

AN UNWELCOME SURPRISE

How New Yorkers Are Getting Stuck
with Unexpected Medical Bills
from Out-of-Network Providers



New York State Department of Financial Services
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EXECUTIVE SUMMARY

Although the nation's health care system is undergoing reform, the persistent problem of unexpected medical bills has not been squarely addressed. The New York State Department of Financial Services ("Department") regularly receives complaints from consumers who have done everything reasonably possible to use in-network hospitals and doctors, but nonetheless receive a bill from a specialist or other provider who the consumer did not know was out-of-network. Related complaints of undisclosed and excessive charges are particularly pronounced in the emergency care setting.

Unexpected and, sometimes, excessive medical bills from out-of-network providers contribute to the growing problem of consumer medical debt, which continues to be a significant cause of personal bankruptcy. Simply put, surprise medical bills are causing some consumers to go broke.

This report reflects the initial results of the Department's investigation of these medical bills. The Department surveyed the eleven companies that offer insurance coverage and health maintenance organization ("HMO") coverage in New York State, which account for approximately 95% of the fully insured New York State health insurance market. The Department asked insurers and HMOs about their policies and procedures for surprise medical bills, coverage of out-of-network services, and excessive charges for emergency services.

The Department also reviewed more than 2,000 complaints it received in 2011 involving payment issues, seeking to better understand contributing factors to the medical bills. Many of the complaints submitted to the Department involve consumers receiving scheduled, non-emergency medical services for which the consumer had received insurer approval, but neither the insurer, the doctor, nor the hospital disclosed to the consumer that other specialists — some

of whom are out-of-network — would also be providing services. In one complaint, a consumer needed heart surgery and confirmed that the hospital and surgeon participated in his insurer's network, meaning the consumer would only be responsible for a co-payment. Yet without the consumer's knowledge, an out-of-network surgeon assisted in the surgery. The consumer thus was responsible for paying a \$7,516 bill from the out-of-network surgeon. In another instance, a consumer went to an in-network hospital for gallbladder surgery with a participating surgeon. The consumer was not informed that a non-participating anesthesiologist would be used, and was stuck with a \$1,800 bill. Providers are not currently required to disclose before they provide services whether they are in-network.

Other complaints have involved large bills for emergency care. In one complaint, a consumer went to the emergency room at a hospital participating with his insurer. The consumer received an \$83,000 bill from the non-participating plastic surgeon for reattaching his finger, which was severed in a table saw accident. The insurer asserted, however, that other physicians in the area typically charge one-fourth, or about \$21,000, for the procedure. The consumer also received a \$16,000 bill from the assistant surgeon. In another complaint, a neurosurgeon charged \$159,000 for an emergency procedure for which Medicare would have paid only \$8,493.

The Department's investigation of unexpected bills to consumers by out-of-network providers revealed unacceptable opaqueness in the health insurance market:

- **Comparison Shopping Difficult.** When consumers are shopping for coverage, many are not able to effectively compare out-of-network benefits that competing policies provide because insurers use multiple benchmarks to determine coverage. For example, consumers may not understand that insurance coverage at 80% of the Usual, Customary and Reasonable ("UCR") rate is more than 140% of the Medicare rate. The inability of

consumers to know which benchmark is used and therefore to effectively comparison shop undermines the efficiency of the health insurance market.

- **Lack of Disclosure for Non-Emergency Care.** For scheduled, non-emergency medical services, consumers typically do not know many of the specialists who are reasonably anticipated to provide treatment, whether those specialists are out-of-network, how much those out-of-network specialists reasonably expect to charge, and how much the insurer reasonably expects to cover. Consumers are also given provider directories that are not up to date, thus compounding the problem for consumers who want to stay in-network. This lack of disclosure is a cause of consumer complaints. Moreover, this lack of disclosure further undermines the efficiency of the health insurance market, as consumers cannot effectively comparison shop for providers.
- **Excessive Bills for Emergency Care.** In emergency situations, consumers typically do not demand or even expect advance disclosure by out-of-network providers. A relatively small but significant number of out-of-network specialists, however, appear to take advantage of the fact that emergency care must be delivered. These providers charge excessive fees, some that are many times larger than what private or public payors typically allow.
- **Missing Protections for Inadequate Networks.** Consumers receive surprise out-of-network bills in part because an in-network provider is not reasonably available and the consumer is not permitted to go out-of-network at no additional cost. Moreover, consumers with insurance coverage that is very similar to HMO coverage are not accorded the protections applicable to HMO coverage with respect to network adequacy and access to out-of-network services.

- **Reduced Insurance Coverage.** Some insurers have significantly reduced the level of out-of-network coverage. Employers, unable to keep up with spiraling premiums, have increasingly chosen these reduced benefits, contributing to consumer debt from surprise bills. Consumers are often not aware that their policies offer less generous out-of-network coverage.
- **Difficulty in Submitting Claims.** Consumers face confusion and speed bumps in submitting out-of-network claims. Not all insurers allow consumers to submit claims electronically. And not all out-of-network providers include a claim form with their bill to the consumer.

The Department recognizes that there are competing interests in crafting solutions to these problems. New rules aimed at addressing these issues should recognize the right of providers to remain out-of-network, and should avoid placing undue burdens that could interfere with patient care or deter specialists from providing emergency care or other needed services.

Nonetheless, there is room for improvement. Reforms will require health plans and health care providers to make changes in current policies and practices. Some of those improvements may include enhanced disclosure, network adequacy requirements, standards for coverage of out-of-network health care services, prohibitions on excessive charges for emergency health care services, and a simplified claim submission process. To solve the problem of surprise medical bills, New York needs a multifaceted approach, with cooperation from stakeholders: health plans, physicians, hospitals, businesses, and consumers alike.

INTRODUCTION AND OVERVIEW

The Basics of Health Insurance Plans

The Department of Financial Services regulates insurers and, in conjunction with the New York State Department of Health, health maintenance organizations (“HMOs”). HMOs provide health care services through a network of participating providers, and the health care services are typically coordinated by an enrollee’s primary care physician. Insurers have moved toward using provider networks as well, and typically offer exclusive provider organization (“EPO”) coverage and preferred provider organization (“PPO”) coverage. EPO coverage requires all health care services, other than emergency services, to be obtained through a network of participating providers. Like an HMO, if the consumer goes out-of-network without the insurer’s permission, the consumer is not covered. PPO coverage permits consumers to obtain the services of out-of-network providers without a referral, but at a higher cost-sharing than in-network services. Consumers with PPO coverage are required to pay the difference between what the provider charges and what their insurer reimburses, in addition to any deductible, co-payment or co-insurance

Even though EPO and HMO coverage look very much alike, only consumers in HMOs have legal protections ensuring adequate networks of providers for the services promised. Likewise, only consumers in HMOs are protected from out-of-network provider bills when they follow all the rules of their health plan. Consumers in EPOs do not enjoy the same protections.

How Surprise Medical Bills Come About

Surprise medical bills occur when a consumer does everything possible to use in-network hospitals and doctors, but nonetheless receives a bill from a specialist or other provider who the consumer did not know was out-of-network. Surprise bills are not limited to situations in which a consumer needs emergency health care services. In fact, surprise bills often occur when a consumer schedules health care services in advance. Consumers with health insurance coverage for out-of-network services are not immune from this problem.

When consumers are shopping for coverage, many are not able to effectively compare out-of-network benefits that competing policies provide. Consumers with policies that provide coverage for out-of-network services have been surprised by the limited amount of coverage once they see the difference between what their HMO or insurer pays for the out-of-network health care service and what the usual, customary and reasonable (“UCR”) reimbursement is for the service.

Contributing to the problem of surprise medical bills is a lack of disclosure. For scheduled, non-emergency medical services, consumers typically do not know: (1) many of the specialists who are reasonably anticipated to provide treatment; (2) whether those specialists are out-of-network; (3) how much those out-of-network specialists reasonably expect to charge; or (4) how much the insurer reasonably expects to cover. Consumers are also given provider directories, but they often are outdated, which compounds the problem for consumers who want to stay in-network.

Surprise medical bills are particularly problematic in cases involving emergency services, when a consumer may not have a choice of health care provider. The problem is exacerbated by the fact that many consumers are unaware that, depending on the type of health insurance

coverage, if the provider does not participate with the consumer's insurer, the services could be covered as out-of-network. In such cases, the reimbursement will be reduced. Moreover, some out-of-network health care providers charge excessive amounts for providing emergency services and the consumer could be responsible for a significant portion of the provider's bill.

Also contributing to the problem of surprise bills is a loophole in the law whereby consumers with HMO coverage are accorded certain protections that are not provided to consumers with insurance coverage that looks just like HMO coverage. Insurance coverage such as EPO coverage and PPO coverage is similar to HMO coverage, except they do not include important HMO protections, such as the right to go out-of-network at no additional cost if there is not an in-network provider who can treat the consumer.

Many insurers also are moving away from reimbursing out-of-network services based on the UCR cost of the services, and instead are using the Medicare fee schedule, which typically provides a lower reimbursement. Consumers are not aware of how this shift affects the insurer's reimbursement of out-of-network services.

Consumers face confusion and speed bumps in submitting out-of-network claims. Not all insurers allow consumers to submit claims electronically. And not all out-of-network providers provide a claim form with their bill to the consumer.

The Department investigated the problem of surprise billing in depth, asking eleven insurers and HMOs extensively about their policies and procedures for surprise medical bills, coverage of out-of-network services, and excessive charges for emergency services.¹ This report

¹ The insurers and HMOs surveyed include: Aetna Health, Inc., Aetna Health Insurance of New York, Aetna Life Insurance Company (collectively "Aetna"); Capital District Physicians Health Plan, CDPHP Universal Benefits, Inc. (collectively "CDPHP"); Empire HealthChoice HMO, Empire HealthChoice Assurance, Inc., Inc. (collectively "Empire"); Excellus Health Plan, Excellus Health Plan, Inc. (collectively "Excellus"); GHI HMO Select, Inc., Group Health Incorporated (Collectively "GHI"); Health Insurance Plan of Greater New York, HIP Insurance Company of New York, (Collectively "HIP"); Healthnow New York, Inc; Independent Health Association, Inc., Independent Health Benefits Corporation (collectively "Independent Health"); MVP Health Plan, Inc., MVP Health

describes the Department’s preliminary findings in relation to the issues involving surprise medical bills, coverage of out-of-network services and excessive charges for emergency services.

Insurance Company, MVP Health Services Corp., Preferred Assurance Company, Inc. (collectively “MVP”); Oxford Health Plans (NY), Inc., Oxford Health Insurance, Inc. (collectively “Oxford”); and UnitedHealthcare Insurance Company of New York. Affiliated HMOs and insurers are counted once. However, for purposes of this report, GHI and HIP are counted separately, and Oxford and UnitedHealthcare are counted separately because their data was reported separately.

FINDINGS

The Department's findings center around six major subjects: (1) the difficulty of consumers to comparison shop for health insurance products; (2) lack of disclosure with regard to out-of-network fees for non-emergency services; (3) surprisingly high and unexpected fees with regard to emergency care; (4) lack of network adequacy for consumers in plans structured like, but legally distinct, from HMOs; (5) reduced insurance coverage as insurers move away from UCR reimbursement and towards a Medicare fee schedule; and (6) consumer difficulty in submitting claims for reimbursement in connection with out-of-network services. Each of these points is discussed below.

I. COMPARISON SHOPPING IS DIFFICULT

A major difference between health insurance policies is the type of coverage provided when a consumer goes out-of-network to seek services, but it is difficult, if not impossible, for consumers shopping for insurance coverage to compare the level of out-of-network benefits offered by various health insurance plans. For example, most New Yorkers do not understand that an out-of-network benefit set at 140% of Medicare is actually significantly less than one set at 80% of UCR. This lack of transparency contributes to consumer confusion and frustration. Moreover, the inability of consumers to compare apples to apples in out-of-network benefits undermines the efficiency of the market. If consumers cannot understand what they are buying, competition cannot effectively compel health plans to set accurate prices.

Insurers offer PPO products typically at an additional premium which, as noted, allow enrollees to obtain health care services from out-of-network providers. Insurers calculate reimbursement for out-of-network services based either on the UCR costs for health care

services or on a fee schedule, such as Medicare. Consumers with out-of-network coverage are required to pay the difference between what the provider charges and what their insurer reimburses, in addition to any deductible, co-payment or co-insurance.

The Department asked insurers to describe how they enable consumers to compare a set fee schedule reimbursement, such as Medicare to UCR, so consumers will understand the difference between what the insurer reimburses and what the out-of-network provider will likely charge.

The best way to allow consumers to compare policies with different reimbursement methods would be to allow consumers to see the different costs for specific services using each of the different schedules. At a minimum, consumers should be given a list of some frequently used services as examples. It would be preferable if consumers could find differing costs for the specific services they expect to need. None of the insurers reported providing this type of comparison to consumers to help them decide which policy to buy.

Once consumers purchase health insurance coverage, they would benefit from being able to determine how much it will cost to obtain out-of-network services. This will allow consumers to make informed decisions about where to seek care. Providing this information could help reduce costs by showing what expenses will be before consumers make decisions and by encouraging consumers to seek lower cost services. And when consumers do decide to go out-of-network, at least they will not be surprised by the cost.

Under current law, insurers and HMOs are required to provide an annual description of the types of methodologies they use to reimburse providers, specifying the type of methodology that is used to reimburse particular types of providers or reimburse particular types of services.²

² See N.Y. Ins. Law §§ 3217-a(a)(4) and 4324(a)(4) and N.Y. Pub. Health Law § 4408(1)(d).

Insurer compliance with this law still does not allow consumers to understand the effect on specific services.

All insurers stated that they inform enrollees of the out-of-network reimbursement methodology through plan disclosure documents that are sent to enrollees. However, these documents do not enable enrollees to estimate the amount their insurer will reimburse for a specific out-of-network service, or the amount that the enrollee in turn will be responsible for paying.

One insurer asserted that it complies with this disclosure requirement by stating “reimbursement is based on a percentile of national prevailing charge data compiled for a specific procedure and adjusted for geographic differences.” Unfortunately, language such as this does not provide consumers with meaningful information about the reimbursement for out-of-network services.

The good news is that it is possible to provide this information in an easily accessible way. Two insurers reported that they provide a “member payment estimator” on their websites so enrollees can look-up their potential out-of-pocket costs when using an out-of-network provider. Another insurer stated that it has a “member payment estimator” but does not make it available on its website. Instead, the insurer will provide the information to enrollees who contact the insurer’s Customer Service Department.

The Department of Financial Services has heard from many consumers who mistakenly believe that reimbursement for out-of-network services will be better if their insurer switches from 80% of UCR to 140% of the Medicare fee schedule. This misunderstanding makes sense: to a consumer who does not have access to the necessary information, 140% is higher than 80%.

As noted, most insurers do not provide benchmark data to allow consumers to compare out-of-network benefits.

The failure of insurers to provide benchmark data to allow consumers to compare out-of-network benefits has at least two detrimental consequences. First, it leads to surprise and anger for consumers who suddenly realize how little their insurance pays for out-of-network provider bills. Second, it contributes to inefficiency in the health insurance market. If consumers are unable to accurately compare apples to apples for out-of-network benefits, they may well, for instance, purchase coverage on the mistaken belief that 140% of Medicare is better coverage than 80% of UCR.

II. LACK OF DISCLOSURE FOR NON-EMERGENCY CARE

Once consumers have enrolled in coverage and use their benefits, another set of problems becomes apparent. For scheduled, non-emergency medical services, consumers are often not made aware of all the specialists who are reasonably anticipated to provide treatment. Nor do consumers know whether those specialists are out-of-network, how much those out-of-network specialists reasonably expect to charge, or how much the insurer reasonably expects to cover. Insurers are not required to update provider directories during the course of a year, thus compounding the problem for consumers who want to stay in-network. This lack of disclosure is a significant consumer complaint. Moreover, this lack of disclosure inhibits the ability of consumers to effectively comparison shop for providers, further undermining the efficiency of the health insurance market.

The Department asked insurers and HMOs to identify the number of complaints that they received in 2010 regarding surprise medical bills. The Department asked insurers and HMOs to classify whether the bills were for emergency or non-emergency services and to identify the specialty of the treating provider. Insurers and HMOs reported that they received 1,401 in 2010 related to a surprise medical bill.³ The majority of those bills, over 90%, were for non-emergency services, and the specialty areas of the treating providers were predominately anesthesiology, lab services, surgery and radiology.

The Department asked insurers and HMOs to explain how consumers know which providers are in-network and which are out-of-network when non-emergency health care services are rendered. The most common response was that it is the responsibility of the

³ GHI reported a total of 15,526 inquiries regarding out-of-network claims in 2010, but was unable to distinguish between general questions and complaints. In addition, GHI was unable to distinguish between surprise bills for emergency and non-emergency services.

consumer to determine whether an out-of-network provider will be used. All insurers and HMOs claimed that consumers are informed of the names of in-network health care providers through a provider directory.

Insurers and HMOs are currently required to give consumers a provider directory that is updated annually and includes the name, address, telephone number and specialty of all participating providers, facilities, and, in the case of physicians, board certification.⁴ However, New York law does not require insurers and HMOs to make the provider directory available electronically. Nor does it require insurers to update their provider directories when a provider leaves the network.⁵

The Department also asked insurers and HMOs to describe how consumers are informed when a non-participating provider will be used during a medical procedure and whether consumers are told how much the non-participating provider will charge. The majority of insurers and HMOs responded that since most health care services do not require pre-authorization, they will not be aware when a non-participating provider is used. One insurer responded, “Identifying when an out-of-network provider will be involved in a procedure is a challenge for both us and our members — we usually do not know that these providers are involved until we receive a bill.” Another insurer responded, “First and foremost they (members) should work with their personal physician to coordinate care with other participating physicians.”

Unfortunately, the use of a non-participating provider can have a significant and detrimental impact on a consumer with EPO or PPO coverage, notwithstanding the higher

⁴ See N.Y. Ins. Law §§ 3217-a(a)(17) and 4324(a)(17) and N.Y. Pub. Health Law § 4408(1)(r).

⁵ In December 2010 and January 2012 the New York State Office of the Attorney General entered into settlement agreements with seven insurers surveyed for this report regarding participating provider directories. Insurers agreed to update participating provider directories within 30 days of receiving verified provider information. A description of the settlement agreements can be found at http://www.ag.ny.gov/media_center/2012/jan/jan19a_12.html.

premium paid for PPO coverage. HMOs are required to hold enrollees harmless when enrollees obtain services from a participating provider.⁶ (“Hold harmless” means that HMOs must ensure that enrollees are responsible only for paying any applicable co-payment, and no other additional charges.) The hold harmless protections extend to *all* services coordinated by that participating provider. As a result, if an enrollee goes to a participating hospital and receives services from an out-of-network radiologist, the radiology services will still be covered. These hold harmless protections are not applicable to EPO and PPO coverage — again, notwithstanding the higher premiums consumers pay for PPO plans in comparison to HMOs. An EPO could deny the radiology services and a PPO could treat the radiology services as out-of-network.

Example:

The Department of Financial Services received a complaint from a consumer with PPO coverage who went to a participating radiology facility for her annual mammogram. The consumer verified ahead of time that the facility participated with her insurer. However, the consumer received a bill for \$110 from a radiologist who read her mammogram. Even though the facility participated with her insurer, the radiologist did not. The insurer allowed \$58.64 (based on 150% of the Medicare fee schedule) for the radiologist, which was applied towards the consumer’s \$500 deductible for out-of-network services. The consumer was responsible for paying the radiologist’s bill in full.

The Department asked insurers and HMOs to describe the protections they have in place to protect enrollees from surprise medical bills. All the insurers and HMOs surveyed for this report stated that they include language in their provider contracts that require participating providers to refer enrollees to other participating providers, to the extent possible. One insurer also reported that it requires participating providers to obtain advance patient notice and consent for the use of a non-participating provider through an “Advance Patient Notice for Use of a Non-Participating Physician, Provider or Facility” form. Two other insurers reported that they are considering use of such a form. In addition, seven of the eleven insurers and HMOs reported

⁶ See 10 N.Y.C.R.R. 98-1.13(i).

that they include language in hospital contracts requiring hospitals that participate with the insurer or HMO to use their best efforts to ensure hospital-based physicians (e.g., radiologists, anesthesiologists and emergency room physicians) who have privileges at the hospital but are not employed by the hospital apply for participation agreements with the insurer or HMO.⁷ One insurer responded that it is attempting to include such language in its contracts going forward.

Along with looking at what disclosure or other measures insurers and HMOs currently undertake to prevent surprise medical bills, the Department also reviewed disclosure requirements for hospitals and physicians. Currently there are no requirements under the law for physicians or hospitals to disclose to patients whether they participate with the patient's health plan. Likewise, there are no requirements for physicians or hospitals to disclose whether services coordinated by the treating physician or provided when the patient is in the hospital will be rendered by participating providers. In addition, there are no requirements for physicians to disclose what they charge for health care services. Only recently, in accordance with the federal Affordable Care Act, will hospitals be required to make public a list of the hospital's standard charges for health care services.⁸

Example:

The Department of Financial Services received a complaint from a consumer whose child had open heart surgery at a participating hospital. The consumer was not told that a non-participating assistant surgeon would be used. The non-participating assistant surgeon's bill was \$6,400. The insurer paid \$1,400 and the consumer was responsible for \$5,000.

Accordingly, lack of disclosure contributes significantly to the problem of surprise medical bills for scheduled, non-emergency medical services. Consumers typically do not know at least some specialists who are reasonably anticipated to provide treatment. Consumers do not

⁷ One insurer specifically reported that it requires hospitals to insert language in their contracts with hospital-based physicians to apply for participation with the insurer.

⁸ See 42 U.S.C. 300gg-18(e).

know whether those specialists are out-of-network. And consumers are not informed how much those out-of-network specialists reasonably expect to charge, or how much their insurer reasonably expects to cover.

III. EXCESSIVE BILLS FOR EMERGENCY CARE

Treatment, not disclosure, is the paramount concern for a consumer in need of emergency care. A relatively small but significant number of out-of-network specialists appear to take advantage of the fact that emergency care must be delivered, and advance disclosure is not typically demanded or even expected by consumers. The fees charged by these providers can, in some instances, be many times larger than what private or public payors typically allow, and are another source of consumer complaints.

Health insurance policies issued in New York are required to provide coverage for emergency services.⁹ Coverage of emergency services includes services to treat an emergency condition provided in hospital facilities without the need for prior authorization, and regardless of whether the provider furnishing such services is a participating provider. In addition, HMOs are required to hold enrollees harmless for emergency care.¹⁰ (“Hold-harmless” means that HMOs must make sure enrollees are only responsible for paying any applicable co-payment for emergency services and no additional charges for the emergency services.) If an out-of-network provider bills a patient for emergency services and the patient has HMO coverage, then the HMO must pay the provider’s bill or otherwise resolve the payment dispute with the provider. The hold harmless protections do not apply to insurance coverage that is similar to HMO coverage, such as EPO coverage or PPO coverage. Consumers covered under an EPO or PPO policy or

⁹ See N.Y. Ins. Law §§ 3216(i)(9), 3221(k)(4), & 4303(a)(2).

¹⁰ See 10 N.Y.C.R.R. 98-1.13(j).

contract can be billed by a provider for any charges for emergency services above the reimbursement amount paid by their EPO or PPO.

The Department of Financial Services has received complaints from consumers regarding coverage for emergency services and excessive charges for emergency services. Consumers in need of emergency care usually do not get to choose their health care provider. Moreover, even when consumers go to an in-network hospital, the emergency services may be provided by a physician who does not participate with their HMO or insurer. In some cases, the charges for the emergency services may be exceptionally high, leaving the consumer with an excessive bill for health care services.

Example:

The Department received a complaint from a consumer who had a brain hemorrhage and was transferred on an emergency basis from one in-network hospital to another in-network hospital that had the capabilities of performing neurosurgery. The neurosurgeon who treated the consumer was out-of-network and charged the consumer \$40,091. The insurer covered the services as out-of-network and paid \$8,386 according to its set fee schedule. The consumer was left with a balance bill of \$31,704.

The Department likewise surveyed insurers and HMOs and asked whether they received bills from non-participating providers that were greater than \$2,500 and over 200% of the Medicare rate for emergency services in 2010. All insurers and HMOs surveyed reported receiving large bills for emergency services. On average, 84% of the bills greater than \$2,500 that insurers and HMOs received from non-participating providers for emergency services were over 200% of the Medicare rate. In fact, four insurers and HMOs reported that 90% — 100% of the bills they received were over 200% of the Medicare rate. Also, the largest bills were reported by insurers and HMOs in downstate New York.

For all the insurers and HMOs, the average out-of-network emergency bill was \$7,006. Insurers and HMOs paid an average of \$3,228, leaving consumers, not covered by an HMO to pay \$3,778 for an emergency in which they had no choice. The average bill was 1,421% or 14 times what Medicare would pay.

The largest gap between what Medicare would pay and what was actually billed was for radiology services. The average bill for radiology services was \$5,406. Insurers and HMOs paid an average of \$2,497, leaving the consumer not covered by an HMO to pay \$2,910. The average bill was 3,372% or more than 33 times what Medicare would pay.

Many complaints relate to assistant surgeons, who are often brought into surgery without a discussion with the consumer and who are often out of network. The average bill was for \$13,914, but insurers paid an average of only \$1,794. That average bill is 21 times what Medicare would pay.

In reviewing the information submitted, the large bills were predominately for orthopedic surgery, plastic surgery and neurosurgery. Insurers and HMOs consistently reported receipt of large bills from these specialties. On average, 50% of the large bills reported by insurers and HMOs were associated with these three physician specialties. One insurer reported that 95% of the large bills it received from non-participating providers for emergency services were for these three physician specialties. The largest dollar gap between how much was billed and how much was paid by the insurer was for neurosurgery, where the average bill was \$22,159 and the average payment was \$8,276, a gap of \$13,883.

In looking at the highest bill in an identified physician specialty received by the eleven insurers and HMOs surveyed, four insurers and HMOs reported it was for orthopedic surgery;

three reported it was for plastic surgery; three reported it was for neurosurgery; and one reported it was for vascular surgery.

Physician Specialty Area for Highest Bill Reported by Insurer in Upstate NY / Western NY	Highest Bill Reported	Percentage of Medicare Billed	The Amount that Would be Paid at 200% of Medicare
Orthopedic Surgery	\$78,750	5,626%	\$2,800
Neurosurgery	\$89,216	2,599%	\$6,866
Plastic Surgery	\$52,721	7,222%	\$1,460
Vascular Surgery	\$8,165	2,053%	\$3,266

Physician Specialty Area for Highest Bill Reported by Insurer in Downstate NY	Highest Bill Reported	Percentage of Medicare	The Amount that Would be Paid at 200% of Medicare
Orthopedic Surgery	\$233,188	5,721%	\$7,802
Neurosurgery	\$282,500	5,149%	\$10,972
Plastic Surgery	\$200,000	13,513%	\$2,960

The Department also analyzed data submitted by insurers and HMOs to determine the average percent of Medicare billed for emergency services, across all insurers and HMOs, according to provider specialty.

Radiology services reflected consistent billing at the highest percent of Medicare, 3,372%, closely followed by otolaryngology, 3,365%, and neurosurgery, 2,297%.

Specialty Area for Highest Medicare Percentage Reported Across all Insurers and HMOs	Average Billed Amount	Average Percentage of Medicare Across all Insurers and HMOs	The Amount that Would be Paid at 200% of Medicare
Radiology	\$6,388	3,372%	\$978
Otolaryngology	\$7,839	3,365%	\$735
Neurosurgery	\$20,672	2,297%	\$2,118
Physician's Assistant	\$23,163	2,134%	\$922
Lab Services	\$1,981	2,105%	\$827

In sum, the Department's review shows that all insurers and HMOs receive large bills for emergency services from out-of-network providers. Some out-of-network emergency services providers charge amounts that are not just large, but many times what private or public payors allow. These excessive charges contribute to the complaints consumers lodge regarding surprise out-of-network medical bills. The complaints are particularly pointed when consumers are in need of emergency care and do not have the ability to choose another provider that charges more reasonable fees.

IV. MISSING PROTECTIONS FOR INADEQUATE NETWORKS

While the Department's investigation shows a significant overlap in the networks for HMO, EPO and PPO coverage, the rules for network adequacy differ. All insurers and HMOs promise similar in-network coverage in their health plan contracts. However, there are at least three legal protections for HMO enrollees that EPO and PPO enrollees do not possess. First, HMO enrollees are entitled to obtain services from an out-of-network provider at the in-network cost sharing (co-payment) if there is not an in-network provider with the appropriate training and experience to meet the health care needs of an enrollee.¹¹ Second, only consumers in HMOs have legal protections ensuring that State regulators review the health plan network to ensure an adequate number of providers for the services promised.¹² Third, only consumers in HMOs have formal protection from in-network provider bills when they follow all the rules of their health plan. These "hold harmless" protections do not apply to EPO and PPO plan enrollees.

In the first area of inquiry, the Department asked insurers about how they handle situations where an enrollee or provider asserts that an appropriate in-network provider is not reasonably available. For enrollees with EPO coverage, all of the insurers stated that if there is not an in-network provider they will, at their discretion, permit an enrollee to obtain the services of an out-of-network provider at no additional cost beyond that which the enrollee would have paid if the enrollee received in-network care. However, one insurer noted that it would look to whether there are participating providers in other service areas or other states that the enrollee could use before granting an exception for a local provider.

¹¹ N.Y. Pub. Health Law § 4403(6)(a) permits enrollees to go out-of-network at no additional cost if there is not an in-network provider. Ins. Law § 4804(a) provides the same right to insureds covered under a "managed care health insurance contract". However, a "managed care insurance contract" is defined so narrowly that insurers do not have EPO or PPO products that fall under the definition. *See also* 10 N.Y.C.R.R. § 98-1.13(a), (h) & (i) for additional HMO protections.

¹² N.Y. Pub. Health Law § 4403(5) establishes network adequacy requirements for HMOs. The New York Insurance Law does not include the same network adequacy requirements for other insurers.

Coverage of out-of-network services at the insurer's discretion also means that protections will vary depending on which insurer offers the EPO coverage. Since these protections are voluntary, there is no guarantee the protections will be applied fairly or consistently by a given insurer. Moreover, consumers may mistakenly believe that the same protections will apply if they change insurance coverage to another EPO, which is not the case. Such variability among EPO coverage and between EPO and HMO coverage is not disclosed to consumers. This contributes to market inefficiency, as consumers cannot account for this benefit variability in shopping for coverage.

Example:

The Department of Financial Services received a complaint from a consumer who needed a specialized surgery due to constant hip pain. The consumer had coverage through an EPO that voluntarily permits enrollees to go out-of-network if there is not an in network provider who can treat the enrollee. The consumer asked to see an out-of-network provider located in New York City (the consumer lives in the Hudson Valley). The insurer denied the out-of-network exception and then suggested in-network providers located 200 miles and almost 600 miles away from the consumer.

For enrollees with PPO coverage, ten of the eleven insurers surveyed responded that at their discretion, they permit enrollees to obtain the services of out-of-network providers at no additional charge when in-network providers are unavailable. However, inasmuch as this determination is completely at the insurer's discretion, there is no guarantee that the services will be covered as in-network. One insurer responded that it does not grant exceptions for enrollees with PPO coverage. When there is no in-network provider, that insurer treats coverage for those services as out-of-network.

Example:

The Department of Financial Services received a complaint from an Albany consumer who had PPO coverage and needed oral surgery. The consumer contacted her insurer and was informed that the closest in-network provider was in Buffalo. The consumer decided to see a local out-of-network surgeon. The consumer paid \$1,143 up front for the surgery. The insurer determined the allowed amount was \$881. After factoring in the deductible and coinsurance, the insurer reimbursed the consumer \$394 for the surgery.

Second, the Department requested information from insurers and HMOs regarding the overall adequacy of their provider networks. Insurers and HMOs reported greater difficulty in attracting participating providers downstate than upstate. With respect to composition of their networks, the majority of insurers and HMOs reported that their HMO, EPO and PPO networks overlap. Of the insurers and HMOs that responded, two stated that their HMO, EPO and PPO networks are exactly the same. The remainder reported close to 100% overlap. For example, one insurer reported that out of 6,000 participating specialists, only 84 specialists participated in the HMO network and not the EPO or PPO networks. Another insurer reported only a difference of 20 providers between the HMO and non-HMO networks. However, some HMOs and insurers reported that they also offer employer groups the option of purchasing HMO, EPO and PPO products with more limited networks at a reduced premium rate.

While the Department's investigation shows a significant overlap in the networks for HMO, EPO and PPO coverage, the rules for network adequacy differ. The Public Health Law establishes network adequacy requirements for HMOs (Public Health Law § 4403[5]). The Insurance Law, although similar to the Public Health Law in some respects, does not include the same network adequacy requirements for other insurers. Thus, only consumers in HMOs have

legal protections ensuring that State regulators review the health plan network to ensure an adequate number of providers for the services promised.

Third, as noted above, HMOs are required to hold enrollees harmless when enrollees obtain services from a participating provider. All the insurers and HMOs surveyed stated that they include language in their provider contracts that requires a participating provider to hold an enrollee harmless for services rendered by that participating provider, notwithstanding that only HMOs are required include such language in their provider contracts. Insurers and HMOs report that, in virtually every instance, they only have one contract with each participating provider. As a result, the hold harmless requirements for HMOs apply to the non-HMOs through the provider contract. However, there is no formal legal requirement that guarantees this important consumer protection.

In sum, New York law affords consumers with HMO coverage certain protections that are not provided to consumers with non-HMO coverage. Non-HMOs do not have a regulatory network adequacy review, nor are they required to afford consumers the right to go out-of-network if there is not an in-network provider who can treat them. In addition, non-HMOs are not legally required to include a hold harmless provision in provider contracts, protecting consumers from being billed for uncovered balances by in-network providers.

V. REDUCED INSURANCE COVERAGE

In recent years, some insurers have significantly reduced the level of out-of-network coverage that they offer to enrollees. Employers that are unable to keep up with spiraling health care premiums have increasingly opted for these reduced benefits. Employers and consumers often are unaware that their policies offer less generous out-of-network coverage. This reduced level of coverage is one source of consumer complaints, and it contributes to consumer debt from surprise bills.

Before 2009, insurers typically used a database supplied by Ingenix, a subsidiary of United Health Group, to determine reimbursement rates for out-of-network care based on UCR. On January 13, 2009, the New York State Office of the Attorney General released a report entitled, “Health Care Report: The Consumer Reimbursement System is Code Blue,” which detailed the flaws in the Ingenix database.¹³ The report found that the Ingenix database systematically understated the market rates for health care services. The report further found that the Ingenix database was tainted by a conflict of interest, since it was compiled by an insurer. The Attorney General entered into settlement agreements with insurers and established a not-for-profit company to create a UCR database. The not-for-profit company, FAIR Health, Inc., was established in October 2009 to provide transparency and an independent source of data for out-of-network reimbursements.

In the current investigation, the Department of Financial Services requested that insurers provide information about their current means for determining the amount of reimbursement for out-of-network services. In reviewing the responses, the Department found that insurers

¹³ “The report is available at http://www.ag.ny.gov/bureaus/health_care/pdfs/FINALHITIngenixReportJan.13,%202009.pdf.

typically base out-of-network reimbursement on one of three sources: the FAIR Health database; the Medicare fee schedule; or a set fee schedule established by the insurer and agreed to by an employer group.

Of the insurers surveyed: two responded that they use only the Medicare fee schedule to calculate their out-of-network reimbursements; three responded that they use only FAIR Health; four responded that they use either FAIR Health or the Medicare fee schedule, depending on the selection of the group policyholder; one responded that it uses either FAIR Health, the Medicare fee schedule, or a fee schedule other than Medicare, depending on the selection of the group policyholder; and one responded that it uses either FAIR Health or a fee schedule other than Medicare, depending on the selection of the group policyholder.

Insurers also differ with regard to the percentages of the Medicare fee schedule or UCR that they use to reimburse for out-of-network services. Insurers responded that they offer options of out-of-network reimbursement under the Medicare fee schedule that range from 80% – 400%, with most options falling in the 110% – 150% range. The percentage of reimbursement under UCR also varies, with a range of 50% – 90%, with most options falling in the range of 80% – 90%. The most variability is seen in the large group market (i.e., groups with more than fifty members), where insurers generally offer either reimbursement based on UCR or the Medicare fee schedule and at varying percentages. Large employers that wish to have a higher percentage of reimbursement pay higher premiums.

While half of the insurers surveyed offer more than one reimbursement methodology for out-of-network services, the data collected by the Department suggests that insurers are moving towards set fee schedules, such as Medicare, for reimbursement of out-of-network services. One insurer stated that in 2008 the majority of groups had contracts in which out-of-network

reimbursement was based on UCR, and by 2011 the majority of groups had shifted to contracts in which reimbursement is based on a set fee schedule. Another insurer stated that it decided to offer the option of the Medicare fee schedule to calculate out-of-network reimbursement because the Medicare fee schedule is set by an independent source that is publicly available, allowing for more transparency with calculating all out-of-pocket costs.

The following chart details the shift in out-of-network reimbursement from UCR to set fee schedules from calendar years 2008 through 2011:

	2008	%	2011	%
Enrollees with UCR	5,824,404	80%	3,693,239	59%
Enrollees with Fee Schedule	1,394,618	19%	2,485,970	40%
Enrollees with Mixed UCR and Fee Schedule	51,531	1%	71,337	1%
Total Enrollees	7,270,553		6,250,546	

By 2012, the ratio between UCR and a set fee schedule, such as Medicare, will have completely switched from UCR dominating to a set fee schedule dominating. In 2008, as noted in the table above, 80% of enrollees were covered by a policy with UCR and only 20% by a policy with a fee schedule, mostly Medicare. After Empire completes the shift in its reimbursement methodology from UCR to the Medicare fee schedule in 2012, the percentage of enrollees with set fee schedules as their reimbursement methodology will be 76%, while the percentage of enrollees with UCR will be 23%, based on 2011 enrollment data.

A summary of the current offerings for out-of-network coverage as reported to the Department is listed below.

Insurer	Current Out-of-Network Reimbursement	Comments
Aetna	Both FAIR Health and Medicare Fee Schedule.	Medicare Fee Schedule used for small group coverage. Large groups have choice of Medicare Fee Schedule or FAIR Health.
CDPHP	FAIR Health.	
Empire	Medicare Fee Schedule.	Moving to Medicare Fee Schedule as small groups renew on and after 1/1/12 and as large groups renew on and after 4/1/12.
Excellus	Both FAIR Health and Medicare Fee Schedule.	
GHI	FAIR Health, Medicare Fee Schedule, and proprietary fee schedule set by GHI.	Medicare Fee Schedule used for small group coverage. Large groups have choice of Medicare Fee Schedule, FAIR Health, or in certain cases a proprietary fee schedule set by GHI.
Healthnow	FAIR Health and proprietary fee schedule set by Healthnow.	
HIP	FAIR Health.	
Independent Health	FAIR Health.	
MVP	Medicare Fee Schedule.	
Oxford	Both FAIR Health and Medicare Fee Schedule.	
UnitedHealthcare	Both FAIR Health and Medicare Fee Schedule.	

The use of the Medicare fee schedule instead of the FAIR Health database lowers the overall out-of-network reimbursement to consumers. Indeed, all insurers that use the Medicare fee schedule reported that the Medicare fee schedule resulted in lower reimbursements as compared to UCR based on the FAIR Health database. One insurer stated that the reimbursement could be as much as 25% lower under the Medicare fee schedule. Examples of reimbursement amounts for three Current Procedural Terminology (“CPT”) codes under each methodology in downstate New York are illustrative; in those cases, reimbursement under the Medicare fee schedule is half or much less of the reimbursement based on the FAIR Health database:

Procedure Code	Description	FAIR Health Database 80th Percentile	110% Medicare
99213	Established Patient Office Visit Level 1	\$160	\$86
19303	Mastectomy, simple complete	\$5,600	\$1,222
97110	Physical Therapy	\$76	\$38

As these examples show, the Medicare fee schedule pays significantly less than UCR. Thus, consumers with Medicare fee schedule based coverage for out-of-network services typically have less generous benefits than those with UCR based coverage. Consumers are responsible to pay the entire out-of-network provider bill. When the insurance coverage amount decreases, the consumer is left paying a greater balance of that same provider bill. Accordingly, consumers with Medicare fee schedule based coverage typically face higher out-of-pocket costs.

Example:

The Department of Financial Services received a complaint from a consumer who needed jaw surgery to treat a malformation of the lower jaw. The consumer’s insurer informed the consumer that it would reimburse \$31,978 of the \$47,685 that the provider would charge, based on the 80th percentile of UCR. Before the surgery could be done, the consumer’s contract was changed. Under the new contract,

reimbursement was based on 110% of the Medicare Fee Schedule. The allowed amount was therefore lowered to \$4,864.62, which is a difference of \$27,113.38.

Indeed, this reduction in benefits from the move to reimbursement rates based on Medicare is borne out in consumer complaints. Not only has the Department received numerous complaints from consumers regarding amounts reimbursed for health care services, but the Department also asked insurers to identify the number of complaints they themselves received between calendar years 2008 – 2011 regarding inadequate reimbursement or confusion in reimbursement for out-of-network services. The chart below summarizes the number of complaints made to insurers and the number of complaints received by the Department regarding reimbursement for health care services:¹⁴

Calendar Year	Number of Reimbursement Complaints Reported by Insurers¹⁵	Number of Reimbursement Complaints Received by the Department of Financial Services
2008	1,600	1,526
2009	1,329	2,698
2010	1,381	2,010
2011	1,310	2,105
Total	5,620	8,339

In many complaints, there is a significant difference between the amount reimbursed by the consumer's insurer and the amount charged by the provider.

Example:

The Department of Financial Services received a complaint from a consumer who had PPO coverage. The consumer's daughter was admitted to a hospital for

¹⁴ The Department's complaint data reflects the number of reimbursement complaints in general.

¹⁵ GHI reported a total of 50,212 complaints specifically related to a non-participating provider allowance but was unable to distinguish by reason. Therefore, GHI's data was not included in this chart.

diagnosis and treatment of seizure activity. The daughter underwent an electroencephalography (EEG) with video monitoring. The physician who interpreted the results did not participate with the consumer's insurer. The physician billed \$1,200 for his services and the insurer allowed \$114 based on the Medicare fee schedule. After the deductible, the consumer received \$38 for the service from the insurer, leaving the consumer responsible for the remaining \$1,162.

One might expect lower rates of reimbursement to lead to lower premiums for consumers. The Department surveyed the impact on premium rates when insurers switched from calculating reimbursement for out-of-network services based on UCR to the Medicare fee schedule. And in some instances, a reduction in out-of-network benefits has modestly reduced the rate of health insurance premium increases for some health plans.

The premium impact reported by insurers that moved from UCR based on the Ingenix fee schedule to UCR based on FAIR Health or a Medicare fee schedule varied, as some insurers indicated a premium savings while others reported no impact on premiums. Of the two insurers that kept UCR but switched from Ingenix to FAIR Health as the underlying database, the premium impact was reported as “no change” or “no material change.”

Insurers that switched from UCR based on Ingenix to the Medicare fee schedule varied in their report of premium impact. One insurer reported no impact on premiums from moving to the Medicare fee schedule. Another insurer stated that for large groups, switching from UCR based on Ingenix to the Medicare fee schedule resulted in an estimated 4% – 5% premium savings when using 110% of the Medicare fee schedule, with a reduction in savings if the group chose a higher Medicare fee schedule reimbursement percentage. That same insurer also reported that small groups had a premium savings of at least 1% and up to 2.1%. Another insurer indicated that the switch from Ingenix to the Medicare fee schedule had a premium savings of 1.4% to 2.8%. Yet another insurer reported that the switch had a premium savings of

only 0.16%. Lastly, an insurer reported that the premium savings ranged from 1% – 8%, depending on group size, with the larger savings seen by large groups.

The information reported to the Department shows that a choice in the out-of-network reimbursement methodology may impact premium rates. Insurers reported varying amounts of savings for enrollees when the enrollee's out-of-network reimbursement switched from UCR to Medicare. However, given the price sensitivity of certain segments of the health insurance market — for small groups (i.e., those with two to fifty members) in particular — even a modest impact on premiums can be significant.¹⁶

In addition, the problem of a decreasing level of out-of-network coverage may have a regional component. At the time of this report, it appears that a greater share of complaints regarding surprise billing from out-of-network providers occur downstate. This would make sense, as upstate insurers report greater in-network participation by providers than their downstate counterparts.

Thus, as insurers switch from UCR to a set fee schedule for reimbursement of out-of-network services, consumers often experience reductions in the level of coverage. The reduced reimbursement contributes to consumer complaints about surprise medical bills. Consumers often expect that their insurance will cover a greater share of the out-of-network bill than it actually covers. Moreover, no minimum standards exist for coverage of out-of-network services. The reduction in coverage is exacerbated by the lack of disclosure. Consumers are unable to easily determine the amount that will be reimbursed for out-of-network services.

¹⁶ “New York State Mandated Health Insurance Benefits.” Donna Novak, NovaRest Consulting (May 2003). “It’s the Premiums, Stupid: Projections of the Uninsured through 2013.” Todd Glimer and Richard Kronick. *Health Affairs* (April 5, 2005).

VI. DIFFICULTY IN SUBMITTING CLAIMS

Consumers that obtain out-of-network services may also encounter difficulties when submitting a claim to their insurer for reimbursement. Out-of-network providers are not required to submit claim forms on behalf of their patients. Although some providers do submit claim forms, in cases when the provider does not, the consumer will ultimately be responsible for obtaining, completing, and submitting the claim form at a time when the consumer may be recovering from a serious medical condition.

The Department asked insurers and HMOs if they have systems in place to accept claims electronically, either on-line or by facsimile, from consumers. Of the insurers and HMOs surveyed, all but one reported that they do not accept claims submitted by consumers over the internet. With respect to the insurer that does accept such claims from consumers, the insurer responded that the consumer would first need to become an Electronic Data Interchange (“EDI”) trading partner, and conduct testing with the insurer's EDI Team, before submitting electronic claims. With respect to consumer claims submitted by facsimile, three insurers responded that they do not have a process to accept such claims.

The Department also asked insurers and HMOs to explain what they do to assist with submissions of claims by consumers. All of the insurers and HMOs responded that they make efforts to help consumers file claims. All of the insurers and HMOs also stated that they provide information to consumers on how to submit a claim in plan materials or through their websites. They also reported that an enrollee may obtain assistance in filing a claim by contacting their Customer Services Departments.

Although insurers and HMOs reported that they assist consumers in submitting claims, they do not all allow consumers to submit claims electronically. In addition, physicians that bill

consumers for out-of-network services may be in a position to provide information that can assist in the claim submission process for their patients.

VII. NEEDED REFORMS

The Department's investigation reveals numerous concerns surrounding the problem of surprise medical bills. Solving the problem of surprise medical bills requires a multifaceted approach, with cooperation from key stakeholders: consumers (including employers), health plans, physicians, hospitals and other providers. Reforms needed to enhance protections for consumers should include consideration of the following.

1. Improve the Ability of Consumers to Comparison Shop. When consumers are shopping for coverage, insurers should enable consumers to compare apples to apples for out-of-network benefits. Insurers should disclose their reimbursement methodology for out-of-network services and describe how it compares to UCR. Insurers should also inform consumers of the reimbursement for a specific service upon request, and disclose anticipated out-of-pocket costs for particular out-of-network services, comparing the difference between the insurer's method and UCR.

2. Improve Disclosure for Non-Emergency Services. Consumers must be given better information by their HMOs, insurers, doctors, and hospitals so they will know whether a provider participates with their health plan, including providers reasonably anticipated to render services during a hospital stay or doctor visit. Consumers also need to be told the amount providers and hospitals will charge for health care services, along with the amount their insurer or HMO will reimburse for services.

3. Prohibit Excessive Emergency Charges. Consumers must also be protected from excessive emergency charges. Often consumers do not have a choice when it comes to obtaining emergency health care services, and the consumer should not be taken advantage of in such

instances. Reforms should consider prohibiting excessive fees, and establishing an independent review to make the determination whether a fee is indeed excessive.

4. Improve Network Adequacy Protections. Consumers with EPO and PPO coverage that looks just like HMO coverage need to be given the same network adequacy protections provided to consumers with HMO coverage. It is patently unfair that consumers with similar coverage are unable to enjoy the same protections, such as the right to go out-of-network at no additional cost when there is not an in-network provider with the appropriate training and experience to meet the health care needs of the consumer.

5. Consider Minimum Coverage. Consumers face decreasing levels of coverage as insurers offer, and employers purchase, out-of-network coverage based on lower paying set fee schedules such as Medicare. While there should be no requirement that insurers offer, or that employers or other consumers purchase, out-of-network coverage, when out-of-network coverage is offered, certain minimum standards may help ensure that consumers are not unduly surprised at the low level of coverage. Any minimum benefit requirement must consider the impact on premiums that result. In addition, any minimum benefit should seek to avoid unduly discouraging providers from participating in a health plan network, recognizing any regional variation in the number of providers participating in health plan networks.

6. Consumer Claim Submissions. Consumers face some speed bumps in submitting out-of-network claims. Not all insurers allow consumers to submit claims electronically. And not all out-of-network providers provide a claim form with their bill to the consumer. Reforms should make it easier for consumers to submit claims for payment for out-of-network health care services.

The Department of Financial Services recognizes that there are competing considerations in crafting improvements to the problems associated with surprise billing. New rules aimed at addressing these challenges should recognize the right of providers to remain out-of-network, and should avoid placing undue burdens that could interfere with patient care or deter specialists from providing emergency care or other needed services.

Nonetheless, there is room for improvement. Reforms will require health plans and health care providers to make changes in current policies and practices. Some of those improvements may include enhanced disclosure, network adequacy requirements, standards for coverage of out-of-network health care services, and prohibitions on excessive charges for emergency health care services. As New York prepares for federal health care reform under the federal Affordable Care Act, we should take this opportunity to improve on problems of surprise bills from out-of-network providers. Working families, employers, and businesses located throughout the state (insurers and non-insurers alike) deserve no less.

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