Callagy Law

NEW EDITION

REMOVING THE SURPRISES FROM THE SURPRISE MEDICAL BILL LAWS

The Essential Guide To The Federal “No Surprises Act” And State Surprise Bill Laws.

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LEGAL DISCLAIMER: This ebook is not intended as legal advice, but rather as general guidance based upon our understanding of the law as of the date published.

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Removing the Surprises from the Surprise Medical Bill Laws

Introduction

Perhaps the most significant development in recent years affecting the financial well-being of the medical community is the advent of surprise medical bill laws (SBL's). The principal aim of these laws is to protect patients from unexpected charges that can occur when they receive medical treatment from healthcare providers that are not within the insurance carrier's network. This occurs most often in the context of emergency medical treatment. The secondary aim of these laws, however, and one that is no less important, should be to ensure that the medical community does not pay an unfair price for these patient protections. Many of the legislative and regulatory bodies passing and implementing these laws are not as sensitive about the second objective as they are the first objective, and this can be a problem not just for the medical community but for the patient community as well.

Why should a patient have to face a bill from a large out-of-network (OON) medical provider when the patient never made the decision to go outside of the network for treatment? The obvious answer is "They shouldn't." Patients must be protected from emergency and "inadvertent" OON balance bills. Just as important, though, is the notion that the medical community must be reimbursed fairly under these legislative and regulatory regimes to ensure that quality medical care—emergency medical care in particular—will not be undermined. If surgeons, for example, are not reimbursed properly for taking ER call, where they are summoned to the hospital at 3 AM to perform emergency surgery, they will simply stop taking ER call. Who then will be performing these emergency surgeries?

The circumstances under which the need for these patient protections arises are twofold. The first is when a patient is taken to an Emergency Room at an OON hospital or is seen by an OON practitioner under emergency circumstances. The other is what is known as "inadvertent" OON services, where an ancillary service provider, such as an anesthesiologist or an intraoperative neuromonitoring service, provides OON services at an in-network (INN) facility. The patient is being treated at an INN facility by an INN surgeon, but the ancillary provider(s) happens to be OON and the patient naturally assumed any treating provider would be INN.

The key features of these laws include the following.

1. **Balance Billing Protections:** Balance billing is the practice of a healthcare provider billing a patient for the difference between the provider's charge and the allowed amount that the insurance covers. SBL's prohibit this practice in the situations described above.

2. **Cost-Sharing Protections:** Some laws protect patients by limiting their cost-sharing responsibilities--copayments, coinsurance, and deductibles--for OON care to the amounts they would owe for INN care.

3. **Disclosure Requirements:** Some laws require healthcare providers and insurers to inform patients about which providers are INN and the potential costs of receiving care from OON providers.

4. **Consent Provisions:** Laws may require that a healthcare provider obtains a patient's consent before providing OON care that could result in a surprise bill.

5. **Arbitration or Mediation Processes:** To help resolve disputes between healthcare providers and insurers, some laws establish an arbitration or mediation process. This process is used to determine a fair payment amount when a provider and insurer cannot agree on a price. Because the patient can no longer be balance billed, there will likely be a payment dispute between the carrier and the OON provider for greater reimbursement from the carrier.

6. **ONN Payment Standards:** These laws may establish a standard rate that insurers must pay to OON providers. Some states base the reimbursement on a percentage of Medicare rates or the median or average INN rate the carrier contracted for with other providers. Other states base the reimbursement on usual and customary rates in that geographic area or "reasonable charges" for the services.

These are general characteristics, and the actual details and provisions can vary widely from state to state.

The No Surprises Act (NSA), a federal law that took effect on January 1, 2022, has expanded these protections so that they now apply across the country. The NSA was aimed at filling in whatever gaps existed in these patient protections. Prior to the NSA, these patient protections did not exist in states without their own SBL's and did not extend to federally regulated health plans in states with their own SBL's. The NSA sought to fill these lacunae.

Accordingly, the NSA creates a bifurcated system for treatment in states with their own SBL's that permits dispute resolution between the medical provider and the insurance carrier, whereby claims related to state-regulated health plans, such as small-employer fully insured plans, are governed by the state SBL's, and claims related to federally regulated health plans, such as large employer self-funded plans and union plans, are governed by the NSA. State-employee plans and federal employee plans typically are governed by the state SBL's and the NSA, respectively. The NSA also governs all of the eligible claims arising out of treatment in states without their own SBL. Finally, the NSA governs out-of-state (OOS) plans, situations where the treatment occurs in one state but the plan is regulated by another state.

Because all of the eligible claims arising in a state without its own SBL and claims involving OOS plans will be resolved under the NSA, this analysis will focus on the jurisdictions with bifurcated processes, that is, those states where some claim disputes will be resolved in the state process and others will be resolved in the federal process.

For purposes of this analysis, a state will be regarded as having its own SBL only when its state law not only protects patients from balance bills but also establishes a state process for dispute

resolution between the provider and carrier. The below analyses are only of states where the arbitration process is bifurcated with some arbitrations going to the state tribunal and some to the federal forum. Understanding how to navigate the bifurcated processes is critical to ensuring proper reimbursement. These states include:

Alaska
California
Colorado
Connecticut
Delaware
Florida
Georgia
Illinois
Maine
Maryland
Michigan
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
Ohio
Texas
Virginia
Washington

The remaining states either have no protections or the laws do not provide for a dispute resolution process between the medical provider and the insurance carrier, and so, they do not offer a genuine comprehensive SBL regime. Each of these states will be addressed in turn below, but before doing so, we will discuss the NSA.

The Federal NSA

The NSA is the federal version of an SBL and was aimed at filling in all of the gaps between the State SBL's, such as OOS plans, federally regulated plans, and plans written in states with no SBL's of their own. *See 26 U.S.C. Section 9816.* The NSA was included as part of the Consolidated Appropriations Act of 2021 and went into effect on January 1, 2022. As with similar laws passed by various states, the NSA:

1. **Prohibits Balance Billing** of patients in emergency and inadvertent OON situations and limits the patient's responsibility to INN cost sharing.

2. **Requires Disclosures to be made** to patients in elective surgery situations to ensure patients make informed decisions to go OON.

3. **Establishes a Dispute resolution Process** to resolve payment disputes between OON medical providers and insurance carriers, a process known as the Federal Independent Dispute Resolution (IDR) process.

The implementation of the NSA is in the hands of several regulatory bodies:

The Department of Health and Human Services (HHS). Specifically, the Center for Medicare and Medicaid Services (CMS), plays a significant role in implementing and enforcing the NSA. CMS has extensive experience in setting healthcare policy and works with healthcare providers, insurers, and patients to ensure the NSA is properly enforced.

The Department of Labor (DOL). The DOL oversees the Employee Benefits Security Administration (EBSA), which is responsible for administering and enforcing the provisions of federal laws related to health benefits under employer-sponsored health plans. The NSA contains numerous provisions that affect these plans, and the EBSA plays a significant role in enforcing these provisions.

The Department of the Treasury. The Department of the Treasury, particularly the Internal Revenue Service (IRS), also has a role in the implementation of the NSA. Certain provisions of the NSA, such as those related to health insurance premiums and tax credits, fall under the jurisdiction of the IRS.

The Office of Personnel Management (OPM). OPM manages the Federal Employees Health Benefits Program and other aspects of federal employee benefits, and it works with other agencies to implement the NSA in the context of federal employee health plans.

The Federal IDR process imposes very strict timelines for arbitrations, envisioning an expeditious and efficient dispute resolution regime. Many delays have plagued the process since its inception, mainly because of the government's gross underestimation of how many arbitrations would be filed. CMS apparently anticipated 17,000 per year and received approximately 100,000 per quarter (300,000 for the three quarters of operation during 2022). The number of filings is likely to increase as the medical industry grows more accustomed to the process. At the same

time, however, it is likely the resolutions ultimately will be rendered more quickly since the tight deadlines described below are required by law.

30 Calendar Days for Carrier to Pay. Once a claim for OON services is submitted, the insurer has 30 days to pay the claim or send a notice of denial.

30 Business Days for the Medical Provider to Take Action. Once a payment is received by the medical provider, the provider has 30 business days to take action, sending a notice objecting to the payment and inviting the carrier to negotiate.

30-Day Open Negotiation Period. The notice objecting to payment triggers a 30-business-day negotiation period, in which the parties are expected to negotiate in good faith to try to agree on a payment amount.

Notice of Arbitration. If the open negotiation period ends without agreement, either party can initiate the IDR process by sending a notice of arbitration. They have 4 business days to notify the other party.

Choosing an Arbitrator. Once the arbitration process is initiated, the parties have 3 days to agree on a certified independent arbitrator from a list provided by the HHS. If they cannot agree, HHS will appoint an arbitrator from the list.

Submission to the Arbitrator. After an arbitrator is chosen, each party has 10 days to submit an offer for the disputed payment amount. They can also submit supporting information, such as the provider's level of experience and the complexity of the services.

Arbitrator's Decision. The arbitrator has 30 days to make a decision. The arbitrator must choose one of the offers submitted by the parties (a "baseball-style" arbitration) and cannot suggest a different amount. The arbitrator's decision is binding, and the losing party generally must pay the arbitration fees.

Payment by Carrier. In the event the medical provider prevails, the carrier has 30 business days to pay the provider in accordance with the determination.

The organizations performing these arbitrations are known as IDRE's, short for Independent Dispute Resolution Entities. They cannot be affiliated with, or have any financial interest in, any insurer or healthcare provider. They must have expertise in healthcare billing, healthcare economics, and OON reimbursement. HHS must maintain a list of IDRE's, from which the participants in arbitration can choose an arbitrator.

The factors that can be considered by an arbitrator in a Federal IDR arbitration are:

1. The level of training, experience and education of the medical provider, including, with respect to facilities, whether the provider-hospital is a teaching facility,

2. The median INN rate, known as the QPA or Qualified Payment Amount,

3. The circumstances and complexity of the case,

4. The relative market shares of the parties,

5. Demonstrations of good faith attempts to enter into network agreements,

6. Prior contract rates between the parties.

Factors that cannot be considered are:

- Medicare and Medicaid rates,

- The medical provider's usual and customary charges.

Outside of the numerous disputes between the medical community and the insurance industry surrounding single claims, the NSA has sparked a number of lawsuits questioning CMS's interpretation of its provisions.

First, a lawsuit was instituted in a federal district court in Texas challenging CMS rules that afforded the QPA a "rebuttable presumption" in its favor. A rebuttable presumption is a legal term indicating a preference for something that can be changed only through evidence sufficient to overcome the presumption. The QPA is regarded by the medical industry as not very favorable because it supposedly represents the median INN rate carriers pay INN providers. But INN rates are often very low and use inputs that include Medicare and Medicaid, which are expressly prohibited. INN rates, the medical community argues, are often paid to young practitioners who believe they need to be INN to obtain patients and so many of those practitioners sign on with carriers at very low rates, as compared with more seasoned practitioners who remain ONN. To pay such practitioners who are doing ER call at median INN rates—not even the high end of INN rates—is a travesty. The Texas Medical Association, who was the plaintiff in the action, argued, moreover, that the NSA did not afford the QPA any preferential treatment above the other factors. The court agreed and vacated the rules affording the QPA the rebuttable presumption in its favor.

A second lawsuit brought by the TMA, known as TMA II, vacated the rules CMS promulgated in replacement of the first set of rules. These new rules were thrown out in February 2023, as still giving favorable treatment to the QPA in a manner not justified by the language in the NSA.

In August of 2023, two additional court rulings affected CMS's interpretation of the NSA. TMA IV, issued before TMA III, vacated a tremendous cost increase imposed by CMS, whereby the filing costs went from $50 to $350 on January 1, 2023 and the arbitrator fees were raised from roughly a range of $200 to $500 to more like $300 to $800, depending upon the IDRE. TMA IV also vacated a strange CMS interpretation of the law that would require arbitrations to be performed on a per-CPT-code basis, rather than a per-claim basis. This interpretation defied the way medical claim dispute resolution takes place across the country and for as long as these disputes have been around. CMS's interpretation was novel to say the least and bore all the indicia

of wanting to discourage these arbitrations. Fortunately, TMA IV threw out this per-Code requirement, and now a single arbitration can be conducted for all codes on a claim.

TMA III was decided shortly after TMA IV and vacated many of the inputs used by the carrier community in calculating the QPA amounts. The court determined that many of the inputs unfairly skewed QPA calculations in favor of the insurance carrier.

The result of the TMA decisions is that the Federal IDR process now seems to be positioned to function in the way the NSA anticipated. This is welcome news for the medical industry.

There are other lawsuits pending that concern peripheral matters. They include a challenge to the New York State Health Insurance Plan (NYSHIP) decision to "opt out" of the New York State IDR process for the Federal IDR process, even though the New York State law obviously applies to New York State employees and New York in all respects has jurisdiction over NYSHIP. This appears to be a cynical attempt on NYSHIP's part to opt into the Federal IDR process which is much more challenging for the medical community than the New York process. Indeed, in New York a medical provider has 3 years to take action, whereby the Federal IDR allows only 30 business days. Also, the New York IDR permits the arbitrator to review usual and customary charge data, which the Federal IDR prohibits. Thus far the courts have upheld NYSHIP's decision.

In addition, CMS takes the view that the Federal IDR does not address claim denials, only underpayments. Accordingly, denials are treated as ineligible by the IDR entities. This view does not seem to be consistent with the language of the NSA, which refers to both underpayments and denials. The NSA makes no distinction between the two in its reference to claims eligible for arbitration. It is likely that CMS's position in this regard will face a challenge in court.

One of the most recent developments in the federal arena is the application of the NSA to primary OON surgeons who perform elective surgeries at INN facilities. SBL's generally apply to ER procedures and inadvertent OON treatment at INN facilities, meaning ancillary OON service providers at INN facilities would be subject to the law, but not the primary surgeons. The primary surgeons were required to make certain disclosures to the patient to ensure the patient was aware of the provider's OON status, but the payment dispute would be governed by the health plan, not the SBL arbitration process. The language of the NSA does suggest that a condition precedent to recovery by a primary surgeon under the OON provisions of the health plan is effective disclosure to the patient of the financial ramifications of the OON treatment. As a practical matter, this controversy is likely to be rendered moot, because it is probable that health plans going forward will state expressly that OON surgeons will be reimbursed at the QPA under the NSA. OON reimbursement provisions that used to call for payment at either UCR rates or percentage-of-Medicare rates will likely now call for reimbursement at the QPA. What this seems to portend is that OON payment disputes, whether for ER, inadvertent or elective treatment, will be resolved in the Federal IDR.

The result of all of these developments could very well be that all OON payment disputes, whether involving ER, inadvertent or elective treatment, and whether it involves a payment denial or an underpayment, will be resolved in the Federal IDR process. This would mean the NSA procedural requirements would replace the appeal provisions in health plans and would effectively

negate the need for medical providers to obtain the health plans altogether. There would be no need for Assignments of Benefits, Powers of Attorney or other items typically required when medical providers seek additional reimbursement under health plans.

The Alaska SBL

The Alaska State SBL took effect July 1, 2017. *3 Alaska Admin. Code § 26.110(a*). The primary feature of the Alaska Law is a requirement that carriers maintain data as to charges on a geographic basis, which must be updated periodically, and that payments must reflect these geographic differences, and that payments can be no less than the 80th percentile of such charge data.

Regarding bifurcation, CMS recognizes:

> Alaska does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with the Alaska Division of Insurance staff, CMS understands that 3 Alaska Admin. Code § 26.110(a) is a specified state law that will apply for purposes of determining the out-of-network rate with respect to items and supplies furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Alaska by nonparticipating providers, nonparticipating emergency facilities or nonparticipating providers of air ambulance services. Therefore, the federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will not apply in those cases in Alaska.
> *CMS Letter to the Governor of Alaska dated February 15, 2022.*

The California SBL

The California State SBL took effect July 1, 2017. Like other State SBL's, the law protects patients from OON balance bills where the patient did not make a conscious decision to be treated by an OON provider. It is comprehensive in the sense that it not only protects patients but establishes a dispute resolution process as well. *Cal. Health and Safety Code § 1371.9 (2016)*. The reimbursement provisions of the California State SBL call for reimbursement for inadvertent OON services at the greater of 125% of Medicare or the average INN rate, and for emergency OON services at usual and customary rates or UCR, as per California case law.

Also, California does have an arbitration process at the state level. As per CMS,

> California does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with California Department of Insurance, Department of Managed Health Care, and Department of Health staff, CMS understands that Cal. Health and Safety Code §§ 1371.30, 1371.31, and 1371.9, and §§ 10112.8, 10112.81 and 10112.82(a) of the Insurance Code are specified state laws that will apply for purposes of determining the [OON] rate with respect to non-emergency services furnished to individuals in health care service plans (and their delegated entities) and certain health insurance plans in California by noncontracting individual health professionals at contracting health facilities.4 The [Federal IDR] process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the [OON] rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in California by nonparticipating providers and nonparticipating emergency facilities to which Cal. Health and Safety Code §§ 1371.30, 1371.31, and 1371.9, and §§ 10112.8, 10112.81 and 10112.82(a) of the Insurance Code do not apply. The [Federal IDR] process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the [OON] rate with respect to any services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in California by nonparticipating providers of air ambulance services. The California Department of Insurance and the Department of Managed Health Care will enforce the outcome of the [Federal IDR] process for such cases in California through a collaborative enforcement agreement.
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> *CMS Letter to the Governor of California dated December 22, 2021.*

The Colorado SBL

Colorado's SBL became effective January 1, 2020. The relevant provisions include: an arbitration process with a 90-day timeframe for taking action, and, depending upon the provider, reimbursement is tied to median INN rates and an All-Payor Health Claims Database (APCD). These databases typically use Medicare and Medicaid rates as inputs, and so Colorado's reimbursement rates in the SBL circumstances are sure to be relatively low. *See Colorado Revised Statutes 10-16-704.*

Regarding bifurcation, CMS gas stated,

> Colorado does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with Colorado Department of Regulatory Agencies and Colorado Department of Health Care Policy and Financing staff, and the Governor's office, CMS understands that C.R.S. § 10-16 704(3)(d)(II), §10-16-704(5.5), and § 10-16-704(15) are specified state laws that will apply for purposes of determining the out-of-network rate with respect to items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Colorado by nonparticipating providers or nonparticipating emergency facilities.4 The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to any services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Colorado by nonparticipating providers of air ambulance services. CMS will enforce the outcome of the federal independent dispute resolution process for such cases in Colorado. *Letter from CMS to Governor of Colorado, dated January 18, 2022.*

The Connecticut SBL

The Connecticut SBL became effective July 1, 2016. The relevant provisions include: reimbursement for OON ER services at UCR rates, and reimbursement for inadvertent OON services at INN rates. *See Connecticut General Statutes Section 38a-477aa.*

Regarding bifurcation, according to CMS,

> Connecticut does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response, CMS research, and CMS communications with the Connecticut Insurance Department and the Department of Public Health staff, CMS understands that CGS Sec. 38a-477aa, is a specified state law that will apply for purposes of determining the out-of-network rate with respect to certain health care services by out-of-network health care providers at an in-network facility or an out-of-network clinical laboratory upon referral of an in-network provider and emergency services furnished to individuals with coverage from health carriers in Connecticut. The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Connecticut by nonparticipating providers and nonparticipating emergency facilities to which CGS Sec. 38a-477aa does not apply. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Connecticut by nonparticipating providers of air ambulance services. Connecticut will enforce the outcome of the federal independent dispute resolution process for such cases in Connecticut under section 2799A-1(c) of the PHS Act. CMS will enforce the outcome of the federal independent dispute resolution process for such cases in Connecticut under section 2799A-2(b) of the PHS Act.
> *Letter from CMS to Governor of Connecticut, dated December 21, 2021.*

The Delaware SBL

The Delaware SBL became effective in 2016. The relevant provisions include: a requirement that carriers pay for OON ER services at "the highest allowable charge," with establishment of an arbitration process to resolve disputes and a 60-day timeline for pursuing arbitration. *Delaware Code Titles 18, Chapter 35.*

Regarding bifurcation, according to CMS,

> Delaware does not have an applicable All-Payer Model Agreement that would determine the out- of-network rate. Based on the survey response and CMS communications with Delaware Department of State Division of Professional Regulation, Delaware Department of Health and Social Services, and Delaware Department of Insurance staff, and CMS research, CMS understands that 18 Del. Code §§ 3349 and 3565 are specified state laws that will apply for purposes of determining the out-of-network rate with respect to covered emergency services furnished to individuals with certain health insurance coverage in Delaware by non-network providers. *Letter from CMS to Governor of Delaware, dated January 31, 2022.*

The Florida SBL

The Florida SBL became effective in 2016. The relevant provisions include:

1. **The Types of State Plans Subject to the Law.** In Florida, the law applies to Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans.

2. **Emergency and Inadvertent.** Florida's law applies to emergency services, as well as non-emergency services performed by an out-of-network provider at an in-network facility.

3. **Arbitration is Voluntary.** In case of a payment dispute Florida case law has determined that the "baseball-style" arbitration process is voluntary for both the carriers and the medical providers. So, if a medical provider brings an arbitration, the carrier can opt-out, forcing the provider to pursue a judicial remedy. A bill is pending before the Florida legislature that would do away with the voluntary nature of the arbitration process.

4. **Reimbursement is at UCR Rates.** Carriers are required to reimburse the medical provider at essentially UCR rates. The law requires carriers to pay the lesser of 1) billed charges, 2) UCR, or 3) agreed-upon reimbursement.

5. **Timeline for Filing.** A medical provider has 12 months to file for arbitration and under Florida regulations most providers have to object to a payment within 12 months. So, though there is a 4-year statute of limitations for statutory causes of action, 12 months is essentially the operative timeline for action by the medical provider, especially since objecting to the payment within 12 months is a condition precedent to the medical provider bringing the action..

   Florida Statute 627.64194.

Regarding bifurcation, according to CMS,

Florida does not have an applicable All-Payer Model Agreement that would determine the OON rate. Based on the survey response and CMS communications with the Florida Office of Insurance Regulation staff, CMS understands that Sections 408.7057, 627.42397, 627.64194(4), 627.64194(6), 641.513(5), and 641.514, F.S. and rule 59A-12.030, Florida Administrative Code are specified state laws that will apply for purposes of determining the OON rate with respect to items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Florida,

as well as claim dispute payment amounts pertaining to health maintenance organizations (HMO) that are above the claims payment thresholds described in the paragraph below, and by nonparticipating providers or nonparticipating emergency facilities. *Letter from CMS to Governor of Florida, dated January 28, 2022.*

The Georgia SBL

The Georgia SBL became effective January 1, 2021. The relevant provisions include:

- An Arbitration process with a 30-day deadline to act.
- A call for establishment of a GA All-Payor Claims Data Base (APCD)
- Standards of reimbursement for both emergency and inadvertent OON services that includes a review of:
    1) The verifiable median contracted amount paid by all eligible insurers,
    2) The most recent verifiable contracted amount between the provider and carrier,
    3) A higher amount if appropriate given the complexities of the case.
- Consideration of other factors, including proofs and UCR data,
- Permitting consolidation of claims,

.

- A requirement that the carrier give notice if a claim is governed by ERISA.

Georgia Code Titles 33, Section 33-20E.

According to CMS,

Georgia does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with Georgia Office of Insurance and Safety Fire Commissioner staff, CMS understands that OCGA 33-20E-8 is a specified state law that will apply for purposes of determining the out-of-network rate with respect to items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Georgia by nonparticipating providers, nonparticipating emergency facilities or nonparticipating providers of air ambulance services. Therefore, the federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will not apply in those cases in Georgia.
Letter from CMS to Governor of Georgia, dated December 13, 2021.

The Illinois SBL

The Illinois SBL became effective January 1, 2019. The relevant provisions include:

- What appears to be a 30-day timeline from the date of the EOB to negotiate and once it fails filing the arbitration. There seems to be no time limit stated for filing the arbitration after the 30-day period runs.

- Emergency and inadvertent OON services are both covered by the law.

- Arbitration is before AAA.

- No reimbursement standard is established but you can assume a "reasonableness" standard would apply. The QPA cannot be given preferential treatment above other considerations.

Illinois Insurance Code 215 ILCS 5/356z.22.

According to CMS,

> Illinois does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with the Illinois Department of Insurance staff, CMS understands that 215 ILCS 5/356z.3a is a specified state law that will apply for purposes of determining the out-of-network rate with respect to pathology, anesthesiology, neonatology, radiology, or emergency department services furnished to individuals enrolled in preferred provider organization (PPO) coverage in Illinois by nonparticipating providers at participating hospitals and ambulatory surgical treatment centers. The federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will apply for purposes of determining the out-of-network rate with respect to any items and services and nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services to which 215 ILCS 5/356z.3a does not apply. CMS will enforce the outcome of the federal independent dispute resolution process for such cases in Illinois.
> *Letter from CMS to Governor of Illinois, dated April 7, 2021.*

The Maine SBL

The Maine SBL became effective January 1, 2018. The relevant provisions include:

- A requirement that the provider be paid the greater of 1) the INN rate of the carrier, or 2) the average INN rate of all carriers from the state All Payor Claims Database (APCD).

- An IDR arbitration process for dispute resolution of claims between the provider and the carrier.

- A 30-day period to negotiate a resolution, starting presumably on the payment date.

- The ability of the arbitrator to consider the provider's level of training, previously contracted rates, UCR as determined by data from the APCD, and other factors.

Title 24-A, Maine Insurance Code, Chapter 56-A, §4303-C.

Regarding bifurcation, according to CMS,

> Maine does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with Maine Bureau of Insurance and the Maine Department of Health & Human Services staff, CMS understands that Title 24-A, Maine Insurance Code, Chapter 56-A, §4303-C is a specified state law that will apply for purposes of determining the out-of-network rate with respect to items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Maine by nonparticipating providers, nonparticipating emergency facilities or nonparticipating providers of air ambulance services. Therefore, the federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will not apply in those cases in Maine. *Letter from CMS to Governor of Maine, dated December 22, 2021.*

The Maryland SBL

The Maryland SBL became effective January 1, 2018. Maryland, thus far it seems, is the only state to employ an All-Payer Model Agreement to determine reimbursement to OON medical providers. Similar to states that employ APCD's, Maryland through the All-Payer Model Agreement considers Medicaid and Medicare payments as relevant inputs to what is fair and reasonable reimbursement. *Title 19, Subtitle 2, Part II (Health Care Facility Rate Setting) of Maryland's Health-General Article; § 14-205.2 of the Maryland Insurance Article.*

According to CMS,

> Based on the survey response and CMS communications with the Maryland Insurance Administration and the Consumer Protection Division of the Maryland Office of the Attorney General staff, CMS understands that Maryland has an applicable All-Payer Model Agreement that would determine the out-of-network rate for hospital services in Maryland (Title 19, Subtitle 2, Part II (Health Care Facility Rate Setting) of Maryland's Health-General Article). CMS understands that § 19-710.1 of the Health General Article also applies as a specified state law for purposes of determining the out-of-network rate with respect to covered services furnished to individuals in HMOs in Maryland by health care providers who are not under contract with the HMO. CMS also understands that § 14-205.2 of the Maryland Insurance Article is a specified state law that will apply for purposes of determining the out-of-network rate with respect to covered services furnished to individuals in EPOs or PPOs in Maryland by nonpreferred on-call and hospital-based physicians who accept assignment of benefits.4 The federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will apply for purposes of determining the out-of-network rate with respect to any items and services and nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services to which Maryland's All-Payer Model Agreement or specified state laws do not apply. The Maryland Insurance Administration will enforce the outcome of the federal independent dispute resolution process for such cases in Maryland. *Letter from CMS to Governor of Maryland, dated May 18, 2022.*

The Michigan SBL

The Michigan SBL became effective October 22, 2020. *MCL 333.24501 to MCL 333.24517 of the Michigan Public Health Code.* Two of the most relevant characteristics of the Michigan law are

- Reimbursement rates that vary depending upon the type of provider and the circumstances of the claim but are always tied to percentages of INN rates and Medicare rates.

- Arbitration is available to obtain a 25% bump up if complicating factors exist.

Regarding bifurcation, according to CMS,

> Based on the survey response and CMS communications with staff in the Michigan Department of Insurance and Financial Services (DIFS), the Michigan Department of Licensing and Regulatory Affairs (LARA), and the Michigan Department of Health and Human Services, CMS understands that DIFS will enforce sections 2719 (as applied by section 110 of the No Surprises Act), 2746 (other than section 2746(c)), 2799A-1, 2799A-2, 2799A-3, 2799A-4, 2799A-5, and 2799A-9 (other than section 2799A-9(a)(4)) of the PHS Act with respect to health insurance issuers; and LARA will enforce section 2799B-1 of the PHS Act with respect to health care providers.
> *Letter from CMS to Governor of Michigan, dated December 27, 2021.*

The Missouri SBL

The Missouri SBL became effective January 1, 2022. *Missouri Revised Statutes, Section 376.690.* The relevant provisions of the Missouri law:

- The carrier is required to pay "reasonable" reimbursement within 45 days.
- If the medical provider objects, they have 60 days to negotiate.
- There is an arbitration process, which must be initiated within 120 days of the end of the negotiation period.
- The process applies to emergency treatment **and does not include inadvertent OON treatment.**
- Claims can be consolidated.
- It is not baseball-style arbitration. The arbitrator can choose an amount between 120% of Medicare and the 70th percentile of an objective value for UCR.
- Several factors can be considered, including standard measures of UCR.

According to CMS,

> Missouri does not have an applicable All-Payer Model Agreement that would determine the [OON] rate. Based on the survey response and CMS communications with Missouri Department of Insurance staff, CMS understands that Section 376.690, Missouri Revised Statute (RSMo), is a specified state law that will apply for purposes of determining the [OON] rate with respect to unanticipated out-of-network care furnished to individuals with coverage from health carriers in Missouri by [OON] health care professionals at an [INN] facility.4 The [Federal IDR] process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the [OON] rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Missouri by nonparticipating providers and nonparticipating emergency facilities to which Section 376.690 RSMo does not apply. The [Federal IDR] process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the [OON] rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Missouri by nonparticipating providers of air ambulance services. CMS will enforce the outcome of the [Federal IDR] process for cases in Missouri.
>
> *Letter from CMS to Governor of Missouri, dated December 23, 2021.*

The Nebraska SBL

The Nebraska SBL became effective October 22, 2020. *Nebraska Revised Statutes 44-6849 and 44-6850.* The Nebraska Law essentially ties reimbursement to either INN rates or 175% of Medicare.

Regarding bifurcation, according to CMS,

> Nebraska does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with the Nebraska Department of Insurance staff, CMS understands that Nebraska Revised Statutes 44-6849 and 44-6850 are specified state laws that will apply for purposes of determining the out-of-network rate with respect to emergency services furnished to individuals in health benefit plans in Nebraska by out-of-network health care providers. 1 The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Nebraska by nonparticipating providers and nonparticipating emergency facilities to which Nebraska Revised Statute 44-6849 and 44-6850 do not apply. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Nebraska by nonparticipating providers of air ambulance services. The Nebraska Department of Insurance will enforce the outcome of the federal independent resolution process for cases in Nebraska through a collaborative enforcement agreement.
> *Letter from CMS to Governor of Nebraska, dated December 27, 2021.*

The Nevada SBL

The Nevada SBL became effective January 1, 2020. *Nevada Revised Statutes 439B.748, 751 and 754.* The relevant provisions of the Nevada law include

- A 30-day window to object to payment and go to arbitration.
- Absent recent contractual reimbursement rates (24 months for facilities and 12 months for practitioners), the standard of reimbursement is "fair and reasonable."
- Claims below $5,000 are arbitrated locally; claims above are before AAA.

Regarding bifurcation, according to CMS,

> Nevada does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with Nevada Department of Insurance staff, CMS understands that NRS 439B.748, 751 and 754 are specified state laws that will apply for purposes of determining the out-of-network rate with respect to medically necessary emergency services furnished to individuals in health benefit plans, the Public Employees' Benefits Program and other organizations under NRS 439B.736(1)(c) in Nevada by an out-of-network emergency facility or out-of-network provider. Specifically, NRS 439B.748 provides predetermined payment amounts to out-of-network emergency facilities for emergency services if the facility had a provider contract as an in-network emergency facility within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person. NRS 439B.751 provides predetermined payment amounts to out-of-network providers that provide emergency services if the provider had a contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person. NRS 439B.754 is a specified state law providing a method for determining the out of network rate when an out-of-network emergency facility did not have a contract 24 months prior to the rendering of the emergency services, an out-of-network provider did not have a contract 12months prior to the rendering of the emergency services, or if the third party that provides coverage for the covered person terminated the most recent applicable provider contract between the third party and the out-of-network provider for cause before it was scheduled to expire.4 The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Nevada by nonparticipating providers and nonparticipating emergency facilities to which NRS 439B.748, 751 and 754 does not apply. The federal independent dispute resolution process under

section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Nevada by nonparticipating providers of air ambulance services. CMS will enforce the outcome of the federal independent dispute resolution process for cases in Nevada. Patient.

Letter from CMS to Governor of Nevada, dated February 24, 2022.

The New Hampshire SBL

The New Hampshire SBL became effective July 1, 2018. *New Hampshire Revised Statutes Annotated Title XXX 329:31-b(III).* The relevant provisions of the New Hampshire law are:

- Reimbursement is to be at a "commercially reasonable value."
- Parties must use best efforts to resolve the dispute prior to arbitration, but no required timeline is stated.
- Good payment proofs can be considered in the arbitration process.

According to CMS,

> New Hampshire does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with the New Hampshire Department of Insurance staff, CMS understands that NH RSA Title XXX 329:31-b(III) is a specified state law that will apply for purposes of determining the out-of-network rate with respect to anesthesiology, radiology, emergency medicine, or pathology services furnished to individuals in a managed care plan in New Hampshire by a health care provider in a hospital or ambulatory surgical center that is in-network. 1 The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in New Hampshire by nonparticipating providers and nonparticipating emergency facilities to which NH RSA Title XXX 329:31-b(III) does not apply. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in New Hampshire by nonparticipating providers of air ambulance services. CMS will enforce the outcome of the federal independent dispute resolution process for such cases in New Hampshire.
> *Letter from CMS to Governor of New Hampshire, dated December 22, 2021.*

The New Jersey SBL

The New Jersey SBL became effective August 30, 2018. *N.J.S.A. 26:2SS-1 to -20.* The relevant provisions of the New Jersey law are

- Reimbursement is to be at a "reasonable" amount.
- The initiating party must object to the payment and file the arbitration within 60 calendar days of the payment.
- UCR data can be submitted and often is the prevailing position in arbitration.

According to CMS,

> New Jersey does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on CMS communications with New Jersey Department of Banking and Insurance staff, CMS understands that N.J.S.A. 26:2SS-1 to -20 includes a specified state law that will apply for purposes of determining the out-of-network rate with respect to out-of-network services rendered on an inadvertent and/or emergency or urgent basis to individuals covered under a health benefits plan issued in New Jersey by a New Jersey licensed or certified health care provider.4 The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in New Jersey by nonparticipating providers and nonparticipating emergency facilities to which N.J.S.A. 26:2SS-1 to -20 does not apply. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to any services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in New Jersey by nonparticipating providers of air ambulance services. New Jersey will seek voluntary compliance with the outcome of the federal independent dispute resolution process for such cases in New Jersey as laid out in the collaborative enforcement agreement mentioned above. If voluntary compliance is not reached, CMS will enforce the outcome of federal independent resolution process in New Jersey.
> *Letter from CMS to Governor of New Jersey, dated February 4, 2022.*

The New Mexico SBL

The New Mexico SBL became effective January 1, 2020. *New Mexico Statutes Annotated Section 59A-57A-1, et. seq 1978 and 13.10.16 and 13.10.33 NMAC.* The relevant provisions of the New Mexico law include:

- A standard of reimbursement at the 60th percentile of "the allowed commercial reimbursement rate" in the geographic area in the 2017 plan year as per a third-party benchmarking database approved by the state.

- A requirement that no reimbursement can be below 150% of the 2017 Medicare rate.

- There is an arbitration process with a 90-day timeline. *13.10.16 NMAC.*

According to CMS,

> New Mexico does not have an applicable All-Payer Model Agreement that would determine the [OON] rate. Based on the survey response and CMS communications with New Mexico Office of Superintendent of Insurance staff, CMS understands that Section 59A-57A-1, et. seq. NMSA 1978 and 13.10.33 NMAC are specified state laws that will apply for purposes of determining the [OON] rate with respect to emergency care provided by nonparticipating providers and nonemergency health care services furnished by a nonparticipating provider at a participating facility where the participating provider is unavailable, a nonparticipating provider furnishes unforeseen services, or a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to furnish the services furnished to individuals in group health coverage governed by the provisions of the Health Care Purchasing Act; individual health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978; multiple-employer welfare arrangements; group and blanket health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978; individual and group health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law; and individual and group nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law in New Mexico. The federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will apply for purposes of determining the [OON] rate with respect to any items and services and nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services to which Section 59A-57-4(B)(3)(d) NMSA 1978 and 13.10.33 NMAC do not apply. The Office of the Superintendent of Insurance will enforce the outcome of the independent dispute

resolution process for such cases in New Mexico, regardless of whether the state or federal process applies.
Letter from CMS to Governor of New Mexico, dated December 22, 2022.

The New York SBL

The New York SBL became effective in 2015. *Financial Services Law Article 6 and 23, NYCRR 400.* The relevant provisions of the New York law include:

- Reimbursement at a "reasonable" amount.
- A 3-year timeline from the date of payment to initiate arbitration.
- UCR data can be submitted and often is the prevailing position in arbitration.
- The medical provider's billed charge for a particular CPT code must remain the demand amount for that CPT code in arbitration.
- NYSHIP, the carrier for NY State employees has opted out of the state process, so, any claim disputes involving NYSHIP must be brought to the Federal IDR.

According to CMS,

> New York does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response, Part AA of Chapter 57 of the Laws of 2022, and CMS communications with New York Department of Financial Services and New York Department of Health staff, CMS understands that Financial Services Law Article 6 and 23 NYCRR 400 are specified state laws that will apply for purposes of determining the out-of-network rate with respect to certain items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in New York by nonparticipating physicians and providers at hospital facilities and ambulatory surgical centers, including when the patient received a referral and inpatient services which follow an emergency room visit, or at nonparticipating emergency facilities. Therefore, the federal independent dispute resolution process under sections 2799A-1(c) of the PHS Act and 45 CFR 149.510 will not apply in those cases in New York..
> *Letter from CMS to Governor of New York, dated July 29, 2022.*

The Ohio SBL

The Ohio SBL became effective April 1, 2021. *Ohio Revised Code 3902.50 – 3902.54.* The relevant provisions of the Ohio law include:

- A requirement that reimbursement for emergency and inadvertent treatment be at the greatest of 1) the median in-network rate, 2) the usual method used by the health plan to pay out-of-network providers, such as UCR, and 3) the Medicare rate.

- An arbitration process if after 30 days the parties cannot agree.

- Arbitration within 1 year of the service date.

- A provision allowing the bundling of up to 15 claims.

Regrading bifurcation, according to CMS,

> Ohio does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on CMS research and CMS communications with Ohio Department of Insurance staff, CMS understands that ORC 3902.50 – 3902.54 are specified state laws that will apply for purposes of determining the out-of-network rate with respect to emergency services and non-emergency services by nonparticipating providers at in-network facilities. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Ohio by nonparticipating providers of air ambulance services. The Ohio Department of Insurance will enforce the outcome of the federal independent dispute resolution process for such cases in Ohio.
> *Letter from CMS to Governor of Ohio, dated February 17, 2021.*

The Texas SBL

The Texas SBL became effective January 1, 2020. *Texas Insurance Code (TIC) Chapter 1467 and rules under 28 TAC Ch. 21, Subchapter PP.* The relevant provisions of the Texas law include:

- A timeline for filing arbitration by medical practitioners between 20 and 90 days from the date of receipt of the original EOB.

- A process of mediation (non-binding) for facilities. If no agreement is reached, a civil judicial action can be instituted.

- Reimbursement for emergency and inadvertent treatment tied to UCR, and the arbitrator can consider numerous factors, including complexity of the case, the provider's expertise, info from benchmark databases. These databases have included the 80th percentile of charge data as well as the 50th percentile of "allowed" data, which vary tremendously.

As for bifurcation, according to CMS,

> Texas does not have an applicable All-Payer Model Agreement that would determine the [OON] rate. Based on the survey response and CMS communications with the Texas Department of Insurance staff, CMS understands that Texas Insurance Code (TIC) Chapter 1467and rules under 28 TAC Ch. 21, Subchapter PP, are a specified state law that will apply for purposes of determining the [OON] rate with respect to emergency care provided in a hospital emergency room or a licensed free-standing emergency room, services provided by an [OON] facility-based provider in an [INN] facility, and [OON] diagnostic imaging or laboratory services that were performed in connection with [INN] care, for individuals in an PPO, EPO, or HMO fully insured commercial health benefit plan regulated by the Texas Department of Insurance in Texas, as well as the Texas state employee and retiree plans for employees of Texas state agencies and active and retired teachers. Under TIC 1467, Texas has two different independent dispute resolution processes that apply separately to health care facilities and health care providers that are not facilities. Mediation, addressed under TIC Chapter 1467, Subchapter B and rules in Division 2 of 28 TAC Chapter 21, Subchapter PP, applies to an [OON] facility. Arbitration, addressed under TIC Chapter 1467, Subchapter B-1 and rules in Division 3 of 28 TAC Chapter 21, Subchapter PP, applies to an [OON] provider who is not a facility.4 The [Federal IDR] process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the [OON] rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Texas by nonparticipating providers of air ambulance services.
> *Letter from CMS to Governor of Texas, dated January 25, 2022.*

The Virginia SBL

The Virginia SBL became effective January 1, 2021. *Sections 38.2-3445.01 through 38.2-3445.07 and 14 VAC 5-405-10 et seq.* The relevant provisions of the Virginia law include:

- Reimbursement to be at "commercially reasonable amounts," which is essentially UCR.

- If there is no resolution within a 30-day negotiation period that starts at the initial payment, either party can arbitrate within 10 days of expiration of the 30-day period.

According to CMS,

> Virginia does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with Virginia State Corporation Commission (SCC) Bureau of Insurance staff, CMS understands that sections 38.2-3445.01 through 38.2-3445.07 and 14 VAC 5-405-10 et seq are specified state laws that will apply for purposes of determining the out-of-network rate with respect emergency services provided to an enrollee, or nonemergency services provided to an enrollee at an in-network facility if the nonemergency services involve surgical or ancillary services provided by an out-of-network provider furnished to individuals in fully insured managed care plans issued or delivered in Virginia, including grandfathered plans. The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Virginia by nonparticipating providers and nonparticipating emergency facilities to which sections 38.2-3445.01 through 38.2-3445.07 and 14 VAC 5-405-10 et seq do not apply. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Virginia by nonparticipating providers of air ambulance services. CMS will enforce the outcome of the federal independent dispute resolution process for cases in Virginia.
> *Letter from CMS to Governor of Virginia, dated December 21, 2021.*

The Washington SBL

The Washington SBL became effective January 1, 2020. *RCW 48.49.030(2).* The relevant provisions of the Washington law include:

- Reimbursement is tied to UCR where several factors can be considered to determine what is "commercially reasonable."
- Arbitration is available when nothing is resolved after the 30-day negotiation period.
- Parties can consult the APCD.
- No timeline stated for instituting arbitration after the 30-day negotiation period runs.
- Notice requirements exist whereby the carrier must inform the provider the claim is subject to the NSA.

With respect to bifurcation, according to CMS,

> Washington does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response, CMS research, and CMS communications with Washington Office of the Insurance Commissioner and Department of Health staff, CMS understands that RCW 48.49.030(2) is a specified state law that will apply for purposes of determining the out-of-network rate with respect to emergency (screening and stabilization) services provided at a hospital; and non-emergency surgery, radiology, anesthesiology, pathology, hospitalist, or laboratory services provided by an in-network hospital or ambulatory surgical facility. The federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Washington and nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services to which RCW 48.49.030(2) does not apply. Washington Office of the Insurance Commissioner will enforce the outcome of the federal independent dispute resolution process for such cases in Washington.
> *Letter from CMS to Governor of Washington, dated December 21, 2021.*