



Out-of-Network Reimbursement: Summary of State Requirements

(as of September 17, 2017)

Background: One tool that health insurance plans use to improve quality and control costs is the establishment of provider networks. Through selectively contracting with credentialed providers, health plans can create networks that provide consumers with lower cost, high-quality care. The majority of private health insurance plans and many public programs offer consumers the choice of using a network of contracted physicians, hospitals, and other health care professionals or receiving care from out-of-network providers.

Out-of-network providers are free to charge whatever fee they choose, with some individual providers charging amounts that can be several thousand times greater than the Medicare reimbursement rate for the same service. Because there are no contracts with out-of-network providers that set the reimbursement rate for covered services, a system must be established for determining what and how it will reimburse out-of-network providers.

There are a number of different data benchmarks that are used to determine the reimbursement level for out-of-network services – commonly referred to as the “usual, reasonable, and customary” (UCR or UC) rate. This includes, but is not limited to billed charge data collected by an external source or vendor, a plan’s own claims database, and other demonstrable benchmarks, such as Medicare payment rates or negotiated fee schedules.

States have also enacted requirements to guide reimbursement for services rendered outside the network. This includes specific payment directives or required reimbursement levels, as well as guidelines for the use and development of payment or reimbursement databases. What follows are details of these state requirements.

At the Federal level, the ACA and subsequent regulations require health benefit plans to reimburse out-of-network emergency services in an amount equal to the greatest of:

- the median amount negotiated with in-network providers for the emergency service;
- the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or
- the amount that would be paid under Medicare for the emergency service (minimum payment standards).

Out-of-Network Reimbursement: Summary of State Requirements

Approaches¹: Forty-one states (AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, IL, IN, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OK, PA, SD, TN, TX, UT, VA, WA, WI and WY) have laws and regulations that establish how health insurance plans must reimburse out-of-network providers.

Scope: Twenty states (AL, AK, AR (HMOs), CA (HMOs), CT, DE, FL, ME, MD, MA, MN, NV (children), NY, PA, SD (GI plans), TN, UT, VA, WI and WY) apply out-of-network reimbursement requirements generally to non-participating health care providers.

- Thirteen states (CO, DE, IL, ME, MI (HMOs), MO, MT, NE, NH, ND, SD, TX, and WA) establish out-of-network reimbursement requirements for situations where there is an insufficient number of in-network providers that are geographically accessible and/or available within a reasonable period of time to render the service(s) in question.
- Twelve states (DE, FL, IL, IN, MD (HMOs), MA, NH (HMOs), NJ, ND, PA, TN (Medicaid), and WI) establish out-of-network reimbursement requirements for situations that involve emergency services.
- Nine states (CO, DE, IL, IN, NM, NY, TN, TX (HMOs), and WA) apply out-of-network reimbursement requirements when a referral is made to an out-of-network provider if services are not available in-network.
- Eight states (AL, AK, AR, GA, LA, MD (Medicaid), MS, and TX) establish out-of-network reimbursement requirements for services provided by dentists or other dental providers.
- Three states (GA, ND and VA) establish out-of-network reimbursement requirements for pharmacy services.
- Two states (CO and TX) establish requirements related to reimbursement to ancillary, hospital based providers (e.g., anesthesiologists, radiologists) who are out-of-network but provide services at in-network facilities.

- One state (NJ (IHC/SEH)) establishes reimbursement requirements for services provided by out-of-network hospitals.
- One state (NY) establishes reimbursement requirements for services provided by out-of-network ambulance service providers.
- One state (UT) establishes reimbursement requirements for federally qualified health centers

Required reimbursement: Thirty states (AL, AK, AR, CA, CO, DE, FL, GA (dental/RX), IL, LA (dental), ME, MD, MI (HMOs), MS, MO, MT, NE, NV (children), NH, NJ (IHC/SEH), NM, NY, NC, ND, SD, TN, TX, UT, VA, and WA) establish specific levels or guidelines for reimbursement for out-of-network services.

- Twelve states (AL, AK (dental), GA (dental/RX), IL, LA (dental), MD (HMOs), MI, MS (dental), ND, TN, TX, and UT (HMOs)) require reimbursement for services rendered by out-of-network providers at the same reimbursement level as in-network providers.
- Twelve states (CO, IL, ME, MI (HMOs), MO, MT, NH, NY, NC, SD, TN, and WA) require coverage such that beneficiaries obtain benefits for covered services at “no greater cost” than if the service had been provided by an in-network provider.
- Ten states establish the UCR rate for payment to out-of-network providers for certain products or entities as follows:
 - AK: equal to or greater than the 80th percentile of charges;
 - AR (dental): payment may differ from capitated dentists by no more than 10%;
 - CA: based on the 50th percentile or higher;
 - FL: no less than 10% lower than the in-network rate;
 - MD: aggregate payments may not be less than 80% of the aggregate payments to in-network providers;
 - NV (children): average amount paid to in-network providers;
 - NJ (IHC/SEH): 80th percentile of the Ingenix database for hospital services;
 - SD (GI plans): no less than the 80th percentile of UCR;

¹ States may fall into multiple categories as they have more than one law

that establishes out-of-network reimbursement requirements.

Out-of-Network Reimbursement: Summary of State Requirements

- TN (Medicaid): no less than 80% of lowest rate paid by the Medicaid carrier for non-emergency claims and 74% of the Medicaid rates for emergency claims; and
- UT: 75% of the average amount paid to in-network providers.
- Five states (CO, FL, IN, MD (HMOs), and NH) require reimbursement at the “lesser of” a list of specific payment levels (e.g. the lesser of the billed charges, the negotiated rate, the Medicare rate, or the UCR amount).
- Two states (CT and MD) require reimbursement at the “greater of” a list of specific payment levels (e.g. the greater of the billed charges, the negotiated rate, the Medicare rate, or the UCR amount).
- Two states (DE and NE) require reimbursement to out-of-network providers at an agreed upon or negotiated rate.
- Two states (MD and MS) establish specific fee schedules for dental services under their respective Medicaid programs.
- One state (PA) requires payment of “all reasonably necessary” costs related to the provision of emergency services.
- One state (PA) identifies payments to out-of-network providers in amounts less than 80% of the payment to in-network providers as leading to under-treatment or poor quality care.

Chart: The following chart catalogs state requirements that impose specific requirements on health insurance plans regarding reimbursement to out-of-network providers.

- The chart does not include information on similar state requirements for non-health insurance products, such as workers’ compensation and automobile insurance.
- This chart also does not include information on continuation of benefits and special reimbursement rules during a state of emergency (e.g., Katrina).

Database/methodology requirements: Fifteen states (AK, CA (HMOs), CO, CT, KS, KY, ME, MN, MS, NJ, NY, OK, UT, WI, and WY) establish parameters for the data or methodology that is used to calculate UCR rates.

- Seven states (CA (HMOs), KS, MS, NJ, NY, WI, and WY) require regular updates to the database (e.g., the data must be updated every 6 months and the database cannot contain data that is more than 18 months old).

Other: Seven states (AZ, CA, DE, FL, MN, MT(air ambulance only), and TX) establish an arbitration process to resolve disputes regarding reimbursement for an individual claim.

- One state (MA) requires rate filings to include an actuarial opinion certifying that UCR rates are, in the aggregate, comparable to the 80th percentile of Ingenix.

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|--|
| <p>Alabama <i>Ala. Code §27-19A-4</i></p> <p>Enacted 1984</p> | <p>Health insurance policies and employee benefit plans</p> | <p><u><i>Required Reimbursement.</i></u> Requires reimbursement for services rendered by non-contracting dentists at the same reimbursement as for a contracting dentist; provided, however, that the health insurance policy or the employee benefit plan is not required to make payment in an amount which is greater than the amount specified in the policy or plan or which is greater than the fee charged by the dentist for the services rendered.</p> <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>Alabama <i>Ala. Code §27-1-19</i></p> <p>Enacted 1994 Amended 2001</p> | <p>Insurers, HMOs, health care service corporations, preferred provider organizations, and other third party payers</p> <ul style="list-style-type: none"> • Does not apply to state administered health benefit plans | <p><u><i>Required Reimbursement.</i></u> Requires affected entities to reimburse a non-participating provider pursuant to an assignment of benefits under the same criteria and payment schedule that would have been used to directly reimburse the contract provider.</p> <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>Alaska <i>Alaska Stat. §21.42.392</i></p> <p>Enacted 2000 Amended 2009</p> | <p>Health care insurers</p> | <p><u><i>Required Reimbursement.</i></u> Allows a health care insurer to reimburse a covered person at a different rate because of the person's choice of a dentist if the dentist is not a part of the covered person's dental network or preferred provider organization agreement.</p> <ul style="list-style-type: none"> • Mandates that the covered expense for non-network providers be no less than the amount allowed to a network provider, although it may be reimbursed at a lower percentage or with higher deductibles than if the service had been provided in-network. <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>Alaska <i>Alaska Admin. Code tit. 3, §26.110</i></p> <p>Enacted 1989</p> | <p>Persons that provide coverage on an expense incurred basis</p> | <p><u><i>Required Reimbursement.</i></u> See <i>Database Requirements</i> (below).</p> <p><u><i>Database/Methodology Requirements.</i></u> Requires a person that provides coverage on an expense incurred basis based on an amount that is less than the actual amount billed to determine the final payment based on an amount that:</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|---|
| Amended 2004 | | <ul style="list-style-type: none"> reflects the general cost differences between the geographical area where the service was performed and the other geographical areas used in establishing the statistically credible profile -- the adjustment may be based on the Consumer Price Index (CPI), the medical care component of the CPI, or another reasonable basis stated in writing; and is equal to or greater than the 80th percentile of charges for the services or supplies. |
| <p>Arizona</p> <p><i>Ariz. Rev. Stat. §§ 20-3111 to 3115</i></p> <p>Enacted 2017</p> | <p>Group and individual health plans</p> | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> None</p> <p><u>Other.</u> The department shall develop a simple, fair, efficient and cost-effective arbitration procedure for surprise out-of-network bill disputes and specify time frames, standards and other details of the arbitration proceeding, including procedures for scheduling and notifying the parties of the settlement teleconference.</p> <p><u>Permits enrollees receiving surprise out-of-network bills to seek dispute resolution of the bill if:</u></p> <ul style="list-style-type: none"> <u>the enrollee has resolved any health care appeal that the enrollee may have had against the insurer following the initial adjudication of the claim.</u> <u>the amount of the surprise out-of-network bill for which the enrollee is responsible for all related health care services provided by the health care provider whether contained in one or multiple bills, after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement, is at least one thousand dollars.</u> <u>the enrollee received a surprise out-of-network bill.</u> <p><u>If an enrollee requests dispute resolution of a surprise out-of-network bill, the enrollee shall participate in an informal settlement teleconference and may participate in the arbitration of the bill. the health care provider or the provider's representative and the health insurer shall participate in the informal settlement teleconference and the arbitration.</u></p> |
| Arkansas | Health benefit plans | |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---|---|
| <p><i>Ark. Code Ann. §23-99-604</i></p> <p>Enacted 1999</p> | | <p><u>Required Reimbursement.</u> Requires every health plan that provides dental benefits to also include a point-of-service option (POS) which provides benefits to covered persons through dentists who are not members of the carrier's network.</p> <ul style="list-style-type: none"> Provides that the rate of reimbursement for out-of-network dentists under the mandatory POS option may differ from the reimbursement for noncapitated dentists in the network by no more than 10%. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Arkansas <i>Ark. Code Ann. §23-86-404</i></p> <p>Enacted 1999</p> | HMOs | <p><u>Required Reimbursement.</u> Provides that the HMO rate of reimbursement for out-of-network health providers shall be no higher than the normal and U&C rate charged by those out-of-network providers on a regular basis, provided that co-pay, coinsurance, and other cost-sharing features may be different for out-of-network providers and in-network providers.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>California <i>Cal Public Health Code. § 1371.30</i></p> <p><i>Cal. Ins. Code § 10112.82</i></p> <p>Enacted 2016</p> | Health insurance policies and health care service plans | <p><u>Required Reimbursement.</u> In cases when an enrollee receives nonemergency covered services at a contracting health facility, provided by a noncontracting provider, the plan shall reimburse the greater of the average contracted rate or 125% of Medicare fee-for-service reimbursement for the same or similar services in the general geographic region.</p> <p><u>Database/Methodology Requirements.</u> By January 1, 2019, the Commissioner shall specify a methodology that insurers shall use to determine the average contracted rates for services. This methodology shall take into account, at a minimum, information from the independent dispute resolution process, the specialty of the individual health professional, and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the insurer includes the highest and lowest contracted rates.</p> <p><u>Other.</u> The Department shall establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health care service plan and a noncontracting individual health professional.</p> <p>If either the noncontracting provider or the plan appeals a claim to the department's independent dispute resolution process, the other party shall participate in the appeal process as described in this section.</p> <p>The department shall permit the bundling of claims submitted to the same plan or the same delegated entity for the same or similar services by the same noncontracting individual health professional.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---------------------------|---|
| | | <p>Physician groups, independent practice associations, or other entities authorized to act on behalf of a noncontracting provider are permitted to initiate and participate in the independent dispute resolution process.</p> <p>In deciding the dispute, the independent organization shall base its decision regarding the appropriate reimbursement on all relevant information.</p> <p>The decision obtained through the dispute resolution process shall be binding on both parties. The plan shall implement the decision obtained through the independent dispute resolution process.</p> |
| <p>California 28 Cal. Code Regs. § 1300.71 Enacted 2003</p> | Health care service plans | <p><u>Required Reimbursement.</u> Defines reimbursement for a claim for contracted providers without a written contract and non-contracted providers as the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:</p> <ul style="list-style-type: none"> • the provider's training, qualifications, and length of time in practice; • the nature of the services provided; • the fees usually charged by the provider; • prevailing provider rates charged in the general geographic area in which the services were rendered; • other aspects of the economics of the medical provider's practice that are relevant; and • any unusual circumstances in the case. <p>For non-emergency services provided by non-contracted providers to PPO and POS enrollees, reimbursement shall be the amount set forth in the enrollee's Evidence of Coverage.</p> |
| <p>California² DMHC September 2, 2005 Letter Issued 2005</p> | HMOs | <p><u>Required Reimbursement.</u> See Database Requirements (below).</p> <p><u>Database/Methodology Requirements.</u> Provides that the Department of Managed Health Care (DMHC) is unable to conclude that a reimbursement methodology is “unfair” or “unjust” if the following requirements are met:</p> |

² The California Department of Managed Health Care (DMHC) established a voluntary independent dispute resolution process (IDRP) for non-contracted providers of required emergency hospital and physician services to resolve claim payment disputes with plans and capitated provider groups. The IDRP is voluntary for the provider and plan/provider group. For additional information on the IDRP, please see http://www.dmhc.ca.gov/providers/clm/clm_idrp.aspx.

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---------------------|--|
| | | <ul style="list-style-type: none"> • the payment is based on the 50th percentile or higher of a statistically credible aggregated billed charge database, updated (at least) annually, for the relevant geographic area; <u>and</u> • a payment methodology based on an amount at least 10% - 20% above the average contracts rates for similar services; <u>and</u>, • a payment methodology based on an amount above the current Medicare fee schedule for similar services (unless the average contract rates for similar services is 10% - 20% less than the current Medicare fee schedule); <u>and</u> • adequate procedures are in place to timely and fully consider the other criteria identified in the definition of “reimbursement of a claim” upon the provider’s submission of relevant supporting documentation as part of either the original claim submission or the appeal /dispute resolution process. |
| <p>California <i>Cal. Code Regs. Tit. 22, §53620, et. seq.</i></p> <p>Enacted 1996 Amended 1997</p> | Medicaid (Medi-Cal) | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> None.</p> <p><u>Other.</u> Establishes procedures for resolution of disputes concerning payment for emergency services rendered by non-plan providers to prepaid health plan members who are Medi-Cal beneficiaries.</p> <ul style="list-style-type: none"> • Prohibits prepaid health plans and non-plan providers from billing members for services which are or have been subject to review under the dispute resolution process. • Allows providers to submit a dispute to the Department of Health Services within 120 days of receiving a notice of rejection or reduction of a demand for payment for care under emergency circumstances or within 60 days after submission of a demand for payment for care under emergency circumstances if the plan fails to pay such demand. • Defines <i>emergency services</i> as: “those health care services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which if not immediately diagnosed and treated would lead to disability or death. Such emergency is deemed to continue until, in reasonable medical judgment, the patient’s condition has stabilized sufficiently so as to permit either: (1) discharge, or 2) referral and transfer of the patient, in accordance with instructions from the patient’s plan, to such level of treatment or care as may be appropriate, and a reasonable time within which to complete such discharge, or referral or transfer.” |
| Colorado | Managed care plans | <p><u>Required Reimbursement.</u> Requires managed care plans to arrange for a referral to a provider with the necessary expertise when the plan has no participating providers to provide a covered benefit and to</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|--|
| <p><i>Colo. Rev. Stat. §10-16-704</i></p> <p>Effective 1997 Amended 2006</p> | | <p>ensure that the covered person obtains the covered benefit at no greater cost to the cover person than if the benefit were obtained from participating providers.</p> <p>Provides that carriers with managed care plans are responsible to pay the provider the lesser of the below identified amounts when a covered person who have to travel beyond a reasonable distance to receive services from a participating provider and knowingly seek services from an out-of-network provider:</p> <ul style="list-style-type: none"> - the non-participating provider’s billed charges; - a negotiated rate; or - the greater of the carrier’s average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such area. <p>Requires covered services or treatment rendered at a network facility – including covered ancillary services rendered by an out-of-network provider in the network facility – be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider.</p> <ul style="list-style-type: none"> • States that when a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. <p>Clarifies that when consumers intentionally use an out-of-network provider, the consumer is only entitled to benefits at the out-of-network rate and may be subject to balance billing.</p> <p><u>Database/Methodology Requirements.</u> Allows the commissioner, upon receipt of one or more complaints, to review the carrier’s UCR rate to determine if the rate is established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.</p> <ul style="list-style-type: none"> • Requires the carrier’s methodology for determining UCR reimbursement rates to be applied in a uniform manner statewide – with an exception for geographic adjustments. |
| <p>Connecticut <i>Conn. Rev. Stat. § 38a-477aa.</i></p> <p>Enacted 2015</p> | <p>Health insurers, HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that issue health care plans in Connecticut.</p> | <p><u>Required Reimbursement.</u></p> <ul style="list-style-type: none"> • Requires health carriers to reimburse out-of-network providers who perform emergency services for insureds the greatest of the: <ul style="list-style-type: none"> ▪ amount the health care plan would pay if the services were rendered by an in-network provider; ▪ usual, customary, and reasonable rate; or ▪ amount Medicare reimburses for those services. |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|--|---|
| | | <ul style="list-style-type: none"> A health carrier and an out-of-network provider may agree to a greater reimbursement amount. The health care provider may bill the carrier directly. <p><u>Database/Methodology Requirements.</u> “Usual, customary, and reasonable rate” means the 80th percentile of all charges for the service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. That organization must not be affiliated with a health carrier.</p> |
| <p>Delaware <i>Del. Code Ann. §§ 18-3371 and 18-3571S</i> Enacted 2016</p> | Health insurance contracts and policies | <p><u>Other.</u> Provides for arbitration to establish an agreed appropriate rate of reimbursement when an out-of-network facility-based provider or health care provider fails to provide required disclosures to the insured person. The Insurance Commissioner shall adopt regulations concerning the arbitration of such disputes.</p> |
| <p>Delaware <i>Del. Code Ann. §18-3348 and §18-3564</i> Effective 2001 Amended 2002</p> | Individual and group health insurance policies | <p><u>Required Reimbursement.</u> Requires all individual and group health insurance policies to allow a referral to a non-network provider and to reimburse the non-network provider at a previously agreed upon or negotiated rate if medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time and a network provider requests the referral from the insurer.</p> <ul style="list-style-type: none"> Prohibits the non-network physician or provider from balance billing the insured. Provides that such a referral cannot be refused by the insurer absent a decision by a physician in the same or a similar specialty as the physician to whom a referral is sought that the referral is not reasonably related to the provision of medically necessary services. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Delaware <i>Del. Code Ann. §18-3349 and §18-3565</i> Effective 1995</p> | Individual and group health insurance policies | <p><u>Required Reimbursement.</u> Requires all individual and group health insurance policies to provide coverage for emergency care services performed by non-network providers at an agreed-upon or negotiated rate, regardless of whether the physician or provider furnishing the services has a contract or other arrangement with the insurer.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---------------------------|---|
| Amended 2002 | | <ul style="list-style-type: none"> • States that if the emergency services provider and the insurer cannot agree upon the appropriate rate, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner following an arbitration of the dispute (described below). • Prior to a determination by the Insurance Commissioner of those charges and rates allowed by the providers of emergency services, the insurer will pay directly to the non-network emergency care provider the highest allowable charge for each emergency care service allowed by the insurer for any other network or non-network emergency care provider during the full 12-month period immediately prior to the date of each emergency care service performed by the non-network provider. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Delaware <i>Del. Code Ann. §18-333 and Code Del. Regs. 18 1300 1313</i></p> <p>Enacted 2007 and 2008</p> | Health insurance carriers | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> None.</p> <p><u>Other.</u> Requires every health insurance carrier to submit to arbitration any dispute with a provider regarding reimbursement for an individual claim, upon a request for arbitration by the provider.</p> <ul style="list-style-type: none"> • States that by requesting arbitration, a provider is deemed to have agreed that it will not bill its patient for the difference between its charge and any reimbursement awarded by the arbitrator if it is forbidden from such billing by its contract with the carrier against whom the award is entered. • Charges the DOI with responsibility for administering the arbitration program. • Exempts the following disputes from the arbitration program: <ul style="list-style-type: none"> – whether the patient for whom services were provided was a policyholder at the time services were rendered, or was otherwise entitled to receive services or reimbursement for services; – those that are already pending before a court of law; and/or – those that fall under a carrier's own arbitration program, which has been granted an exemption by the DOI in accordance with state law. <p>Requires health insurance carriers to notify providers in writing of the right to request arbitration if the carrier does not authorize reimbursement of the provider's charges in its entirety.</p> <ul style="list-style-type: none"> • Mandates that this notice be provided at the time a carrier gives a provider written notice of its final reimbursement decision. • Requires the notice to contain, at a minimum, the following language: <ul style="list-style-type: none"> – “You have the right to seek review of our decision regarding the amount of your reimbursement. The Delaware Insurance Department provides claim arbitration services which |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|---|
| | | are in addition to, but do not replace, any other legal or equitable right you may have to review of this decision or any right of review based on your contract with us. You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322. You may also go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the arbitration process. All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final.” |
| <p>Delaware Code Del. Regs. 18 1400 1403 (11.3.1.2), (11.3.1.3), and (11.3.3.2)</p> <p>Enacted 1988 Amended 2007</p> | Managed care organizations (MCOs) | <p><u>Required Reimbursement.</u> Requires an MCO to cover non-network providers and prohibit balance billing if the MCO has an insufficient number of providers that are geographically accessible and available within a reasonable period of time to provide covered health services to enrollees.</p> <ul style="list-style-type: none"> • Defines <i>geographically accessible</i> as: a location no greater than 30 miles or 40 minutes driving time from 90% of enrollees within the MCO's geographic service area. <p>Requires MCOs to allow referrals to a non-network provider, upon the request of a network provider, when medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time.</p> <ul style="list-style-type: none"> • Requires the MCO to make acceptable service arrangements with the provider and enrollee, and prohibit balance billing in such circumstances. <p>Requires MCOs to make acceptable service arrangements with the provider and enrollee, and prohibit balance billing when emergency care services are performed by non-network providers.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Florida Fla. Stat. ch. §627.647 and §627.6472</p> <p>Enacted 1991 Amended 1997</p> | Preferred provider and exclusive provider network policies | <p><u>Required Reimbursement.</u> Requires health insurance policies which include coverage for services performed by a network of preferred providers or a network of exclusive providers to provide reimbursement at a rate no less than 10 percentage points lower than the percentage rate paid to preferred providers if any covered service or treatment is not within the scope of services provided by preferred providers.</p> <ul style="list-style-type: none"> • Clarifies that the reimbursement rate must be applied to the U&C charges in the area. <p><u>Database/Methodology Requirements.</u> None.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---|---|
| <p>Florida <i>Fla. Stat. ch. §627.64194</i> Enacted 2016</p> | <p>Preferred provider and exclusive provider network policies</p> | <p><u>Required Reimbursement.</u> For covered emergency services, reimbursement for services by a provider who does not have a contract shall be the lesser of:</p> <ul style="list-style-type: none"> • provider’s charges; • usual and customary provider charges for similar services in the community where the services were provided; or • the charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim. <p>Other. Any dispute with regard to the reimbursement to the nonparticipating provider of emergency or nonemergency services shall be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process in Fl. Stat. Ann. § 408.7057.</p> |
| <p>Florida <i>Fla. Stat. ch. §641.513</i> Enacted 1996</p> | <p>HMOs and Medicaid</p> | <p><u>Required Reimbursement.</u> States that reimbursement for emergency services and care by a provider who does not have a contract with the HMO shall be the lesser of:</p> <ul style="list-style-type: none"> • provider’s charges; • usual and customary provider charges for similar services in the community where the services were provided; or • the charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim. Provides that reimbursement for emergency services and care to Medicaid recipients by a provider who does not have a contract with the HMO shall be the lesser of: <ul style="list-style-type: none"> • the provider’s charges; • the U&C provider charges for similar services in the community where the services were provided; • the charge mutually agreed to by the HMO and the provider within 60 days of the submittal of the claim; or • the Medicaid rate. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Georgia <i>Ga. Code Ann. §33-30-23 and §33-51-6</i> Enacted 1988 and 2008</p> | <p>Health benefit plans</p> | <p><u>Required Reimbursement.</u> Requires health benefit plans that provide incentives for covered persons to use pharmaceutical or dental services of preferred providers to contain a provision which clearly identifies that the payment or reimbursement for a non-contracting provider of covered pharmaceutical or dental services shall be the same as the payment or reimbursement for a preferred provider of covered pharmaceutical or dental services.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|--|---|
| Amended 2000 and N/A | | <ul style="list-style-type: none"> Does not require payment or reimbursement in an amount which is greater than the actual fee charged by the provider for the dental or pharmaceutical services rendered. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Illinois 215 Ill. Comp. Stat. 5/370o</p> <p>Enacted 1937 Amended 1988</p> | Preferred provider contracts | <p><u>Required Reimbursement.</u> Requires preferred provider contracts to provide emergency care coverage such that payment is not dependent upon whether services are performed by a preferred or non-preferred provider and is at the same benefit level as if the service had been rendered by a plan provider.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Illinois Ill. Admin. Code tit. 50, §2051.55</p> <p>Effective 1997 Amended 2003</p> | Preferred provider administrators (PPAs) | <p><u>Required Reimbursement.</u> Requires PPAs to ensure that beneficiaries are provided covered services at no greater cost than if the service had been provided by a preferred provider in cases where the beneficiary has made a good faith effort to utilize network providers and it is determined that the PPA does not have the appropriate preferred providers due to insufficient number, type or distance.</p> <ul style="list-style-type: none"> Provides that whenever a PPA or a preferred provider finds it medically necessary to refer a beneficiary to a non-preferred provider, the payer shall ensure that the beneficiary shall incur no greater out of pocket liability than had the beneficiary received services from a preferred provider. <ul style="list-style-type: none"> Clarifies that a beneficiary who willfully chooses to access a non-preferred provider for services available through the administrator panel of participating providers can be subject to financial penalties as prescribed by the payer. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Illinois 215 Ill. Comp. Stat. 356z.3a</p> <p>Enacted 2013</p> | Insurers and health plans | <p><u>Required Reimbursement:</u> If a beneficiary, insured, or enrollee agrees in writing, any benefits received for services when utilizing a network hospital with non-participating facility-based providers are assigned to the nonparticipating facility-based providers. For such assigned bills, the nonparticipating facility-based provider may bill the insurer or health plan for the services rendered, and the insurer or health plan may pay the billed amount or attempt to negotiate reimbursement with the nonparticipating facility-based provider.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---------------|---|
| | | <ul style="list-style-type: none"> • If attempts to negotiate reimbursement for services provided by a nonparticipating facility-based provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the insurer or health plan, then an insurer or health plan or nonparticipating facility-based physician or provider may initiate binding arbitration to determine payment for services provided on a per bill basis. • Requires the insurer to provide the nonparticipating provider with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment or coinsurance amounts owed by the insured, beneficiary or enrollee. The insurer or health plan shall pay any reimbursement directly to the nonparticipating facility-based provider. <p>Enrollees are not to be billed by the provider except for applicable deductible, copayment, or coinsurance amounts that would apply if the beneficiary, insured, or enrollee utilized a participating physician or provider for covered services. If an enrollee rejects assignment of benefits in writing, the nonparticipating facility-based provider may bill the beneficiary for the services rendered.</p> <p>If an enrollee willfully chooses to access a nonparticipating facility-based physician or provider for health care services available through the insurer's or plan's network of participating physicians and providers, the contractual requirements for nonparticipating facility-based provider reimbursements will apply.</p> |
| <p>Indiana <i>Ind. Code §27-13-36-5 and §27-13-36-9</i> Enacted 1998</p> | <p>HMOs</p> | <p><u>Required Reimbursement.</u> Requires HMOs, when the enrollee is referred out-of-network following a determination by the HMO that the type of service needed by the enrollee is not available from the HMO's network of participating providers, to cover and reimburse for out-of-network services at a rate equal to the lesser of the following:</p> <ul style="list-style-type: none"> - the UCR charge in the HMO's service area for the services provided by the out-of-network provider; or - an amount agreed to between the HMO and the out-of-network provider. <ul style="list-style-type: none"> • Requires HMOs to cover and reimburse expenses for emergency services at a rate equal to the lesser of the following: <ul style="list-style-type: none"> - the UCR charge in the HMO's service area for services provided during the emergency; or - an amount agreed to between the HMO and the out of network provider. <p><u>Database/Methodology Requirements.</u> None.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|--|
| <p>Kansas <i>Kan. Stat. Ann. §40-2202</i></p> <p>Enacted 1951 Amended 2004</p> | <p>Accident and sickness insurance policies</p> | <p><u>Required Reimbursement.</u> See <i>Database Requirements</i> (below).</p> <p><u>Database/Methodology Requirements.</u> Requires policies of accident and sickness insurance that purports to base the payment of benefits on “UCR charges” or a standard of similar import to determine payable benefits from a statistically valid sample which:</p> <ul style="list-style-type: none"> • equitably recognizes geographic variations; • is produced at least every 6 months; and • is collected on the basis of the most current codes and nomenclature developed and maintained by recognized authorities. |
| <p>Kentucky <i>806 Ky. Admin. Regs 17:030</i></p> <p>Effective 1975 Amended 2007</p> | <p>Health policies and riders for surgical coverage</p> | <p><u>Required Reimbursement.</u> See <i>Database Requirements</i> (below).</p> <p><u>Database/Methodology Requirements.</u> States that a health policy or rider that provides coverage for surgical care through an operation or surgical schedule will not be approved unless it complies with the following:</p> <ol style="list-style-type: none"> 1. where the indemnity is limited to the listed operation(s), the policy or rider shall indicate in unequivocal language that indemnity will be paid only for listed operations; and 2. if the company is to determine the amount to be paid for any unlisted operation, the policy must provide that the amount will be determined: <ol style="list-style-type: none"> a. on a basis of comparative severity or original difficulty with operations listed in the schedule of operations; b. on the basis of U&C charges in the community by accredited physicians for comparable services; or c. on some other basis as may be approved by the executive director. |
| <p>Louisiana <i>La. Rev. Stat. Ann. §22:1154</i></p> <p>Enacted 1985 Amended 2003</p> | <p>Health insurance policies and employee benefit plans</p> | <p><u>Required Reimbursement.</u> Provides that payment or reimbursement for a non-contracting provider dentist must be the same as for a contracting provider dentist; provided, however, that the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the amount specified in the policy or plan, or which is greater than the fee charged by the providing dentist the dental care services rendered.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|----------------------------------|--|
| <p>Maine <i>Me. Rev. Stat. Ann. Tit. 24-A, §4303 and Code Me. R. 02-031 Ch. 850, § 7</i></p> <p>Effective 1997 Amended 2017</p> | <p>Carriers</p> | <p><u>Required Reimbursement.</u> With regard to surprise bills, carriers shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider.</p> <p>Requires carriers to reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the average network rate under the enrollee's health care plan as payment in full, unless the carrier and out-of-network provider agree otherwise.</p> <p>If a carrier has an inadequate network, as determined by the superintendent, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the service were obtained from a network provider or shall make other arrangements acceptable to the superintendent.</p> <p><u>Database/Methodology Requirements.</u> States that the Superintendent, when considering the reasonableness of the methodology for calculating maximum allowable charges, shall consider whether the methodology takes into account relevant data specific to Maine -- if there is sufficient data to constitute a representative sample of charge data for the same or comparable service.</p> |
| <p>Maine <i>Me. Rev. Stat. Ann. Tit. 24-A, §4318-B</i></p> <p>Enacted 2017</p> | <p>Carriers</p> | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> A carrier may use the average price paid to a network provider for the covered comparable health care service under the enrollee's health plan in lieu of the statewide average price on the Maine Health Data Organization's publicly accessible website as long as the carrier uses a reasonable method to calculate the average price paid and the information is available to enrollees through a website accessible to the enrollee and a toll-free telephone number that provide, at a minimum, information relating to comparable health care services.</p> <p><u>Other.</u> Requires carriers to permit enrollees to elect to obtain covered services from out-of-network providers at a price that is the same or less than the statewide average for the same covered health care service, based on data in the publicly accessible health care costs website of the Main Health Data Organization. For the purposes of this section, "out-of-network provider" means a provider located in Massachusetts, New Hampshire or this State that is enrolled in the MaineCare program and participates in Medicare.</p> |
| <p>Maine</p> | <p>Health insurance policies</p> | <p><u>Required Reimbursement.</u> None.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|------------------------------------|--|
| <p><i>Code Me. R. 02-031 Ch. 755, § 7</i></p> <p>Enacted 2004</p> | | <p><u><i>Database/Methodology Requirements.</i></u> States that the Superintendent, when considering the reasonableness of the methodology for calculating maximum allowable charges, shall consider whether the methodology takes into account relevant data specific to Maine -- if there is sufficient data to constitute a representative sample of charge data for the same or comparable service.</p> |
| <p>Maryland <i>Md. Code Ann. Ins. §14-205</i></p> <p>Enacted 1997 Amended 2010</p> | <p>Preferred provider policies</p> | <p><u><i>Required Reimbursement.</i></u> The insurer's allowed amount for a health care service covered under the preferred provider insurance policy provided by non-preferred providers may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same health care service in the same geographic region.</p> <p><u><i>Database/Methodology Requirements.</i></u> If the rates for each institutional provider under a preferred provider insurance policy offered by an insurer vary based on individual negotiations, geographic differences, or market conditions and are approved by the Health Services Cost Review Commission, the rates do not constitute unfair discrimination under this article.</p> |
| <p>Maryland <i>Md. Code Ann. Health – Gen. §19-710.1</i></p> <p>Enacted 1991 Amended 2009</p> | <p>HMOs</p> | <p><u><i>Required Reimbursement.</i></u> Requires HMOs to pay claims submitted for covered services rendered to an enrollee by a provider not under written contract with the HMO as follows:</p> <ul style="list-style-type: none"> - a hospital at the rate approved by the Health Services Cost Review Commission; - a trauma physician for trauma care at the greater of: <ul style="list-style-type: none"> ▪ 140% of the rate by the Medicare program for the same covered service to a similarly licensed provider; or ▪ the rate that the HMO paid in the same geographic area for the same service to a similarly licensed provider; and - any other health care provider for an <i>evaluation and management service</i> no less than the greater of: <ul style="list-style-type: none"> ▪ 125% of the average rate the HMO paid as of January 1st of the prior year in the same geographic area for the same covered service to similarly licensed providers under contract with the HMO; or ▪ 140% of the rate paid by Medicare for the same covered service to a similarly situated provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; and |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|---|
| | | <ul style="list-style-type: none"> – any other health care provider for a service that is not an <i>evaluation and management service</i>, no less than 125% of the average rate the HMO paid as of January 1st of the prior calendar year in the same geographic area to a similarly licensed provider under written contract with the HMO for the same covered service. • Mandates that HMOs calculate the average rate paid to similarly licensed providers under written contract with the HMO for the same covered service by summing the contracted rate for all occurrences of the CPT code for that service and then dividing by the total number of occurrences of the CPT code. • Defines <i>evaluation and managed service</i> as: “any service with a Berenson-Eggers type of service code (e.g. a code in a classification system developed by Centers for Medicare and Medicaid (CMS) that groups CPT codes together based on clinical consistency) in the category of evaluation and management.” <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Maryland Md. Regs. Code. tit. 31, §12.02.08.05 and 12.02.08.06</p> <p>Enacted 1977 Amended 2010</p> | HMOs | <p><u>Required Reimbursement.</u> Requires each HMO to pay nonparticipating providers for covered services, an amount not less than the greater of:</p> <ul style="list-style-type: none"> • 125 percent of the fee for the covered evaluation and management service in the annual fee schedule applicable to similarly licensed providers in the same geographic area; or • 140 percent of the fee for the covered evaluation and management service paid by Medicare as published by the Centers for Medicare and Medicaid Services as of August 1, 2008, inflated by the four quarter moving <p>Requires each HMO to pay nonparticipating providers for covered service other than a covered evaluation and management service, an amount not less than 125 percent of the rate for the covered service in the annual rate schedule applicable to similarly licensed providers in the same geographic area.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Maryland Md. Regs. Code tit. 10, §09.65.20; and, §09.67.28</p> | Medicaid managed care organizations (MCOs) | <p><u>Required Reimbursement.</u> Requires Medicaid MCOs to reimburse out-of-plan providers to whom enrollees have self-referred at the established Medicaid rates for the following services:</p> <ul style="list-style-type: none"> • school-based services and family planning services including office visits (CPT codes 99201 – 99205 and 99211 – 99215); • preventive medicine office visits (CPT codes 99383 – 99386 and 99393 – 99396); |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---------------|--|
| <p>Enacted 1996, 1996, and 1996 Amended 2009, 2009, and 2007</p> | | <ul style="list-style-type: none"> • all FDA-approved contraceptive devices, methods, and supplies; • an initial examination of a child in state-supervised care (CPT codes 99381-99384 and 99391 – 99394); and • medically necessary pharmacy and lab services when the service is provided in connection with one of the self-referred services described above and on-site by the out-of-plan provider at the same location that the self-referred service was delivered. <p>Requires Medicaid MCOs to reimburse out-of-plan providers the Medicaid rates for the following services:</p> <ul style="list-style-type: none"> • family planning services specified in COMAR 10.09.65.20A(2), (6), and (7); • services performed by school-based health centers, as provided in COMAR 10.09.68; • pregnancy-related services for women who are pregnant and, at the time of initial enrollment, have received prenatal care during their current pregnancy from an out-of-plan provider; • initial medical examination for children in State custody when performed by an EPSDT certified provider; • one annual diagnostic and evaluation service (DES) visit for any enrollee diagnosed with HIV/AIDS, which the MCO is responsible for facilitating on the enrollee's behalf; • Renal dialysis services performed in a Medicare-certified facility; • initial medical examination of a newborn; • emergency services as described in COMAR 10.09.66.08B; and • prenatal, intrapartum, and postpartum services performed at a free-standing birth center located in Maryland or a contiguous state. <p>Requires Medicaid MCOs to reimburse all providers, regardless of contracting status, at least the Medicaid fee-for-service rate for inpatient services performed in all hospitals.</p> <ul style="list-style-type: none"> • States that MCOs may not be required to pay more than the Medicaid fee-for-service rate. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Massachusetts <i>Mass. Regs. Code tit. 211, §41.06</i></p> <p>Enacted 2002 Amended 2007</p> | Carriers | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> None.</p> <p><u>Other.</u> Requires carrier filings that base payments on U&C charges for non-contracting providers for guarantee issue medical plans and for the out-of-network benefits of guarantee issue preferred provider</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|----------------------|--|
| | | plans include an actuarial opinion certifying that the carrier has used a methodology to determine its U&C charges that results in U&C charges that are, in the aggregate, at least comparable to, and not lower than, the 80th percentile of charges based on Health Insurance Association of America data that are not more than 18 months old, as well as a description of the methodology. |
| <p>Massachusetts <i>Mass. Gen. Laws Ch. 176I §.3</i></p> <p>Effective 1988</p> | Health Benefit Plans | <p><u>Required Reimbursement.</u> Requires payment for emergency care for covered individuals who cannot reasonably reach a preferred provider, payment for care related to the emergency to be made at the same level and in the same manner as if the covered person had been treated by a preferred provider.</p> <p><u>Other.</u> Requires a procedure to be specified for resolving consumer complaints and grievances the disclosure to covered persons of the names of current preferred providers by specialty and geographic area.</p> |
| <p>Michigan <i>Mich. Comp. Laws §500.3530</i></p> <p>Effective 1956 Amended 2000</p> | HMOs | <p><u>Required Reimbursement.</u> Requires HMOs to ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner, if it has an insufficient number or type of participating providers to provide a covered benefit.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Minnesota <i>Minn. Stat. §72A.20</i></p> <p>Enacted 1967 Amended 2009</p> | Insurers | <p><u>Required Reimbursement.</u> See <i>Database Requirements</i> (below).</p> <p><u>Database/Methodology Requirements.</u> Prohibits insurers, including but not limited to health plan companies, from considering any of the following discounted payment situations when determining a provider's U&C, standard, or allowable payment:</p> <ul style="list-style-type: none"> • care provided to relatives of the provider; • care for which a discount or free care is given in hardship situations; and • care for which a discount is given in exchange for cash payment. |
| <p>Minnesota <i>Minn. Stat. §62Q.556</i></p> | Health plans | <u>Required Reimbursement.</u> None. |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---------------|--|
| Enacted 2017 | | <p><u>Database/Methodology Requirements.</u> None</p> <p><i>Other.</i> A health plan company must attempt to negotiate reimbursement, less any applicable enrollee cost sharing, for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration. The cost of arbitration must be shared equally between the parties.</p> <p>The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.</p> <p>Unauthorized provider services occur when an enrollee receives services:</p> <ul style="list-style-type: none"> • from a nonparticipating provider at a participating hospital or ambulatory surgical center, when the services are rendered: <ul style="list-style-type: none"> ○ due to the unavailability of a participating provider; ○ by a nonparticipating provider without the enrollee's knowledge; or ○ due to the need for unforeseen services arising at the time the services are being rendered; or • from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility. <p>Unauthorized provider services do not include emergency services. The services are not unauthorized provider services if the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.</p> |
| <p>Mississippi <i>Miss. Code Ann. §43-13-117</i></p> <p>Effective 1969 Amended 2008</p> | Medicaid | <p><u>Required Reimbursement.</u> Requires the Division of Medicaid (Division) to establish a fee schedule, to be effective from and after July 1, 2007, for dental services.</p> <ul style="list-style-type: none"> • Requires the schedule to be reviewed annually and the underlying dental fees adjusted to reflect the percentile determined by the Division. <p><u>Database/Methodology Requirements.</u> Mandates that the schedule contain a fee for each dental service that is equal to a percentile of normal and customary private provider fees, as defined by the Ingenix Customized Fee Analyzer Report, which percentile shall be determined by the Division.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|---|
| <p>Mississippi <i>Miss. Code Ann. §83-51-5</i> Enacted 1985</p> | <p>Health insurance policies and employee benefit plans</p> | <p><u><i>Required Reimbursement.</i></u> Requires health insurance policies and employee benefit plans to pay or reimburse non-contracting provider dentists the same as contracting provider dentists; however, the policy or plan shall not be required to make payment or reimbursement in an amount which is greater than the amount specified or which is greater than the fee charged.</p> <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>Missouri <i>Mo. Code Regs. Ann. tit. 20, § 400-2.165</i> Effective 2006</p> | <p>Health benefit plans, except HMOs and individual coverage and plans that provide the same degree of management of care for all health conditions</p> | <p><u><i>Required Reimbursement.</i></u> Requires affected entities to provide coverage of mental health treatment outside the network at no greater cost upon the insured than if the treatment were delivered inside the network if the provider network lacks an appropriate provider or it cannot assure access to medically necessary care without unreasonable delay.</p> <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>Missouri <i>Mo. Code Regs. Ann. tit. 20, § 400-7.095</i> Effective 1997 Amended 2007</p> | <p>HMOs</p> | <p><u><i>Required Reimbursement.</i></u> Requires HMOs access plans to include written policies and procedures that show that the HMO will provide access to out-of-network services at no greater cost to the enrollee than for access to in-network services if access to in-network providers cannot be assured without unreasonable delay.</p> <ul style="list-style-type: none"> • Mandates that HMOs shall ensure that an enrollee obtains covered benefits at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director, in any case where a network has an insufficient number or type of participating providers to provide a covered benefit. • Requires HMOs to make arrangements with a nonparticipating provider, pursuant to a treatment plan developed in consultation with the primary care provider, the nonparticipating provider and the enrollee at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network if there is no participating provider in network with the appropriate training and experience. <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---------------------------------|--|
| <p>Montana <i>Mont. Code Ann. §33-36-201</i></p> <p>Effective 1997 Amended 2009</p> | Health carriers | <p><u>Required Reimbursement.</u> Mandates that health carriers ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers, or make other arrangements acceptable to the department, whenever a carrier has an insufficient number or type of participating providers to provide a covered benefit.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Nebraska <i>Neb. Rev. Stat. §44-7105</i></p> <p>Enacted 1998</p> | Health carriers | <p><u>Required Reimbursement.</u> Requires health carriers reimburse nonparticipating providers at the health carrier's U&C rate or at an agreed upon rate if there is an insufficient number or type of participating providers to provide the covered benefit.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Nevada <i>Nev. Rev. Stat. 695B.193 and 695C.173</i></p> <p>Enacted 1975 Amended 1997</p> | Nonprofit corporations and HMOs | <p><u>Required Reimbursement.</u> Requires nonprofit corporations and HMOs which provide coverage for a family member of the subscriber to reimburse non-contracted providers in an amount equal to the average amount of payment for which the corporation has agreements, contracts, or arrangements for covered services provided to a newly born, adopted children and/or children placed for adoption.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>New Hampshire <i>N.H. Rev. Stat. Ann. §420-B:8-n</i></p> <p>Enacted 2002</p> | HMOs | <p><u>Required Reimbursement.</u> Requires point-of-service (POS) plans offered by HMOs to cover out-of-network emergency services as if they had been provided in-network.</p> <ul style="list-style-type: none"> • Allows POS plans offered by HMOs to limit or exclude specific types of services, other than emergency services, from coverage when obtained out-of-network. • Requires subscriber contracts and member handbooks to contain a clear and concise explanation of the POS plan, including, but not limited to, the method of reimbursement. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>New Hampshire</p> | Health carriers | |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|--|
| <p><i>N.H. Code Admin. Ann. R. Ins. 2701.02</i></p> <p>Effective 2002</p> | | <p><u><i>Required Reimbursement.</i></u> Requires health carriers to cover services provided by a non-participating provider at no greater cost to the covered person than if the services were obtained from a participating provider in any geographic area in which the carrier’s network is insufficient.</p> <ul style="list-style-type: none"> Provides that carriers are not required to provide coverage for services provided by a non-participating provider who has been excluded from the network for failing to meet any applicable credentialing standards. <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>New Jersey <i>N.J. Admin. Code §11-20-24.5 and §11-21-7.13</i></p> <p>Enacted 2006 and 1997 Amended 2008</p> | <p>Carriers providing coverage under the New Jersey Individual Health Coverage Program (IHC)³ or the New Jersey Small Employer Health Benefits Program (SEH)⁴</p> | <p><u><i>Required Reimbursement.</i></u> Requires carriers, when paying benefits under the IHC or the SEH for covered services provided on an out-of-network basis by providers not subject to a capitated or negotiated fee, to pay covered charges on the allowed charges or actual charges, except as required by state law.</p> <ul style="list-style-type: none"> Establishes the maximum allowed charge based on the 80th percentile of the Prevailing Healthcare Charges System profile. <p><u><i>Database/Methodology Requirements.</i></u> Mandates that carriers shall update their databases within 60 days after receipt of periodic updates released by Ingenix. Defines <i>allowed charge</i> as: “a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, published and available from Ingenix.</p> |
| <p>New Jersey <i>N.J. Admin. Code § 11:24-5.3</i></p> <p>Enacted 2008</p> | <p>HMOs</p> | <p><u><i>Required Reimbursement.</i></u> Requires HMOs to reimburse hospitals and physicians for all medically necessary emergency and urgent health care services covered under the health benefits plan, including all tests necessary to determine the nature of an illness or injury, in accordance with the provider agreement when applicable.</p> |

³ The IHC Program was created to ensure that people without access to employer or government sponsored health care programs could purchase health coverage for themselves and their families from a variety of private carriers. Individuals, regardless of their age or health status, are guaranteed renewable health coverage under standard individual health benefits plans designed by the IHC Program Board.

⁴ The SEH Program was created to ensure small employers: (1) have access to small group health benefits plans without regard to the occupation of the group, or the health status of any of the group’s members; and (2) have the ability to renew the coverage from year to year regardless of the group’s claims experience or any changes in the health status of the group’s members. The SEH Program establishes standard benefit plans and restricts carrier use of small group participation requirements, employer contribution requirements, preexisting condition limitation provisions, and rating factors.

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|--|
| <p>New Mexico <i>N.M. Admin. Code tit.13 §10.9.9 and §10.13.11</i></p> <p>Enacted 1992 and 1997 Amended N/A and 2007</p> | <p>Health insurers, HMOs, fraternal benefit societies, and nonprofit health care plans</p> | <p><u>Required Reimbursement.</u> Requires contracts, policies, and certificates issued by an affected entity to provide that in the event medically necessary covered services are not reasonably available through participating providers, the participating provider shall refer an enrollee to a non-participating physician or provider and the entity shall fully reimburse the non-participating physician or provider at the U&C rate or at an agreed upon rate.</p> <ul style="list-style-type: none"> • Establishes that a UCR charge shall be the lesser of: <ul style="list-style-type: none"> - the customary charge which would be made by the healthcare services provider for the same service or medical supplies in the absence of insurance; - general level of charge for a comparable service or medical supplies made by other healthcare service providers in the same geographic area; or - the actual charge made by the healthcare services provider. • States that in determining whether the rate to be paid to a non-participating physician or provider is U&C the division may rely upon accepted insurance industry standards for determining such rates. <p><u>Database/Methodology Requirements.</u> See <i>Required Reimbursement</i> (above).</p> |
| <p>New Mexico <i>N.M. Admin. Code tit.13 §10.22.7 and §10.22.8</i></p> <p>Enacted 2009</p> | <p>Managed health care plans (MHCP)</p> | <p><u>Required Reimbursement.</u> Requires the MHCP, in the event medically necessary covered services are not reasonably available through participating health care professionals, to provide in the contract terms that the MHCP or participating health care professional shall refer a covered person to a non-participating health care professional and the MHCP shall fully reimburse the non-participating health care professional at the <i>usual, customary, and reasonable rate</i> or at an agreed upon rate.</p> <ul style="list-style-type: none"> • Defines <i>UCR</i> as “health care services, medical supplies and payment rates for health care services provided by a health care practitioner at or near the median rate paid for similar health care services within a surrounding geographic area where the charges were incurred. Surrounding geographic area may be determined by the type of service and access to that service in the geographic area.” <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>New York <i>N.Y. Ins. Law §3217</i></p> <p>Enacted 1984</p> | <p>Contracts which incorporate UCR reimbursement</p> | <p><u>Required Reimbursement.</u> See <i>Database Requirements</i> (below).</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|--|
| Amended 1996 | | <p><u>Database/Methodology Requirements.</u> Requires the Superintendent to issue, with regard to contracts which incorporate a UCR form of reimbursement, to issue such regulations he deems necessary or desirable.⁵</p> <ul style="list-style-type: none"> • Requires the Superintendent’s UCR rules to require that the UCR schedules be updated periodically, to accurately reflect geographic differences in costs. |
| <p>New York <i>N.Y. Ins. Law §3216</i></p> <p>Enacted 1984 Amended 2009</p> | Individual accident and health insurance policies | <p><u>Required Reimbursement.</u> Requires coverage for second medical opinion from a non-participating specialists at no additional cost to the insured beyond what such insured would have paid for services from a participating appropriate specialist when a referral to the non-participating specialist is made by a participating provider.</p> <ul style="list-style-type: none"> • Requires the insurer to compensate the non-participating specialist at the UCR rate, or at a rate listed on a fee schedule filed and approved by the superintendent which provides a comparable level of reimbursement. • Requires coverage for <i>pre-hospital emergency medical services</i> for the treatment of an <i>emergency condition</i> when such services are provided by an ambulance service and to pay for such services at rates negotiated between the insurer and the provider or, in the absence of agreed upon rates, at the U&C charge, which shall not be excessive or unreasonable. <ul style="list-style-type: none"> – Defines <i>pre-hospital emergency medical services</i> as: “the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person’s bodily functions; (3) serious |

⁵ The regulations issued by Superintendent to set minimum standards for the form, content and sale of health insurance, including standards of full and fair disclosure that are codified at *N.Y. Comp Codes R. & Regs., tit. 11, §52.1, et. seq.* do not currently include requirements related to UCR determinations. In June 2009, the N.Y. Insurance Department released draft proposed UCR regulation that requires, among other things, insurers and HMOs to ensure that out-of-network provider reimbursement schedules fairly and accurately reflect market rates, provide specific reimbursement amounts upon request by the insured, post a copy of the reimbursement schedule on the organization’s secure website, and to disclose the reimbursement method (including the percentile) in rate filings and policy forms. The June 2009 draft rule has not yet been formally introduced in the rule-making process.

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|---|
| | | <p>dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.”</p> <ul style="list-style-type: none"> - Defines <i>emergency condition</i> as: “a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.” • Effective January 1, 2010, prohibits managed care policies from providing benefits for services rendered at a participating hospital on an out-of-network basis solely because the provider admitting or rendering services is not a participating provider. <ul style="list-style-type: none"> - Also prohibits managed care policies from providing that services of a participating provider will be covered as out-of-network solely on the basis that the services are rendered in a non-participating hospital. - Defines <i>managed care policy</i> as “a policy that require that services be provided by a provider participating in the network in order for the insured to receive the maximum level of reimbursement under the policy.” <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>New York <i>N.Y. Ins. Law §3221</i> Enacted 1984 Amended 2009</p> | <p>Group or blanket accident and health insurance policies</p> | <p><u>Required Reimbursement.</u> Requires coverage for second medical opinion from a non-participating specialists at no additional cost to the insured beyond what such insured would have paid for services from a participating appropriate specialist when a referral to the non-participating specialist is made by a participating provider.</p> <ul style="list-style-type: none"> • Requires the insurer to compensate the non-participating specialist at the UCR rate, or at a rate listed on a fee schedule filed and approved by the superintendent which provides a comparable level of reimbursement. • Requires coverage for <i>pre-hospital emergency medical services</i> for the treatment of an <i>emergency condition</i> when such services are provided by an ambulance service and to pay for such services at rates negotiated between the insurer and the provider or, in the absence of agreed upon rates, at the U&C charge, which shall not be excessive or unreasonable. <ul style="list-style-type: none"> - Defines <i>pre-hospital emergency medical services</i> as: “the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|---|
| | | <p>this paragraph, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.”</p> <ul style="list-style-type: none"> - Defines <i>emergency condition</i> as: “a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.” • Effective January 1, 2010, prohibits managed care policies from providing benefits for services rendered at a participating hospital on an out-of-network basis solely because the provider admitting or rendering services is not a participating provider. <ul style="list-style-type: none"> - Also prohibits managed care policies from providing that services of a participating provider will be covered as out-of-network solely on the basis that the services are rendered in a non-participating hospital. - Defines <i>managed care policy</i> as “a policy that require that services be provided by a provider participating in the network in order for the insured to receive the maximum level of reimbursement under the policy.” <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>New York <i>N.Y. Ins. Law §4303</i> Enacted 1984 Amended 2009</p> | <p>Nonprofit medical, hospital, and health service corporations</p> | <p><u>Required Reimbursement.</u> Requires coverage for second medical opinion from a non-participating specialists at no additional cost to the insured beyond what such insured would have paid for services from a participating appropriate specialist when a referral to the non-participating specialist is made by a participating provider.</p> <ul style="list-style-type: none"> • Requires the insurer to compensate the non-participating specialist at the UCR rate, or at a rate listed on a fee schedule filed and approved by the superintendent which provides a comparable level of reimbursement. • Requires coverage for <i>pre-hospital emergency medical services</i> for the treatment of an <i>emergency condition</i> when such services are provided by an ambulance service and to pay for such services at |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|--|---|
| | | <p>rates negotiated between the insurer and the provider or, in the absence of agreed upon rates, at the U&C charge, which shall not be excessive or unreasonable.</p> <ul style="list-style-type: none"> - Defines <i>pre-hospital emergency medical services</i> as: “the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.” - Defines <i>emergency condition</i> as: “a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.” • Effective January 1, 2010, prohibits managed care contracts from providing benefits for services rendered at a participating hospital on an out-of-network basis solely because the provider admitting or rendering services is not a participating provider. <ul style="list-style-type: none"> - Also prohibits managed care contracts from providing that services of a participating provider will be covered as out-of-network solely on the basis that the services are rendered in a non-participating hospital. - Defines <i>managed care contract</i> as “a contract that require that services be provided by a provider participating in the network in order for the insured to receive the maximum level of reimbursement under the policy.” <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>New York <i>N.Y. Ins. Law §4804 and N.Y. Public</i></p> | <p>Insurers offering a managed care product and HMOs</p> | <p><u>Required Reimbursement.</u> Requires coverage for services provided by a non-participating provider pursuant to a referral at no additional cost to the consumer beyond what the insured/enrollee would otherwise pay for services received within the network if the insurer or HMO does not have an in-network provider with appropriate training and expertise to meet the particular health care needs of the consumer.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|---|--|
| <p><i>Health §4403</i></p> <p>Enacted 1996 and 1976 Amended N/A and 1999</p> | | <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>New York <i>N.Y. Ins. Law §§ 3217-a and 4324; Public Health Law § 4408</i></p> <p>Amended 2014</p> | <p>All comprehensive, expense-reimbursed health insurance contracts and managed care health insurance contracts</p> | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> Requires health plans to disclose the following for to out-of-network coverage:</p> <ul style="list-style-type: none"> • a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services; • the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and • examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services. <p>The information in writing and through an internet website must be disclosed to reasonably permit an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.</p> <p><i>"Usual and customary cost"</i> shall mean the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent.</p> |
| <p>New York <i>N.Y. Ins. Law §3241</i></p> <p>Enacted 2014</p> | <p>Health plans issuing comprehensive group policies with OON services</p> | <p><u>Required Reimbursement.</u> Requires health plans that issue a comprehensive group policy that covers out-of-network services to make available at least one alternative option for out-of-network coverage using UCR after imposition of 20% coinsurance.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|----------------------|---|
| | | <p>UCR in this case is the 80th percentile of charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as the requested service as reported in a benchmarking database maintained by a nonprofit organization specified by the Superintendent of Financial Services.</p> <p>This benefit does not require health plans to offer out-of-network benefits in a market in which they do not currently offer any coverage, or in which they do not offer out-of-network coverage.</p> |
| <p>North Carolina <i>N.C. Gen. Stat. §58-3-200(d)</i></p> <p>Enacted 1998 Amended 2002</p> | Health benefit plans | <p><u><i>Required Reimbursement.</i></u> Prohibits insurers from penalizing an insured or subject an insured to the out-of-network benefit levels offered under the insured's approved health benefit plan, including an insured receiving an extended or standing referral unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.</p> |
| <p>North Dakota <i>N.D. Cent. Code §26.1-47-03</i></p> <p>Enacted 1987 Amended 2017</p> | Insurers | <p><u><i>Required Reimbursement.</i></u> Requires insurers that issue policies or subscriber agreements which provide for incentives for covered persons to use the health care services of preferred providers to include in the policy or subscriber agreement, among other things:</p> <ul style="list-style-type: none"> • a provision that if a covered person receives emergency care and cannot reasonably reach a preferred provider that care will be reimbursed as though the covered person had been treated by a preferred provider; • a provision that if covered services are not available through a preferred provider, reimbursement for those services will be made as though the covered person had been treated by a preferred provider; and • a provision that entitles the covered person, if any health care services covered under the health benefit plan are not available through a preferred provider within 50 miles of the policyholder's legal residence, to the provision of those covered services under the health benefit plan by a health care provider not under contract with the health care insurer and located within 50 miles of the policyholder's legal residence. <ul style="list-style-type: none"> ▪ For the covered person to be eligible for benefits under this subdivision, the health care provider not under contract with the health care insurer must furnish the health care services at the same cost or less that would have been incurred had the covered person secured the health care services through a preferred provider. |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|-------|---------------|---|
| | | <p>If the policy or subscriber agreement provides differences in benefit levels payable to preferred providers compared to other providers, the differences may not unfairly deny payment for covered services and may be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.</p> <p><u>Database/Methodology Requirements.</u> A health benefit plan may not be issued in this state unless the plan provides the reimbursement rate for out-of-network air ambulance provider services is equal to the average of the insurer's in-network rates for air ambulance providers in the state.</p> <p>Prohibits insurers from using the average in-network rates in order to decrease current or future contractual rates between an insurer and an air ambulance provider.</p> <p>For purposes of settling a claim made by the insured for air ambulance services, a payment made by an insurer under the plan in compliance with this section is deemed to be the same as an in-network payment and is considered a full and final payment by the insured for out-of-network air ambulance services billed to the insured.</p> <p>Requires health care insurers to develop a program for payment of out-of-network air ambulance bills.</p> <p>A health benefit plan may not be issued in this state without the terms of the health benefit plan including the provisions of the health care insurer's program for payment of out-of-network air ambulance bills.</p> <p>Insurers may elect to pay out-of-network air ambulance provider bills as submitted, or the health care insurer may elect to use the out-of-network air ambulance provider mediation process described below.</p> <p>This does not preclude an insurer and an out-of-network facility air ambulance provider from agreeing to a separate payment arrangement.</p> <p><u>Other.</u> Requires health care insurers to establish an air ambulance provider mediation process for payment of out-of-network air ambulance provider bills. A health benefit plan may not be issued in this state if the terms of the health benefit plan do not include the provisions of the health care insurer's air ambulance provider mediation process for payment of out-of-network air ambulance provider bills. The mediation process must be established in accordance with mediation standards recognized by the department by rule.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|----------------------|--|
| | | <p>If the health care insurer and the out-of-network air ambulance provider agree to a separate payment arrangement or if the covered person agrees to accept and pay the out-of-network air ambulance provider's charges for the out-of-network services, compliance with the air ambulance provider mediation process is not required.</p> <p>Requires insurers to maintain records on all requests for mediation and completed mediation for one year and, upon request of the commissioner, submit a report in a specified format.</p> |
| <p>Oklahoma Okla. Admin. Code §365:40-5-123 Enacted 2003 Amended 2004</p> | HMOs | <p><u>Required Reimbursement.</u> See Database Requirements below.</p> <p><u>Database/Methodology Requirements.</u> Mandates that HMOs that use reasonable and customary charge determinations to authorize settlements to base such determinations on prevailing charges for services and supplies common to a geographic area.</p> |
| <p>Pennsylvania Pa. Cons. Stat. 40, §991.2111 and Pa. Cons. Stat. 31, §154.14 Enacted 1921 Amended 1999</p> | Managed care plans | <p><u>Required Reimbursement.</u> Requires managed care plans to, among other things, ensure that emergency services are provided 24 hours a day/7 days a week and provide reasonable payment or reimbursement for emergency services.</p> <ul style="list-style-type: none"> Requires managed care plans to pay all reasonably necessary costs for enrollees meeting the prudent layperson definition of emergency services provided during the period of the emergency, including evaluation, testing, and if necessary, the stabilization of the condition of the enrollee. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Pennsylvania 31 Pa. Code §152.4 Enacted 1987</p> | Health benefit plans | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> None.</p> <p><u>Other.</u> Provides that arrangements or provisions which may lead to under-treatment or poor quality care include, but are not limited to:</p> <ul style="list-style-type: none"> health benefit plans under which the reimbursement received by an enrollee for a service rendered by a non-preferred provider is less than 80% of the payment which a preferred provider would receive from the preferred provider organization for the same service; and |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---|--|
| | | <ul style="list-style-type: none"> health benefit plans under which an enrollee who receives a service from a non-preferred provider is liable for payment of more than 20% of the payment which a preferred provider would receive from the preferred provider organization for the same service. |
| <p>South Dakota <i>S.D. Codified Laws § 58-17-123</i></p> <p>Enacted 2003 Amended 2015</p> | <p>Health carriers</p> | <p><u><i>Required Reimbursement.</i></u> Requires reimbursement for health care providers using Medicare reimbursement methodologies at a rate that is designed to achieve a payment that is equivalent to 135 percent of South Dakota's Medicaid reimbursement for the goods or services delivered. Each provider of pharmacy goods or services shall be reimbursed at 115 percent of South Dakota's Medicaid reimbursement for any goods or services provided. Any reimbursement rate to a provider is limited to the lesser of billed charges or the rates as provided by this section.</p> <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>South Dakota <i>S.D. Admin. R. 20:06:39:30</i></p> <p>Enacted 2001</p> | <p>Guarantee issue individual market standard and basic plans</p> | <p><u><i>Required Reimbursement.</i></u> Requires eligible benefits under the state's guarantee issue individual market standard and basic plans to include:</p> <ul style="list-style-type: none"> payment for anesthesia given by the operating physician or the surgical assistant is limited to 50 percent of the UCR amount or the allowable charge, whichever is applicable; payment for multiple surgical procedures, not including the primary surgical procedure, performed at the same time may be reduced to 50 percent of the allowable charge or the UCR amount, whichever is applicable; any claim for which the UCR policy or contract provision is used must be paid at no less than the 80th percentile of the UCR amount. <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>Tennessee <i>Tenn. Code Ann. §56-32-128</i></p> <p>Effective 1999</p> | <p>Managed health insurance issuers</p> | <p><u><i>Required Reimbursement.</i></u> Requires managed health insurance issuers to reimburse out-of-network providers under a point-of-service option (POS) or preferred provider plan at the same rate of reimbursement for non-capitated providers in the network.</p> <ul style="list-style-type: none"> Provides that a managed health insurance issuer is not required to reimburse an out-of-network provider for non-emergency services unless the provider has disclosed to the patient a reasonable range of the total charges for the services being provided; and has advised the patient that the provider may balance bill the patient. |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|---|---|
| | | <u>Database/Methodology Requirements.</u> None. |
| <p>Tennessee <i>Tenn. Code Ann. §56-7-2356</i></p> <p>Effective 1999</p> | <p>Managed health insurance issuers</p> | <p><u>Required Reimbursement.</u> Requires managed health insurance issuers to arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a network provider when the issuer has no participating providers to provide a covered benefit.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Tennessee <i>Tenn. Comp. R. & Regs. 1200-13-13.0; 1200-13-13-.08; 1200-13-14-.01, and 1200-13-14-.08</i></p> <p>Effective 2002 Amended 2009</p> | <p>Managed care contractors (MCCs) -- defined to include a managed care organization, behavioral health organization, pharmacy benefits manager, and/or a dental benefits manager which has signed a TennCare contract with the state, operates a provider network, and provides covered health services to TennCare enrollees.</p> | <p><u>Required Reimbursement.</u> Requires MCCs, in situations where it authorizes a service to be rendered by a provider who is not a participating network provider, to reimburse the provider no less than 80% of the lowest rate paid by the MCC to equivalent participating network providers for the same service.</p> <ul style="list-style-type: none"> Also mandates MCCs reimburse non-contracted hospitals for covered medically necessary outpatient emergency services provided to Medicaid managed care enrollees at 74% of the 2006 Medicare rates for these services. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Texas <i>Tex. Ins. Code Ann. §1301.005</i></p> <p>Enacted 2003 Las amended 2011</p> | <p>Preferred provider benefit plans or exclusive provider benefit plans</p> | <p><u>Required Reimbursement.</u> Requires insurers to reimburse a physician or other provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider if services are not available through a preferred provider within a designated service area.</p> <ul style="list-style-type: none"> Clarifies that this does not mandate reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience. <p><u>Database/Methodology Requirements.</u> None.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|--|--|
| <p>Texas <i>Tex. Ins. Code Ann. §1271.055 and 28 Tex. Admin. Code §11.506</i></p> <p>Enacted 2003 and 1980 Amended 2005</p> | <p>HMOs</p> | <p><u>Required Reimbursement.</u> Requires HMOs to include a provision in the evidence of coverage regarding non-network physicians and providers that states if medically necessary covered services are not available through network physicians or providers, the HMO, on the request of a network physician or provider and within a reasonable period, shall allow referral to a non-network physician or provide and fully reimburse the non-network physician or provider at the U&C rate or at an agreed rate.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Texas <i>28 Tex. Admin. Code §21.3604</i></p> <p>Enacted 2004</p> | <p>Health insurance policies</p> | <p><u>Required Reimbursement.</u> Prohibits health insurance policies from providing a different level of payment or reimbursement for covered dental care services based on whether the services are provided by a contracting or non-contracting dentist.</p> <ul style="list-style-type: none"> • Mandates that health insurance policies define and explain the standard of payment or reimbursement for dental care services. • Allows a policy to express the level of payment or reimbursement as a percentage of charges, provided the insurer uses the same percentage for both contracting and non-contracting dentists. • Clarifies that an insurer is not required to make payment to a non-contracting dentist that is greater than the actual fee charged for the dental care service. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Texas <i>28 Tex. Admin. Code §3.9203</i></p> <p>Enacted 2003</p> | <p>Exclusive provider benefit plans</p> | <p><u>Required Reimbursement.</u> Requires exclusive provider benefits plans to, if medically necessary covered services are not available through exclusive providers and upon the request of an exclusive provider, allow referral within a reasonable period to a non-network health care provider and fully reimburse the non-network health care provider at the usual and customary or an agreed rate.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Texas <i>Tex. Ins. Coed Ann. §1467.001, et. seq.</i></p> | <p>Preferred provider benefit plans and health benefit plans</p> | <p><u>Required Reimbursement.</u> None.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--------------------------------------|--|---|
| <p>Enacted 2009 Amended 2017</p> | <ul style="list-style-type: none"> • Does not apply to HMOs | <p><i>Other.</i> Allows enrollees of preferred provider benefit plans and health benefit plans to request mediation of a settlement of an out-of-network claim if:</p> <ul style="list-style-type: none"> - the amount for which the enrollee is responsible to a facility-based provider or emergency care provider (after co-pays, deductibles, and coinsurance), including the amount unpaid by the administrator or insurer, is greater than \$500; and - the claim is for a medical service or supply provided by a facility-based provider or emergency care provider in a hospital that is a preferred provider or that has a contract with the administrator or insurer. <ul style="list-style-type: none"> • Provides that the focus of the mediation will be an evaluation of whether the amount charged by the facility-based provider or emergency care provider is excessive and whether the amount paid by the insurer or administrator represents the U&C rate for the medical service or supply or is unreasonably low. • Requires the facility-based provider or emergency care provider and the insurer or administrator to participate in the mediation if an enrollee requests mediation. • Mandates “complete” disclosure by the facility-based provider or emergency care provider to the enrollee, upon request, before services are rendered (except in cases of an emergency) of the following information: <ul style="list-style-type: none"> - an explanation that the facility-based provider or emergency care provider does not have a contract with the enrollee’s plan; - a disclosure of the projected amounts for which the enrollee may be responsible; and - a disclosure of the circumstances under which the enrollee would be responsible for those amounts. • Provides that a facility-based provider or emergency care provider who makes the required disclosure and obtains the enrollee’s written acknowledgement of that disclosure may not be required to mediate a billed charge is the amount billed is less than or equal to the maximum amount projected in that disclosure. • Requires the facility-based provider or emergency care provider to include notice of the consumer’s right to mediation in any billing statement sent to the patient if the amount the enrollee is responsible for (after co-pays, deductibles and coinsurance) is greater than \$500. • Also requires facilities to disclose the following information to consumers: <ul style="list-style-type: none"> - that they may receive bill from a facility-based provider or emergency care provider for an amount unpaid by the insurer or administrator; - that they can request a list of facility-based provider or emergency care provider who medical staff privileges at the facility; and |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|--|--|
| | | <ul style="list-style-type: none"> - that they can request information from a facility-based provider or emergency care provider on whether the physician has a contract with an insurer or administrator and under which circumstances the consumer may be responsible for amounts not paid by the insurer or administrator. • Charges the Department of Insurance, the Texas Medical Board and the State Office of Administrative Hearings with responsibility to adopt regulations to implement this new process. <ul style="list-style-type: none"> - Also requires the adoption of rules by the Department of Insurance and the Texas Medical Board (as appropriate) regarding the investigation and review of complaints that relate to the settlement of an out-of-network claim. • Clarifies that the remedies provided through this new dispute resolution process are in addition to any other defense, remedy, or procedure provided by law (including common law). • Defines facility-based provider as a physician, health care practitioner, or other health care provider • "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care. |
| <p>Utah <i>Utah Code Ann. §31A-8-501 and §31A-22-617</i></p> <p>Enacted 1997 Amended 2017</p> | <p>Managed care organizations and preferred provider contracts</p> | <p><u><i>Required Reimbursement.</i></u> Requires managed care organizations and preferred provider contracts to reimburse a <i>non-contracting provider</i> for covered services a like dollar amount as it pays to contracting providers under a non-capitated arrangement for comparable services if the services are rendered by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:</p> <ul style="list-style-type: none"> - the enrollee: (i) lives or resides within 30 paved road miles of the independent hospital or (ii) lives or resides in closer proximity to the independent hospital than a contracting hospital; - the independent hospital is located (prior to December 31, 2000) in a county with a population density of less than 100 people per square mile or it is located in a county with a population density of less than 30 people per square mile; and - the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract. <p>Requires managed care organizations and preferred provider contracts to reimburse a federally qualified health center or the enrollee for covered services a like amount as paid by the managed care organization under a non-capitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service if:</p> <ul style="list-style-type: none"> • the enrollee: (i) lives or resides within 30 paved road miles of the federally qualified health center; or (ii) lives or resides in closer proximity to the federally qualified health center than a contracting provider; |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|---|
| | | <ul style="list-style-type: none"> • the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and • the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract. <p>Defines the term <i>non-contracting provider</i> as: “an independent hospital, federally qualified health center, or credentialed staff member who has not contracted with a managed care organization to provide services to managed care organization enrollees.”</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Utah <i>Utah Admin. Code R590-126-3, R590-126-6, R590-233-3, and R590-233-6</i> Enacted 2005</p> | <p>Insurers Does not apply to employer accident and health insurance</p> | <p><u>Required Reimbursement.</u> See <i>Database Requirements</i> (below).</p> <p><u>Database/Methodology Requirements.</u> Requires insurers, when determining whether a charge is U&C to consider one or more of the following factors:</p> <ul style="list-style-type: none"> • the level of skill, extent of training, and experience required to perform the procedure or service; • the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; • the severity or nature of the illness or injury being treated; • the amount charged for the same or comparable services, medicines or supplies in the locality; • the amount charged for the same or comparable services, medicines or supplies in other parts of the country; • the cost to the provider of providing the service, medicine or supply; and • other factors determined by the insurer to be appropriate. |
| <p>Virginia <i>Va. Code Ann. §38.2-3407.12</i> Enacted 1998 Amended 2010</p> | <p>Insurers, non-stock corporations, HMOs, and any other person licensed to provide health care benefits or coverage in the large group market</p> | <p><u>Required Reimbursement.</u> Prohibits carriers providing a point-of-service (POS) benefit section from using an allowable charge as the basis for determining the amount to be reimbursed or paid to any provider for covered services received under the POS benefit which is not at least as favorable to the provider as that used:</p> <ul style="list-style-type: none"> - in calculating the reimbursement to be made to similarly situated providers under another group plan providing a POS benefit which is currently offered or arranged and actively marketed in the state, if the affected entity offers or arranges another such group plan providing a POS benefit; or - for HMOs, in calculating the reimbursement to be made to similarly situated providers on the affected entity’s provider panel. |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|--|
| | | <ul style="list-style-type: none"> Defines <i>allowable charge</i> as: “the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.” <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Virginia <i>Va. Code Ann. §38.2-3407</i></p> <p>Enacted 1986 Amended 2008</p> | Preferred provider policies or contracts | <p><u>Required Reimbursement.</u> States that preferred provider policies or contracts must provide for payment for services rendered by non-preferred providers, but the payments need not be the same as for preferred providers.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Virginia <i>Va. Code Ann. §38.2-3407.7, §38.2-4312.1, and §38.2-4209.1</i></p> <p>Enacted 1994 Amended 1995</p> | Insurers, HMOs, and non-stock corporations | <p><u>Required Reimbursement.</u> Prohibits affected entities from imposing upon any person receiving pharmaceutical benefits furnished under any such policy or contract any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are non-preferred providers.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Washington <i>Wash. Rev. Code §48.43.043</i></p> <p>Enacted 2007</p> | Health carriers | <p><u>Required Reimbursement.</u> Requires health carriers that refer an individual to a nonparticipating provider for colorectal screening exam services or resulting treatment to provide coverage at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating provider.</p> <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Washington <i>Wash. Admin. Code §284-43-200</i></p> <p>Effective 1998 Amended 2001</p> | Health carriers | <p><u>Required Reimbursement.</u> Requires health carriers to ensure through referral by the primary care provider (or otherwise) that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained in- network, or shall make other arrangements acceptable to the commissioner, in any case where the carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered service.</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|--|--------------------------|---|
| | | <ul style="list-style-type: none"> • Mandates that health carriers ensure that American Indians who are covered persons may obtain covered services from the Indian Health System at no greater cost to the covered person than if the service were obtained from network providers and facilities. • Clarifies that nothing prohibits a carrier from limiting payment to that amount payable if the service were obtained in-network. <p><u>Database/Methodology Requirements.</u> None.</p> |
| <p>Wisconsin <i>Wis. Admin. Code Ins. §3.60 and Wis. Bulletin February 12, 1993</i> Enacted 1993</p> | <p>Insurers and HMOs</p> | <p><u>Required Reimbursement.</u> See <i>Database Requirements</i> (below).</p> <p><u>Database/Methodology Requirements.</u> Requires insurers and HMOs that issues an individual or group health insurance, policy, contract or certificate of individual coverage that provides for settlement of claims based on a specific methodology, including but not limited to, UCR charges or prevailing rate in the community, by which the insurer determines the eligible amount of a provider's charge must comply with the following database requirements:</p> <ul style="list-style-type: none"> - the fees in the database shall accurately reflect the amounts charged by providers rather than amounts paid to or collected by providers, and may not include any Medicare charges or discounted charges from preferred provider organization providers; - the database shall be capable of all of the following: <ol style="list-style-type: none"> 1. compiling and sorting information for providers by C.D.T. code, C.P.T. code or other similar coding acceptable to the commissioner of insurance; and 2. compiling and sorting by zip code or other regional basis, so that charges may be based on the smallest geographic area that will generate a statistically credible claims distribution; - the database shall be updated at least every 6 months; and - no data in the database at the time of an update may be older than 18 months. <ul style="list-style-type: none"> • Mandates that if the insurer or HMO uses an outside vendor's database the insurer may supplement it with data from the insurer's own claim experience. <ul style="list-style-type: none"> - Allows insurers and HMOs to supplement a statistical database with other information that establishes that providers accept as payment without balance billing amounts less than their initial or represented charge only if: <ol style="list-style-type: none"> 1. the insurer or HMO makes the required disclosures (described below); 2. the information establishes that the provider generally and as a practice accepts the payment without balance billing regardless of which insurer is providing coverage; and <p>the information is no older than 18 months before the date of an update, clearly establishes the practice, is documented and is maintained in the insurer's records during the period that the information is used and</p> |

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|---|--|--|
| | | for 2 years after that date. |
| <p>Wisconsin <i>Wis. Admin. Code Ins. §9.32</i></p> <p>Enacted 2006 Amended 2007</p> | Insurers | <p><u><i>Required Reimbursement.</i></u> Requires insurers offering a defined network plan that is not a preferred provider plan to provide coverage for <i>emergency medical conditions</i> as a covered benefit when the enrollee receives treatment from a nonparticipating provider.</p> <ul style="list-style-type: none"> • Mandates that the insurer cover the treatment rendered by a nonparticipating provider as though the services were rendered by a participating provider if the insurer provides coverage for emergency medical services and the enrollee cannot reasonably reach a participating provider or, as a result of the emergency, is admitted for inpatient care. • Provides that the insurer shall compensate the nonparticipating provider at the rate the insurer pays nonparticipating providers and after applying any co-pays, coinsurance, deductibles or other cost-sharing provisions that apply to participating providers. • Defines <i>emergency medical condition</i> as: “a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following: (i) serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child; (ii) serious impairment to the person's bodily functions; or (iii) serious dysfunction of one or more of the person's body organs or parts.” <p><u><i>Database/Methodology Requirements.</i></u> None.</p> |
| <p>Wyoming <i>Wyo. Stat. Ann. §26-40-101, et. seq.</i></p> <p>Enacted 1989</p> | Disability insurance policies ⁶ | <p><u><i>Required Reimbursement.</i></u> See <i>Database Requirements</i> (below).</p> <p><u><i>Database/Methodology Requirements.</i></u> Requires disability insurance policies that provide for settlement of a claim for payment of medical services or procedures provided by a provider using a UCR to:</p> <ul style="list-style-type: none"> – use data for services performed not more than 1 year prior to the date of the most recent data; and – settle any claim for medical services or procedures only on the basis of charges made by Wyoming health care providers of similar qualifications or experience for the same or similar medical services or procedures if the service or procedure for which payment is sought was obtained in Wyoming. |

⁶ In Wyoming, health insurance is known as “disability insurance.” For more information, see AHIP’s *Disability Income Protection and Health Insurance: State Definitions* chart.

Out-of-Network Reimbursement: Summary of State Requirements

| State | Applicability | Summary of Payment & Database Requirements |
|-------|---------------|--|
| | | <ul style="list-style-type: none"> • Allows insurers to include in the profile or survey charges from another similar geographic and demographic area so that a reliable basis is established if the Wyoming specific profile or survey does not contain a statistically credible sample of charges. • Requires disability insurance policies that provide for settlement of a claim for payment of medical services or procedures provided by a provider using a UCR or any similar basis to comply with the following: <p><i>Other.</i> Grants the commissioner authority to: (i) order the company to show cause why the settlement(s) should not be changed if based either on a review of the submitted statistical data or on the receipt of complaints from one or more insureds, has reason to suspect that a claim or 1 or more classes of claims is not being settled on the basis provided by the policy; and (ii) after notice and opportunity for hearing, order a different settlement(s) if the company is not settling a claim or 1 or more classes of claims on the basis provided by the policy.</p> • Provides that any person who violates these requirements is subject to denial, suspension or revocation of a license or certificate of authority in addition to any other penalty provided under state law. • Defines <i>usual, customary and reasonable (UCR) basis</i> as: “the method by which an insurer determines the amount to be paid on a claim for disability benefits by comparing the amount of the claim to amounts charged by other health care providers for the same or similar medical services or procedures.” |
| | | |