TEXAS DEPARTMENT OF INSURANCE

Balance Billing

Glossary of Terms

Allowed amount - The maximum amount on which payment is based for **covered health care services**. From the health plan's perspective, this is the fair price for a health care service. This may be called "eligible expense," "payment allowance," "contracted rate," or "negotiated rate." If your doctor or hospital charges more than the allowed amount, you may have to pay the difference. This is called **balance billing**.

Balance billing - When a doctor or hospital bills you for the difference between their charge and the **allowed amount**. For example, if their charge is $100 and the allowed amount is $70, they may bill you for the remaining $30. A **preferred provider** may not balance bill you for **covered services**.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. In most plans, after meeting your **deductible** , you must pay coinsurance until you reach your **out-of-pocket limit**. For example, if your plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount. Coinsurance usually does not apply to **HMOs**.

Deductible - The amount you must pay **out-of-pocket** for **covered services** before your plan begins to pay its portion of your medical expenses. You usually must meet a deductible each year. For example, if your deductible is $1,000, your plan won't pay anything until you've paid $1,000 out-of-pocket for covered health care services subject to the deductible. If you have a family plan that covers your spouse or dependents, you may have one deductible for the entire family, or you may have to meet a separate deductible for each family member.

Exclusive provider organization (EPO) - A type of health plan where services are covered only if you go to **preferred providers**. **Out-of-network** care is only covered in an emergency, or if you can't access the care you need **in-network**. EPO plans are similar to **HMO** plans, but EPOs are offered by insurance companies, which are regulated differently than HMOs.

Health maintenance organization (HMO) - A type of health plan that usually limits coverage to care from **preferred providers.** **Out-of-network** care is only covered in an emergency, or if you can't access the care you need **in-network**. In an HMO plan, your care is managed by your **primary care provider** and you need a **referral** in order to see a **specialist**. HMO plans are similar to **EPO** plans, but HMOs are regulated differently than insurance companies.

Non-preferred provider - Any **provider** outside an insurer's **network**. Visiting a non-preferred provider can incur **balance billing -** synonymous to an **out-of-network** provider.

Out-of-pocket maximum or limit - The most you will have to pay during a policy period (usually a year) before you no longer have to pay **cost-sharing** for **covered health services**. Once you've reached your out-of-pocket maximum, your health plan generally pays 100 percent of your covered essential health benefits. You are still

responsible for paying your **premium**. This maximum or limit does not include your premium, **balance-billed** charges, spending for non-essential health benefits, or spending for **non-covered services**.

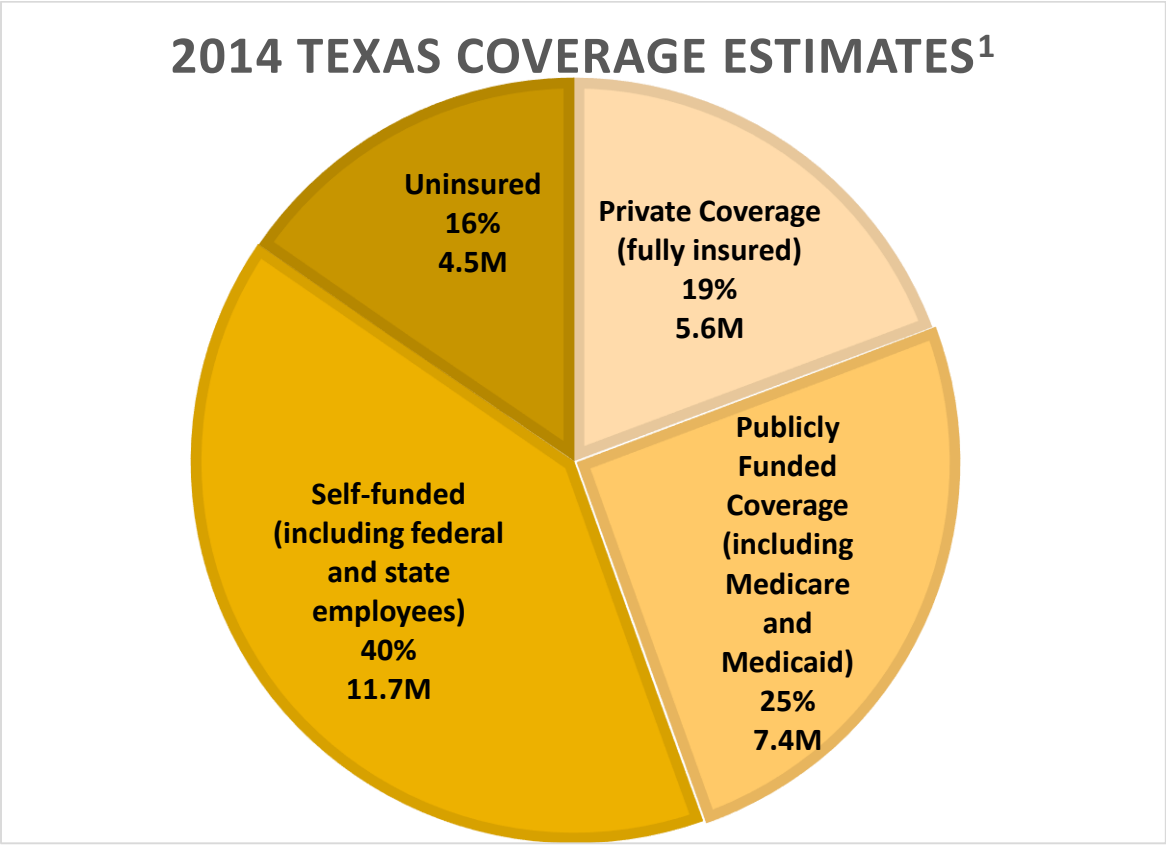
Preferred provider organization (PPO) - A type of health plan that contracts with doctors and hospitals to create a network of **preferred providers** that can provide care to **enrollees** at a discounted cost. PPOs will cover some **out-of-network** costs, but you will pay more and may be **balance billed**.

Self-funded plans - Plans funded strictly from employer contributions and employee premiums. These plans are authorized by the federal Employee Retirement and Income Security Act (ERISA) of 1974 and are regulated by the U.S. Department of Labor. State regulation of these plans is limited. Although an insurance company may be hired to administer the plan, the insurance company assumes no risk. (Also known as ERISA plans.) The state may regulate state employee self-funded plans and multiple employer self-funded plans.

Usual and customary charges - The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The usual and customary charge amount sometimes is used to determine the allowed amount.

Market Overview

TDI regulates private fully insured coverage, as shown below.



1 Note that some individuals have multiple coverages.

Balance Billing Laws and Regulations

Transparency Requirements – Insurers (non-HMOs) must:

- use language in insurance policies that:
  - is readable and understandable;
  - discloses how reimbursements of non-preferred providers will be determined and the insured's financial responsibilities for out-of-network services;
  - if usual and customary charges are used, discloses the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied; and
  - if anything other than full billed charges is used, discloses the possibility of balance billing, provides a description of the payment methodology, and provides a method for consumers to obtain a real-time estimate of how much a non-preferred provider will be paid;

- use provider directories that are:
  - updated at least every month;
  - identify hospitals that facilitate the use of preferred providers;
  - identify all in-network, facility-based physicians at network facilities and specifically identify facilities without any contracts with different types of facility-based physicians; and
  - identify, for each contracted hospital, the percent of the total dollar amount of out-of-network claims filed by facility-based physicians, broken down by specialty;

- provide consumers notices of their rights and of substantial decreases in the availability of facility-based physicians at contracted hospitals and provide policyholders annual detailed notices regarding any inadequacies in their network.

Network Standards – Insurers must:

- meet qualitative and quantitative network adequacy requirements;
- not market where they have an inadequate network unless they obtain a TDI waiver on a showing of good cause, giving providers an opportunity to respond;
- file a detailed network adequacy report with the department each year; and
- if an EPO, meet rigorous prior approval and examination processes, with standards for quality improvement programs.

Payment Standards – Payments to non-preferred providers must:

- be calculated pursuant to an appropriate methodology that:
  - if based upon usual and customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;
  - if based on claims data, is based on sufficient data;
  - is updated no less than once per year;
  - does not use data that is more than three years old; and
  - is consistent with nationally recognized and generally accepted bundling edits and logic.

- take into account emergency, inadequate network, and inaccurate provider directory situations by:

- paying those claims, at a minimum, based on the usual or customary charge, less any coinsurance, copayment, or deductible;
- paying those claims at the in-network coinsurance percentage;
- in addition to any amounts that would have been credited had the provider been a preferred provider, crediting any out-of-pocket amounts paid to the non-preferred provider above the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services; and
- if an EPO, protecting the consumer from balance billing.

Mediation

- HB 2256 created a mediation process for balance billing issues in 2009.
- TDI began accepting mediation requests in 2010 and has seen a gradual increase over time as more consumers and providers become aware of the program.
- The scope of the statute is limited to balance bills by facility-based non-preferred physicians incurred at preferred (in-network) facilities.
- In 2015, SB 481 lowered the dollar threshold to balance bills of more than $500 (not including applicable coinsurance, copays, or deductibles).
- Most mediation requests are settled informally prior to actual mediation.

MEDIATION REQUEST SUMMARY							
	CY 2009	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**
Total Number Received	5	14	21	7	146	893	1,062
Mediation Billed Amount*							$1,220,554.44
Mediation Paid Amount**							$190,720.82
Total Referred to SOAH	0	0	0	0	3	126	82
Number Received - $1,000 and over							1,000
Number Received - $500-$999***							46
Number Received - $499 amount or below							7
Number Received - Did not qualify****							9
Total Number Received							1,062
*The Mediation Billed Amount is the amount entered on the Mediation Request form submitted to TDI.							
**The Mediation Paid Amount is the amount paid by the carrier to the provider as a result of the informal settlement telephone conference. This does not include mediation settlements.							
***The mediation request threshold changed from $1,000 to $500 on 9/1/2015.							
****These mediation requests did not qualify because 1) they involved a self-funded or other type of health plan that is not eligible for this program or 2) the requester did not provide sufficient information.							

Questions for the Texas Department of Insurance (TDI) from the Chair of the House Insurance Committee

1) How many complaints were made related to §1301.051(a) for failure to be provided a fair, reasonable, and equivalent opportunity to apply to be designated as a preferred provider?

TDI received only six complaints from January 1, 2013, through December 31, 2015, regarding failure to provide an opportunity to apply to be a preferred provider. Of these, only one complaint was confirmed. A complaint is confirmed if there is an apparent violation of an insurance policy provision, contract provision, rule or statute, or there is a valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice. TDI has issued two consent orders since 2013, when two providers, both optometrists, could not join a plan's medical panel without our assistance.

2) How many providers have made complaints on insurers for violating 28 TAC §3.3703 (Contracting Requirements)?

The chart below shows the number of complaints from providers regarding insurers violating contracting requirements; virtually all of these complaints are about denial of a claim.

	CY 2013	**CY 2014**	**CY 2015**
Total complaints	595	711	616
Confirmed complaints	142	284	89
Percent confirmed	24%	40%	14%

3) What percentage of health plans are operating under a waiver? How many individuals are covered in those plans operating under the waiver? How many individuals are covered by plans that maintain adequate networks?

- To date, TDI has received approximately 137 annual reports from insurance companies for the 2016 reporting period.

- Approximately 34 preferred provider networks (25 percent) currently have approved waivers and access plans. However, waiver requests and access plans will increase as TDI completes adequacy reviews for those insurers who represent to TDI that their networks are adequate. In the majority of cases, waivers are requested and granted because no providers of a particular type are located in a particular area of the state. Ten waivers have been granted because an insurer was unable to contract with an available provider, and in each instance, TDI did not receive a reply from the provider regarding the failure to contract.

- Data on the number of enrollees covered by preferred provider networks is not available because insurers do not report enrollment data by networks. Insurers have submitted adjusted access plans in support of a waiver request for some networks but not others. Please keep in

mind, a waiver does not remove the insurer from the statutory and rule requirements to provide all covered necessary health care to an enrollee. Further, insurers are required to pay higher amounts to out-of-network providers if no network provider is available, regardless of whether a waiver is in place.

4) For plans that operate under a waiver, what is the renewal rate for those waivers?

The 34 networks have renewed their waivers and filed access plans each of the three years that the reporting requirement has been in place. Generally, waivers due to the absence of providers in the region will be renewed until an applicable provider moves into the region.

5) Are there particular specialists that tend to be unavailable to contract or refuse to contract which leads to having to file for a waiver?

- Unavailability of specialists primarily depends on the Texas region in question. For example, numerous rural counties and areas have few or no available specialists and therefore, the health plan has few, if any opportunities, for contracting. In these counties or areas, enrollees normally travel to cities where specialists are available. This pattern of travel to obtain health care services occurs even if the insurer has filed a waiver and access plan.

- Providers refuse to contract with health plans for a number of reasons. Therefore, refusal to contract may not always depend on the specialty itself. TDI has found that behavioral health specialists and facilities and specialists, such as neurosurgeons and hand surgeons, are few in number throughout the state and may not wish to contract with health plans.

- TDI can say with certainty that hospital-based providers often refuse to contract with health plans. Hospital-based providers include emergency room providers, anesthesiologists, radiologists, pathologists, and neonatologists. However, even if some contracted hospitals do not have contracted hospital-based providers, TDI generally requires insurers to have at least one hospital in each area that has contracted hospital-based providers. Thus, waiver requests for this provider type are relatively rare.

6) Do you see a demographic trend among waiver applications? For example, do plans that require waivers tend to come from rural markets?

- Insurers request waivers and access plans for rural areas because of unavailability of specialists and facilities (including primary care). As previously stated, enrollees normally travel to cities where specialists are available and this pattern of travel to obtain health care services occurs even if insurers file waivers and access plans.

- Insurers also request waivers and access plans for urban areas for hospital-based providers who decline to contract with any health plan.

7) How comparable are local market access plans to adequate networks? Are the differences dramatic or are they missing just a few services? How many complaints have been made related to local market access plans? How bad are the burdens on the enrollee?

- Due to shortages of particular provider types in Texas, it currently appears impossible for any insurer to have an adequate statewide network under TDI's rules. The insurer with the largest statewide network has waivers of various types in 155 counties.

- Most local market access plans are similar because all of them tend to refer to the same types of specialists, such as hospital-based providers or specialists, that are not available in particular Texas counties or areas.

- The access plan may also depend on typical travel and referral practices. For example, for some rural areas in Texas, primary care providers regularly send their patients to Dallas or San Antonio for specialized care because specialists are not available locally. As previously stated, this pattern of travel to obtain health care services occurs even if insurers file waivers and access plans.

- If a network is not adequate, the health plan must provide or arrange for health care for enrollees, even if it means that enrollees must obtain health care from out-of-network providers.

- The burdens to enrollees are typically due to distance and travel cost; however, these burdens already exist in rural areas. Because insurers are required to pay at the in-network level of benefits calculated off of, at least, the usual and customary billed charge, it is anticipated that balance billing in these instances should be minimal.

When TDI receives a complaint, the name of the insurer or Health Maintenance Organization (HMO) complained about is entered in the complaint tracking database. We do not enter the name of the health plan network and are not able to identify complaints regarding local market access plans. Please see the chart in number 9.

8) Are plans timely and accurately filing their Annual Network Adequacy reports?

The graph below reflects intake data since 2014 Preferred Provider Organization (PPO)/Emergency Provider Organization (EPO) rule implementation.

CY	RECEIVED	REFERRED TO ENFORCEMENT
2014	71	9
2015	95	59
2016	137	15

Annual network adequacy reports became a requirement on April 1, 2014. At the time, TDI did not have a reference for the number of PPO/EPO filers that should report. In April 2014, 71 network plans were received and 9 network plans were referred to our agency's Enforcement Office. No fines resulted from TDI's first year compliance efforts.

As reflected in the table above, and as a result of ongoing regulation, insurers have a better understanding of the annual filing requirements and compliance with annual reporting has improved. Since April 1, 2016, 137 network plans have reported their filing requirements and TDI is auditing these submissions to determine any deficiencies. Thus far, 15 network plans have been referred to our agency's Enforcement Office.

9) How many complaints have been made regarding inaccuracy of preferred provider listings?

The number of complaints regarding inaccuracy of provider listings is shown below. TDI sends these complaints to the insurer or HMO responsible for the health plan's provider listing. The insurer or HMO responds they have corrected the problem or provides another explanation, for example, the provider recently left the network. TDI monitors insurers for patterns of using inaccurate directories and can request a management conference with the insurer or take enforcement action as appropriate. TDI's rules offer protection to consumers in this instance by requiring the insurer to pay at a higher rate (similar to emergency care) if the consumer relies on the inaccurate directory for their care.

	CY 2013	CY 2014	CY 2015
Total complaints	0	3	31
Confirmed complaints	0	0	15
Percent confirmed		0%	48%

10) How many balance billing complaints have been made and what specialties tend to be the greatest?

A summary of balance billing complaints is shown below, including dollars returned to consumers through the complaint process.

	CY 2013	CY 2014	CY 2015
Total complaints	277	1,220	1,331
Confirmed complaints	18	168	68
Percent confirmed	6%	14%	5%
Dollars returned to consumers	$ 216,220.90	$ 769,204.91	$ 621,694.87

Regarding provider specialties, TDI tracks provider specialties associated with mediation requests. Anesthesiologists and emergency room physicians are the most frequent specialties.

Provider Type	CY 2013	CY 2014	CY 2015
Out-of-Network Anesthesiologist	122	792	922
Out-of-Network ER Physician	17	106	199
Out-of-Network Neonatologist	3	2	3
Out-of-Network Pathologist	11	25	79
Out-of-Network Radiologist	1	9	1

11) How many times has the Commissioner used his or her §3.3710 (Failure to Provide an Adequate Network)?

To date, TDI has not denied any waivers. However, insurers are beginning to voluntarily reduce their service areas when TDI requests insurers to "prove" their claims that the networks are adequate. TDI expects this trend to continue in 2016 as TDI requires all insurers to provide proof of adequacy. If insurers fail to prove their claims that the networks are adequate, TDI will either reject the waivers or ask the insurers to reduce their service area.

12) Is TDI using the Plan Designations section in 28 TAC §3.3705(p)? If they are used, what percentage of plans are designated as Limited Hospital Care Networks?

Networks are not designating the plans as Limited Hospital Care Networks.

13) How many unsuccessful mediations have been reported in accordance with §1467.057 of the Insurance Code?

Please see chart in response to question 14.

14) How many bad faith mediations have been reported? Of those, how many are against the insurer and how many are against the provider?

The State Office of Administrative Hearings (SOAH) provided the summary shown below of mediation cases, as of May 10, 2016.

How many cases were received from TDI (since 2009)?	238
How many mediation requests were resolved by SOAH prior to actual mediation?	213
How many mediations were actually completed?	5*
How many mediations were successful?	3
How many unsuccessful mediations have been reported?	2*
How many bad faith mediations have been reported?	0
How many bad faith mediations are against the insurer?	0
How many bad faith mediations are against the provider?	0

*Two of the cases involved the same patient and physician with the two procedures separated by several months. As the second case was not ready for mediation when the first case was mediated, the parties entered into a stipulation that, were the second case mediated, it would have failed for the same reasons the first cased failed to resolve at mediation. Subsequently, both cases were forwarded to the same Special Judge for trial, and they settled prior to trial. The purpose for entering the stipulation on the second case was to avoid unnecessary costs and to allow the cases to be bundled for the Special Judge.

15) How many complaints have been made regarding out-of-network settlements and delayed medical care in accordance with §1467.151 of the Insurance Code?

Complaint data regarding balance billing generally is addressed above. TDI is not aware of any complaints regarding the mediation process, regarding out-of-network settlements, or regarding delayed medical care. Generally, balance billing disputes arise after care has been provided.

16) What data is available on out-of-network claims? Is it grouped by the total insurer claims or by the networks established by the Plans? What is the ratio of out-of-network claims to in-network claims? How many of the out-of-network claims arise from an emergency situation? What types of providers are most frequently billed as out-of-network? Are pharmacy claims included in this data? If so, is there a way to separate out the pharmacy claims?

Networks have aggregated their claims data on the annual reports. TDI is continuing to require plans to resubmit their reports and break out the claims data by regions. In-network claims data is not collected by TDI. Emergency services claims are not captured in the required reports. Claims billed as out-of-network claims are frequently from hospital-based providers, neurosurgeons, behavioral health specialists, and hand surgeons. The overwhelming majority of

pharmacy networks are adequate. Currently, two statewide pharmacy networks have requested waivers. Pharmacy claims are not captured in the reporting.

Balance Billing – What are States Doing?

TDI Issue Brief
May 2016

Introduction

About one-fourth of states protect consumers against balance bills in some circumstances.[1] Some protect against balance bills for emergency services from non-network providers, often by requiring Health Maintenance Organizations (HMOs) (and sometimes Preferred Provider Organizations (PPOs)) to hold consumers harmless for bills from non-network providers. Less frequently, states protect against balance bills in "surprise billing" situations, for instance where a consumer uses an in-network hospital, but is treated by non-network providers like anesthesiologists, radiologists, or assistant surgeons. These protections, too, are often limited to HMOs, though they sometimes extend to PPOs as well. A few states accompany balance billing protections with some form of mediation of out-of-network provider charges.

State Protections

The list below reviews approaches to balance billing protection in states that figure significantly in the available literature. It is not an exhaustive list, but more of an attempt to broadly review current approaches and capture major trends. It may appear to vary from other lists because some concentrate only on emergency services, for instance, or because it has not yet been possible to verify (by reference to state statutes, for example), statements by others who have reviewed balance billing issues. As noted in at least one study, commonly referenced reports in this area differ in their interpretations of state statutes. Continued research may unearth more accurate information. In the meantime, there appears to be at least one 50-state academic survey in process that may produce more useful information this fall.

California

California prohibits providers[2] from balance billing consumers covered by HMOs in emergency cases.[3] When an enrollee requires immediate medically necessary health care services, health care service plans must pay for all medically necessary health care services rendered to an enrollee.[4] Reimbursements are based on a "reasonable and customary value" for non-network providers.[5] The state provides a voluntary, non-binding dispute resolution process,[6] but it is not clear how frequently this is used or how effective it is.

---

[1] This figure is not based on a 50-state survey, but on information from the American Health Lawyers Association and the Kaiser Family Foundation which differ in their interpretation of state statutes. Hoadley, Ahn, and Lucia, "Balance Billing: How are States Protecting Consumers from Unexpected Charges?", Center on Health Insurance Reforms, Georgetown University Health Policy Institute, September 2015. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966. The Hoadley, Ahn, and Lucia paper forms a basis for much of the information collected here. Other reports adopt generally the same statistic figure, but assessments differ. See, for instance, Christina Cousart, "Answering the Thousand-Dollar Debt Question: An Update on State Legislative Activity to Address Surprise Balance Billing," National Academy for State Health Policy, April 2016, http://nashp.org/wp-content/uploads/2016/04/BCBS-Brief.pdf; Avalere Health LLC, "An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey," http://www.horizonblue.com/sites/default/files/ah_analysis_of_policy_options_wp_v3b.pdf; September 2015; Public Citizen, Out of Control: Patients Are Unwittingly Subjected to Enormous, Unfair, Out-of-Network 'Balance Bills,' April 2014; Hoadley, Lucia, and Schwartz, "Unexpected Charges: What States Are Doing About Balance Billing," California HealthCare Foundation, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiRm-ze3N7MAhVrzoMKHX0oAYQQFggdMAA&url=http%3A%2F%2Fwww.chcf.org%2Fpublications%2F2009%2F04%2Funexpected-charges-what-states-are-doing-about-balance-billing&usg=AFQjCNEOVFVKVQOX6viOSyISzsj8pRLUXg, April 2009; Lucas, C., et. al., "Fifty State Survey of Balance Billing Laws," American Health Lawyers Association, 2006.

[2] "[I]ncluding but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists," April 2014, http://www.citizen.org/documents/out-of-network-balance-billing-report.pdf.

[3] 28 Cal. Code Regs. §1300.71.39.

[4] 28 Cal. Code Regs. §1300.71.4(a).

[5] " For contracted providers without a written contract and non-contracted providers, … : the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which

Colorado

Colorado treats covered services by non-network providers at network facilities as if they were in-network and requires health plans to hold their members harmless in both emergency and surprise billing situations when treated at in-network facilities. The same is true for referrals for inadequate network situations.[7]

Connecticut

Connecticut prohibits health care providers from balance billing (except for copayments and deductibles) enrollees of managed care plans. It also prohibits health care providers from reporting to a credit reporting agency an enrollee's failure to pay a bill for medical services when a managed care organization has primary responsibility for payment.[8]

Florida

Florida limits reimbursement for out-of-network emergency care by HMOs and PPOS to the lesser of the provider's charges; the usual and customary provider charges for similar services in the community where the services were provided; or the charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim. The consumer is held harmless except for a reasonable copayment for the use of the emergency room[9]

Florida has recently amended its statutes in what is described by Consumers Union as "among the strongest and most comprehensive bills in the country."[10] The Florida legislation[11] had the backing of the Florida Medical Association and the Florida Association of Health Plans, while the Florida Hospital Association said it agreed with the "general direction" of the bill. Anesthesiology and radiology groups opposed it.[12] The statute protects patients who go to an in-network healthcare facility and inadvertently receive services from non-network providers by making the insurer solely liable for the payment of fees and the insured only liable for applicable copayments, coinsurance, and deductibles.[13] It extends similar protections to "surprise billing" for contracted nonemergency services provided in an in-network facility by a non-network provider "when the insured does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the insured."[14] The balance billing protections apply to both physicians and facilities. Non-network providers are banned from balance billing.[15] Reimbursement disputes are resolved in court or in a voluntary dispute resolution process.[16]

Hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers are required to comply with balance billing restrictions as a condition of licensure,[17] and willfully failing to comply with them "with such frequency as to

---

the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case …" 28 Cal. Code Regs §1300.71(a)(3).

[6] California DMHC, Independent Dispute Resolution Process (IDRP). Available at https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/IndependentDisputeResolutionProcess.aspx#.V W-Ces9Viko

[7] Colo. Rev. Stat. §10-16-704(3)(b).

[8] Conn. Gen. Stat. § 20-7f.

[9] Fla. Stat. Ann. §641.513.

[10] http://www.miamiherald.com/news/health-care/article66965817.html

[11] HB 221.

[12] http://www.modernhealthcare.com/article/20160414/NEWS/160419946

[13] Fla. Stat. Ann. §627.64194(2).

[14] Fla. Stat. Ann. §627.64194(3).

[15] Fla. Stat. Ann. §627.64194(5).

[16] Fla. Stat. Ann. §627.64194(6).

[17] Fla. Stat. Ann. §395.003(5)(d).

indicate a general business practice is grounds for discipline.[18] Failing to comply with the general balance billing requirements is also an unfair method of competition and an unfair act or practice.[19]

Illinois

Illinois provides protections for balance bills from out-of-network facility-based physician or other providers[20] practicing in network hospitals or ambulatory surgery centers. Hold harmless provisions apply, and if the beneficiary, insured, or enrollee executes an assignment to the provider, balance billing is prohibited except for applicable deductible, copayment, or coinsurance amounts that would have applied in-network.[21] The insurer or health plan may pay the billed amount or attempt to negotiate reimbursement. If attempts to negotiate reimbursement for services provided by a nonparticipating facility-based provider are not successful, then an insurer or health plan or nonparticipating facility-based physician or provider may initiate binding arbitration to determine payment for services.[22]

Maryland

Maryland prohibits providers from balance billing HMO consumers in emergency and surprise billing situations.[23] In addition, HMOs must hold consumers harmless for covered services from by non-network providers and pay at prescribed rates.[24] Patients who assign benefits to their physicians are protected against balance billing.[25]

New Jersey

New Jersey does not ban balance billing, but requires HMOs to hold consumers harmless in emergency,[26] inadequate network,[27] and surprise billing[28] situations. Consumers pay copays, coinsurance, and deductibles. Although a voluntary mediation process exists, it is unclear how frequently it is used, and health plans find themselves paying billed charges or litigating over provider charges to hold enrollees harmless.[29] Legislation to create a binding arbitration process died in the New Jersey legislature in December 2015.[30]

New York

New York bans balance billing by providers in emergency situations, and does the same in surprise billing and inadequate network situations as long as the consumer assigns the provider's claim to the insurer.[31] The provider or health plan (all managed care plans) can use a binding independent dispute resolution process to determine reimbursement. The independent dispute resolution entity can order the provider and insurer to mediation. If that fails, the dispute resolution entity picks either the provider's bill or the insurer's payment as the reimbursement amount.[32] The New York protections do not apply to facility charges

---

[18] Fla. Stat. Ann. §§456.072(1)(oo); 458.331(1)(tt), 459.015(vv).
[19] Fla. Stat. Ann. §626.9541(1)(gg).
[20] Radiologists, anesthesiologists, pathologists, neonatologists, or providers of emergency department services. 215 ILCS 5/356z.3a(a).
[21] 215 ILCS 5/356z.3a(b) and (c).
[22] 215 ILCS 5/356z.3a(d).
[23] MD. Code Ann. Health-Gen. §§19-710(p); 19-710.1 and 19-712.5.
[24] MD. Code Ann. Insurance §§14-205.2 and 14-205.3.
[25] MD. Code Ann. Insurance §14-205.3.
[26] N.J.A.C. 11:24-5.3.
[27] N.J.A.C. 11:24-5.1(a), N.J.A.C. 11:24-9.1(d).
[28] N.J.A.C. 11:22-5.8(b).
[29] Avalere Health LLC, "An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey," September 2015. http://www.horizonblue.com/sites/default/files/ah_analysis_of_policy_options_wp_v3b.pdf
[30] http://www.nj.com/politics/index.ssf/2015/12/greed_sidelines_nj_out-of-network_insurance_legisl.html
[31] N.Y. Fin. Services Law §§603 and 606.
[32] N.Y. Fin. Services Law §605 and 607.

Texas

Texas provides varying protections for HMOs, Emergency Provider Organizations (EPOs), and PPOs. For HMOs, regulators interpret the law to hold consumers harmless for emergency services and in inadequate network situations.[33] Texas rules require EPOs to hold consumers harmless in inadequate and emergency situations; this approach also includes surprise billing situations.[34] In emergency or inadequate network situations, Texas requires PPOs and EPOs to pay at least the usual and customary charge for services.[35]

Texas has a mandatory mediation process for PPO plans and administrators of health plans (other than HMO plans) under Insurance Code 1551 (the Texas Employees Group Benefits Act)[36] The mediation process is limited to facility-based physician charges[37] and allows consumers to initiate mediation if the balance bill exceeds $500.[38] Once a request for mediation is filed, the insurer or administrator and the physician participate in an informal settlement teleconference.[39] If the case does not settle, it proceeds to mediation with a mediator chosen by the chief administrative law judge of the State Office of Administrative Hearings.[40] If there is no agreed resolution, the case proceeds to a special trial under Chapter 151 of the Texas Civil Practice and Remedies Code.[41]

[33] Tex. Ins. Code §1271.055 and §1271.155.
[34] 28 Tex. Admin. Code §3.3725.
[35] 28 Tex. Admin. Code 3.3708.
[36] Tex. Ins. Code §1467.002.
[37] Radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, or assistant surgeons. Tex. Ins. Code §1467.002.
[38] Tex. Ins. Code §1467.051.
[39] Tex. Ins. Code §1467.054.
[40] Tex. Ins. Code §1467.053.
[41] Tex. Ins. Code §1467.057.

Balance Billing – What are States Doing?

State Approaches

	California	Colorado	Connecticut	Florida	Illinois	Maryland	New Jersey	New York	Texas
Hold harmless or prohibition on balance billing in emergency situations	Yes, for HMOs and PPOs	Yes	Yes, included in general prohibition against balance billing enrollees of managed care plans	Yes, for managed care plans	No	Yes, for HMOs and tied to assignment for PPOs	Yes, for HMOs and PPOs	Yes	Yes, for HMOs and EPOs
Hold harmless or prohibition on balance billing in surprise bills	No	Yes	No	Yes, for managed care plans	Yes, for managed care plans, for some facility-based physicians and providers, tied to assignment	Yes, for HMOs and tied to assignment for PPOs	Yes	Yes, tied to assignments	Yes, for HMOs and EPOs
Hold harmless or prohibition on balance billing in inadequate network situations	No	Yes	No	No	No	Yes, for HMOs and tied to assignment for PPOs	Yes	Yes, tied to assignments	Yes, for HMOs and EPOs
State mediation or dispute resolution process	Yes, not much used	No	No	Voluntary	Binding arbitration.	No	Yes, not much used	Yes, arbitrator picks provider's bill or insurer's payment	Mandatory mediation, for PPOs, for some facility-based physicians and if more than $500