American Cancer Society ☙ Children's Defense Fund of New York ☙ Community Service Society of NY
Make The Road New York ☙ Metro New York Health Care for All Campaign☙ Medicare Rights Center ☙
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices ☙ Schuyler Center for Analysis and Advocacy

Consumer Statement on Out-of-Network Billing Health Insurance Legislation by Health Care for All New York in Cooperation with AARP of NY, the Center for Medical Consumers Consumers' Union of NY and National Association of Social Workers—NY

HCFANY, a statewide coalition of over 130 organizations committed to winning quality, affordable health coverage for all New Yorkers, issues this statement to urge the Legislature and the Cuomo Administration to enact legislation by the end of this session which would protect New York consumers from out-of-network billing problems. HCFANY strives to bring consumer voices to the policy conversation, ensuring that real consumer concerns are reflected. We also provide expert policy analysis, advocacy, and education on important health reform issues and policies that affect New Yorkers around the state. For more information on HCFANY, visit us on the web at www.hcfany.org.

Consumer Groups Urge the Legislature to Address Three Important Consumer Concerns:

1. "Surprise" out-of-network bills by health providers.

The problem of "surprise" out-of-network medical billing has been well documented in the press[1] and by the New York State Department of Financial Services in its report, "An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers" (March 2012). Community Health Advocates, New York's premiere patient assistance program, reports that nearly 20 percent of its helpline cases are related to billing problems.

"Surprise" medical bills typically occur in one of two scenarios. Some consumers are treated by out-of-network providers following medical emergencies during which they had no time to choose

[1] *See, e.g.* "Hidden Costs that Can Make You Sick," New York Daily News, January 29, 2012; "Waking Up to Major Colonoscopy Bills," New York Times, May 28, 2012.

a hospital or doctor. Other consumers may receive non-emergency services at in-network hospitals or clinics, expecting those services to be fully covered, but discover that is not the case when they receive bills from out-of-network doctors and services, such as anesthesiologists, radiologists, pathologists, or laboratories who have been brought in to provide treatment without the advance knowledge of the patient. Even when a consumer has out-of-network coverage, the plan may have reimbursement policies that result in only a small portion of the out of network fees being covered, leaving the consumer with a "balance bill," for the remainder. If a consumer has no out-of-network coverage, he or she still faces balance billing for emergency care, and may be billed the full amount of for non-emergency ancillary services. There is no opportunity for, and the patient has little power to, negotiate these amounts billed.

The stories of seven real New Yorkers are provided at the end of this document. All had good health insurance and all faced surprise medical bills, one of more than $150,000, due to events entirely beyond their control. None are protected from liability for those bills under current New York law.

2. Consumers who need to go out-of-network.

People with serious or chronic health conditions often need to see doctors with very specialized expertise and experience. A person with a soft tissue sarcoma, for example, may need access to a surgeon experienced with treating such a rare cancer in order to have the best possible outcome. But the plan may not have within their network a surgeon who has the experience and skill to optimize the benefit of treatment. Consumers may then be forced to go out-of-network, and either assume the full cost of accessing high quality care if they have no out-of-network coverage, or, if they do have such coverage, be charged fees well above the amounts reimbursed by their insurers.

3. Consumers deprived of adequate information.

Consumers who prudently try to manage their health care expenses face daunting obstacles. Health insurance providers lists quickly become outdated and routinely include providers who are no longer affiliated with the plan. Others do not know the network status of other providers who are likely to be called in by their treating doctor or hospital to participate in their care. Most do not know in advance the cost of procedures – and are shocked to learn the costs of care after they have received services. Few consumers know that doctors treating them in a hospital may not be employed by that hospital, and may not accept the insurance. Finally, only a few health plans offer a transparent way for consumers to look up reimbursement levels for planned out-of-network procedures in advance.

Consumer Groups' Recommendations:

1. Meaningfully protect insured consumers from "Surprise" out-of-network billing.

To address the first problem of "surprise" balance billing, doctors whom the patient had little or no role in choosing should be required to accept the in-network reimbursement rates of the insurers contracting with the hospitals where the care was provided. Further, insured patients should be completely financially protected in medical emergencies, even if they arrive at an out-of-network emergency room. While HCFANY supports the rights of patients and doctors to agree to financial terms without State intervention, patients must be protected when this type of voluntary arrangement is essentially impossible.

If providers at network hospitals and clinics cannot be mandated to accept network rates, HCFANY believes the best way to address the surprise balance bill is to enact a statute similar to one recently enacted by the State of Illinois. (Public Act 096-1523, amending Illinois Insurance Code §356z.3, 356z.3a.) In Illinois, consumers who receive services from certain categories of specialists (e.g. radiology, anesthesiology, pathology, neonatology, or emergency department staff) may assign their claims to that specialist, who must then negotiate his or her fee directly with the insurance company or submit to binding arbitration. The consumer is only responsible for the amount of his or her regular in-network copayment, and the insurer and provider, who have the best bargaining positions, negotiate fee arrangements themselves or through independent arbitration.

2. Require all insurers to have adequate networks and offer a reasonable mechanism to go out-of-network when medically appropriate.

To address the problem of consumers who need to go out-of-network in order to receive adequate medical care, HCFANY recommends that all health insurance products sold in New York, including the EPOs and PPOs that currently are not subject to such rules, be required to have adequate provider networks, as determined by state regulators. When the network turns out to be inadequate for any reason, consumers should have the same rights as those in managed care plans and HMOs: to have the health plan pay for the consumer to see an out-of-network specialist, with the consumer charged only the regular in-network co-payment. Rules for working out disputes over the adequacy of network specialists should provide decision-making guidelines and a mechanism for external review when the consumer and health plan cannot agree.

3. Ensure transparency about billing from health providers and plans.

To address the third problem of lack of information, HCFANY recommends strong transparency requirements for providers, hospitals, and health plans.

Doctors should be required affirmatively to disclose:

- The identity of all ancillary providers who will participate in a patient's treatment, as well as their network affiliation status to the extent they know it; and
- The estimated price of the services they are scheduled to provide.

Hospitals should be required affirmatively to disclose:

- The identity of all doctors and ancillary providers (e.g. radiology, anesthesiology, pathology) who are expected to participate in treatment; together with information about whether those providers' services are billed separately from the hospital's, as well as their network affiliation status.
- The estimated price of the services they are scheduled to provide.

Insurers should be required to disclose and make available on their websites:

- Network provider listings which are updated regularly and promptly;
- Out-of-network reimbursement levels for all procedures enrollees may seek on an out-of-network basis.

Hospitals, doctors, and insurers must be held accountable to these new transparency rules, with real consequences when they fail to comply.

A ban on surprise balance billing, requiring network adequacy and mandating meaningful transparency are the three legs on which strong consumer protections regarding out-of-network care must rest. HCFANY looks forward to working with the Cuomo Administration, members of the legislature, insurers and medical providers to enact the necessary legislation now.

Appendix: Real Stories of How Current Law Fails to Protect New York Patients[2]

Story 1 – Jonathon

Jonathon is a Long Island resident insured by an EPO plan. Last fall he complained to his doctor of losing feeling in his hands, and his doctor sent him to the emergency room immediately. He went to an in-network hospital and had an MRI, after which the treatment team decided he needed immediate back surgery. They took out three disks and put in a metal plate. An in-network surgeon performed the procedure, but requested assistance from a provider of inter-operative neuro-physiological monitoring, which reduces risk of damage to the nervous system during surgery by providing guidance to the surgeon and anesthesiologist. This provider was out-of-network. Jonathon's EPO does not include out-of-network coverage, so it paid no part of the $8,000 bill. Current law does not protect Jonathon from liability for the $8,000 bill, even though he went to an in-network hospital and an in-network surgeon provided his necessary emergency surgery.

Story 2 – Marcia

Marcia is a 49 year-old cancer survivor with multiple sclerosis. She is insured by the Empire Plan, a PPO which covers most New York State employees and retirees. Last summer she was hospitalized at a network hospital for a month with a serious C-diff. infection. She was visited on four consecutive days by an internist whom she did not request. In fact, she has specifically requested to be seen by her long-standing neurologist, who also practiced at that hospital. The internist was out-of-network and billed Marcia $12,500 for the four visits. Her PPO plan has out-of-network coverage, but it only reimbursed $1,777. Current law does not protect Marcia from liability for the balance of more than $10,000 owed to the out-of-network internist, even though she specifically requested that a different doctor treat her.

Story 3 – Connor

Connor is a 68-year-old Westchester resident with heart problems, insured in a PPO. He had a stent put in last year, and when he was experiencing extreme shortness of breath he rushed to his local in-network hospital. The heart problem was too severe to be treated there, so he was transferred to a major academic medical center nearby, also in-network. After observation and testing, his treatment team decided that he needed emergency open heart surgery to implant a special pump. Though he was at an in-network hospital, neither the surgeon nor his assistant was in-network. The surgeon billed $71,000, out of which his insurer's out-of-network benefit paid $29,000. The assistant billed $35,000, out of which his insurer paid $6,737. In total, Connor was left owing more than $70,000 for his surgery, even though he had "good insurance" and went to in-network facilities for his emergency treatment.

Story 4 – Juan

[2] Stories adjusted to protect anonymity of patients.

Juan is a corrections officer from Long Island, employed by a county government and insured through a PPO. After his thumb was cut in half in a table-saw accident, he went to an in-network emergency room. The on-call plastic surgeon, though, was not in-network. After the surgery Juan's insurance only paid about $7,000 out of the $17,000 bill. Current law does not protect Juan liability for the $10,000 balance on the bill, even though he was insured and sought emergency care at an in-network hospital.

Story 5 – Giuseppe

After Giuseppe fell and injured himself, his wife made sure that the ambulance took him to an in-network hospital near their Westchester County home. Giuseppe had the Empire Plan, a PPO that covers many New York State workers, retirees, and their dependents. He was treated at the hospital for five days, and they thought the insurance would take care of everything. But they were surprised to get a bill for $700 from a plastic surgeon who was called in for a consultation during Giuseppe's stay. Giuseppe does not remember seeing the doctor and certainly had no idea he was being seen by an out-of-network specialists. His PPO has out-of-network coverage, but it only covered $360. Current law does not protect Giuseppe from owing the $340 balance on this bill. Giuseppe's wife wants to make a sign to hang around her husband's neck next time he is in the hospital requesting that he not be seen by out-of-network doctors.

Story 6 – Melissa

Melissa is a 59-year-old breast cancer survivor living on Long Island. She works as a billing assistant in a doctor's office and is covered by an EPO offered at her job. She received a double mastectomy and the first stage of her reconstruction in March of 2011. Her plan's network included only one plastic surgeon within 30 miles of her home, and this doctor was not yet board certified in plastic surgery at the time. New York law did not protect Melissa's right to have access to an out-of-network plastic surgeon to perform the procedure. She went to an out-of-network surgeon and was stuck with a financially-crippling bill far larger than she expected. In January of 2012 Melissa needed a revision to the reconstruction to remove temporary tissue expanders. By this time her insurer's one network plastic surgeon had attained board certification, but Melissa felt more comfortable maintaining continuity with the surgeon who performed the first operation. New York law does not protect Melissa's right to see an out-of-network surgeon, or even to have a neutral medical expert determine the gravity of her continuity of care issue. New York law also did not require Melissa's doctor to discuss his fees with her before providing the surgery.

Story 7 - David

David of Long Island fell from the roof a three-floor building and was rushed to the nearest emergency room, which happened to be out-of-network. He was insured through a PPO plan, which provides out-of-network coverage but did not pay his bills in full. The lead surgeon, who performed extensive life-saving procedures, sent David a bill for $169,000, out of which his insurer paid only $15,000. New York law does not protect David from liability for the balance bill of $154,000.