STOP Third-Party Providers from Driving Up Health Care Costs for All

YES on SB 1156

SB 1156 will increase consumer protection and provide transparency to health plans about where the payments for treatment are coming from, and remove the financial incentive of third-party payers to bill health plans for inflated and unnecessary medical claims.

What does SB 1156 do?

- Sets requirements for a person or company that purchases or pays for health insurance on behalf of someone else if the purchaser stands to benefit financially from that health insurance policy.
- Establishes safeguards to protect patients who get caught up in these schemes and removes the financial incentive for unscrupulous providers to take advantage of the system.
- Protects patients by requiring financially interested third-party payers to disclose to the patient and the health plan their intention to pay a patient's premiums, and requiring financially interested third-party payers to pay premiums for the full plan year, even if a patient stops treatments that benefit the provider (in order to ensure continuity of care for patients).
- Prohibits financially interested third parties from balance billing a patient for the difference between a Medicare rate and the contracted rate.
- Removes the financial incentive for third-party providers who directly or indirectly pay for a patient's health insurance premiums by setting the reimbursement rate to whichever is lower, the Medicare rate or the rate set by the patient's health insurance policy DMHC and CDI would be able to fine financially interested providers that try to evade the bill's requirements.

Concerned consumer, labor, and health care groups agree. YES on SB 1156!

For more information, please go to www.calhealthplans.org

California Association of Health Plans

FACT vs. FICTION: SB 1156

Some dialysis providers and loosely regulated residential addiction treatment centers are putting patients at risk and driving up health care rates by coaxing lucrative patients to sign up for expensive health plans with a strings-attached promise to pay their premiums. Exposing patients to significant financial risk and disrupting their care, these providers have especially preyed on vulnerable individuals suffering from opioid addiction and kidney disease — in search of a big pay day from insurers.

SB 1156, introduced by Senator Connie Leyva, will help to rein in these predatory scams by ensuring transparency and accountability so patients receive the continued care they need at a price they can afford.

Opponents of SB 1156 WANT YOU TO BELIEVE...	BUT THE FACT IS...
FICTION: SB 1156 would put poor patients at risk and make it harder for thousands of kidney and drug rehabilitation patients to get the care they need.	**FACT: According to a 2016 CMS analysis, financially interested third parties who pay commercial premiums on behalf of patients, can harm patients by interfering with transplant readiness, subjecting them to additional financial exposure, and creating mid-year disruptions to their coverage. SB 1156 protects patients by requiring third parties to pay patient premiums for a full year and prohibits them from balance billing patients.**
FICTION: SB 1156 gives health plans broad new powers to decide which patients would be allowed to keep private insurance coverage for treatment and which ones would not.	FACT: SB 1156 does not prevent third-party payers from making premium payments on behalf of patients. It simply removes the financial incentive for unscrupulous providers to take advantage of the system, with inflated medical claims.
FICTION: SB 1156 would allow health plans to deny coverage for low-income patients receiving charitable premium assistance from third-party payers.	FACT: SB 1156 does not allow health plans to deny coverage or care to patients. It does require sensible disclosure requirements so that the reimbursement rate for the financially interested provider will not reward the provider for steering patients to their clinics.
FICTION: SB 1156 would have disastrous consequences for low-income kidney patients and would lead to cutbacks in services or even cause dialysis center closures across the state.	FACT: 80% of dialysis patients are covered by Medicare, and in California, many dialysis patients are also covered by Medi-Cal. These patients have access to exactly the same dialysis clinics and dialysis treatment that commercially insured patients do. Dialysis clinics in California had an average operating margin of 18.3% in 2017.
FICTION: SB 1156 would slash what health plans must pay to dialysis clinics for treatment of patients who receive chartable assistance, reducing these payments to the Medicare rate, which is notoriously low and barely covers the cost of care.	FACT: A major dialysis provider reports its patient care costs are $224 per treatment. By comparison, Medicare's base rate averages $300 per treatment. But unscrupulous providers are billing health plans at 3 to 4 times more than the Medicare rate for patients who are eligible for Medicare.

Bottom line? Unnecessary inflated medical claims drive up the cost of health insurance premiums for everyone. Californians should not have to pay the price for unscrupulous third parties seeking to profit off inflated medical claims.

YES on SB 1156.