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Expert Analysis

New Law Addresses 'Surprise' Billing for Medical Services

By **Francis J. Serbaroli**

For many years, consumers of health care services have complained about unexpectedly large bills they received for medical services from providers who turned out to be outside of the network offered by their health insurance benefit plan. These complaints prompted the New York State Department of Financial Services (DFS) to undertake a study of this problem, and the DFS issued a report in 2012.[1]

The report indicated that its findings and recommendations were based in part upon DFS's review of more than 2,000 complaints it received in 2011 involving payment issues for emergency as well as non-emergency medical services.

> Many of the complaints.... in-volve consumers receiving scheduled, non-emergency medical services for which the consumer had received insurer approval, but neither the insurers, the doctor, nor the hospital disclosed to the consumer that other specialists—some of whom are out-of-network—would be providing services.

The report cited as examples:

• A consumer needing heart surgery confirmed prior to the surgery that the hospital and surgeon were in-network with the consumer's health plan, but without the consumer's knowledge, an out-of-network surgeon assisted in the surgery and billed the consumer $7,516.

• A consumer whose finger was severed in a table saw accident went to the emergency room of an in-network hospital to have his finger re-attached. The plastic surgeon who did the surgery was out-of-network and billed the consumer $83,000, as was the assistant surgeon who billed another $16,000.

• A neurosurgeon charged $159,000 for an emergency procedure for which Medicare would have paid only $8,493.

> The law took effect on March 30, 2015, and offers new protections for patients who receive bills for emergency medical care from providers that are not in their insurer's network.

After a detailed analysis of the problem, the report set forth six recommendations for reforms:

• Improve the ability of consumers to comparison shop;

• Improve disclosure for non-emergency services;

• Prohibit excessive emergency charges;

• Improve network adequacy protections;

• Consider minimum coverage requirements for insurers that offer out-of-network coverage;

• Make it easier for consumers to submit claims for payment for out-of-network health care services.

The governor and Legislature responded to the DFS's report with a new "Emergency Medical Services and Surprise Bills" law,[2] which was enacted in 2014. The law took effect on March 30, 2015, and offers new protections for patients who receive bills for emergency medical care from providers that are not in their insurer's network, as well as patients who use in-network providers but then receive unexpected bills for services provided by OON (out-of-network) providers. This is a rather complicated law, and this column will summarize only its more significant parts.

Insurer Obligations

The law extends certain requirements currently applicable to health insurers and plans to other types of entities, including preferred provider organizations (PPO) and exclusive provider organizations (EPO). For example, the law requires that they all maintain a network of health care providers adequate to meet the needs of its insured, and provide an appropriate choice of providers sufficient to render the services covered under the insurer's policy or contract.

An insurer that offers coverage for OON services is also required to make available at least one option for coverage for at least 80 percent of the usual and customary cost of an OON service, subject to any deductible or permissible maximum benefit. The insurer is required to offer the "make available" product only in those markets in which it offers OON coverage.

The law requires insurers, with respect to out-of-network coverage, to provide to their insureds:

• A clear description of the methodology used by the insurer to determine payment for OON health care services;

• The amount that the insurer will pay

FRANCIS J. SERBAROLI *is a shareholder in Greenberg Traurig and the former vice chair of The New York State Public Health Council.*

under the methodology as a percentage of the usual and customary cost for OON health care services;

• Examples of anticipated out-of-pocket costs for frequently billed OON services; and

• Information in writing and on a website that reasonably permits insureds or prospective insureds to estimate their anticipated out-of-pocket costs for OON services in a geographic area or zip code, based upon the difference between what the insurer will pay for OON services and the usual and customary cost for OON services.

The law requires insurers to disclose to their insureds:

• Whether a health care provider scheduled to provide a service to the insured is an in-network provider; and

• The approximate dollar amount that the insurer will pay for a specific OON service, and that such approximation is not binding on the insurer, and may change.

When a member of an insurer that is a managed care plan (Plan) receives emergency medical services from an OON provider, the Plan is required to ensure that the member incurs no greater out-of-pocket costs then the member would have incurred using an in-network provider. If a Plan denies a member access to an OON provider because the Plan has an in-network provider(s) with the appropriate training and experience to treat the member and is able to provide the needed service, the Plan must also provide the member with the information needed in order to appeal the denial of the OON provider referral.

An insured can appeal such a denial by submitting a written statement from the insured's attending physician (who must be a licensed and Board-certified or Board eligible physician qualified in the medical specialty involved) that:

• The in-network health care provider or providers recommended by the Plan do not have the appropriate training and experience to meet the particular health care needs of the insured; and

• Recommends an OON provider with the appropriate training and experience to meet the insured's particular health care needs and is able to provide the requested health care service.

Current law requires that, in the case of health care services requiring pre-authorization, the insurer's utilization review agent must notify the insured and the insured's health care provider of the agent's determination within three days of receipt of necessary information. The new law requires that this notification identify:

• Whether the services are considered in-network or OON;

• Whether the insured will be held harmless for the services and not be responsible for any payment other than applicable co-payment, co-insurance or deductible;

• The dollar amount that the Plan will pay if the service is OON;

• Information explaining how an insured may determine the anticipated out-of-pocket costs for OON services in a geographical area or zip code based upon the difference between what the Plan will reimburse for OON services and the usual and customary cost for such OON services.

With regard to bills for emergency services provided at an out-of-network provider, the law requires that health plans must protect their members from such bills to the extent that such bills exceed what the member normally would have to pay as an in-network co-payment, coinsurance or deductible.

Hospitals

The law requires hospitals to establish, update and post on their websites a list of the hospital's standard charges for its items and services, including their Medicare diagnosis-related group (DRG) charges. It also requires hospitals to post on their websites:

• The health care plans in which the hospital is a participating provider;

• A statement that:

1. Physician services provided in the hospital are not included in the hospital's charges;

2. Physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital; and

3. The prospective patient should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates;

• As applicable, the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services including anesthesiology, pathology or radiology; instructions on how to contact these groups to determine the health care plan participation of the physicians in these groups; and

• As applicable, the name, mailing address and telephone number of hospital-employed physicians providing medical services at the hospital and the health care plans in which they participate.

Hospitals are also required to include in registration or admissions materials provided to the patient in advance of non-emergency hospital services:

• Advice to the patient to check with the physician arranging the hospital services to determine the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician, and whether the services of physicians who are employed or contracted by the hospital to provide services (such as anesthesiology, pathology or radiology) are reasonably anticipated to be provided to the patient; and

• Information as to how to timely determine the health care plan participation of physicians who are reasonably anticipated to provide services to the patient at the hospital, as determined by the physician arranging the patient's hospital services, and who are employed or contracted by the hospital to provide services (such as anesthesiology, pathology or radiology).

Physicians, Clinics

The law places new requirements on health care professionals, group practices of health care professionals, diagnostic and treatment centers (i.e., clinics, ambulatory surgery centers (ASC), dialysis centers, etc.) and federally qualified health centers. These providers must disclose to patients—in writing or on their websites—the health care plans in which they are a participating provider, and the hospitals with which the health care professional is affiliated, prior to providing any non-emergency services and verbally at the time of scheduling an appointment for a patient. If any of these providers do not participate in a patient's health care plan, the provider must:

• Prior to the provision of non-emergency services, inform the patient that the amount

the provider will bill the patient for health care services is available upon request; and

• Upon receipt of a patient's request, disclose to the patient in writing the amount or estimated amount or a schedule of fees that will be billed for services provided or anticipated to be provided to the patient absent unforeseen medical circumstances.

The law places specific requirements on physicians. They are required to provide a patient with the name, practice name, mailing address and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office, or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.

For a patient's scheduled in-patient or out-patient hospital services, the physician must provide the patient with the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of pre-admission testing, registration, or admission at the time non-emergency services are scheduled, as well as information on how to determine the health care plans in which such physician participates.

Surprise Bills

The law then goes on to define a "surprise bill" as a bill for non-emergency medical services received by:

• An insured, for services rendered by an OON physician at an in-network hospital or ASC where an in-network physician is unavailable or an OON physician renders services without the insured's knowledge, or unforeseen medical circumstances arose at the time the health care services were provided; or

• An insured, for services rendered by an OON provider, where the services were referred by an in-network physician to an OON provider without explicit written consent of the insured acknowledging that the in-network physician is referring the insured to a non-participating provider, and that the referral may result in costs not covered by the insured's plan; or

• A patient who is not an insured (i.e., not covered by an insurer but by a union health benefit plan or employer self-insurance) for services rendered by a physician at a hospital or ASC, where the patient has not timely received all of the required disclosures.

The law specifically excludes from the definition of "surprise bill" a bill for health care services when an in-network physician is available and the insured has elected to obtain services from an OON physician.

The law specifies that, in order for a patient to be protected from a surprise bill and only owe the in-network coinsurance and deductible, the patient must:

• Sign an assignment of benefits form permitting the medical services provider to seek payment for the provider's bill from the patient's insurer; and

• Send a form to both the provider and the insurer and include a copy of the bill that the patient does not think he should be responsible for paying.

Emergency Services

With regard to bills for emergency services provided at an OON provider, the law requires that health plans must protect their members from such bills to the extent that such bills exceed what the member normally would have to pay as an in-network co-payment, coinsurance or deductible. In other words, the member will have to pay no more than what the member would have paid if the emergency services had been furnished at or by an in-network provider.

Dispute Resolution

The law establishes an independent dispute resolution process for patients, insurers and providers for disputed surprise medical bills and disputed bills for OON emergency services. It authorizes the Superintendent of DFS to certify and regulate independent dispute resolution entities (IDRE) to which payment disputes can be submitted. IDRE decisions on payment of disputed bills are to be made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges, in consultation with a licensed physician in active practice in the same or similar specialty as the physician who provided the service for which the bill is being disputed. The IDRE will consider:

• Whether there is a gross disparity between the fee charged by the provider and (1) fees paid to the provider for the same services provided to other patients in health care plans in which the provider is non-participating, and (2) the fees paid by the health plan to reimburse similarly qualified out-of-network providers for the same services in the same region;

• The provider's training, education, experience, and usual charge for comparable services when the provider does not participate with the patient's health plan;

• The circumstances and complexity of the case;

• Patient characteristics; and

• The usual and customary cost of the service.

For disputes involving insurers, the IDRE will choose either the OON provider's bill or the insurer's payment. For disputes submitted by uninsured patients or patients with employer or union self-insured coverage, the IDRE will determine the fee. The IDRE is authorized to direct a good-faith negotiation between the insurer and provider if settlement is likely, or if the proposed payment and the provider's fee are unreasonably far apart. An IDRE's determination must be made within 30 days, is final, and is admissible in court.

Conclusion

This new law attempts to address problems posed by disputed medical bills, and to provide patients, providers and payors with mechanisms for resolving disputes more expeditiously. The ongoing movement away from fee-for-service medical care should also result in fewer payment disputes in the future.

1. New York State Department of Financial Services, "An Unwelcome Surprise: How New Yorkers Are Getting Stuck With Unexpected Medical Bills From Out-of-Network Providers," March 7, 2012.

2. Part H, Chapter 60 of the Laws of New York (2014).