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January 9, 1998

DIRECTIVE NO. 1-98

TO: **ALL HEALTH MAINTENANCE ORGANIZATIONS, THIRD PARTY ADMINISTRATORS AND HEALTH CARE PROVIDERS**

FROM: **ARKANSAS INSURANCE DEPARTMENT**

SUBJECT: **PROHIBITION AGAINST "BALANCE BILLING"**

NOTE: This Directive is inapplicable to indemnity plans, it applies only to all managed care plans.

The purpose of this Directive is to express the Department's position concerning the responsibility of Health Maintenance Organizations ("HMOs"), Third Party Administrators ("TPAs") and health care providers over "balance billing." "Balance billing" is the practice of a medical provider billing enrollees or plan participants for services which are covered under managed care plans. Each person enrolled in an HMO plan, or a self-insured medical plan administered by a TPA, is entitled to rely on the fact that, for incurred medical treatments or medical benefits which the provider has timely filed or presented for payment to the HMO or TPA and which are covered under the contract itself, the enrollee should not have to receive or respond to bills or notices from providers to pay any amounts which are covered under the plan. This practice may result in credit problems for some enrollees, and in situations where a provider is paid twice (once by the enrollee and once by the HMO/TPA), with the enrollee not receiving proper credit or reimbursement for his/her payment. The Department also is aware that the provider agreements with the HMOs and TPAs will likely contain a "hold harmless" clause which prohibits the provider from seeking any payment from the plan enrollee for benefits provided under the plan. A medical provider under such a contract who balance bills an enrollee may be in violation of the "hold harmless" clause. The Department realizes the HMOs and TPAs desire to prohibit this practice of "balance billing" and that the occurrence is inadvertent by the providers. However, the HMOs and TPAs are responsible for enforcing this clause in their own provider contracts, and this Department has jurisdiction and authority to prevent the practice of "balance billing" under the Arkansas Insurance Code.It is the Department's position that, as related to HMOs and the occurrence of

medical provider "balance billing," the enrollee or participant is not receiving a "health care plan" as defined under Ark. Code Ann. § 23-76-102(4) (Michie 1987) if an enrollee has been frequently billed or charged by the provider for benefits which are covered under the HMO plan. Ark. Code Ann. § 23-76-102(4) (Michie 1987) defines a "health care plan" to be any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, and at least part of the arrangement consists of arranging for, or the provision of, health care services as distinguished from mere indemnification against the cost of the services on a prepaid basis through insurance or otherwise." Under this definition, an HMO is not providing, arranging, paying for, or reimbursing health care services if the enrollee is being charged for them by the medical provider for timely submitted claims for covered benefits.

It is the Department's position that, as related to the TPA's administration of a plan and the occurrence of provider "balance billing" under contracts it is administering with providers, the HMO or TPA is not competently administering the claims if an enrollee or plan participant has been frequently billed or charged by the medical provider for benefits which were intended to be covered under the self-insured plan. Ark. Code Ann. § 23-92-203(f) (Michie 1987) provides that a TPA must continue to competently administer the plan, as one requirement in Ark. Code Ann. § 23-92-203(d)(1) (Michie 1987) for maintaining a certificate of registration to conduct business in the State of Arkansas.

The Department directs that the HMOs and TPAs administering plans in this State make efforts to timely pay covered claims, and to educate, enforce and prohibit the practice of "balance billing" with their contract providers. Failure to do so may result in sanctions from this Department, up to and including loss of the HMOs'/TPAs' authority to transact business in the State of Arkansas.

Finally, it should be noted that, pursuant to the Arkansas Insurance Code and the Insurance Fraud Act of 1997, this Department is charged with the responsibility and authority to issue cease and desist orders, and take other necessary and appropriate action, against health care providers who persist in the practice of balance.

It should be noted the Insurance Department does not have jurisdiction or regulatory authority over the contractual arrangements between providers and insurers since these agreements are, properly, matters of private contract between the parties.

Mike Pickens
Insurance Commissioner