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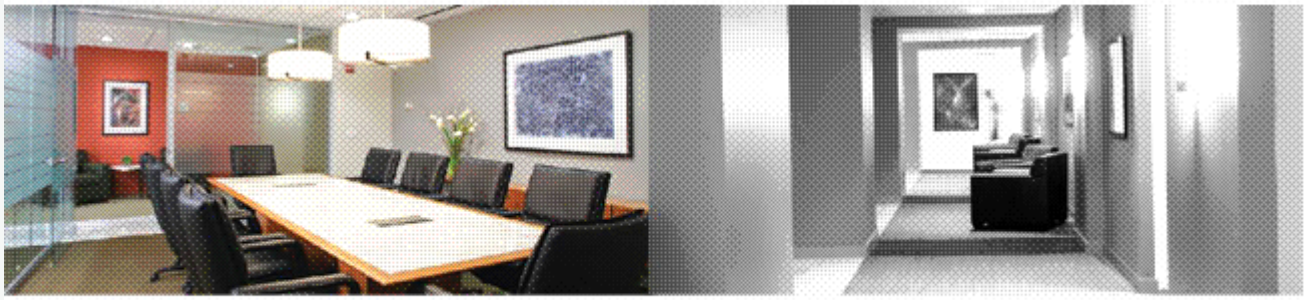

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New Surprise/Out-of-Network Billing Law Changes Health Care Providers' Billing

All health care providers in New York State who are out-of-network with any of their patients' insurance plans (or refer patients to out-of-network providers) should immediately review their billing practices for compliance with the state's new *Emergency Medical Services and Surprise Bills* law (the "Surprise Bill Law"). The Surprise Bill Law went into effect on March 31, 2015. It subjects every NY licensed health care provider – physicians, physical therapists, hospitals, ambulatory surgery centers, home care agencies, etc. – to rules that:

- May reduce the amounts providers bill out-of-network patients,
- Impose substantial new disclosure requirements regarding health plan coverage and patient fees, and
- Set up a new dispute resolution process to resolve billing disputes between providers and health plans.

OVERVIEW OF THE SURPRISE/OUT-OF-NETWORK BILL LAW

The Surprise Bill Law is a response to health care consumer complaints about hefty bills from non-network medical providers. Last fall, for example, *The New York Times* ran a story on "surprise medical bills," highlighting a bank manager who after neck surgery was blindsided by a $117,000 bill from an "assistant surgeon" that the patient did not remember meeting. The patient was unaware that his in-network primary surgeon had arranged for an assistant not in-network.

The Surprise Bill Law protects two classes of patients: (i) patients receiving

out-of-network bills for emergency medical care by providers who are not in their insurer's network, and (ii) patients, like the patient in the NY Times, who use in-network providers only to be confronted with unexpected "surprise" bills by out-of-network providers. Both classes of patients now may not be forced to pay more than they would have paid had the provider been in-network.

A bill for non-emergency health care services is defined as a "Surprise Bill" when:

- An insured patient in a participating hospital or ambulatory surgical center receives out-of-network services because an in-network professional was unavailable, or out-of-network services are rendered without the insured's knowledge that the services are out of network, or unforeseen circumstances arose; or
- An insured patient's in-network provider refers the insured to an out-of-network provider without the insured's consent; or
- Mandated disclosures are not made to uninsured or self-insured patients.

Patients are required to pay only their usual in-network cost-sharing and co-payments when they receive out-of-network bills for emergency services. Bills for emergency services must be submitted by an out-of-network provider directly to the patient's insurer and reimbursement negotiated with the insurer, with any disputes regarding reimbursements to be submitted to an independent review entity. Patients receiving "surprise" (non-emergency) bills may assign their right to payment to the out-of-network provider and pay only their co-pay and deductible while the providers negotiate with health plans for additional payment. If the out-of-network provider and the insurer cannot agree on the bill, either can start an independent review process to determine what fees shall be paid. This review process can also be used by uninsured consumers who wish to challenge the reasonableness of a provider's fees.

PROVIDER DISCLOSURES. The Surprise Bill law subjects providers to a host of new disclosure obligations regarding their fees, plan participation, hospital affiliations, etc. Physicians and other professionals are required to tell the patient:

- In which health plans the provider participates and with which hospitals they are affiliated (both in writing and by posting the information on-line);
- If they participate in the patient's network (at the time the patient makes the appointment);
- Before providing non-emergency care, of the patient's right to know what they will be billed for a procedure, and, *if then requested by the patient*, the anticipated cost with a warning that

such costs may go up if unanticipated complications arise; and

- The identity of any provider to whom the patient may be referred, or who may later bill for the patient's care (such as anesthesiologists, pathologists, lab, radiologists or assistant surgeons), so that the patient may learn the network status of those providers.

Providers should take care to make mandatory disclosures to avoid having an out-of-network bill deemed a Surprise Bill, with the result that (as with emergency services bills) patients need pay only their usual in-network cost-sharing and assign their payment to the out-of-network providers, who then must deal with the applicable insurer or resort to the state's independent review process to obtain any additional payment. In addition, according to the regulations, an explicit written consent of the insured to an out-of-network referral must be obtained, including acknowledgement that the referral may result in costs not covered by the insured's health plan.

HOSPITAL DISCLOSURES. Hospital disclosure obligations under the Surprise Bill Law include:

- Publicly posting a schedule of charges for items and services, including DRGs;
- Listing the health plans in which they participate;
- Warning patients that physician services provided in the hospital may not be included in the hospital's bills but may be billed separately, and that the plans the hospital participates in may not be the same as those of the provider:
- Telling patients to check with their providers regarding what plans the providers participate in;
- Posting the names of providers and practice groups for such services as radiology, anesthesiology and pathology services with which the hospital has a contract, and providing information on how patients can determine in which plans these providers participate;
- Posting the names, addresses, and phone numbers of physicians employed by the hospital and whose services may be provided at the hospital, and which plans they participate in.

Hospitals also must include in registration or admission materials, provided before any non-emergency services, advice to the patient to check with his or her provider for the name, practice name, address, and phone number of any physicians such provider will be arranging to provide services to the patient, whether any anesthesiology, pathology, and/or radiology are reasonably anticipated to be provided to patient and how to determine the

health plans such physicians participate in.

HEALTH PLAN OBLIGATIONS. Health plans must also provide certain disclosures, some of which are automatic, while others need only be made upon request. Automatic disclosures include:

- Posting any changes to the provider directory, with updates at least every 15 days;
- Describing how an insured submits a claim;
- Telling insureds how much the plan reimburses, and how its reimbursement compares to the usual, customary, and reasonable ("UCR") fees; and
- If the plan permits access to out-of-network services, providing examples of anticipated out-of-pocket costs for common medical procedures and how those amounts compare to typical charges, such that an insured can estimate the anticipated cost for out-of-network services.

A health plan must also post on its website and include in material provided to insureds:

- A description of what constitutes a Surprise Bill;
- A description of the independent review process;
- Information on how to submit a dispute to an independent review entity;
- An assignment of benefits form for Surprise Bills; and how to submit it to the plan.

Plans must disclose upon request whether a provider scheduled to provide a service is in-network, and the approximate amount the plan will pay for a specific out-of-network service.

Health plans are also subject to new "network adequacy rules" under which they will be required to be certified as having provider networks that can meet the health needs of their members without resorting to out of network providers. (While such rules have applied to HMOs, they now also apply to PPO and EPO networks.) If a plan's network does not satisfy the network adequacy standards, it must permit members to seek out-of-network providers without having to pay more than their usual in-network costs.

INDEPENDENT DISPUTE RESOLUTION PROCESS

The Surprise Bill Law establishes an independent dispute resolution ("IDR") process to settle disputes over out-of-network fees relating to both emergency services and Surprise Bills. A patient, provider or insurer may apply to have a dispute reviewed by an entity certified by the state to

decide out-of-network billing disputes. The State has selected three vendors to adjudicate disputes: Island Peer Review Organization (IPRO) in Lake Success, NY, Independent Medical Expert Consulting Services in Lansdale, PA, and MCMC in Quincy, Mass. Each party should submit information justifying their position, including an explanation of the circumstances and complexity of the case, and information on the usual and customary cost for such services. The reviewer is to conduct the examination in consultation with a physician in active practice in the same or similar specialty as the physician in the dispute.

The IDR reviewer must choose whether the fee from the provider or the insurer is more reasonable. The reviewer may direct the parties to negotiate in good faith before making her own determination. Where there is an assignment of benefits, the plan is required to pay that part of the fees that it considers reasonable while the IDR process is pending. The process from submission to determination must occur within 30 days, with the reviewer's determination binding on all parties (parties may appeal the resolution; however, the review will be admissible in such suit). The losing party must pay the whole cost of the IDR, while costs are shared if the parties reach a settlement.

The State Department of Financial Services has posted further information on the law on its website.

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