#

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

***As of December 22, 2016***

***(Redline reflects discussions at the ACEP, ASA, EDPMA & PFC meeting***

***Nov. 30, 2016 in Dallas, TX and PFC workgroup discussions of Dec. 9, 2016)***

1. **Premises and Guiding Principles:**
	1. **Executive Summary of the Redlined Changes vs. 12/3/16 Draft:**
		1. **This draft addresses the surprise billing situation in several contexts and based on discussions of the PFC workgroup;**
		2. **First, for any Patient services in the ED place of service (POS 23), there is an absolute ban on OON balance billing provided the minimum benefit standard (MBS) of 80th percentile of Fair Health is reimbursed to the Clinicians; if the MBS is not reimbursed, the Clinician shall be barred from balance billing the Guarantor but may initiate mediation against the Insurance Carrier; the Guarantor “cost sharing”, e.g. co-insurance and/or deductible, shall be reimbursed to the Clinician by the Insurance Carrier and then billed to the Guarantor by the Insurance Carrier.**
		3. **Second, for services in place of service 21 (inpatient hospital) or 22 (outpatient hospital), there is also a ban on OON balance billing provided that the MBS is reimbursed and where there was not an “opt out” by the Patient pursuant to the required “Notice and Consent” to be financially responsible for OON services;**
		4. **Using the CA AB 72 concepts, there is an “opt out” for patients treated in POS 21 and 22 provided that the “Notice and Consent” conditions listed below are met including the 24 hour prior notice requirement; certain hospital based and outpatient services may or may lend themselves to the opt out provisions. The situations where the patient is provided Notice and Consent and agrees to be financially responsible for an OON balance bill are not “surprise billing” situations and AB 72’s provisions have been modified below;**
		5. **Clinicians in other places of service, e.g. physician’s offices, are not addressed in the model provisions as these are not the “surprise billing” situations that cause the most concern. The focus here as with most of the state laws that address OON balance billing is on “facility” or “hospital based” clinicians and emergency care situations.**
		6. **Mediation by the Patient or Clinician would be very rarely needed except when the Clinician’s actual OON charges are impacted by unforeseen circumstances that were not known when the estimated OON charges were provided to the Patient as part of the Notice and Consent for the “opt out”. Mediation could also be initiated by the Clinician if the Insurance Carrier does not reimburse the MBS as required by the law.**
		7. **Mediation would also be permitted where the Clinician believes that the MBS is not sufficient and has the opportunity under the “Gould Criteria” to argue for higher reimbursement from the Insurance Carrier. The Patient’s cost sharing would not be impacted as the model language would require that the Patient’s out of network cost sharing be the same as their in network cost sharing.**
	2. By “Model Legislation” we mean optimum legislation. Stakeholders at the state level may have to compromise on several of the major issues noted below. As with the American College of Emergency Physicians (ACEP)/Emergency Department Practice Management Association (EDPMA) Joint Task Force (JTF) Strategies White Paper, Physicians for Fair Coverage (PFC) understands that deference to these state level stakeholders is required in these areas.
	3. PFC believes strongly that the issues must be framed to indicate that Insurance Carriers are narrowing networks, the vast majority of Patients do not understand their insurance coverage, and with the high deductible plans of today that Patients are essentially self-insured outside of a major hospitalization or an extensive procedure.
	4. Insurance Carriers should be required to reimburse clinicians the Patient’s co-insurance, deductible and/or co-pay (collectively “Patient cost sharing”) and that the Insurance Carrier should collect the same directly from the Patient.
	5. In that Fair Health is a widely recognized independent and verified database of over 20 Billion claims, the Fair Health 80th percentile standard should be the Minimum Benefit Standard (MBS) under the law as it is both transparent to all stakeholders and removes the Patient from potential reimbursement disputes between the Clinicians and Insurance Carriers. Fair Health was also cited in comparison to all other known alternatives as the most comprehensive and transparent benchmark for OON reimbursements by the University of Chicago’s 2014 report (NORC report), when CMS requested the University to analyze potential databases, both commercial and non-profit.
2. Mediation cannot be solely initiated by the Insurance Carrier.
3. Finally, PFC believes that OONML should not be coupled with provisions addressing “network adequacy” for several reasons:
	* 1. Many states have existing laws on network adequacy and the issue is that these laws are not enforced by regulators;
		2. The ACA’s network adequacy provisions are general and have no specific requirements or enforcement regime to ensure that networks are in fact adequate;
		3. In the past two years of the ACA, networks have become more narrow despite year-over-year (YOY) premium increases that have averaged 25-30% per year; and,
		4. “Network adequacy” provisions if coupled with OONML could result in Clinicians being penalized by Insurance Carriers for failing to go In-Network and at unfair network reimbursement rates (“coercive contracting”).
		5. “Network adequacy” provision also may result in hospitals leveraging those requirements against hospital based Clinicians by insisting that they accept unfair network reimbursement rates.
4. **Format:** the OONML will be followed by explanatory notes (Annotations) regarding the purpose, origins in current or pending legislation, and/or reference to stakeholder documents.
5. **Definitions** *(modified from the ACEP/EDPMA JTF Strategies White Paper, May, 2016*):
	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 midwives (“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 payment for a service.
		1. **Annotations**: Also sometimes referred to as the Clinician’s Actual Charge. Note: avoid the terms “usual, customary and reasonable charges or amounts”: also known as the “UCR”, this concepts dates back to when Medicare reimbursed physicians (in the pre-physician fee schedule days) on a percentage of their UCR. Insurance Carriers prefer to include the word “reasonable” to the “usual and customary” term to permit them to determine, in their sole discretion, if the charges are reasonable or not. As was stated recently in the Center for Consumer Information and Insurance Oversight (CCIIO) explanation for the final rule, the Insurance Carriers would like to move the definitions away from “usual and customary charges” to “usual and customary amounts”. By shifting the focus away from what Clinicians charge to all Patients and payers regardless of Insurance Carrier or status—their “usual” and “customary” charges—the Insurance Carriers again introduce unilateral judgment over how the “usual and customary amount” for a particular service should be determined. In short, Clinicians do not know the “amounts” for other Clinicians—only the Insurance Carriers know the amounts for other Clinicians—and the substitution of “amounts” for “charges” reflects that the Insurance Carriers seek to have sole discretion to determine “reasonable amounts.”
	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.
6. **“Guarantor Co-Insurance”:** Shall be defined as the percentage of the Clinician’s charge for professional services that Guarantor is financially responsible for reimbursing directly the Clinician who rendered the professional services pursuant to the terms of the contractual arrangement between the Guarantor and the Insurance Carrier.

iv. **Annotation:** For example, in Medicare Part B, the Patient’s co-insurance, after applying the deductible, is 20% of the Medicare allowable charge (e.g., if $1000 is the charge, and $800 is allowed by Medicare, then the Patient’s co-insurance is $160, or 20% of the $800 Medicare allowable charge). Co-insurance terms are defined in the Patient’s insurance agreement with his/her respective Insurance Carrier.

1. **“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).

v. **Annotations:** Co-payments are sometimes paid to and collected by the facility at the time of service. Co-payment terms are defined in the Patient’s insurance agreement with his/her respective Insurance Carrier.

1. **“Guarantor Cost Sharing”:** Shall be defined as used in the Affordable Care Act (ACA) to describe the combination of the Guarantor Deductible, Co-Insurance and Co-Payments or those amounts 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 that the Patient would have reimbursed the Clinician for In-Network services.
2. **“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.

vi. **Annotations:** For example, a $1000 charge with a $700 allowable charge and $500 deductible would result in $500 of the charges applied to the deductible (Patient responsibility), $140 applied to the co-insurance amount (presuming 20% of $700 – the Patient’s responsibility), $60 paid by the plan, and the $300 remainder billed to the Patient as a “balance bill” IF the Clinician was OON and balance billing of the claim was not restricted by state law. The deductible amounts are defined in the Patient’s insurance agreement with his/her respective Insurance Carrier.

1. **“Insurance Carrier”**: 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).]

ii. **Annotations:** The Connecticut law was used as a reference but uses the terms “health carrier.” That term was avoided as the Medicare Part B contractors were for decades known as “Carriers” until they were renamed to be “Medicare Administrative Contractors or MACs”.

1. **“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.

iii. **Annotations:**  This OON benefit amount may be less than the benefit that the Insurance Carrier will allow for in network service.  Insurance Carriers may use this lower OON benefit as an incentive for Patients to utilize in network Clinicians. In certain OON circumstances, Insurance Carriers may refuse to recognize the Patient’s signed “assignment of benefits” to the Clinician, and send the OON allowable benefit amount (less coinsurance and deductible payments) to the Patient instead of directly to the Clinician.  Insurance Carriers may use both tactics to try to coerce Clinicians to contract with the plan.  Plans should honor assignment of benefits, and base their OON benefits on Clinicians' usual and customary charges for these services.  Since contracted Clinicians discount their services to the plan in exchange for contract considerations, like faster payment, plans should be reimbursing higher, not a lower, benefit for OON services.

1. **“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.
2. **“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 III 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 sue except where parties’ have agreed not to sue pursuant to a settlement agreement.
3. **“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.
4. **“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; The MBS shall not be linked to, defined in whole or in part as or otherwise referenced to the MPFS.
5. **“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, a written disclosure of OON Charges and consents in writing to be treated by and financially responsible for OON Services (“Notice and Consent” as defined below). Opt Out Services shall not include POS 23, emergency department. ,
6. **“Place of Service (POS) 21, Inpatient Hospital”:** shall be defined as a facility, other than psychiatric, 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.
7. **“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.
8. **“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.
	1. **Annotations:** The POS definitions above are quoted directly from CMS and as they appear in CPT. POS codes are required under the HIPAA Transactions and Code Set Standard Regulations by Clinicians who code and bill for their professional services to all payor who accept and receive electronic transactions via the ANSI 837-P or CMS 1500 claim form. The POS codes are a perquisite for reimbursement of Clinicians’ services.
9. **“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.

vii. **Annotations:** For example, assume a Clinician’s $1000 actual charge and the Insurance Carrier’s OON allowable is $450. The Patient would be responsible for paying the “balance bill” or a total of $550. If the Patient’s co-insurance payment for the ED Clinician’s services is 20% of $450 or $90, and the plan pays $360 ($450 OON allowable less the $90 co-insurance), then the Actual Charge ($1000) minus the Patient’s cost sharing (co-insurance of $90) leaves $640 ($1000 charge less the OON allowable of $360) as the OON balance billing amount. Although the $90 co-insurance payment can be billed, certain states restrict the right of the Clinicians to bill the $550 remainder and would require that this remainder be written off. If the same facts are present as noted above, but the Patient was In-Network, the issue of OON balance billing usually doesn’t arise due to prospective contractual adjustment arrangements between the Insurance Carrier and the Clinician.

1. **“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.

viii. **Annotations:** Pursuant to the Patient’s health insurance policy, the co-insurance percentage for elective OON services is generally greater than for in network services, but per the ACA, Patient cost-sharing for emergency care must be the same for In- and Out-Of-Network services. Some Insurance Carriers specify different benefit amounts for In-Network and OON services. If the benefit amount is less, the Patient in turn is responsible for a greater portion of the unpaid balance after the OON allowable is applied. Some states restrict the right of the Clinicians to bill the Patient for the remaining balance of the charges after the OON allowable and Patient cost sharing are applied.

1. **“Patient”:** the recipient of the Clinician’s professional services.
2. **The Minimum Benefit Standard (MBS) for OON Services** (*the material in quotes is suggested OONML language; the annotations follow*):
	1. “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;
	2. Insurance Carriers, as the owners of the insurance policies, shall reimburse directly to the Clinician all applicable charges for OON Services within thirty (30) calendar days of the submission of claim by the Clinician;
	3. Insurance Carriers shall reimburse the Guarantor’s Cost Sharing amount directly to the Clinician and the Insurance Carriers may subsequently bill the Guarantor for the applicable Guarantor Cost-Sharing amount;
	4. 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 amount that the Guarantor would have reimbursed the Clinician for In-Network services;
	5. Guarantor Deductible for OON services shall be applied by the Insurance Carrier to Guarantor’s in-network deductible;
	6. Insurance Carriers shall reimburse OON Services at an amount not less than the Minimum Benefit Standard for Clinicians in the same health care specialty.
	7. 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;
	8. 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.
	9. The non-profit organization and database upon which the Minimum Benefit Standard is based shall not be affiliated, financially supported and/or otherwise supported by an Insurance Carrier;
	10. The Clinician’s Usual and Customary Charges shall be the charges submitted to Medicare for the rolling twelve (12) months prior to the effective date of these provisions, subject to annual healthcare CPI adjuster”;

ix. **Annotations:** The provisions above are adopted in part from the Connecticut (CT) law that applies the MBS only to ED services; the proposed OONML expands the MBS to POS 21 and 22. As with the CA law AB 72, there is an opt out as explained further below that permits the Clinician and Guarantor to opt out of the OON balance billing restrictions. The opt out addresses the “surprise billing” situation by requiring 24 hour advance notice, written estimate of charges and signed Guarantor consent in advance of services. The services as “coded and billed” is to protect against potential “downcoding” or “payable diagnosis lists” that have been used in the past by payers. Requiring the Insurance Carriers to reimburse the Patient’s cost sharing directly to Clinicians was adopted and promoted by the FL-ACEP (FCEP) and WA-ACEP state chapters, respectively, and was strongly supported by PFC. Likewise, the generic description of the non-profit entity, e.g. Fair Health, was taken from WA-ACEP and from the CT law that requires that the non-profit entity not be affiliated with an Insurance Carrier; see CT Senate Bill No. 811. It is also believed that using “Medicare charges” in the Fair Health database would be more appealing and understandable to legislators.

1. **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 a. above;
	3. Notice and Consent for Opt Out Services shall be obtained at least twenty four (24) hours in advance 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, 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, that 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.”

**Annotations:** The foregoing provisions are conceptually based on California’s recently enacted AB 72. That law addresses the “surprise bill” situation in the non-emergency context and provides essentially an opt-out of the law’s restrictions on OON balance billing where the Patient/ Guarantor is provided the legally required notice and written consent. Emergency services (POS 23 are never subject to an “Opt Out” by the Patient—these services would always be subject to an OON Balance Billing restriction. AB 72’s minimum benefit standard (MBS) provisions were changed in the proposal above as the CA law ties the MBS to the greater of the in network rates (which Clinicians would not know but for disclosures by the health plans) and 125% of Medicare. As stated above, the Medicare fee schedule should never serve as the basis for an MBS.

1. **Mediation:**
	1. “Mediation may be initiated by the Guarantor provided that the amount in controversy per Current Procedural Terminology (CPT) code is $500 or more (“Mediation Threshold); 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 MBS is not reimbursed pursuant to the requirements above by the Insurance Carrier.
	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 V 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 $500 or the complaint arises out of alleged regulatory non-compliance by the Insurance Carrier.”

**Annotations:** The foregoing was referenced to provisions in the TX state law, the ACEP/EDPMA JTF Strategies White Paper and the WA-ACEP Balanced Billing / Surprise Coverage Proposal. The factors listed in c. above are taken from the so-called “Gould Criteria” in California and are published by the CA Dept. of Managed Health Care as factors used to determine if Insurance Carriers reimburse “reasonable and customary” amounts to Clinicians. The adoption of the 30 day resolution and bundling of claims are expressly intended to disincentive Insurance Carriers from unnecessary and lengthy mediation tactics.

1. **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.”

xi. **Annotations:** Insurance Carriers have in the past used misleading statements in their EOBs to Patients for OON reimbursements, claiming that they have paid “XX%” of Medicare and have paid the providers fairly or the “usual, customary and reasonable” payment. The plans have instructed Patients to involve the plans if the Patients are in turn sent an OON balance bill and that the plans will address issues with the providers. When providers attempt to engage Insurance Carriers, the plans indicated that providers are OON and the plans will not communicate with the providers or their representatives. ACEP has, with the support of an ED group, challenged and successfully settled disputes with the Insurance Carriers over misleading EOBs, through the “compliance dispute” process established by the Thomas/Love class action cases filed by the AMA and select state medical societies.

1. **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.”

xii. **Annotations:** States vary greatly in terms of which medical board and regulatory agency has jurisdiction over non-compliance issues. The key for Clinicians is to avoid CT’s language that sets up a potential litigation trap for Clinicians who may have an OON bill sent to a Patient and then find themselves in potential treble damages and attorney fees litigation for “false and deceptive” trade practices. Medical boards have existing infrastructure to address physician group practices that are alleged to be in violation of the law and the state department of insurance could also have co-jurisdiction for enforcement over both Insurance Carriers and Clinicians.