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Health Law Advisory

How New York's Emergency Medical Services and Surprise Bills Law Impacts Providers and Plans

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Last year New York passed legislation known as the "Emergency Medical Services and Surprise Bills" law, a much-heralded consumer protection law primarily intended to guard against surprise bills for out of network (OON) health care services. We wrote about the law, which went into effect on March 31, 2015, in two separate blog posts, but this advisory consolidates and clarifies the various obligations that are now required of health plans and providers.

Below is a summary of some of the key provisions in the legislation, which, in short, (i) ensures that consumers who receive surprise bills pay no more than their usual in-network cost sharing and/or copayment amounts, regardless of the network status of the treating physician, (ii) mandates greater transparency obligations on the part of providers and health plans regarding OON charges and network participation, and (iii) incorporates broader rights for a patient to go OON if the insurance plan's existing network is insufficient.

Surprise Bills and the Independent Dispute Resolution Process

Imagine that you go to your gastroenterologist because you have been experiencing terrible abdominal pain. Your GI takes a CT scan, which is read by a radiologist and shows a mass on your appendix. A week later you have a laparoscopic appendectomy to remove your appendix, which is performed by a top notch surgeon in your plan's network, and the mass is sent to a clinical laboratory to be biopsied in order to determine if it is cancerous. Three months later you receive an invoice for radiology, anesthesiology and clinical lab services from OON providers.

The new legislation is designed to prevent this type of situation. A consumer who receives an invoice from an OON provider will now be responsible only for in-network costs if the invoice constitutes a surprise bill, which is an invoice for health care services, other than emergency services, received by a patient in one of three circumstances:

- An insured receives services from an OON physician at an in-network hospital or ambulatory surgery center, where (i) a participating physician is unavailable or (ii) an OON physician renders services without the patient's knowledge.
- An insured receives services from an OON provider, where the services were referred by an in-network physician without the patient's express written acknowledgment that the referral is to an OON provider, and that the referral may result in costs not covered by the health plan.
- An uninsured patient receives services at a hospital or ASC and did not receive the disclosures required under the new Public Health Law Section 24, discussed in more detail below.

In regulations issued by the New York State Department of Financial Services (DFS), the term "health care provider" was defined to include home health agencies and clinical laboratories. DFS also clarified that a surprise bill that results from a "referral" without the required patient consent includes instances in which a "participating physician sends a specimen taken from the patient in the participating physician's office to a non-participating laboratory or pathologist."

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In order to be protected from a surprise bill, a consumer must sign an assignment of benefits form permitting the provider to seek payment directly from the consumer's health plan, and send the form to the plan with a copy of the bill believed to constitute a surprise bill. Once the health plan pays the provider an amount that it determines to be reasonable, the provider can dispute that amount through the independent dispute resolution (IDR) process. The IDR entity will make a determination within 30 days of receipt of the dispute.

As part of the IDR entity's review, the IDR will consider, among other things, whether there is a "gross disparity" between the fee charged by the physician as compared to other fees paid to similarly qualified OON physicians in the same region, the level of training, education and experience of the physician, and the circumstances and complexity of the case, including the time and place of the services.

In the case of claims for emergency services rendered to an insured patient by an OON physician, a health plan must also pay an amount it deems to be reasonable and notify the physician of how to initiate the IDR process. The patient must be notified that he or she will not incur greater out of pocket expenses for the services had they been provided by in-network physicians.

Disclosure Obligations

The law also imposes new disclosure obligations for health care professionals and plans:

Healthcare Providers: Healthcare providers, including licensed professionals and their group practices, diagnostic and treatment centers and health centers, must:

- Disclose to patients and prospective patients, in writing or through their website, their plan and hospital affiliations prior to the provision of non-emergency services and verbally at the time the appointment is scheduled.
- An out of network provider must inform the patient, prior to providing non-emergency services, that (i) the actual or estimated amount for the service is available upon request, and (ii) if requested, will be disclosed in writing with a warning that costs could go up if unanticipated complications occur.

Physicians: In addition to the foregoing, a physician must provide a patient and the inpatient or outpatient hospital in which the patient is scheduled for admission with the name, practice name, mailing address and phone number of any other physician scheduled to treat the patient and information as to how to determine the health plan(s) in which the provider(s) participates.

Hospitals: Hospitals must post the following information on their website:

- standard charges for services provided by the hospital, including diagnosis-related groups (DRGs);
- the health plans in which they participate;
- a warning that (i) charges for physicians who provide services in the hospital are not part of the hospital's charges, and (ii) physicians who provide services in the hospital may not be in the same networks as the hospital; and
- the name, address and phone number of both contracted specialty practice group providers and employed physicians, together with information regarding how they can be contacted to determine their plan affiliations.

In addition, in the registration and admission materials provided in advance of the provision of non-emergency services, hospitals must (i) advise patients to check with the physician arranging their services to determine the name, address and phone number of any other physician involved in the patient's care, and whether any employed or contracted specialty physicians are expected to participate in the patient's care, and (ii) provide patients with information regarding how they can timely determine the health plans in which the physicians participate.

Health Plans: Insurers, including HMOs, are currently obligated to give consumers a provider directory that is updated annually and that includes the name, address, phone number and specialty of all participating providers, facilities, and, in the case of physicians, board certification. Under the new law, insurers also will be obligated to have information in writing and on the Internet that allows consumers to estimate anticipated out-of-pocket costs for OON services in a particular geographic area based on the difference between what the insurer will reimburse for the OON services and the usual and customary costs for the OON services.

In addition, upon request from an enrollee or prospective enrollee, insurers must disclose the approximate dollar amount that the insurer will pay for a particular OON service but that the approximation is not binding on the insurer and may change.

Network Adequacy and Coverage

All health insurers, not just HMOs, are now required to have adequate networks to ensure greater choice and access to care. If a plan's network does not have a geographically accessible provider with appropriate training and expertise to treat a patient's condition, the patient can seek services from an OON provider without incurring additional out-of-pocket expenses.

If the plan covers OON care, it must make available one option for coverage at 80% of "usual and customary costs" (and if the plan doesn't offer any OON coverage the Superintendent may require such coverage at 80% of U&C costs unless it will cause undue hardship on the insurer). "Usual and customary cost" is defined as the 80th 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."
Denials based on OON coverage – where the plan disagrees that there is no in-network provider that can meet the insured's medical needs – can go through the state's external review process.

Conclusion

The new law puts the onus on health plans and providers to address what DFS has described as "unacceptable opaqueness" in the healthcare marketplace. Through improved disclosure obligations, new network adequacy requirements, balanced billing prohibitions, and a dispute resolution process that takes the consumer out of the ring, the hope is that plans and providers will collaborate to change this perception. Meanwhile, over the next few months a government-appointed workgroup that includes plans, physicians and consumers will be studying and making recommendations for changes in the rules regarding the availability of OON coverage and the level of reimbursement for OON services. The group's report is due on January 1, 2016.

If you have any questions about this topic, please contact the author(s) or your principal Mintz Levin attorney.

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