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State Balance Billing Protections Survey

* *Surprise Billing or Balance Billing*. The terms "surprise" or "balance" billing typically refer to situations in which patients—either unbeknownst to them or absent an affirmative choice by them—receive out-of-network (OON) care or treatment from an OON physician or provider at an otherwise in-network facility and then are billed at OON rates. The surprise charges, representing the difference between what the patient's insurer paid and the non-discounted "list" rate charged by the provider, often are well above (in fact, multiples of) in-network or Medicare reimbursement rates for the same services.

* *Comprehensive Approach vs. Piecemeal Approach*. State approaches to balance billing protections vary with respect to the scope of the protections and associated prohibitions, the types of plans covered and market participants affected, and other applicable obligations (e.g., determinations of provider payment and disclosure/transparency requirements). A study conducted by the Commonwealth Fund established a set of standards to identify "comprehensive" approaches to balance billing as compared to more piecemeal approaches. Under the study, to qualify as "comprehensive," a state's approach to balance billing must:

  - Extend protections to both emergency service and non-emergency services (i.e., apply to both emergency and in-network hospital settings);
  - Apply to all types of insurance, including both HMOs and PPOs;
  - Protect consumers by holding them harmless from extra provider charges (i.e., ensuring that consumers are not responsible for the charges beyond the applicable cost-sharing under their insurance plans) and/or outright prohibiting providers from balance billing; and
  - Adopt an adequate payment standard/method to determine how much the insurer owes the provider or a dispute-resolution process to resolve payment disputes between providers and insurers.

  The below survey utilizes this framework to distinguish between states that have adopted comprehensive models—including California, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New Mexico, New York, and Oregon—and those that have taken a more segmented approach—including Arizona, Colorado, Delaware, Indiana, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Missouri, North Carolina, Pennsylvania, Rhode Island, Texas, and West Virginia.

  Note: Unlike the Commonwealth Fund's survey, we have included New Mexico among the "comprehensive" states because of its recent enactment of legislation that extends significant protections to covered persons well beyond what was previously codified. We also included Missouri among the "piecemeal" states, as the state legislature enacted a partial approach to balance billing in 2018. We did not, however, include Vermont among the states with piecemeal/partial protections because it appeared to be specific to Medicare recipients. For more information on these provisions, *see* 33 VT. STAT. ANN. § 6502 et seq.

* *Emergency Services vs. Non-Emergency Services*. Many states—Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Massachusetts, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Washington, and West Virginia—have provisions that are specific to the offering of emergency services and the treatment of emergency medical conditions. In the majority of states that make this distinction, an emergency medical condition is defined as a condition that manifests itself by "acute symptoms of sufficient severity" such that a prudent layperson with an average knowledge of health and medicine could reasonably expect—in the absence of immediate medical attention—that the condition could place the health of the individual in serious jeopardy, seriously impair bodily functions, cause serious dysfunction of any bodily organ/part, or result in serious disfigurement. Within this framework, emergency services often include medical screening examinations and such further medical examinations and treatment as may be required to stabilize an individual. Some states (e.g., Illinois) also include related transportation services (e.g., ambulance services) within its definition of emergency services; other states (e.g., New Mexico) explicitly do not.

  Non-emergency services, on the other hand, are typically those that do not qualify as emergency services. To the extent that states have established distinct frameworks for/treatment of emergency and non-emergency services, we have separated the content into distinct columns. If, however, the balance billing protections apply to both emergency and non-emergency services, we have combined the two columns.

* *Treatment of Self-Funded Plans*. In general, state protections against balance billing are limited by the federal Employee Retirement Income Security Act, which exempts self-insured or self-funded employer-sponsored plans from state regulation. To the extent a state law expressly addresses the treatment of self-insured or self-funded plans, it is noted in the ***Miscellaneous*** column below.

- *Disclosure.* Beyond the above factors and where possible, we have sought to incorporate statutory and regulatory provisions that require related disclosures by carriers (e.g., descriptions of what constitutes a "surprise bill" that must be provided in their description of coverage); transparency requirements (e.g., provider directories); and other notices that must be given to consumers.
- We consider this to be an evergreen document. We ask that you continuously review the document for updates to any statutes, regulations, bulletins, or other guidance documents.

Comprehensive Balance Billing Protections

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
California	Interprets legislative intent to prohibit emergency room health care providers from engaging in "balance billing" by billing plan members directly for sums that the plan has failed to pay for the member's emergency room treatment, even if there is no preexisting contract between the provider and the plan regarding payment for emergency care. *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 198 P.3d 86, 92 (Cal. 2009) (perceiving a clear legislative policy not to place patients in the middle of billing disputes between doctors and plans). Requires emergency services and care to be rendered without first questioning the patient or any other person as to his or her ability to pay. CAL. HEALTH & SAFETY Code § 1317(d). Requires plans to reimburse emergency health care providers for emergency services and care provided to its enrollees without first questioning the patient's ability to	Requires plans/policies to provide that, if an enrollee/insured receives covered services (i.e., not emergency services and care) from a contracting health facility (i.e., an in-network facility) at which/as a result of which the enrollee receives services provided by a noncontracting individual health professional, then the enrollee will pay no more than the in-network cost sharing amount.[1] CAL. HEALTH & SAFETY CODE § 1371.9(a)(1); CAL. INS. CODE § 10112.8(a)(1). Prohibits the noncontracting individual health professional from billing/collecting any amount from the enrollee/insured for covered services, except for the in-network cost-sharing amount. CAL. HEALTH & SAFETY CODE § 1371.9(a)(3)-(4); CAL. INS. CODE § 10112.8(a)(3)-(4).		For emergency services, prohibits plans from engaging in unfair payment patterns involving unjust payment reductions, claim denials, and other unfair practices (as defined in statute) and by authorizing monetary and other penalties against plans that engage in these patterns. CAL. HEALTH & SAFETY CODE §§ 1371.37, 1371.39. For non-emergency services, if a noncontracting individual health professional believes that higher payment is warranted, refers them	*Out-of-Pocket Limit*. For non-emergency services, cost-sharing arising from services provided by noncontracting individual health professionals will count toward any deductible and annual out-of-pocket maximum in the same manner as an in-network provider. CAL. HEALTH & SAFETY CODE § 1371.9(b); CAL. INS. CODE § 10112.8(b). *Consent*. If an enrollee has a plan that includes coverage for OON benefits, allows a noncontracting individual health professional to bill/collect from the enrollee the OON cost sharing only when the enrollee consents in writing at least 24 hours in advance of receiving the treatment. CAL. HEALTH & SAFETY CODE § 1371.9(c); CAL. INS. CODE § 10112.8(c); FAQs. *Application*. Applies non-emergency services provisions only to individuals enrolled in health plans regulated by

[1] *In-Network Cost Sharing Amount*. An amount no more than the same cost sharing the enrollee would pay for the same covered service received from a contracting health professional. CAL. HEALTH & SAFETY CODE § 1371.9(f)(4); CAL. INS. CODE § 10112.8(f)(4).

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	pay/requiring the provider to obtain authorization. CAL. HEALTH & SAFETY Code § 1371.4(b); *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 198 P.3d 86, 90 (Cal. 2009) (noting that this language was enacted to impose a mandatory duty on plans to reimburse noncontracting providers for emergency medical services). Allows payment for emergency services and care to be denied only if the plan reasonably determines that the emergency services and care were never performed. CAL. HEALTH & SAFETY Code § 1371.4(c). *Payment Method*. Requires the plan to pay the "reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually" for contracted providers without a written contract and non-contracted providers. Requires the reimbursement value to consider the • Provider's training, qualifications, and length of time in practice; • Nature of the services provided; • 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 provider's practice that are relevant; and • Any unusual circumstances in this case. CAL. CODE REGS., tit. 28, § 1300.71(a)(3)(B).	*Payment Method*. Unless otherwise agreed to by the noncontracting individual health professional and the plan/policy, requires the plan/policy to reimburse the greater of: • The average contracted rate (i.e., the average of the contracted commercial rates paid by the plan/policy for the same or similar services in the geographic region); or • 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. CAL. HEALTH & SAFETY CODE § 1371.31(a); CAL. INS. CODE § 10112.82(a).		to the independent dispute resolution process developed by the Department of Insurance, which allows a noncontracting individual health professional to contest the payment amount. CAL. HEALTH & SAFETY CODE §§ 1371.30, 1371.9(a); CAL. INS. CODE §§ 10112.81(a), 10112.8(f)(5); Provider Independent Dispute Resolution Process. Broadly requires HMOs to ensure that a dispute resolution mechanism is accessible to noncontracting providers to resolve billing and claims disputes. CAL. HEALTH & SAFETY CODE § 1367(h)(2).	the Department of Managed Health Care or the California Department of Insurance. Does not apply to Medi-Cal plans, Medicare plans, or self-insured plans. CAL. HEALTH & SAFETY CODE § 1371.9(j); CAL. INS. CODE § 10112.8(c); FAQs. *Data Submission*. Requires all health plans and their delegated entities to submit—among other things—data listing its average contracted rates for the plan for services most frequently provided by noncontracting individual health professionals as a result of non-emergency covered services provided to plan enrollees/insureds at contracting health facilities. CAL. HEALTH & SAFETY CODE § 1371.37(a)(2)(A)(i); CAL. INS. CODE § 10112.82(a)(2)(A)(i); All Plan Letter 17-011 (2017).

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Connecticut	Prohibits carriers from requiring prior authorization for rendering emergency services to an insured. CONN. GEN. STAT. §§ 38a-477aa(b)(1). *Payment Method*. If emergency services were rendered by an OON provider: • Prohibits carriers from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible, or other out-of-pocket expense that would be imposed if such services were rendered by an in-network provider. • Allows the OON provider to bill the carrier directly and requires the carrier to reimburse the provider the greatest of: – The amount the insured's plan would pay for such services if rendered by an in-network provider; – The "usual, customary, and reasonable rate" for such services; or – The amount Medicare would reimburse for such services. • Allows an OON provider and a carrier to agree to a greater reimbursement amount. CONN. GEN. STAT. §§ 38a-477aa(b)(2)-(3).	With respect to surprise bills,[2] only requires the insured to pay the applicable coinsurance, copayment, deductible, or other out-of-pocket expense that would be imposed for health care services, if such services were rendered by an in-network health care provider. CONN. GEN. STAT. § 38a-477aa(c)(1). *Method of Payment*. Requires carriers to reimburse the OON provider or insured for health care services rendered at the in-network rate under the insured's plan as payment in full, unless the carrier and the provider agree otherwise. CONN. GEN. STAT. § 38a-477aa(c)(2).	Requires carriers to: • Provide a description of what constitutes a "surprise bill" in their description of coverage; • Inform the enrollee of the network status of providers and an estimate of how much the insurer will pay for the service; and • Make available to consumers a way to determine accurately whether a specific health care provider or hospital is in-network. CONN. GEN. STAT. §§ 38a-591b(d)(1)(E), (d)(3); 38a-477aa(d), 38a-477d(a)(2). *Provider Directories*. Requires carriers to post on their websites a current and accurate participating provider directory—updated on a monthly basis—for each of its network plans. CONN. GEN. STAT. § 38a-477h.	Renders it an unfair trade practice for a provider to request payment from an insured—other than a coinsurance, copayment, deductible, or other out-of-pocket expense—for: • Health care services/a facility fee covered under a plan; • Emergency services covered under a plan and rendered by an OON provider; or • A surprise bill. CONN. GEN. STAT. § 20-7f(b); Makes it an unfair trade practice for a provider to report an enrollee's failure to pay bill to a credit reporting agency. CONN. GEN. STAT. § 20-7f(c).	*Application*. Applies to insurance companies; health care centers; hospital service corporations; medical service corporations; fraternal benefit societies; or other entities that deliver, issue for delivery, renew, amend, or continue a health care plan in Connecticut. CONN. GEN. STAT. § 38a-477aa(a)(5). With respect to plans, applies to individual or group health insurance policies of the following types: basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, hospital or medical service plan contract, and hospital and medical coverage provided to subscribers of a health care center. CONN. GEN. STAT. §§ 38a-477aa(a)(3), 38a-469(1)-(2), (4), (11)-(12). *Hold Harmless*. Requires carriers to pay billed charges or include hold harmless clauses in their provider contracts to ensure enrollees are not balance billed beyond the copayment. CONN. GEN. STAT. § 38a-477g; Bulletin HC-109.

[2] *Surprise Bill*. A bill for health services—other than emergency services—received by an insured for services rendered by an OON provider, where such services were rendered: (1) at an in-network facility; (2) during a service/procedure performed by an in-network provider or during a service/procedure previously approved/authorized by the insurer; and (3) the insured did not knowingly elect to obtain such services from the OON provider. It does not include a bill received by an insured when an in-network provider was available to render such services and the insured knowingly elected to obtain such services from an OON provider. CONN. GEN. STAT. § 38a-477aa(a)(6).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
Florida	*PPO – Emergency.* Renders an insurer solely liable for payment of fees to a nonparticipating provider of covered emergency services provided to an insured in accordance with the coverage terms of the health policy (i.e., the insured is not liable for payment of fees to a nonparticipating provider of covered emergency services, other than applicable copayments, coinsurance, and deductibles). FLA. STAT. ANN. § 627.64194(2). Requires an insurer to provide coverage for emergency services that: • May not require prior authorization. • Must be provided regardless of whether the services are furnished by a participating provider or a nonparticipating provider. • May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider, only if the same requirement applies to a participating provider. FLA. STAT. ANN. § 627.64194(2). *PPO – Non-Emergency*. Renders an insurer solely liable for payment of fees to a nonparticipating provider of covered nonemergency services provided to an insured in accordance with the coverage terms of the health policy (i.e., the insured is not liable for payment of fees to a nonparticipating provider, other than applicable copayments, coinsurance, and deductibles, for covered nonemergency services that are: • Provided in a facility that has a contract for the nonemergency services with the insurer which the facility would otherwise be obligated to provide under contract with the insurer; and • Provided when the insured does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the insured). FLA. STAT. ANN. § 627.64194(3). *HMO.* Renders HMOs liable for services to a subscriber/patient by a provider, regardless of whether a contract existed between the HMO and the provider (i.e., prohibits providers from balance billing HMO subscribers). *See generally* FLA. STAT. ANN. §§ 641.3154, 641.513; *Riley Anesthesia Assoc. v. Stein*, 27 So.3d 140 (Fla. 2010). *Payment Method*. Requires an insurer/HMO to reimburse a nonparticipating provider the lesser of: • The provider's charges;			*Dispute Resolution*. Requires any dispute with regard to the reimbursement to the nonparticipating provider of emergency or nonemergency services be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process (i.e., the state's provider and health plan claim dispute resolution program). FLA. STAT. ANN. §§ 627.64194(6); 408.7057. *Penalties.* Renders it an unfair trade practice for an insurer or provider to willfully fail to comply with the state's laws governing balance billing with such frequency as to indicate a "general business practice." FLA. STAT. ANN. § 626.9541(gg).	*Assignment of Benefits*. Requires insurers to make payments directly to any provider not under contract with the insurer if the insured makes a written assignment of benefits and requires the payment from the insurer to the provider not be more than the amount the insurer would have paid (to the insured) if an assignment has not been executed. FLA. STAT. ANN. § 627.638. *Application*. Subjects the following health plans to the dispute resolution process: HMOs, prepaid health plans, EPOs, major medical expense health insurance policies offered by a group or individual health insurer (including PPOs). FLA. STAT. ANN. § 408.7057.

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	• The usual and customary provider charges for similar services in the community where the services were provided; or • The charge mutually agreed to by the insurer/HMO and the provider within 60 days of the submittal of the claim. Prohibits a nonparticipating provider from being reimbursed in a greater amount than described above and from collecting/attempting to collect from the insured any excess amount other than copayments, coinsurance, and deductibles. FLA. STAT. ANN. §§ 641.513(5), 627.64194(4)-(5). With respect to HMOs, applies only for non-network providers of emergency services. Balance Billing by Health Care Providers: Assessing Consumer Protects Across States (June 2017).				
Illinois	When (1) an insured uses a participating network hospital or ambulatory surgery center and (2) in-network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician/provider, requires the insurer to ensure that the insured "incur[s] no greater out-of-pocket costs" than the insured would have incurred with a participating physician/provider for covered services. 215 ILCS 5/356z.3a(a)-(b). In the emergency context, specifically requires health care plans that provide/are required by law to provide coverage for emergency services to provide coverage such that payment is not dependent on whether the services are performed by a plan or non-plan provider (i.e., coverage should be at the same benefit level as if the services or treatment had been rendered by the plan/provider) and without regard to prior authorization. 215 ILCS 134/65(a); 215 ILCS 124/10(b)(6)-(7). Does not apply to an insured who willfully chooses to access a nonparticipating facility-based provider for services available through the insurer's network of participating providers (i.e., the contractual requirements for nonparticipating facility-based provider reimbursements will apply). 215 ILCS 5/356z.3a(f). Prohibits the nonparticipating facility-based provider from billing the insured, except for the applicable deductible, copayment, or coinsurance amounts that		*Disclosure*. Requires insurers that contract with providers to include a disclosure on its contracts/evidences of coverage that explains that "limited benefits will be paid when nonparticipating providers are used." 215 ILCS 5/370i(c). *Notice*. When a person presents a benefits information card, requires a provider to make a good faith effort to inform the person if the provider has a participation contract with the insurer/HMO identified on the card. 215 ILCS 5/368c(c). *Network Adequacy*. Requires insurers' description of services to include certain provisions related to the receipt of covered services (e.g., ensuring that whenever a beneficiary has made a good faith effort[3] to utilize preferred providers for a covered service and it is determined that the insurer does not have the	*Dispute Resolution*. If attempts to negotiate reimbursement between the provider and the insurer do not result in a resolution of the payment dispute within 30 days of receipt of the written explanation of benefits, allows an insurer or provider to initiate a binding arbitration to determine payment for services provided on a per bill basis. 215 ILCS 5/356z.3a(d)-(e); Bulletin 2011-07.	*Assignment of Benefits.* Requires the insured to agree in writing to assign any benefits received to the nonparticipating facility-based provider. 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. • Pay any reimbursement directly to the nonparticipating facility-based provider. If, however, an insured rejects assignment in writing to the nonparticipating facility-based provider, allows the provider to bill the insured for the services rendered

[3] *Good Faith Effort*. A good faith effort may be evidenced by accessing the provider directory, calling the network plan, or calling the provider. 215 ILCS 124/10(b)(6).

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	would apply if the insured used a participating provider for covered services. 215 ILCS 5/356z.3a(c); 215 ILCS 134/65(a). *Payment Method*. Does not adopt a standard for adequate payment.		appropriate preferred providers (e.g., due to insufficient number, type, travel distance, or delay), the insurer must ensure that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. *Does not apply to a beneficiary who willfully chooses to access a nonpreferred provider or a beneficiary enrolled in an HMO*).		(i.e., balance billing protections attach when the insured assigns the benefit to provider; absent this, the prohibitions will not apply). 215 ILCS 5/356z.3a(c). *Application*. Does not apply to self-insured employers/health and welfare benefit plans, as the Department of Insurance does not have jurisdiction over such plans. Understanding the Provider Complaint Process.
Maryland	*PPO*. Prohibits an insured from being held liable to an on-call or a hospital-based physician (e.g., emergency room doctors, anesthesiologists, radiologists, etc.) for covered services rendered thereby. MD. INS. CODE §§ 14-205.2(b)(1), 14-205(b); Maryland FAQS: In-Network vs. Out-of-Network Providers. Prohibits an on-call or a hospital-based physician from: • Collecting from an insured any money owed to the physician for covered services rendered; or • Maintaining any action against an insured to collect any money owed to the physician for covered services rendered. MD. INS. CODE § 14-205.2(b)(2); MD. HEALTH & SAFETY CODE § 19-710(p)(2). Authorizes an on-call or a hospital-based physician to collect from an insured: • Any deductible, copayment, or coinsurance amount owed for covered services rendered; • If Medicare is the primary insurer, any amount up to the Medicare approved or limiting amount; and • Any payment or charges for services that are not covered services. MD. INS. CODE § 14-205.2(b)(3); MD. HEALTH & SAFETY CODE § 19-710(p)(3).		If a physician (not an on-call or hospital-based physician) who is a nonpreferred provider seeks an assignment of benefits from an insured, requires the physician to provide the following information to the insured prior to performing a health service: • Statements informing the insured that the physician: – is a nonpreferred provider, – may charge the insured for noncovered services, and – may charge the insured the balance bill for covered services; • An estimate of the cost of services that the physician will provide to the insured; • Any terms of payment that may apply; and • Whether interest will apply and, if so, the amount of interest charged by the physician. MD. INS. CODE § 14-205.3(d); MD. ADMIN. CODE §	*Enforcement*. Authorizes physicians to enforce the payment method for covered services rendered by physicians by filing a complaint against an insurer with the Maryland Insurance Administration or by filing a civil action in a court of competent jurisdiction. MD. INS. CODE § 14-205.2(h); MD. HEALTH & SAFETY CODE § 19-710.1(g). *Fines/Penalties*. Authorizes the Commissioner of Insurance to impose a penalty of no more than $5,000 on an	*Assignment of Benefits*. Bars an insurer from prohibiting the assignment of benefits to a provider who is a physician by an insured; or refusing to directly reimburse a nonpreferred provider who is a physician under an assignment of benefits. Does not apply to on-call physicians or hospital-based physicians. MD. INS. CODE § 14-205.3(b). *Hold Harmless*. Requires the agreements between HMOs and providers of health services to contain a hold harmless clause providing that the provider may not bill, charge, have any recourse against the subscriber, etc. for services provided in accordance with the contract. MD. HEALTH & SAFETY CODE § 19-710(i). Provides that subscribers or members owe no debt to any health care

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	Prohibits an insurer's "allowed amount"[4] for a health care service covered under the policy provided by a nonpreferred provider from being less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same service in the same geographic region. MD. INS. CODE § 14-205(b). *Payment Method*. For a covered service rendered to an insured by an on-call or a hospital-based physician, requires the insurer to pay a claim submitted by a physician no less than the greater of: • 140% of the average rate the insurer paid for the 12-month period of the previous calendar year in the same geographic area for the same covered service to similarly licensed providers under written contract with the insurer; or • The average rate the insurer paid for the 12-month period that ended on January 1, 2010 in the same geographic area for the same covered service to a similarly licensed provider not under written contract with the insurer, inflated by the change in the Medicare Economic Index from 2010 to the current year. MD. INS. CODE § 14-205.2(c)-(e); MD. HEALTH & SAFETY CODE § 19-710(p)(3). In short, if the PPO is subject to Maryland law and there is an assignment of benefits, then requires the plan to send payment to the physician (i.e., the hospital-based or on-call physician will be paid based on state law and cannot balance bill[5] the insured), but still requires the insured to pay any applicable deductible, copayment, or coinsurance. Maryland FAQS: In-Network vs. Out-of-Network Providers. *HMO*. Prohibits any provider under contract with an HMO or a non-contracting provider who provides a covered service to an HMO member from balance billing a member for any covered service; allows the provider to bill the member directly, however, for any non-covered service. 83 Attorney General Opinion 128; 85 Attorney General Opinion 330; 88 Attorney General Opinion 44; 90 Attorney General Opinion 29.		31.10.41.06; Maryland FAQS: In-Network vs. Out-of-Network Providers.	insurer for any violation of the payment method for covered services rendered by physicians. MD. INS. CODE § 14-205.2(j); MD. HEALTH & SAFETY CODE § 19-710.1(j).	provider for any covered services. 88 Attorney General Opinion 44. *Self-Funded Plans*. Does not apply to self-funded plans because the Maryland Insurance Administration does not have jurisdiction over such plans. *See e.g.*, Assignment of Benefits Report (2010). *Nonpreferred Provider Benefit*. Requires employers, associations, other private groups offering health benefit plans to employees or individuals only through preferred providers to offer (and disclose) an option to include preferred and nonpreferred providers as an additional benefit at the employee's or individual's option. MD. INS. CODE § 14-205.1(a)-(b). If an employee or individual accepts the additional coverage, allows the employer, association, or other private group to require the recipient to pay a premium greater than the amount of the premium for the coverage offered for preferred providers only. MD. INS. CODE § 14-205.1(c). *PPO-Specific Provisions*. Allows the Commissioner to authorize an insurer to offer a preferred provider insurance

[4] *Allowed Amount*. The dollar amount that an insurer determines is the value of the health care services provided by a provider before any cost sharing amounts are applied. MD. INS. CODE § 14-201(b).

[5] *Balance Bill*. The difference between a nonpreferred provider's bill for a health care service and the insurer's allowed amount. MD. INS. CODE § 14-201(d).

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	Prohibits HMO enrollees and subscribers from being held liable to any health care provider for any covered services rendered thereby. MD. HEALTH & SAFETY CODE § 19-710(p)(1). Prohibits a health care provider from: • Collecting from an insured any money owed to the provider for covered services rendered; or • Maintaining any action against an insured to collect any money owed to the provider for covered services rendered. MD. HEALTH & SAFETY CODE § 19-710(p)(2). Authorizes a provider to collect from an insured: • Any deductible, copayment, or coinsurance amount owed for covered services rendered; • If Medicare is the primary insurer, any amount up to the Medicare approved or limiting amount; and • Any payment or charges for services that are not covered services. MD. INS. CODE § 14-205.2(b)(3); MD. HEALTH & SAFETY CODE § 19-710(p)(3). *Payment Method*. For a covered service rendered to an HMO enrollee by an OON provider, requires the insurer to pay a claim submitted by: • A hospital at the rate approved by the Health Services Cost Review Commission. • A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of: – 140% of the rate paid by Medicare for the same covered service to a similarly licensed provider; or – The rate as of January 1, 2001 that the HMO paid in the same geographic area for the same covered service to a similarly licensed provider. • Any other health care provider: – *For an evaluation and management service*: no less than the greater of: ▪ 125% of the average rate the HMO paid for the previous calendar year in the same geographic area for the same covered service to similarly licensed providers under written contract with the HMO; or ▪ 140% of the rate paid by Medicare for the same covered service to a similarly licensed provider in the same geographic area as of August				policy that conditions the payment of benefits on the use of preferred providers, so long as the insurer does not restrict payment for covered services provided by nonpreferred providers for: • Emergency services; • Unforeseen illness, injury, or condition requiring immediate care; or • Referral to a specialist. MD. INS. CODE §§ 14-205, 14-205.1(a). *HMO-Specific Provisions*. Requires HMOs to reimburse a hospital emergency facility/provider—less any applicable copayments—for medically necessary services provided to a member of the HMO, if the HMO authorized, directed, or referred the member to use the emergency facility and the medically necessary services are related to the condition for which the member was allowed to use the emergency facility. MD. HEALTH & SAFETY CODE § 19-712.5(a). Does not require a provider to obtain prior authorization or approval for payment from an HMO in order to obtain reimbursement. MD. HEALTH & SAFETY CODE § 19-712.5(d). Allows a hospital emergency facility/provider (or an HMO that has reimbursed a provider) to collect payments from a member provided for a medical condition that is determined

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year. – *For a service that is not an evaluation and management service*: no less than 125% of the average rate the HMO paid for the previous calendar year in the same geographic area to a similarly licensed provider under written contract with the HMO for the same covered service. MD. HEALTH & SAFETY CODE § 19-710.1(b); 83 Attorney General Opinion 128.				not to be an emergency. MD. HEALTH & SAFETY CODE § 19-712.5(e). Additionally, offers specific rules when an HMO authorizes, directs, or refers a member to a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery. MD. HEALTH & SAFETY CODE § 19-712.5(f).
Nevada **AB 469** **Enacted 5/15/19** **Effective Jan. 1, 2020**	Prohibits OON providers/facilities from collecting from enrollees more than in-network cost-sharing amounts for medically necessary emergency services (MNESs). *Required carrier payment to OON facilities:* • If the OON facility had an in-network contract with the carrier within the 12 months preceding the MNESs, the carrier must pay and the facility must accept 108% of the amount that would have been paid under the most recent contract, less the patient's cost-sharing; • If the OON facility had an in-network contract with the carrier within 13-24 months preceding the MNESs, the carrier must pay and the facility must accept 115% of the amount that would have been paid under the most recent contract, less the patient's cost-sharing; • If no contract was in place within the preceding 24 months, the carrier must pay what it determines to be	Does not cover non-MNESs.	OON provider/facility that provides MNESs must, when possible, notify the carrier within 8 hours of an enrollee presenting, and notify the carrier within 24 hours of the enrollee becoming stabilized and transferable to an in-network facility	If an OON facility/provider rejects carrier's discretionary payment offer (i.e., "fair and reasonable payment" or "offer of payment in full"), facility/provider must come back with an additional amount it will accept. If the carrier rejects the counteroffer, must proceed to binding arbitration. Arbitrators choose between the carrier's original offer and the facility/provider's counteroffer.	*Application:* Applies to all issuers of health benefit plans, but excludes Medicaid and CHIP. Does not apply if health coverage was purchased outside of the state. *Self-insured plans:* May elect to participate. NV HHS shall maintain a list of electing entities and promulgate regulations for the opt-in procedures/requirements. *Arbitrator reports:* Requires annual reports to NV HHS by participating arbitrators of anonymized arbitration outcomes.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	"fair and reasonable payment" for the services. *Required carrier payments to other OON <u>providers</u> (i.e., other than facilities):* If the provider had a contract with the carrier within the preceding 12 months – • If the provider terminated the contract early without cause, must accept 100% of the contract rate, less the patient's cost-sharing; • If the provider terminated early for cause or the carrier terminated without cause, must accept 108% of the contract rate, less patient's cost-sharing; • The carrier terminated the contract early for cause, must pay a "fair and reasonable payment," less patient's cost-sharing; • If neither party terminated early, must pay/accept the rate under the most recent contract, PLUS CPI Medical Care Component percentage for the last calendar year, less patient's cost-sharing. If there was no contract in place within the last 12 months, the carrier must submit "an offer of payment in full" minus the patient's cost-sharing.				

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
New Hampshire	For services performed in a hospital or ambulatory surgical center that is in-network under a commercially insured patient's managed care plan, prohibits providers performing anesthesiology, radiology, emergency medicine, or pathology services from balance billing the patient for fees or amounts other than copayments, deductibles, or coinsurance. N.H. REV. STAT. § 329:31-b(I); N.H. Health Cost; Balance Billing: Quick Facts for Granite Staters. *Payment Method*. Limits fees for health care services submitted to an insurer for payment to a "commercially reasonable value" based on payments for similar services from New Hampshire insurers to New Hampshire providers. N.H. REV. STAT. § 329:31-b(II).		*Notice*. At least annually (and at the request of a covered person), requires health carriers to notify covered persons of their consumer rights, including (but not limited to) the right to access OON services when the covered person contacts the carrier directly requesting assistance finding clinically appropriate in-network care. N.H. REV. STAT. § 420-J:8-e; Bulletin 17-048-AB.	With respect to disputes between providers and insurers relative to the reasonable value of a service, grants the Insurance Commissioner exclusive jurisdiction to determine if the fee is commercially reasonable. N.H. REV. STAT. §§ 329:31-b(III), 420-J:8-e.	
New Jersey	Places certain limitations on charges in excess of the network cost-sharing by OON providers/prohibits providers from balance billing a covered person above the amount of their cost-sharing obligation in two situations: • If a covered person receives medically necessarily services at any health care facility on an emergency or urgent basis; and • Inadvertent OON services.[6] Bulletin No. 18-14. Ensures that a covered person's liability for services rendered during a hospitalization at an in-network hospital (including, but not limited to, anesthesiology and radiology) where the admitting physician is an OON provider is limited to the copayment, deductible, and/or coinsurance applicable to network services. N.J. ADMIN. CODE § 11:22-5.8(b)(2). *Health Care Facility for Emergency/Urgent Care*. Prohibits a health care facility (e.g., a general acute care hospital, satellite emergency department, ambulatory surgical facility, etc.) from billing a covered person in excess of any deductible,		*Health Care Facility*. Prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, requires the health care facility to: • Disclose whether the health care facility is in-network or OON; • Advise the covered person to check whether the physician arranging the facility services is in-network or OON and provide information about how to determine the in-network/OON status of any physician who is reasonably anticipated to provide services to the covered person;	*Dispute Resolution*. If the carrier and facility or provider cannot resolve a payment dispute, and the difference between the carrier's and the provider's final offer is not less than $1,000, the carrier or OON provider may initiate binding arbitration to determine payment for the services. N.J. STAT. ANN. §§ 26:2SS-7(b), 26:2SS-	*Assignment of Benefits*. In the case of inadvertent OON services or services at an in-network or OON health care facility on an emergency or urgent basis, requires benefits provided by a carrier to be assigned to the OON provider (which requires no action on the part of the covered person). Once assigned, requires: • Any reimbursement paid by the carrier to be paid directly to the OON provider; and • The carrier to provide the OON provider with a written remittance of payment that specifies the proposed reimbursement and the

[6] *Inadvertent OON Services*. Health care services that are (1) covered under a managed care health benefits plan that provides a network; and (2) provided by an OON provider in the event that the covered person utilizes an in-network health care facility for covered health services and—for any reason—in-network health care services are unavailable in that facility. This includes laboratory testing ordered by an in-network provider and performed by an OON bio-analytical laboratory. N.J. STAT. ANN. § 26:2SS-3.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	copayment, or coinsurance amount applicable to in-network services for medically necessary services[7] on an "emergency or urgent basis." N.J. STAT. ANN. § 26:2SS-7(a). *Health Care Professional for Inadvertent OON Service or Emergency/Urgent Care*. If a covered person receives inadvertent OON services or medically necessary services at an in-network or OON health care facility on an "emergency or urgent basis," requires the health care professional performing those services to: • In the case of inadvertent OON services: not bill the covered person in excess of any deductible, copayment, or coinsurance amount. N.J. STAT. ANN. § 26:2SS-8(a)(1). • In the case of emergency and urgent services: not bill the covered person in excess of any deductible, copayment, or coinsurance amount, applicable to in-network services. N.J. STAT. ANN. § 26:2SS-8(a)(2). *Carrier for Inadvertent OON Service or Emergency/Urgent Care*. If a covered person receives inadvertent OON services or medically necessary services at an in-network or OON health care facility on an "emergency or urgent basis," requires the carrier to ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care professional/facility. N.J. STAT. ANN. § 26:2SS-9(a). *Payment Method*. Leaves reimbursement rate decisions up to carriers and health care professionals.		• Advise the covered person that—among other things—at an in-network facility, the covered person will have a financial responsibility, (but it will not exceed their copayment, deductible, or coinsurance); and will not incur any out-of-pocket costs, unless the covered person knowingly, voluntarily, and specifically selects an OON provider to provide services; and • Advise the covered person that—among other things—at an OON health care facility, certain health care services may be provided on an OON basis; and the covered person may have a financial responsibility applicable to health care services provided at an OON facility in excess of their copayment, deductible, or coinsurance. N.J. STAT. ANN. § 26:2SS-4(a). *Health Care Professional.* Requires health care professionals to disclose to a covered person—either in writing or electronically—the plans with which the professional is affiliated prior to the provision of non-emergency services. N.J. STAT. ANN. § 26:2SS-5. If a professional is OON, requires them to disclose—among other things:	8(b), 26:2SS-9(c), 26:2SS-10-12. For more information on how the arbitration process works in practice, *see* Bulletin No. 18-14. *Penalties.* Establishes the following penalties for violations of the law: • Renders a health care facility or carrier that violates the law liable for a penalty of not more than $1,000 for each violation (considers each day for which a violation occurs to be a separate violation and provides that the penalty may not exceed $25,000 for each occurrence). • Renders all other persons/entities	applicable deductible, copayment, or coinsurance amounts owed by the covered person. N.J. STAT. ANN. § 26:2SS-9(b). *Consent.* Allows a covered person to elect an OON provider for a health care service, as long as the person "knowingly, voluntarily, and specifically" elects the OON provider with full knowledge that the provider is OON. N.J. STAT. ANN. § 26:2SS-4(a); Bulletin No. 18-14. *Rebating.* Renders it a violation of law if an OON provider knowingly waives, rebates, gives, or pays all or part of the deductible, copayment, or coinsurance as an inducement for the covered person to seek health care services from that provider. N.J. STAT. ANN. § 26:2SS-15. *Application*. Applies to insurance companies; HMOs; health, hospital, or medical service corporations; MEWAs, etc. Does not include any other entity providing or administering a self-funded health benefits plan, but allows self-funded plans to opt in to certain requirements and protections of the law. N.J. STAT. ANN. § 26:2SS-3; Bulletin No. 18-14.

[7] *Medical Necessity/Medically Necessary*. A health care service that a provider—exercising their prudent clinical judgment—would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is (1) in accordance with the generally accepted standards of medical practice; (2) clinically appropriate; (3) not primarily for the convenience of the covered person or the provider; and (4) not more costly than an alternative service at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered person's illness, injury, or disease. N.J. STAT. ANN. § 26:2SS-3.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
			• Their OON status prior to scheduling a non-emergency procedure; • The amount/estimated amount that the professional will bill the covered person for the services (and the Current Procedural Terminology code associated with the service); and • That the covered person will have a financial responsibility applicable to the services provided by an OON professional, in excess of their copayment, deductible, or coinsurance. N.J. STAT. ANN. § 26:2SS-5(a). Imposes additional disclosure obligations on health care professionals that are physicians (e.g., providing to a covered person the contact information of any provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care). N.J. STAT. ANN. § 26:2SS-5(b)-(c). *Carrier*. With respect to OON services, for each plan offered, requires a carrier to provide—among other things: • A description of the plan's OON benefits; • The methodology used to determine the allowed amount for OON services and allowed amount the plan will reimburse under that methodology; and	not otherwise covered that violate the law liable for a penalty of not more than $100 for each violation (considers each day for which a violation occurs to be a separate violation and provides that the penalty may not exceed $2,500 for each occurrence). N.J. STAT. ANN. § 26:2SS-17.	*Public Information*. Requires health care facilities to post an array of information on their websites, including: • The plans in which the facility is a participating provider; • Statements regarding participating physicians (and that some physicians may not participate with the same plans as the facility); • Contact information for physician groups that the facility has contracted with to provide certain services (e.g., anesthesiology, pathology, and radiology); and • Contact information and plan participation of physicians employed by the facility. Requires the health care facility to make available to the public a list of the facility's standard charges for items and services provided by the facility. N.J. STAT. ANN. § 26:2SS-4(b)-(c). Requires carriers to update their website within 20 days of adding/terminating a provider from their network or changing a physician's affiliation with a facility. N.J. STAT. ANN. § 26:2SS-6(a). Annually requires Commissioner of Banking and Insurance to publish a list of—among other things:

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
			• Examples of anticipated out-of-pocket costs for frequently billed OON services. N.J. STAT. ANN. § 26:2SS-6(b). Imposes additional notification requirements on carriers (e.g., notify the covered person if a provider's or facility's status changes to OON) and requires them to include a notice in their explanation of benefits that "inadvertent and involuntary" OON charges are not subject to balance billing beyond the contracted-for financial responsibility. N.J. STAT. ANN. § 26:2SS-6(c)-(d).		• All arbitrations; • The percentage of facilities and professionals that are in-network for each carrier; • The number of complaints received relating to OON charges; and • Annual trends on premium rates, total amount of spending on inadvertent and emergency OON costs by carriers, and medical loss ratios in the state. N.J. STAT. ANN. § 26:2SS-12.
New Mexico ***Effective 2020*** For information on New Mexico's current balance billing law (which applies only with respect to the treatment of	Prohibits providers from knowingly submitting to a covered person a surprise bill[8] that demands payment for any amount in excess of the cost-sharing amounts that would have been imposed by the covered person's plan if the service had been rendered by a participating provider. SB 337, § 14(A); N.M. STAT. ANN. §§ 59A-57-4(B)(3)(d), 59A-22A(A)(1); N.M. ADMIN. CODE § 13.10.21.8(D)(6). *Emergency-Specific Provisions*. Requires carriers to: • Reimburse a nonparticipating provider for emergency care necessary to evaluate and stabilize a covered person, if a prudent layperson would reasonably believe that emergency care is necessary, regardless of eventual diagnoses; and • Not require prior authorization for emergency care to be obtained by a covered person prior to the point of stabilization of that covered person, if a prudent		*Provider/Carrier*. Requires that any communication—other than a receipt of payment— from a provider/carrier pertaining to a surprise bill must clearly state that the covered person is responsible only for payment of applicable in-network cost sharing amounts. SB 337, § 5(D). *Nonparticipating Provider*. If nonparticipating providers in nonemergency circumstances have advance knowledge that they are not	*Unfair Practice.* Renders it an unfair practice for a provider to knowingly submit a surprise bill to a collection agency. SB 337, § 14. *Appeal.* Authorizes a person to appeal a carrier's determination made regarding a	*Consent*. In the non-emergency context, does not preclude a nonparticipating provider from balance billing an individual who has knowingly chosen to receive services from a nonparticipating provider. SB 337, § 4(B). With respect to emergency or non-emergency situations, does not define "surprise billing" to include services received by a covered person when a participating provider was available to

[8] *Surprise Bill*. A bill that a nonparticipating provider issues to a covered person for services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same services if they had been provided by a participating provider:

- Emergency care provided by a nonparticipating provider;
- Health care services—that are not emergency care—rendered by a nonparticipating provider at a participating facility where:
  - A participating provider is unavailable;
  - A nonparticipating provider renders unforeseen services; or
  - A nonparticipating provider renders services for which the covered person has not given specific consent. SB 337, § 1(Y).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
emergency services), *see* Bulletin 2017-009	layperson would reasonably believe that the covered person requires emergency care. SB 337, § 3(A)-(B). Allows a carrier to: • Impose a cost-sharing/limitation of benefits requirement for emergency care performed by a nonparticipating provider only to the same extent that the copayment, coinsurance, or limitation of benefits requirement applies for participating providers and is documented in the policy. • Require an emergency care provider to notify a carrier of a covered person's admission to the hospital within a reasonable time period after the covered person has been stabilized. SB 337, § 3(C)-(D). *Non-Emergency Specific Provisions*. Other than applicable cost sharing that would apply if a participating provider had rendered the same services, requires a carrier to provide reimbursement for/a covered person to not be liable for charges and fees for covered non-emergency care rendered by a nonparticipating provider that are delivered when: • The covered person at an in-network facility does not have the ability/opportunity to choose a participating provider who is available to provide the covered services; or • Medically necessary care is unavailable within a plan's network. SB 337, § 4(A). *Payment Method*. Requires carriers to directly reimburse a nonparticipating provider for care rendered at the surprise bill reimbursement rate for services. Establishes the surprise bill reimbursement rate as the 60th percentile of the allowed commercial reimbursement rate for the particular service performed by a provider in the same/similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization (provided that no surprise bill reimbursement rate will be paid at less than 150% of the 2017 Medicare reimbursement rate for the applicable health care service provided). Calculates the surprise bill reimbursement rate using claims data reflecting the allowed amounts paid for claims paid in the 2017 plan year. SB 337, § 13. Requires the Superintendent to annually convene appropriate stakeholders to review the reimbursement rate for surprise bills to "ensure fairness to providers and		contracted with the covered person's carrier, requires them to inform the covered person of their nonparticipating status and advise the covered person to contact the covered person's carrier to discuss their options. SB 337, § 5(E). *Health Facility*. Requires health facilities (e.g., general hospitals, ambulatory surgical centers, birth centers, diagnostic centers, urgent care centers, etc.) to post the following on their websites in a publicly accessible manner: • Information about all of the carriers with which the hospital has a contract for services; • A statement that sets forth that: – Services may be performed by both participating and nonparticipating providers who may separately bill the patient; – Providers that perform services in the hospital may or may not participate in the same plans as the hospital; and – Prospective patients should contact their carriers in advance of receiving services to determine whether the scheduled services in that hospital will be covered at in-network rates; • The rights of covered persons under the state's Surprise Billing Protection Act; • Instructions for contacting the Superintendent of Insurance. SB 337, § 5(C).	surprise bill. SB 337, § 5(B). *Refund*. If a nonparticipating provider fails to make a full refund to a covered person for any amount paid in excess of the in-network cost sharing amount within 45 calendar days, allows the covered person to seek recovery by appealing to the Superintendent of Insurance. SB 337, §§ 6, 10.	render the services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorizations. SB 337, § 1(Y)(2). *Hold Harmless*. Requires insurers and HMOs to hold covered persons harmless for balance bills for OON emergency care services. Bulletin 2017-009 *Rebating*. Prohibits nonparticipating providers from knowingly waiving, rebating, giving, or paying all or part of a cost-sharing amount owed by a covered person pursuant to the terms of the covered person's plan as an inducement for the covered person to seek services from that nonparticipating provider. SB 337, § 7. *Information from Provider Networks*. Authorizes the Superintendent of Insurance to require: • Carriers to report the annual percentage of claims and expenditures paid to nonparticipating providers for services; and • By rule, a report on changes to the percent of claims paid as an emergency claim. SB 337, § 11. *Applicability*. Applies to health insurance companies, HMOs, hospital and health service corporations,

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	to evaluate the impact on health insurance premiums and health benefits plan networks." SB 337, § 8.		For an overview of how a covered person's health benefits plan covers OON treatment, *see* Disclosures to Covered Persons Regarding Out-of-Network Treatment.		provider service networks, and nonprofit health care plans, among others. SB 337, §§ 1(O), 12.
New York	When a plan receives a bill for emergency services from a non-participating physician, requires the plan to: • Ensure that the insured will incur no greater out-of-pocket cost for the emergency services than the insured would have incurred with a participating physician; and • Pay an amount that it determines is reasonable for the emergency services rendered by the non-participating physician (except for the insured's copayment, coinsurance, or deductible). N.Y. FIN. SERV. L. §§ 602(b)(2), 605(a). *Payment Method*. Does not adopt a standard for reasonable payment, rather it leaves it to the independent dispute resolution entity (IDRE) to determine a reasonable fee for the services rendered. N.Y. FIN. SERV. L. § 605(a)(2)-(4).	If an insured assigns benefits to a non-participating physician, allows: • The non-participating physician to bill the plan for the services rendered and requires the plan to pay the non-participating physician the billed amount (or attempt to negotiate reimbursement with the non-participating physician); or • If the plan's attempts to negotiate are unsuccessful, requires the plan to pay the non-participating physician an amount the plan determines is reasonable for the services rendered. N.Y. FIN. SERV. L. §§ 606, 607(a)(1)-(3).	*Health Care Professionals.* Requires health care professionals in private practice and diagnostic and treatment centers to disclose to patients (or prospective patients) in writing or online the plans in which they are participating providers and the hospitals with which they are affiliated prior to the provision of non-emergency services and verbally at the time an appointment is scheduled. If such providers do not participate in a patient's health care plan, requires them to—upon request from a patient—inform the patient of the estimated amount they will bill absent unforeseen medical circumstances that may arise. N.Y. PUB. HEALTH § 24(1)-(2); DOH – Surprise Bills FAQs. Additionally, requires physicians in private practice to provide:	Requires the Superintendent of the Department of Financial Services to establish a dispute resolution process under which a dispute for a bill for emergency services or a surprise bill[9] may be resolved. N.Y. FIN. SERV. L. §§§ 601, 604, 608; 23 NYCRR § 400 et seq. Subjects disputes to review by independent dispute resolution entities (IDRE), which must make a determination within	*Assignment of Benefits*. When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, prohibits the non-participating physician from billing the insured, except for any applicable copayment, coinsurance, or deductible that would be owed if the insured utilized a participating physician. N.Y. FIN. SERV. L. § 606. If a patient has a fully-funded New York health plan, protects them from a surprise bill (i.e., makes them responsible only for the in-network copayment, coinsurance, or deductible) if they: • Sign an assignment of benefits form to permit the provider to

[9] *Surprise Bill*. A bill for health care services—other than emergency services—received by:
- An insured for services from a non-participating physician at a participating hospital or ambulatory surgical center where:
  - A participating physician is unavailable,
  - A non-participating physician renders services without the insured's knowledge, or
  - Unforeseen medical services arise at the time the health care services are rendered;
- An insured for services rendered by a non-participating provider, where the services were referred by a participating physician to a non-participating provider without explicit, written consent of the insured; or
- A patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center, where the patient has not received all of the disclosures required in a timely manner. DFS - Surprise Medical Bills.

It does not include a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician. N.Y. FIN. SERV. L. § 603(h).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	For disputes involving HMO or insurance coverage, requires the IDRE to choose either the non-participating provider bill or the health plan payment. N.Y. FIN. SERV. L. § 605(a)(4). For disputes submitted by uninsured patients or patients with employer or union self-insured coverage, requires the IDRE to determine the fee. N.Y. FIN. SERV. L. § 605(b); DFS - Surprise Medical Bills.	*Payment Method*. Does not adopt a standard for reasonable payment, rather it leaves it to the independent dispute resolution entity (IDRE) to determine a reasonable fee for the services rendered. N.Y. FIN. SERV. L. § 607(a)(4)-(6). For disputes involving an insured who assigns benefits, requires the IDRE to choose either the non-participating provider bill or the health plan payment. N.Y. FIN. SERV. L. § 607(a)(6). For disputes submitted by insureds who do not assign benefits or uninsured patients or patients with employer or union self-insured coverage, requires the IDRE to determine a reasonable fee for the services rendered. N.Y. FIN. SERV. L. § 607(b)(2).	• Information regarding any other health care providers scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with the care to be provided in the physician's office; • For a patient's scheduled hospital admission or scheduled outpatient hospital services, information on any of the physicians whose services will be arranged/are scheduled at the time of the pre-admission testing, registration, or admission at the time non-emergency services are scheduled; and • Information as to how to determine the health plans in which the physicians participate. N.Y. PUB. HEALTH § 24(3)-(4); DOH – Surprise Bills FAQs. *Hospitals*. Requires hospitals to post on their websites a list of the hospital's standard charges for items and services provided by the hospital and advise patients regarding the physicians who are reasonably anticipated to provide services. N.Y. PUB. HEALTH § 24(5)-(7); DOH – Surprise Bills FAQs.	30 days of receipt of the dispute. N.Y. FIN. SERV. L. §§ 605, 607. In determining the appropriate amount to pay for health care services, requires the IDRE to consider all relevant factors, including: • Whether there is a gross disparity between the fee charged by the physician and fees paid to the same physician in similar circumstances; • The level of training, education, and experience of the physician; • The physician's usual charge for comparable services in similar circumstances; • The circumstances and complexity of the particular case; • Individual patient characteristics; and	seek payment for the bill from their health plan; and • Send the form to the health plan and provider and include a copy of the bill(s) that the patient does not think they should pay. DFS - Surprise Medical Bills. *Self-Insured Coverage*. Allows uninsured individuals or individuals whose employer or union self-insures to dispute a surprise bill for services provided by a doctor at a hospital or ambulatory surgical center when they have not provided all of the required information about the individual's care. Broader protections do not apply to self-insured plans. DFS - Surprise Medical Bills. *Hold Harmless*. When health care service is provided by a participating provider, requires an HMO to hold its subscriber harmless from charges in excess of any contractual copayment amounts. Similarly, when emergency services are furnished by a non-participating provider/the HMO refers the subscriber to the non-participating provider, requires an HMO to hold the subscriber harmless from any additional charge. 10 NYCRR § 98-1.5(6)(ii); 11 NYCRR § 101.4(a)(2); OGC Opinion No. 09-10-07. *Application*. Applies to an insurer licensed to write accident and health insurance; a municipal cooperative

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
				• The usual and customary cost of the service. N.Y. FIN. SERV. L. §§ 603(i), 604. States that determinations made by the IDRE are binding on all parties. N.Y. FIN. SERV. L. §§ 605(c), 607(c).	health benefit plan; an HMO; or a student health plan. N.Y. FIN. SERV. L. § 603(c). Does not apply to—among other things—health care services (including emergency services) where physician fees are subject to schedules or other monetary limitations under New York law (e.g., workers' compensation, etc.). N.Y. FIN. SERV. L. § 602.
Oregon	Prohibits an OON provider for a health benefit plan or health care service contractor from billing an enrollee in the plan or contract for emergency services or other inpatient or outpatient services provided at an in-network health care facility (e.g., a hospital, ambulatory surgical center, outpatient renal dialysis facility, etc.). OR. REV. STAT. § 743B.287(2); Bulletin 2018-02. Does not apply to applicable coinsurance, copayments, or deductible amounts that apply to services provided by an in-network provider or to services—other than emergency services—provided to enrollees from an OON provider. OR. REV. STAT. § 743B.287(3). *Payment Method*. Requires insurers/health care service contractors to reimburse an OON provider for emergency services or other covered inpatient or outpatients services provided at an in-network health care facility in the following amounts: • For OON reimbursement for non-anesthesia-related claims: no less than base rate x modifier adjustment x CPI adjustment (if there is no base rate listed on the non-anesthesia fee schedule, requires reimbursement at a rate agreed upon in good faith by the insurer and the provider to be usual and customary for in-network commercial claims, using best efforts to establish a rate within a reasonable time). OR. ADMIN. R. § 836-053-1610; OR. REV. STAT. § 743B.287(3), (6). • For OON reimbursement for anesthesia-related claims: no less than (base units + time units + physical status units) x anesthesia conversion factor x Q modifier adjustment x CPI adjustment (if there is no number of base units		Requires insurers to establish a procedure for providing an enrollee a reasonable estimate of their costs for an in-network or OON procedure or service covered by the enrollee's plan in advance of the procedure or service when an enrollee provides certain information to the insurer (e.g., the type of procedure/service, the name of the provider, the enrollee's policy number, etc.). OR. REV. STAT. §§ 743B.281-743B.282. If an enrollee chooses to receive services from an OON provider, requires the provider to inform the enrollee that they will be financially responsible for coinsurance, copayments, or other out-of-pocket expenses attributable to choosing an OON provider. OR. REV. STAT. § 743B.287(5); Bulletin 2018-02.		*Consent*. If a consumer chooses to receive care from an OON provider in an in-network setting, requires the consumer's choice to be documented. For this exception to apply, requires the consumer to have: • Had a reasonable alternative to the OON service, been informed of the alternative, and been informed of the out-of-pocket cost of the OON service; • Provided informed consent to the OON service; and • Their choice document. Bulletin 2018-02. If there is no evidence that the consumer consented to receive the service, applies the prohibition on balance billing and the reimbursement rate controls. Bulletin 2018-02. *Application*. Applies to any hospital expense, medical expense, or hospital/medical expense policy;

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	published in the physician fee schedule final rule, requires reimbursement at a rate calculated with a number of base units agreed upon in good faith by the insurer and provider to be usual and customary for in-network commercial claims, using best efforts to establish a rate within a reasonable amount of time). OR. ADMIN. R. § 836-053-1615; OR. REV. STAT. § 743B.287(3), (6); Bulletin 2018-02. For more information on the necessary calculations, *see* OR. ADMIN. R. § 836-053-1605 et seq.				subscriber contract of a health care service contractor; or MEWA plan. Does not apply to—among other plans—any employee welfare benefit plan that is exempt from state regulation because of ERISA. OR. REV. STAT. § 743B.005(16)(a)-(b).
Washington ***HB 1065, Effective 2020***	Prohibits an OON provider or facility from balance billing an enrollee for: • Emergency services provided to an enrollee; or • Non-emergency services provided to an enrollee at an in-network hospital or ambulatory surgical facility if the services: (1) involve surgical or ancillary services; and (2) are provided by an OON provider. *Payment Method*. Within 30 days of receipt of a claim from an OON provider or facility, requires carrier to offer "a commercially reasonable amount" based on payments for the same or similar services provided in a similar geographic area. An enrollee is only responsible for the in-network cost-sharing amount. In-network rates must be determined using the carrier's median in-network contracted rate for the same or similar service in the same/similar geographical area. *Emergency-Specific Provisions.* Requires coverage of in-network and OON emergency services without prior authorization up to the point of patient stabilization. Requires a health plan to immediately arrange an alternate plan of treatment if an OON emergency provider and the plan cannot reach agreement on which services are necessary.		*Carriers.* Requires carries to make electronically available information regarding whether an enrollee's health plan is subject to the balance billing provisions; requires carriers to update website and provider directory within 30 days of an addition or termination of a facility/provider; and provide an enrollee with: • A description of OON benefits; • A notice on the prohibition of balance billing; • Notification of OON financial responsibility; • Information on how to use the carrier's transparency tools; • Upon request, information on a provider's network status, and whether there are in-network providers available at the specified facility; and • Upon request, estimated total of out-of-pocket costs. *Hospital/ Surgical Facility*. Requires hospital or ambulatory surgical facilities	*Arbitration.* If, after negotiating in good faith, the carrier and provider/facility do not agree on a payment amount within 30 days of the carrier's offer, and the carrier, provider, or facility chooses to pursue further action to resolve the dispute, it must be resolved through arbitration. Approved arbitrators will be provided by the commissioner. Arbitrators must decide between final offer amounts (backed up with evidence and methodologies for the amounts asserted) submitted by the parties.	*Application.* Applies to all insured small group, large group, and individual plans; excludes Medicaid. *Self-Funded Plans*. Not covered unless they elect to participate; must opt in on an annual basis attesting to participation and agreeing to comply with the law. *Hold Harmless.* Requires carriers to hold individuals harmless for OON costs when emergency services are provided by an OON hospital in a state that borders WA, unless (1) federal legislation is enacted; (2) an interstate compact is enacted; or (3) legislation is enacted in the bordering state that prohibits balance billing for emergency services. *Claims Database.* Requires the Office of the Insurance Commissioner to establish a data set and business process to assist carriers, providers, and facilities in determining commercially reasonable payments.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
			post on website a list of in-network facilities for health plans and must provide an updated list within 14 days of a request for an updated list by a carrier. *Providers*. Requires a provider's website to list the carriers with which the provider contracts.	*Penalties*. Subjects non-compliant carriers, providers, and facilities to disciplinary proceedings and fines.	Requires the data to include amounts for emergency services and OON services provided at in-network facilities (i.e., services covered by the balance billing prohibition); and must be drawn from commercial health plan claims and exclude Medicare and Medicaid claims and claims paid on other than a fee-for-service basis.

Piecemeal/Partial Balance Billing Protections

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
Arizona	Authorizes an enrollee to request a mediation of a settlement of an OON benefit claim if all of the following apply: • The amount for which the enrollee is responsible—after copayments, deductibles, and coinsurance (and including the amount unpaid by the insurer)—is greater than $1,000; • The OON health benefit claim is for a medical service or supply provided by a provider in a facility that is a preferred provider; and • The enrollee received a surprise OON bill.[10] ARIZ. REV. STAT. § 30-2853(A); FAQ. *Payment Method*. Does not adopt a standard for reasonable payment.		Except in an emergency, if requested by an enrollee, requires a provider—before providing a medical service or supply—to provide a complete disclosure to an enrollee that: • Explains that the provider does not have a contract with the enrollee's plan; • Discloses the projected amounts for which the enrollee may be responsible; and • Discloses the circumstances under which the enrollee would be responsible for those amounts. May not require a provider that makes such a disclosure/obtains the enrollee's written acknowledgement of that disclosure to mediate a billed charge if the amount billed is	If an enrollee requests mediation, generally requires the provider and the insurer to participate in the mediation. ARIZ. REV. STAT. § 30-2853(B). For more on the dispute resolution/arbitration process, *see* FAQ and ARIZ. ADMIN. CODE §§ 20-6-2401 et seq.	*Application*. Does not apply to enrollees covered by health care services organizations (e.g., HMOs), limited benefit coverage, health and accident insurance coverage for state employees and their dependents, self-funded or self-insured employee benefit plans, health plans that exclude OON coverage (unless otherwise required by law), health care services that the insurer denied or that are otherwise not covered by the health plan, provider or health facility charges that an individual agreed to pay rather

[10] *Surprise Out-of-Network Billing*. A bill for any medical service performed at a network facility by a provider that is not a preferred provider if the enrollee: (1) did not know that the provider that was performing the service was not a preferred provider; (2) a preferred provider was not available; (3) it was impractical to wait for a preferred provider; and (4) the patient did not elect to obtain an OON service. ARIZ. REV. STAT. § 30-2852(15).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
			less than or equal to the maximum amount projected in the disclosure. ARIZ. REV. STAT. § 30-2853(C)-(D).		than using the health plan, etc. FAQ.
Colorado	Requires carriers that provide any benefits with respect to services in an emergency department to cover emergency services: • Without the need for any prior authorization determination; • Regardless of whether the provider furnishing emergency services is a participating provider with respect to emergency services; • For services provided OON; • Without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements/limitations that apply to emergency services received from in-network providers; and • With the same cost-sharing requirements as would apply if the emergency services were provided in-network. COLO. REV. STAT. § 10-16-704(5.5)(a). *Payment Method*. Does not adopt a standard for reasonable payment.	When a covered person receives services or treatment in accordance with plan provisions at a network facility, requires the benefit level for all covered services and treatment received through the facility to be the in-network benefit. COLO. REV. STAT. § 10-16-704(3)(b). Prohibits covered services or treatment rendered at a network facility—including covered ancillary services or treatment rendered by an OON provider at the network facility—from being covered at a greater cost to the covered person than if the services or treatment were obtained from an in-network provider. COLO. REV. STAT. § 10-16-704(3)(a)(III), (b). *Payment Method*. Does not adopt a standard for reasonable payment.	Does not require notice or disclosure to consumers about their existing protections, but encourages health care facilities, carriers, and providers to provide consumers disclosure about the potential impact of receiving services from an OON provider. COLO. REV. STAT. § 10-16-704(3)(a)(III).		*Consent*. When consumers intentionally use an OON provider, entitles the consumer only to benefits at the OON rate and finds that they may be subject to balance billing by the OON provider. COLO. REV. STAT. § 10-16-704(3)(a)(IV). *Hold Harmless*. Holds the consumer harmless for additional charges from OON providers for care rendered at an in-network facility. COLO. REV. STAT. § 10-16-704(3)(a)(II), (III), (V). *Application*. Applies to all managed care plans—except for workers' compensation and automobile insurance contracts—that are issued, renewed, extended, or modified after 1998. COLO. REV. STAT. § 10-16-703. Does not apply to self-funded, ERISA-regulated plans. Surprise Billing Issue Brief (Aug. 2018); COLO. REV. STAT. § 10-16-704(3)(a)(III).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
Delaware	Prohibits non-network providers from balance billing an insured for emergency services, but does not prevent the operation of policy provisions involving deductibles or copayments. 18 DEL. CODE § 3349(b), (e). Requires individual and group health insurance policies to provide that persons covered thereunder will be insured for emergency care services performed by non-network providers at an agreed-upon or negotiated rate, regardless of whether the physician or provider has a contractual or other arrangement with the insurer to provide items or services to persons covered under the policies. 18 DEL. CODE § 3349(b). *Payment Method*. Prior to an arbitration determination by the Insurance Commissioner, requires the insurer to 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/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. 18 DEL. CODE § 3349(c).	Prohibits non-network providers from balance billing an insured in the event of a referral, but does not prevent the operation of policy provisions involving deductibles or copayments. 18 DEL. CODE § 3348. Requires individual and group health insurance policies to provide that if medically necessary covered services are not available through network providers (or the network providers are not available within a reasonable period of time) the insurer will, at the request of the network provider: • Allow referral to a non-network provider; and • Reimburse the non-network provider at a previously agreed-upon or negotiated rate. 18 DEL. CODE § 3348(b). Prohibits the insurer from refusing such a referral, absent a decision by a physician in the same/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. 18 DEL. CODE § 3348(b). *Payment Method*. Does not adopt a standard for adequate payment.	*Facility-Based Provider*. When a facility-based provider (i.e., a provider who provides services to patients who are in an in-patient or ambulatory facility) schedules a procedure, seeks prior authorization from an insurer for the provision of non-emergency covered services, or prior to the provision of any non-emergency covered services, requires the provider to ensure that the covered person has received a timely, written OON disclosure. Requires such disclosures to state—among other things: • Whether the facility is a participating or OON facility; • That certain facility-based providers may be OON; • That services provided on an OON basis may result in additional charges for which the covered person may be responsible, etc. 18 DEL. CODE §§ 3370A, 3571S. Requires the disclosure to include a written consent form that enables the covered person who wishes to utilize an OON provider to affirmatively elect to obtain services and agree to accept/pay the charges for the OON services. 18 DEL. CODE §§ 3370A, 3571S Prohibits a facility-based provider from balance billing a covered person for health care services not covered by an insured's policy/contract if the provider fails to provide the timely disclosure or fails to obtain a copy of the written consent form included with the disclosure prior to rendering services. 18 DEL ADMIN. CODE § 1317.	In the emergency services context, if the provider of emergency services and the insurer cannot agree on the appropriate rate, entitles the provider to charges and rates allowed by the Insurance Commissioner following an arbitration of the dispute. 18 DEL. CODE § 3349(b). Requires the Insurance Commissioner to adopt regulations concerning the arbitration of such disputes. 18 DEL. CODE § 3349(b), (g).	*Standing Referrals*. Requires policies that do not allow insureds to have direct access to health care specialists to establish a procedure by which insureds can obtain a standing referral to a specialist. 18 DEL. CODE § 3348(c)-(d). *Managed Care Organizations*. States that specific network adequacy and balance billing provisions apply to managed care organizations. 18 DEL ADMIN. CODE § 1403.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
Indiana	Does not require providers that make referrals for treatment of an emergency medical condition to receive a copy of the otherwise required notice. Specifically, does not impose notice requirements on referrals: • For treatment of an emergency medical condition; • Made immediately following treatment of an emergency medical condition and by the provider that rendered the treatment of the emergency medical condition; or • For medically or psychologically necessary therapeutic services rendered to a patient in a hospital or other facility to which a patient may be admitted for more than 24 hours. IND. CODE § 25-1-9.1-1(b). *Payment Method*. Does not adopt a standard for reasonable payment.	Requires providers that make referrals to provide the covered individual with a copy of a written notice that states all of the following: • That an OON provider may be called upon to render health care items or services to the covered individual during the course of treatment; • That an OON provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan; and • That the covered individual may contact their health plan before receiving health care items or services rendered by an OON to obtain a list of network providers that may render the health care items or services and for additional assistance. IND. CODE § 25-1-9.1-12(b). *Payment Method*. Does not adopt a standard for reasonable payment.			*Application*. Applies to an accident and sickness insurance policy; an individual contract or a group contract with an HMO; or another plan/program that provides payment, reimbursement, or indemnification for the costs of health care items or services. IND. CODE § 25-1-9.1-5(a). Does not apply to worker's compensation or similar insurance, benefits provided under a certificate of exemption issued by the worker's compensation board, or Medicaid. IND. CODE § 25-1-9.1-5(b).
Iowa	States that carriers that provide coverage for emergency services are responsible for charges for emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. IOWA CODE § 514C.16(1). Does not require prior authorization for emergency services (including all services necessary to evaluate and				*Application*. Applies to insurance companies offering accident and sickness policies, HMOs, nonprofit health services corporations, or any other entities providing a plan of health insurance, health benefits, or health services. IOWA CODE § 513B.2(4).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	stabilize an emergency medical condition). IOWA CODE § 514C.16(2). *Payment Method*. Does not adopt a standard for reasonable payment.				
Maine		With respect to a surprise bill,[11] requires 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 an in network provider. Phrased differently, prohibits an OON provider from billing an enrollee for health care services beyond the applicable coinsurance, copayment, deductible, or other out-of-pocket expense that would be imposed for the health care services if the services were rendered by a network provider under the enrollee's health plan. ME. REV. STAT. tit. 24-A § 4303-C(2)(A). *Payment Method*. Requires a carrier to reimburse the OON provider or enrollee for health care services rendered at the average network rate under the	*Provider Directories*. Requires carriers to post (electronically and in print) a current and accurate provider directory for all of its network plans that includes—among other things—information on health care professionals, hospitals, other facilities, etc. Requires carriers to include in plain language in both electronic and print directories the following information: • A description of the criteria the carrier used to build its provider network; • A description of the criteria the carrier used to tier providers; how the carrier designated the different provider tiers/levels in the network; and how the carrier identifies tier placement for each provider, hospital, and other type of facility in the network (if applicable); • The authorization or referral that may be required to access some providers (if applicable). ME. REV. STAT. tit. 24-A § 4303-D.		*Consent.* Does not apply to a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an OON provider. ME. REV. STAT. tit. 24-A § 4303-C(1). *Application*. Applies to insurance companies, HMOs, preferred provider arrangement administrators, fraternal benefit societies, nonprofit hospital or medical service organizations, MEWAs, a self-insured employer subject to state law, etc. Does not apply to an employer exempted from the application of state law under ERISA. ME. REV. STAT. tit. 24-A § 4301-A(3).

[11] *Surprise Bill*. A bill for health care services (other than emergency services) received by an enrollee for covered services rendered by an OON provider—when such services were rendered by that OON provider as a network provider—during: (1) a service/procedure performed by a network provider; or (2) service/procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that OON provider. ME. REV. STAT. tit. 24-A § 4303-C(1).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
		enrollee's health care plan as payment in full, unless the carrier and OON provider agree otherwise. ME. REV. STAT. tit. 24-A § 4303-C(2)(B).			*Network Adequacy*. If the carrier has an "inadequate network"—as determined by the Superintended of Insurance—requires the carrier to ensure that the enrollee obtains the covered service at no greater cost than if the service were obtained from a network provider. ME. REV. STAT. tit. 24-A § 4303-C(2)(C).
Massachusetts	*HMO.* Requires an HMO to provide/arrange for indemnity payments to a member or provider for a reasonable amount charged for the cost of emergency medical services by a provider who is not normally affiliated with the HMO when the member requires services for an emergency medical condition. MASS. GEN. L. ch. 176G, § 5(f). *PPO*. If a covered person receives emergency care and cannot reasonably reach a preferred provider, requires 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. MASS. GEN. L. ch. 176I, § 3(b).	Requires insurers to cover services from OON providers practicing inside in-network facilities with no greater cost-sharing to the patient where the patient did not have a "reasonably opportunity" to have the service performed by a network provider. MASS. GEN. L. ch. 176O, § 6(a)(4)(ii); Health Policy Commission, *Policy Brief on Out-of-Network Billing* (Jan. 2016). In their evidence of coverage, requires carriers to provide a complete statement of the locations where—and the manner in which—health care services and other benefits may be obtained, including an explanation that: • Whenever a proposed admission, procedure, or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier will cover the OON admission, procedure, or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures, or services offered within the carrier's network; and • Whenever a location is part of the carrier's network, the carrier will cover medically necessary covered benefits delivered at that location and the insured will not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless the insured has a reasonable opportunity to choose to have the service performed by a network provider. MASS. GEN. L. ch. 176O, § 6(a)(4)(ii).			*Application*. With respect to the provision of non-emergency services, applies to insurers licensed to transact accident or health insurance, nonprofit hospital service corporations, nonprofit medical service corporations, HMOs, organizations entering into preferred provider arrangements, etc. Does not apply to an employer purchasing coverage MASS. GEN. L. ch. 176O, § 1.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
Minnesota	Prohibits a network provider from billing an enrollee for any amount in excess of the allowable amount the carrier contracted for with the provider as total payment for the health care service. Authorizes a network provider to bill an enrollee the approved copayment, deductible, or coinsurance. MINN. REV. STAT. § 62K.11(a).			*Dispute Resolution*. If negotiation for reimbursement is unsuccessful, allows the health plan company to refer the matter for binding arbitration. MINN. REV. STAT. § 62Q.556(2)(b)-(d).	*Out-of-Pocket Limit.* Requires plans to apply any enrollee cost-sharing requirements (i.e., copayments, deductibles, and coinsurance) for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied. MINN. REV. STAT. § 62Q.556(2)(a). *Consent.* Does not define "unauthorized provider services" to include lab, pathologist, or other specimen testing 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 enrollee's health plan. MINN. REV. STAT. § 62Q.556(1)(c). Permits a provider to bill an enrollee for services not covered
		Prohibits an enrollee's financial responsibility for unauthorized provider services[12] from exceeding the cost-sharing requirements (i.e., copayments, deductibles, coinsurance, etc.) under their insurance had the service been provided by a participating provider. MINN. REV. STAT. § 62Q.556(2)(a). *Payment Method*. Requires the health plan company to attempt to negotiate the reimbursement—less any applicable cost sharing—for the unauthorized provider services with the nonparticipating provider. MINN. REV. STAT. § 62Q.556(2)(b).			

[12] *Unauthorized Provider Services*. Such services occur when an enrollee receives services from:
- A nonparticipating provider at a participating hospital or ambulatory surgical center, when the services are rendered:
  - 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
- 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.

It does not include emergency services. MINN. REV. STAT. § 62Q.556(1)(a)-(b).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
		Payment Method. Does not adopt a standard for reasonable payment.			by the enrollee's plan, as long as the enrollee agrees in writing in advance before the service is performed to pay for the noncovered services. MINN. REV. STAT. § 62K.11(b). *Application*. Applies to health carriers (i.e., a licensed insurance company, a nonprofit health service plan corporation, an HMO, a fraternal benefit society, or a joint self-insurance employee health plan operating under state law) or a community integrated service network. MINN. REV. STAT. § 62Q.501(4).
Mississippi *Prohibits a provider from balance billing an insured*	If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the insured's policy be paid to a provider rendering hospital, nursing, medical, or surgical services, then requires the insurer to pay the provider directly. Requires the payment to the provider to be considered "payment in full" and prohibits the provider from billing or collecting from the insured any amount above that payment, other than the deductible, coinsurance, copayment, or other charges for equipment or services requested by the insured that are noncovered benefits. MISS. CODE ANN. § 83-9-5(1)(i). *Payment Method*. Does not adopt a standard for reasonable payment.			Does not define a patient's recourse if they receive a balance bill, though the state Attorney General will accept balance billing complaints that are handled through voluntary mediation. *See* *You Might Not Have to Pay That Medical Bill. Here's the Law You Need to Know*, CLARION LEDGER (2018).	*Application.* Applies to HMOs, insurance companies, or other entities responsible for the payment of benefits under a policy or contract of accident and sickness insurance. MISS. CODE ANN. § 83-9-5(1).
Missouri	*Emergency Services.* Requires carriers to cover emergency services necessary to screen and stabilize an enrollee and prohibits requiring prior authorization of such services. MO. REV. STAT. § 376.1367(1).			Requires the Director of Insurance to ensure access to an external arbitration process when a health care	*Out-of-Pocket Limits*. Applies the in-network deductible and out-of-pocket maximum cost-sharing requirements to the

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	Subjects coverage of emergency services to applicable copayments, coinsurance, and deductibles. MO. REV. STAT. § 376.1367(2). When a patient's health benefit plan does not provide for payment to OON providers for emergency services, including but not limited to HMO and EPO plans, requires payment for all emergency services necessary to screen and stabilize the enrollee to be paid directly to the health care provider by the health carrier. MO. REV. STAT. § 376.1367(5); Summary of SB 982 (2018). *Unanticipated OON Care*. When unanticipated OON care is provided,[13] prohibits the health care professional who sends a claim to a carrier to bill a patient for more than the cost-sharing requirements. MO. REV. STAT. § 376.690(3). *Payment Method*. After providing unanticipated OON care, authorizes health care professionals to send a claim for charges incurred to the patient's health carrier. Following receipt of the claim, requires the carrier to offer to pay the professional at a reasonable reimbursement rate for unanticipated OON care based on the health care professional's services. If the health care professional declines the carrier's initial offer of reimbursement, requires both parties to negotiate in good faith to attempt to determine the reimbursement for the unanticipated OON care. If the carrier and health care professional do not agree to a reimbursement amount during the negotiation period, requires the dispute to be resolved through arbitration. MO. REV. STAT. § 376.690(2). Does not, however, require the enrollee to participate in the arbitration process. MO. REV. STAT. § 376.690(8).			professional and carrier cannot agree to a reimbursement. MO. REV. STAT. § 376.690(4)-(5). Requires the arbitrator to determine a dollar amount due between: • 120% of the Medicare allowed amount; and • The 70th percentile of the usual and customary rate for the unanticipated OON care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provide organizations. MO. REV. STAT. § 376.690(6). Requires the arbitrator to consider several factors (e.g., the nature of the service provided, the health care professional's training, etc.) when determining a reasonable reimbursement rate. MO. REV. STAT. § 376.690(7).	claim for the unanticipated OON care. MO. REV. STAT. § 376.690(3)(4). *Application*. Applies to entities that contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services (e.g., sickness and accident insurance companies, HMOs, nonprofit hospital and health service corporations, etc.). MO. REV. STAT. § 376.1350(22).

[13] *Unanticipated Out-of-Network Care*. Health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged. MO. REV. STAT. § 376.690(1)(5).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
North Carolina	Requires insurers to provide coverage for emergency services to the extent necessary to screen and stabilize a covered person and does not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. N.C. GEN. STAT. ANN. § 58-3-190(a). With respect to emergency services provided by a provider who is not under contract with the insurer, requires the services to be covered if: • A prudent layperson acting reasonably would have believed that a delay would worsen the emergency; or • The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person. N.C. GEN. STAT. ANN. § 58-3-190(b). Subjects coverage of emergency services to coinsurance, copayments, and deductibles applicable under the plan, but prohibits an insurer from imposing cost-sharing for emergency services that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer. N.C. GEN. STAT. ANN. § 58-3-190(d).		Requires insurers to provide information to their covered persons on—among other things—any cost-sharing provisions for emergency medical services, the process and procedures for obtaining emergency services, etc. N.C. GEN. STAT. ANN. § 58-3-190(f). If an insured is liable for an amount that differs from a stated fixed dollar copayment/stated coinsurance percentage and providers are permitted to balance bill the insured, requires the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels to contain the following statement: "NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations." N.C. GEN. STAT. § 58-3-250.	Requires the emergency department and the insurer to make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence. N.C. GEN. STAT. ANN. § 58-3-190(e).	*Applicability.* Applies to entities that write health benefit plans (e.g., an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; an HMO subscriber contract; or a plan provided by a MEWA) and that is an insurance company, a service corporation, an HMO, or a MEWA. N.C. GEN. STAT. ANN. § 58-3-190(g)(4). Does not apply to the following kinds of insurance: accident, credit, disability income, Medicare supplement, insurance under which benefits are payable with our without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance, etc.. N.C. GEN. STAT. ANN. § 58-3-190(g)(3).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	Payment Method. Does not adopt a standard for reasonable payment.				
Pennsylvania	Prohibits a plan from denying any claim for emergency services on the basis that the enrollee did not receive permission, prior approval, or referral prior to seeking emergency service. 28 PA. ADMIN. CODE § 9.672(b). If a plan has no participating providers within an approved service area available to provide covered services, requires it to arrange/provide coverage for services provided by a nonparticipating provider and cover the non-network services at the same level of benefit as if a network provider had been available. 28 PA. ADMIN. CODE § 9.681(c). *Payment Method*. Does not adopt a standard for reasonable payment.		Requires plans to provide enrollees with information regarding access to providers that offer covered benefits in certain service areas. If a plan is unable to meet the required standards, requires it to disclose to the Department a description of how it intends to provide access to health care services (e.g., the use of participating or nonparticipating providers, applicable payment arrangements, etc.). 28 PA. ADMIN. CODE § 9.679. Requires plans to provide enrollees with a list of the participating health care providers to which an enrollee may have access either directly or through a referral. 28 PA. ADMIN. CODE § 9.681.		*Applicability.* Applies to managed care plans—including HMOs and gatekeeper PPOs—and subcontractors of managed care plans for services provided to enrollees. 28 PA. ADMIN. CODE §§ 9.651, 9.671. *Provider Notice*. Requires the emergency health care provider to notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee. 28 PA. ADMIN. CODE § 9.672(f)-(h).
Rhode Island	Requires carriers to provide coverage for emergency services in the following manner: • Without the need for any prior authorization determination, even if the emergency services are provided on an OON basis; • Without regard to whether the provider furnishing the emergency services is a participating network provider with respect to the services; • If the emergency services are provided OON:				*Deductibles/Out-of-Pocket Maximums.* Authorizes any cost-sharing requirement other than a copayment/coinsurance (e.g., a deductible or out-of-pocket maximum) to be imposed with respect to emergency services provided OON if the cost-sharing requirement generally applies to OON benefits. R.I. GEN. L. § 27-18-76(d)(2).

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	– Without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers, and – By complying with the state's cost-sharing requirements; and • Without regard to any other term or condition of the coverage, other than (1) the exclusion of or coordination of benefits, (2) an affiliation of waiting period under ERISA, or (3) applicable cost-sharing. R.I. GEN. L. § 27-18-76(c). Prohibits any cost-sharing requirement as expressed as a copayment amount or coinsurance rate imposed with respect to a participant/beneficiary for OON emergency services from exceeding the cost-sharing requirement imposed with respect to a participant/beneficiary if the services were provided in-network. R.I. GEN. L. § 27-18-76(d)(1). *Payment Method*. Requires a carrier to provide benefits with respect to an emergency service in an amount equal to the greatest of the following: • The amount negotiated with in-network providers for the emergency service furnished (excluding any in-network copayment/coinsurance imposed with respect to the participant/beneficiary);				*Application*. With respect to the emergency services provisions, applies to nonprofit hospital service corporations, nonprofit medical service corporations, and HMOs. R.I. GEN. L. §§ 27-19-66, 27-20-62, 27-41-79.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	• The amount for the emergency services calculated using the same method the plan generally uses to determine payments for OON services (e.g., the usual, customary, and reasonable amount); or • The amount that would be paid under Medicare for the emergency service. R.I. GEN. L. § 27-18-76(d)(1)(A)-(C). May require a participant/beneficiary to pay—in addition to the in-network cost-sharing—the excess of the amount of the OON provider charges over the amount the carrier is required to pay. R.I. GEN. L. § 27-18-76(d)(1).				
Texas	Allows an enrollee to request mediation of a settlement of an OON health benefit claim if: • The amount for which the enrollee is responsible to a facility-based provider or emergency care provider—after copayments, deductibles, and coinsurance—is greater than $500; and • The health benefit claim is for emergency care or a health care/medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator. TEX. INS. CODE § 1467.051(a). Prohibits an insurer from terminating an insured's participation in a preferred provider benefit plan solely because the insured uses an OON provider. TEX. INS. CODE § 1301.0057. For more information, *see* Surprise Medical Bills (Mar. 2019) , Avoiding Surprise Bills (Oct. 2018), Handling Surprise Bills (Oct. 2018).		Except in the case of an emergency and if requested by the enrollee, requires a facility-based provider—before providing a health care or medical service/supply—to provide a complete disclosure to an enrollee that: • Explains that the facility-based provider does not have a contract with the enrollee's health benefit plan; • Discloses projected amounts for which the enrollee may be responsible; and • Discloses the circumstances under which the enrollee would be responsible for those amounts. TEX. INS. CODE § 1467.051(c).	*Mediation.* Authorizes enrollees to request mandatory mediation for the settlement of an OON health benefit claim. TEX. INS. CODE §§ 1467.051-1467.060. On receipt of the request for mediation, requires the Department of Insurance to notify the facility-based provider (or emergency care provider) and insurer (or administrator) of the request. TEX. INS. CODE § 1467.054.	*Consent.* A facility-based provider that makes the required disclosure and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge if the amount billed is less than or equal to the maximum amount projected in the disclosure. TEX. INS. CODE § 1467.051(d). *Out-of-Pocket Maximum*. When an insured or enrollee pays a balance bill resulting from emergency or inadequate network treatment, requires

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	HMO. Requires HMOs to cover emergency services and comply with the payment requirements regardless of whether the physician/provider furnishing the emergency care has a contractual or other arrangement with the HMO to provide items or services to covered enrollees. TEX. INS. CODE § 1271.155(e). Requires HMOs to pay for emergency care performed by non-network physicians/providers at the usual and customary rate or at an agreed rate. TEX. INS. CODE § 1271.155(a). *PPO.* If a nonpreferred provider provides emergency care to an enrollee in an exclusive provider benefit plan, requires the issuer to reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services. TEX. INS. CODE § 1301.0053. *EPO.* If an insured cannot reasonably reach a preferred provider, requires an insurer to provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider: • A medical screening examination that is necessary to determine whether a medical emergency condition exists;	*HMO.* If medically necessary covered services are not available through network physicians/providers, requires HMOs—at the request of a network physician/provider and within a reasonable period to: • Allow a referral to a non-network physician/provider; and • Fully reimburse the non-network physician/provider at the usual and customary rate or at an agreed rate. TEX. INS. CODE §§ 1271.055(b), 1272.301(a)(1). *PPO.* If medically necessary covered services are not available through a preferred provider, requires the insurer of an exclusive provider benefit plan, at the request of a preferred provider, to: • Approve the referral of an insured to a nonpreferred provider within a reasonable period; and • Fully reimburse the nonpreferred provider at the usual and customary rate or at an agreed rate. TEX. INS. CODE § 1301.0052(a). *EPO.* If medically necessary covered services—excluding emergency care—are not available	Requires a bill sent to an enrollee by a facility-based provider or emergency care provider—or an explanation of benefits sent to an enrollee by an insurer/administrator for an OON claim—to contain, in not less than 10-point boldface type, an explanation of the mediation process similar to the following: "You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at (website) and (phone number)." TEX. INS. CODE § 1467.0511. If an enrollee contacts an insurer, administrator, facility-based provider, or emergency care provider about a bill that may be eligible for mediation, encourages them to inform the enrollee about mediation and provide the enrollee with the Department of Insurance's toll-free number and website. TEX. INS. CODE § 1467.0511.	If the mediation is unsuccessful, refers the matter to a special judge or requires one of the parties to elect to continue mediation to further determine their responsibilities. TEX. INS. CODE §§ 1467.057-1467.058. For more information on the mediation process, *see* Handling Surprise Bills (Oct. 2018). *Penalties.* Imposes an administrative penalty on bad faith mediation (e.g., failing to participate in the mediation, failing to provide information necessary to facilitate an agreement, etc.) by a party other than the enrollee. TEX. INS. CODE §§ 1467.101-1467.102.	preferred providers to count this amount toward the insured's/enrollee's in-network deductible and out-of-pocket maximum. Handling Surprise Bills (Oct. 2018). *Hold Harmless.* Requires insurers reimbursing a nonpreferred provider to ensure that the insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider. TEX. ADMIN. CODE § 3.3725(d); Bulletin B-0011-99. *Workers' Compensation.* For more information on OON billing in the workers' compensation context, *see* TEX. INS. CODE § 1305.006.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	• Necessary emergency care services (including the treatment and stabilization of an emergency medical condition); and • Services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition. TEX. INS. CODE § 1301.155(b); TEX. ADMIN. CODE § 3.3725(a). *Method of Payment*. Does not adopt a standard for reasonable payment.	through a preferred provider upon the request of a preferred provider, requires the insurer to: • Approve a referral to a nonpreferred provider within the time appropriate given the circumstances (but not to exceed 5 days); and • Provide for a review by a health care provider with expertise in the same/similar specialty (before the insurer may deny the referral). TEX. ADMIN. CODE § 3.3725(b)-(c). *Method of Payment*. Does not adopt a standard for reasonable payment.			
West Virginia	Requires insurers to provide coverage for emergency medical services—including prehospital services—to the extent necessary to screen and stabilize an emergency medical condition without requiring prior authorization for the screening services or stabilization of the emergency medical condition. W. VA. CODE § 33-25A-8d(a), (b)(1). Subjects coverage of emergency services to coinsurance, copayments, and deductibles applicable under the health benefit plan. W. VA. CODE § 33-25A-8d(b)(3).		Requires each HMO to provide the enrolled member with a description of procedures for emergency services, including—among other things—the potential responsibility of the member for payment for nonemergency services rendered in an emergency facility, any cost-sharing provisions for emergency services, etc. W. VA. CODE § 33-25A-8d(b)(6).	Requires the emergency department and the insurer to make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition. W. VA. CODE § 33-25A-8d(b)(4).	*Applicability.* Applies to HMOs, health care corporations, individual accident and sickness insurers, group accident and sickness insurers, hospital service corporations, medical service corporations, dental service corporations, and health service corporations, etc. W. VA. CODE §§ 33-25A-8d; 33-16-3i; 33-24-7e; 33-25-8d.

States	Treatment of Emergency Services	Treatment of Non-Emergency Services	Disclosure	Dispute Resolution/Penalties	Miscellaneous
	Method of Payment. Does not adopt a standard for reasonable payment.				