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February 7, 2018

The Honorable Charles Schumer
U.S. Senate Minority Leader
322 Hart Office Building
Washington, DC 20510

Dear Senator Schumer:

We are writing to you to urge that any federal legislation to address “surprise” out of network medical bills be consistent with the law that was adopted by New York State in 2014. New York’s comprehensive law addressing this issue has been hailed as a model for the rest of the country because of the delicate balance it struck among key health care stakeholders (such as physicians, hospitals and health insurers) to protect patients from large “surprise” medical bills, while at the same time being constructed in such a way that it did not adversely affect the ability of hospital emergency departments to have adequate on-call specialty physician care.

Importantly, New York’s law addressed a number of factors that have led to surprise medical bills faced by our patients, which includes narrow and inadequate health insurance provider networks as well as inadequate insurance coverage for out of network (OON) physician care. To this end, New York’s law contains provisions to ensure patients have better understanding of the scope of a health insurer’s out-of-network (OON) coverage, expand the availability of a patient to have coverage for an OON physician if the insurer’s existing participation physician network is insufficient, assure that OON benefits offered by insurers are more comprehensive, and establish a process to define the extent of insurer coverage for emergency and “surprise” OON medical bills.

Patient Marketplace Protections for Voluntary OON Care

In particular, New York’s law contained the following key reforms to help patients obtain and better understand their coverage for out of network care:

- Requires all health insurance products regulated by the State of New York to meet physician network adequacy requirements, based upon review by New York’s Department of Financial Services (DFS);
- Affords patients enrolled in any health insurance product regulated by the State of New York the right to receive treatment from a specialist appropriately qualified to treat a patient’s particular condition at no additional cost to the patient, if the network of such insurance product fails to include such appropriately qualified physician specialist.
- Establish a patient right to have an independent external appeal to be treated by an OON physician if the patient can show that the insurer network is insufficient to meet the health care needs of the patient.
- Requires health insurers to describe its OON coverage in a manner that is based upon the percentage of the “usual and customary cost” of OON health care services, including examples of anticipated out of pocket costs for frequently billed OON health care services, and an internet site that enables patients to determine what our of pocket

costs they can reasonably expect to face based upon the OON coverage provided by the insurer. *This was to address concerns that OON coverage based upon Medicare or insurer “allowed” amounts were poor predictors to patients of what they could reasonably expect to be their out of pocket costs when treated by an OON physician.*

- Requires health insurers to offer coverage to consumers of policies that cover at least 80% of the usual and customary cost of any OON health care service.

Importantly, the law defines “Usual and customary cost” as the 80th percentile “of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent”. This reflects the manner by which out of network medical services are being regularly collected and reported by publicly available benchmarking services such as Fair Health. Indeed, Fair Health’s “usual and customary” data has become the benchmark for many different state programs across the country because of the comprehensiveness of its data. Furthermore, it employs mechanisms to ensure that “outliers” in charges are deleted from its regional collections of data. Therefore, it is a far more predictive indicator to patients of what their potential out of network costs could be rather than health insurer controlled in-network rates or grossly insufficient Medicare or Medicaid rates.

Assuring Protections for “Surprise” Hospital Bills

Most importantly, with regard to bills for emergency care and other “surprise bills” for care by non-participating physicians, it held patients “harmless” for amounts above the patient’s otherwise required cost-sharing (had the care been provided in-network). To ensure fair payment to the physician from the health insurer, it employed the following process:

1. The physician submits the OON claim to the insurer.
2. The health insurer pays what it deems to be reasonable
3. If efforts to informally settle the payment dispute are unsuccessful, either the physician or insurer can bring the claim to an Independent Dispute Resolution (IDR) process.

To encourage reasonableness on both the part of physicians and health plans, the IDR entity must choose between the plan’s payment or the non-participating physician’s fee (otherwise known as “baseball arbitration”), and may not set their own amount. In rare instances the arbitrator can direct the parties to negotiate a settlement.

As part of the IDR entity’s review, they are required to consider: the usual and customary cost of the service (as defined by the 80th percentile of charges for that service in that region); Whether there is a “gross disparity” between the fee charged by the physician as compared to other fees paid to similarly qualified non-par physicians in the same region; The non-par physician’s usual charge for comparable services; individual patient characteristics; the level of training, education and experience of the physician; and the circumstances and complexity of the case.

To discourage the frivolous bringing of such claims, the IDR is statutorily defined as a “loser pays” process. Moreover, to ensure that claims are not inappropriately “dragged out”, the statute requires a decision to be rendered within 30 days of claim submission. The expeditious nature of this process is one of its key features.

From the statistics, it is clear that the law is working as it was intended. For example, according to the 2018 New York State Consumer Guide to Health Insurance (https://www.dfs.ny.gov/consumer/health/cg_health_2018.pdf - p.64), the “winners” of these IDRs have generally been evenly split between health insurers and providers, with health insurers “winning” slightly more, as noted below.

CATEGORY	EMERGENCY SERVICES	SURPRISE BILLS
Health Plan Payment More Reasonable	203	49
Provider Charges More Reasonable	61	141
Split Decision	102	75
Settlement	109	67

Health Care Provider/Health Insurer Transparency

We would further note that, since one of the major goals of New York's law was to reduce the incidence of "surprise" medical bills, to better assure patients are made aware of situations where they may end up receiving treatment by an out-of-network physician, the law also imposes significant disclosure requirements on physicians, including requiring that they:

- Disclose the plans in which the physician participates and the hospitals where the physician is privileged;
- Disclose the anticipated fee a non-par physician will charge the patient for scheduled services after informing the patient that they have the right to request the cost of such health care services; and
- Disclose the identity and contact information of other health care providers who may be involved in the patient's care when a non-emergency service is scheduled.

Similar additional disclosure requirements are also imposed on health insurers and hospitals including:

- Hospitals are required to post on their website certain standard charges for items and services provided by the hospital and the plans in which the hospital is a participating provider.
- Hospitals are required to post on their website and provide to a patient in advance on non-emergent hospital services in registration or admission the names and contact information for physician groups with which the hospital has contracted to provide anesthesia, pathology or radiology.
- Health Insurers are required to update their websites regarding physician participation status with plans or hospitals within 15 days of a change.

For more information about New York's law, you can go to the NY DFS summary page "Protection from Surprise Bills and Emergency Services" for this law at: <https://www.dfs.ny.gov/consumer/hprotection.htm>.

In summary, New York's comprehensive law sought to address the various circumstances under which a patient's interaction with the health care system could unfortunately lead to that patient receiving a "surprise" medical bill. It has set a model for the nation. In this regard, we urge you to advocate to ensure that New York's law forms the basis for any federal legislation to address the issue of "surprise" medical bills.

We would be happy to answer any questions you may have.

Sincerely,



THOMAS MADEJSKI, MD
President, MSSNY