s deductible;
      3. Under the moral imperative and since the passage of EMTALA in 1986, the ED has provided critical access to care and continues to do so today for those citizens who remain in the ACA’s coverage gaps or cannot access primary care;
      4. The Prudent Lay Person amendments to the Balanced Budget Act of 1997 (BBA ’97) further extended the patient protections to all Medicare and Medicaid health plan patients such that prior authorization and diagnosis lists of approved emergencies should not prevent patient access to the ED;
      5. Today with the huge increase in high deductible health plans (HDHPs) patients may be hesitant or choose not to go to the ED out of concern over the full amounts of the Provider’s usual and customary charges being applied to their deductible that may exceed several thousand dollars for a family of four—thus potentially causing harm to patients and their families;
      6. ED services that are not subject to the deductible address the core concerns of the moral and legal imperatives above—and further the patient protection provisions of the ACA;
      7. The patients would continue to have a financial stake in their care via their co-insurance and/or co-payments which are generally higher for ED services versus other care settings like an urgent care**.**

**Conclusion:** This document outlines those provisions that should be included in any legislation designed to address OON ED provider claims, and some options for dealing with balance billing.  This legislation can be applied to ED physician and non-physician APPs in the ED, or to all professional services provided in the ED, or to all professional services subject to the EMTALA mandate, including stabilizing care provided to patients treated initially in the ED.  Regardless, it will likely be necessary to get concurrence with the chosen approach from other emergency care provider stakeholders, particularly on-call specialists.

These suggested strategies are intended to be for general guidance only; state-specific laws/issues might mandate that some considerations be changed. Consultation with knowledgeable counsel and professional advisors is highly recommended.

This document was created to provide up-to-date information about active and pending state legislation relating to balance billing for emergency services. It will be updated periodically to reflect ongoing legislative efforts. Please send updates to [danyelleredden@gmail.com](mailto:danyelleredden@gmail.com).

The information included in this report was obtained from numerous sources, including feedback from ACEP state chapters, ACEP State Legislative and Regulatory Committee members, state statutes, media reports, journal articles, and institutional reports.

**Background**

The issue of fair payment for out of network providers has been a topic of intense debate recently. Over the last few years, legislation restricting “balance billing” has been proposed at federal and state levels and several states have passed such bills. Some states have enacted bans on the practice, while others have implemented measures to limit balance billing or to provide reimbursement guidelines.

Health insurance companies are failing to provide fair coverage for emergency patients and fair payment for emergency services. As insurance networks narrow, deductibles increase, and co-payments and co-insurance increase, there has been a public outcry about out-of-pocket medical costs. The balance billing scenarios most under scrutiny are those related to emergency services and “surprise bills” – bills from an out-of-network provider at an in-network facility.

Balance billing typically occurs when a provider is not in-network with a patient’s HMO or PPO, but it can also occur for in-network services. Forty-nine states and D.C. have banned balance billing for HMO in-network services. Just over half of states have a ban on balance billing for PPO in-network services. The majority of recently proposed legislation addresses balance billing for out-of-network services.

There are serious concerns that such legislation could be detrimental to physicians and to health care systems, particularly if such legislation does not include proper provisions to protect physician reimbursement. If not carefully crafted, balance billing restrictions can lead to situations in which insurance companies have the liberty of determining payment and physicians have no power to negotiate or dispute the payment terms.

The argument against balance billing has been framed and publicized by the insurance lobby. It has been a prominent topic in state and national media recently, including articles in *TIME Magazine* and the *New York Times*. Thirteen states have already instituted restrictions on balance billing for out-of-network services. Legislation has been proposed in several states this year and it appears that other states are at risk of balance billing bans in the near future.

**Summary of findings**

All states except Alaska have banned balance billing by in-network HMO providers. Over half of states have banned balance billing by in-network PPO providers. Thirteen states have legislation addressing out-of-network balance bills for HMO patients, and eight states have similar laws regarding out-of-network balance bills for PPO patients. Several states have proposed legislation to be considered during this year’s legislative sessions, and others are expecting legislation to be proposed in the near future. Of note, some states with existing legislation have additional legislation pending.

Legislation enacted:

California

Colorado

Connecticut

Delaware

Florida

Illinois

Maryland  
Massachusetts

New Jersey

New York

Rhode Island

Texas

Utah

West Virginia

Legislation pending/expected:

California

Colorado

Georgia

Hawaii

Louisiana

Maryland

New Mexico

New Hampshire

Ohio

North Carolina

Pennsylvania

Rhode Island

Washington

Media attention:

Arizona

Montana

Nebraska

Wisconsin

No activity reported:

Alabama

Alaska

Arkansas

D.C.

Idaho

Indiana

Iowa

Kansas

Kentucky

Maine

Michigan

Minnesota

Mississippi

Missouri

Nevada

North Dakota

Oklahoma

Oregon

South Carolina

South Dakota

Tennessee

Vermont

Virginia

Wyoming

The approach to balance billing legislation varies widely from state to state. Legislation may be specific to emergency services or it may address other balance billing scenarios, such as out-of-network providers at in-network facilities. In some cases, balance billing is addressed as part of a much broader healthcare bill. Some states have enacted outright bans on the practice, while others have implemented certain restrictions. An alternative to a ban is a “hold harmless” provision, in which a patient is not held liable for charges not covered by their insurance. In such situations, a provider may send the patient a bill, but the patient is not obligated to pay it and can instead pass it on to their insurer.

Guidelines for fair payment are usually included, although they can be quite vague, such as “usual and customary” charges or payments. Some states have tied reimbursement guidelines to Medicare rates. Physician groups have advocated for inclusion of an independent source of fair market pricing, such as New York’s FAIR Health database.

Another component of balance billing legislation is provision for a dispute resolution process. Important details include cost, minimum disputed charge, ability to aggregate claims, timeframe for decision and payment, and neutrality of the panel reviewing the disputes.

Some states have also included transparency requirements for both providers and insurers. Providers may be required to notify patients of their network status with insurers or provide pricing information, while insurers may be required to provide more detailed and clear information to patients regarding what their plan covers and what charges may be the patient’s responsibility.

For additional details on key components of state legislation on this issue, we refer the reader to the ACEP-EDPMA Joint Task Force document *“Strategies to Address Balance Billing and Out of Network (OON) Benefits For Professional Emergency Care Services.”*

**State Reports**

The data included here refers to balance billing for emergency services by out-of-network providers. Restrictions on balance billing by in-network providers and for non-emergency services are not addressed in this report.

California

Balance billing is prohibited for emergency cases. The ban applies to plans under jurisdiction of Department of Managed Health Care, which includes most HMOs and PPOs. Payment guideline is “reasonable and customary” – payment must be based on statistically credible information that is updated at least annually, and must take into account the provider’s training and experience, the nature of service provided, and fees usually charged by provider. The law includes a voluntary, non-binding independent dispute resolution process. There is no provision for transparency requirements. Physicians report significant impact to income.4 There has been limited use of the dispute resolution process reported.

Cal. Code Regs. tit. § 1300.71.39, 2008

*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et. al.*

Balance billing is still permitted for PPO products regulated by the Department of Insurance. A ban on balance billing for these products is likely in the near future.

Colorado

Balance billing is generally allowed for out-of-network providers.  However, the state has a “hold harmless” statute pertaining to balance bills for out-of-network emergency services and surprise bills. The statute applies to plans regulated by the Colorado Division of Insurance. Self-funded health insurance plans governed under the Employee Retirement Income Security Act (ERISA) are not covered.  Over 50% of the insured in Colorado are insured by ERISA plans, so the majority of Coloradoans are not protected by the “hold harmless” provision.

Colo. Rev. Stat. § 10-16-704 (3)(a)(I)

Expected legislation:

Last congressional session, physician-legislator Dr. Iren Aguilar proposed a ban on balance billing (SB15-259). It was defeated in committee with a 5-4 vote on party lines. The bill was killed with the intention of drafting new legislation based on the findings of an interim study, which is ongoing. The Colorado Medical Society convened a workgroup over the summer to formulate recommendations for the interim study with both physician and insurance company representation.  The insurance company representatives pulled out of the discussions. CO ACEP participated in the workgroup and has provided input into the legislation. The Colorado Medical Society is currently negotiating the language of the legislation with representatives from the health plans. It will likely contain language to improve transparency, restrict balance billing, and establish “adequate” payment for out-of-network services. One major point of contention is the database to be used as an index for minimum OON payments. A simplified version of the NAIC balance billing model legislation, which ties minimum out-of-network payment to Medicare rates was introduced in this session again by Dr. Aguilar (SB152) and defeated in committee again on a party line vote.  In addition, it had language in it that removed patient hold harmless clauses and made it fraud for a provider to balance bill a patient unless the patient signed a disclosure at the time of service that disclosed that the provider was out of network.

Connecticut

Legislation prohibits a health insurer from charging an insured patient a higher coinsurance, deductible, or other out-of-pocket amount for emergency services provided by an out-of-network provider than would be charged if the services were provided by an in-network provider. In the event that an out-of-network provider renders emergency services to an insured, this legislation requires the health insurer to reimburse such health care provider at the greater of (1) the in- network rate; (2) the usual, customary, and reasonable rate; or (3) the Medicare reimbursement rate. This legislation defines “usual, customary and reasonable rate” as the 80th percentile of all charges for the service provided in the same geographic region by a same or similar specialty, as determined by reference to a database designated by the insurance commissioner. This legislation does not prohibit the health care provider and health insurer from agreeing to a higher reimbursement amount. The balance billing ban applies to HMO’s and PPO’s. There is no dispute resolution process.

This comprehensive legislation addresses several other aspects of healthcare costs. It requires disclosure of actual contracted rates for the most common outpatient, inpatient, surgical, and imaging procedures and will make that information available to the public to compare prices by provider, service and payer. The legislation also bans certain facility fees, creates a statewide health information exchange, and requires that large hospital mergers and acquisitions be subject to appropriate market review in terms of costs and market power. Additionally, it creates a cabinet to study cost containment models in other states and requires a study on price disparity.

Statute: 369-20-7f

Conn. Gen. Stat. 20-7f(b)

[Public Act No. 15-146](http://www.cga.ct.gov/2015/act/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf)

Delaware

Balance billing is banned for HMO out-of-network emergency services. The insurer is required to pay the lesser of the non-network provider billed fee or the highest negotiated rate between the insurer and any network provider for the service based on CPT code. The legislation does include a dispute resolution process.

In 2001, a state law was passed that banned balance billing except in instances in which the patient agreed in writing to be billed. The statute included an exception for emergency services, mandating that the Department of Insurance write regulations governing rules for balance billing. A regulation was created and has been revised several times. Another statute was passed a few years ago that banned the practice of insurance companies making direct payment to patients for out-of-network emergency services. The statute also outlined minimum levels of payment. It is anticipated that the existing statute will be challenged sometime soon.

Statute 18-3565

Florida

Florida law prohibits balance billing for out-of-network emergency services for HMO patients. Insurers are required to pay the lesser of: charges, usual and customary rates for similar services in the same geographic area, or a mutual agreed upon charge. Dispute resolution is administered by Florida’s Agency for Health Care Administration. A private dispute resolution firm has 60 days to recommend a solution to the Agency and the Agency has 30 days to issue a final order based on the recommendation. The process is rarely used, as it is perceived to favor the insurer. The non-prevailing party pays for the cost of the review. There is no provision for transparency requirements.

Florida statute 641.513 (5)(6)

Florida passed legislation in March 2016 (HB 221) that bans balance billing for PPO patients. It goes into effect July 2016. It requires out-of-network PPO insurance payments to mirror the HMO payment provisions for emergency care and non-emergency care providers in a facility that has a contract with an insurer. The bill also includes changes to the provider and health plan claim dispute resolution program. It creates a process for a settlement “best offer” to be made by both parties and requires AHCA to develop rules to the dispute resolution program including: requirement for the dispute program to review and consider all documentation submitted, requirement for the program to make findings of fact, allows for either party to request an evidentiary hearing, prohibits ex parte communication with either party during the dispute resolution, requires that finding of fact must be supported by evidence relied upon in making final order and must be part of final recommendation, and stipulates that disputes with regard to reimbursement to the nonparticipating provider of emergency or nonemergency services shall be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process of 408.7057.

Florida Statue 627.64194

Florida Statute 408.7057(h).

Georgia

In 2016, the Georgia Senate considered SB 382 which would have prohibited balance billing for HMO and PPO patients. The draft language used 80% of UCR as the benchmark but did not define the methodology for defining UCR. There was no provision for dispute resolution. The bill died in committee, and instead the Senate passed a resolution to create the Senate Surprise Billing Practices Study Committee, which is charged with studying the issue and providing a report to possibly include proposed legislation by the end of the year.

Hawaii

Hawaii has restrictions for in-network balance billing for HMO plans. SB 2668 is currently being considered, addressing disclosure requirements for out of network providers, maximum bill allowable by non-participating provider without prior authorization from a patient’s healthcare plan, and limitations on how much non-participating providers can charge for emergency services. As introduced, the legislation set the maximum out-of-network bill at 120% of the Medicare rate and a limitation that non-participating providers for emergency services cannot charge more than the insured rate from a participating provider. After passing the Senate with amendments, the House further amended the bill requiring out of network payments at some percent of usual and customary charges, with U/C charges determined by the 80th percentile of charges in the region. As of the end of March, the amended bill had been passed by one House committee and was scheduled to be heard in another.

Full Text: <http://www.capitol.hawaii.gov/session2016/bills/SB2668_.PDF>

Bill Progress: <http://openstates.org/hi/bills/2016%20Regular%20Session/SB2668/>

Illinois

Balance billing is restricted for out-of-network emergency services for HMO and PPO patients provided by nonparticipating facility-based providers. The legislation requires that the patient not pay more than would be required for in-network services. The insurer must provide the physician a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance. The physician is prohibited from billing the patient, except for applicable deductible, copayment, or coinsurance. The physician may bill the insurer and the insurer may pay the bill or attempt to negotiate. If attempts at negotiation do not result in resolution of dispute within 30 days of receipt of written explanation of benefits by the insurer, then either party may initiate binding arbitration after stating its final offer. The non-requesting party shall inform the requesting party of its final offer prior to arbitration. Arbitration is initiated by filing a request with the Department of Insurance.

Arbitration

Both parties must agree on an arbitrator form the list provided by the Department of Insurance. (Arbitrators are American Arbitration Association or American Health Lawyers Association trained.) If no agreement can be reached then a list of 5 arbitrators shall be provided by the Department of Insurance. From the list of 5 arbitrators, the insurer can veto 2 arbitrators and the provider can veto 2 arbitrators. The remaining arbitrator shall be the chosen arbitrator. This arbitration shall consist of a review of the written submissions by both parties. Binding arbitration shall provide for a written decision within 45 days after the request is filed with the Department of Insurance. Both parties shall be bound by the arbitrator's decision. The arbitrator's expenses and fees, together with other expenses, not including attorney's fees, incurred in the conduct of the arbitration, shall be paid as provided in the decision.

215 ILCS 5/356z.3a

P.A. 98-154, eff. 8.2.13

<http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021500050K356z.3a>

Louisiana

Legislation banning balance billing has been introduced in the 2016 session. HB412, filed by Rep. Thibaut, is specific to emergency medicine and would set out-of-network payment rates at the greatest of the payers’ in-network rate, their out of network rate or Medicare. SB 316, filed by Sen. Donahue, includes all facility-based providers and has the same greatest of three payment formula.

Maryland

Balance billing is banned for out-of-network emergency services for HMO patients. It does not apply to ERISA plans. For out of network claims, emergency services must be paid at 125% of the average HMO rate as of January 1 of the previous calendar year or 140% Medicare rate as of August 1, 2008. Dispute resolution consists of appeals to the Maryland Insurance Commissioner.

There is a provision within the legislation that bans balance billing for HMO and PPO patients in cases in which the patient signs an assignment of benefits. In such cases, the payment formula applies and balance billing is not allowed.

Chapter 250 of the Laws of the State of Maryland, 2002

Statute 19-710.1

Statute 14–205.2.

Pending legislation:

Legislation has been introduced that would further restrict balance billing to include PPO patients.

Massachusetts

There are currently three statutory bans on balance billing in Massachusetts. They apply to patients who are: (1) Medicare eligible, (2) state employees and retirees covered by Group Insurance Commission, or (3) covered by Blue Cross/Blue Shield indemnity policies. Bans on balance billing for managed care patients are contractual, not statutory. They apply to HMO’s and PPO’s. There are provisions for payment guidelines, dispute resolution, and transparency requirements.

Chapter 224 law

<https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

Missouri

Balance billing is a frequent topic of interest, but no legislation has been introduced to date.

Montana

There has been considerable discussion regarding balance billing for air medical transport services.

Nebraska

There has been some media coverage of balance billing issues relating to air medical transport.

New Hampshire

HB1516, filed 2016, did not pass and was sent for study. The bill proposed a ban on out of network billing by physicians at in-network facilities.

New Mexico

Public forums were held in March by the Office of Superintendent of Insurance to address “surprise bills” and balance billing.

<http://krwg.org/post/surprise-medical-bills-cause-confusion-new-mexico-public-forums-planned>

New Jersey

New Jersey has a prohibition on balance billing that applies to out-of-network emergency care and urgent care for HMO’s and PPO’s. New Jersey’s balance billing state statutes and regulations only apply to state regulated health plans, not ERISA and self-funded plans, which make up about 80% of the market. Balance billing for ERISA and self regulated plans is guided by federal regulations.

Effective May 1, 2000: N.J.A.C 11:24-9.1 (d)(9) requires that an HMO must include in a patient's statement of rights the right to be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract.

Effective March 17, 2008: N.J.A.C. 11 :24-5.3(B) requires that HMO’s limit a member's liability for emergency care rendered by non-participating providers, including ambulances, to the network copayment, deductible or co-insurance

Effective May 1, 2000: N.J.A.C. 11:24-5.1 (a) requires that an HMO that refers a member to a non-participating provider is fully responsible for payment to the provider and the member's responsibility is limited to the network copayment, coinsurance or deductible.

NJ Department of Banking and Insurance has interpreted these regulations to mean that in cases of emergency and urgent care rendered by an out of network provider, or cases in which the HMO has referred a member to an out-of-network provider, it must pay the out-of-network provider a benefit large enough to ensure that the provider does not balance bill a member. In such circumstances, payers have been required to reimburse out-of-network providers up to their actual charges.

New York

For emergency services, a non-participating physician may bill the health plan and the health plan must pay the physician the billed amount or attempt to negotiate.  If the negotiation does not result in resolution of the dispute, the health plan must pay the non-participating provider an amount it deems reasonable, less applicable patient cost sharing.  Either party may file a dispute with the Independent Dispute Resolution Entity, which involves a panel that includes actively practicing physicians. Insurance companies are required to disclose their methods for determining reasonable payment, which are compared to 80th percentile of FAIR Health database. The panel rules in favor of either the provider’s original charges or the insurer’s initial payment. There are also transparency requirements for providers, hospitals, and insurers. .  There is no restriction on the physician to balance bill the patient. The law places the responsibility on thehealth plan to ensure that the patient receives no greater out-of-pocket costs than they would have incurred with a participating health care provider. Legislation took effect March 31, 2015.

There have been no reports to suggest physician reimbursement has been impacted by the legislation. New York ACEP made an inquiry of the Department of Financial Services on implementation at the six-month mark on September 30, 2015. The information they received indicated that the IDR process has been utilized by providers and plans. There are three IDR entities; the fees for full review are $325, $225 and $300 respectively. During the six month period, with approximately 3.498 million ED visits, 59 emergency service IDRs were received by the Department of Financial Services. Of the 59, 21 were rejected as ineligible (most often because the plan was from out of state); 11 were resolved through settlement; 8 were resolved in favor of the health plan; 4 were resolved in favor of the provider and 3 were split decisions (multiple CPT codes).

Emergency Medical Services and Surprise Bills Law: Chapter 60, Part H, of the Laws of New York (2015)

Ohio

As of March 2016, a bill has been drafted but not yet filed. It bans balance billing for emergency services. A meeting will take place in March between the representative introducing the bill and interested parties to discuss the details.

Oregon

The chair of the House Health Care Committee introduced HB 2303 during the 2015 session, which if passed, would have required advance notification including cost estimates, for out-of-network health care providers. The bill died in committee without a hearing, likely because of health care price transparency legislation in the Senate. Here’s a link to the bill: <https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2303/Introduced>

The OR-ACEP position was to support the intent of price transparency and to protect consumers from excessive bills when a patient unknowingly receives services from a physician not part of their health care plan’s network of provider. However, the chapter opposed HB 2303, which would have placed an undue burden on emergency physicians, who are subject to EMTALA regulations.

During the 2016 interim, OR-ACEP will monitor similar legislation in other states. The Oregon Medical Association and the Oregon Association of Hospitals and Health Systems have indicated interest in forming a workgroup around this issue. It’s expected to resurface during the 2017 Legislative Session.

Pennsylvania

SB1158 has been introduced which would ban balance billing and in the case of emergency services, requires disputes over payment for out-of-network physicians to be settled by a dispute resolution organization who must choose either the billed charge or the paid amount as the appropriate amount, basing that decision on such factors as the providers normal charges, the amount the insurer typically pays for out of network care, and the usual and customary cost, defined as the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in an independent benchmarking database maintained by a nonprofit organization.

Rhode Island

Balance billing is prohibited for out-of-network emergency services for HMO patients. Legislation was introduced in 2016 (S 2462 and H 8004 that would prohibit balance billing and require payment for most out of network emergency services to be the greatest of three options that includes the 80th percentile of charges in an independent database of local charges. However, it excludes certain CPT codes from that formula, directing the Insurance Commissioner to set the out of network payment rate for those. The Senate bill died in committee. The House bill was introduced in late March.

Texas

Texas has no direct restrictions on out-of-network balance billing besides disclosure laws. It relies on mediation for balanced bills exceeding a certain amount. In the recent legislative session, an attempt was made to remove the minimum limit on mediation (previously $1000). Compromise was reached with SB 481, allowing for mediation of any individual balanced bill above $500. From an emergency medicine standpoint, this was an acceptable compromise, because balance bills rarely exceed that bar. There are concerns that this may become a stepping-stone for more restrictions in the future.

House Bill 2256, passed in 2009, allows patients in certain circumstances to dispute out-of-network bills from facility-based physicians through mediation, and led to the adoption of other consumer protections surrounding network adequacy.

Revisions to Texas Department of Insurance (TDI) network adequacy rules in late 2013 allow patients in preferred provider benefit plans to get credit for emergency balance bills toward their in-network insurance deductibles and out-of-pocket maximums.

Additional legislation is expected in the next session (2017).

SB 481: <https://legiscan.com/TX/text/SB481/id/1235763/Texas-2015-SB481-Enrolled.html>

HB 2256: <http://www.legis.state.tx.us/tlodocs/81R/billtext/pdf/HB02256F.pdf>

Washington

HB 2447, outlining a ban on balance billing, did not pass. Money has been allocated in the House proposed supplemental budget for the OIC to study the issue. Further legislation is expected next session.

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