



CALIFORNIA MANAGED RISK MEDICAL INSURANCE BOARD

Agenda Item 7(a)(3)
05/21/08 Meeting

BILL ANALYSIS

Topic: Senate Bill 697 (Yee) – Balance Billing in the Healthy Families and Access for Infants and Mothers programs. Analysis information as of May 15, 2008.

SUMMARY

SB 697 would prohibit all providers, including non-contracting providers, from seeking payment from HFP and AIM subscribers for any covered services in order to supplement reimbursement received from health plans or insurers (also called “balance billing”).

Specifically, SB 697 would:

- Make legislative findings and declarations concerning HFP, Medi-Cal and the practice of balance billing.
- Prohibit all health care providers who have been furnished documentation of a person’s enrollment in HFP or AIM from seeking payment from those subscribers for any covered services. Such a prohibition would not apply to any required copayments or deductibles.

RECOMMENDED POSITION: SUPPORT

The Managed Risk Medical Insurance Board (MRMIB) staff recommends a **SUPPORT** position on SB 697 for the following reasons:

1. SB 697 is consistent with existing practice in the Healthy Families and Access for Infants and Mothers programs, and further protects subscribers since MRMIB’s contractual relationship is with health plans, not providers.
2. Balance billing places consumers unfairly in the middle of disputes between health plans and physicians. HFP and AIM subscribers are lower-income and more vulnerable to the high costs of health care and unexpected bills than higher income persons.
3. Both federal and state law prohibit balance billing under Medicare and Medi-Cal. Thus, HFP and AIM subscribers deserve this same protection as those in Medicare and Medi-Cal against potentially debilitating expense and threats of court judgments related to unpaid health care bills.

BACKGROUND

Balance Billing

Balance billing is when a health care provider charges an insured patient for service above what an insurer paid for it, not including co-payments and deductibles. In the commercial market, providers contracting with health plans (in network) are prohibited from this practice, however, non-contracting (out of network) providers may engage in the behavior.

Criticism of balance billing has focused on, but is not limited to, non-contracting providers, such as emergency room doctors and anesthesiologists, who practice at a hospital within a health plan's network, but who do not contract with the hospital or health plan. After such a provider treats a patient and are reimbursed by a health plan for a portion of their charges, they may send a bill for the balance of their charges to the patient. This is "balance billing."

Existing Law

- State law requires health care service plans contracting with providers to prohibit those providers from balance billing the subscriber for payment owed by the health plan.
- Federal law prohibits balance billing in Medicare and Medicaid by contracting and non-contracting providers. This means that providers cannot bill subscribers under existing law more than an insurer pays them in Medi-Cal.
- Federal regulations, with limited exceptions, require a state's Medicaid agency to limit provider participation to those who accept the amount paid by the agency plus any deductible, co-insurance or co-payment (cost-sharing) required as payment in full.
- State regulations specify HFP and AIM subscribers' cost-sharing amounts and prohibit health plans from charging deductibles to HFP and AIM subscribers.
- MRMIB interprets existing state law in conjunction with health plans' Evidence Of Coverage (EOC) documents and program benefit regulations to require health plans to ensure subscribers are not balance billed.

Governor's Executive Order

Governor Schwarzenegger issued Executive Order S-13-06 on July 25, 2007. The Executive Order included declarations that emergency care providers have the right to be paid fairly and promptly for their services; some Californians have suffered great economic harm due to balance billing, and; persons with health coverage should be able to trust their health plan to fairly and promptly reimburse emergency medical providers for services.

The Executive Order directs the Department of Managed Health Care (DMHC) Director to:

1. "Take all steps necessary to protect Californians from balance billing, including the full and complete enforcement of existing regulations and the promulgation of additional regulations to further protect Californians from balance billing, if necessary.
2. "Re-double efforts to enforce the Knox-Keene Health Care Service Plan Act of 1975's provisions relating to the fair and prompt payment of non-contracted provider claims.
3. "Conduct a review of the current criteria used to determine the reasonable and customary value of non-contracted emergency services to ensure that it results in fair reimbursement for the provider, while not adversely affecting the financial viability of California's health care delivery system.
4. "Expediently implement a fair, fast, and inexpensive Independent Dispute Resolution Process to avoid placing enrollees in the middle of payment disputes between health plans and providers and to ensure that non-contracted providers who deliver critical services without regard to a patient's financial ability to pay are paid the reasonable and customary value for their services."

DMHC has held numerous public hearings on proposed regulations related to balance billing and provider reimbursement. The department published its latest such regulations for public comment on March 28, 2008 and held public hearings on the regulations on May 14, 19 and 20.

Balance Billing Prevalence in HFP, AIM and the Larger Market

Comprehensive balance billing data is not readily available either for persons covered in commercial products or for HFP and AIM subscribers. All health care service plan subscribers are required by law to file complaints first with their health plan, as a prerequisite to submitting the complaint for DMHC review. Neither the health plan nor the DMHC is required to break out or report data regarding HFP or AIM.

Balance billing data is not readily available from the DHMC. In a June 20, 2005 Assembly Committee on Health analysis of SB 417 (2005 – Ortiz), DMHC staff acknowledged that the department can only assist subscribers who are aware of the opportunity to submit complaints. The analysis continues: "In fact, DMHC assumes many, if not most enrollees who find themselves in this situation pay providers because they do not know their rights and are anxious to not jeopardize their credit ratings." Consequently, DMHC data would not likely accurately reflect the extent of balance billing occurrences.

Beginning early in 2007, MRMIB staff began collecting data to better capture balance billing occurrences among HFP and AIM subscribers. It is important, however, that these results are put into context since HFP and AIM subscribers must report such complaints to their health plan and then may report to the DMHC. Neither the health plans nor DMHC have been able to identify the number of balance billing or other complaints for HFP or AIM subscribers.

Consequently, the number of balance billing complaints received by MRMIB should not be inferred to accurately represent the extent of the problem among HFP or AIM enrollees. Within this context, from January 2007 to March 2008 (14 months), MRMIB data show 16 (4%) balance billing cases among 456 complaints to MRMIB's Benefits & Quality Monitoring Division, excluding complaints related to subscriber's who transferred health plans.

Within the larger insurance market, the California Association of Health Plans cites a 2007 APCO Insight Survey which estimates 1.76 million insured Californians were balance billed for emergency room services in the last two years, 56 percent (985,600) of whom personally paid the bill.

RELATED LEGISLATION

- **ABX1-1 (Nunez - 2007)**, a broader health care reform bill, contains provisions that would also ban balance billing among persons insured through any commercial plan. The bill failed passage of Senate Health Committee.
- **AB 1321 (Yee - 2005) and SB 389 (Yee - 2007)**, identical bills, would have required a hospital-based non-contracting physician practicing in a contracting hospital to seek reimbursement solely from the patient's health plan or medical group. Hospital-based non-contracting physicians would be prohibited from seeking payment directly from a patient for services covered by the patient's health plan. The bills died or failed to meet the necessary deadlines to continue.
- **SB 417 (Ortiz – 2005)** would have prohibited hospital-based non-contracting providers from billing patients with health insurance an amount other than applicable co-payments, unless the provider has been denied payment by the patient's insurer. The bill also would have required providers to include in the patient's bill a notice that the charges may be covered by the patient's health plan and that the patient may contact the DMHC if they believe they have been billed incorrectly. The bill died in committee.

IMPACT ON MRMIB

This bill is not expected to impact MRMIB's costs for administering its programs or for coverage by or contract negotiations with its health plans. It is also not expected to conflict with MRMIB's current policies.

STATUS & HISTORY OF THE BILL

The bill was most recently referred to the Assembly Health Committee. It should return to the Senate for concurrence before it may be sent to the Governor.

POSITIONS OF ORGANIZATIONS

Support: California Association of Physician Groups

Opposed: None currently on file.