

Patient Friendly Billing

This publication is made possible through the cooperative efforts of the members of the

Louisiana Managed Care Coalition

LOUISIANA HOSPITAL ASSOCIATION



9521 Brookline Avenue
Baton Rouge, LA 70809
(225) 928-0026
www.lhaonline.org

LOUISIANA MEDICAL GROUP MANAGERS ASSOCIATION



P.O. Box 60275
Lafayette, LA 70596
(337) 984-9777
www.lmgma.org

LOUISIANA STATE MEDICAL SOCIETY



6767 Perkins Road, Suite 100
Baton Rouge, LA 70808
(225) 763-8500
www.lsms.org



*A Guide to Understanding Provider
Responsibilities Under Louisiana's*

HEALTH CARE CONSUMER BILLING AND DISCLOSURE PROTECTION ACT OF 2003

BACKGROUND

In the spring of 2003, representatives of the **Louisiana Hospital Association**, the **Louisiana Medical Group Managers Association**, and the **Louisiana State Medical Society** joined forces to address a number of managed care issues before the Louisiana State Legislature.

Working with **Representative Troy Hebert (D-Jeanerette)**, Chair of the House of Representatives Insurance Committee, the group brought provider consensus to several major bills. One of the most important results from this collaborative effort was passage of

THE HEALTH CARE CONSUMER BILLING

AND

DISCLOSURE PROTECTION ACT OF 2003.

Also known as the *Patient Friendly Billing legislation*, this law, **effective January 1, 2004**, addresses the issue of “balanced billing,” a practice in which healthcare providers bill for the balance of a bill for care rendered by the provider and not paid for by insurer health benefits.

Under the new law, detailed provisions now prohibit, in most cases, the act of balanced billing by healthcare providers. The law also contains specific language to go on patient bills generated by both providers and insurers, and outlines the process for registering complaints and for levying penalties.

This publication is offered to provide understanding and guidance to healthcare providers as they strive to comply with this new law.

COMPLAINTS, CORRECTION, PENALTIES

PATIENTS OR HEALTH PLANS

Any insured or enrollee, or any health insurance issuer acting on his or her behalf may file a complaint with the **Consumer Protection Section** of the **Louisiana Department of Justice** if he or she received a bill or activity statement from a contracted healthcare provider in violation of the new law.

In such instances, the state Attorney General is authorized to issue a Notice of Unfair Trade Practices to the healthcare provider. If the provider fails to correct his or her billing and refund the amount in question, the Attorney General is authorized to proceed in accordance with existing law, the Unfair Trade Practices and Consumer Protection Law, including pursuing such remedies as injunctive relief, voluntary compliance agreements, and **fines of up to \$5,000 per violation**.

However, if the billing activity was based on information received from the health insurance issuer, the contracted healthcare provider will not be in violation, and the state Attorney General will refer the violation to the state DOI.

PATIENTS OR PROVIDERS

Any insured, enrollee, contracted healthcare provider, or non-contracted facility-based physician may request a Cease and Desist Order from the state Commissioner of Insurance if he or she identifies any issuer in violation of the law. The Commissioner is authorized to issue such an order directing the issuer to correct the violation. If the issuer fails to do so, he or she is subject to a **fine of 50% of any amount in violation** of the law up to a **maximum fine of \$1,000 per claim**, or **for violations not related to a reimbursement amount, a fine of \$1,000 per violation**.

*Note that the state **Office of Group Benefits** is **not** subject to such penalties. Should the OGB be found in violation, the state Commissioner of Insurance shall notify the state Commissioner of Administration of such violations in writing within 60 days.*

NOTICE REQUIREMENTS

Any written or electronic notice issued by or on behalf of a healthcare facility or a health insurance issuer that identifies any contracted health insurance issuer or network of providers must state that facility-based physicians providing healthcare services at that facility may not be contracted healthcare providers.

In addition, facilities and health insurance issuers must make specific information on contracted or non-contracted physicians available upon the request of an insured or enrollee or patient.

NON-CONTRACTED PROVIDERS

The law does not affect **non-contracted physicians**, with one exception:

IF a non-contacted, facility-based physician provides healthcare services in a base healthcare facility to an insured or enrollee,

AND files a claim for those services, the health insurance issuer must then provide the facility-based physician with an **Explanation of Benefits (EOB)** as to any payment determination.

Health plans are subject to fines of up to \$5,000 per violation.

Providers may face fines of up to \$1,000 per claim or violation.

PROVIDER PROHIBITIONS

Contracted healthcare providers are prohibited from attempting to collect, or from collecting, from an insured or enrollee any amount that is:

- ◆ In excess of the contracted reimbursement rate for covered healthcare services (“discount billing”)
- ◆ A health insurance issuer liability (“dual billing”)
- ◆ Or, any amount other than coinsurance, co-payments, deductibles, payment for non-covered or non-contracted healthcare services, or any other amount identified by the health insurance issuer on an EOB as the liability of the health insurance issuer

→ **NOTE:** *If any of the above occur based on information received from the insurer, the provider shall not be in violation*

Contracted healthcare providers are prohibited from maintaining any legal action against an insured or enrollee for a health insurance issuer liability or for payment of any amount in excess of the contracted reimbursement rate; in the event of such an action, the prevailing party may recover all costs incurred.

**The new law
goes into effect
January 1, 2004**

PROVIDER REQUIREMENTS

Contracted healthcare providers are required to:

- ◆ Clearly delineate the amount billed to their health insurance issuer and the amount owed by the enrollee or insured
- ◆ Include certain language on activity statements and bills, as follows:

Activity Statements must have the following language on the front in at **least 12-point font, boldface capital letters**:

NOTICE:

THIS IS NOT A BILL. DO NOT PAY. IF IT IS DETERMINED THAT THIS SERVICE OR A PORTION OF THESE SERVICES IS NOT PAYABLE BY YOUR HEALTH PLANS, YOU WILL BE RESPONSIBLE.

Bills (and **Combination Activity Statements/Bills**) must have the following language on the front in at **least 12-point font, boldface capital letters**:

NOTICE:

THIS IS A BILL. BASED UPON INFORMATION FROM YOUR HEALTH PLAN, YOU OWE THE AMOUNT SHOWN.

CORRECTION OF PATIENT CREDIT RECORD

Any contracted healthcare provider who files, refers, or sends a report to a credit reporting agency for nonpayment by an insured or enrollee of any amount which he or she is prohibited from billing or collecting, shall assist in correcting a credit record by providing a letter to the credit reporting agency and the enrollee or insured.

If this letter is not sent within 10 days of certain written notice, the healthcare provider will be liable for all reasonable costs incurred by the insured or enrollee in correcting the credit report.

HEALTH PLAN REQUIREMENTS

Each health insurance issuer is required to:

- ◆ Ensure that all identification cards issued contain sufficient information to clearly identify that issuer
- ◆ Ensure that the following notice is contained in or accompanies each health insurance policy, certificate of coverage, or health insurance identification card:

NOTICE:

YOUR SHARE OF THE PAYMENT FROM HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLING CHARGES.

- ◆ Update its list of contracted healthcare providers on at least an annual basis, and make current versions available upon request to enrollees or insureds
- ◆ If any amount due a healthcare provider is the responsibility of the insured or enrollee, the issuer must set forth in its EOB the contracted reimbursement rate, identify the amount due from the enrollee or insured, and the reasons the amount is due
- ◆ If issuer needs additional information for payment, the issuer must notify the provider AND the enrollee in writing, and identify the party responsible for providing the information; if the patient is responsible and does not provide the information within 45 days, the provider may bill patient up to contracted reimbursement rate
- ◆ If contracting with a network of providers, the issuer will pay a contracted healthcare provider the rate established in the contract
- ◆ If issuer does not pay an amount equal to its liability to the provider, the provider may collect the difference from the insured or enrollee (up to contracted rate); such collection efforts will not violate the new law