



Surprise Billing Action Kit

Learn the latest about surprise billing legislation

- Please read the AMA's sign-on letter to Congress and the other documents included in this kit.
- Key talking points on what surprise billing legislation should include:
 - Establish benchmark rates that are fair to all stakeholders in the private market; benchmark rates should include actual local charges as determined through an independent claims database.
 - Establish a fair and independent dispute resolution (IDR) process to resolve disputes about payments from insurers to unaffiliated providers for services rendered out of network to their beneficiaries.
 - Protect patients from out-of-network billing and preserve patient access to hospital-based care by holding insurers accountable for addressing their own contributions to the problem.
 - Require insurers to give patients a robust choice of physicians, including hospital-based emergency physicians, and on-call surgeons and anesthesiologists, who will be there for patients in life and death emergencies.

Take action

1. [Email Congress](#) using the Physicians Grassroots Network's (PGN) contact Congress tool.
2. Connect with your legislators on Twitter and ask them about surprise billing. Use the PGN's [legislator look-up tool](#) to be matched to your legislators and quickly find them on Twitter.
3. Schedule a meeting with your representative or their staff. You can use the [Congressional district office directory](#) to help set up a meeting.
4. Brush up on grassroots best practices with the AMA's [Guide to Physician Advocacy](#).

Let us know what you are hearing

After you've taken action please let us know about your interaction or any intel you learned by filling out the brief [3 question feedback form](#). Your feedback is extremely important and helps us focus our efforts and resources on where they are most needed.

Unanticipated (“Surprise”) Medical Bills

The American Medical Association agrees fully with efforts to protect patients from the financial impact of unanticipated medical bills.

Unanticipated, or surprise, medical bills can arise when patients reasonably believe the care they received would be covered by their health insurer but it was not. Such situations may include:

- When a patient receives care in an emergency from physicians or facilities who have not been contracted by their health insurance company; or
- When a patient receives scheduled care from an in-network physician at an in-network facility but other participants in the episode of care, whom the patient did not have an opportunity to choose, are not in their insurer’s network.

In these cases, patients should be responsible only for the cost-sharing amounts they would otherwise have been subject to if the care had been provided in-network and these costs should count toward their in-network out-of-pocket maximums and annual deductibles.

While out-of-network physicians are willing to forgo the ability to balance bill patients for amounts not covered by their patient’s insurance company, there must be a fair mechanism for settling disputes between physicians and plans over the appropriate payment amount.

Some congressional proposals would mandate that in cases where patients receive out-of-network services in an emergency or from out-of-network physicians at an in-network facility, the plan would only be required to pay the physician at the plan-specific median in-network rate

By establishing this government mandated payment benchmark, plans have strong incentives to eliminate providers with contracts above that amount or to reduce the rates in those contracts.

Legislation which limits plan obligations to only the median rate paid to in-network physicians also greatly advantage insurers by absolving them of the need to create strong networks for the provision of hospital-based and other services and protecting them from the consequences of their failure to create those networks. Regardless of their lack of effort to create an adequate network, they would enjoy federal limits on the amount they would have to pay for care.

Median in-network rates do not fairly reflect the cost of providing services by all providers nor do they capture other benefits that go hand-in-hand with being in-network, such as additional incentive payments as part of value-based contracts, prompt and direct payment by plans, listing in provider directories, etc.

It is not reasonable, therefore, to impute that adequate rates for in-network physicians are sufficient or equitable for those that do not enjoy the additional benefits of being in network and are therefore not able to discount their rates.

It is critical therefore that there be a fair and balanced mechanism for arriving at the appropriate rate for those providers who do not have a contract with a given insurer. At no point should negotiated, discounted in-network rates be used as a benchmark to determine fair payment to out-of-network physicians, and at every point commercial data from independent sources should inform the payment standard.

When the minimum payment from the payer for out-of-network care is insufficient, an independent dispute resolution (IDR) process should be developed to determine a fair payment by the health insurance company for the care provided. The IDR should be structured with

clear factors that an arbiter, familiar with health care billing, must consider when deciding such as the complexity of the case, the experience of the physician, and the rate that physicians charge for that service in the area.

Such an IDR, or appeals, process was included in legislation adopted by the House Committee on Energy and Commerce. Congress should continue to improve this proposal by requiring the independent third party to consider additional information, such as charge data, when determining the appropriate payment amount.

To ensure that patients are completely protected, benefits should be assigned to the physician or other providers so that they may pursue payment for services provided directly with the insurer without further involving the patient. This is to ensure that games that have been played by insurers, such as making periodic payments directly to the patient, are not allowed and that the patient is fully kept out of the middle.

Adequate Networks

Federal legislation should also protect patients from the failure of their health insurer to provide an adequate network of physicians—not protect plans that decided to limit the number of physicians they contract with on behalf of their insureds nor eliminate the need to negotiate contracts altogether.

Congress should ensure that patients are able to access the benefits their health plans promised when they signed up for coverage in a timely and convenient manner.

Health care insurance markets are increasingly concentrated (73% of markets in 2017 according to federal guidelines), meaning physicians frequently have little leverage to negotiate fair contracts with dominant health insurers.

- Most contracts are offered on a take-it-or-leave-it basis.
- Plans may find it to their financial benefit to have narrow or inadequate networks of physicians and other providers because patients frequently pay higher cost-sharing and have separate, higher deductibles for care received out of network—where federal limits on out-of-pocket expenses do not apply.
- Studies have shown that many networks include only a fraction of the required numbers of mental health and substance use disorder physicians, making in-network care difficult to access for patients—many of whom will have other comorbidities as well.

It is imperative therefore that any federal bill include strong and enforceable network adequacy requirements based on measurable standards and that federal parity laws be enforced to ensure patients have access to in-network physicians to prevent surprise bills before they happen.

Physicians and other providers, as well as insurers, must also be transparent. Physicians and other providers should inform patients of expected charges when they choose to receive scheduled care out of network, and insurers must be transparent in advance about the amount of those charges they will cover.

Insurers must also ensure that their provider directories are accurate and up-to-date so patients can make informed decisions about their care.

The issue of unanticipated out-of-network bills is complex and requires a balanced approach to solve. The principles outlined above will improve transparency, promote appropriate access to medical care and avoid creating disincentives for insurers and physicians to negotiate contracts in good faith.



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July 24, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

Congress is currently engaged in an important debate over protecting patients from unanticipated medical bills received in situations where no in-network physician was available to provide necessary care. In situations where a coverage gap occurs and patients unknowingly or without a choice receive care from an out-of-network physician or other provider, all stakeholders agree that patients should be held harmless for any costs above their in-network cost-sharing, and that patients should be completely removed from any payment disputes between their health insurance company and their physician or other health care provider.

Stakeholder positions diverge, however, once the overriding goal of protecting patients is addressed, with some seeking to obtain market-disrupting financial advantage through deceptive claims and advertisements.

One of the concepts being considered is the provision of an independent dispute resolution (IDR) or appeals process to resolve questions of appropriate payment amounts by health insurers when no agreement can be reached with the physician who provided the care. Such models have been successfully implemented in several states and are a proven solution to resolving these disputes while fully protecting the patient. In fact, despite political advertisements stating otherwise, the patient is in no way involved or affected by a decision by either party to engage in the IDR process.

Last week, the House Committee on Energy and Commerce reported the “No Surprises Act” as part of a broader package of bills. During that mark up, the Committee adopted an IDR process as a backstop should the bill’s underlying payment methodology not result in a resolution that is acceptable to both parties. While there are additional improvements that can be made going forward, the American Medical Association commends the Committee for this important step toward maintaining balance in the health care marketplace.

It is discouraging, however, that America’s Health Insurance Plans (AHIP) declared that the Committee’s actions would allow providers to “price gouge patients.” This is a clear mischaracterization of the actions taken by the Committee. Under the Committee’s bill, no patient who receives a surprise bill would be obligated to pay more than if they received care by an in-network provider—identical to the protection

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provided by a previous version of the bill supported by health plans. AHIP's angst apparently results from the fact that the "baseball style" arbitration adopted by the Committee, like New York's successful system, would allow an independent third party to determine whether the plan payment amount or the provider bill represents the most appropriate resolution to the claim. This mischaracterization of the Committee's actions is doubly confusing because the language adopted by the Committee is still heavily skewed to the benefit of health plans.

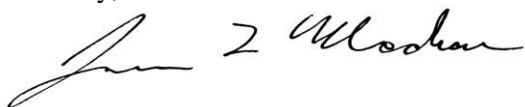
These views are clearly not shared by all health plans, however. Health plans in New York have spent much of the year advocating for an expansion of New York's system to additional providers, with the New York Health Plan Association (NYHPA) noting in a May 17 release its support for the proposal to expand the IDR system to hospitals. NYHPA stated that the proposal "Takes a balanced approach to address the issue of out-of-network emergency services, requiring hospitals to utilize the IDR process in the same manner that out-of-network physicians must follow, prohibiting balance billing by hospitals for emergency room services and holding the consumer harmless."

In Texas, where baseball style arbitration was adopted earlier this year, Blue Cross Blue Shield of Texas declared that "Texas now boasts the nation's strongest laws to shield patients from surprise bills." In the July 16 statement, the CEO of BCBS of Texas went on to call the bill "milestone legislation" and "courageous" and suggested that it should "serve as a beacon for other states looking for an answer to the issue of balance billing."

Others, such as the Blue Cross Blue Shield Association, have criticized the proposed IDR process as "cumbersome." To the contrary, the New York process essentially involves visiting www.dfs.ny.gov and filling out a two-page form. This contrasts with the often voluminous filing requirements necessary for physicians and other providers to obtain prior authorization from many health plans just to provide covered benefits to their patients needing health care services and prescriptions.

The actions of the Committee on Energy and Commerce are an important acknowledgement that the Committee's original proposal will benefit by adding a backstop process should the underlying methodology fail to arrive at a resolution that was fair to both parties. The Committee took no action that in any way weakened the crucial patient protections enshrined in the original proposal. It is a critical step and we look forward to working with Congress to further refine this key element of the bill as the process moves forward.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD



FOR IMMEDIATE RELEASE

July 11, 2019

AMA Reacts to House Energy and Commerce Health Subcommittee Passage of Surprise Billing Legislation

**Statement Attributable to
Patrice A. Harris MD., MA
President, American Medical Association**

“While the AMA supports the goal of protecting patients from payment disputes, further modifications are needed to protect patient access to care in rural areas and other underserved populations. Reps. Raul Ruiz, M.D., (D-Calif.) and Larry Bucshon, M.D.,(R-Ind.) led a bipartisan call to address concerns about the current imbalanced rate-setting scheme and are pressing for changes to make it more fair before the full committee markup next week. Other subcommittee members expressing concerns about the potential harm to access for rural and underserved populations included Reps. Gus Bilirakis (R-Fla.), Doris Matsui (D-Calif.), John Shimkus (R-Ill.), G.K. Butterfield (D-N.C.), Richard Hudson, (R-N.C.) and Lisa Blunt Rochester (D-Del.).

“Members of Congress made it clear they are hearing from the physicians back home and continued grassroots engagement is essential before the upcoming full committee markup. We remain committed to working with all the committees of jurisdiction to forge a more balanced approach to best protect patients and their access to health care.”

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About the AMA

The American Medical Association is the physicians’ powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises and, driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.



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Dear Chairman Pallone and Ranking Member Walden:

On behalf of our physician and medical student members, the American Medical Association (AMA) is compelled to oppose H.R. 3630, the “No Surprises Act,” scheduled for mark up by the Committee on Energy & Commerce Health Subcommittee tomorrow.

As we have noted in previous correspondence, meetings, comment letters, and public statements, the AMA has long been concerned about the coverage gaps that occur when patients unknowingly or without a choice receive care from an out-of-network provider. We agree that the central tenet of legislation to address unanticipated out-of-network billing is to protect patients from the financial hardships associated with these coverage gaps. As such, we strongly support provisions in the No Surprises Act that would ensure that patients are only responsible for in-network cost-sharing when these surprise coverage gaps occur, and that their cost-sharing count toward deductibles and out-of-pocket maximums. We also support efforts to remove the patient completely from payment disputes between their health insurance plan and provider when an unanticipated gap in their coverage occurs.

However, a key component on which the bill is structured is fundamentally flawed and would essentially institute a federal government rate setting scheme for private sector payments and force physicians, hospitals, and other health care providers to accept unreasonable rates dictated by private health insurance companies. Moreover, the bill would fundamentally alter deeply rooted principles of freedom to contract by effectively placing all negotiating power in the hands of insurance companies. We do, however, believe the bill could be modified to create a more balanced and market-focused approach that retains strong protections for patients while preserving the viability of physician practices.

More specifically, the No Surprises Act fails to address some of the major drivers of surprise billing—deliberate decisions by health insurance companies to narrow their networks of providers available to patients, shift more and more costs on to patients by limiting or providing no coverage for out-of-network services, and employ utilization management programs such as prior authorization and step therapy. Instead, the bill takes a one-sided approach by erroneously assuming that all incentives need to be placed on providers to contract with health insurance companies, failing to recognize that many local health insurance markets are highly concentrated by a few health insurance companies that use their dominant negotiating power to offer take-it-or-leave-it contracts to providers. Any legislation to remedy the surprise billing issue must incentivize insurers to expand their networks and offer fair contracts to physicians. Without such incentives, insurers will continue to realize financial gains by constructing networks where patients have limited access to timely care.

Further, the payment solution offered in the legislation would make these fundamental problems worse. By establishing a federal government payment maximum at the individual plans’ median in-network amount,

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insurers will have even less incentive to negotiate private contracts with individual providers. Even with the provision that ties the in-network rate to CPI-U, the bill still poses a federal government rate setting scheme on private sector payment forcing providers to accept discounted, below market payments from health insurance companies without having ever negotiated any contract terms or reaching mutual agreement. Moreover, such a scheme alters freedom of contract principles by shifting all negotiating power into the hands of health insurance companies. They can drive down the median in-network amount by simply dropping from their networks providers who are currently paid above the median. Or, they can simply stop negotiating altogether, knowing that their financial obligation is limited to their own median in-network payment amounts.

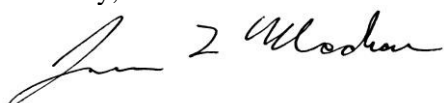
At a time when large insurer mergers are drawing increasing scrutiny for their anticompetitive impact on local markets, with 73 percent of markets in 2017 characterized as highly concentrated according to federal government guidelines, this is not the time to grant still more market power to such a dominant industry.

The AMA recommends the following improvements to H.R. 3630:

- Establish benchmark rates that are fair to all stakeholders in the private market. Experience at the state level shows that insurer-reported data is frequently inaccurate, as demonstrated by the class action lawsuit against United Health Care, settled for \$350 million in 2009, in which its Ingenix usual, customary, and reasonable database for determining out-of-network payments was found to be inaccurate and unreliable. More recent efforts by the state of Georgia's Department of Insurance to collect plan-reported data on mean and median contracted payment rates yielded similar inconsistencies and was abandoned. Benchmark rates should include actual local charges as determined through an independent claims database. This model has worked in states like New York with no inflationary impact on bill charges or premiums.
- Establish a fair and independent dispute resolution (IDR) process to resolve disputes about payments from insurers to unaffiliated providers for services rendered out-of-network to their beneficiaries. The process should be structured to include a range of factors to be considered in the case of an appeal; not just the median rate paid by the insurer, but factors such as the complexity of the service rendered, the experience of the physician providing the service, and the rate that physicians charge for the service in a geographic area. We recommend the Subcommittee look to the states for examples of appeals processes that are working, where any cost to use the process is minimal, there is no adverse impact on premiums, consumer complaints have been reduced, there is no apparent bias in the appeals process for or against insurers or providers, and providers and insurers remain encouraged to reach agreements.
- Protect patients from out-of-network billing and preserve patient access to hospital-based care. Insurers must be held accountable for addressing their own contributions to the problem. Any legislation addressing surprise billing should also establish strong, measurable, and enforceable network adequacy requirements, as well as require stronger enforcement of federal mental health and substance use disorder parity and prudent layperson laws.

The AMA shares the Committee's goal of treating patients fairly and assuring that their health insurance plans actually deliver the benefits that were promised and that their premium payments were expected to cover. However, experience with Medicare's sustainable growth rate system has shown how difficult and costly it can be to enact remedies after flawed payment policies are enacted. We will continue to work with the leaders in the House and Senate to advance effective proposals to lower health care costs, protect patients from surprise bills, and promote greater access to in-network care.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

MAY 2019

By Sabrina Corlette and Olivia Hoppe



**Robert Wood Johnson
Foundation**

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Authors

Sabrina Corlette and Olivia Hoppe



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Introduction

In March 2014, the New York legislature passed the Emergency Services and Balance Billing Law (“Surprise Billing” law), which went into effect in March 2015.¹ The law protects consumers from charges for out-of-network (OON) services not paid by an insurance plan, in cases of emergency or circumstances in which the patient did not have a reasonable choice between an in-network and out-of-network provider. New York’s law has been touted as a model for other states as

well as potential federal legislation because of its unique “baseball-style” arbitration approach to settling payment disputes, which generated broad buy-in among a set of stakeholders that typically have strongly opposing views.² Five years post-enactment, this study assesses the implementation of New York’s law and how it is working for consumers, providers, and insurance company stakeholders today.

Background

What is a surprise balance bill?

Surprise bills can arise from both emergency and planned health care services, and can lead to significant financial liability for patients, even though they have health insurance. For many consumers, a “surprise bill” is any bill they receive from a medical provider that is larger than expected. A “balance bill” is a bill the patient receives from a medical provider that charges the balance remaining after the insurer makes a payment and any plan cost-sharing or deductible is applied; it may or may not be larger than expected. Insured patients may receive *surprise* balance bills in the case of an emergency when they unknowingly receive services from an out-of-network provider, in the case of a scheduled procedure when they make a good faith effort to ensure that the facility and treating physician are in-network but receive services from a non-participating provider, or when they are misinformed about a provider’s network status

by their health plan or provider (New York’s law defines a surprise balance bill somewhat more narrowly; see Glossary).

Insurers and providers participate in negotiations to determine the rate the insurer will pay for the provider’s services. Typically, in-network providers agree to accept rates that are lower than what they would otherwise charge (often called the “allowed amount”; see Glossary) in return for the guarantee of patient volume among the insurer’s members. Some physicians, such as anesthesiologists, emergency room physicians, radiologists, and pathologists, gain patients by practicing within a particular facility, and do not have the same incentive to participate in a plan’s network. They can often earn more revenue by charging a higher, out-of-network price for their services. For example, out-of-network emergency department physicians charge, on average, 2.4 times more than the in-network rate for their services.³

Glossary of Key Terms

Allowed amount: The maximum amount a health plan will pay for a covered health care service. In-network providers typically agree to accept this amount as payment (plus any patient cost-sharing) and not to balance bill the patient.

Baseball-style arbitration: Also referred to as “final offer” arbitration. Each party to the dispute (the payer and the physician) must submit to the arbiter their best offer. The arbiter must choose one of the two offers without compromising between the two sides. This encourages the parties to submit reasonable bids.

Emergency services bills (as defined by New York law): Bills that arise from a medical screening examination conducted within the emergency department of a hospital, including ancillary services routinely available within the emergency department needed to evaluate and, if needed, stabilize the patient with an emergency condition.

Health Maintenance Organization (HMO): An HMO is a network-based health insurance product. Enrollees generally need to receive a referral from a primary care provider for specialty services and HMOs typically do not cover the cost of care delivered by an out-of-network provider.

Participating hospital or physician: A provider who has a contract with a health insurer to provide services to their members. These providers typically agree to accept the insurer's allowed amount as payment (plus any patient cost-sharing) and not to balance bill the patient.

Preferred Provider Organization (PPO): A PPO is a network-based health insurance product. Unlike an HMO, enrollees are typically allowed to see the providers of their choice without a referral from a primary care provider. Additionally, the plan may cover a portion of the cost of care received from an out-of-network provider.

Self-funded health plan: A plan in which the sponsor (typically a large employer) takes on the risk of paying its members' health care claims. State laws that relate to such plans are generally preempted by the federal Employee Retirement Income Security Act (ERISA).

Surprise bills (as defined by New York law): Bills that arise from non-emergency services (1) in a participating hospital or ambulatory surgical center when an in-network physician is unavailable, or an out-of-network physician renders services without the patient's knowledge; (2) when a participating physician refers a consumer to an out-of-network provider without the consumer's consent; or (3) for uninsured or self-insured patients when disclosure is not made.

Usual and Customary Rate (UCR) (as defined by New York Law): The 80th percentile of all (non-discounted) charges for a particular health care service performed by a provider in the same or similar specialty within the same geographic area. New York law requires these charges to be reported by a benchmarking database maintained by an independent nonprofit organization.

Surprise medical bills are a top concern for consumers. Thirty percent of privately insured Americans received a surprise bill between 2013 and 2015, with 76 percent left unresolved or unsatisfactorily resolved.⁴ Between 2008 and 2011, the New York Department of Financial Services (DFS, which houses New York's insurance department) received 8,339 consumer complaints related to reimbursement for health care services. The DFS investigation found systemic challenges for consumers, including the inability to compare out-of-network benefits

across competing insurers, a lack of disclosure of providers' network participation, excessive billed charges for emergency services, inadequate provider networks and coverage of out-of-network services, and administrative complexity in submitting out-of-network claims.⁵

New York's Surprise Bills Law

Various states have implemented policies designed to curb surprise bills, but most states lack comprehensive consumer protections. New

York is one of just 9 states with laws that extend protections to both emergency and in-network hospital services, apply protections across all types of state-regulated insurance, hold

consumers harmless from extra provider charges, and adopt either an adequate payment standard or establish a dispute resolution process.⁶ See Text Box.

New York Surprise Billing Law: New Requirements for Insurers and Providers

Consumer Protections

- Requires insurers to protect consumers from all out-of-network emergency room (ER) bills.
- Requires both insurers and physicians to protect consumers from non-ER out-of-network claims:
 - > In a participating hospital or ambulatory surgery center when a participating physician is unavailable, or an out-of-network physician renders services without the consumer's knowledge, or unforeseen medical services arise at the time the health care services are rendered; or
 - > Whenever a participating physician refers the consumer to an out-of-network provider without the consumer's consent; or
 - > For uninsured or consumers in self-funded plans, unless certain disclosures are made.

Dispute Resolution

- Establishes an independent dispute resolution (IDR) process for out-of-network ER services and surprise bills for non-ER services.
 - > IDR chooses either the provider bill or the insurer's payment as reimbursement for services.
 - > IDR must consider (1) whether there is a gross disparity between the provider charge and (a) fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating; and (b) fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan; (2) the provider's training, education, experience, usual charge, the complexity of the case, individual patient characteristics, and UCR as reported by a benchmarking database.
 - > The loser pays for the cost of the IDR process.

Consumer Disclosures

- Requires insurers to disclose their reimbursement methodology for out-of-network services and provide examples of out-of-pocket costs for frequently billed out-of-network services.
- Requires insurers to keep provider directories up to date (web updates within 15 days)
 - > When a service is scheduled in advance:
 - > Requires insurers to inform the consumer which of their providers are out-of-network and the reasonably anticipated out-of-pocket costs;
 - > Requires hospitals to make public the health plans in which the hospital is a participating provider and disclose the physician groups that the hospital has contracted with to provider services. Hospitals must also inform consumers how to determine the health plans in which these physicians participate.
 - > Requires physicians to inform the consumer whether they participate in their health plan. Physicians who are arranging a scheduled hospital service must inform the patient which other physicians will be providing services.

Network Adequacy

- Extends state network adequacy requirements to non-HMO plans (i.e., PPOs).
- Requires insurers to hold consumers harmless for out-of-network cost-sharing if the insurer does not have an appropriate in-network provider.

Importantly, the requirements of New York's law do not extend to self-funded health plans, as the state is preempted from regulating such plans. In addition, while insurers and out-of-network physicians are subject to the IDR process described above, other out-of-network providers, including hospitals, ambulances, and dialysis facilities are not. In the case of out-of-network emergency services, insurers must protect

enrollees from out-of-network charges, but only the physician fees are subject to the IDR process; hospital charges are not. The law also does not protect consumers who are misinformed about their provider's network status, either because they relied on an out-of-date provider directory or were given inaccurate information by their physician's office staff.

Case Study Approach

This brief evaluates the implementation and operation of New York's Surprise Billing law, 5 years post-enactment. The findings herein are based on a review of New York's law and implementing regulations and published reports and analyses about New York's experience to

date. In addition, we conducted ten structured interviews with state regulators, consumer advocates, insurance company representatives, physician and hospital representatives, and expert observers. The interviews took place between January 16 and March 20, 2019.

Findings

Insurer, provider, and consumer stakeholders generally agree that the implementation of New York's Surprise Billing law went smoothly, was relatively fair to all parties, and is working as intended to protect consumers from a significant source of financial hardship. However, several stakeholders noted continued gaps in consumer protections, as well as the potential that the IDR process could lead some physicians to inflate their charges.

Implementation eased by front-loaded legislative process

Negotiating and drafting New York's law was, by all accounts, a "pretty intense process." Stakeholders gave extra credit to DFS and the Governor for their commitment to the issue, beginning with the publication of a 2012 DFS report quantifying the level of consumer complaints associated with surprise balance billing.⁷ That report was "a really important first step," said one stakeholder. "We have this law because [the regulator] gives a damn...and embraced the idea of putting the consumer first." At the same time, the report put provider

advocates on the defensive, prompting media coverage of high provider charges and raising public awareness.

DFS' efforts to subsequently draft a bill that all parties could support – or at least agree not to oppose – were lauded by all sides. Stakeholders credit the agency for listening to their feedback and making changes to the bill in response. "It was a collaborative process," shared one industry stakeholder. Indeed, key to the bill's success were the administration's efforts to bring all the relevant interest groups together. As one observer put it: "The message [from the administration] was: 'This is going to happen, so you better be here.'"

The emergence of baseball-style arbitration as a mechanism to solve provider-payer disputes was critical to the bill's passage. "It was easier for these interest groups to agree to [IDR] because it's not forcing them to adopt a religious position with which they violently disagree," said one observer. "IDR allows both sides to come to the middle." Ultimately, the bill was enacted thanks to support from "elated" consumer groups, provider groups who were "mostly ok," and insurer groups

who were “concerned,” but did not actively oppose it.

That front-end negotiation, while “intense,” generated stakeholder buy-in and ultimately eased the path from enactment to implementation. The bill that was passed is quite detailed and “got into the weeds,” leaving few post-enactment battles to be fought. “All the hard work, hard decisions – it was front-loaded,” commented one insurance expert.

Stakeholder consensus: New York regulatory agencies managed implementation well

Recognizing that implementing the broad and complicated Surprise Billing law would be no small lift, New York lawmakers provided a year of lead time for the agencies – DFS and the Department of Health (DOH) – to draft regulations, prepare and publish templates for provider and plan disclosure notices, and educate the public about their rights and obligations under the new law.

Engaging stakeholders

State officials worked hard to reach out to provider, payer, and consumer stakeholders and incorporate their feedback and concerns during implementation. For example, many health plans were concerned that the IDR process would lead automatically to provider reimbursements set at the 80th percentile of UCR, an amount typically much higher than negotiated in-network rates. This, in turn, would create a disincentive for affected physicians to join the health plans’ networks and incentives for physicians to increase their billed charges. Insurers pushed DFS to ensure that IDR reviewers could consider other factors, including negotiated (allowed) rates as well as Medicare rates, in rendering a decision. DFS was able to help alleviate payers’ concerns by clarifying their ability to submit alternative fees for the IDR reviewer to consider.⁸

Consumer advocacy organizations had words of praise for DFS’ efforts to engage them in the review of draft regulations and disclosure forms. “They consulted us on the mechanics,” said one advocate, particularly with respect to how consumers interact with providers and payers in both emergency and elective health care scenarios, and whether and how they would

likely respond to the language of the required disclosure notices.

Provider representatives also reported “lots of meetings and discussions” with the implementing agencies and applauded their willingness to listen and modify certain requirements. For example, hospital representatives reported working closely with the agencies to design a monitoring and audit program to assess hospitals’ compliance with the law.

Leveraging existing resources

Proactive efforts to generate stakeholder buy-in paid off, as the agencies were able to leverage the infrastructure and dissemination capabilities of the state’s provider and payer associations and consumer advocacy organizations to educate stakeholders and the public about the new law. DFS also tapped an existing help line for consumers with insurance problems – run by the Community Service Society of New York – to help consumers with balance billing issues. Their phone number, along with information about how to protest a surprise balance bill, now appears on the “Explanation of Benefits” form that patients receive after claims are submitted on their behalf.⁹

New York was also able to streamline implementation by taking advantage of relationships it had in place with external appeal organizations. These are independent, third-party entities that make determinations on consumers’ plan appeals regarding utilization review issues. As such, they had many of the same personnel and policies needed to step in as IDR review entities, making it easy for the state to implement the IDR process. Unfortunately, not all states have a similar external review infrastructure in place.¹⁰

Stakeholder consensus: Law has achieved its primary goal; views are mixed about impact

Virtually all stakeholders we interviewed reported that New York’s law has successfully helped protect consumers from a major source of surprise balance bills. “[The law] is working great...it works really well for consumers,” said one consumer advocate. An analysis of calls to the Community Service Society’s consumer help line related to surprise balance billing found that 57 percent were resolved thanks to the law’s protections.¹¹

State officials report a “dramatic” decline in consumer complaints about balance billing: “It’s downgraded the issue from one of the biggest [consumer concerns our call center receives] to barely an issue,” said one regulator. Insurance company representatives also reported a decline, although they were unable to quantify it. Further, several stakeholders reported that the accuracy of insurers’ provider directories had improved since the law was enacted (although there are still problems); others suggested that many consumers have become savvier about the risks of out-of-network billing and are asking more questions about providers’ network status prior to scheduled procedures.

In general, respondents viewed the IDR process as fair, although providers were more bullish on it than insurers. As of October 2018, IDR decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider (see Table 1). However, insurers have tended to win the majority of out-of-network emergency services disputes (534-289), while providers have won the majority of surprise bill disputes (272-84). Additionally, insurers and

physicians appear to be making “a real concerted effort” to work out their payment disputes before filing with IDR; experts on the IDR process assert that filed complaints represent just “a tip of the iceberg” of the number of relevant payment disputes that occur.

Physician representatives appear largely satisfied with the process and its results. One specialist representative reported “the law worked better than we ever anticipated.” Physician-members of his association who had used the IDR process had “no complaints.... They appreciate the fairness of it,” he said. He also observed that the law may have prompted insurers to “be a little looser” during network negotiations, offering his members higher reimbursements to be in-network than they had prior to the law. Insurers too told us that the incentives are for their networks to be as “expansive as possible.” This observation is consistent with a recent analysis of claims data, which found a 34 percent drop in out-of-network billing in New York since the law was in effect.¹² State officials reported receiving some complaints from providers, but that they tend to be from physicians who have traditionally charged very high rates.

Table 1. Independent Dispute Resolution Results: Emergency Services and Surprise Bills (as of October 25, 2018)

IDR Results for Bills for Emergency Services							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision*	Settlement Reached
2,104	534	150	1,431	534	289	364	244
IDR Results for Surprise Bills**							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision**	Settlement Reached
1,294	399	186	709	84	272	211	142
IDR Results, Total							
Total Received	Not Eligible	Still in Process	Decision Rendered	Decided in Favor of Health Plan	Decided in Favor of Provider	Split Decision**	Settlement Reached
3,398	933	336	2,104	618	561	575	386

Source: Oechsner T. “New York’s Out-of-Network Legislation.” (Presentation to the NYS Health Foundation, October 29, 2018). On file with authors.

*A split decision occurs when more than one CPT code is submitted in a dispute and the IDR entity finds in favor of different parties for different codes.

**See Glossary for definition of “surprise bill.”

Insurers and other observers raised concerns that IDR reviewers' use of the 80th percentile of UCR as a benchmark for settling payment disputes could open the door for "the provider community to...just drive up the UCR." Further, they noted that certain specialty groups (neurosurgeons and emergency doctors in particular) now have "no real incentive" to join plan networks because they can gain higher reimbursement through IDR. However, insurer respondents acknowledged that the ability to submit alternative data, such as network or Medicare rates, to the IDR reviewer enables them to make the best possible case for a reasonable rate. "We're creating ways to present [rate] information to the IDR that's outside the 80 percent UCR...to create a willingness to change the pricing," said one insurer representative.

It may be too soon to know whether New York's approach to settling billing disputes will lead providers to inflate their out-of-network charges. Indeed, one study found a 13 percent average *reduction* in physician payments since the law was enacted.¹³ State regulators report that there has not been, as yet, an indication of an inflationary effect in insurers' annual premium rate filings. Observers further noted that, prior to the law, New York HMOs were required to pay out-of-network doctors' full billed charges for emergency services if the provider would not agree to a negotiated rate; the IDR process has likely reduced those payers' costs.

In short, IDR is not perceived as "a slam dunk for either side." But observers do believe the legislation has sent a signal to insurers and providers alike to "just be reasonable and work it out amongst yourselves if you can."

Stakeholders identify needed improvements, continued challenges for consumers

Although it helped solve two types of surprise billing problems for consumers, the New York law has left them exposed to others. First, stakeholders across the spectrum noted with

regret that self-funded plans are not subject to requirements to hold the consumer harmless, as state regulation of those plans is preempted under ERISA.

Second, advocates identified network "misinformation" as the biggest remaining problem for consumers receiving surprise bills. "It's enraging," one said. When a consumer gets a balance bill after they've relied in good faith on information that the provider is in-network, "that's a surprise bill." In some cases, in-network consumers may rely on inaccurate, out-of-date plan provider directories (although New York has created its own provider look-up tool, which consumer advocates report has been helpful).¹⁴ In others, they are misinformed by physicians' office staff, who represent that they participate in the patient's network when in fact they do not. The representative of a consumer help line has reported that complaints about inaccurate network information represent 35 percent of calls about surprise bills, with the source of the problem roughly evenly split between plan directories and providers' office staff.¹⁵ Although regulators report that they require insurers to hold consumers harmless if the consumer files a complaint showing they relied on an inaccurate plan provider directory, they are as yet unable to hold providers similarly accountable.

Advocates – and insurers – have also called for the legislature to amend the law to subject out-of-network hospital facilities to the IDR process. In an emergency, if a patient is taken to an out-of-network hospital by an out-of-network ambulance, health insurers must limit the patient's out-of-pocket costs to the in-network cost-sharing. If there is a balance bill, the insurer must pay it. However, several observers noted that these providers often submit "excessive charges," knowing the insurer is on the hook to pay them. Further, advocates noted that these hospitals often initially send the bill directly to the patient, "which is completely confusing." Many patients pay it without realizing they don't need to.

Conclusion

Health care is complicated. Determining how providers set prices for their services, how insurers determine what to pay for those services, or ultimately what those services should actually cost is “three-dimensional chess.” New York’s Surprise Billing law doesn’t attempt to answer any of those questions. It simply says that patients should not be the ones expected to figure it out. On that score, the law has been a success. Consumer complaints have declined dramatically. For the most part, insurers and providers appear to be working out their differences without resorting to arbitration. Further, there is not yet clear evidence that the law’s use of UCR as a benchmark price has had broadly inflationary

effects. However, it can take time for a policy change to change behavior, including the billing practices of a diverse array of specialty physicians.

The law also contains some significant gaps, particularly with respect to surprise balance bills that occur when patients are misinformed about their providers’ network status and when patients are taken to out-of-network facilities in an emergency. Additionally, like all states, New York must await federal action to amend ERISA before it can act to protect patients enrolled in self-funded employer plans.

Endnotes

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