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KOEHLER FITZGERALD

| REFERENCE-BASED PRICING NEWSLETTER |

Koehler Fitzgerald

Koehler Fitzgerald LLC provides highly specialized legal services to TPAs, HCSMs and Plan Sponsors offering reference-based medical plans.

Central to those services are the defense of balance billing claims, from provider billing to jury trial, utilizing the firm's highly rated trial lawyers, nationally recognized experts and affiliated local counsel throughout the U.S.

Koehler Fitzgerald's multilingual services are supported by the use of proprietary and customized software to track and support group calendaring, task management, contact management, conflicts checking, integrated document assembly and customized weekly reports of the status of claims and activity.

James F. Koehler
Koehler Fitzgerald LLC
1111 Superior Ave.
Cleveland, Ohio 44114
216.539.9370

Credit Reporting Assurances of Voluntary Compliance Revisited

As reported in our February 2016 newsletter, following a settlement between the State of New York and Experian Information Solutions, Inc., Equifax Information Services, LLC, and TransUnion LLC (a "CRA" or the "CRAs"), the Attorney Generals of AL, AK, AZ, AR, FL, GA, HI, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MO, NE, NV, NM, NC, ND, OH, OR, PA, RI, TN, TX, VT, and WI entered into Assurances of Voluntary Compliance/Assurance of Voluntary Discontinuance which became effective on May 15, 2015 (the "AVCs").

Have the AVCs alleviated the adverse impact on members of RBP plans when unpaid balance bills are reported to a CRA? Not really, and they were not so intended.

Generally the AVCs require CRAs to complete "reasonable reinvestigations of consumer disputes" within designated time periods, unless the CRA reasonably determines the dispute to be frivolous; require the provision of a notice from the CRA to any person who provided the information in dispute within five business-days of the receipt of notice of the

Texas' Balance Billing Act

Texas S.B. 507 becomes effective on September 1, 2017. The legislation provides for mediation, and for disclosure of the availability of mediation, to "enrollees" for out-of-network health benefit claims, where the balance bill is over $500 and the health benefit claim is for emergency care, or a health care or medical service/supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with a public employee health plan administrator. Texas Insurance Code Section 1301.001(A)(8) defines a "Preferred provider" as a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy. Section 1301.001 (A)(9) defines a "Preferred provider benefit plan" as a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

consumer dispute; where the reinvestigation finds the information to be inaccurate, incomplete, or unverifiable, the prompt deletion or modification of that information; notice to the provider of the information of its deletion or modification; and notification to the consumer that the CRA has completed its reinvestigation. The AVCs further mandate reasonable procedures to prevent the reappearance of inaccurate or deleted information, additional notices to the consumer when the furnisher of the information certifies that it is accurate, the revision of training materials, revised policies and procedures, identification of collection furnishers who misreport on a recurring basis and prohibit collection furnishers from reporting debt that did not arise from any contract or agreement to pay, such as fines, tickets and certain other assessments.

To allow for time for "insurance remediation and clarity on what a consumer's individual payment obligation is for a medical account," effective June 5, 2018, the CRAs are not to report and display medical debt when the first delinquency is less than 180 days prior to the date the account is reported to the CRAs.

Apart from the latter provision, the AVCs have had little impact upon the angst suffered by RBP plan members when otherwise credit-worthy persons become the subject of aggressive efforts to collect balance bills. The providers, collection agencies, and CRAs can be forced to follow and adhere to the procedures, but a properly verified medical bill remains unpaid unless it is settled or adjudicated as not owed by the member.