PCC OT
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S.B. 1264 By Sen. Hancock

- ***Prohibits Balance Billing for:***
  - An amount greater than an applicable copayment, coinsurance, or deductible under the enrollees health care plan that is based on the amount initially determined payable by the health insurance company; or
  - A modified amount as determined under the health benefit plans internal dispute resolution process

- ***Applicable to:***
  - Emergency Care
  - A health care or medical service or supply provided by a facility-based provider in a facility that is a participating provider or that has a contract with the administrator
  - an out-of-network laboratory service
  - an out-of-network diagnostic imaging service

- ***The Arbitrators determination must, at a minimum, take into account:***
  - Whether there is a gross disparity between the fee billed by the out-of-network provider and:
    - Fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and
    - Fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;
  - The level of training, education, and experience of the out-of-network provider;
  - The out-of-network provider's usual billed amount for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider;
  - The circumstances and complexity of the enrollees particular case, including the time and place of the provision of the service or supply;
  - The individual enrollee characteristics
  - The 80th percentile of all billed amounts for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database established by the commissioner

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- The 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geographical area as reported in a benchmarking databased determined by the commissioner.

- ***Arbitration:***
  - The parties may agree to submit multiple claims to arbitration in one proceeding
  - 30 days after the date arbitration is requested, an arbitrator will be determined by the commissioner if one is unable to be agreed upon by both parties
  - Not later than the 75th day after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision of the reasonable amount for services or supplies rendered
  - Whichever party is closest to the arbitrators "reasonable amount", is awarded/allowed their request/initial payment
  - Not later than the 90th day after the date of an arbitrators decision, a party not satisfied with the arbitrators decision may file an action to determine the payment due to an out-of-network provider
  - Arbitration fees shall be split evenly among both parties
  - An arbitrator shall not be affiliated with an insurer or have conflicts of interest

- ***Usual, customary, and reasonable rate:***
  - UCR is defined for HMO, PPO, and EPO's within the private insurance market as currently what is established in statute; no change in UCR is included for these plans
  - UCR is defined for HMO, PPO, and EPO's as, "the relevant allowable amount as described by the applicable master benefit plan document or policy"
    - This definition is only applicable to ERS and TRS policies (state employee benefit plans)

Brief Synopsis of S.B. 1264 by Sen. Hancock

Those applicable healthcare providers as mentioned above, will not be able to balance bill their patients if an insurer reimburses at an anemic rate; If the reimbursed amount is acceptable, nothing changes. If the reimbursed amount is unacceptable, an arbitration process is provided so that healthcare providers can recoup the amount rightfully deserved. Since the "guardrails" utilized by the arbitrator are the 50th percentile of paid claims In Network and the 80th percentile of out-of-network billed charges, a provider should never bill higher than the 80th percentile according to the database established by the commissioner of insurance. The goal of this arbitration process is to determine who is closer to the reasonable amount determined by

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the arbitrator. If your billed charge is outside the 80th percentile, the likelihood of recouping an amount that was unpaid by an insurer, is highly unlikely. Each party is afforded one charge/paid amount for consideration by the arbitrator; negotiation will not occur within this process. The party that is closest to the arbitrators reasonable amount, will be awarded their initial billed amount or paid amount as acceptable

Changes that are needed:

- ***Loser pays arbitration***
  - This will de-incentivize "bad actors" from continually utilizing arbitration
- ***Strike UCR defintion for ERS and TRS health benefit plans***
  - This definition allows insurers to manipulate reimbursements; the state does not adjudicate claims therefore, insurers have far too much leverage over healthcare providers
- ***UCR should be defined appropriately, as a percentile of billed charges determined by a database unaffiliated by an insurer***
  - By defining UCR correctly, arbitration will become the exception rather than the rule