

Out-of-Network Billing: The Impact of Consumer Protection Measures on Health Plans & Providers

November 16, 2015

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Agenda

1. Introduction
2. Federal Protections on Coverage of and Costs for Out-of-Network Emergency Services
3. State Action on Out-of-Network Emergency Services: Overview and Examples
 - i. National Overview
 - ii. Texas
 - iii. Illinois
 - iv. Florida
 - v. California
4. The New York Emergency Medical Services & Surprise Bills Law
5. Final Thoughts/Questions

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Introduction

Controversy and Confusion



Socked With an Out-of-Network Medical Bill?

How to navigate the system and prevent it from happening again.



Slippery financial bills can add to the stress of an out-of-network visit.

By Melissa Green | Aug 13, 2014 | 2:36 pm EDT

As if the human price of illness weren't enough, a seemingly unconnected medical bill that follows may feel like rubbing salt in the wound. And yet, it happens — all the time, to the best of us.

"I think a lot of people are going to be struggling with these issues," says Chuck Bell, program director at Consumers Union in New York. Bell helped get a consumer protection bill passed in New York last March, which has certain protections for patients against out-of-network billing. "People are busy. They don't have a lot of time to sort through bureaucracy. I have lawyers come to me and say, 'I'll carry the bill out. How can someone else?'"

The New York Times | <http://nyti.ms/1u9I4E6>

U.S. | PAYING TILL IT HURTS: Surprise Bills

After Surgery, Surprise \$117,000 Medical Bill From Doctor He Didn't Know

By ELISABETH ROSENTHAL | SEPT. 20, 2014

Before his three-hour neck surgery for herniated disks in December, Peter Drier, 37, signed a pile of consent forms. A bank technology manager who had researched his insurance coverage, Mr. Drier was prepared when the bills started arriving: \$56,000 from Lenox Hill Hospital in Manhattan, \$4,300 from the anesthesiologist and even \$133,000 from his orthopedist, who he knew would accept a fraction of that fee.

He was blindsided, though, by a bill of about \$117,000 from an "assistant



The Agony of Medical Bills

Even for people with generous insurance plans, a trip to an in-network doctor can result in thousands of dollars in unexpected charges. Can anything be done?



OLGA KHAZAN

MAY 21, 2015 | HEALTH

It shouldn't take a Harvard expert in health policy to understand a doctor's bill. But sometimes, it does. In August of last year, Liz was a medical student whose doctor found a lump on her tonsils. Her primary-care physician referred her to an in-network ear-nose-and-throat specialist.

LancasterOnline

Pennsylvania Insurance Department scrutinizes surprise out-of-network medical bills

HEATHER STAUFFER | Staff Writer (/staff/heatherstauffer) | Oct 29, 2015

Before having surgery at Heart of Lancaster Regional Medical Center in March 2013, Maribeth Driver made sure it was pre-approved and in network for her Aetna health insurance.

Yet, she got a surprise bill of roughly \$3,200.



HEALTH CARE | NOVEMBER 2, 2015

Miami lawmaker pushes bill to ban unexpected medical charges for emergency services

BY DANIEL CHANG
dchang@miamiherald.com

Like most patients, Robert Delfino did what his doctor told him: Go to the hospital for an outpatient cardiac procedure to determine the cause of his heart condition.

Delfino, 54, was following the advice of his cardiologist, listed in his insurance company's provider network catalog.

Fortunately for Delfino, of Delray Beach, his coronary blockage was not serious enough to require a stent. The real problem came two months later, when Delfino received a bill for \$15,000 from the hospital, which was not an in-network provider.

How do surprise bills arise?

- Enrollee receives care in the emergency room (ER) at an in-network hospital, though is treated by providers who are not in-network with the enrollee's health plan
- Enrollee receives scheduled surgical or other care at an in-network facility though is treated by providers who are not in-network with the enrollee's health plan

NAIC Network Adequacy Model Act

Protections From Surprise Medical Bills And Balance Billing

- Scheduled to be finalized November 22, 2015
- Notice Requirements – In-network facilities with non-participating facility-based providers must provide
 - For non-emergency services: written notice within 10 days of scheduling or at time of pre-certification and at admission that services may be furnished by OON providers;
 - For OON emergency services bills must include notice stating the patient is only responsible for in-network cost-sharing amount;
 - “Payment Responsibility Notice” language must be included on all balance bills, including description of carrier’s OON provider billing process
- Notice Requirements – From Carriers
 - Pre-certification notice must state that some services may be provided by OON providers
- Mediation Process
 - Carriers must establish mediation process for providers who object to rates set by carrier’s OON provider billing process

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Federal Protections

Federal Protections for Out-of-Network Services

Patient Protections For Emergency Services

- If a plan or health insurance coverage includes benefits for emergency services in a hospital, it must cover emergency services:
 - Received from both in and out-of-network providers
 - With administrative requirements or benefit limitations that are no more restrictive than as apply to emergency services from in-network providers
 - Using cost-sharing requirements that do not exceed those that would apply were the services received from in-network providers
 - At a reasonable level of reimbursement
- Apply across the health insurance market, to group health plans, and group and individual health insurance coverage, including
 - Large group and self-insured coverage
 - Individual and small group market coverage both on and off of the Exchanges

Federal Protections for Out-of-Network Services

Patient Protections For Emergency Services

- Out-of-network emergency services provider may balance bill, if allowed under state law
- Where balanced billing allowed, plan must provide a “reasonable level of reimbursement,” defined as the greatest of three amounts:
 - Amount negotiated with in-network providers for the emergency services furnished
 - Amount calculated using the same method the plan generally uses to determine payments for other out-of-network services (e.g., UCR)
 - Amount that would be paid under Medicare for the emergency service
- Minimum payment protection does not apply where states prohibit balanced billing or plan itself is responsible for balance billed amounts
- Plan must provide patient with “adequate and prominent notice” of their lack of financial responsibility with respect to balanced billed amounts

Cost-Sharing for Out-of-Network Emergency Services

Maximum Out-of-pocket Limits

- Cost sharing other than co-pay/co-insurance (e.g., deductible or out-of-pocket maximum) may be imposed on the out-of-network emergency services if such cost sharing generally applies to out-of-network services
- Plans may but are not required to count cost sharing or balance bill amounts for out-of-network services toward meeting maximum out-of-pocket limits

Out-of-pocket limits applicable to non-grandfathered plans	
2015	2016
\$6,600 for individual	\$6,850 for individual
\$13,200 for family	\$13,700 for family

- If plan does not have a network for a type of service, e.g., emergency services, all emergency service providers would be considered in-network for purposes of applying the out-of-pocket maximum

Section 2719A of the Public Health Service Act, as amended by the ACA; 45 CFR 147.138(b)(3); <http://www.dol.gov/ebsa/faqs/faq-aca.html>

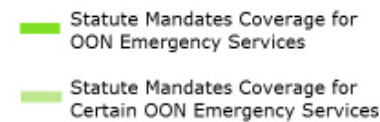
Section 2719A of the Public Health Service Act, as amended by the ACA; 45 CFR 147.138(b)(3); <http://www.dol.gov/ebsa/faqs/faq-aca.html>

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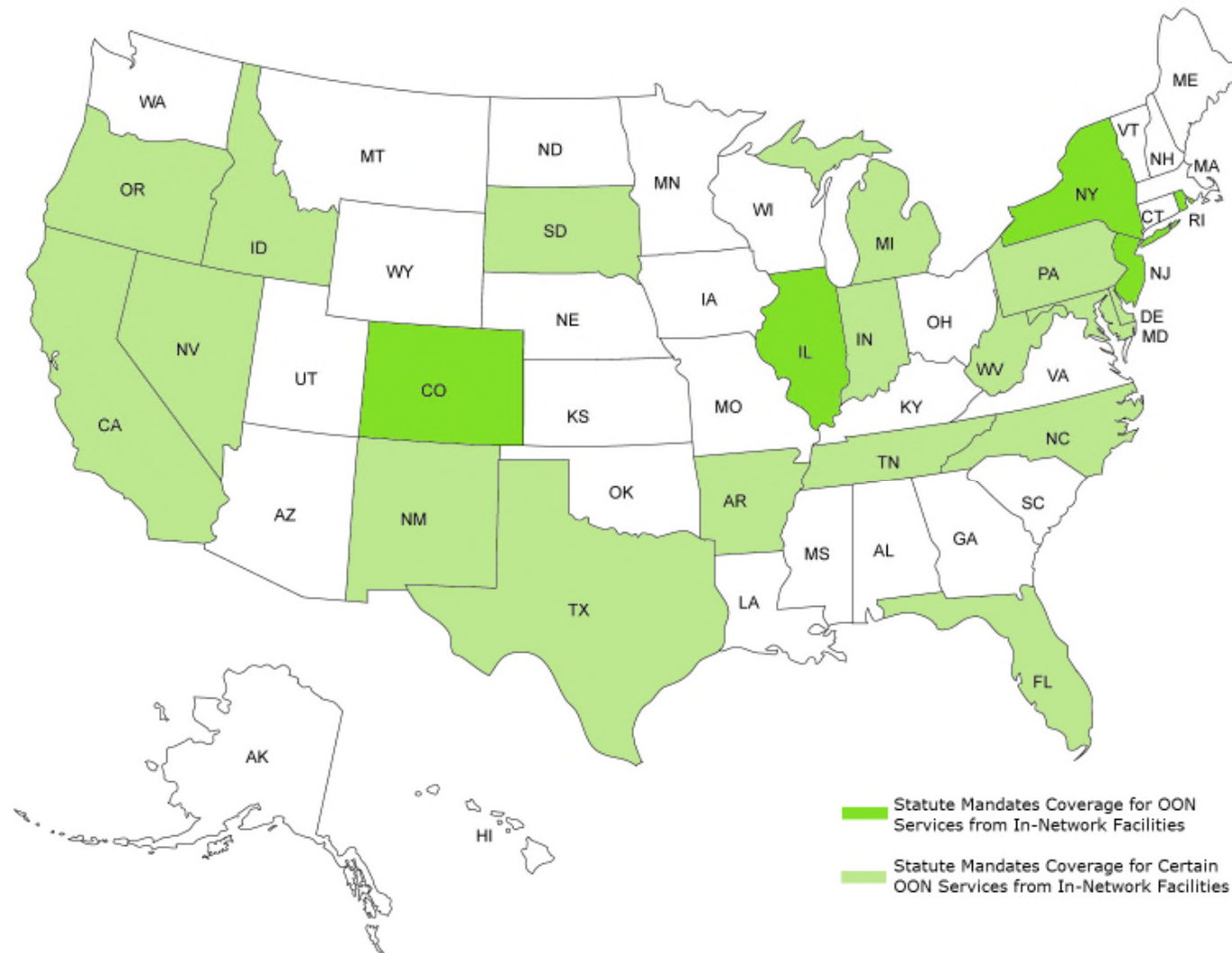
State Overview and Examples

Mandates Coverage Of Emergency Services At Out-of-network Facilities

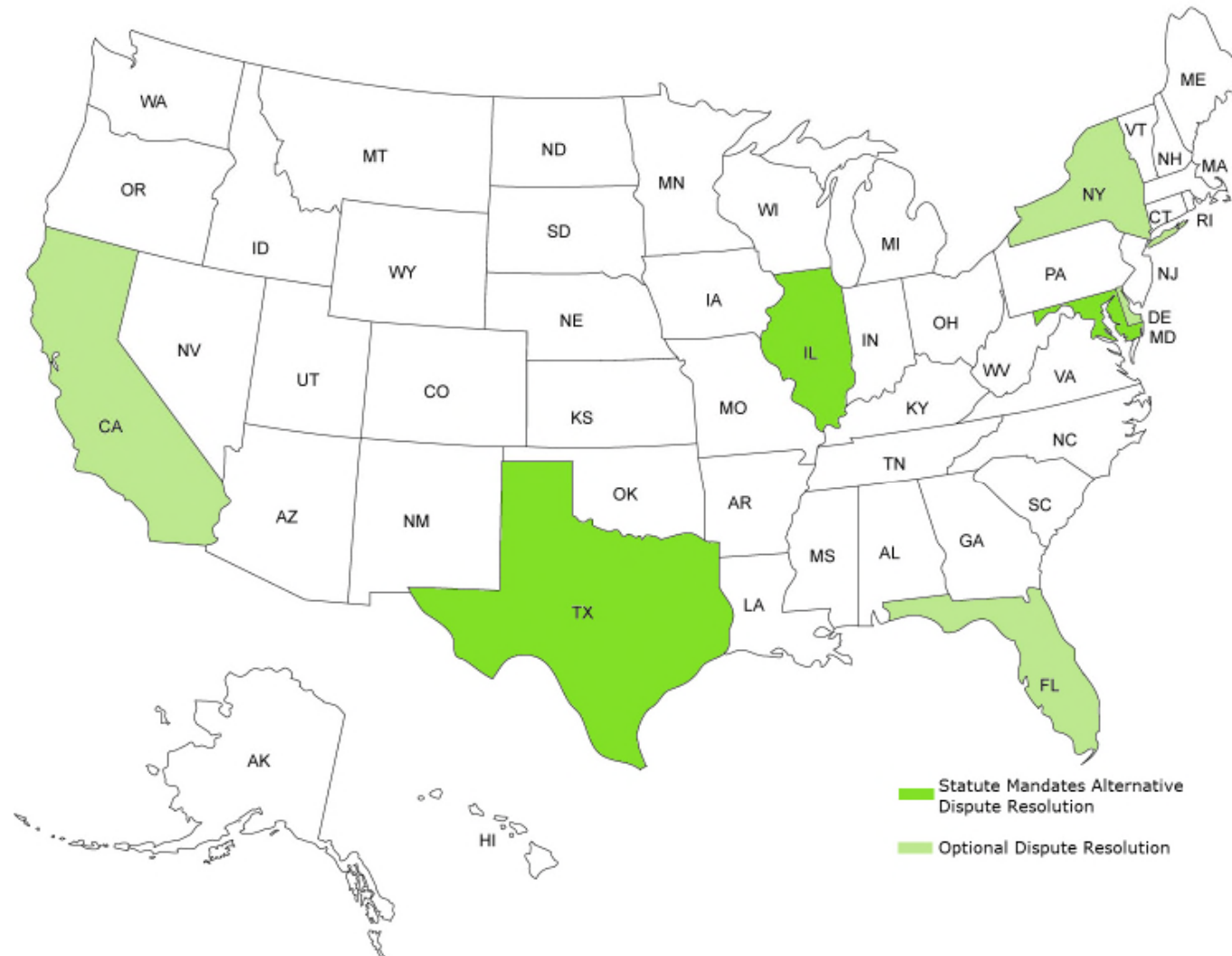


Overview of State Laws on Surprise Bills

Mandates Coverage Of Out-of-network Services At In-network Facilities

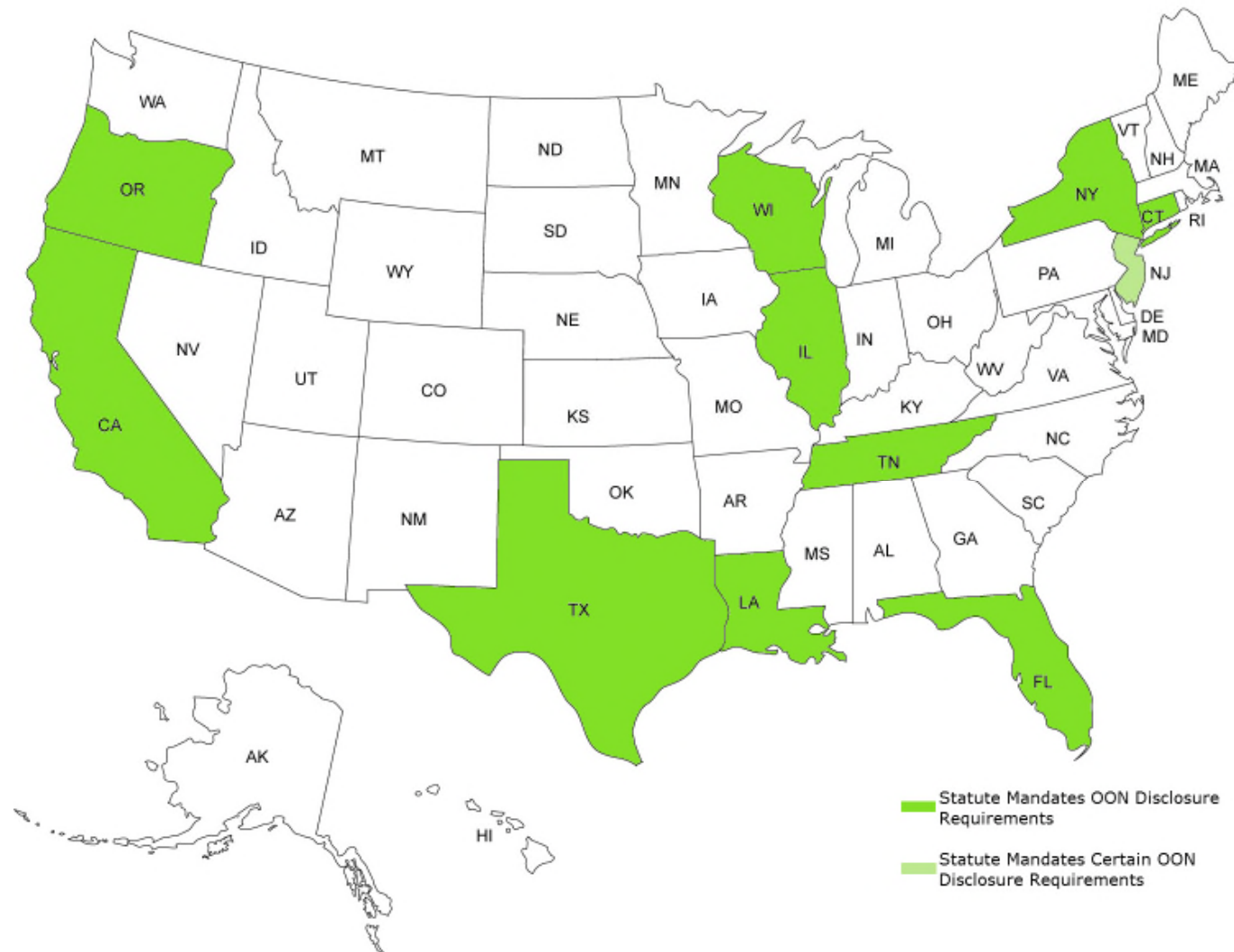


Overview of State Laws on Surprise Bills



Overview of State Laws on Surprise Bills

Mandates Out-of-network Disclosure Requirements

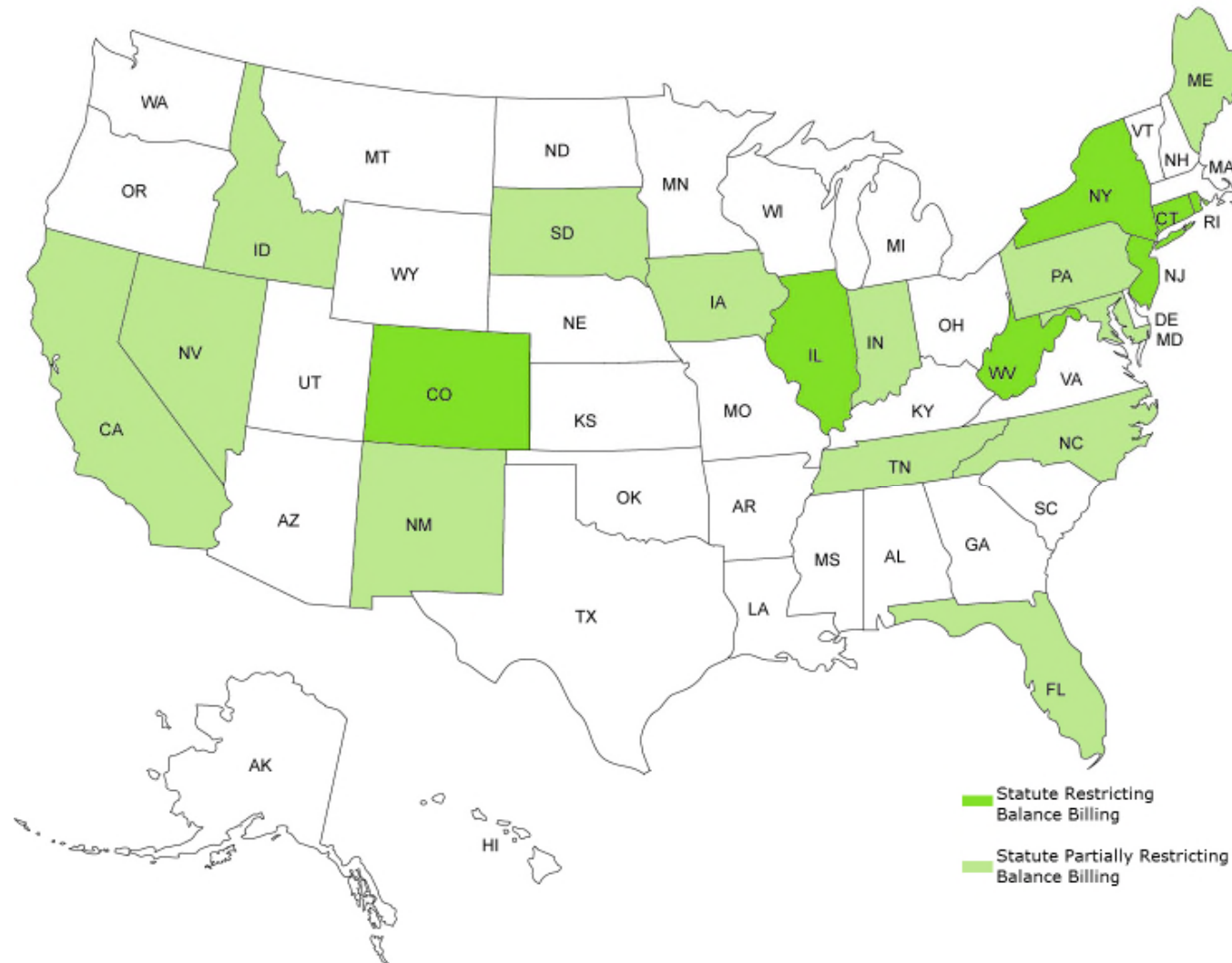


Restricts Balance Billing For Out-of-network Emergency Services



Overview of State Laws on Surprise Bills

Restricts Balance Billing For Out-of-network Emergency Services Delivered At In-network Facility



Texas

Summary



- HMOs/EPOs must pay negotiated or usual and customary rate for OON emergency services
- Balance billing allowed
- Disclosure requirements for health plans and providers about OON providers and billing policies
- State-administered dispute resolution system for resolving OON claims recently expanded

Texas

Out-Of-Network Billing Restrictions

- Under 28 Tex. Admin. Code § 11.204(20):
 - HMOs (and EPOs) must pay a negotiated or usual and customary rate for emergency services performed by OON providers but balance billing is still allowed
- H.B. 1638, introduced in February 2015 (but not enacted), proposed to eliminate balance billing for OON emergency services
 - Under this proposed legislation:
 - Consumers would be held harmless from all OON emergency bills for services at emergency rooms, whether the care is provided at an in-network hospital or a free-standing emergency room
 - Consumers would only be responsible for their usual in-network cost sharing
 - Providers and insurers would be able to access a dispute resolution process to find a fair price for emergency medical services

Texas

Disclosure Requirements

- S.B. 1731 (effective September 1, 2007) implemented disclosure requirements for health benefit plans and physicians related to pricing and network participation
- 8 Tex. Ins. Code § 1456.003 requires health benefit plans to:
 - Provide the disclosures about OON providers in writing to each enrollee: (1) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage, (2) in an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan, and (3) conspicuously displayed, on any health benefit plan website that an enrollee is reasonably expected to access
 - Clearly identify any health care facilities within the provider network in which facility-based physicians do not participate in the health benefit plan's provider network
 - Health care facilities identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory
 - Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to an OON physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment

Texas

Disclosure Requirements

- 8 Tex. Ins. Code § 1456.004 requires outpatient and facility-based physicians serving OON beneficiaries to comply with specific disclosure requirements
 - All physicians must:
 - Post a notice in their waiting rooms to inform patients they can request a copy of the physician's billing policies;
 - Adopt billing policies and procedures that inform patients: (1) about possible patient discounts for charity care and the uninsured, (2) whether late payments will incur interest, and (3) about your billing complaint process and procedures
 - Physicians treating OON and uninsured patients must:
 - Allow patients to request (1) a written estimate of their out-of-pocket expenses, (2) an itemized statement of the charges within one year, and (3) up to two additional statements for free;
 - Refund a patient overpayment within 30 days
 - Facility-based physicians billing an insured patient for OON services must disclose:
 - Itemized list of services and supplies and the date the services and supplies were provided
 - Clear statements that (1) the physician is not in the patient's health plan, (2) the health plan does not cover total charges, (3) the patient can call to discuss billing arrangements, and (4) if a payment arrangement is made, the physician will not report the patient to a collection agency if payments are made according to the agreement
 - Billing phone number and information on how to file a complaint with the Texas Medical Board

Texas

Dispute Resolution Process

- Texas has created a state-administered mandatory binding dispute resolution system under Tex. Ins. Code Chap. 1467
 - The state's dispute resolution system is applicable to preferred provider benefit plans and administrators of health benefit plans (other than an HMO plan)
 - An enrollee may request mediation of a settlement of an OON health benefit claim if the claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the health benefit plan
- S.B. 481 (effective September 1, 2015) expands mediation rights to insured patients who go into an in-network hospital but leave with OON bills under the state's dispute resolution system
 - Formerly, a patient could only seek mediation if the surprise medical bill exceeds \$1,000; S.B. 481 makes mediation available to patients with surprise medical bills over \$500
 - Mediation rights apply to services provided by anesthesiologists, radiologists, pathologists, emergency physicians, neonatologists, and assisting surgeons

Illinois

Summary



- For OON emergency services and other OON services meeting the good faith and network adequacy tests, the beneficiary pays in-network rates and is held harmless from balance billing
- Disclosure requirements between health plan and OON providers about proposed reimbursement
- Arbitration process between health plans and OON providers

Illinois

Out-Of-Network Billing Restrictions

- Under 215 Ill. Comp. Stat. 5/356z.3a and 50 Ill. Admin. Code 2051.310:
 - In all situations where an Illinois insured has made a good faith effort to use the services of a contracted provider and where there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider
 - This protection does not apply to insured members who willfully choose to access an OON provider for health care services available through the administrator's panel of participating providers
 - Payment for emergency care is not dependent on whether the services are performed by a preferred or non-preferred provider
 - Coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider, meaning the insured will be provided the covered service at no greater cost than if the service had been provided by a preferred provider

Illinois

Disclosure Requirements

- Statutory requirements at 215 Ill. Comp. Stat. 5/356z.3a state that:
 - The insurer or health plan shall provide the OON provider with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment or coinsurance amounts owed by the insured, beneficiary or enrollee
 - If a beneficiary, insured or enrollee assigns benefits to the OON facility-based provider, the insurer or health plan shall pay any reimbursement directly to the OON facility-based provider
 - The OON facility-based physician or provider shall not bill the beneficiary, insured, or enrollee, except for applicable deductible, copayment, or coinsurance amounts that would apply if the beneficiary, insured, or enrollee utilized a participating physician or provider for covered services
 - If a beneficiary, insured, or enrollee specifically rejects assignment in writing to the OON facility-based provider, then the OON facility-based provider may bill the beneficiary, insured, or enrollee for the services rendered

Illinois

Dispute Resolution Process

- Statutory requirements at 215 Ill. Comp. Stat. 5/356z.3a establish an arbitration process between OON facility-based providers and insurers or health plans as follows:
 - If attempts to negotiate reimbursement for services provided by an OON facility-based provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the insurer or health plan, then an insurer or health plan or OON facility-based physician or provider may initiate binding arbitration to determine payment for services provided on a per bill basis
 - The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration
 - In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs
 - Arbitration shall be initiated by filing a request with the Department of Insurance

Florida

Summary



- HMOs must pay for OON emergency services and for OON services that are covered and authorized by the HMO
- Balance billing prohibited
- Disclosure requirements for insurers about exclusive providers, coverage, and billing policies
- State-administered dispute resolution program applicable to all plans

Florida

Out-Of-Network Billing Restrictions

- Under Fla. Stat. 641.513, for an emergency condition or for services provided to evaluate whether an emergency condition exists, the HMO is liable for payment to the OON provider and balance billing is prohibited (this does not apply to PPOs)
- Under Fla. Stat. 641.3154, Florida also prohibits OON providers from balance billing HMO patients for covered services that are authorized by the HMO (this does not apply to PPOs)
 - Regulators interpret the statute as prohibiting balance billing for any ancillary services provided to a patient in an in-network hospital if admitted by an in-network physician, including services by OON providers

Florida

Out-Of-Network Billing Restrictions

- H.B. 681, S.B. 516 which failed in the Florida Senate in the 2015 session would have expanded emergency OON coverage
 - The bill would have:
 - Prohibited coverage for emergency services from requiring prior authorization determination;
 - Required such coverage to be provided regardless of whether a service is furnished by a participating or nonparticipating provider;
 - Specified coinsurance, copayment, limitation of benefits, and reimbursement requirements for nonparticipating providers;
 - Prohibited nonparticipating providers from collecting or attempting to collect amounts in excess of the specified amounts;
 - Revised the methodology for determining HMO reimbursement amounts for certain services

Florida

Out-Of-Network Billing Restrictions

- Payment Requirements for Emergency Services
 - For emergency services and services to evaluate if an emergency condition exists, the HMO must pay OON providers the lesser of:
 - The provider's billed charge;
 - The usual and customary provider charge (not specifically defined in statute) for similar services in the community where the services were provided; or
 - The charge mutually agreed to by the HMO and provider
 - Payment must be made to the OON provider directly
- Payment Requirements for Non-Emergency Services
 - For OON non-emergency services, HMOs can negotiate with OON providers on rates

Florida

Disclosure Requirements

- Under Fla. Stat. 627.6472, insurers must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the policy or certificate to each policyholder and certificate-holder, including at least the following:
 - A description (including address and phone number) of the exclusive providers, including primary care physicians, specialty physicians, hospitals, and other providers
 - A description of the exclusive provider provisions, including coinsurance and deductible levels if providers other than exclusive providers are used
 - A description of coverage for emergency and urgently needed care and other out-of-service area coverage
 - A description of limitations on referrals to restricted exclusive providers and to other providers
 - A description of the insurer's quality assurance program and grievance procedure
- Prior to or at the time of the sale of a policy or certificate that is subject to an exclusive provider organization, the insurer must obtain from the policyholder or certificate-holder a signed and dated form stating that the policyholder or certificate-holder has received the information described above and that the policyholder or certificate-holder understands the restrictions of the policy or certificate

Florida

Dispute Resolution Process

- The Statewide Provider and Health Plan Claim Dispute Resolution Program was created in 2000 under Fla. Stat. 408.7057 and Fla. Admin. Code r. 59A-12.030 to “provide assistance to contracted and non-contracted providers and managed care organizations for resolution of claims disputes that are not resolved by the provider and the managed care organization”
 - The Program was expanded in 2002 to mediate provider disputes with plans other than HMOs
- Participation is optional for providers, but the review organization’s determination is binding on both parties
 - The losing party must pay the cost of the review
- The review process is administered through a contract with Maximus

California

Summary



- HMOs and some PPOs must pay reasonable and customary value for OON emergency services; balance billing prohibited
- Health insurers required to provide OON care at in-network prices due to network inadequacy
- Disclosure requirements for network facilities to insureds about OON providers who are likely to be involved in providing non-emergency care, and the estimated cost of that OON care
- Voluntary, non-binding dispute resolution process to resolve claim payment disputes for emergency services

California

Out-Of-Network Billing Restrictions

- Under Cal. Code Regs. tit. 28, § 1300.71.39, OON providers are prohibited from balance billing for emergency services
 - All emergency services are treated as in-network services
 - This restriction only applies to plans under the jurisdiction of the Department of Managed Health Care, including HMOs and some PPOs
 - The policy was challenged in court by providers, but was affirmed unanimously by the California Supreme Court in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497 (Cal.), Jan. 8, 2009 (emergency room physicians may not bill service plan members directly for sums that the plan has failed to pay for the members' emergency room treatment)

California

Out-Of-Network Billing Restrictions

- Emergency regulations currently in effect until October 27, 2015 require health insurers to make arrangements to provide OON care at in-network prices when there are insufficient in-network care providers under amendments to Cal. Code Regs. tit. 10, § 2240.1
 - “Networks must provide access to medically appropriate care from a qualified provider. If medically appropriate care cannot be provided within the network, the insurer shall arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only the in-network cost sharing for the service. In addition to in-network copayments and coinsurance, in-network cost sharing includes applicability of the in-network deductible and accrual of cost sharing to the in-network out-of-pocket maximum.”

California

Out-Of-Network Billing Restrictions

- A.B. 533, introduced in February 2015, requires a health care service plan contract or health insurance policy to provide that if an enrollee or insured receives covered services from a contracting health facility, at which, or as a result of which, the enrollee or insured receives covered services provided by an OON provider, the enrollee or insured would be required to pay the OON provider only the same cost-sharing required if the services were provided by a contracting provider
 - The bill would prohibit an enrollee or insured from owing the OON provider more than the in-network cost sharing amount if the OON provider receives reimbursement for services provided to the enrollee or insured at a contracting health facility from the plan or health insurer
 - The prohibition on balance billing would be effective on July 1, 2016
 - The bill would require an OON provider who collects more than the in-network cost sharing amount from the enrollee or insured to refund any overpayment to the enrollee or insured
 - The bill also would require the development of an independent dispute resolution process for OON providers who rendered services at a contracting health facility to appeal a claim payment
- On September 12, 2015, the California Assembly refused to concur with Senate Amendments to A.B. 533 and a motion to reconsider was filed

California

Out-Of-Network Billing Restrictions

- Under Cal. Code Regs. tit. 28, § 1300.71, payment requirements for HMOs and PPOs include:
 - For contracted providers without a written contract and OON providers, the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:
 - The provider's training, qualifications, and length of time in practice;
 - The nature of the services provided;
 - The fees usually charged by the provider;
 - Prevailing provider rates charged in the general geographic area in which the services were rendered;
 - Other aspects of the economics of the medical provider's practice that are relevant; and
 - Any unusual circumstances in the case
 - For non-emergency services provided by OON providers to PPO and POS enrollees, plans must pay the amount set forth in the enrollee's Evidence of Coverage

California

Disclosure Requirements

- Cal. Code Regs. tit. 10, § 2240.4 requires network facilities to determine and disclose to insured persons prior to an insured person's non-emergency episode of care the OON providers who are likely to be involved in providing care, and the estimated cost of that OON care to the insured person
- Emergency regulations currently in effect until October 27, 2015 provide examples and further disclosure guidance under amendments to Cal. Code Regs. tit. 10, § 2240.4
 - “For a surgery in a network hospital, the hospital shall disclose to the insured person, prior to the surgery, all non-network providers, such as anesthesiologists, radiologist, and pathologists, who are anticipated to be involved in the person's care, and the estimated cost of their non-network services. This disclosure is to be made sufficiently in advance of the scheduled episode of care to afford the insured person a reasonable opportunity to explore alternate arrangements.”

California

Dispute Resolution Process

- The Department of Managed Health Care has established an Independent Dispute Resolution Process (“IDRP”) to resolve claim payment disputes
- OON providers who deliver EMTALA-required emergency services to members of health care service plans or capitated providers are eligible to submit an IDRP request form concerning the “reasonable and customary” value of services rendered
- The IDRP is a voluntary and non-binding process, but providers and payers are encouraged to comply with the decisions issued by the IDRP External Reviewer

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The New York Emergency Medical Services & Surprise Bills Law

The Emergency Medical Services and Surprise Bills Law



- New York law impacts billing and reimbursement and disputes for some out-of-network health care services, requires new disclosures from providers and plans, adds new rules for health plans regarding networks and reimbursement for out-of-network services.
- The implementation date for this law in New York was March 31, 2015.

New Disclosure Requirements For Professionals, Group Practices, Diagnostic and Treatment Centers, and Health Centers:

Pursuant to the law, the following information must be disclosed by professionals, group practices, diagnostic and treatment centers, and health centers to patients or prospective patients:

- The **names of the health plans with which such provider participates** (either in writing or via the provider's website);
 - If participation is with all lines of business, the plan name is sufficient; if only with some lines of business, all those lines of business must be listed
- The **names of the hospitals with which such provider is affiliated** (either in writing or via the provider's website and verbally when an appointment is made);
- **That the amount or estimated amount for the service is available upon request** (must be disclosed before the provision of non-emergency services); and
- **Upon receipt of a request, the amount or estimated amount that will be billed**—or the fee schedule if a health center—absent unforeseen medical circumstances (must be disclosed in writing).

Additional Disclosure Requirements for Physicians

- The following information must also be disclosed by physicians:
 - To patients or prospective patients—the name, practice name, address, and phone number of any provider (or practice of referral is to practice) 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.
 - To both patients scheduled for hospital admission or outpatient hospital service and the hospital—the name, practice name, address, and phone number of any other physician (or practice of referral is to practice) whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration, or admission at the time that the non-emergency services are scheduled*, and information as to how to determine the plans in which the physician participates.

** Note this would not apply to unscheduled inpatient admissions.*

New Disclosure Requirements for Hospitals

The following information must be disclosed by hospitals:

- The law requires that a hospital post on its website:
 - A list of the hospital's standard charges for items and services provided by the hospital, including diagnosis-related groups ("DRGs"); and
 - The health care plans with which the hospital is a participating provider (same line of business listing requirements apply), and it must specifically state the following:
 - That the physician services provided in the hospital may not be included in the hospital's charges;
 - That physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital;
 - That the prospective patient should check with the physician arranging for the hospital service to determine the health care plans with which the physician participates; and

New Disclosure Requirements for Hospitals

Continued

- The law requires that a hospital post on its website (cont.):
 - As applicable, the names, mailing address, and phone numbers of practice groups that the hospital has contracted with, including radiology, anesthesiology, and pathology services, and information on how to determine the health care plans in which they participate.
 - Individual physicians in those groups must be listed by those groups.
- In situations where a hospital contracts with or employs professionals, the hospital is required to list the names of those professionals and may provide a central contact (mailing address and telephone number) that a patient can contact for more information.
 - This includes physicians employed full time or part-time by a hospital.
- The hospital disclosure requirements regarding employed physicians apply regardless of whether or not the services will be billed by the hospital or the employed physician.

New Disclosure Requirements for Hospitals

Continued

- Hospitals also need to include in registration or admission materials in advance of non-emergency services:
 - Advice that the patient should check with his or her physician arranging such hospital service to determine the (1) name, practice name, address, and phone number of any physicians whose services will be arranged by such physician; and (2) whether the services of physicians employed or contracted by the hospital to provide anesthesiology, pathology, and/or radiology are reasonably anticipated to be provided to patient; and
 - Information as to how to timely determine the health care plans participated in by all such physicians, as determined by the physician arranging the hospital service.

New Disclosure Requirements for Health Plans

■ Provider Directory

- Requires health plan provider directories to include a listing by specialty of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals.
- Requires a health plan to post the listing on its website and further requires a health plan to update its website within 15 days of the addition or termination of a provider from its network or a change in a physician's hospital affiliation. Health plans should include language in their provider contracts requiring physicians to annually report hospital affiliations and languages spoken to health plans for inclusion in the health plan's provider directory, and to report any changes in hospital affiliations within 15 days of the change.

New Disclosure Requirements for Health Plans

Continued

■ **OON Reimbursement Compared to UCR**

- Requires health plans to disclose the amount they will reimburse under their OON methodology set forth as a percentage of the usual and customary cost ("UCR"). This requirement will be satisfied if a health plan provides the approximate percentage of UCR that equates to the reimbursement under the health plan's OON methodology.

■ **OON Reimbursement Examples**

- Requires health plans to provide examples of anticipated out-of-pocket costs for frequently billed OON services. This requirement will be satisfied if a health plan provides at least three examples which include examples for a colonoscopy (CPT code 45380), spinal surgery (CPT code 63030), and breast reconstruction (CPT code 19357) in a format provided by the Department of Financial Services.

New Disclosure Requirements for Health Plans

Continued

■ **Determining OON Out-of-Pocket Costs**

- Requires health plans to disclose information that permits an insured or prospective insured to determine out-of-pocket costs for OON services.
- A health plan may satisfy this requirement through a link on its website to an independent source which can be used to determine UCR for OON services. NYS FAIR Health may be used as the independent source to determine UCR and use of FAIR Health will satisfy the requirements of these sections.
 - If a health plan uses FAIR Health, the health plan will need to contact FAIR Health in order to set up a licensing arrangement to establish a link. If a health plan does not use FAIR Health, the health plan will need to contact the Department of Financial Services for approval.

New Disclosure Requirements for Health Plans

Continued

■ Reimbursement for Specific OON Service

- Requires health plans to disclose, upon request, the approximate dollar amount that they will pay for a specific out-of-network service. If a health plan is unable to identify a specific dollar amount because the current procedural terminology (CPT) code(s) or diagnosis code(s) were not submitted with the request, a health plan may disclose the range of dollar amounts that it will pay for the OON service.
- The health plan should also include a disclaimer that the dollar amount could change based on the actual services provided and CPT code(s) or diagnosis code(s) submitted. One example of such a disclaimer is:
 - “This payment estimate is not a guarantee. The actual payment will depend on a number of factors, including, for example, the services you receive, the amount billed by your doctor or other provider, the actual procedure codes submitted, and your eligibility for benefits at the time you receive the services.”

Health Plan Network Adequacy Requirements

- Now, all New York health insurance plans that issue policies that provide for the use of a provider network are required to obtain network adequacy certification.
 - Previously, this only applied to HMO products in New York; the requirement now expands to other products, including preferred provider organizations (“PPOs”) and exclusive provider organizations (“EPOs”).
 - The law requires that the networks be approved by the Superintendent of Financial Services at the time that the policy is approved and at least every three years thereafter, as well as upon application for expansion of any service area.
- The standard for network adequacy is described as whether the network is sufficient to meet the health needs of the insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract.
 - The criteria for making this assessment are the same ones that apply to HMOs, as set forth in New York Public Health Law § 4403(5); see next slide for specifics.

Health Plan Network Adequacy Requirements

Continued

- Basic network adequacy requirements under Public Health Law § 4403(5):
 - There are a sufficient number of geographically accessible participating providers;
 - There are opportunities to select from at least three primary care providers pursuant to travel and distance time standards, providing that such standards account for the conditions of accessing providers in rural areas;
 - There are sufficient providers in each area of specialty practice to meet the needs of the enrollment population;
 - There is no exclusion of any appropriately licensed type of provider as a class; and
 - Contracts entered into with health care providers neither transfer financial risk in a manner inconsistent with the provisions of the law, nor penalize providers for unfavorable case mix.
- Also considered are: compliance with the ADA regarding timely care; provision of culturally and linguistically competent care; and the number of grievances filed by enrollees related to waiting times for appointments, appropriateness of referrals, and other indicators of plan capacity.

Health Plan Network Adequacy Requirements

Continued

- If a plan covers out-of-network care, it must provide at least one option for coverage for at least eighty percent of the usual and customary cost of each out-of-network health care service after imposition of a deductible or any permissible benefit maximum.
 - “Usual and customary cost” is defined as the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent.

What is a “Surprise Bill?”

A bill for non-emergency services is a “surprise bill” if:

The service is provided by a ...	To:	Where:	And:
A non-participating physician	An insured patient	At an in-network hospital or ambulatory surgery center	<p>The participating physician is unavailable; or</p> <p>The service was rendered without the patient’s knowledge; or</p> <p>Unforeseen medical services arose at the time that the health care services were rendered</p>
A non-participating provider (including professionals licensed under Title 8 and various facilities)	An insured patient	Anywhere	The patient was referred by a participating physician without the patient’s explicit written consent that the referral was to a non-participating provider and that it may result in costs not being covered by the patient’s plan
A physician	An uninsured patient	At any hospital or ambulatory surgery center	The patient has not timely received all disclosures required from providers under Section 24 of the Public Health Law

What is a “Surprise Bill?”

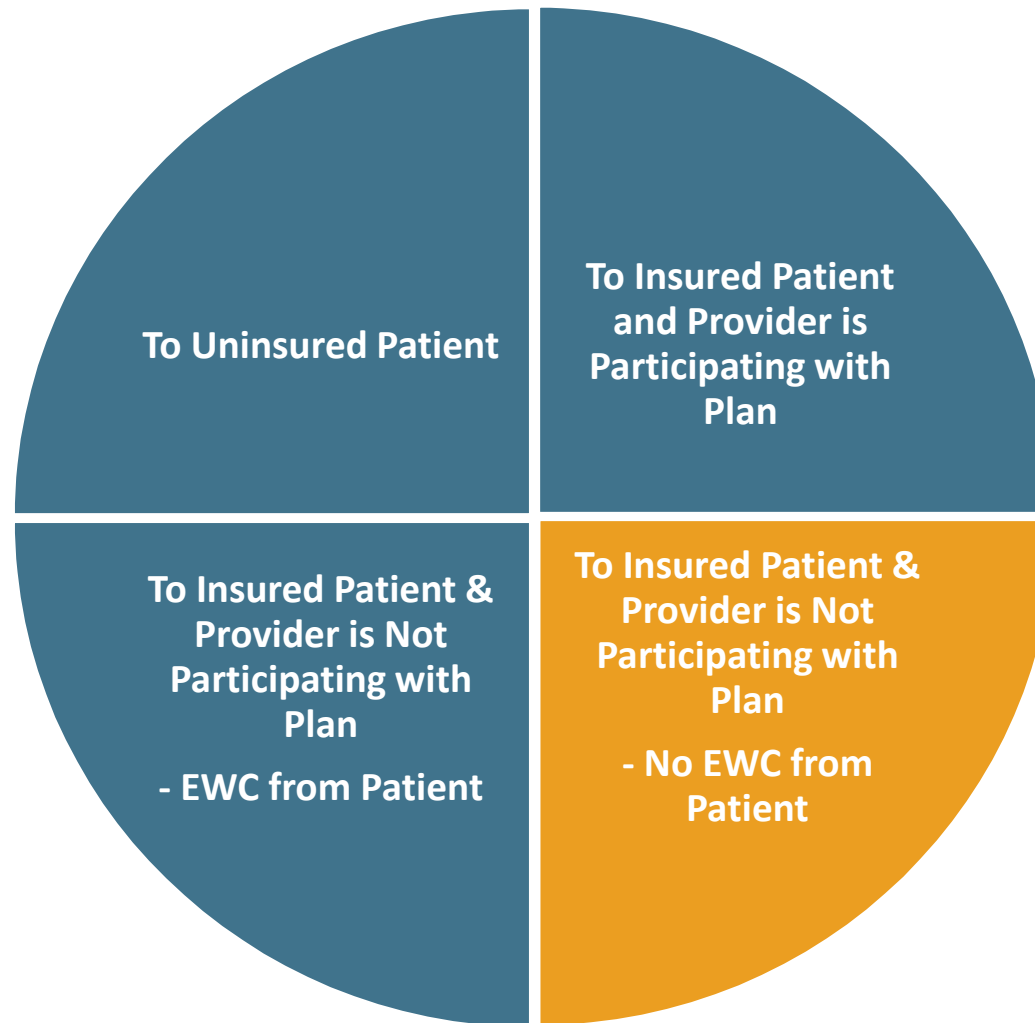
Continued

A “surprise bill” is a bill for health care services, other than emergency services, received by:

1. An insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered.*
2. An insured for services rendered by a non-participating health care provider, where the services were referred by a participating physician to a non-participating health care provider without explicit written consent of the insured acknowledging that the participating physician is referring to a non-participating health care provider and that the referral may result in costs not covered by the health care plan.
3. A patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center, where the patient has not timely received all of the disclosures required pursuant to Public Health Law Section 24.

**It does not apply when a participating physician is available and the insured has elected to obtain services from a non-participating physician.*

For Providers Receiving “Referrals” Only Bills in Orange Could = “Surprise Bills”



**EWC = Explicit Written Consent*

Referrals

- “Referral” to a non-participating provider occurs when:
 - The health care services are performed by a non-participating health care provider in the participating physician’s office or practice during course of the same visit;
 - The participating physician send a specimen taken from the patient in the physician’s office to a non-participating laboratory or pathologist; or
 - Any other health care services when referrals are required under the insured’s contract (i.e. a gatekeeper).
- Example of surprise bill based on referral (from 3/17/15 DFS guidance):
 - An insured’s contract does not require the insured to obtain a referral before getting services and the contract covers out-of-network services. The insured has blood drawn in a participating physician’s office and the specimen is sent to a non-participating laboratory without the insured’s explicit written consent acknowledging that the participating physician is referring the insured to a...

Referrals

Continued

...non-participating laboratory and that the referral may result in costs not covered by the health plan. The bill would be a surprise bill and would be covered as in-network.

- Example of bills that are not surprise bills (from 3/17/15 DFS guidance):
 - An insured's contract does not require the insured to obtain a referral before getting services. A participating physician provides the insured with a list of local laboratories and recommends that the insured makes an appointment to have blood work done.
 - An insured's contract does not require the insured to obtain a referral before getting services. A participating provider who is not a physician (for example a speech therapist) refers the insured to a non-participating provider (for example a durable medical equipment provider).
 - An insured requests a referral or authorization to a non-participating provider, the referral or authorization is denied by the health plan, and the insured subsequently obtains the services of the non-participating provider.

Obtaining Explicit Written Consent for Referrals (to avoid “surprise bills”)

- EWC can be obtained by the **referring provider** before referring the patient:
 - We recommend giving referring providers a standard consent form they can use.
- EWC may be obtained by the **provider receiving the referral**:
 - Providers receiving referrals who are unaware of if EWC has been obtained have the option to obtain EWC from patients; if the provider receives the consent, it would not be a surprise bill under Financial Services Law § 603(h)(2).
 - If the patient later submits a bill to dispute resolution as a surprise bill, the out-of-network provider may submit this consent form for consideration by the IDRE.
- The EWC must be signed by the patient, acknowledging:
 - Services will be performed by an out-of-network provider; and
 - Patient may incur greater expense than if services performed by in-network provider.

Billing For Services

- Any Surprise Bill Sent to Patient From a Physician (not all Providers) Must Include Assignment of Benefits (“AOB”) Form* & Claim Form**

** DFS regulations adopted on emergency basis require AOB and claim form be sent (copy of AOB form is attached to DFS guidance 3/17/15)*

*** statute requires claim form be sent*

- If Patient Signs & Returns AOB (e.g., to a *Provider* receiving referral), then:
 - Provider can negotiate with plan if plan does not pay Provider’s billed amount; plan must pay reasonable amount.
 - Provider can dispute amount paid by plan (IDRE must pick amount billed by Provider or amount paid by plan).
 - Provider can only bill patient per EOB (member cost sharing).

Billing For Services

- If Patient Does Not Sign & Return AOB, then:
 - Plan processes it in usual way
 - Provider can bill patient but patient may dispute before paying
 - IDRE can decide reasonable fee (taking into account factors in law)

Emergency Services Provided By Physicians

- Law also provides new rules for emergency services provided by a physician:
 - to insured with plan with which that physician does not participate;
 - to uninsured
- Excludes many emergency services with bills less than \$600 (annual inflator)
- If physician bills insured patient's plan, plan must hold patient harmless (HMO and insurance laws now) and pay amount per ACA (greater of 3 amounts); provider can dispute amount paid by plan and IDRE must select plan's payment or physician's billed amount
- If physician bills uninsured patient, patient may file dispute if DFS agrees and IDRE would then decide reasonable fee

Scope of Law: Products Exempt Under New Law

- Exempt products under surprise bill provisions: Medicare, MLTC, Medicaid FFS, WC and no fault
- Products exempt from emergency services protections: same exemptions as above, plus Medicaid managed care
- Also, self-funded plans are not subject to the law since they are not governed by HMO or insurance law
- Exempt products under emergency services provisions: same as above plus Medicaid managed care
- Self-funded plans also not subject to law since not governed under HMO or insurance laws

Independent Dispute Resolution Entity (IDRE) Process, Explained

- Statutory language (23 NYCRR 200) concerns disputes involving surprise bills and has been adopted.
- Health care plans, physicians, and, when applicable, other health care providers and patients, have the right to request a review by an Independent Dispute Resolution Entity (IDRE) to resolve a payment dispute regarding a bill for certain emergency services or surprise bills.
- Different procedural flows exist based on whether the patient who is impacted by the surprise bill is:
 - Insured with Assignment of Benefits;
 - Insured without Assignment of Benefits; or
 - Uninsured.

Independent Dispute Resolution Entity (IDRE) Process, Explained

Continued

- For out-of-network physician services that include an assignment of benefits from an insured, the health plan must pay the physician the billed amount or attempt to negotiate a different amount. If the latter fails to resolve any payment dispute, the plan must pay an amount that the plan determines is reasonable and either party may submit the dispute to an Independent Dispute Resolution Entity (provided, however, that, if the plan wants to submit the dispute, it must first pay pursuant to the prior sentence).
- For out-of-network physician services provided to an insured that do not include an assignment of benefits, or provided to an uninsured patient, such patient may submit the dispute regarding the surprise bill for review to an Independent Dispute Resolution Entity (and the patient does not need to pay the bill before disputing).

Independent Dispute Resolution Entity (IDRE) Process, Explained

Continued

- If a health plan or provider does not believe that a bill meets the definition of a surprise bill, the health plan or provider may contact the Consumer Assistance Bureau of the Department of Financial Services and may submit any relevant information to the Consumer Assistance Bureau. If the dispute has been submitted to an IDRE, a health plan, provider or consumer should also submit any relevant information to the IDRE.
- The current IDRE entities in New York are:
 - IMEDECS
 - IPRO
 - MCMC
- However, these entities are serving as temporary IDREs, and an RFP for permanent IDRE entities is forthcoming.

Independent Dispute Resolution Entity (IDRE) Process, Explained

Continued

- The Independent Dispute Resolution Entity will make a binding decision within 30 days and:
 - For out-of-network physician services that include an assignment of benefits from an insured, select either the plan's payment or the physician's fee (taking certain factors into account); or
 - For out-of-network physician services provided to an insured that do not include an assignment of benefits, determine a reasonable fee (taking certain factors into account).
- When billing for out-of-network services (other than for copay, coinsurance, or deductible), all physicians must provide patients with claim forms for patients to use with third-party payers.

Out-of-State Referrals and the “Nexus” Test

- It is a surprise bill if a participating physician with the patient's health plan is located outside New York and refers the patient to a non-participating provider without the patient's explicit written consent advising that the provider is out-of-network and the referral may result in costs not covered by the health plan.
- Note that the independent dispute resolution process in Article 6 of the Financial Services Law could apply to surprise bills for health care services that are provided by out-of-state providers if the service is performed in part in New York and the out-of-state provider has a “sufficient nexus” with New York.
 - For example, if the insured is covered under an HMO or insurance policy or contract that is issued for delivery in New York and has blood drawn in New York by his or her participating physician and the participating physician sends the sample to an out-of-state laboratory that regularly conducts business with the New York provider.

New York Guidance Links

■ New York State Department of Financial Services (Insurance):

- General Information:
 - <http://www.dfs.ny.gov/consumer/hprotection.htm>
- Guidance/FAQ:
 - http://www.dfs.ny.gov/insurance/health/OON_guidance.htm
 - http://www.dfs.ny.gov/insurance/health/OON_law_supplement_qa.htm

■ New York State Department of Health:

- General Information:
 - http://www.health.ny.gov/regulations/public_health_law/surprise_bill_law/
- Guidance/FAQ:
 - http://www.health.ny.gov/regulations/public_health_law/surprise_bill_law/emergency_and_surprise_bills_law_faq.htm

Final Thoughts

- Nationally, there are measures being put in place, albeit to varying degrees, to address issues related to out-of-network billing, adequate disclosure and surprise bill concerns
- These laws and regulations place additional responsibility on health plans and providers to help increase transparency in the healthcare marketplace
- National standards are being developed to assist in standardization of these requirements, while states themselves are establishing new disclosure obligations, network adequacy requirements, balance billing prohibitions, and dispute resolution processes

EBG As A Resource For Clients

- Visit the www.ebglaw.com website for the various alerts we have published on a wide range of issues related to health regulation, reform and the Medicare and Medicaid programs



Questions and Answers

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