
Introduction

About one-fourth of states protect consumers against balance bills in some circumstances. 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 from balance billing consumers covered by HMOs in emergency cases. 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. Reimbursements are based on a "reasonable and customary value" for non-network providers. The state provides a voluntary, non-binding dispute resolution process, but it is not clear how frequently this is used or how effective it is.


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 room9

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 legislation11 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).
11 HB 221.
12 http://www.modernhealthcare.com/article/20160414/NEWS/160419946
indicate a general business practice is grounds for discipline. Failing to comply with the general balance billing requirements is also an unfair method of competition and an unfair act or practice.

**Illinois**

Illinois provides protections for balance bills from out-of-network facility-based physician or other providers 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. 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.

**Maryland**

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

**New Jersey**

New Jersey does not ban balance billing, but requires HMOs to hold consumers harmless in emergency, inadequate network, and surprise billing 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. Legislation to create a binding arbitration process died in the New Jersey legislature in December 2015.

**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. 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. The New York protections do not apply to facility charges.

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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).
24 MD. Code Ann. Insurance §§14-205.2 and 14-205.3.
26 N.J.A.C. 11:24-5.3.
28 N.J.A.C. 11:22-5.8(b).
31 N.Y. Fin. Services Law §§603 and 606.
32 N.Y. Fin. Services Law §§605 and 607.
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.\(^{41}\)

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\(^{33}\) Tex. Ins. Code §1271.055 and §1271.155.

\(^{34}\) 28 Tex. Admin. Code §3.3725.


\(^{36}\) 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.
## State Approaches

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