Surprise Bills Laws Enacted in California and New York

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What Do They Mean for Providers?

Both California and New York have recently enacted so-called "Surprise Bills Laws" that require out-of-network providers to give notice to patients that a particular item or service might not be paid by the patient's insurance. These laws may spread to other states and have major ramifications for any entity that submits claims to health insurers.

Background

"Surprise bills" are unexpected bills incurred by patients for health care services provided by an out-of-network provider when the insured was unaware that the provider was out-of-network or did not have a choice to receive services from an in-network provider. Recently, New York and California have passed "surprise bills" laws that shift the burden of unknowingly receiving out-of-network services away from consumers. Insurers and providers need to be aware of these requirements so they make the necessary disclosures and avoid being stuck with the cost of surprise bills.

In March 2014, New York passed an "Emergency Medical Services and Surprise Bills Law" ("NY Surprise Bills Law"); this law requires disclosure by providers and imposes restrictions on the amounts consumers can be charged for surprise bills. It went into effect on March 31, 2015. In the wake of the NY Surprise Bills Law, on January 20, 2015, the California Department of Insurance filed emergency regulations governing health insurance provider networks. The regulations drew the attention of providers by including disclosure requirements to prevent "surprise bills."

The New York and California laws were spurred by public discourse about insured individuals who were facing steep medical bills for services received at out-of-network providers. In New York, the Department of Financial Services examined the over 2,000 complaints it received in 2011 on medical payment issues, and released a report analyzing the substantial medical bills facing consumers who had tried to remain in network. The New York Times ran a prominent feature on the issue in 2013.

Prior to New York's Surprise Bills Law, 13 states had some restrictions on billing insured individuals for the balance of a bill not covered for services provided by an out-of-network provider. However, these restrictions were mostly limited. Some states applied restrictions just to HMOs and others limited application to ambulatory or emergency services.

Summary of New York's Surprise Bills Law

The NY Surprise Bills Law aims to reduce the number of consumers facing unexpected out-of-pocket expenses for services by out-of-network providers by: (1) applying network adequacy requirements for health plans with comprehensive provider networks; (2) requiring disclosures about possible out of network costs; and (3) restricting the amount a patient can be charged in certain situations.

Adequacy Provisions – The statute requires that all health plans based on comprehensive provider networks, including HMOs, PPOs and EPOs, be certified as able to meet the demands of their members. If a plan's network does not have an accessible provider with appropriate expertise, the patient can seek services from an appropriate out-of-network provider and pay the cost sharing expenses as if it were an in-network provider.

Disclosure Requirements – The statute includes a series of disclosure requirements for insurers and providers.

- **Insurers** must, on their websites, have updated provider listings and examples of frequently billed out-of-network services, which

have yet to be defined, to assist patients in determining the cost of out-of-network services.

- **Health Care Professionals, Group Practices, Diagnostic and Treatment Centers, and Health Centers** must list on their websites the health plans and hospitals with which they are affiliated and disclose that patients have a right to be informed of the anticipated out-of-pocket costs for out-of-network providers.
- **Physicians** must notify the patient of any provider scheduled to perform services for care provided in the physicians' offices or coordinated or referred by the physician for the patient at the time of referral or coordination. For non-emergency scheduled hospital admission or outpatient hospital services, the physician must disclose any other physician whose services are scheduled at pre-admission testing and information on how to determine whether that physician is in-network. None of the regulations yet issued addresses how this notice must be provided or whether these notice requirements extend beyond physicians to nurse practitioners and physician assistants.
- **Hospitals** must post on their websites schedules of charges for various services, the health plans in which they participate, the names of practice groups that provide services such as radiology, anesthesiology, and pathology, and guidance to patients on how to check their own physician's network affiliations. There are also required disclosures for pre-registration materials.

Restrictions on Surprise Bills – Insured patients receiving emergency services or receiving surprise bills will not have to pay more than their usual in-network cost sharing for services provided by out-of-network providers. When a provider bills a patient for what could be a surprise bill, they are required to include an assignment of benefits form. When a patient assigns benefits to the provider, the provider may only bill the patient for their in-network cost sharing. In the case of a surprise bill, the providers and health plans can negotiate fees directly, or either party can submit their proposed fee to an Independent Dispute Resolution Organization.

The New York Department of Financial Services has recently released regulations clarifying the dispute resolution procedures for when insurers and providers dispute the fees for a surprise bill, and the New York insurance industry is already pushing for modification in the bill to strengthen the requirements on physicians to disclose fee information.

Summary of the California Regulation

In comparison to the New York statute, the scope of the California emergency regulations is more modest. These new regulations amend the state's previous network access standards and adopt disclosure requirements for out-of-network services. The California regulations do not include the balance billing restrictions that are central to the New York law.

Network Adequacy Provisions – Insurers must now show their network providers are sufficient in capacity and specialty to be capable of furnishing the health care services covered by the insurance contract. Additionally, there must be enough primary care physicians in the network accepting new patients covered by the policy to accommodate anticipated enrollment growth. When there are insufficient network providers, the insurance plan must make arrangements to provide out-of-network care at in-network prices.

Disclosure Provisions – An important distinction between the New York and the California provisions is the scope of the disclosure requirement. The California regulations require contracts between network providers and insurers to contain a provision requiring network facilities to determine and disclose to the insured person (1) the non-network providers who are likely to be involved in providing care and (2) the estimated cost of that non-network care to the insured person. Insurers must also post their updated network provider directory on their website.

The emergency regulations adopted in California are only valid for 180 days, until July 30, 2015, with the possibility of two 90-day extensions if the agency is in the process of adopting permanent regulations. The agency has not yet issued proposed permanent regulations.

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