

HOLLAND & HART<sup>LLP</sup>



**SURPRISE BILLING LEGISLATION**

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# Today's Agenda



- --Surprise billing: what is it? How prevalent is it?
- --Brief Summary of Federal Legislation
- --Summary NAIC Model Network Adequacy Act Changes
- --Discussion of surprise billing laws enacted and legislation pending in various states

# Surprise Billing--What is it?



- Covered persons receive emergency or non-emergency services from an in-network facility but some of the services provided by out-of-network facility-based providers (i.e. pathologists, radiologists or anesthesiologists).
- Covered persons receive emergency services from an out-of-network facility and out-of-network provider(s).
- Covered person receives bill from out-of-network facility/provider asking for out-of-network cost-sharing levels, and where allowed by state law, balance bills for difference between provider's charges and the insurer's allowed amounts for the services.



# Surprise Billing Prevalence

## Kaiser Family Foundation 3-17-16



- Kaiser Family Foundation study:
- --among insured, non-elderly adults struggling with medical bill problems, charges from out-of-network providers were a contributing factor about one-third of the time.
- --nearly 7 in 10 of individuals with unaffordable out-of-network medical bills did not know the health care provider was not in their plan's network at the time they received care.
- <http://kff.org/private-insurance/issue-brief/surprise-medical-bills/>
- <http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/>

# Federal law Surprise Billing Legislation



- The Bipartisan Budget Act of 2015: Signed in November 2015, the Act eliminates Medicare incentives for hospitals or other providers to contract with supplementary providers “off-campus”. The Act restricts new off-campus outpatient facilities from receiving reimbursements at, the often enhanced, outpatient prospective payment system (OPPS) rates, instead tying them to other Medicare payment schemes such as the physician fee schedule.
- The Patient Protection and Affordable Care Act (ACA): The ACA requires non-grandfathered health plans to cover emergency services received at out-of-network facilities at least at the same rate of cost-sharing requirements stipulated for in-network emergency services. The ACA also compels the health insurance marketplaces to collect and make public information on cost-sharing and payments for out-of-network services, though these provisions have yet to be enforced.
- The Omnibus Budget Reconciliation Act of 1989: Governing physician fee schedules for Medicare, the Act limits non-participating Medicare providers to only billing up to 115 percent of Medicare’s fee-schedules. Furthermore, balance billing is prohibited in Medicare Advantage with the exception of private fee-for service plans.
- <http://nashp.org/answering-the-thousand-dollar-debt-question-an-update-on-state-legislative-activity-to-address-surprise-balance-billing/>

# NAIC Model Network Adequacy Act Changes



- “Managed Care Plan Network Adequacy Model Act” renamed “Health Benefit Plan Network Access and Adequacy Model Act”
- Revised “for consistency with the Patient Protection and Affordable Care Act to reflect changes in the way health care services are delivered since [the model act] was initially adopted in 1996.”
- “Managed care plan” replaced with “network plan” – broadened to encompass PPO, HMOs, ACOs and other delivery models.
- Approved by NAIC November 22, 2015



# NAIC Model Act: Primary Revisions/Additions



- New sections:
  - out of network surprise billing
    - regulation of participating facilities with non-participating facility-based providers (**Section 7**)
    - disclosure and notice requirements related to out-of-network professionals (**Section 8**)
  - provider directories; tiering (**Section 9**)

## NAIC Model Act Section 7: Surprise Billing Program Requirements



- Carrier must establish program for payment to out-of-network facility-based providers where difference in billed charge and plan's allowable amount exceeds \$500:
  - Insurer may pay submitted facility-based out-of-network provider bill; OR
  - pay in accordance with benchmarks set by state, with benchmark deemed reasonable if higher of contracted rate and % Medicare for same service in same geographic area.
- Provider mediation process for out-of-network providers who object to benchmark rates.



# NAIC Model Act Sections 7-8: Surprise Billing Notice Requirements



- Notice that out-of-network provider services may be provided at in-network facility must be provided to covered persons:
  - By participating facility:
    - **for non-ER services** at time of scheduling or prior authorization, which must be signed by covered person at time of admission and **for ER services** with billing notice.
    - pursuant to its contract with a carrier, within ten (10) days of an appointment for inpatient or outpatient services,
  - By carriers at pre-certification including
    - possibility of higher cost sharing; and
    - options available to access participating providers

## NAIC Model Act Sections 7(D): Surprise Billing Notice Requirements non-participating facility-based providers



Non-participating facility-based providers may not balance bill unless they notify covered persons of their payment options in a Payment Responsibility Notice:

--The service[s] outlined below [were] performed by a facility-based provider who is a non-participating provider with your health care plan.

--You are responsible for paying your applicable copayment, coinsurance or deductible amount. For the remaining balance, you have three choices:

1) you may choose to pay the balance of the bill; OR

2) if the difference in the billed charge and the plan's allowable amount is more than [\$500], you may send the bill to your health care plan for processing pursuant to the carrier's non-participating facility-based provider billing process or the provider mediation process required by [this Section] OR

3) you may rely on other rights and remedies that may be available in your state."

# NAIC Model Act Sections 9(A): Provider directory requirements



Carrier shall:

- post searchable electronic current and accurate provider directory for each of its network plans.
- ensure that the general public is able to view all of the current providers for a plan.
- update each network plan provider directory at least monthly.
- periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.
- shall provide a print copy, or a print copy of the requested directory information, of a current provider directory upon request of a covered person or a prospective covered person.
- explain criteria used to build networks and tiers.
- provide consumer hotline to notify carrier of errors in directory.



# NAIC Model Act Sections 9(B): Provider directory requirements



Carrier shall make available through a searchable electronic provider directory, for each network plan:

**For health care professionals:** (a) Name; (b) Gender; (c) Participating office location(s); (d) Specialty, if applicable; (e) Medical group affiliations, if applicable; (f) Facility affiliations, if applicable; (g) Participating facility affiliations, if applicable; (h) Languages spoken other than English, if applicable; and (i) Whether accepting new patients

**For hospitals:** (a) Hospital name; (b) Hospital type (i.e. acute, rehabilitation, children's, cancer); (c) Participating hospital location; and (d) Hospital accreditation status; and

**For facilities, other than hospitals, by type:** (a) Facility name; (b) Facility type; (c) Types of services performed; and (d) Participating facility location(s).

# States Passing Surprise Billing Related Laws in 2015-2016



- 2015-2016 Legislative session—19 states proposed legislation addressing surprise billing. Of those, these 7 states successfully passed legislation:
  - California AB1305
  - Connecticut SB 433
  - Florida HB 221/HB1175
  - Georgia SR974/SB302
  - Minnesota HF3142
  - Texas SB 481/SB 425
  - Utah SB216
- See National Academy for State Health Policy
- <http://nashp.org/surprise-billing-legislation-passed-in-2016/>

# States Addressing Surprise Billing in 2017



In 2017– Seven (7) states so far have proposed surprise billing legislation:

1. Rhode Island — [House Bill 5012](#)

The legislation would allow the state's health insurance commissioner to establish a process for patients to challenge disputed medical bills.

2. Georgia — [House Bill 71](#), Senate Bill 8

The bills would mandate caregivers improve transparency with patients regarding which physicians will be participating in the patients' care journey. Both bills do not require the hospital to explicitly state which physicians would be considered in-network for each patient. Neither bill would eliminate patients' out-of-pocket expenses, such as deductibles and co-pays.

3. Ohio — [Senate Bill 284](#)

The proposed legislation would prohibit emergency physicians from billing out-of-network payers at a higher rate than the payer's in-network reimbursement rate for emergency care. The bill also aims to create patient scheduling services to provide patients with more information about potential out-of-pocket costs.



# States Addressing Surprise Billing in 2017



## 4. Oregon — [House Bill 2339](#)

The bill would regulate the rate insurance companies pay out-of-network providers for services to ensure "fair and reasonable" payment.

## 5. Arizona — [Senate Bill 1441](#)

The bill would allow the Arizona Department of Insurance to intervene in some balance billing cases. Specifically, the bill would apply to instances when patients were unable to determine whether the medical provider was in-network, and feel they were unfairly charged. Under the bill, patients would also only be responsible for paying the normal co-pay amount and deductible, in most situations.

## 6. Utah — [House Bill 395](#)

The legislation aims to regulate the rate out-of-network emergency physicians can charge payers for emergency. The law would institute a national benchmark for usual emergency care to determine the maximum price.

# States Addressing Surprise Medical Billing in 2017



## 7. Texas — [Senate Bill 507](#)

Under the proposed legislation, the state would be allowed to mediate balance bills for care administered by an out-of-network physician at in-network freestanding emergency departments and in-network hospitals and for all providers. The bill also calls for an expansion of the state's disclosure requirement and would require providers to include a disclosure stating "this is a balance bill that may be eligible for mediation."

<http://www.beckershospitalreview.com/finance/7-states-addressing-surprise-medical-billing-so-far-in-2017.html>

# State approaches to surprise billing



- July 2015 Robert Wood Johnson Foundation Report lists four approaches states have taken to protect consumers from balanced billing:
  - 1) enhanced disclosure and transparency requirements;
  - 2) prohibition on balance billing by providers;
  - 3) requirements for insurers to hold consumers harmless from surprise charges; and
  - 4) regulations that insure fair payment for billed services.
- <http://www.rwjf.org/en/library/research/2015/06/balance-billing--how-are-states-protecting-consumers-from-unexpe.html>



# New York Effective 3/31/15



N.Y. Fin. Services Law §§ 601 to 608 (McKinney 2015)

N.Y. Comp. Codes R. & Regs. tit. 23 § 200 (2014).

--First comprehensive state law protection against surprise medical bills.

--New York's law limits surprise medical bills from out-of-network providers in emergency situations and in non-emergency situations when patients receive treatment at an in-network hospital or facility.

--For emergency services, patients insured by state-regulated health plans (e.g., not including self-funded employer plans) are held harmless for costs beyond the in-network cost sharing amounts that would otherwise apply.

# New York



- For non-emergency care, patients who receive surprise out-of-network bills can submit an assignment form authorizing the provider to bill the insurer directly, and then are held harmless to pay no more than the otherwise applicable in-network cost sharing.
- In both situations, out-of-network providers are prohibited from balance billing the patient;
- Providers who dispute the reasonableness of health plan reimbursement may appeal to a state-run binding arbitration process to determine the payment amount.
- The New York law applies only to state-regulated health plans.

# New York



- New York requires plans to establish a reasonable payment amount, and plans must disclose their methodology and how it compares to usual and customary rates, which are defined as the 80<sup>th</sup> percentile of the amounts made available by Fair Health, an independent entity created in 2009 to maintain a database of charges for medical procedures.
- If the provider is not satisfied with the amount paid, the state has created an independent dispute resolution process. The IDR process uses licensed physicians in active practice; they can choose either the provider's original billed charge or the plan's original payment – as opposed to any amount in the middle. In making a decision, the IDR must consider the patient's characteristics, the doctor's training and experience, and the usual and customary rate based on the Fair Health data.
- As an alternative, the parties can negotiate a settlement on their own and notify the IDR. The IDR can also direct the parties to negotiate a settlement. The IDR system is designed to create incentives for providers and plans to set their charges and payments at more reasonable levels.



# New York



- New York includes a more extensive set of disclosure requirements for health plans, hospitals, physicians, and other providers. The goal is to make it easier for consumers to look at out-of-network benefits when doing comparison shopping prior to selecting a plan and to understand the potential charges prior to using services from an out-of-network provider.
- Health plans are required to maintain accurate and regularly updated provider directories, provide clear statements of how bills are calculated, and provide examples of out-of-pocket costs for frequently billed services.
- Hospitals are required to provide lists of their standard charges, the insurance plans with which they participate, and whether their employed or contracted physician groups participate in these insurance plans.
- Physicians are required to make available their participation status with health plans and their “reasonably anticipated charges” (on request). Also, if a doctor is scheduling a hospital service and that particular doctor knows who else is going to be providing additional services or “be in the room,” he or she must disclose whether those doctors participate with the patient’s insurance.
- <http://www.rwjf.org/en/library/research/2015/06/balance-billing--how-are-states-protecting-consumers-from-unexpe.html>

# Florida



- Florida prohibits balance billing for emergency services but only for HMO products.
- Plans are required to pay the lesser of the provider's charges, the usual and customary charges for similar services in the community, or a charge mutually agreed to by the plan and the provider.
  - Fla. Stat. Ann. § 641.513 (West 2014).
- Florida also prohibits out-of-network providers from balance billing HMO patients for covered services that are authorized by the HMO.
  - Fla. Stat. Ann. § 641.3154 (West 2014).

# Florida



- --If disputes arise, the state has an independent dispute resolutions (IDR) process administered by a third party.
- --Fla. Admin. Code r. 59A-12.030 (2014).



# California ER Services



- California prohibits physicians from balance billing in emergency cases. The policy, established by a regulatory interpretation of the Knox-Keene Act by the Department of Managed Health Care (DMHC), treats all emergency department services as in-network and applies only to plans under DMHC's jurisdiction (i.e. HMOs. PPOs).
- Cal. Code Regs. tit. 28, § 1300.71.39 (2014).
- The policy was challenged in court by providers, but was affirmed unanimously by the California Supreme Court. *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497 (Cal.), Jan. 8, 2009.

# California ER Services



- --California requires that plans pay providers a “reasonable and customary” payment rate.
- --Payment must be based on “statistically credible information that is updated at least annually” and must take into account factors such as the provider’s training and experience, the nature of the service provided, and fees usually charged by a provider.
- --Cal. Code Regs. tit. 28, § 1300.71 (2015).

# California ER Services



- --If providers are unhappy with the plan's payment, they can use the state's voluntary, non-binding independent dispute resolution process (IDRP).
- California DMHC, *Independent Dispute Resolution Process (IDRP)*. <https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/IndependentDisputeResolutionProcesses.aspx#.VW-Ces9Viko>
- --California has no disclosure requirements beyond the standard information required at the point of service regarding the use of out-of-network providers.



# California ER Services



- DMHC also has the authority to enforce its regulations, which make it an “unfair billing pattern” for an emergency services provider to bill a health plan enrollee for amounts beyond in-network cost sharing obligations. See Cal. Code. Regs. tit. 28 § 1341. In 2015 DMHC reached a settlement with a group of emergency department physicians for sending illegal balance bills to 324 patients.

# California AB 72



- Signed into law: September 23, 2016
- Applies to health plans and health insurance policies issued, amended or renewed on or after July 1, 2017.
- Non-contracted providers are entitled to the greater of the average contracted rate or 125% of the Medicare fee-for-service rate for similar services in a similar geographic area.
- Doesn't apply to Medi-Cal managed care plans, whose beneficiaries already enjoy balance billing protections.
- State insurance and Medicaid Managed Care regulators must establish an independent process to facilitate resolution of payer/provider payment disputes.

# Nevada Assembly Bill 382



- AB 382 would amend NRS Chapter 439B Restraining Costs Of Health Care
- Goal is to get the patient out of the middle of the surprise billing dispute and put the dispute between sophisticated parties: the insurer and provider.
- Only applies to patients who have insurance.
- Only covers emergency services “. . . other than services and care provided to stabilize the patient. . .”



# Nevada Assembly Bill 382



Requires insurers to pay (excluding any deductible, copayment or coinsurance paid by the patient) the greater of:

- The average amount negotiated by insurers with Nevada in-network hospitals/in-network physicians for the same or similar emergency services and care; and
- 125% Medicare fee-for-service for the same or similar emergency services and care in the geographic region in which the emergency services and care are rendered.

The Commissioner of Insurance shall adopt regulations that interpret the provisions of this subsection including a system for verifying a negotiated contract price submitted to the Commissioner of Insurance by insurers described.

# Nevada Assembly Bill 382



- --Applies to:
  - out-of-network hospitals with at least 100 beds (N/A federal, state or local government operated hospitals)
  - out-of-network independent centers for emergency medical care [IEC] operated by same person who operates such a hospital out-of-network physicians on the medical staff of an out-of-network hospital with at least 100 beds out-of-network independent center for emergency medical care operated by same person who operates such a hospital
  - out-of-network physicians on the medical staff of an in-network hospital with at least 100 beds or in-network independent center for emergency medical care operated by same person who operates such a hospital
- Requires out-of-network hospitals, IECs and out-of-network providers to accept as payment in full the mandated rate for ER services and care other than services and care to stabilize the patient.

# Nevada Assembly Bill 382



- Requires that the Patient:
- (a) Was presented to an out-of-network hospital or IEC/out-of-network physician for the provision of medically necessary emergency services; and
- (b) Has a policy of insurance or other contractual agreement with a third party [insurer] that provides coverage to the patient for emergency services and care provided by more than one hospital and IEC for emergency medical care in this State other than the hospital or IEC to which the patient was presented.



# Nevada Assembly Bill 382



3. An out-of-network hospital, out-of-network independent center or out-of-network provider for emergency medical care is **not** required to accept as payment in full the mandated amount if:

(a) The third party [insurer] that issued the policy of insurance or other contractual agreement which provides coverage to the patient has not submitted the quarterly reports required by section 20 of this act;

(b) The third party [insurer] which provides coverage to the patient has not, in good faith, participated in a negotiation or mediation and has not documented the occurrence and outcome of any negotiation or mediation;

# Nevada Assembly Bill 382



(c) The patient has not paid the deductible, copayment or coinsurance that the patient would have paid for the provision of emergency services and care at an in-network hospital, in-network independent center for emergency medical care, or by an in-network physician; or

(d) The third party [insurer] has not paid the out-of-network hospital, out-of-network independent center for emergency medical care or out-of-network provider, as applicable, for the emergency services and care within 60 days after receipt of the bill and all necessary medical records required to pay the claim or, if applicable, within 60 days after the conclusion of any negotiation or mediation between the third party and the out-of-network hospital, out-of-network independent center for emergency medical care or out-of-network physician.

# Nevada Assembly Bill 382



If an out-of-network hospital, out-of-network independent center or out-of-network physician for emergency medical care believes that the amounts prescribed in statute are insufficient to compensate it for emergency medical care for the emergency services and care provided, it (he/she) must:

-- Within 30 days of receiving written notice of such amount from the insurer, request in writing to enter into negotiations with the insurer to resolve the difference between the amount charged and the amount paid by the insurer.

--Such negotiations must begin within 2 weeks of the request for negotiation.

--If such negotiations do not result in an agreement on the amount that will be paid for the emergency services and care, the out-of-network hospital, out-of-network independent center or out-of-network provider may file a complaint with the Governor's Health Advocate pursuant to NRS 223.560 and request that the Advocate mediate to determine the amount that must be paid for such emergency services and care.



# Nevada Assembly Bill 382



In no event shall the patient who received emergency services and care be:

(a) Responsible for payment of any amount greater than any deductible, copayment or coinsurance paid by the patient pursuant to his or her policy of insurance; or

(b) Required to participate in any negotiation entered into pursuant to this section or any mediation entered into pursuant to NRS 223.560.

## Nevada Assembly Bill 382: Required insurer review, education and reporting



If a insurer who issues an health insurance contract in Nevada wishes out-of-network hospitals, out-of-network independent centers for emergency medical care and out-of-network physicians to accept as payment in full the amounts prescribed in this act, the third party shall:

1. Review its contracts with in-network hospitals, in-network independent centers for emergency medical care and in-network physicians of the third party to determine whether a person who is covered by that policy of insurance or other contractual agreement that provides coverage for health care has adequate access to health care, including, without limitation, a review of:

## Nevada Assembly Bill 382: Required insurer review, education and reporting



(a) The number and types of in-network hospitals, in-network independent centers for emergency medical care and in-network physicians, including, without limitation, emergency room physicians, anesthesiologists and specialty physicians;

(b) Whether a person who is covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care has access to in-network hospitals, in-network independent centers for emergency medical care and in-network physicians without experiencing an unreasonable delay in the provision of health care; and



## Nevada Assembly Bill 382: Required insurer review, education and reporting



(c) The in-network hospitals and in-network independent centers for emergency medical care which provide emergency services and care and the number and type of in-network physicians on the medical staff of those in-network hospitals and in-network independent centers for emergency medical care to ensure that the third party has contracted with a sufficient number and type of physicians who are on the medical staff of those in-network hospitals and in-network independent centers for emergency medical care.

## Nevada Assembly Bill 382: Required insurer review, education and reporting



2. Review the frequency with which persons covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care are treated for emergency services and care by out-of-network physicians at in-network hospitals and in-network independent centers for emergency medical care and the rate at which those services and care are reimbursed by the third party.

## Nevada Assembly Bill 382: Required insurer review, education and reporting



3. Ensure that persons covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care receive adequate information regarding in-network hospitals, in-network independent centers for emergency medical care and in-network physicians and the financial impact of receiving emergency services and care from out-of-network hospitals, out-of-network independent centers for emergency medical care and out-of-network physicians, including, without limitation, the financial impact of receiving emergency services and care from an out-of-network physician on the medical staff of an in-network hospital or in-network independent center for emergency medical care. The information must be provided in a format that is meaningful for persons making an informed decision concerning emergency services and care and must be accessible to persons covered by the policy of insurance or other contractual agreement.



## Nevada Assembly Bill 382: Required insurer review, education and reporting



4. Submit once each calendar quarter to the Commissioner of Insurance and the Legislative Committee on Health Care a report containing a summary of the reviews conducted pursuant to subsections 1 and 2 and the educational efforts undertaken pursuant to subsection 3.

## Nevada Assembly Bill 382: Required hospital/IEC annual report



Each hospital with 100 or more beds that is not operated by a federal, state or local governmental agency and each independent center for emergency medical care that is operated by a person who also operates such a hospital shall submit to the Department an annual report which must include:

1. The number of patients from whom the hospital or independent center for emergency medical care or a person acting on its behalf has attempted to collect a debt for any amount owed to the hospital or independent center for emergency medical care for emergency services and care;
2. The number of patients from whom a physician on the medical staff at the hospital or independent center for emergency medical care or a person acting on behalf of such a physician has attempted to collect a debt for any amount owed to the physician for emergency services and care;

# Nevada Assembly Bill 382



3. The amount of any increase in the rate negotiated with a third party for emergency services and care that exceeds the percentage of increase in the Consumer Price Index, Medical Care Component, for the year in which the rate is increased and any justification for the increase; and
4. The amount of each payment negotiated by the hospital or independent center for emergency medical care pursuant or by the out-of-network negotiation options of this act.



# Nevada Assembly Bill 382



Chapter 223 of NRS is amended by adding a new section to read as follows:

1. The procedure established by regulation pursuant NRS 223.560(1)(j) for filing and processing complaints concerning the rate of payment prescribed by this act and the mediation of those complaints must:

(a) Require the Advocate or the Advocate's designee to determine, if an agreement between the parties cannot be reached, an acceptable rate that must be paid to the hospital, independent center for emergency medical care or physician within 10 days of the conclusion of the mediation;

(b) Provide that a decision made by the Advocate or the Advocate's designee is binding on both parties subject to the mediation; and

(c) Provide that the costs of the mediation must be equally shared between the two parties subject to the mediation.

2. Except as otherwise provided in NRS 239.0115, any information received by the Advocate or the Advocate's designee during the mediation procedure established pursuant to paragraph (j) of subsection 1 of NRS 233.560 must be kept confidential by the Advocate or the Advocate's designee..

# Nevada Assembly Bill 382



NRS 223.560 is hereby amended to read as follows:

1. The Advocate shall:

(j) Establish by regulation a procedure for filing and processing complaints concerning the rate of payment prescribed this act and the mediation of those complaints to determine:

(1) Whether the rates paid pursuant to this act are sufficient in a particular circumstance; and

(2) If a determination is made that a rate is not sufficient, an acceptable rate that must be paid to the hospital, independent center for emergency medical care or physician that filed the complaint;

# Nevada Assembly Bill 382



Network Adequacy NRS 687B.490(7) is hereby amended to read as follows:

7. When making any determination concerning the availability and accessibility of the services of any network plan or proposed network plan pursuant to this section, the Commissioner shall consider ~~[services]~~:
  - (a) **Services** that may be provided through telehealth, as defined in NRS 629.515, pursuant to the network plan or proposed network plan to be available services.
  - (b) *The information contained in the most recent report submitted pursuant to section 20 of this act that pertains to the network plan, if such a report has been submitted.*



# Nevada Assembly Bill 382



- April 27, 2017 Hearing before Assembly Ways and Means Committee
- Assemblywoman Maggie Carlton reported that the various parties failed to agree on the rate so the rate provisions would be removed.
- The insurer would make an initial offer to the facility/provider.
- If offer is unacceptable the two sophisticated parties—insurer and the hospital/provider could settle the matter with binding arbitration through Governor’s Health Advocate’s office.
- The patient’s responsibility would be limited to deductibles , copayments or coinsurance under his/her insurance policy.
- The hospitals argued that there needs to be a reasonableness/good faith standard for initial offer to settle by the insurer.

# THANK YOU



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