New York ACEP scored a major victory in the 2014-15 State Budget by getting an amendment to the Out-of-Network health insurance bill to exempt emergency services from the burdensome Independent Dispute Resolution (IDRE) process.

I want to thank the New York ACEP membership for joining me, Executive Director JoAnne Tarantelli, and our contract lobbyists Reid, McNally and Savage for working around the clock to stop health insurance companies from dictating fees for all emergency services in the State.

Although the New York State Department of Financial Services has found no complaints against emergency physicians for charging patients excessive fees for out-of-network services, the original State Budget proposal **required emergency physicians to accept a rate for out-of-network emergency services that is "determined reasonable" by an insurer**. If the physician disagreed with the insurer's fee, their only recourse was to file a dispute with an Independent Dispute Resolution Entity (IDRE) **for each and every claim**. The final State Budget which was signed into law Tuesday, April 1, by Governor Andrew Cuomo exempts bills for emergency services that are under $600 from the IDRE process and the requirement to accept an insurer's fee.

Based on our analysis, this exemption will include claims for some evaluation, management, critical care and most observation care provided by emergency physicians. Utilizing the Fair Health Consumer database as a resource, New York ACEP members can reference 12 broad geographic areas for the 18 CPT codes listed in the bill at the New York ACEP web site (see the link below).

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The legislation does not prohibit balancing billing for out-of-network emergency services. Responsibility is placed on the insurance company to negotiate with physicians to "ensure that the patient receives no greater out-of-pocket costs" than they would have incurred with a participating health care provider.

The amendments achieved by New York ACEP will help ensure that patients have access to emergency services and protect the emergency health care safety net.

A summary of key provisions of the bill is outlined below.

New Consumer Protections

- The bill affords patients enrolled in all health insurance products the right, currently only available to those enrolled in HMOs, to access out-of-network health care providers at no additional cost to the patient if the insurer does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient.
- A new right is established for a patient to file an appeal through the Independent External Appeals process when an insurance company denies a patient request to receive services from an out-of-network provider.
- Insurance companies, health care professionals, hospitals and other health care facilities are required to disclose significant information to patients so that they can determine how insurance companies calculate rates, whether a health care provider is in their insurance company's network and, if not, what the patient will be billed for the services.

Out-of-Network Rates and Adequacy

- Usual and customary cost (UCR) is defined as the 80th percentile of all charges for health services performed by a provider in the same or similar specialty and provided in the same geographic area as reported by a benchmarking database maintained by a nonprofit organization specified by the DFS Superintendent (This is understood to mean FAIR Health).
- Insurers that issue a comprehensive group or group remittance policy for out-of-network coverage must "make available" at least one policy that provides coverage of at least 80% of the UCR.
- All insurance products, not just HMOs, are required to have adequate networks.

Independent Dispute Resolution for Emergency Services and Surprise Bills

- Excluded from the Independent Dispute Resolution process are specific emergency services CPT codes in which the amount billed is under $600 (annually adjusted for inflation) and the amount does not exceed 120% of UCR (80th percentile of Fair Health).
- A non-participating physician or health care plan may submit a dispute regarding a fee to an Independent Dispute Resolution Entity (IDRE) for emergency services and for "surprise bills" for non-emergency services provided in a hospital or ambulatory surgery center.
- An uninsured patient may submit a dispute if they have not timely received all of the required disclosures under the law.
- The IDRE must select either the physician's charges or the insurer's payment based on the following criteria:
    - whether there is a gross disparity between the fee charged by the physician as compared to their usual charges for the same services when the physician is not participating in a health care plan;
    - whether there is a gross disparity between the fee paid by the health care plan to

reimburse similarly qualified providers for the same services in the same geographical region who are not participating with the health care plan;
    - individual patient characteristics;
    - the level of training, education and experience of the physician;
    - the circumstances and complexity of the case; and
    - the usual and customary cost of the service (defined as 80th percentile of Fair Health)
- In instances where the IDRE disagrees with both the physician's fee and the insurer's payment, the reviewer would be permitted to ask the parties to negotiate a fee.
- All decisions by the IDRE are required within 30 days.
- The IDRE is required to use licensed physicians in active practice in the same or similar specialty as the physician subject to review. To the extent practicable, the physician must be licensed in this State.
- The losing party pays for the dispute resolution process, except in the case where a health care plan and a physician reach a settlement after being directed to negotiate by the IDRE in which case responsibility for payment is evenly divided between the health care plan and the physician.
- When the IDRE rules in favor of a physician for a dispute brought by an uninsured patient, payment shall be the responsibility of the patient unless the Superintendent determines that this would pose a hardship to the patient.

Out-of-Network Workgroup

A nine member Workgroup is established and appointed by the Governor with recommendations from the Legislature. The Superintendent of the Department of Financial Services and the Commissioner of the Department of Health will serve as Co-Chairpersons. The Workgroup is charged with reviewing current out-of network rates and coverage and making recommendations to the Governor and the Legislature no later than January 1, 2016.

This law takes effect one year after signed, April 1, 2015.

Out-of-Network Health Insurance Bill
State Budget Actions of Interest to Emergency Medicine

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