

APPENDIX

State	Payment standard
California	<p>For emergency services, insurer must reimburse the reasonable and customary value for health care services based on statistically credible information that is updated at least once a year and which takes into consideration the following factors:</p> <ul style="list-style-type: none"> • provider’s training, qualifications and length of time in practice • nature of services provided • fees usually charged by the provider • prevailing provider rates in the same geographic region • other relevant aspects of the economics of the provider’s practice, and • any unusual circumstances in the case. <p>The state also has a voluntary, nonbinding dispute-resolution process for emergency services, but it is rarely used.</p> <p>For nonemergency services provided by out-of-network providers at in-network facilities, insurers must reimburse the greater of:</p> <ul style="list-style-type: none"> • 125% of Medicare or • average contracted rate for that health plan and for that region. The Department of Managed Health Care has developed a methodology to determine the average contracted rate based on the above specifications. <p>The state also has a dispute-resolution process in place for out-of-network care at in-network facilities if the regular process for applying the payment standard fails in some way.</p>
Colorado	<p>For services provided by out-of-network providers at in-network facilities, the insurer must reimburse the greater of:</p> <ul style="list-style-type: none"> • 110% of the insurer’s median in-network rate of payment for that service in the same geographic region, or • 60th percentile of the in-network rate of payment for the same service in the same geographic area for the prior year based on commercial claims data from the all-payer health claims database to be created by the state. <p>For services provided by out-of-network facilities not operated by the Denver Health and Hospital Authority, the insurer must reimburse the greater of:</p> <ul style="list-style-type: none"> • 105% of the insurer’s median in-network rate of payment for that service provided in a similar facility or setting in the same geographic area, or • the median in-network rate of payment for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the all-payer health claims database to be created by the state. <p>For services provided by out-of-network facilities operated by the Denver Health and Hospital Authority, the insurer must reimburse the greater of:</p> <ul style="list-style-type: none"> • the insurer’s median in-network rate of payment for the same service provided in a similar facility or setting in the same geographic area • 250% of Medicare payment rate for the same service provided in a similar facility or setting in the same geographic area, or • the median in-network rate of payment for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the all-payer health claims database to be created by the state. <p>The above payment rates only apply if the provider/facility submits a claim to the insurer within 180 days of receiving insurance information. If a claim is submitted after the 180-day period, the insurer is only required to reimburse the provider/facility 125% of the Medicare payment rate for the same services provided in the same geographic region.</p> <p>A provider/facility that finds the payment rate to be insufficient given the complexity and circumstances of the services provided is allowed to initiate binding arbitration</p>

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Connecticut	<p>For emergency services, insurer must reimburse the greatest of:</p> <ul style="list-style-type: none"> • the amount the plan would pay for such services if rendered by an in-network provider • the usual, customary and reasonable rate for such services (80th percentile of all charges for the particular service performed a provider in the same specialty in the same geographical area as reporting in a benchmarking database maintained by a nonprofit organization picked by the Insurance Commissioner), and • the Medicare payment rate. <p>For nonemergency services provided by out-of-network providers at in-network facilities, the insurer must reimburse the out-of-network provider at the in-network rate under the health plan as payment in full unless the insurer and provider agree otherwise.</p>
Florida	<p>For PPOs, state payment standard applies to 1) emergency services, and 2) nonemergency services provided by out-of-network providers at in-network facilities. Any dispute with respect to payment according to the payment standard as described below must be resolved either through the courts or through a voluntary dispute resolution process.</p> <p>For HMOs, state payment standard only applies to emergency services but the state also has a voluntary claim dispute resolution process in place.</p> <p>Where a payment standard applies, the insurer or HMO must reimburse the lesser of:</p> <ul style="list-style-type: none"> • the provider's billed charges • the usual and customary provider charges for similar services in the community where services were provided, or • the charge mutually agreed to by the insurer and provider within 60 days of claim submittal.
Maryland	<p>For PPOs, the insurer is required to reimburse:</p> <ul style="list-style-type: none"> • on-call physicians within 30 days of the receipt of claim no less than the greater of: <ul style="list-style-type: none"> – 140% of the average rate insurer paid in the previous year for the same covered service in the same geographic region to similarly licensed in-network providers, or – the average rate the insurer paid in 2009 for the same covered service in the same geographic region to similarly licensed out-of-network providers inflated by the change in Medicare Economic Index from 2010 to current year. • hospital-based physicians within 30 days of the receipt of claim no less than the greater of: <ul style="list-style-type: none"> – 140% of the average rate insurer paid in the previous year for the same covered service in the same geographic region to similarly licensed in-network hospital-based physician providers, or – the final allowed amount the insurer paid in 2009 for the same covered service inflated by the change in Medicare Economic Index from 2010 to current year to the hospital-based physician billing under the same federal tax ID number the physician used in 2009. <p>For HMOs, the insurer is required to reimburse:</p> <ul style="list-style-type: none"> • a hospital at the rate approved by the Health Services Cost Review Commission • a trauma physician providing trauma care at the greater of: <ul style="list-style-type: none"> – 140% of Medicare rate for the same covered service by a similarly licensed provider, or – the rate as of 01/01/2001 that the HMO paid for the same covered service in the same geographic region to similarly licensed providers • any other health care providers: <ul style="list-style-type: none"> – For an evaluation and management service, no less than the greater of: <ul style="list-style-type: none"> ▶ 125% of the average rate the HMO paid in the previous year for the same covered service in the same geographic region to similarly licensed in-network providers, or ▶ 140% of 2008 Medicare rate for the same covered service in the same geographic region to similarly licensed providers inflated by the change in Medicare Economic Index from 2008 to current year. – For a service that is not an evaluation or management service, no less than 125% of the average rate the HMO paid in the previous calendar year for the same covered service in the same geographic region to similarly licensed in-network providers.

State	Payment standard
New Mexico	Insurer must reimburse 60th percentile of the allowed commercial payment rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area in the 2017 plan year, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent. No surprise bill payment rate can be less than 150% of the 2017 Medicare payment rate.
Oregon	Oregon determines payment rates for anesthesia and nonanesthesia claims according to two separate payment formulas. Generally speaking, these rates are based on allowed claims data for commercial carriers from 2015 as obtained from the Oregon all-payer claims database, which are then adjusted for a variety of factors including geographic region, changes to the consumer price index, and complexity of service.

Data: Authors' analysis