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**Regulations take effect outlawing the practice of
“balance billing” for emergency care**
Patients no longer in the middle of billing disputes between providers and payers

(Sacramento) – The Department of Managed Health Care (DMHC) announced today that regulations to go into effect on Wednesday, October 15, will restrict the practice of “balance billing” for emergency care services. Consumers will now be fully protected from balance billing in emergency cases, taking the patient out of the middle of billing disputes between providers and payers.

“No longer will Californians face the possibility that if they have to use an emergency room, they may be stuck with a bill, asking them to pay a second time for emergency care which they already purchased with their policy,” said Cindy Ehnes, Director of the DMHC. “It is the epitome of ‘unfair’ for consumers to pay for emergency services twice.”

Balance billing is a controversial practice that happens most often in emergency care settings, when a doctor or hospital is not contracted with the patient’s health plan or medical group. Health plans and medical groups by law must pay only the reasonable and customary value of those services, often less than the provider’s billed charge, leaving a balance then passed on to the consumer.

The new regulations restrict balance billing by making it an unfair billing practice, thus allowing DMHC enforcement actions against providers and health plans. By law, the DMHC has a duty to protect consumers, giving it the authority to bring the regulations forward.

The DMHC is also aggressively addressing the root cause of balance billing, which is unfair or untimely claims payment by health plans and medical groups. It is launching a special Fair Claims Payment Initiative dedicated to faster investigations and enforcement of claims

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payment violations, such as low reimbursement and late or incomplete payments.

In addition, the DMHC has a strong record of protecting consumers from unfair balance billing. It recently sued a major provider, a serial balance biller, whose actions have unjustly threatened the credit rating of thousands of Californians, and issued a major fine against a California health plan for consistently underpaying and late payment of claims to providers.

The DMHC has been committed to ensuring providers have a fair and equitable way to solve claims disputes through an independent review. The DMHC recently submitted 10 provider complaints to its existing Independent Dispute Resolution process. This process offers a fair, fast and free way for providers to get a determination of the value of their services. These test cases will demonstrate the effectiveness of the DMHC process, which providers have been reluctant to use, depending instead on a legislative solution that has to date not been successful. The results of these test cases should be available by mid-November.

Another way that the DMHC has assisted providers to be paid fairly and on time is through its highly successful Provider Complaint Unit, which has recovered more than \$10 million in additional payments to providers since it was established in 2004.

The California Department of Managed Health Care is the only stand-alone HMO watchdog agency in the nation, touching the lives of more than 21 million enrollees. The DMHC has assisted more than 800,000 Californians resolve their HMO problems through its 24-hour Help Center, educates consumers on health care rights and responsibilities, and works closely with HMO plans to ensure a solvent and stable managed health care system.

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