**ACEP/EDPMA Joint Task Force (JTF)**

**Model Clinician Out-of-Network (OON) Legislation**

1. **Definitions**:
	1. **“Clinician(s)”**: Shall be defined as a physician or advance practice provider, including but not limited to a physician assistant, nurse practitioner, certified registered nurse anesthetist and certified nurse midwife (“Advanced Practice Provider”).
	2. **“Clinician’s Allowed Charge”**: Shall be defined as the Clinician’s Usual and Customary Charge after the discount applied under a Clinician’s contractual arrangement with an Insurance Carrier (if contracted) or the amount of the allowed benefit if the Clinician is out of network. The Clinician’s Allowed charge constitutes the Clinician’s contractually adjusted total expected payment for a professional service (if contracted).
	3. **“Clinicians’ Usual and Customary Charge”**: Shall be defined as the charges routinely billed by Clinicians’ for their professional services regardless of payer involved and before any discounts that are applied pursuant to charity or indigent Patient charge policies or Insurance Carrier contracting discounts. Absent other considerations (e.g., in network services) the usual and customary charge constitutes the Clinician’s total expected reimbursement for a service.
	4. **“Guarantor”:** Shall be defined as the person who is financially responsible for the professional services rendered to the Patient by the Clinician. The Guarantor may also be the Patient. However, when the Patient is a minor, the Guarantor is the minor’s parent or guardian; for purposes of this model language, “Patient” and “Guarantor” will be synonymous.
2. **“Guarantor Co-Insurance”:** Shall be defined as the percentage of the Clinician’s charge for professional services that the Guarantor is financially responsible for reimbursing directly to the Clinician who rendered the professional services pursuant to the terms of the contractual arrangement between the Guarantor and the Insurance Carrier.
3. **“Guarantor Co-Payments”:** Shall be defined as the amounts that are the Guarantor’s responsibility for professional services received from the Clinicians, as dictated by the terms of the contractual arrangement between the Guarantor and the Insurance Carrier. Co-pay amounts may be stated as a percentage, as in the case of co-insurance, or may be stated as a flat rate for services on the Patient’s insurance card (e.g., $50 co-pay for ED services).
4. **“Guarantor Cost Sharing”:** Shall be defined as used in the Affordable Care Act (ACA) to describe the combination of the Guarantor Deductible amount, Co-Insurance percentage, and Co-Payment amount that are the responsibility of the Guarantor for a Clinician’s professional services. Guarantor Cost Sharing for OON Services shall be limited to the amount and/or the percentage that the Patient would have reimbursed the Clinician for In-Network services.
5. **“Guarantor Deductible”:** Shall be defined as the Guarantor’s financial responsibility for the Clinician’s charges that is applied to the Clinician’s Usual and Customary charges before applying either co-insurance or co-payments.
6. **“Insurance Carrier”**: Shall be defined as an insurance company, health care center, health services corporation, medical services corporation, fraternal benefit society or other entity that issues for delivery, renews and/or amends a health care plan in the state, including but not limited to preferred provider organization and/or third party administrators who provide administrative services to any of the foregoing; [Potential alternative language: shall be defined as an individual or group plan that provides or pays the cost of medical care as such term is defined under 42 U.S.C. §300gg-91(a)(2).]
7. **“Insurance Carrier Out of Network Allowable” or “Insurance Carrier OON Allowable”**: Shall be defined as the benefit amount that the Carrier assigns for the service rendered by a Clinician that has not entered into a contractual arrangement with the Insurance Carrier that insures the Patient.
8. **“In Network Services”:** Shall be defined as professional services provided to Patients by Clinicians who have contracted with the Insurance Carrier that insures the Patient.
9. **“Mediation”**: Shall be defined as the process to mediate claims disputes between Insurance Carriers and Clinicians that are conducted outside of a formal court process as further described under Section VI below. Mediation shall not be legally binding unless the parties have mutually agreed in writing to resolve their dispute per a settlement agreement. Nothing here shall be construed as barring any parties’ right to pursue any legal remedy otherwise authorized under this model legislation except where parties’ have agreed not to sue pursuant to a settlement agreement.
10. **“Medicare Physician Fee Schedule (MPFS)”:** Shall be defined as the fee schedule modified and published annually by the Centers for Medicare and Medicaid (CMS) for professional services rendered by Clinicians that are subject to multiple federal statutes and regulations and budgetary constraints that have an impact on the changes in the fee schedule year to year.
11. **“Minimum Benefit Standard”** **(MBS):** Shall be defined as an amount equal to the eightieth (80th) percentile of a geographically comparable database of Clinician Usual and Customary Charges maintained by an independent non-profit organization that is not affiliated, financially supported and/or otherwise supported by an Insurance Carrier (e.g. FAIR Health); The MBS shall not be linked to, defined in whole or in part as or otherwise referenced to the MPFS.
12. **“Opt Out Services”:** Shall be defined as OON Clinician Services in Inpatient Hospital (POS 21) or Outpatient Hospital (POS 22) where the Patient is provided written notice at least twenty four (24) hours in advance, which includes a written disclosure of OON Charges and that the patient consents in writing to be treated by an out of network provider and will be financially responsible for OON Services (“Notice and Consent” as defined below). Opt Out Services shall not include POS 23, emergency department.
13. **“Place of Service (POS) 21, Inpatient Hospital”:** Shall be defined as a facility, other than a psychiatric facility, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
14. **“Place of Service (POS) 22, Outpatient Hospital”**: Shall be defined as a portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
15. **“Place of Service (POS) 23, Emergency Department”**: Shall be defined as a portion of a hospital where emergency diagnosis and hospital treatment of illness or injury is provided.
16. **“Out of Network Balance Billing” or “OON Balance Billing”:** Shall be defined as the amount of the Clinician’s Usual and Customary Charge that remains after the Insurance Carrier determines the Insurance Carrier OON benefit and Guarantor Cost Sharing amount.
17. **“Out of Network Services” or “OON Services”:** Shall be defined as a Clinician’s professional services provided to Patients where the Clinicians are not contracted with the Patient’s Insurance Carrier.
18. **“Patient”:** the recipient of the Clinician’s professional services.

**II. Payment to Providers Directly**

If OON Services are provided to a Patient by a Clinician, such Clinician shall bill the Patient’s Insurance Carrier directly and the Insurance Carrier shall reimburse the Clinician for the professional services as coded and billed by the Clinician.

**lll. Cost sharing**

* 1. Insurance carriers shall not apply deductibles and co-insurance for non-elective services.
	2. The Insurance Carrier shall adjudicate the Guarantor’s claim for OON Services at the Guarantor’s In-Network benefits levels and the Guarantor’s Cost Sharing for OON Services shall be limited to the amount that the Guarantor would have reimbursed the Clinician for In-Network services for elective and non-elective services.

**lV. The Minimum Benefit Standard (MBS) for OON Services**

1. The allowed out-of-network benefit shall be reimbursed at an amount that is not less than the Minimum Benefit Standard for Clinicians as defined in Section (**l) (n)**: Minimum Benefit Standard” (MBS ) as an allowed amount equal to the eightieth (80th) percentile of a geographically comparable database of Clinician Usual and Customary Charges maintained by an independent non-profit organization that is not affiliated, financially supported and/or otherwise supported by an Insurance Carrier (e.g. FAIR Health);
2. The MBS shall not be linked to, defined in whole or in part as or otherwise referenced to the Medicare Physician Fee Schedule (MPFS).
3. Clinicians shall be prohibited from submitting a claim and/or charges for OON Services and/or OON Balance Bills to the Guarantor if the Clinicians’ Place of Service (POS) code is 21, 22 or 23, provided that the Minimum Benefit Standard (MBS) has been reimbursed to the Clinician by the Insurance Carrier and provided that the Guarantor has not Opted Out of these protections for POS 21 and 22 pursuant to these provisions;
4. **Opt Out Services for Non-Emergency based care:**
	1. Except for Clinician Services provided in POS 23 emergency department, Clinicians providing Services shall not be prohibited from OON Balance Billing provided the following Guarantor notice provisions are provided and written Guarantor consent is obtained as provided herein (“Notice and Consent”).
	2. Clinicians shall be prohibited from OON Balance Billing except where Notice and Consent is obtained from the Guarantor pursuant to these provisions for POS 21 and 22 and except as noted in Subsection (V.)(a) above;
	3. Notice and Consent for Opt Out Services shall be obtained at least twenty four (24) hours in advance of the provision of OON Services, and the Clinicians’ Notice shall be in advance of the Guarantor’s admission;
	4. The Clinician shall provide in the Notice a disclosure of OON charges that shall explain the Guarantor’s OON benefit and cost sharing to the extent known to the Clinician;
	5. The Clinician shall not be reimbursed for more than the total disclosed OON charges in the Notice unless there are unforeseen circumstances not anticipated at the time of Services, except as provided below;
		1. Exception for Time Based Services: Time based charges for surgeries or procedures shall be reimbursed by the Insurance Carrier at rates based on the actual procedure time; however, the Guarantor’s cost sharing shall remain as above at the in-network rates for these OON services.
	6. If there are disputes regarding the OON charges that arise out of unforeseen circumstances, either the Clinician or Guarantor may institute mediation pursuant to the provisions below.
	7. If Notice and Consent is not obtained pursuant to these provisions for POS 21 and 22, the Clinician shall be prohibited from OON Balance Billing the Guarantor provided that he/she is reimbursed the Minimum Benefit Standard as stated above.
5. **Mediation**
	1. Mediation may be initiated by the Guarantor provided that the amount in controversy per Current Procedural Terminology (CPT) code is $1000 or more (“Mediation Threshold), and further provided that the Insurance Carrier either did not reimburse at or above the MBS or the Guarantor “opted-out” as provided above in V. The Mediation Threshold shall be calculated net of the Insurance Carrier’s OON Allowable and after deducting the Guarantor’s Cost Sharing.
	2. The Clinician may initiate mediation if the Insurance Carrier does not reimburse the MBS to the Clinician as required above but shall be barred from submitting OON Balance Bills to the Guarantor prior to the completion of the mediation process.
	3. The Clinician may initiate mediation if the Clinician believes that the Minimum Benefit Standard does not properly recognize the Clinician’s training, qualifications and length of time in practice, the nature of the services provided, the Clinician’s Usual and Customary Charges and for Clinicians practicing in the same geographic area, and other aspects of the Clinicians’ practice that may be relevant to the value of the Clinician’s OON services. Clinicians who have been found in violation of these provisions shall not have the right to initiate mediation pursuant to Section VIII below.
	4. Unless otherwise agreed to by the parties’ in a settlement agreement, nothing contained herein shall be construed as a waiver of the right to sue.
	5. The Guarantor or Clinician may initiate the mediation process by providing written notice of the dispute to the Insurance Carrier and the entity that will determine the mediation process.
	6. Mediation resolution shall be within thirty (30) days of the date the mediation request is received by Insurance Carrier from the patient and the state regulatory agency or its designee shall determine the mediation process.
	7. Clinicians shall be permitted to bundle similar claims and/or claims presenting common issues of fact and/or law can be bundled together and adjudicated in one mediation process to promote speedy dispute resolutions;
	8. The mediation official may select from either party’s proposal but shall not create their own reimbursement rate.
	9. The Medicare Physician Fee Schedule (MPFS) shall not be used as a reference point for mediation process as the MPFS is recognized as statutory and regulated fee schedule subject to budgetary and policy limitations established by Congress and Center for Medicare and Medicaid Services.
	10. The Guarantor and/or Clinician shall retain whatever rights if any under existing law to file administrative complaints or cases with appropriate state regulatory officials where the amount in controversy is less than $1000 or the complaint arises out of alleged regulatory non-compliance by the Insurance Carrier.
6. **False or Misleading Statements in Insurance Carrier explanation of benefits (EOBs):** Insurance Carriers shall not state, communicate and/or include in written form false, misleading and/or confusing information in their explanation of benefits (EOBs) to Patients and/or Guarantors regarding Clinician Usual and Customary Charges, OON Balance Billing and/or mediation disputes between Clinicians and Insurance Carriers.
7. **Enforcement for non-compliance by Insurance Carriers or Clinicians:**
	1. Clinicians shall be prohibited from submitting a claim or charges for OON Services and/or OON Balance Bills to the Guarantor except as provided above for Opt Out Services;
	2. Clinicians that engage in a pattern and practice of regularly sending or communicating OON Balance Bills to Patients in violation of these provisions, except for cases of excusable neglect, shall lose the right to file mediation demands under provisions of this law.
	3. Insurance Carriers that are in violation of these provisions may be subject to sanctions, penalties and other corrective actions by the appropriate insurance regulator.