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Unexpected Charges: What States Are Doing About Balance Billing

Prepared for

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by

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About the Foundation

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I. Introduction

TO MOST CONSUMERS, HEALTH INSURANCE means protection against large bills from health care providers. But in some situations involving managed care organizations (MCOs), the provider expects a higher payment than the amount the health insurer is willing to pay. The result can be a bill for the remaining balance, sent to the patient—a practice known as balance billing.

Most people with private health insurance are covered by an MCO, a category that includes both health maintenance organizations and preferred provider organizations. MCO members take comfort in the belief that if they follow MCO rules they will not face costs greater than their premium and required cost sharing (copayments, deductibles, and co-insurance). MCOs have networks of providers with whom they have negotiated reimbursement contracts. For the most part, members understand that they must use these network providers to minimize their out-of-pocket expenses. However, even a careful consumer can end up being treated by an out-of-network provider. When this happens, the patient is at risk of receiving a bill from the provider for the difference between the provider's charge and the amount the MCO is willing to pay. In some cases, patients face hundreds of dollars in charges—referred to as balance bills—above their expected cost sharing.

Many states have struggled to produce legislative or regulatory solutions to address balance billing. To date, relatively few states have passed laws protecting patients from balance billing by out-of-network providers. Those laws appear relatively successful in protecting MCO members from large balance bills. But they have been less successful in navigating

the competing interests of MCOs and health care providers in determining an appropriate, equitable payment; most laws seem to impose higher costs on one group or the other. The fundamental conflict is how to protect MCO members while establishing a clear means of determining a payment level appropriate for both MCOs and providers.

This paper provides context on the extent of out-of-network service utilization and the potential problem imposed by balance billing, and then describes how some states have responded. It shares observations based on an examination of state laws and interviews with regulators, providers, MCOs, and consumer advocacy organizations that may be helpful for policymakers considering balance billing legislation in California and elsewhere.

II. How Does Balance Billing Happen?

An Introduction to Balance Billing

Balance billing is when a provider seeks to collect from an MCO member the difference between the provider's billed charges for a service and the amount the MCO paid on that claim.

Key Concepts

Balance bill: A bill sent to an MCO member by a provider to collect the difference between the provider's charge and the amount paid by the MCO (does not include the copayment, deductible, or co-insurance).

Assignment: A patient can request that payment be made directly by the MCO to the provider. Assigned claims are normally submitted directly to the MCO by the provider, making it easier for the provider to receive payment.

Mandatory assignment: An MCO must pay a provider directly for services when a member assigns a bill to the provider. Depending on state law, payment on assignment may or may not be available for non-network providers.

Hold harmless: An MCO must make certain that the patient does not receive a balance bill from a provider.

Before the rise of managed care, consumers with insurance typically expected some balance billing. Under traditional indemnity insurance, the insured person paid the provider directly and then sent the bill to the insurer. The insurer reimbursed the patient, minus any cost sharing, up to a certain amount. If the reimbursement was below the billed charge, then the patient would not be fully reimbursed. Today, most privately insured people are covered by an MCO, which contracts with a network of providers to offer medical services to members. In return, providers agree to deliver services at a

negotiated rate that is generally below their usual charges. Providers also agree to “hold harmless” (i.e., not to balance bill) members for the difference between the contracted rate and their typical billed charge.¹ This benefits providers by offering a steady flow of insured patients for whom they are paid promptly and directly by the MCO.

Why Does Balance Billing Occur? How Often Does It Happen?

There are many reasons why a provider may choose not to contract with an MCO. The decision may be based on a clinical preference or economic consideration. In the absence of a contract between an MCO and an out-of-network provider, there is no negotiated reimbursement rate.² When outside the network, providers expect to receive their billed charges for services provided. Some providers use balance billing as a mechanism to put pressure on the plan in negotiations to join the network at a favorable rate. Since patients who are balance billed are more likely to complain to the government, MCOs may agree to pay a higher rate or even the full billed charges to reduce the possibility of regulatory attention. Balance billing also allows providers the potential to recoup their full billed charges, though collecting the amount from the patient is often a challenge and may not be successful. Some providers require payment in advance of providing a service—a situation that makes it particularly difficult to avoid a balance bill. But not all providers collect balance bills. Some report that they would prefer not to balance bill their patients because it intrudes on their clinical relationship. Nevertheless, state regulators and consumer advocates report

that some patients pay the balance of the bill even when not required under state law or the terms of their insurance contract—perhaps out of a sense of obligation or to avoid the risk of debt collection or an adverse credit report.

MCOs use the benefit of “prompt, fair, and direct payment” as a primary incentive to encourage providers to join a network.³ Insurers argue that paying out-of-network providers their billed charges creates a disincentive for providers to join the plan’s network. Unless required under state law, some MCOs will not reimburse out-of-network providers directly (on assignment), instead sending the reimbursement to patients and forcing the providers to bill the members.

An analysis conducted for the California HealthCare Foundation by Thomson Reuters among a sample of 1.2 million Californians with employer-sponsored, fully or partially capitated commercial insurance for 2006 found that almost 11 percent of the study population used out-of-network services at some point during the year.

The greatest proportion of out-of-network utilization involved a hospital admission or emergency department visit without resulting admission. Researchers calculated the gap between out-of-network provider charges and provider reimbursement under the plan provisions in order to measure the potential magnitude of balance billing. Reimbursement was tracked by summing payments made by the plan or any third party (such as a secondary insurer) and patient cost sharing (in the form of copayments, deductibles, and co-insurance). The data do not indicate if patients were balance billed or, if they were billed, the extent to which providers sought to collect the full cost.

Among the 11 percent of the population with some out-of-network services, the average potential balance bill amount (across facilities, physicians, and

other professional providers) was \$1,289, in addition to the average patient cost-sharing amount of \$433. At an individual health care service level (such as a single procedure), potential balance billing amounts associated with a facility substantially exceeded those associated with a physician or other provider. For example, the average potential balance bill for an emergency department service was \$27 for a physician as opposed to \$188 for a facility. Among the 476,000 claims for emergency department services in the study’s sample, about 18 percent were out of network. Potential balance bills for inpatient settings were much larger. Among the 57,000 inpatient stays in the study sample, 17 percent included some out-of-network service. The potential balance bill for hospital stays averaged \$6,812 when all professional and facility charges for inpatient services delivered during a stay were aggregated.

These findings show how often patients land in situations where they do not choose a network provider and tally the potential added costs they may incur. The California Association of Health Plans reported in 2007 that 1.76 million Californians who visited emergency rooms in a two-year period were balance billed by providers for an average of \$300 each; about half of these patients paid the bill.⁴ Anecdotal reports have called attention to specific cases where individuals have received bills, but otherwise information on the actual frequency or magnitude of balance billing is unavailable.

Scenarios Likely to Result in Balance Billing

In general, MCO members face balance billing only when treated by an out-of-network provider. Members can avoid this by seeking care through network providers, and should expect balance billing when they choose out-of-network care. However, through no fault of their own, patients sometimes

end up being treated by out-of-network providers and may face balance billing.

Care from an Out-of-Network Provider on an Outpatient Basis

Sometimes a member selects an out-of-network provider for outpatient care. For example, a patient may want to see a well-regarded provider outside the network. In a preferred provider organization (PPO) or other open-network plan, the member typically would face higher cost sharing and the likelihood of being balance billed. In a closed-network health maintenance organization (HMO), this type of care would be uncovered and the member would be responsible for the entire bill. In either case, consumers should be aware of the consequences of seeking care outside the network, and most providers inquire about insurance coverage when the appointment is made.

Even when an MCO approves a referral to an out-of-network provider and agrees to treat the care as a network service, a member may still face balance billing, depending on the MCO's payment rules. For example, some PPOs approve the use of an out-of-network provider for care but reimburse the provider using their network fee schedule. Since the non-network provider is under no obligation to accept the PPO's fee as payment in full, a member may receive a balance bill.

Care from an Out-of-Network Hospital in an Emergency

In emergency situations, a person often goes to the closest hospital with an emergency room. If the hospital does not contract with the member's MCO, the member may face balance billing. If a patient is treated in an emergency department at a hospital that does contract with the member's MCO, the patient could still receive a balance bill if the treating

physician is not part of the network. That situation is further discussed below.

Care from an Out-of-Network Physician at a Network Hospital

MCO members typically do not expect to face balance bills when receiving inpatient care at a network hospital, especially when they choose a hospital that is in the network. Nonetheless, members may encounter out-of-network providers at network hospitals—such as anesthesiologists providing services during surgical procedures—and face the possibility of balance billing. While radiologists, anesthesiologists, and pathologists are hospital-based physicians, they are almost never hospital employees and may or may not contract with the same MCOs as the hospital. In addition, members may receive services from out-of-network providers if their network physician consults with an out-of-network specialist. For example, before a patient is cleared for surgery, a non-network cardiologist may be consulted to evaluate whether the patient is capable of tolerating the surgery.

III. State Restrictions on Balance Billing in Private Markets

Balance Billing by Network Providers

Contracts between participating providers and MCOs typically include hold harmless provisions that protect members from being balance billed by a network provider for covered services. In consenting to these provisions, participating providers generally agree not to seek reimbursement from a patient beyond payment of applicable cost-sharing requirements such as copayments, co-insurance, or deductibles for services covered by the HMO.⁵ In most states, including California, state law requires hold harmless provisions in contracts between HMOs and participating providers.⁶ States may also require this type of language in contracts between providers and PPOs.

Balance Billing by Non-Network Providers

In California, the Department of Managed Health Care (DMHC) has a longstanding interpretation that state law prohibits balance billing by non-network providers. This position, with regard to emergency services, was upheld by the California Supreme Court on January 8, 2009, although it left unresolved payment issues between the MCOs and the providers.⁷ At the direction of Governor Schwarzenegger, DMHC enacted a regulation that took effect October 15, 2008, prohibiting balance billing of HMO members by network and out-of-network providers for care administered in emergency room settings. In the meantime, in addition to pursuing legal action against a provider group for improper balance billing, DMHC has attempted to address the “root causes of balance billing” by assisting providers in recovering

payments, fining HMOs for underpayment and late payment of claims, offering dispute resolution to mediate disputes between providers and HMOs, and initiating a fair claims payment initiative.⁸ In September 2008, the California Legislature passed two bills that directly addressed balance billing of privately insured MCO members, but only one was signed into law: AB 1203, which was approved in 2008 (Chapter 603), prohibits in some situations non-contracting hospitals from billing patients for care after the patient is stabilized.⁹ The second bill—SB 981, which was vetoed in 2007—would have addressed balance billing by emergency room doctors.¹⁰ In the past, California has attempted various legislative and regulatory approaches to addressing balance billing of MCO members.

A 2006 survey published by the American Health Lawyers Association identified nine states with laws that prohibit non-network providers from balance billing members of HMOs.¹¹ The nine states were Colorado, Delaware, Florida, Indiana, Maryland, New York, Rhode Island, West Virginia, and Wisconsin. In addition to these nine, Connecticut has language in statute that, if interpreted broadly, may restrict balance billing of HMO members by some out-of-network providers.¹² Protections vary significantly from one state to another.¹³

State Approaches to Protecting Patients from Balance Billing by Non-Network Providers; Stakeholder Perspectives

This project selected four states with laws that take varying approaches to balance billing. The four—Colorado, Florida, Maryland, and Texas—were chosen because they offer unique policy approaches

to balance billing. Researchers conducted a systematic review of the statutory provisions and interviewed key stakeholders in each state, including regulators from relevant departments and agencies, hospitals, physicians, MCOs, and consumer advocacy organizations.¹⁴ Because the project entailed only a small set of interviews, it is not a fully representative assessment of stakeholders, but the interviews should capture the essence of stakeholder perspectives. The objective of this project was to identify promising options for policymakers wishing to protect MCO members from balance billing by non-network providers.

Each of the four states profiled differs in its approach to protecting consumers from balance billing by non-network providers and, depending on the stakeholder perspective, its degree of success (Table 1, page 16). In Colorado, a requirement that

insurers hold PPO and HMO members harmless protects consumers from paying beyond standard network cost sharing for care received from non-network providers at network facilities. In Florida, HMO members are protected from being balance billed by non-network providers for emergency care by a law that provides reimbursement guidelines and direct payment of non-network providers by HMOs. In Maryland, a general restriction against balance billing of HMO members for “covered services” is supplemented by standardized reimbursement rates for hospitals and non-network providers. Finally, Texas recently passed “transparency” legislation that attempts to ensure HMO and PPO members have access to data, such as pricing and network participation information, needed to estimate their financial liability for medical services.

State Profiles

Colorado: MCOs Required to Hold Members Harmless from Balance Bills

Colorado law requires that if an MCO (in this case, a PPO or an HMO) does not maintain an “adequate” network, then the MCO must arrange for a patient to see an out-of-network provider at no greater cost than if the member had been treated by a network provider.¹⁵ A separate state law requires that patients who receive care from an out-of-network provider at a network facility must be held harmless by the MCO for costs above what they would have faced for treatment by a network provider.¹⁶ Under state law, there is no explicit rule against an out-of-network provider balance billing a patient. But since the patient must be held harmless, the MCO is essentially responsible for resolving the bill before the provider pursues action against the member, thus precluding a balance bill. Typically, the MCO either pays the billed charges or comes to an agreement with the provider for less.

In most situations where consumers might face balance bills, HMO and PPO members are not asked to pay them. In interviews, however, stakeholders emphasized that members are not protected from receiving a balance bill but are, because they are held harmless, protected from paying such a bill. Even so, the Colorado Division of Insurance reports some anecdotal evidence that members sometimes receive balance bills and may not understand their right not to pay.¹⁷

Although Colorado law does not impose reimbursement standards for these situations, MCOs generally comply by paying out-of-network providers’ billed charges. In addition, under the state mandatory assignment law, MCOs must pay these providers directly when a patient assigns a bill to the provider. For out-of-network providers, the combination of direct payment and receipt of billed charges appears to eliminate the need to balance bill MCO members.

Colorado MCOs argue that the combination of the requirement that they pay billed charges and a broad mandatory assignment law acts as a disincentive for providers to join managed care networks. In support of this, regulators point out that some MCOs are having difficulty contracting with some specialty groups, even when the MCO has network agreements with the hospitals in which these providers practice. MCOs further suggest that the current regulatory

State Profiles, *continued*

Colorado, *continued*

framework hampers their ability to negotiate discounted rates with network providers and ultimately may increase insurance costs for everyone. In addition, MCOs point out that with fewer network providers, members of self-insured plans that are not protected by state law may be more likely to receive balance bills.

Florida: Balance Billing Restrictions with Payment Rate Requirements in Emergency Settings

In general, out-of-network providers in Florida may not balance bill an HMO member when an HMO is liable for services covered and authorized by the HMO.¹⁸ When services are provided for an emergency condition or to evaluate if such a condition exists, a separate law makes the HMO liable and restricts the non-network provider from balance billing the member. Florida law specifies that in these emergency situations, HMOs must pay non-network providers the lesser of: (1) the provider's billed charge, (2) the usual and customary provider charge (not specifically defined in statute) for similar services in the community where the services were provided, or (3) the charge mutually agreed to by the HMO and the provider.¹⁹ HMOs must make these payments directly to the non-network provider of emergency services.²⁰

The Florida stakeholders interviewed agreed that HMO members are protected from balance billing in most situations. Regulators indicate that the law has been effective for HMO members. Complaint data support this conclusion. Florida reports only 24 complaints for the year between June of 2007 and June of 2008, although the number of actual consumer calls may have been significantly higher. However, state law does not protect PPO members from balance billing by out-of-network providers. Regulators suggest that PPO members face the same concern HMO members did before the state intervened with legislation. One regulator cited "repeated complaints and concerns from PPO policyholders," particularly where the PPO has no contract with a provider.

Florida providers of emergency room services are guaranteed their "provider charges" (billed charges) or their "usual and customary" fee. In addition, emergency physicians are guaranteed direct payment from the HMO on assigned claims. Florida's emergency physicians successfully lobbied against including the term "reasonable" in the state's rate setting standards, in part because of their concern that insurers have used that term to justify reimbursing providers at rates below what providers believe to be usual and customary. Providers indicate concern, however, that even though the statute excludes the term "reasonable," some HMOs are setting reimbursement rates too low (i.e., only 120 percent of the Medicare rate).

The law establishes clearly that out-of-network providers cannot balance bill HMO members for covered, authorized care for which the HMO is "liable." Outside of the emergency setting, HMOs have the opportunity to negotiate reimbursement rates with out-of-network providers. Generally, the industry finds that this works well. However, in the emergency setting, the inability to make advance agreements leads to debate about the term "usual and customary." Providers and HMOs continue to debate the definition of the term on an individual basis and in the court system. Florida has a dispute resolution process, but it has not proved helpful in many cases.

Maryland: Balance Billing Restrictions with Payment Rate Requirements

In Maryland, out-of-network providers may not balance bill an HMO member for a "covered service."²¹ In general, a covered service is one authorized under the terms of a contract.²² Emergency care and out-of-area urgent care are generally considered covered services. Because hospital rates are set by the Maryland Health Services Cost Review Commission, hospitals must be paid at this rate. Under Maryland law, reimbursement rates for covered services provided by non-network physicians to HMO members are also standardized. In general, an HMO must pay the greater of (1) 125 percent of the rate it pays in the same geographic area for the same service to a provider under written contract or (2) the rate it paid in 2000 to a non-contract provider in the same geographic area for the same service. For trauma physicians providing care at a trauma center, a Medicare-based rate is substituted for the HMO's contract rate. Thus payment is the greater of (1) 140 percent of the rate paid by Medicare for the same covered service to a similarly licensed provider or (2) the rate paid by the HMO in 2001 in the same geographic area for the same covered service to a similarly licensed provider.

State Profiles, *continued*

Maryland, *continued*

Stakeholders interviewed in Maryland report that consumers are generally protected from balance billing by out-of-network providers for care that has been authorized by the HMO. This restriction has been in place for over 20 years, and most providers are aware of the rule. Inappropriate balance billing, though it does happen, is minimal. The Maryland Insurance Administration received 37 balance billing-related complaints from HMO members in 2006 and 27 in 2007. The state is considering a proposal to make changes to these rates.²³

Providers, however, expressed serious concerns about reimbursement rates, complaining that some HMOs manipulate the standards so that rates are most advantageous for the HMO. For example, providers report that in setting rates for a specific geographic area, some HMOs look to the lowest rate they paid a single provider in that area, even if that provider's billed charge was significantly less than that of most other providers in the area. One physician suggested that current payment standards in Maryland may be a factor in driving providers to other markets. HMOs, by contrast, were satisfied with the law, suggesting that the same approach might work in the PPO market.

Texas: Increased Transparency with Regard to Balance Billing

In Texas, MCO members are not protected, *per se*, from balance billing by non-network providers.²⁴ In part as an alternative to a direct ban on balance billing, Texas in 2007 passed SB 1731, which attempts to increase transparency by providing consumers access to data, such as pricing and network participation information, needed to estimate their financial liability for medical services. Specific reporting and disclosure requirements are placed on facilities, physicians, and insurers, including MCOs. For example, MCOs must disclose, in writing, whether a network facility uses non-network providers and that a member may be balance billed by a non-network provider. In addition, this law requires state regulators to publish a "Consumer Guide to Health Care" providing, among other information, (1) pricing information and variation among providers, (2) information on the correlation between billed charges and actual charges, (3) member liability for costs, and (4) advice to members for obtaining cost information in advance of treatment.²⁵ When the legislation is fully enacted, MCO reporting requirements will provide detailed data, including billed charges and reimbursement rates for a variety of medical services. Aggregated data will be made available online. In addition, regulators are collecting additional data from MCOs to show the extent to which members receive care from facility-based, non-network providers. This one-time effort will be evaluated to see whether it might help consumers understand situations that could lead to balance billing.²⁶

SB 1731 is yet to be fully implemented, and stakeholders report concerns about how effective this law will be in helping MCO members evaluate their risk for being balance billed by non-participating providers. For example, one stakeholder questioned how valuable this information would be for patients receiving emergency room services, without a *per se* restriction against balance billing. Another considered the challenges the state faces in gathering and presenting these data in a way that would allow patients to accurately evaluate their potential financial risk for medical care.

IV. Considerations for State Policymakers

THIS SECTION DRAWS UPON THE EXPERIENCE of states with laws regulating balance billing. Although it is difficult to draw firm conclusions, some considerations may be useful to state policymakers.

Factors That Can Be Included in a Clearly Defined Payment Standard

Whether legislation starts from a hold harmless approach or a direct ban on balance billing, the path to a satisfactory solution encompasses the establishment of a clear, state-defined reimbursement standard. The availability of a well-defined payment rate avoids placing all the leverage on either the provider or the MCO side, as occurs without a payment standard. Such approaches are found in some existing state laws, such as in Florida and Maryland, but the results in these states have left some stakeholders dissatisfied. Florida law indicates that providers should receive “the usual and customary provider charges for similar services in the community where the services were provided,” and part of Maryland’s formula is based on the rate paid by the HMO in the same geographic area. Such standards may create as many problems as they settle. MCOs and providers debate the standards for establishing “usual and customary” fees, and providers claim that some Maryland HMOs manipulate the historical rate standard. These examples illustrate the challenges that policymakers face in trying to identify an approach for setting rates.

The Medicare Fee Schedule offers another basis for setting rates. It is part of the approach used in Maryland for paying trauma physicians, and was

included in a recently vetoed bill in California.²⁷

Under this approach, the Medicare fee is the baseline for a rate structure, but a multiplier is applied so that actual payment levels are higher than Medicare’s. California’s approach would have set an interim payment rate at 250 percent of the Medicare rate for 2007 for the California region.²⁸ In Maryland, the rate is much lower. For trauma care, insurers pay the higher of their historical rate or 140 percent of the Medicare rate.

The advantage in using the Medicare Fee Schedule approach is that the underlying relative value scale (RVS) used by Medicare is reasonably well accepted as a means of avoiding reliance on submitted charges. The Medicare RVS sets a value for the work and practice expense entailed in delivering a given service, measured relative to all other services. The relative value is the same regardless of the type or location of the physician delivering the service, but the multiplier used to determine the actual fee can vary by payer or geographic location. Although some issues regarding the fairness of relative fees are still being debated, many private payers use the Medicare Fee Schedule as the basis for payment.

Policymakers considering the Medicare Fee Schedule approach would need to decide on a multiplier as low as the 140 percent multiplier used in Maryland or as high as the 250 percent in California’s vetoed bill. Policymakers should consider local market circumstances and regional variations in making this decision. A subsidiary question is whether all specialties should be treated equally. Even though the theory of the Medicare Fee Schedule says that relative values are determined to reflect the relative work involved across specialties, local market

circumstances might call for variations. For example, emergency physicians argue that their higher level of uncompensated care should support higher rates for them.

Structure for Monitoring and Enforcing Balance Billing Protections

In passing legislation that restricts balance billing, states should consider a comprehensive means of implementing, monitoring, and enforcing the law.

States may need more information than consumer complaint data to determine whether providers and MCOs are compliant with balance billing laws. Many consumers who are faced with a balance bill pay it to avoid problems, while others may call their MCO. But few know to contact the state. State regulators recognize that many consumers are unaware of existing protections and that complaint data may underestimate the extent to which consumers are inappropriately balance billed. In addition, depending on how the state documents complaints, the information collected may not provide the level of detail policymakers need. For example, a state may identify whether a caller is covered under a state-regulated plan but not identify the exact type of plan. To supplement consumer complaint data, Maryland also monitors provider complaints. A trend may prompt a market examination by the Maryland Insurance Administration or an investigation by the attorney general's office. Texas, looking beyond complaint data, recently directed MCOs to report data regarding the number of claims where members were seen by facility-based, non-network providers as well as the billed charges and reimbursed rates on those claims. Policymakers should recognize the limitations of relying only on consumer complaint data and consider other mechanisms to monitor compliance with a state balance billing restriction.

The challenge with enforcement is that such legislation affects both providers and MCOs. Approaches such as hold harmless provisions are aimed at MCOs, while direct bans on balance billing are aimed at providers. Ideally, the insurance department, with jurisdiction over MCOs, would coordinate with the board of medicine, which regulates providers.²⁹ In reality, state medical boards typically focus on licensure and medical practice and rarely, if ever, become involved in billing disputes. Since state insurance departments generally lack jurisdiction over providers, improper balance billing may go unchecked. In Maryland, the Health Education and Advocacy Unit in the office of the attorney general has used the state's Consumer Protection Act to claim jurisdiction over unlawful balance billing of consumers. This office works closely with the insurance department to investigate and mediate unlawful balance billing practice by providers and MCOs. Several observers have suggested that this coordinated effort has helped drive down the number of balance billing complaints in Maryland. In California, two regulators oversee different segments of the health insurance industry, further complicating monitoring and enforcement.³⁰ Policymakers seeking to address balance billing should consider collaboration among agencies that have jurisdiction over implementation and enforcement.

Avenues for Member Education, Disclosure, and Transparency

Many MCO members are not well informed of their payment responsibilities when seeing an out-of-network provider. Members may find guidance in the summary plan description or certificate of coverage provided by their plan, but many do not read these documents. Further, without exact pricing information for a specific service (i.e., how much

the provider will charge and how much the MCO will pay), it is difficult for members to determine their financial liability for a balance bill. Regulators report that most consumer calls about balance billing are resolved with a discussion about what is permitted under law and a review of the terms of the consumer's coverage policy. However, regulators also note that consumers, unaware of their rights, may unwittingly pay the balance bill.

Some states require that MCOs provide certain information to members about payment responsibilities when receiving out-of-network care. In Colorado, MCOs must disclose when the member may be balance billed by an out-of-network provider, the "usual, customary, and reasonable rate" that an MCO pays for a service, and how the member can obtain the rates the MCO pays to an out-of-network provider.³¹ In addition, the MCO must inform members of any "material change" to the MCO network.³² Even with these requirements, regulators in Colorado noted that consumers might not know that the law protects them from paying balance bills from out-of-network providers in a network facility.³³ A 2007 Texas law takes a transparency approach by requiring providers and MCOs to make available pricing and network participation information to help members estimate their financial liability for out-of-network services. In addition, regulators are collecting "reimbursement data" from MCOs, including billed charges and rates for a variety of medical services, and will make this information available online. Policymakers may want to consider disclosure requirements for MCOs and providers to promote transparency and ensure that members understand their rights and responsibilities with regard to member liability for out-of-network care.

Dispute Resolution Mechanism for Arbitrating Payment Disagreements

In 2000, the Florida Legislature created the Statewide Provider and Health Plan Claim Dispute Resolution Program to "provide assistance to contracted and non-contracted providers and managed care organizations for resolution of claims disputes that are not resolved by the provider and the managed care organization."³⁴ Providers were encouraged by the possibility of resolving billing disputes without the high cost of litigation. In 2002, the program was expanded to mediate provider disputes with plans other than HMOs. Although participation is optional for providers, the review organization's determination is binding on both parties with the losing party paying the cost of the review. Since the program's inception, Florida has contracted with a private company (Maximus) to review claims disputes. Since 2005, the number of claims submitted for review has declined significantly, from 175 cases in 2005 to 59 in 2006 and just 15 in 2007. Some observers suggest that providers grew dissatisfied with early rulings, which generally favored MCOs. Of the nine cases that were fully reviewed in 2005, Maximus found for the MCO in two cases and split the decision in the other seven.³⁵ In the split decisions, providers were awarded significantly less than what they sought. Hospitals have all but abandoned using the process. Similarly, few physicians have turned to the program in recent years (one interviewed for this project called it a "tortuous process"). California has an independent dispute resolution process that has seen little activity.³⁶ Although some see dispute resolution as a valuable component of balance billing legislation, policymakers may want to limit their expectations for its usefulness.

Comprehensiveness of Balance Billing Protections

Most state protections against balance billing apply only to members of HMOs, not PPOs. These different regulatory approaches may be justified, as the PPO model is designed to offer patients the flexibility of going outside the network for care. The option to see out-of-network providers, even with greater out-of-pocket costs, is a primary reason for choosing a PPO over an HMO. However, some regulators point out that balance billing complaints are not received exclusively from HMO members. PPO members may not complain about balance bills for elective services from out-of-network providers, but, like HMO members, they may be unhappy with balance bills from out-of-network providers seen in emergency situations, or from hospital-based physicians in connection with care at a network hospital. In addition, many states do not maintain the same network adequacy standards for PPOs as for HMOs, so PPO members may be more likely to seek specialty care from out-of-network providers. Colorado has extended the same balance billing protections to both HMO and PPO members. Both HMO and PPO members in Colorado who receive care from an out-of-network provider at a network facility are held harmless by the plan from any higher costs. Some stakeholders interviewed in other states expressed interest in seeing either stronger network adequacy standards or balance billing protections extended to PPO members.

Another limitation, imposed by the federal Employee Retirement Income Security Act, prevents states from regulating self-insured employer health plans. Approximately 55 percent of covered workers nationally—30 percent in California, or roughly 5 million Californians—are enrolled in self-insured employer health plans and therefore are not affected by the state balance billing restrictions described

in this paper.³⁷ For example, the Colorado law that requires MCOs to hold members harmless regarding costs above what they would have faced had they been treated by a network provider does not apply to members of self-insured plans even if they use a managed care model to administer the plan. Regulated plans typically include those sold on the individual market and employer-sponsored plans for companies (especially smaller firms) that choose not to self-insure. Certainly, there is the possibility that a state solution to balance billing, especially one that has a large impact on provider networks, may ultimately affect members of self-insured plans to the extent that they use the same provider networks as MCOs. However, policymakers should be aware that state legislation would not directly apply to a large segment of their insured population and should consider the impact of this limitation. Furthermore, it is unclear whether providers or consumers understand what type of plan is involved and thus whether state laws might apply. This limitation could compromise broad efforts to educate MCO members about their rights.

The Market Environment

A state must consider its unique market environment when crafting laws to protect consumers from balance billing. For example, when a single MCO dominates the state's insurance market, providers who choose not to join its network run the risk of reducing the number of insured patients they may be able to see. As a result, dominant MCOs are more likely to have large provider networks and can reduce the likelihood of balance billing in the absence of legislation. But even in such markets, physicians in some specialties (such as anesthesiology) may choose to stay out of the dominant MCO's network. In a market with a dominant MCO, physicians have less bargaining power to obtain favorable contracted

rates. The reverse may be true where physicians in a particular specialty are organized into larger groups and obtain greater bargaining leverage. In such situations, physicians may stay out of networks and insist on collecting their full billed charges. California's tradition of organizing physicians into large groups may increase their leverage with MCOs, but it adds complexity by building in an additional organizational layer when MCOs delegate risk—and thus payment rates—to the physician groups. Policymakers need to understand their state's market environment in establishing how best to protect consumers in addressing balance billing. For example, market differences might influence the relative effectiveness of the hold harmless approach versus direct bans on balance billing.

When providers are not paid for services delivered to those without insurance, they tend to cover the cost of that uncompensated care through higher charges to other payers. Since payment rates set by public and private payers are lower than providers' billed charges, balance bills can help cover the cost of uncompensated care. On the other hand, billed charges may be well above the amounts needed to cover actual costs.³⁸ If uncompensated care volume is higher for physicians in some geographic areas or specialties, their incentive to collect balance bills is considerably higher.³⁹ For example, emergency physicians may experience more uncompensated care (and more Medicaid patients) since they are required under federal law to provide certain services to any patients who come to the emergency room. One emergency physician interviewed for this report suggested that physicians might be willing to see balance billing restricted if they received some compensation for the 30 percent of patients who pay nothing today. Those who set policies to restrict balance billing and to set payment levels where services are provided in the absence of a contracted

payment amount may want to take into account these variations in uncompensated care volume by location or provider type.

V. Conclusion

THE FEW STATES WITH BALANCE BILLING laws have been relatively successful in developing and implementing policies to protect MCO members from unexpected bills when using out-of-network health care providers. States typically ban balance billing by providers or require that MCOs hold their members harmless from balance billing. Either approach generally ensures that the member is not liable for balance bills. But no matter how states choose to address balance billing and the related payment standards, it will be important to recognize each state's particular market environment. The relative market strength of MCOs and providers, together with the need to cross-subsidize low public program payments and costs associated with treating the uninsured, may influence the effectiveness of different policy approaches such as direct bans or hold harmless requirements.

Successful state policies appear to require additional strategies to enhance their effectiveness. Some important strategies that states are likely to find valuable include: (1) ensuring patients are educated by regulators, MCOs, and health care providers about balance billing policies and potential member liability when seeking out-of-network services; (2) monitoring member, MCO, and health care provider complaints; and (3) incorporating an enforcement program that promotes collaboration between MCOs, providers, consumers, and regulators. As part of monitoring and enforcement, states may choose to consider a formal dispute resolution program. The success with those programs to date, where they have been tried, is quite limited.

State policies considered for this report, however, have been less successful in preventing payment

disputes between MCOs and providers. Identification of a fair payment standard for out-of-network claims continues to impose a significant challenge. Rate standards such as “usual and customary” are complicated by longstanding disagreements between MCOs and providers. An external standard, such as Medicare's fee schedule, although with higher levels than paid by Medicare, offers an approach that might prove more acceptable to both sides.

Table 1. Examples of State Laws Protecting Patients from Balance Billing by Non-Network Providers*

	SCOPE OF LAW			BILLING SCENARIO, BY SERVICE					REGULATORY FRAMEWORK
	PLANS	TYPE OF SETTING	TYPE OF CARE	COVERED BUT NOT AUTHORIZED, ON AN OUTPATIENT BASIS	COVERED AND AUTHORIZED, ON AN OUTPATIENT BASIS	ER, AT A NETWORK FACILITY	ER, AT AN OUT-OF-NETWORK FACILITY	COVERED AND AUTHORIZED, AT A NETWORK FACILITY	
Colorado	HMOs and PPOs	All	Arranged by insurer, in cases of inadequate network	No	Yes	Yes	No	Yes	<ul style="list-style-type: none"> • Hold harmless • Assignment
		Network hospital	Covered services						
Florida	HMOs	All	Services for which HMO is "liable"	No	Yes	Yes	Yes	Yes	<ul style="list-style-type: none"> • Hold harmless • Assignment[†] • Standardized reimbursement (ER services only)
		ER	Emergency care services						
Maryland	HMOs	All	Covered services	No [§]	Yes	Yes	Yes	Yes	<ul style="list-style-type: none"> • Hold harmless • Assignment[†] • Standardized reimbursement

*Although this project selected four states with laws that take varying approaches to balance billing, this exhibit excludes Texas (which does not restrict balance billing, per se, by non-network providers, but instead relies on an approach intended to make information more available to consumers). Colorado's law was enacted in 2006, but the 2006 legislation restated an interpretation that had been in place earlier. Florida passed legislation dealing with emergency services in 1996 and added broader protections in 2000. Maryland enacted legislation protecting balance billing by non-participating providers starting in 1989, and the current framework for reimbursement was established in 2002 and 2003 with amendments in 2005.

[†]Florida law requires HMOs to pay directly out-of-network providers that provide emergency services to HMO members (Florida Statutes § 641.513[5][2008]).

[‡]In Maryland, although there is no general mandatory assignment law, the state balance billing law requires HMOs to pay directly out-of-network providers that provide "covered services" to HMO members.

[§]If the HMO contract does not require authorization for the out-of-network services, then Maryland law would prohibit the out-of-network provider from balance billing. In Maryland, a "covered service" is generally considered authorized if it was included under the health benefit package of the HMO and provided by the out-of-network provider, in accordance with the member's contract, per referral, or otherwise approved by the HMO or a provider under contract with the HMO (Annotated Code of Maryland, Health-General § 19-701 [d][2][i][iii]).

Appendix: Balance Billing and Medicare

Most Medicare beneficiaries have traditional Medicare coverage that resembles indemnity insurance. From the start of the Medicare program in 1965, physicians were permitted to decide on a claim-by-claim basis whether to submit bills on assignment and accept Medicare's fee as payment in full or to bill the patient directly, leaving the patient responsible for the balance bill amount. In the program's early years, physicians accepted assignment for over half of all claims, with the share rising to about two-thirds by the mid-1980s. As of 1985, Medicare-allowed charges were usually below the billed charges (85 percent of the time), with a typical balance bill of about one-fourth of the billed charge.⁴⁰

In 1984, Medicare initiated a participating physician program in which physicians agree to accept assignment for all beneficiaries. In return the doctors are listed in published directories (now available on the Web) and receive a slightly higher allowed charge on their claims. About one in four physicians initially signed up for this program, with participation rising to over 50 percent by the early 1990s.⁴¹ Legislation in the 1980s also placed limits on the actual charges by physicians, somewhat limiting the size of balance bills. But even with these changes, more than half of all beneficiaries were paying balance bills at some point each year. Furthermore, a 1988 survey of Medicare beneficiaries found that a majority did not understand concepts such as assignment and participation and rarely discussed these matters with their doctors.

In 1989, Congress completely revamped Medicare's approach to paying physicians, including changes to the rules for balance billing. The legislation limits balance billing amounts to no more than 9.25 percent of the Medicare Fee Schedule amount received by those in the participating physician program. The program monitors the claims of nonparticipating physicians; if frequent violations are found, more intensive monitoring follows, and more serious cases can be referred to the inspector

general. Reviews can also be initiated in response to beneficiary complaints.

As a result of these policy changes, 99.4 percent of all Medicare claims were paid on assignment in 2006, so balance billing has become a rare event in Medicare. Apparently, the small size of the allowed balance bill means that the advantages of being able to submit bills as assigned claims mostly outweigh the value of collecting an extra payment from the beneficiary. In fact, 93 percent of physicians now enroll in the participating physician program, thus agreeing never to balance bill.⁴²

Endnotes

1. “Hold harmless” provisions are standard in most contracts between managed care plans and network providers and in most states are required by law in HMO contracts. *See* Lucas, C., et al. 2006. *Fifty State Survey of Balance Billing Laws*. American Health Lawyers Association.
2. Generally, except when authorizing care in advance, an HMO will not reimburse an out-of-network provider at all, leaving the patient responsible for the entire bill. If the care is authorized by the HMO, the situation is comparable to an in-network service and the patient should not face balance billing. By contrast, members of PPOs or similar open-network plans generally may choose to receive services from a network or out-of-network provider and receive reimbursement from the PPO. But when care is received out of network (unless authorized or in an emergency), the patient may expect to pay a higher cost-sharing rate and may be balance billed.
3. *Mandatory Assignment of Benefits*. Anthem Fact Sheet, January 2006. On record with authors.
4. California Association of Health Plans. October 24, 2007. “CAHP Calls For Ban On ‘Balance Billing.’” News release and related fact sheet (www.calhealthplans.org/documents/pr102307.pdf, www.calhealthplans.org/documents/balance%20billing%20fact%20sheet.pdf).
5. In Kentucky, for example, “A managed care plan shall file with the executive director sample copies of any agreements it enters into with providers for the provision of health care services. The executive director shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following: (a) A hold harmless clause that states that the provider may not, under any circumstance, including 1. Nonpayment of moneys due the providers by the managed care plan, 2. Insolvency of the managed care plan, or 3. Breach of the agreement bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, co-insurance amounts, and amounts for non-covered services.” *See Kentucky Revised Statutes Annotated* § 304.17A-527(1)(a) (2008). In Michigan, although the term “hold harmless” is not specifically stated, “an affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments, co-insurances, and deductibles directly from enrollees.” *See Michigan Compiled Laws Service* § 500.3529(3)(2008).
6. In California, a law governing HMOs states that “(a) every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan. (b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan. (c) No contracting provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan.” *See California Health and Safety Code* § 1379 (2008). Note that this statute addresses written contracts as well as a contract that “has not been reduced to writing.” The California Department of Managed Health Care (DMHC) has interpreted this language, along with other provisions of the Knox-Keene Act, as a total restriction on balance billing of HMO members by emergency providers, even by non-network providers. *See Lucas, Fifty State Survey*, p. x, p. 5.
7. *Prospect Medical Group Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497 (Cal. January 8, 2009).
8. California Department of Managed Health Care. August 2008. “DMHC Builds on Efforts to Protect Patients from Unfair and Unexpected Bills.” Press release (www.hmohelp.ca.gov/library/reports/news/prbbregs.pdf).

9. In addition, SB 697 (Chapter 606), prohibiting health care providers from balance billing members of two state programs (Healthy Families and Access for Infants and Mothers), was signed into law in 2008.
10. In addition, AB 2220 was passed by the legislature in 2007, but vetoed by the governor. Although it did not address balance billing directly, AB 2220 would have established a process for mandatory mediation in physician-HMO contract negotiations where the physician sees more than 5 percent of the HMO's members and a hospital contracting with the HMO requests the physician enter into a contract negotiation with the HMO.
11. For more information about these specific laws, see Lucas, *Fifty State Survey*. Some states, such as Virginia, have read into state law a protection for HMO members from balance billing by out-of-network providers in certain situations, although this is accomplished by interpretation and not expressly stated in statute. See Virginia Bureau of Insurance, June 16, 2008, Administrative Letter 2008–09, Commissioner of Insurance to All Health Maintenance Organizations Licensed in Virginia and Interested Parties (www.scc.virginia.gov/division/boi/webpages/adminlets/08-09.pdf).
12. In Connecticut, questions of interpretation remain about a statute sometimes reported as prohibiting non-network providers from balance billing HMO members. Connecticut specifies under Connecticut General Statutes § 20-7f(b) (2008) that “it shall be an unfair trade practice for any health care provider to request payment from an enrollee, other than a copayment or deductible, for medical services covered under a managed care plan.” A recent court ruling suggests a very broad reading of this statute to include restricting balance billing of HMO members by out-of-network providers. See *Charles D. Gianetti, M.D. v. Fortis Insurance Company et al.*, 2007 Conn. Super. LEXIS 838.
13. Some states, such as Delaware and Colorado, also extend protections to PPO members. A state protection may broadly apply to all covered services, as in Maryland, or apply only to a limited number of services, as in New York, where the protection only applies to two specific types of services: pre-hospitalization emergency care provided by a licensed ambulance company (*N.Y. Insurance Law* § 3221[I][15] [Consol. 2008], *N.Y. Insurance Law* § 3216[i][24] [Consol. 2008] and *N.Y. Insurance Law* § 4303[aa] [Consol. 2008]) and end-of-life care exclusively for those with terminal cancer (*N.Y. Insurance Law* § 4805 [Consol. 2008] and *N.Y. Public Health Law* § 4406-e [Consol. 2008]). Finally, a state protection may apply to all settings, as in Maryland, or only in limited settings, as in Indiana, which protects HMO members from balance billing by out-of-network providers only in emergency care settings. A state may take a broader approach to protecting patients from balance billing by also regulating provider reimbursement in these situations. For example, West Virginia law requires payment of the “provider’s normal charges” for emergency care services. Four other states (Delaware, Florida, Indiana, and Maryland) also provide statutory guidance for reimbursement rates of out-of-network providers in certain circumstances. Finally, Delaware and Florida make available a formal dispute resolution system to help resolve reimbursement issues between providers and insurers. Some states have also sought to increase the transparency around provider payments with better information for consumers on what they should be paying and what they can expect their insurers to pay.
14. Researchers conducted 33 interviews from May through September 2008. Most interviews were conducted by the two senior investigators on the project, with another team member taking notes.
15. *Colorado Revised Statutes* § 10-16-704(1) and (2) (2008).
16. *Colorado Revised Statutes* § 10-16-704(3) (2008). This statute codifies the Colorado General Assembly’s intent to require MCOs to hold patients harmless for covered services received from non-network providers at in-network hospitals. Interestingly, in 1997, the general assembly passed legislation later interpreted by the Colorado Division of Insurance (CDI) to do the same. This regulatory interpretation was challenged by insurers and ultimately overturned by a Colorado Court of Appeals ruling in 2006. That year, almost 10 years after the original legislation, the general assembly passed legislation that confirmed that the CDI had “correctly interpreted” the original legislation.

17. In 2005, public hearings conducted by CDI noted that “some consumers in fully insured plans may not know of the law and may pay balance-billed charges.” See Report by the Colorado Division of Insurance on the issue of balance billing, 2005, p. 2. On file with author.
18. *Florida Statutes* § 641.3154 (2008).
19. *Florida Statutes* § 641.513(5) (2008).
20. *Florida Statutes* § 641.513(5) (2008). Per discussion with the Florida Office of Insurance Regulation, February 2009.
21. *Annotated Code of Maryland, Health-General* §19-710(i) and (p) (2008).
22. *Annotated Code of Maryland, Health-General* § 19-701 (d) (2)(i)(ii)(iii) (2008).
23. *Annotated Code of Maryland, Health-General* § 19-710.1 (b)(1)(ii) (2008). In a recent draft report, the Maryland Task Force on Health Care Access and Reimbursement recommended a change in the statutory rule regarding these reimbursement standards. Generally the recommendation would set reimbursement for evaluation and management services as the greater of 140 percent of the Medicare fee or 125 percent of the average network rate. Procedures, tests, and imaging services would be reimbursed at 125 percent of the average network rate (using an average is intended to address the concern that some MCOs use the lowest fee paid in an area). See Maryland Department of Health and Mental Hygiene. December 2008. *Draft Report of the Task Force on Health Care Access and Reimbursement. Final Report and Recommendations*. Recommendation #3, p. 34 (www.dhmh.state.md.us/hcar/pdf/nov2008/nov25/draft_hcar_final_report.pdf). Proposed legislation, consistent with the recommendation, was recently introduced to the 424th session of the Maryland General Assembly.
24. Under a Texas law, PPO members have virtually no protection against balance billing. There is not a “per se” rule restricting non-network providers from balance billing HMO members, but the Texas Department of Insurance interprets the HMO Act to allow an HMO to contract with a physician practicing in a network facility to honor the facility’s hold harmless agreement. This interpretation is limited by a 2003 Texas attorney general’s opinion concluding that, in the absence of such a contract, “the Act does not prohibit a physician who is not under contract with an HMO from balance billing.” However, this opinion does not consider “whether state law permits a network facility to require non-network physicians with privileges at the facility to honor the facility’s hold harmless agreement with an HMO.” See Attorney General of Texas. March 2003. *Opinion No. GA-0040* (www.oag.state.tx.us/opinions/opinions/50abbott/op/2003/pdf/ga0040.pdf).
25. Longley, Dianne. February 18, 2008. *Health Care Pricing Transparency For Consumer: Senate Bill 1731 Implementation*. Presentation prepared by the Texas Department of Insurance; *House Research Organization Bill Analysis for Senate Bill 1713* (www.hro.house.state.tx.us/pdf/ba80r/sb1731.pdf); Enrolled Summary for Senate Bill 1731 (www.legis.state.tx.us/billlookup/billssummary.aspx?legsess=80r&bill=sb1731).
26. For more detail, see Texas SB 1731 (2007).
27. SB 981 (2007).
28. Earlier versions of this legislation had different payment standards. One defined the interim payment rate as the 50th percentile of submitted Medi-Cal charges related to emergency care and adjusted annually for inflation. A later version used the 50th percentile of physician charges as collected for a commonly used commercial database. By contrast, the regulation (28 *California Code of Regulations* §1300.71.39 [2008] [wps0.dmhc.ca.gov/regulations/docs/regs/19/1221585440921.pdf]) issued by the Department of Managed Health Care in 2008 builds on the existing requirement that plans pay the reasonable and customary value of the services rendered as stated in the department’s explanation of its regulation (www.oal.ca.gov/pdfs/notice/13z-2008.pdf).
29. California’s situation is more complex because two different agencies regulate health plans.

30. Oversight of health insurance carriers in California is divided between two state departments. The Department of Managed Health Care regulates health care service plans whose products have historically emphasized service delivery through HMOs. The California Department of Insurance has jurisdiction over health insurers whose products have historically emphasized the financial protection aspects of insurance, rather than service delivery. Roth, Debra L., and Kelch, Deborah Reidy. December 2001. *Making Sense of Managed Care Regulation in California*. California HealthCare Foundation.
31. *Colorado Revised Statutes* §10-16-704(2)(d),(e) (2008).
32. *Colorado Revised Statutes* §10-16-704(2.5)(a) (2008).
33. Report by the Colorado Division of Insurance on the issue of balance billing. 2005. p. 2. On file with author.
34. Florida Agency for Health Care Administration. 2008. *Statewide Provider and Health Plan Claim Dispute Resolution Program: Annual Report 2008* (www.fdhc.state.fl.us/mchq/managed_health_care/sphclaimdrp/annualreport2008.pdf).
35. The number of cases reviewed in full was significantly less than the number of applications. For example, of 175 cases submitted in 2005, only 14 were found to be eligible for review; the rest were ineligible because they did not meet basic eligibility criteria or had incomplete data. Ultimately, after three parties withdrew from the process, only 11 cases were fully reviewed. By the time of the printing of the *Annual Report 2006*, only nine cases were completed with final decisions posted. Florida Agency for Health Care Administration. 2006. *Statewide Provider and Health Plan Claim Dispute Resolution Program: Annual Report 2006*.
36. DMCH Director Cindy Ehnes stated in a prepared statement issued October 14, 2008, regarding balance billing regulations: “The DMHC has also made available a fair, fast, and free way for providers to solve their claims disputes, through our Independent Dispute Resolution process. Unfortunately, physician advocates have discouraged their members to use this process, opting instead for other avenues. Therefore, the DMHC is conducting a test to prove its effectiveness. We recently submitted 10 provider complaints to this independent review and findings should be available in mid-November.” (www.hmohelp.ca.gov/library/reports/news/tpbbeffpub.pdf).
37. National Opinion Research Center. December 2008. *California Employer Health Benefits Survey*. California HealthCare Foundation (www.chcf.org/topics/healthinsurance/index.cfm?itemID=133543).
38. For physicians, unlike institutional providers, the concept of actual costs is not well defined because compensation to the physician—the physician’s net income—is a major component of actual costs. Still, it is clear that uncompensated care means a reduction in physicians’ income.
39. In states with low Medicaid payment rates, high Medicaid caseloads may have the same effect.
40. Physician Payment Review Commission. March 1, 1987. *Medicare Physician Payment: An Agenda for Reform: Annual Report to Congress*.
41. Physician Payment Review Commission. 1992. *Monitoring the Financial Liability of Medicare Beneficiaries*.
42. Medicare Payment Advisory Commission. March 2008. *Report to the Congress: Medicare Payment Policy*.



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