On October 15th a full day forum was hosted by our state's Insurance Consumer Advocate (ICA), Ms. Sha'Ron James, on balance billing practices of healthcare providers. Titled ***Finding a Balanced Approach to Unexpected Medical Expenses***, it included a series of presentations with Q&A from various sides of the issue.

Meeting information, including the full agenda and speaker presentations, can be found: http://www.myfloridacfo.com/Division/ICA/ICAsForum-MedicalExpenses.html

From a very high level - the Discussion focused on 3 primary types of occurrences where balance billing usually occurs -

1. A medical emergency where the patient is taken to an out of network hospital without a choice – their health plan covers little if any of the cost and the hospital bills them for the rest.

2. A patient appropriately selects an in network facility but is unaware that services may be/were provided by independent (contracted) providers within the facility who are not in network, and those services are billed separately (ex: anesthesia, path, therapies, etc.)

3. A patient performs their due diligence to select an in network provider (using web directories, calls the provider office, calls plan, etc.) - only to be balance billed later and when they question the provider or health plan about the bill are told "provider participation can change at any time."

With all of these it is also noted that the Explanation of Benefits (EOBs) that come from the insurance companies to show what was and was not paid are usually extremely difficult to understand, even for educated and informed consumers.

Estimates of the impact of this issue, as presented by some of the speakers, referenced data indicating that balance billing and/or "surprise" bills affect 35% of healthcare consumers. In 2014, 62% of bankruptcies nationally indicated medical expense as the primary cause...and 75% of those had health insurance.

There is currently no specific authority to stop or prevent the practice. There are some prohibitions on the books (example HMOs) but they are difficult and rarely enforced.

There were multiple studies referenced indicating that there is a trend among plans of narrowing their provider networks which is contributing to the problem.

Primary strategies offered by speakers and guests aligned to 2 overarching themes:

1. Regulate plans to ensure they cover a larger share of costs/charges
    - Pay full charges as billed
    - Pay the Medicare Usual and Customary Rate (UCR) as a minimum starting point
    - Pay Medicare UCR plus some percent as minimum threshold

2. Regulate providers and cap charges
    - Use Medicare as benchmark

Since both of these essentially establish a standardized Usual and Customary Rate (UCR) from one side or the other - the big question of the day then became who should set that rate. Everyone agrees there is no simple answer - and that multiple stakeholders should be involved in the process.

There was a strong call for transparency around what health plans are paying providers so that some average UCR could be determined. There were numerous references to FairHealth.com, a national All Payer Claims Database. FHA advocated strongly for a statewide All Payer Claims Database (APCD) for Florida.

ICA will take all of the feedback into consideration on any future policy development involving this topic.

No future meetings are planned for this group at this time.