Understanding the NYS Out of Network and Surprise Billing Law

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Continuing Education

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What we're going to cover

- An overview of the Statute
  - Insurance Law changes
  - Network adequacy requirements
- What is "Out of Network"?
  - How providers contract with insurers
  - Health plan and physician disclosure requirements
- Out of Network Reimbursement
  - Medicare RBRVS
  - Fair Health
  - Requirements for disclosure of out of network payments
- Out of Network Requirements
  - Make available
  - Referrals to Out of Network Requirements
- What's Surprise Billing?
- The Independent Dispute Resolution Center
- Q and A

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Why do we need an OON Law?

- Inadequate of no OON reimbursement
- Patients not told in advance that the treating provider was OON.
- OON complaints like these outnumbered all other complaints to DFS, DOI, AG's Health Bureau and other consumer assistance agencies
  - 8,000 complaints to DFS (DOI) between 2008 and 2014
- OON bills are a major source of credit problems and bankruptcies*

*Families USA 4/10/2014

Attorney General sues GHI

2014: Comprehensive Benefit Plan offered to NYC employees

The plan had OON benefits available

Reimbursement was based on a 1983 fee schedule

AG felt GHI didn't adequately disclose the potential OOP costs to the members

For example:

Ave Cost (NYC area)	CBP	OON
Hip Replacement	$7,375	$2,732
Office visit	$247	$36

Attorney General Charges

1. GHI didn't make the schedule available to members
2. GHI didn't tell members there could be large OOP costs
3. GHI didn't tell members how they could encounter OON providers
4. GHI misrepresents the frequency in which the schedule is updated.

Result

- Improved disclosure to members
  - Revised summary program description language for NYC ee's
  - Revised member facing materials
  - Train staff and create website for NYC ee's and retirees
- Pay:
  - $3,500,000 to establish a Consumer Assistance Fund
  - $120,000 to fund 2 FTE's to staff the Fund annually
  - $50,000 for cost of administration of the Fund
  - $300,000 to NYS OAG in penalties

Changes to NY Statutes

- Provider Directory Requirements:
  - NY Insurance Law 3217A(a)(17)
  - NY Insurance Law 4324(a)(17)
  - Public Health Law 4408(r)
- OON Reimbursement
  - NY Insurance Law 3217A (a)(19)(B)
  - NY Insurance Law 4324(a)(20)(B)
  - Public Health Law 4408(1)(t)(ii)
- OON Reimbursement Examples
  - NY Insurance Law 3217A(a)(19)(C)
  - NY Insurance Law 4324(a)(20)(C)
  - Public Health Law 4408(t)(iii)
- Determining OON Costs
  - NY Insurance Law 3217A(a)(20)(C)
  - NY Insurance Law 4324(a)(21)
  - Public Health Law 4408(u)
- Reimbursement for specific OON Service
  - NY Insurance Law 3217A(b)(14)
  - NY Insurance Law 4324(b)(14)
  - Public Health Law 4408(2)(n)

Changes to NY Statutes

- OON Make Available Benefit:
  - NY Insurance Law 3241(b)(1)(A)
- Claim Submission
  - NY Insurance Law 3217A (a)(19)(B)
  - NY Insurance Law 4324(a)(20)(B)
  - Public Health Law 4408(1)(t)(ii)
- OON Reimbursement Examples
  - NY Insurance Law 3224-a
- UR and Pre Authorization
  - NY Insurance Law 4903(b)
  - Public Health Law 4903(2)
- OON Referral Denial and Appeals
  - NY Insurance Law 4904(a-2)
  - NY Insurance Law 4914(b)(4)(D)(ii)(I)
  - Public Health Law 4904 (1-b)
  - Public Health Law 4914(2)(d)(D)(ii)(1)
- Physician Disclosure
  - Public Health Law 24(1)
  - Public Health Law 24(2)
  - Public Health Law 24(3)
  - Public Health Law 24(4)

Changes to NY Statutes

- Dental Claim Submission
  - NY Insurance Law 3224-a(j)
- Dental Network Adequacy
  - NY Insurance Law 3241(a)
- Dental External Appeal
  - NY Insurance Law 4900(g-6-a)
- Dental UR
  - NY Insurance Law 4903(b)

Effective Date

- Plan years beginning on or after March 31, 2015
- Exception is HMO contracts which already had
  - Right to OON Doctor
  - External appeal rights

Network Adequacy Requirements

Non-HMO plans now required to review networks

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The law applies to these plans that maintain a network of providers

- Insurers
- Not for Profit insurers
- Article 47 Municipal Cooperative Health Plans
- Student Health Plans

Network Requirements

"…shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract."

- DFS will review the network;
  - when the plan files for initial approval of a contract,
  - when they apply for an expansion of service area and;
  - every 3 years after that.
- The standards are similar to those used by DOH to approve HMO networks
- The standard applies to existing contracts upon first renewal after 3/31/2015

Additional Requirements

- If the carrier offers an OON benefit in a region, they must make available at least one option at 80/20 UCR, an upfront deductible is allowed
- The OON benefit is not required to be attached to every metal level in the small group market but cannot only offer OON at the bronze level
- If OON is available outside the Marketplace, then it must be available on the same terms inside the Marketplace and vice versa
- If there is no OON benefit available in a region then the Superintendent MAY REQUIRE an insurer to make one available at 80/20 UCR

Hold Harmless Provision

Reimbursement of Health Care Providers

Understand where the costs are coming from

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Fee for Service

- Fee for Service
  - Fee is paid for each service rendered.
  - Can be based on a flat fee schedule, negotiated discounted fee or RBRVS
  - Usually paid retrospectively
  - Predominant form of payment in commercial health insurance
  - Provider revenue varies with the number of services

Episode of Care

- Capitation
  - Per head fee usually expressed as pmpm
  - Reimbursement is based on the number of members enrolled or assigned to a specific provider
  - Revenue doesn't vary with the number of services
  - Most frequently seen with primary care, lab services, mental health or radiology
- Global payment or Global capitation
  - One combined payment made to cover multiple providers
  - The extent of the payment varies from across the board (total episode of care) to less comprehensive versions

Episode of Care

- Global payment or Global capitation
  - Comprehensive global payments include facility costs, physician fees, technical and professional components of lab, radiology and pathology as well as home care
  - Less comprehensive versions are termed ambulatory episode of care and inpatient episode of care and usually run for a specified period of time
  - Medicare uses this for home health services. The payment covers skilled nursing visits, home health aide visits, social services and routine medical supplies

Episode of Care

- Prospective payment methods
  - Based on average amount of resources used so some are winners, some are losers
  - **Per Diem** payment reimburses the provider for each day of care and is usually used for IP care. The payment usually doesn't recognize different conditions but may allow for certain critical conditions to be carved out due to the amount of resources used
  - **Case-Based** payments are set for the type of health condition
  - Medicare DRG's are an example of a case based payment methodology

Episode of Care

- Clinical Risk Groups (CRG) :A capitated PPS that predicts future healthcare expenditures
- Patients are classified into categories that account for the severity of the illness or condition and that predicts the costs of future medical care
- There are over 1,000 CRG statuses which are risk adjusted to each patient

Disclosure Requirements Applicable to Networks

For Physicians and For Health Plans

Physician Disclosure Requirements

- Physicians must;
  - Provide a written disclosure as to what health plans they participate in unless it's an unscheduled appointment such as admission through ER
  - Provide name and address of any provider scheduled to perform medical services (surgery, lab, radiology, etc.) including referrals in their own practice
  - Provide name and address of any provider who will perform care during a scheduled hospital admission

Health Plan (Insurer) Requirements

- Provider directories
  - Required of all health plans to include basic info plus
    - Board certifications
    - Languages spoken
    - Hospital affiliations, if any
    - Any changes must be noted within 15 days

Calculating OON Reimbursement

Ingenix lawsuit

Who is Fair Health?

What is Medicare RBRVS?

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Ingenix and Attorney General Andrew Cuomo

- 2007, the AG initiated an investigation into OON reimbursement in the insurance industry
- The feeling was that the reimbursement was too low and members were bearing too much of the cost
- Most carriers at the time were using the database of Ingenix, a company at that time owned by United Healthcare
- February 2008 subpoenas sent to 16 health insurance companies looking for information on how UCR is set

Ingenix and Attorney General Andrew Cuomo

The AG found:

- The structure of the OON reimbursement system is broken
- UHC has a conflict of interest in owning and operating the Ingenix database
- Other health insurers have a financial incentive to manipulate the data they provide to the database so that it skews reimbursement downward
- The rate of underpayment ranged from 10% to 28% for the various medical services it looked at

Ingenix and Attorney General Andrew Cuomo

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Other States

- 2007: New Jersey class action lawsuit had similar findings Health Net agreed to set up a fund of $215 million for class members and stop using Ingenix
- 2000: Massachusetts appellate court agreed there were numerous errors in Ingenix database
- 2009: AMA and other plaintiffs sued UHC who agreed to pay $350 million to resolve that case

Who is FAIR Health?

- "FAIR Health is a national, independent, nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information through data products, consumer resources and health systems research support."
- FAIR Health, Inc. was established in October 2009 as part of the settlement of an investigation by New York State into certain health insurance industry reimbursement practices which had been based on data compiled and controlled by a major insurer.

Mission

To provide:

- An independent database of information contained in healthcare claims contributed by payers nationwide, developed with the support of independent academic experts;
- A free website to educate consumers about the cost of care in their geographic areas and the insurance reimbursement process; and
- A research platform for policymakers, government officials and academic researchers.

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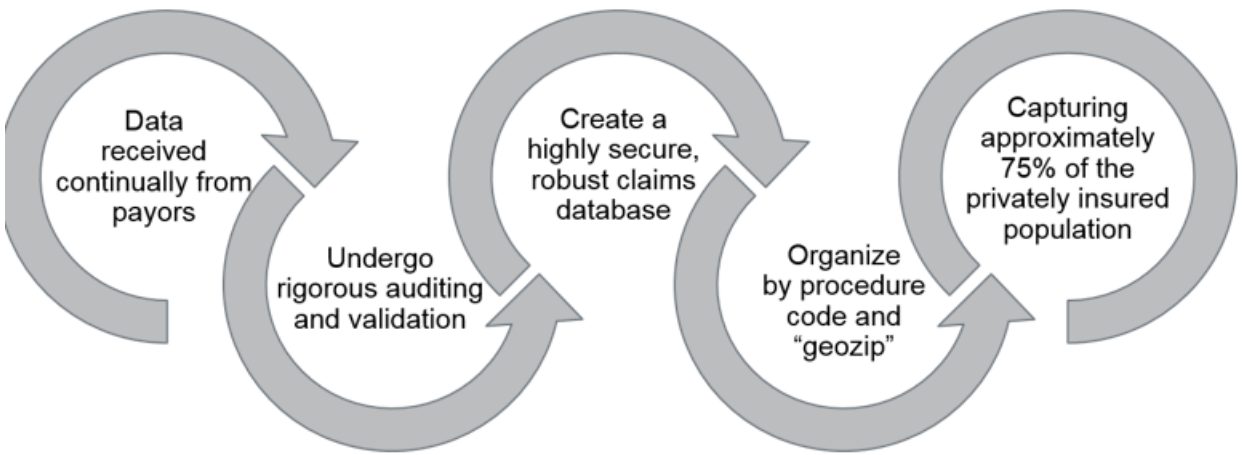
23B+
Medical & Dental Procedures Performed Since 2002 Nationwide

151M
Covered Lives from Contributors

493
Geozips Reflecting Local Billing Patterns



Over 23 billion privately billed medical and dental claims in FAIR Health's repository.

13 Years of claims data in our repository, back to 2002.

151 million lives covered by our data contributors.

493 distinct geographic regions nationwide into which our data are organized.

FAIR Health

- www.fairhealth.org
- www.fairhealthconsumer.org
- www.consumidor.fairhealth.org
- FH Cost Lookup

NEW

Learn about experimental treatments and clinical trials

ESTIMATE YOUR HEALTHCARE COSTS

DENTAL GET STARTED

MEDICAL GET STARTED

For business uses of FAIR Health data click here

Healthcare Professionals click here

A user-friendly guide to reimbursement fundamentals

FH HEALTH INSURANCE 101

« VIEW ALL TOPICS »

COST SHARING: KNOW WHAT YOU MAY OWE

VIEW NOW

eHealthcare Leadership Awards 2016 WINNERS

FAIR Health is a national independent, not-for-profit corporation whose mission is to bring transparency to healthcare costs and health insurance information through comprehensive data products and consumer resources. FAIR Health uses its database of billions of billed medical and dental services to power a free website that enables consumers to estimate and plan their medical and dental expenditures. The website also offers clear, unbiased educational articles and videos about the healthcare insurance reimbursement system.

WELCOME MESSAGE
from FAIR Health President Robin Gelburd

Keyword Search

FH MEDICAL COST LOOKUP: GET STARTED

Use this tool to estimate your costs for medical procedures and services in the ZIP code where you receive care. Whether you are insured or uninsured, the cost estimate you receive will show how much you may be asked to pay for your care. Learn more about our medical cost estimates here.

STEP 1 Enter the location of your service or procedure

zip code or (city, state)

2 Are You Insured? Yes ◉ No ○

Why is this important

3 Type of Service or Procedure

Browse for Service or Procedure by Category

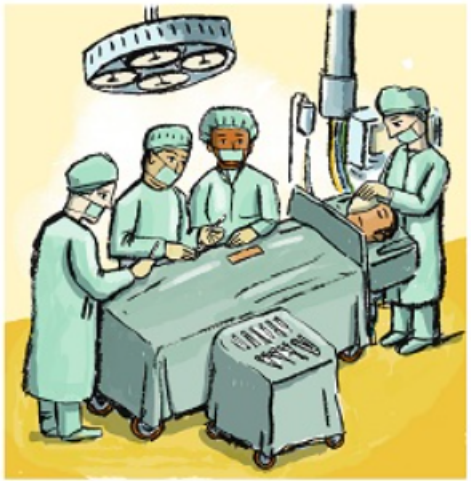
Medical Glossary

- Ambulance Transportation
- Colonoscopy and Other Endoscopy
- Counseling (Mental Health)
- Diabetes and Medical Supplies
- Electrical Stimulation
- Hearing and Speech Supplies

OR Enter a keyword or a procedure code

GO

You may conduct up to 20 searches per week.



Estimate Your Medical Costs

Use the FH Medical Cost Lookup to estimate your out-of-pocket costs according to what healthcare professionals commonly charge for a wide range of medical procedures, services and supplies.

Our cost estimates, which are based on FAIR Health's national database of healthcare claims, offer a neutral, objective source of information that you can trust.

If you are new to the site and would like to estimate your out-of-pocket costs, please learn more here.

SELECT CODE FOR BRAIN AND NERVES

Procedures are listed in order from most commonly to least commonly performed

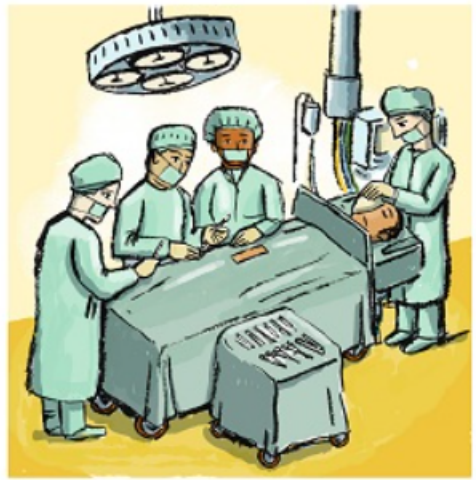
	Code	Description
☐	70450	CT scan head or brain
☐	70460	CT scan head or brain with contrast

1

GO

Reminder: Due to licensing requirements, you are limited to 20 searches per week. To help keep within those limits and avoid repeat searches, remember to print the results of your search for easy reference.

Search Again



UCR - Based | Medicare - Based | Compare Both

ESTIMATED OUT-OF-POCKET COSTS: UCR-BASED

PRINT

Select	Code/Facility	Consumer Description	Est. Charge	Est. Reimbur-sement	Out-of-Pocket Cost
Select all professional charges that apply					
☑	**† 70460**	**CT scan head or brain with contrast**	**$190.00**	**$133.00**	**$57.00**
☐	01922	Anesthesia for X-ray or radiation therapy	$993.16	$695.21	$297.95
Select one type of facility (if applicable)					
○	Hospital Outpatient	Hospital Outpatient Facility (HOSPF) estimate for procedure code 70460 (in addition to your doctor's fee)	$1,508.01	$1,055.61	$452.40

† Many imaging tests are billed in two parts, one relating to the reading and interpretation of the test results and another related to the use of the equipment at the facility where you have the test performed. The FH Medical Cost Lookup currently includes only the charge related to the reading and interpretation of the test results. The Lookup tool does not currently estimate charges related to the facility where a test is performed, nor does it include those services where the reading and facility are bundled together into a single "global" charge. We are working to include estimates for these components at a later date.

Estimated Out-of-Pocket Cost $57.00

Estimating Your Out-of-Pocket Costs

Your actual out-of-pocket costs may vary based on factors specific to your provider and/or your plan. Some plans base their reimbursement rates on a percentage of "usual, customary, and reasonable" charges, which is referred to as "UCR". Others use a formula based on the Medicare fee schedule that is published by the US Department of Health and Human Services. To learn how your health plan determines out-of-network reimbursement rates and covered services, call the number listed on the back of your insurance card. Then, using the buttons below, estimate your out-of-pocket costs using the method that your plan uses to calculate reimbursement. You may also view a comparison of both

Estimated Out-of-Pocket Cost

$57.00

GEOZIP: 120xx
This GEOZIP includes zip codes with the following prefixes: 120-121

Reimbursement Percentage is set at 70%
Estimated Charge is set at FAIR Health's 80th percentile

Adjusting Estimated Reimbursements

Adjust Percentage

The Estimated Reimbursement amounts above are initially set to 70% of the Estimated Charge. Click here to learn more about percentages and how they can factor into reimbursement.

If you find that your plan uses a different percentage in determining reimbursement amounts, you can adjust the level used in the estimates above using the slider.

Click here to use our Advanced Charge Estimator

Reminder: Due to licensing requirements, you are limited to 20 searches per week. To help keep within those limits and avoid repeat searches, remember to print the results of your search for easy reference.

Estimating costs for a single code using the UCR-based and Medicare-based reimbursement methods counts as one (1) search.

Date of Search: 03/23/2017

pocket costs using the method that your plan uses to calculate reimbursement. You may also view a comparison of both reimbursement methods.

Please note: the Medicare-based method is not intended to reflect estimated reimbursement amounts for Medicare beneficiaries. It is meant to reflect reimbursement amounts for members of private health plans that base reimbursement rates on the Medicare fee schedule.

FAIR Health Does Not Determine Your Plan's UCR

FAIR Health does not determine, develop, or establish any fee, reimbursement level or UCR for any procedure or service. Your plan is responsible for setting your actual reimbursement level, or UCR, and may use FAIR Health benchmark data when making this determination. FAIR Health data reflect benchmark market rates, which are what providers typically charge for a procedure or service in a particular geographic area. Estimates provided on this website are for informational purposes only.

A Note on Office Visits

A Note on Treatments Involving Related Procedures

You can also learn more about provider and plan-related variables that may affect your

Medicare RBRVS

What is it

How is it used for UCR

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RBRVS

- The resource-based relative value scale (RBRVS) is the physician payment system used by the Centers for Medicare & Medicaid Services (CMS) and most other payers. The RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it.

RBRVS

- In this system, payments are determined by the resource costs needed to provide them, with each service divided into three components:
- Physician work
- Practice expense
- Professional liability insurance (PLI)
- Payments are calculated by multiplying the combined costs of a service times a conversion factor (a monetary amount determined by CMS) and adjusting for geographical differences in resource costs.
- Annual updates to the physician work, practice expense and professional liability insurance relative values are based on recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC), which was formed to make recommendations to CMS on the relative values to be assigned to new or revised codes in the Current Procedural Terminology (CPT®) code book

RBRVS vs FAIR Health

- Fair health captures physician practice patterns by using 3 digit zip codes resulting in 491 distinct regions
- Medicare RBRVS uses wider geographic areas called geographic practice cost indices. In 2011, there were 90 GPCI's
- While NYS has 5, upstate NY has only 1

Fair Health vs. RBRVS

FIGURE 1: FAIR HEALTH, COMPARED WITH RBRVS (ALBANY, N.Y.)

FAIR HEALTH PERCENTILE	% OF RBRVS
50TH PERCENTILE	217%
60TH PERCENTILE	228%
70TH PERCENTILE	241%
75TH PERCENTILE	248%
80TH PERCENTILE	255%
85TH PERCENTILE	265%
90TH PERCENTILE	276%
95TH PERCENTILE	309%

FIGURE 2: GEOGRAPHIC REGION FEE DIFFERENCES

AREA	ZIP CODES	220% RBRVS/ 50TH PERCENTILE OF FAIR HEALTH
ALBANY	122	101%
KINGSTON, MONTICELLO	124-127	98%
SYRACUSE	132	111%
BINGHAMTON, VESTAL, ONEONTA	137-139	101%
BUFFALO	142	126%

Milliman white paper February 2002

Disclosure Requirements

Applicable to OON reimbursement

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Health Plan (Insurer)Requirements

- Reimbursement
  - Plans must disclose the amount they will reimburse under their OON methodology
  - Plans must include examples of anticipated OOP costs for frequently billed OON services; colonoscopy, spinal surgery, breast reconstruction in a format prescribed by DFS
  - Plans must provide information for members to determine OOP costs for OON services. A link on their website to an independent source will satisfy this requirement. If not using Fair Health, DFS needs to approve.

Health Plan (Insurer)Requirements

- Reimbursement
  - If a member is contemplating a specific OON service, the health plan must provide the amount they will pay. If the member does not provide a specific CPT Code, the plan must provide a range of dollar amounts
  - The health plan must provide a disclaimer with these amounts. Language is supplied by DFS

Disclosure of OON Coverage and Cost Information

There are several steps CDPHP® is taking to comply with the OON Mandate and provide our members with the information they need to make informed decisions:

- We are continuing to ensure our provider directories are accurate and up-to-date, including listings of participating providers and the languages spoken by those providers.
- To help you understand how much we would pay for certain OON services, we've created some out-of-network reimbursement examples for small business coverage and out-of-network reimbursement examples for large business coverage.

You can also visit the Fair Health website to determine the usual and customary rate (UCR) for OON services. For more information about your rights as a health insurance consumer, visit the Department of Financial Services website.

Out-of-Network Reimbursement Examples for Small Group Coverage

This summary gives examples of typical costs for out-of-network services under our three most commonly sold health insurance plans in Saratoga County that includes ZIP code 12065. If you want details about your coverage and costs, you can get the complete terms in the policy or plan document at www.cdphp.com, or by calling 1-800-777-2273.

Colonoscopy
(Biopsy of Large Bowel Using an Endoscope)
CPT Code: 45380
Anesthesia CPT Code: 00810
Pathology CPT Code: 88305

Sample care costs:

	UCR	Plan EPO $30	Plan HDEPO	Plan Embrace Health
Hospital Services	N/A	N/A	N/A	N/A
Physician Services	$600	$0	$0	$0
Anesthesia	$735	$0	$0	$0
Pathology	$200	$0	$0	$0
Total	**$1,535**	$0	$0	$0

Patient pays:

Deductibles	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A
Difference between UCR and what the plan pays	$1,535	$1,535	$1,535
Total	**$1,535**	**$1,535**	**$1,535**

Laminotomy
(Partial Removal of Bone with Release of Spinal Cord or Spinal Nerves of 1 Interspace in Lower Spine)
CPT Code: 63030
Anesthesia CPT Code: 00630

Sample care costs:

	UCR	Plan EPO $30	Plan HDEPO	Plan Embrace Health
Hospital Services	N/A	N/A	N/A	N/A
Physician Services	$3,795	$0	$0	$0
Anesthesia	$1,400	$0	$0	$0
Total	**$5,195**	$0	$0	$0

Patient pays:

Deductibles	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A
Difference between UCR and what the plan pays	$5,195	$5,195	$5,195
Total	**$5,195**	**$5,195**	**$5,195**

Breast Reconstruction
(Insertion of Tissue Expander in Breast)
CPT Code: 19357
Anesthesia CPT Code: 00402

Sample care costs:

	UCR	Plan EPO $30	Plan HDEPO	Plan Embrace Health
Hospital Services	N/A	N/A	N/A	N/A
Physician Services	$4,155	$0	$0	$0
Anesthesia	$506	$0	$0	$0
Total	**$4,661**	$0	$0	$0

Patient pays:

Deductibles	N/A	N/A	N/A
Copays	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A
Difference between UCR and what the plan pays	$4,661	$4,661	$4,661
Total	**$4,661**	**$4,661**	**$4,661**

UCR (usual and customary cost) is the amount providers typically charge for a service. This chart uses UCR based on FAIR Health at the 80th percentile for ZIP code 12065. Your provider may bill more than UCR.
Patient pays represents sample cost-sharing. Your cost-sharing may vary.

Out of Network Requirements

When plans need to make OON available

Make Available Benefit

- If the carrier offers an OON benefit in a region, they must make available at least one option at 80/20 UCR
  - An upfront deductible is allowed
- The OON benefit is not required to be attached to every metal level in the small group market but cannot only offer OON at the bronze level
- If OON is available outside the Marketplace, then it must be available on the same terms inside the Marketplace and vice versa
- Carrier can embed OON in the contract or offer as a rider

Make Available Benefit

- The requirement does not obligate a plan to make OON available in a market in which they don't currently offer OON (think large group market versus small group market
- If there is no OON benefit available in a region then the Superintendent MAY REQUIRE an insurer to make one available at 80/20 UCR

Referrals to OON Providers

- A member can request a referral to an OON provider but it is subject to approval by the health plan
- If the request is for a service that requires pre-authorization, such as under a POS or PPO contract, the plan must identify the dollar amount they will pay for the service under their OON reimbursement
- The OON law proscribes specific rules around appeals of denied OON referrals

Referrals to OON Providers

- Initial denial
  - If the denial of the referral is because there is an appropriate INN provider the plan needs to provide name and address of that provider and also indicate that you can submit a statement from your physician explaining why the OON referral is needed
- Internal appeal of denial:
  - Plan must review physician statement in its review and reply to both patient and physician
  - Plan must also provide at least one INN provider who can perform the service
- External appeal
  - External appeal agent will only consider the INN providers who are identified by the insurer

Surprise Billing

Defined

Independent Dispute Resolution

If you receive care at an INN Facility:

- It is a surprise bill if;
  - An INN provider was not available
  - An OON doctor provided services without your knowledge
- It is not a surprise bill if:
  - You chose to receive services from an OON doctor and an INN doctor was available
- Referral from an INN provider to an OON provider

If you are referred by an INN doctor to an OON doctor:

- It is a surprise bill if;
  - You did not sign a written consent that you knew the doctor was OON
  - Your doctor sends a lab specimen to an OON provider without your knowledge and written consent
  - Your plan requires a referral or preauthorization and you receive services at an INN facility or INN office from an OON doctor without your knowledge
- It is not a surprise bill if:
  - Your plan requires a referral and you receive services from an OON provider without requesting a referral
  - You receive services from an OON provider after signing a written consent

Protecting against surprise bills

- If a member receives a surprise bill, they should'
  - Sign an assignment of benefits form to permit your provider to seek payment from your health plan
  - Send the form and bill you don't think you should pay to your health plan and provider
- The assignment of benefits form is available on all plan websites
- The same process applies to uninsured and self-funded plans

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in-network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician; OR

2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____

Patient Address: _____

Insurer Name: _____

Patient Insurance ID No.: _____

Provider Name: _____ **Provider Telephone Number:** _____

Provider Address: _____

Emergency Care

- ACA: Emergency care at OON provider must be reimbursed at the greater of
  - Amount the plan negotiated with INN providers
  - 100% of allowed amount for services provided by a OON provider (reimbursement minus any OON cost sharing)
  - Amount that would be paid under Medicare
- IDR process can be used for OON ER appeals and may result in more than ACA requirements
- ER physician who requests consult with OON doctor is not eligible for IDR since it's covered under ER rule

Dental

- The following processes of the OON law apply to dental
- Electronic claim submission
- Network adequacy requirements
- Right to external appeal of OON referral denial if it is a managed care product

Independent Resolution Center

- This section is under the Financial Services Law so obligates physicians and plans to abide by it
- Financial Law Sec. 606 requires providers to hold insured patients harmless who have completed an assignment of benefits form
- Public Health Law requires HMO's and gatekeeper EPO's to hold members harmless

Independent Resolution Center Who Pays?

Disputes Between a Provider and a Health Plan, Involving an Insured Patient.

- The provider pays the cost of the dispute when the IDRE determines that the health plan payment is reasonable
- •The health plan pays the cost of the dispute resolution when the IDRE determines that the provider's fee is reasonable.
- •The provider and the health plan share the prorated cost when there is a settlement.
- •There may be a minimal fee to the provider or health plan submitting the dispute if the dispute is found ineligible or incomplete.

Independent Resolution Center Who Pays?

Disputes involving a Patient who is not an Insured.

- The doctor pays the cost of the dispute resolution when the IDRE determines that the doctor's fee is not reasonable.
- The patient pays the cost of the dispute resolution when the IDRE determines that doctor's fee is reasonable, unless it would pose a hardship to the patient. "Hardship" means a household income below 250% of the Federal Poverty Level.

IDR Results

Emergency Services	Number received
1. Total	1. 341
2. Not eligible	2. 79
3. Health plan more reasonable	3. 83
4. Provider more reasonable	4. 42
5. Split Decision	5. 31
6. Settlement Reached	6. 44

IDR Results

Surprise Bills	Number
1. Total Received	• 69
2. Not eligible	• 50
3. Health plan more reasonable	• 2
4. Provider more reasonable	• 2
5. Split decision	• 1

IDR Results

Surprise Bills (not eligible)	Number
1. Application not received	1. 11
2. Application withdrawn	2. 2
3. Self-funded	3. 3
4. DOS before eff date of law	4. 8
5. Wrong insurer	5. 5

Resources

- NYS Department of Financial Services link to Network Adequacy and OON Guidance (for insurers and agents)
  - http://www.dfs.ny.gov/insurance/ihealth.htm
- NYS DFS link to Protection from Surprise Bills (for consumers)
  - http://www.dfs.ny.gov/consumer/hprotection.htm
- Fair Health
  - www.fairhealth.org
- Questions on the IDR process
  - IDRquestions@dfs.ny.gov

Questions?

Thank You

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