Balance Billing: A Survey Report of Recent Efforts to Protect Consumers

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Introduction

Even the most diligent of savvy health care consumers can be hit with large bills from services rendered as a result of what is referred to as balance billing. For purposes of this report, balance billing is defined as the practice of a provider charging an enrollee the difference between the provider's fee and the sum of what the enrollee's health insurance company pays. There is another form of balance billing referred to as surprise balance billing, which refers to billing a consumer for the full charge of a service due to the fact that the provider is out of the enrollee's network, but providing care at an in-network facility.[1] Even when a consumer finds an in-network facility and confirms the coverage of services rendered as in-network, the consumer cannot reasonably be in control of all aspects of their care once at the facility. See *Figure 1* for more detail.

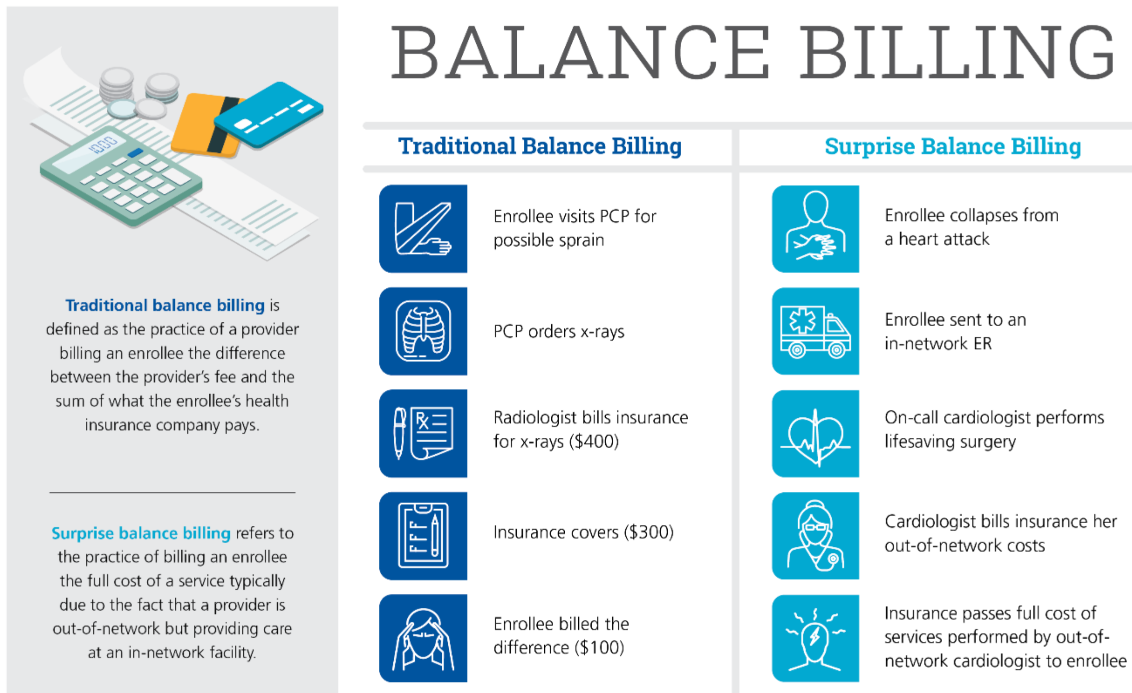

Figure 1: Definition of Balance Billing

States are taking action to protect consumers from the practice of balance billing. As of today, 21 states have some level of consumer protection from balance billing in place. In the sections to follow, we have included more details on the standards currently in place, as well as ongoing efforts in a number of states to enact balance billing legislation.

Insurance regulators are seeing an increase in consumer inquiries related to the practice of balance billing, especially as narrow networks are increasingly used to contain rising premiums costs. One regulator PCG interviewed for this report indicated that although this practice has been historically commonplace, recent reforms efforts have aimed to make consumers more educated about their care. At the same time, the regulations often don't do enough to protect smart health care users from medical debt that is potentially out of their hands, especially in an emergency department setting.

[1] Healthcare.gov defines balance billing as "When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered service."

For those states contemplating crafting consumer balance billing protections, this report aims to provide a landscape of the options available, with national models outlined, as well as pending and enacted legislation in a variety of states. See *Appendix A & B* for a comprehensive list outlining enacted and pending balance billing legislation by state.

National Models

National Association of Insurance Commissioners Model Act

The National Association of Insurance Commissioners (NAIC) released the Health Benefit Plan Network Access and Adequacy Model Act ("the Act") in 2015, which includes Section 7 entitled "Requirements for Participating Facilities with Non-Participating Facility Based Providers." The Act seeks to provide states with model language designed to protect consumers from unexpected medical bills that result from care provided by out-of-network providers. The Act contains multiple provisions designed to protect consumers, including suggestions for mandated provider contract language providing protection against balance billing in the event of a carrier or provider insolvency or operational shutdown. Providers must continue to render services without balancing billing until the termination of the consumer's coverage for those in active treatment, or until the conclusion of the carrier/provider contract period.

NAIC proposed to mandate that in the case of non-emergency services, in a participating facility, a facility must provide an out-of-network written disclosure notice and obtain consent from the consumer for the potential of out-of-network services and charges. Additionally, NAIC states that health carriers shall develop a written notice or disclosure to be provided at the time of pre-certification about the potential for costs incurred when a non-network provider renders care in a network facility.

For emergency services rendered out-of-network, NAIC proposes that the non-participating facility provider shall include a statement/billing notice that the consumer is responsible for the in-network share but has no legal obligation to pay the remaining balance (with suggested language include in Section 7, subsection C the Act), and should send the bill to their insurance carrier for consideration under the NAIC proposed Provider Mediation process (included in Section 7, Subsection G of the Act). Similar to the approach of states with comprehensive protections in place, the Act extends protection to the health insurance carrier and requires them to develop a payment plan for out-of-network facility-based provider payments, suggesting that the benchmark for non-participating payments is presumed reasonable "if it is based on the higher of the contract rate or a percentage of the Medicaid payment rate for similar services in the same geographic area." With a comprehensive proposed approach, many of the NAIC suggested protections have been adopted or are currently pending in state based legislation.

National Conference of Insurance Legislators Model Act

The National Conference of Insurance Legislators (NCOIL) is currently working on a model act entitled "Out of Network Balance Billing Transparency Act" ("the Act"). NCOIL currently has in place a Healthcare Balance Billing Disclosure Model Act, originally adopted in 2011, but the pending draft Model Act would represent a significant expansion of the topics addressed therein. The Act goes further than previously outlined approaches and proposes that all services rendered in the emergency setting are covered at an in-network provider rate. NCOIL proposes that the facility, provider and the health insurance carrier are all bound by notice requirements, and the Act contains many efforts aimed at greater network and price transparency.

Proposed Changes for Health Insurance Carriers

The Act outlines a multitude of notice requirements for health insurance carriers to include on their website; including, but not limited to; referral or preauthorization requests for services from an out-of-network provider when the network does not have a geographically accessible similarly-situated provider, a clear methodology of the reimbursement for out-of-network health care services, and the description of the amount the carrier will

reimburse for out-of-network services set forth as a percentage of the usual and customary cost for out-of-network services, examples of the anticipated out-of-pocket costs for frequently billed out-of-network health care services, and information that permits an enrollee to estimate the cost based on the proposed geographic location of the services to be rendered.

Similar to the standards set forth in the NAIC Act, NCOIL outlines that enrollees be provided, no later than 48 hours after pre-certification, an electronic or written communication that details; whether the enrollee's provider is a participating provider and in-network, whether the proposed non-emergency care is a covered benefit; what the cost will be for co-pays and deductibles, what co-insurance will be imposed based on the providers contract rate for in-network services or the usual and customary for out-of-network services (as outlined in Section 8 of the Act).

Proposed Changes for Providers

Putting the burden on providers, as well as facilities and carriers, NCOIL proposes that providers include in writing or on their website the list of health plans they participate in, as well as the hospitals they are affiliated with, and in non-emergency setting only, notice to the consumer prior to providing services that they are a non-participating provider and the amount they will bill or estimate of services upon request. Additionally, if coordination with other providers (for example; anesthesiologist, pathologist, radiologist) is required the provider should outline that other specialists or providers may be involved including names, and in what network the provider participates at the time of referral or upon coordination of the services.

Proposed Changes for Facilities

Lastly, facilities are urged to establish the facilities standard charge for items and services provided (in the non-emergency setting and post this publically along with the following; the networks in which the health care facility is participating, an explanation that physician charges may be separate from facility charges, that certain providers may not be in the same network as the facility, that an enrollee may be billed for the amount of what the non-participating provider charges and what the carrier pays, and that such charges may be the enrollee's responsibility. For those providers that commonly result in balance billing (anesthesiology, pathology, and or radiology), facilities are urged to list the facility employed or contracted providers, and how to determine network participation for said service providers.

Upcoming Movement on the NCOIL Model

The NCOIL Health, Long Term Care and Health Retirement Issues Committee will be meeting via conference call on October 13, 2017, to discuss the comments received from interested parties on the Act and to navigate a path towards adopting the Act. Adoption could come as soon as the NCOIL Annual Meeting in Phoenix, Arizona (November, 2017), or at its Spring Meeting in Atlanta, Georgia (March, 2017).

NCOIL has also expressed interest in promoting the use of a "baseball style" mediation process to solve balance billing disputes, similar to what is already in place in New York and pending in New Mexico. A "baseball style" mediation process refers to a process by which the provider and health plan each submit their best and final offer, and an independent reviewer then must select one of the two offers as final payment, consistent with certain guidelines. NCOIL believes that this approach, if setup and executed properly, can be more streamlined and help consumers more than other offered approaches because if each party knows there is a distinct possibility that they can lose outright, a strong incentive is created for the parties to negotiate and settle. NCOIL is also considering draft Model legislation that would involve a "baseball style" mediation process to help those consumers facing exorbitant balanced bills after receiving healthcare services from air ambulance providers.

Federal Protection for Marketplace Participants

The federal government has taken steps to protect consumers as well. For the past couple of years, the Centers for Medicare and Medicaid Services (CMS) has included notice requirements in regulations pertaining to the offering of plans on healthcare.gov. Currently, marketplace insurance carriers in some circumstances must

provide notice to enrollees 48 hours prior to likely out-of-network costs incurred at an in-network facility.

In the 2018 Letter to Issuers in the Federally-Facilitated Marketplace, CMS outlined new notice and payment provisions designed to protect consumers from balance billing. CMS detailed that carriers participating on the federal marketplace were required to count cost sharing paid for essential health benefits provided by an out-of-network provider at an in-network setting towards the in-network maximum out-of-pocket.

Additionally, CMS imposed notice requirements on the likely accumulation of out-of-network costs. CMS instructed carriers to provide written notice to consumers either 48 hours prior to the service being provided or within the carrier's typical prior authorization approval timeline.

The notice must state that "additional costs may be incurred for the EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing" so long as such notice is sent within the time included above. [2]

State Efforts to Protect Consumers

As previously mentioned, 21 states have state balance billing protections in place, but the level of protection varies from state to state. Currently, six states have what is categorized as a comprehensive approach meaning the protections extend to emergency and non-emergency department settings, apply to both HMO and PPO type plans, hold the consumer harmless and prohibit providers from billing in the first place, payment standards (limitations of what can be charged), and lastly dispute resolution. The remainders of the states with limited approaches to consumer protection include some of the following types of consumer protective measures; limit the protection to an emergency department setting only (aimed mostly to prevent surprise billing), limit to HMO only, one or both types of cost containment measures (hold consumer harmless or provider prohibition) and a payment protection or dispute resolution requirement. See *Appendix A & B* for more on efforts underway in a number of states that are working on legislation to enact balance billing consumer protections.

Comprehensive Approach

Six states are following a more comprehensive approach and have implemented protections that extend beyond emergency room protections to include provisions such as dispute resolution and balance billing cost containment. As shown in *Figure 2:* California, Connecticut, Florida, Illinois, Maryland and New York have implemented protections across categories in order to be able to protect consumers directly and in more than one setting.

The state of California has a long legislative history of protecting consumers against balance billing. The most recent developments include Assembly Bill (AB) 72 "Healthcare Coverage: Out-of-Network Coverage" an act that would require a health care service plan, contract or insurance policy to provide the same cost-sharing regulations for out-of-network providers as it does for in-network providers. This bill requires the establishment of a dispute resolution process as well.

New York's recent legislative action addressing surprise medical bills includes AB06669, "An Act to Require Notification of Out-of-Network Providers." This bill holds hospitals accountable for written notification to consumers indicating if treatment providers are in or out-of-network. Such notification must be made prior to rendering services. If the enrollee is unable to provide consent before receiving emergency services, this act requires that insurance carriers cover the costs of emergency services for out-of-network providers, while limiting the cost-sharing for the enrollee to be the same as an in-network provider.

[2] Full text included in the 2018 Letter to Issuers in the Federally-Facilitated Marketplace,

Limited Approach

Fifteen states have implemented protections for the emergency room setting, including hold harmless provisions for consumers in these situations.[3] Three states, Pennsylvania, New Mexico and Mississippi, are currently working on legislation to expand previously implemented consumer balance billing protections, as outlined in *Appendix A & B*.

Massachusetts

Massachusetts recently introduced legislation protecting enrollees from paying an out-of-pocket max for out-of-network providers greater than in-network providers. Senate Bill 526 "An Act Relative to Out-of-Network Services Provided by Emergency Medicine Clinicians" would require providers to bill insurance carriers for out-of-network services, and carriers to pay at a minimum the cost associated with the emergency services rendered. Several recent bills in Massachusetts prohibit providers from billing consumers directly, and must accept the rate paid by the carriers or the Medicaid reimbursement rate for such services.

New Jersey

New Jersey is taking a similar cost containment approach via Senate Bill 786 "Limits Payments Under Health Benefits Plans to In-Network Amounts in Certain Circumstances" requiring that out-of-network providers bill at the in-network provider rate, so long as that cost does not exceed 150 times the Medicaid rate for those services.

Maryland

Maryland's legislative actions have been more focused on emergency services and provisions around assignment of benefits (AOB). House Bill 1505 "Health Insurance-Assignment of Benefits and Reimbursement of Non-Preferred Providers-Modifications" amends language in previous balance billing legislation. This act requires all on-call and out-of-network hospital staff to submit a claim for AOB 24 hours prior to providing services (excluding emergency services) with failure to do so resulting in the enrollee being held harmless for such services.

Pennsylvania

Pennsylvania has two bills that address balance billing pending, Senate Bill 678 and House Bill 1553. SB. 678 "An Act Providing for the Protection of Consumers of Health Care Coverage Against Surprise Balance Bills for Emergency Services and Certain Covered Health Care Services" prohibits providers from balance billing patients who received emergency services by an out-of-network provider in an in-network facility. HB. 1553, the "Surprise Balance Bill Protection Act" protects consumers from being balance billed for emergency services provided by an out-of-network provider/facility and from non-emergency services in an in-network facility provided by an out-of-network provider. The house bill further prevents the out-of-pocket max from exceeding what the enrollee would be expected to pay for an in-network provider. Lastly, like the protection included in the NCOIL model act, this bill requires notification of an out-of-network provider being included in the patient's treatment plan for both non-emergency and emergency services.

New Mexico

New Mexico has also drafted a more comprehensive version of the "Surprise Billing Protection Act" (HB313), which would follow the same guidelines as Pennsylvania's "Surprise Billing Protection Act" but would also require a dispute resolution process and the establishment of penalties for violators.

[3] As outlined in *Appendix A & B,* these include**:** Colorado, Delaware, Indiana, Iowa, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont and West Virginia**.**

Mississippi

Lastly, Mississippi has drafted legislation focusing on notifying patients if the doctor rendering services is out-of-network. House Bill 603 "An Act to Require Certain Consumer Information Concerning Facility-Based Physicians and Notice and Availability of Mediation for Balance Billing" requires that mediation be made available for balance billing if the person's out-of-pocket costs exceeds $250 after the deductible, cost-sharing and co-pays.

Upcoming Legislative Efforts

Many states are currently exploring how to best protect consumers from balance billing, and we are focusing on two in particular that are actively pursuing initial legislative protection (with a larger outline included in *Appendix A & B*). Washington and Oklahoma are in the legislative drafting process, and are attempting to protect consumers while simultaneously reducing the out-of-pocket costs associated with services rendered by an out-of-network physician.

Washington state has drafted HB2114 "Protecting Consumers from Charges for Out-of-Network Health Services" which prohibits providers from balance billing patients for services rendered in an in-network hospital, regardless of the providers' affiliation. The bill would also limit the amount an individual spends on cost-sharing to be equal to the costs associated with an in-network provider. Washington is working to pass several similar bills in order to better address balance billing in the state.

Oklahoma is working towards passing HB2216 "Insurance; Requiring Contracted Hospital or Inpatient Facility to Provide Certain Notice to Enrollee; Notice, Estimate and Disclosure by Non-contracted Providers" which would require the hospital or facility that is providing the services to provide a notice that includes: the providers' affiliation, whether the carrier chooses to accept the assignment of benefits or balance bill a patient for services, and a quote of the estimated costs to the individual.

Current legislative efforts across states demonstrate a changing landscape for consumer protections. States seeking to draft legislation to protect against balance billing should consult the national models mentioned above. Furthermore, information regarding current state efforts against balance billing can be found in more detail in *Appendix A and B*.

Challenges & Lessons Learned

In a 2016 report by the Kaiser Family Foundation entitled *"The Burden of Medical Debt: Results from the Kaiser Family Foundation/NYT Medical Bills Survey,"* [4] a quarter of U.S adults aged 18-64 reported problems paying medical bills, with out-of-network charges noted as a contributing factor. Two-thirds of the respondents indicated that the main cause of medical bill problems were one time medical expenses, like a hospital stay or accident, and it's those instances for which protections against balance billing could make a real difference.

The challenge is finding a way to do so that takes into consideration all the parties to the issue of balance billing. With options from simple emergency room protections to full prohibitions, methods for dispute resolution, and notice requirements the range between approaches is vast. States need to look closely at the practice among providers in their state and most common causes of balance billing, while learning from states that have restrictions currently in place.

The practice of balance billing and resulting surprise medical debt is not going to self-correct. States need to take preemptive action to protect consumers while balancing the interests of the facilities, providers and the insurance industry.

[4] https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf

Appendix A

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	Setting		Type of Managed Care Plan		Type of Protection		State Specific Method of Payment	
States with a Comprehensive Approach	**Emergency Department**	**Nonemergency Case in Network Hospital**	**HMO**	**PPO**	**Hold Harmless**	**Provider Prohibition**	**Payment Standard**	**Dispute Resolution Process**
California	✔	✔	✔	✔ [a]	✔	✔	✔	✔
Connecticut	✔	✔	✔	✔	✔	✔	✔	
Florida	✔	✔	✔	✔	✔	✔	✔ [b]	✔
Illinois	✔	✔	✔	✔	✔ [c]	✔ [d]		✔
Maryland	✔	✔	✔	✔	✔ [e]	✔ [d]	✔ [e]	
New York	✔	✔	✔	✔	✔	✔ [d]	✔	✔
States with a Limited Approach								
Colorado	✔	✔	✔	✔	✔			
Delaware	✔ [f]		✔	✔	✔	✔		✔
Indiana	✔		✔		✔	✔		
Iowa	✔		✔	✔	✔			
Massachusetts		✔	✔	✔	✔			
Mississippi	✔	✔	✔	✔	✔	✔ [d]		
New Hampshire	✔	✔	✔		✔			
New Jersey	✔	✔	✔	✔	✔			
New Mexico	✔		✔	✔	✔			
North Carolina	✔		✔	✔	✔			
Pennsylvania	✔		✔	✔ [g]	✔			
Rhode Island	✔	✔	✔		✔			
Texas	✔	✔	✔ [h]		✔			
Vermont	✔		✔	✔	✔			
West Virginia	✔		✔		✔			

Appendix B

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States	Type of Approach	Name of Bill	Status	Summary	Date of Last Action	Link	Setting		Type of Carrier		Type of Protection			State Specific Method of Payment			Personnel	
							ER	ER & Non-ER	HMO	PPO	Hold Harmless	Notice Requirement	Provider Prohibition	Payment Standard	Dispute resolution Process	Assign Benefits	Clinician	Other
California	Comprehensive	(AB72)Health care coverage: out-of-network coverage	Enacted	This bill would require a health care service plan contract or health insurance policy on or after July 1, 2017, to provide the same cost-sharing for an out-of-network provider as an In network-provider. Also the department and the commissioner would be required to each establish, by September 1, 2017 a dispute resolution process.	9/23/2016	http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72		Receives covered services at a in-network health facility				If the provider collects funds exceeding the established costs- they must provide a notice and refund to the insurer or insured			To be established by Sept 1, 2017		If the provider is out-of network	
California	Comprehensive	(SB538) Hospital contracts.	Pending	This act requires that no hospital contract, health care service plan or insurer shall set payment rates or other terms for out-of-network affiliates.	7/7/2017	https://legiscan.com/CA/text/SB538/2017								Hospitals can't set rates for out of-network affiliates				Hospital contracts with plan, contracting agency, or insurer
New York	Comprehensive	(AB06669) (AB06119)An Act to Require Notification of Out-of-Network Providers	Pending	This bill would require hospitals to inform emergency room patients whether the doctors they are seeing are covered under their plan, and would require insurance companies to cover the out-of-network cost for a patient who is in emergency care and unable to provide consent.	1/06/2016 2/23/2017	http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A06119&term=2017&Summary=Y	full coverage if patient can't provide consent					Provide notice if provider is not covered in the insurance plan					Out-of-network provider giving services in an in-network hospital	
New York	Comprehensive	(AB07107) Assignment of Benefits	Pending	This bill would require health insurers to give covered patients the option to assign the payment of emergency services to an out-of-network provider	4/10/2017	http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A07107&term=2017&Summary=Y&Memo=Y	Emergency Services					Provide Health Insurance Claim form to give patient the option				Allow a consumer to assign benefits to an out-of-network provider		
New York	Comprehensive	(AB03526) (SB03118) Notification of Out-of-Network Provider Used In Rendering Services	Pending	An act to require notification to a patient, prior to a procedure, if the doctor being used to provide services is out-of-network and not covered by the insurers plan. If such notice is not provided it requires the insurance company to cover all out-of-network costs.	1/06/2016 1/19/2017	http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=S03118&term=2017&Summary=Y		Applies to procedure, test or surgery			Failure to notify/ full coverage of services	Notification of out-of-network physician used in procedure					Out-of-network provider included in procedure	
New York	Comprehensive	(SB06363) Amends Language for Dispute Process	Pending	This bill would include hospitals in the language for dispute process for charges incurred during emergency services. (Prior to this bill, an individual could be held harmless from emergency services bills from a non-participating physician)	5/11/2017	http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=S06363&term=2017&Summary=Y	Emergency Services				From Surprise Bills				Includes Hospitals into dispute process			Physician + Hospital
Massachusetts	Limited	(SB526) An Act Relative to Out-of-Network Services Provided by Emergency Medicine Clinicians	Pending	An act requiring emergency room clinicians to bill the insurance company for out-of-network services, and the insurance carrier needs to pay at the minimum the emergency medicine services benefit. The insured shall no the held financially responsible.	5/2/2017	https://malegislature.gov/Bills/190/S526	Emergency Services						Must not bill or hold the insured accountable	Carriers must pay minimum emergency services benefit ($1,500)			Specific to ER Clinician Billing	
Massachusetts	Limited	(SB603) An Act Relating to Equitable Provider Reimbursement	Pending	This bill would require insurance companies to cover out-of-network costs for emergency room services at a rate equal to the rate paid by Medicaid, having the insurer only pay an out-of-pocket max that would be identical to that incurred if the services were provided by an in-network clinician.	5/3/2017	https://malegislature.gov/Bills/190/S603		Services rendered by an out-of-network physician	Includes MCO		Only responsible for deductible, co-pays, coinsurance of the same amount as in-network				Prohibited from seeking reimbursement from patient		Clinician Billing	
Massachusetts	Limited	(SB522) An Act Reducing the Financial Burden of Surprise Medical Bills for Patients	Pending	This bill would require the insurance carrier to cover the at minimum out-of-network provider rate for emergency services. The act prohibits providers from billing the insured directly(except for co=pays, deductibles and coinsurance).	5/2/2017	https://malegislature.gov/Bills/190/S522		Emergency facility that is out-of-network or services from an out-of-network provider in an in-network facility			If provider fails to do an eligibility check/gain consent	Perform an eligibility check/ provide written notice of out-of-network/obtain consent in writing	Can only collect co-payment, coinsurance or deductibles	Non-participating provider rate				Provider + carrier
Massachusetts	Limited	(HB2188) An Act Relating to Equitable Provider Reimbursement	Pending	This bill would require an out-of-network provider to accept a rate equal to the rate paid by Medicaid for emergency services that have were pre-approved by an MCO. Also the out-of-network provider cannot Bill the insurer directly.	5/2/2017	https://malegislature.gov/Bills/190/H2188	Emergency Services		MCO prior-approval of emergency services				Can only collect co-payment, coinsurance or deductibles	If pre-approval -must accept rate paid by Medicaid for same/similar services- if not : non-participating provider rate				Provider + carrier
Massachusetts	Limited	(HB2164) An Act to Ban Hospital Facility Fees and Surprise Billing	Pending	This bill requires carriers to pay for the out-of-network provider rates for the emergency services. The insurer is to be held harmless and can assign benefits for out-of-network provider services to the carrier and thus cannot be billed directly.	5/2/2017	https://malegislature.gov/Bills/190/H2164	Emergency Services				Only responsible for deductible, co-pays, coinsurance of the same amount as in-network	Provide an out-of-network written disclosure prior to procedure	Can't bill insured outside of "harmless requirements"	Carrier pays out-of-network rate		If they chose to assign to out-of-network - paid the out-of-network rate		
Massachusetts	Limited	(HB848) An Act to Ensure Rate Equity and Cost Savings (HB1014) An Act to Promote Affordable Health Care	Sent to Study	This bill would require all health care providers who provide out-of-network services to any person covered under a contract with a Risk-Bearing Provider Organization to provide such services at the reimbursement rate and may not balance bill the patient for such services.	3/28/2016 9/26/2016	https://malegislature.gov/Bills/189/H1014												
Massachusetts	Limited	(HB4348) An act Relative to Equitable Health Care Pricing	Enacted	This bill requires that health care providers accept payment by a carrier and may not balance bill the insurer for any amount beyond that which is paid by the carrier.	5/31/2016	https://malegislature.gov/Bills/189/H4348												
New Jersey	Limited	(SB1511) Tiered Network	Pending	This bill requires that in the case that a health benefits plan has a tiered network, in the event that an insured receives emergency services, the insurer cannot be billed by the facility or professional a rate that exceeds the lowest cost-sharing amount.	2/16/2016	https://legiscan.com/NJ/bill/S1511/2016	Emergency Services				Responsible for lowest cost-sharing amount applicable to preferred tier		Can't bill insured outside of "harmless requirements"	Tired basis				Provider + Carrier
New Jersey	Limited	(AB1952) Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act several versions of this are pending (SB1285)	Pending *Amendment passed	This bill states that unless a covered person has specifically asked for an out-of-network provider, the person cannot be charged an out -of-pocket max that is greater than an in-network provider rate.	6/29/2017	https://legiscan.com/NJ/text/A1952/2016		Includes non-emergency procedures			co-pays etc.	Provide information on in/out of network providers	Can't bill insured outside of "harmless requirements"					Provider + Carrier
New Jersey	Limited	(AB4956) " " (SB3299) Requires Providers, Carriers and Employers to make Certain Disclosures Regarding Health Care Costs	Pending	Requires health care facilities to disclose if a provider is out-of-network and not covered prior to non-emergency services.	6/08/2017 6/26/2017	https://legiscan.com/NJ/text/S3299/2016						Provide in writing or on the internet a lists of in-network prior to services						Provider + Carrier
New Jersey	Limited	(SB786) Limits Payments (AB1664)	Pending	This bill states that in the event that a patient receives emergency services the provider shall not bill the insured an amount greater than the costs from an in-network provider. If the services are rendered by an out-of-network provider the carrier shall not be charged more than 150 times the Medicaid rate for that service.	1/12/2016 1/27/2016	https://legiscan.com/NJ/bill/S786/2016	Emergency Services				co-pays etc.		Can't bill insured outside of "harmless requirements"				Out-of-network	
New Jersey	Limited	(AB2935) requires In-Network Hospitals to Notify Patients of Out-of-Network Health Care Professionals who Provide Services in Hospital	Pending	This bill would require an in-network hospital to provide notice (in writing) if the provider rendering the services is out-of-network.	2/16/2016	https://legiscan.com/NJ/text/A2935/2016		Specifies Services in hospitals				Hospitals provide notice if out-of-network provider						Hospitals

Maryland	Limited	(SB1121)(HB1376) Health Insurance- Coverage of Air Ambulance Transport Services	Pending	This bill would require that a carrier to provide coverage for air transport. If the providers giving care during air transport are out-of-network the insured must be held harmless for the amount of the balance bill.	3/14/2016	http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&stab=01&id=sb1121&tab=subject3&ys=2016rs	Air Ambulatory Transport				if out-of-network- held harmless of balance bill							Carriers
Maryland	Limited	(HB1505) (SB335)Health Insurance-Assignment of Benefits and Reimbursement of Non-preferred Providers-Modifications	Pending	This bill modifies the language around consumer protection against balance billing. It includes all out-of-network on-call and hospital-based health care practitioners rather than only physicians. The Bill requires providers to submit a claim for AOB 24 hours prior, except in emergency circumstances, and failure to do so prohibits the provider from billing the insured.	2/15/2016 3/29/2016	http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&stab=01&id=hb1505&tab=subject3&ys=2016rs		Covered Services		AOB under a PPO	co-pays etc.		If insured provides AOB can't bill outside of "harmless requirements"	If AOB insurer must provide at most 140% of the average rate that a carrier paid in the same geographic location		Must allow for out-of-network provider		All on-call hospital based personnel
Maryland	Limited	(HB0800)	Withdrawn?	This bill would require carriers(HMO, Dental etc.) to pay an amount at least/equal to 140% of the Medicaid rate for covered services provided by an out-of-network provider	3/17/2016	http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&stab=03&id=HB0800&tab=subject3&ys=2016rs												
Washington	Upcoming	(HB2114) Protecting Consumers from Charges for Out-of-Network Health Services (SB5654)	Pending *the first is further along (50% progress)	This bill states that an out-of-network provider may not balance bill an insured person for: emergency services , non-emergency services in an in-network hospital, services rendered by an out-of-network provider in the absence of an in-network one. The out-of-network cost must not exceed that of an in-network provider.	6/21/2016 6/21/2017	https://legiscan.com/WA/text/HB2114/2017		Emergency facility that is out-of-network or services from an out-of-network provider in an in-network facility			co-pays etc.	Before provider bills- obtain written explanation of benefits from carrier	Can't collect outside of in-network cost-sharing expectations					Carrier + Provider
Washington	Upcoming	(SB5619)(HB1117) Addressing Health Care Services Balance Billing	Pending	This bill states that an out-of-network provider may not balance bill an insured person for: emergency services , non-emergency services in an in-network hospital, services rendered by an out-of-network provider in the absence of an in-network one. The out of pocket costs must not exceed that of an in-network provider.	6/21/2017	https://legiscan.com/WA/bill/SB5619/2017	Emergency facility that is out-of-network or E. services from an out-of-network provider in an in-network facility				co-pays etc.	Before provider bills- obtain written explanation of benefits from carrier	Can't collect outside of in-network cost-sharing expectations					Carrier + Provider
Washington	Upcoming	(HB2447) Addressing Emergency Health Care Balanced Billing	Pending	An act to protect covered individuals from surprise billing following emergency services rendered by an out-of-network provider. (Similar to previous two).	3/10/2016	http://app.leg.wa.gov/billsummary?BillNumber=2447&Year=2015	Emergency services				co-pays etc.	Before provider bills- obtain written explanation of benefits from carrier	Can't collect outside of in-network cost-sharing expectations			Out-of-network		Carrier + Provider
Oklahoma	Upcoming	(HB2216) Requiring Contracted Hospital or Inpatient Facility to Provide Certain Notice	Pending	This bill would require a hospital or facility to provide notice of out-of- network services and whether the carrier choses to balance bill or not for the non-emergency services, and provide the estimated quote	3/28/2017	https://legiscan.com/OK/bill/HB2216/2017		covered services				Provide notice of out-of-network, estimate of costs, decision to balance bill					out-of-network provider	
Pennsylvania	Upcoming	(SB678) An Act providing for the protection of consumers of health care coverage against surprise balance bills for emergency services and certain covered health care services.	Pending	This bill protects the insured from balance billing as a result of emergency services provided by an out-of-network facility or clinician	5/5/2017	http://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2017&sind=0&body=S&type=B&bn=0678		Emergency facility that is out-of-network or services from an out-of-network provider in an in-network facility			If submits surprise bill form to insurer - held harmless except for in-network cost-sharing	Provide written disclosure of out-of-network prior to procedure			After form is filed if the carrier and insurer can't come to an agreement on payment	Only if no surprise billing		Carrier + Provider
Pennsylvania	Upcoming	(HB1553) Surprise Balance Bill Protection Act	Pending	This bill protects the insured from balance billing as a result of emergency services provided by an out-of-network facility or clinician. This bill also requires that the insurer be notified of out-of-network services and that the maximum out-of-pocket amount spent by the insurer must not exceed that of an in-network provider. In the case that it does, the carrier is responsible for refunding the money to the insurer.	6/16/2017	http://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2017&sind=0&body=H&type=B&bn=1553		Emergency facility that is out-of-network or services from an out-of-network provider in an in-network facility			If submits surprise bill form to insurer - held harmless except for in-network cost-sharing	Provide written disclosure of out-of-network prior to procedure			After form is filed if the carrier and insurer can't come to an agreement on payment	Only if no surprise billing		Carrier + Provider
New Mexico	Upcoming	(HB 313) Surprise Billing Protection Act	Pending	This act would protect a covered individual from surprise billing from out-of-network providers, require dispute resolution, and establish penalties. It would require the carrier to cover emergency services regardless of affiliation. The out-of-pocket costs for the insured must not exceed that of an in-network provider and thus the carrier cannot bill for an amount exceeding this.	2/2/2017	https://nmlegis.gov/Legislation/Legislation?Chamber=H&LegType=B&LegNo=313&year=17		Emergency facility that is out-of-network or services from an out-of-network provider in an in-network facility. Or if medically necessary and no other provider is available			If submits surprise bill form to insurer - held harmless except for in-network cost-sharing							Carrier + Provider
Mississippi	Upcoming	(HB 603) Notification	Pending	This bill requires notification of services/costs rendered by an out-of-network provider. If services provided by an out-of-network provider exceeds $250 after deductibles, cost-sharing and co-pays the insured can request mediation for balance billing	1/13/2017	http://index.ls.state.ms.us/isysnative/UzpcRG9jdW1lbnRzXDIwMTdccGRmXGhiXDA2MDAtMDY5OVxoYjA2MDNpbi5wZGY=/hb0603in.pdf#xml= http://10.240.72.35/isysquery/irl72ca/1/hilite		Services rendered by an out-of-network physician			co-pays etc.	Provide notice of out-of-network, estimate of costs, and explanation of mediation process			If the out-of-pocket costs exceeds $250 can request mediation for balance billing		out-of-network provider	

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