LAW ALERT
HEALTH CARE

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# "Surprise Medical Bills" Law

Consider the following scenario. You are a patient who had a colonoscopy performed by a physician who participates in your health insurance plan. A week later, you receive two "surprise" medical bills from an anesthesiologist and a pathologist for services they rendered in connection with your colonoscopy. Since these providers are out-of-network (OON) with your health plan, they bill you directly at their usual rates for their services. You never saw nor were told about these providers and had no idea that your physician would arrange for OON providers to provide services for you.

This scenario and many others where patients receive unexpected charges in both emergency and non-emergency situations, has prompted New York State to enact the new "Emergency Medical Services and Surprise Bills" Law,[1] which goes into effect on March 31, 2015. The new law is intended to: (1) protect patients from "surprise bills" by OON providers (especially where patients have no say in choosing the provider), (2) provide greater transparency regarding OON charges and the providers who are in-network and OON, (3) limit the OON physician's ability to "balance-bill" the patient if the patient has not knowingly consented to the OON services, (4) impose certain requirements on insurers to provide adequate provider networks, and (5) expand a patient's right to seek OON services without incurring additional cost if the patient's health plan fails to supply in-network providers in a reasonable geographic proximity who can treat the patient's condition.

**What is a "Surprise Bill?"**

A "Surprise Bill" is defined in the new law and its proposed regulations[2] as a bill received by (1) an insured for services rendered by an OON physician at a hospital or Ambulatory Surgery Center (ASC) where an in-network physician is unavailable or where the patient had no knowledge that the physician was OON; or (2) an insured who did not explicitly consent in writing to the services by the OON provider; or (3) an uninsured patient who receives non-emergency treatment without first receiving disclosures required under the new law, as discussed below. A bill is not a "surprise bill" if an in-network physician is available but the patient elects to obtain services from an OON physician.

Some of the key provisions of the Surprise Bill Law are summarized below:

- Patients who receive emergency room medical services will not have to pay more than their usual in-network cost-sharing and/or co-payment amounts, even if the providers of care are OON. The patient's health plan and the OON provider will have to negotiate the fees directly or utilize an independent dispute resolution (IDR) process as provided under the new law.[3]

- Similarly, patients who receive non-emergency services from an OON provider where adequate in-network providers are not available, or where OON services are rendered without proper prior disclosure to the patient, will not have to pay more than the usual in-network cost-sharing/co-payment amounts. If a health plan disagrees with the consumer on whether there is adequate in-network coverage available, the parties can bring the dispute to New York's external review system

- Where there is a disputed “surprise bill”, either the health plan or the OON provider may submit the disputed “surprise bill” to an IDR for review if the parties are unable to negotiate a mutually agreeable rate. The health plan must pay a reasonable payment to the provider while the IDR is pending. The IDR will consider, among other things, whether there is gross disparity between the fees charged compared to similarly qualified providers in the same area, the level of training, education and experience of the provider, and the circumstances and complexity of the case. The IDR decision must be issued within 30 days of submission and is binding on the parties. When IDR is used, the patient is taken out of the payment negotiation process – it is left to the health plan, the provider and the IDR entity. A “baseball style” arbitration will be used by the IDR entity, i.e. choosing between the charge by the provider and the payment by the insurer. This is intended to promote reasonableness on both sides. The losing party in the IDR pays for the costs of the IDR process. If the IDR parties agree on a mutual settlement, the costs of the IDR will be shared equally by both parties. An IDR process will also be available for patients who are not insured.

- Consumers in all health plans who suffer life-threatening or seriously
disabling or degenerative diseases will be given the right to have specialists serve as their primary care doctors and to request access to specialty centers to treat their conditions.

**Obligations and Disclosures by Healthcare Providers**

· Providers (including physicians, dentists, group practices, clinics and FQHCs[4]) must disclose in writing or via website to all patients the names of the health plans and hospitals they are affiliated with prior to providing non-emergency services, and verbally at the time of appointments.[5]

· If the provider is not in the patient’s health plan network he/she must advise the patient that the estimated charge for the service is available upon request, prior to providing any non-emergency services. If requested, the amount of charges must be disclosed in writing to the patient with a warning that the costs could be higher if unanticipated complications occur.

· Physicians must provide patients with the name and other applicable information about any other providers scheduled or referred to provide services to the patient in the physician’s office, a hospital or ASC, and how to obtain information about the health plans in which such providers participate. Such other providers may include anesthesiologists, laboratories, pathologists, radiologist, or assistant surgeons.

· Providers who bill patients for OON services must include claim forms and assignment of benefits forms with their billing statements to patients.

· Hospitals must disclose on their websites (1) the health plans in which they participate; (2) a warning that (a) charges for physicians who provide services at the hospital are not part of the hospital’s charges and (b) physicians at the hospital may not participate in the same health plans as the hospital; (3) the names of the physician groups and providers that the hospital has contracted with to provide services, including such services as radiology, anesthesiology, pathology and laboratory; (4) instructions on how such providers can be contacted to learn their plan affiliations; (5) a schedule of charges for various services the hospital provides; and (6) information, including network affiliations, about physicians employed by the hospital.

· If a physician fails to inform the patient prior to treatment that the physician is OON, the patient will only be required to pay the usual in-network cost sharing and co-payment amounts. Conversely, although not stated expressly in the new law, if a physician makes the necessary disclosures to a patient regarding OON affiliation status and his charges for non-emergency services, the physician should be able to charge and expect payment from the patient for such services, including the “balance billed” to the patient for amounts above what is paid by the patient’s health plan.

**Obligations and Disclosures by Health Plans**

· All health plans, which now include PPO and EPO plans, not just HMO or managed care plans as under current law, must maintain an adequate network of providers to meet the needs of covered members. This is intended to reduce the need for patients to go OON to obtain quality care.

· Currently health plans are obligated to provide consumers with a provider directory that is updated annually with the names and other relevant information about all providers in the networks. Under the new law, health plans will be required, in addition, to update their websites within 15 days of the addition or termination of any provider in the network, or a change in his/her hospital affiliation.

· Health plans will be required to provide information in writing and on their websites identifying the specific methodology used to reimburse for OON services. This should enable consumers to calculate anticipated out-of-pocket costs they will likely incur for OON services in their geographic area based on the difference between the insurer's reimbursement and the usual and customary rate (UCR) for such OON services.

· Health plans must prominently post on their websites and in disclosure materials to insured members (1) a description of what constitutes a "surprise bill," (2) a description of the IDR process and how to submit a dispute to IDR; (3) an assignment of benefits form; and (4) the health plan's address and email for mailing the assignment form.

· Health plans will be required to disclose if a particular provider is in-network, and if not, the approximate dollar amount that the plan will pay for particular OON services if the consumer has OON coverage, and is scheduled to receive such services. The plan will not be bound by such cost estimate.

· When pre-authorization is sought for a particular service, the health plan must advise its member the amount it will reimburse and how that compares to the UCR fee.

· If a health plan provides OON coverage, it must make available at least one option for coverage at 80% of the UCR. UCR is defined as the 80th percentile of all charges for a particular health service in the same specialty and geographical area, as reported in a benchmarking database maintained by a non-profit organization specified by the Superintendent of the Department of Financial Services (DFS).[6] This requirement in the new law appears to be a response to insurers' attempts to limit their reimbursement for OON coverage to 120% - 150% of the lower Medicare rates, rather than 80% of UCR. Although insurers will be required to offer the option of coverage at 80% of UCR if OON coverage is provided, it is not clear that there will be any reasonable restriction on the amount that the insurer will be allowed to charge the consumer for such option. If the cost is prohibitive, the 80% of the UCR requirement may turn out to be of little value to consumers, in the view of this writer.

· Other notable provisions of the new law are that: (1) the State has the option to require insurers that have not offered OON coverage, to offer it in areas where it has not been available; and (2) an OON reimbursement rate working group will be established with health plan representatives, physicians, and consumer members to study and recommend changes regarding the availability and charges for OON coverage. This working group's report must be issued by January 1, 2016.

ACTIONS FOR PROVIDERS TO TAKE BEFORE MARCH 31, 2015

· Educate office staff about in-network and OON health plan and hospital affiliation disclosure requirements and the need for claim and assignment forms to be sent with OON billing.

· Update written materials for patients and websites to include disclosure of all health plan and hospital affiliations and continue updates on regular basis as affiliations change.

· Prepare and maintain cost estimates for services typically rendered in order to respond to patient inquiries regarding cost of OON services.

· Identify all physicians and other providers (e.g. laboratories, pathology, radiology, anesthesiology, physical therapy, assistant surgeons, etc.) to whom provider regularly refers patients, including those in hospitals and ASCs, and review their plan affiliations to determine if in-network.

· Evaluate whether to alter referral patterns to in-network providers where possible.

· Become familiar with the UCR fees identified by the non-profit organization established by the Superintendent for services in the physician's specialty.

The new “Surprise Bill” law is reputed to be the toughest in the nation thus far. Undoubtedly, many questions remain and many issues will need to be resolved, but it appears that the new law is a major step towards greater transparency and fairness for consumers and providers, even if it comes with a somewhat burdensome disclosure requirement.

FOOTNOTES

[1] Part H of Chapter 60 of the Laws of New York (2014); The Surprise Bill Law amends provisions of the Insurance Law, Public Health Law, and Financial Services Law of the State of N.Y.
[2] The first set of proposed regulations issued under the Surprise Bill Law can be found at 23 NYCRR 200.
[3] N.Y. Financial Services Law, Article 6, Section 601 et. seq; The IDR process will not apply to: (1) health care services including emergency services where physician fees are subject to schedules or other monetary limitations, such as Worker’s Compensation and No Fault; (2) emergency services billed under certain CPT Codes when the amount does not exceed 120% of the UCR; or (3) certain dollar amounts specified by the Superintendent of DFS on its website. The amount specified for 2014 is $600, i.e. a billed amount below $600 will not be subject to IDR.
[4] Federally Qualified Health Centers.
[5] See Section 24 of the N.Y. Public Health Law;
[6] It is believed that the Superintendent of DFS will designate Fair Health, Inc. as the non-profit organization. http://www.fairhealth.org.

**For more information please contact**
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