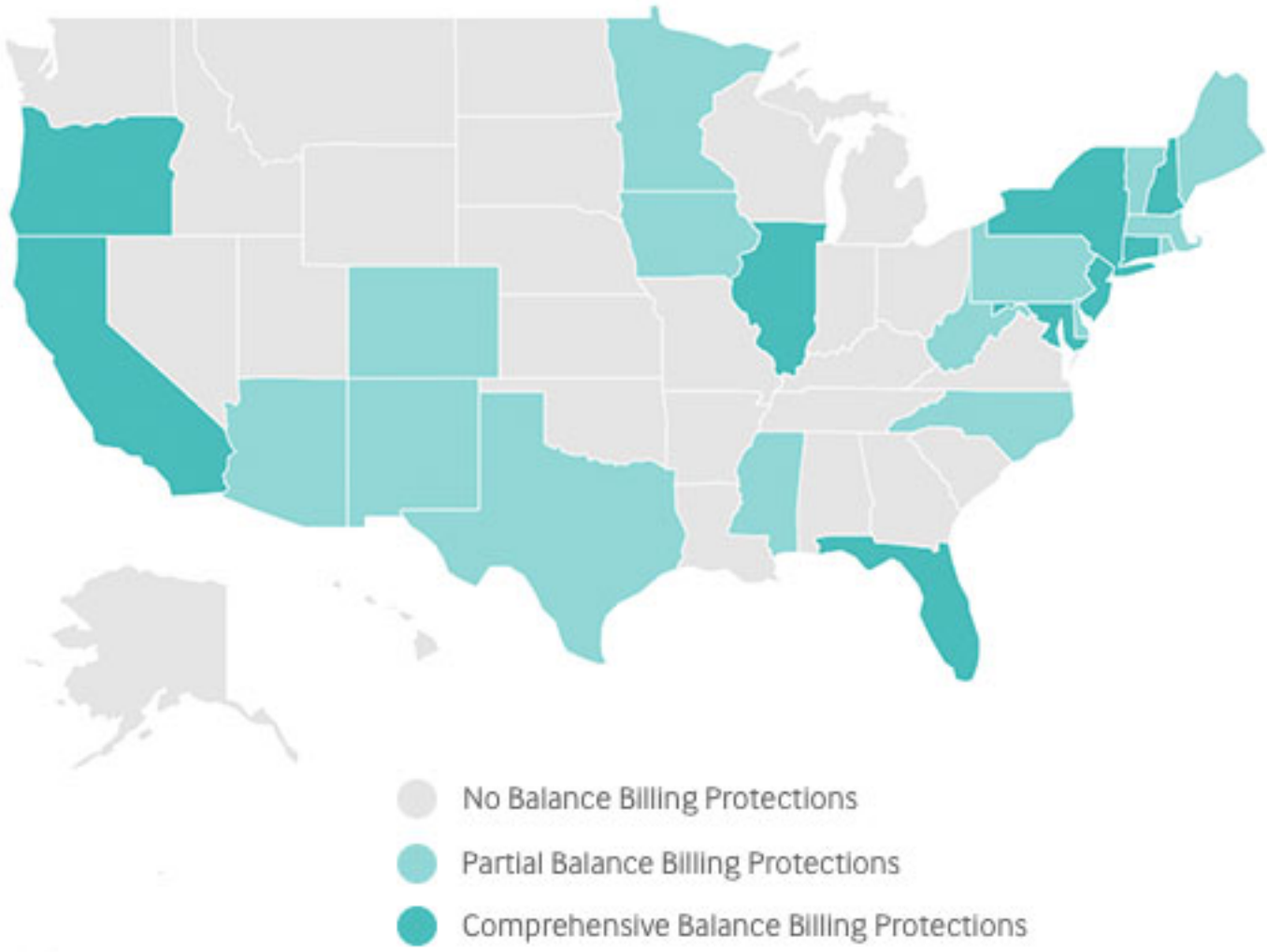


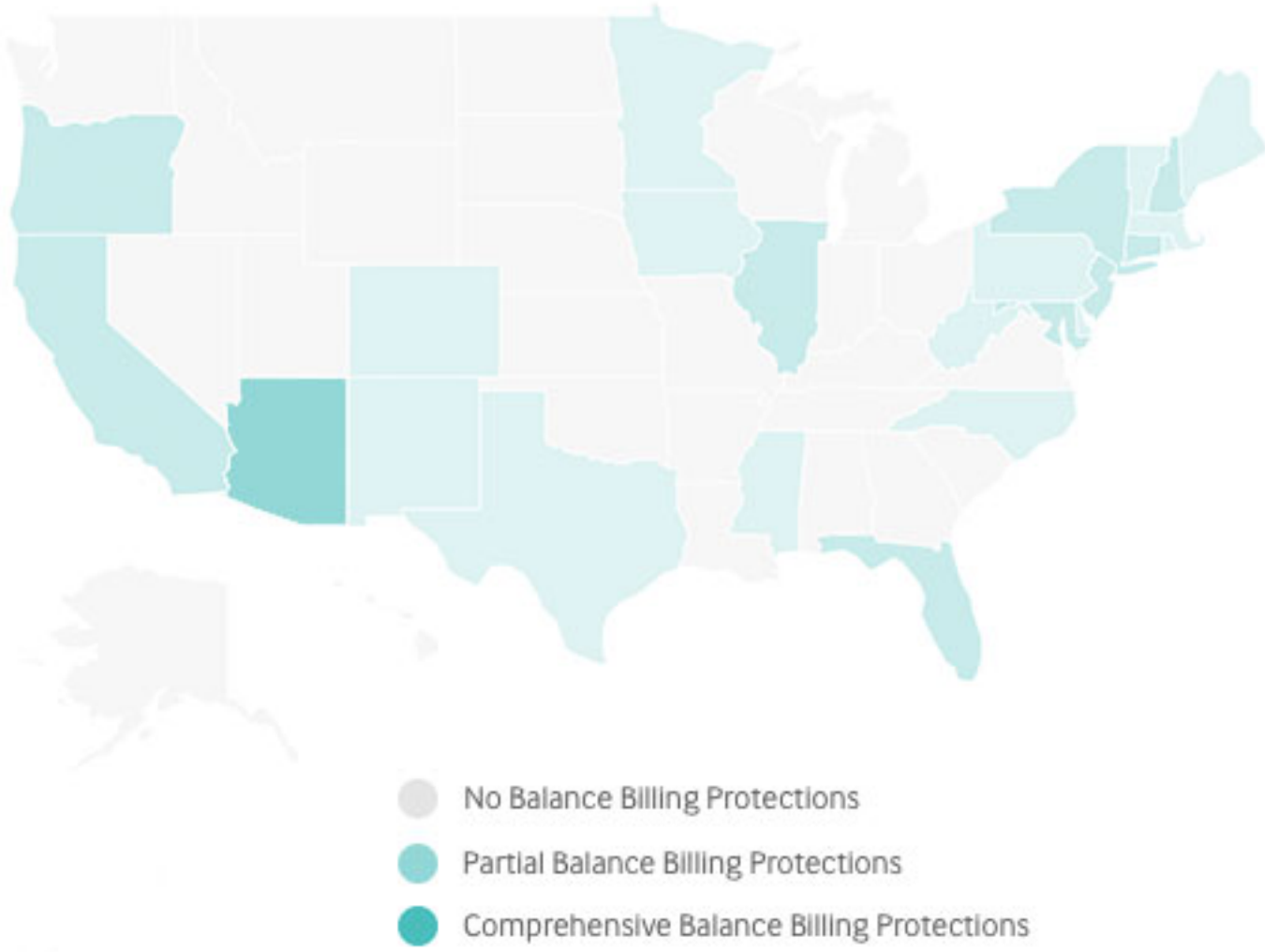
No Balance Billing Protections

Partial Balance Billing Protections

Comprehensive Balance Billing Protections

Select a state

Click on a state to learn how it protects consumers against balance billing



Arizona

Partial Balance Billing Protections

PROTECTIONS AVAILABLE

- Hold Harmless*
- Apply to HMO and PPO enrollees**
- Apply to (1) emergency services provided by out-of-network providers at in-network facilities and (2) non-emergency services provided by out-of-network providers at in-network facilities***
- Apply to services provided by all or most classes of health care providers
- State provides a dispute resolution process for claims over $1000, which must be initiated by the enrollee****

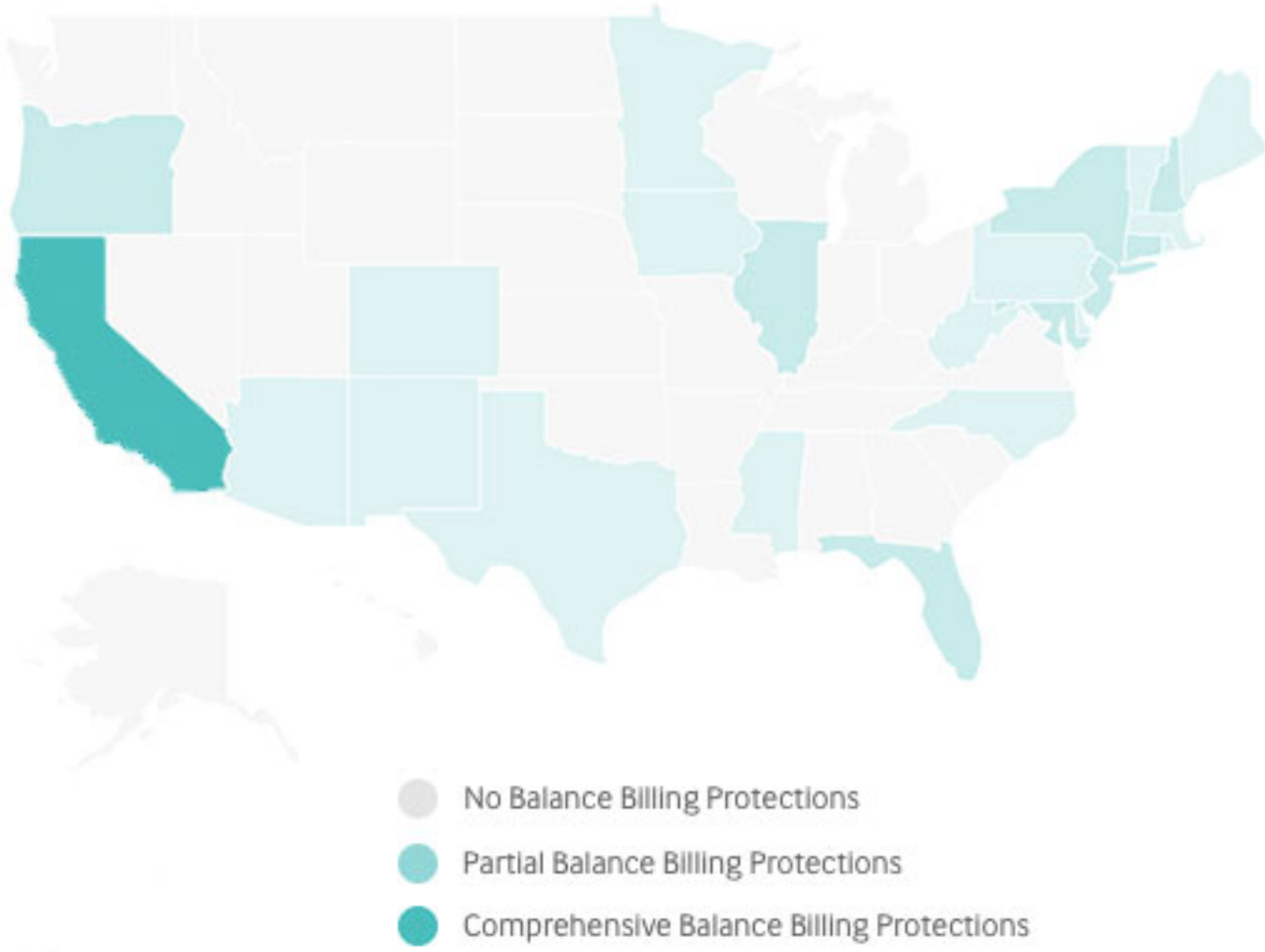
NOTES

* In Arizona, providers are not prohibited from balance billing PPO members. But in cases where a dispute-resolution process is used, a balance bill cannot be submitted after the arbitrator has made a decision.

** Protections apply only to health plans that cover out-of-network care and according to state interpretation, the Arizona protection covers enrollees in HMOs.

*** Protections in nonemergency situations are contingent on disclosure to the consumer but if the consumer declines to agree to the disclosure, the protections still apply.

**** State requires the arbitrator to allow parties to provide the following information to inform the decision: (1) the average contracted amount the health insurer pays for the services at issue in the county where the services were performed; (2) the average amount the provider has contracted to accept for the services at issue in the county where the services were performed; (3) Medicare and Medicaid reimbursement rates; and (4) the provider's direct pay rate for the services at issue, if any.



California

Comprehensive Balance Billing Protections

PROTECTIONS AVAILABLE

- Hold Harmless and Provider Prohibition
- Apply to HMO and PPO enrollees*
- Apply to (1) emergency services* and (2) non-emergency services provided by out-of-network providers at in-network facilities
- Apply to services provided by all or most classes of health care providers
- State provides a payment standard**

NOTES

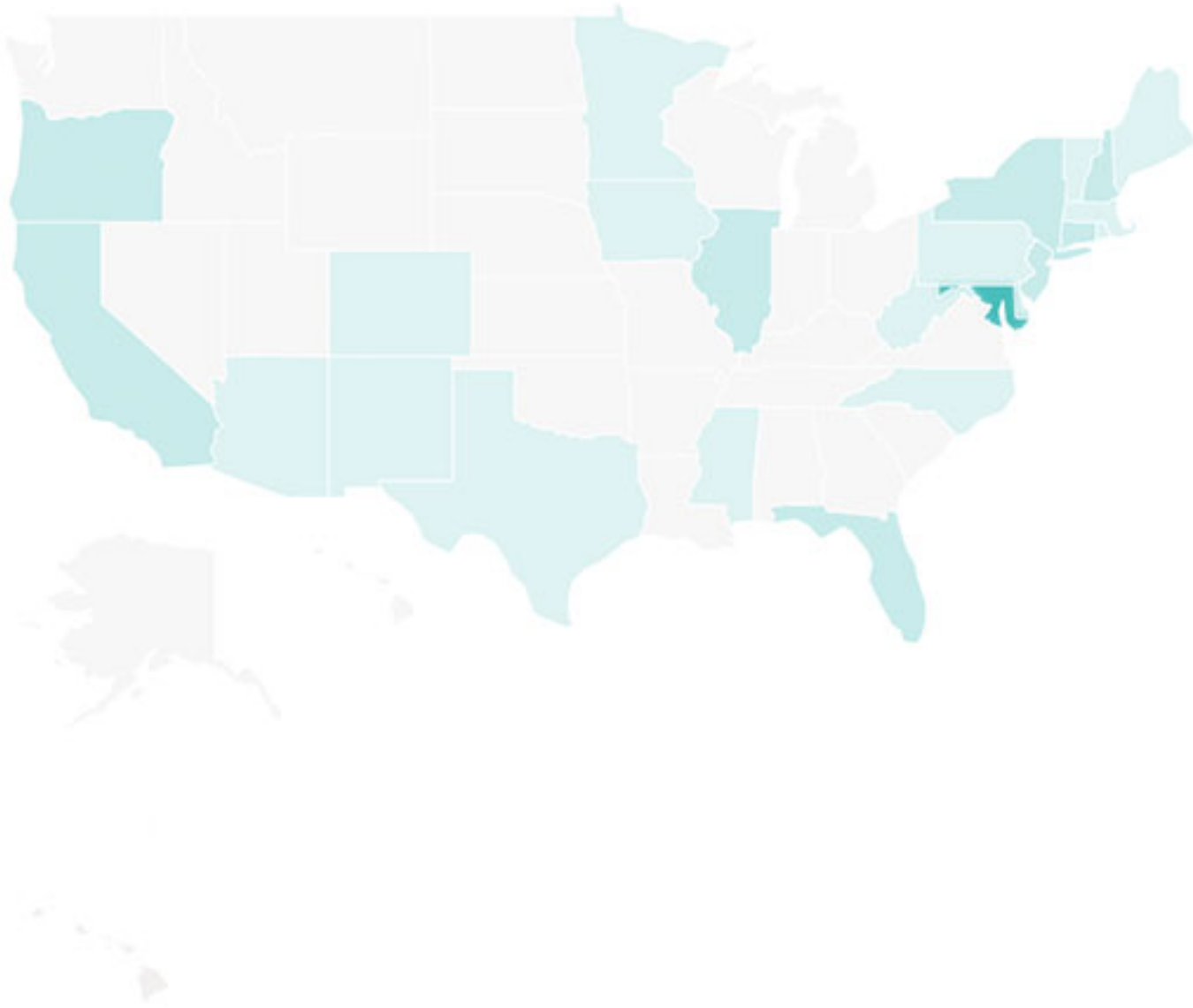
* Balance-billing protections in the emergency department setting apply only to those plans regulated by the California Department of Managed Care, which includes HMOs and most PPOs.

** For emergency services, insurer must reimburse the reasonable and customary value for health care services based on statistically credible information that is updated at least once a year and which takes into consideration the following factors: (1) provider's training, qualifications and length of time in practice; (2) nature of services provided; (3) fees usually charged by the provider; (4) prevailing provider rates in the same geographic region; (5) other relevant aspects of the economics of the provider's practice; and (6) any unusual circumstances in the case. The state also has a voluntary, nonbinding dispute-resolution process for emergency services, but it is rarely used.

For non-emergency services provided by out-of-network providers at in-network facilities, insurers must reimburse the greater of: (1) 125% of Medicare or (2) average contracted rate for that health plan and for that region. The Department of Managed Health Care has developed a methodology to determine the average contracted rate based on the above specifications. The state also has a dispute-resolution process in place for out-of-network care at in-network facilities if the regular process for applying the payment standard fails in some way.

Louisiana

No Balance Billing Protections



Maryland

Comprehensive Balance Billing Protections

PROTECTIONS AVAILABLE

- Hold Harmless and Provider Prohibition
- Apply to (1) emergency services and (2) non-emergency services provided by out-of-network providers at in-network facilities
- Apply to HMOs for services provided by all types of out-of-network health care providers
- Apply to PPOs only for services provided by on-call or hospital-based physicians who agree to accept assignment of benefits
- State provides a payment standard*

NOTES

Maryland has an all-payer rate setting system in place for hospital-based services that is governed by the Health Services Cost Review Commission (HSCRC).

* **For PPOs,** the insurer is required to reimburse hospital-based and on-call physicians within 30 days of the receipt of claim no less than the greater of: (1) 140% of the average rate insurer paid in the previous year for the same covered service in the same geographic region to similarly licensed in-network providers, or (2) the average rate the insurer paid in 2009 for the same covered service in the same geographic region to similarly licensed out-of-network providers inflated by the change in Medicare Economic Index from 2010 to current year.

  For HMOs, the insurer is required to reimburse:
  (1) a hospital at the rate approved by the HSCRC;
  (2) a trauma physician providing trauma care at the greater of: (a) 140% of Medicare rate for the same covered service by a similarly licensed provider, or (b) the rate as of 01/01/2001 that the HMO paid for the same covered service in the same geographic region to similarly licensed providers;
  (3) any other health care providers:
  - For an evaluation and management service, no less than the greater of: (a) 125% of the average rate the HMO paid in the previous year for the same covered service in the same geographic region to similarly licensed in-network providers; or (b) 140% of 2008 Medicare rate for the same covered service in the same geographic region to similarly licensed providers inflated by the change in Medicare Economic Index from 2008 to current year.
  - For a service that is not an evaluation or management service, no less than 135% of the average rate the HMO paid in the previous calendar year for the same covered service in the same geographic region to similarly licensed in-network providers.