# SURPRISE BILLING
# OUT-OF-NETWORK REIMBURSEMENT

## IMPORTANT NEW PROTECTIONS FOR NEW YORK CONSUMERS

New York HPA Health Plan Association

**ISSUE BRIEF** **March 2015**

Beginning April 1st, a new law takes effect giving New York health care consumers important new "protections." These include:

- ✓ New safeguards against balance billing and surprise bills from out-of-network providers.
- ✓ More information about the charges that might result from receiving care from a provider not in the plan's network.
- ✓ The right to have requests to see providers outside the plan's network reviewed by an outside party.

The following provides a brief overview of what these new protections mean to consumers and how the new law works.

## Surprise Bills and Emergency Services/Balance Billing

Each year, millions of New Yorkers turn to their health insurance coverage to help them ensure access to health care. Most insured New Yorkers are comforted by the fact that their health coverage protects them and their families from the financial uncertainties of a health crisis. When a patient uses a network physician, the patient is only charged their portion (co-payment and deductible) of the fee agreed to between the physician and the health plan. However, when a patient receives services from an out-of-network physician, even when receiving services while at an in-network hospital, they often receive unexpected bills from the provider for large amounts that exceed the rate normally charged and paid by the health plan. This practice is known as balance billing and the bill is usually a big surprise to the consumer.

The new law protects consumers from balance billing for surprise bills or emergency services. A "surprise bill" is a bill received by a consumer for health care services, other than emergency services, from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable, or services from a non-participating physician are rendered without the insured's knowledge, or when unforeseen medical services arise at the time the health care services are provided. It is *not* a surprise bill if the insured has elected to obtain services from a non-participating physician when a participating physician is available. Another type of surprise bill is when a bill is received for services from by a non-

participating provider where a participating provider referred the insured to a non-participating provider without obtaining explicit written consent of the insured acknowledging that the referral is to a non-participating provider and that the referral may result in costs not covered by the health plan.

In cases where a consumer receives a surprise bill, New York's new law protects the consumer from being put in the middle of a billing dispute between the health plan and the provider. The consumer can simply assign their benefits to the health care provider and the consumer will be held "harmless" for the surprise bill. If the plan and provider cannot work out a payment agreement, either the health plan or the provider can submit a dispute regarding a surprise bill to the Department of Financial Services asking that the bill be reviewed by an "independent dispute resolution entity" (IDRE), an outside party designated to help resolve the billing disagreement. The IDRE will review information from both the plan and provider about the services and the resulting bill, and issue a decision — all while holding the consumer harmless and keeping them out of the negotiation process.

This independent dispute resolution process can also be used to resolve charges related to emergency services. Current New York law requires health maintenance organizations (HMOs) to hold insureds harmless for charges in excess of the in-network deductible, copayments or coinsurance for out-of-network emergency services in a hospital and beginning April 1st, this standard will apply to other types of managed care health plans such as preferred provider organization (PPO) or exclusive provider organizations (EPO). The hold harmless requirements for out-of-network emergency services apply to both physician services in a hospital and hospital charges.

## Out-of-Network Services

Health plans create physician networks to ensure patients have access to a wide choice of high quality providers. Over decades, patients have saved billions of dollars in premiums and out-of-pocket costs by using in-network providers who have agreed to set rates for their services. Nationally, approximately 88% of all claims were paid on an in-network basis in 2011.[1]

Although health plans design their products to offer members wide provider choice, some employers want added flexibility and choose a coverage option that allows their employees to see providers outside the plan's network. When consumers elect to seek services from non-participating providers, they are responsible for paying the difference between what the non-participating provider charges and the amount the health plan reimburses the provider for these services. In most circumstances, the result is higher out-of-pocket costs for the consumer. It is important that consumers

[1] *Update: A Survey of Health Insurance Claims Receipt and Processing Times, 2011,* AHIP Center for Policy and Research, January 2013.

who choose to seek care out-of-network understand the impact that choice can have on their health care costs. The following chart illustrates the value of choosing a participating provider by showing the difference in estimated costs for services received in-network versus out-of-network.[2]

| | Example 1: Standard Office Visit | | Example 2: Colonoscopy (at Ambulatory Surgery Center) | |
|---|---|---|---|---|
| | In Network | Out-of-Network | In Network | Out-of-Network |
| A. Amount billed by provider | $215 | $215 | $875 | $875 |
| B. Maximum reimbursement allowable under plan contract | Contracted rate | $125 | Contracted rate | $600 |
| C. Amount paid by plan (example = 80%) | Contracted rate | $100 (80% of $125) | Contracted rate | $480 (80% of $600) |
| D. Network copay/out-of-network coinsurance (example = 20%) | $25 | $25 (20% of $125) | $75 | $120 (20% of $600) |
| E. Member responsibility between (A) provider's billed charges and (B) amount paid by plan | $0 | $90 (A minus B) | $0 | $275 (A minus B) |
| **Total member financial responsibility** | **$25** | **$115 (D plus E)** | **$75** | **$395 (D plus E)** |

Until now, it was often difficult for consumers to get information on the cost of out-of-network services. New York's new law provides greater transparency that helps consumers get this much needed information. Beginning April 1st:

- ✓ Health plans are required to provide detailed information about the providers in their networks.
- ✓ Providers are also required to tell patients whether or not all services are in-network before such services are provided.
- ✓ Providers must tell how much they will charge for out-of-network services, if asked.
- ✓ Health plans are required to disclose the amount they will reimburse a non-participating provider, showing cost information based on the methodology the plan uses to calculate out-of-network reimbursements as well as how that compares to a percentage of what is known as the "usual and customary cost."
- ✓ Health plans are required to provide reimbursement examples, similar to the chart in this document.

Disclosure of this information is designed to ensure consumers have tools available that help them make educated decisions about their health care and to know how those decisions might impact what they must pay for care.

[2] Examples calculated using FAIR Health Consumer Cost Lookup.

## Out-of-Network Appeals

Consumers who want to see providers outside their plan's network will have the ability to have their request reviewed by an outside party. This is an expansion of New York's highly successful external appeals law that allows consumers to seek an outside opinion when health care services are denied by a health plan as not medically necessary, experimental/investigational, a clinical trial, or a rare disease treatment. Under the new law going into effect, consumers can now also seek an outside opinion when a health plan denies a member's request to see an out-of-network provider. Consumers must first file an "internal appeal" of the coverage denial with their plan. If the plan still believes the request to see an out-of-network provider is not necessary, the consumer can then file for an "external appeal" and an independent reviewer not affiliated with the plan will examine the case and determine: 1) if the service required is medically necessary; and 2) if there is not an appropriate provider in the plan's network, therefore supporting the request to see an out-of-network provider.

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New York's health plans are committed to ensuring New Yorkers have access to quality health care services and a choice of health plan options. They are equally committed to efforts to control costs so that coverage remains affordable. New York's new law on surprise and balance billing and out-of-network services is an important tool to help keep health coverage accessible and affordable.