American Cancer Society ☙ Children's Defense Fund-New York ☙ Community Service Society of New York
Empire Justice Center ☙ Institute for Puerto Rican and Hispanic Elderly
Make the Road New York ☙ Medicare Rights Center
Metro New York Health Care for All Campaign ☙ New Yorkers for Accessible Health Coverage ☙
New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority

HEALTH CARE FOR ALL NEW YORK
MEMO OF SUPPORT FOR OUT-OF-NETWORK LEGISLATION (TED ARTICLE VII, §U)
JANUARY 2014

HCFANY is a statewide coalition of over 160 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that the concerns of real New Yorkers are heard and reflected. We also provide expert policy analysis, advocacy, and education on important health policy and coverage issues that affect New Yorkers around the state. For more information on HCFANY, visit us on the web at **www.hcfany.org**.

HCFANY strongly supports provisions in Governor Cuomo's proposed 2014-2015 Executive Budget that would offer out-of-network protections, including protection against "surprise" medical bills, and improve overall network adequacy for health care consumers (TED Article VII, p. 126). This legislation would improve coverage for thousands of New Yorkers by:

- **Setting a fair process** for providers and insurers to negotiate over coverage disputes, so consumers aren't left in the middle with a bill;
- **Holding consumers harmless** for surprise bills from emergency room or out-of-network charges that were outside of their control;
- Requiring all products to meet a set of **provider network adequacy standards**, so fewer New Yorkers end up seeing out-of-network providers, whether planned or unplanned;
- **Allowing consumers to go out-of-network** when their plan's provider network doesn't have a specialist who meets their medical needs;
- **Improving transparency**, to prevent surprise bills; and
- **Streamlining out-of-network claims**.

<u>Surprise Bills</u>

HCFANY supports provisions that would protect consumers from surprise bills. Without these critical protections, too many New Yorkers face large medical bills that they had no way to

prevent. Too often, consumers who make every attempt to stay with in-network providers end up receiving out-of-network services. In an emergency situation, a consumer may end up in an out-of-network hospital or treated by an out-of-network provider, with no time to choose otherwise. Another consumer may have a non-emergency, scheduled procedure in an in-network hospital or clinic, only to find that an out-of-network provider, like an anesthesiologist or a radiologist, played some part in their care. These individuals are then faced with surprise bills, many of which are higher than they can afford to pay.

Without the proposed legislation, there is no opportunity for, and the patient has little bargaining power to negotiate these amounts billed. Under the legislation, the insurer and provider, who have the best bargaining positions, would negotiate fee arrangements themselves or through independent arbitration. Additionally, consumers who visit an emergency room and end up being seen by an out-of-network provider – with no choice in the matter – will be held harmless from out-of-network bills.

Network Adequacy

This bill requires all plans to meet the same network adequacy standards. New York State law already requires that all Health Maintenance Organizations (HMOs) offer products that meet a set of network adequacy standards. The New York State of Health Marketplace has instituted similar standards for Qualified Health Plans. The bill will amend insurance law to extend these same protections to New Yorkers with Preferred Provider Organization (PPO) coverage and Exclusive Provider Organization (EPO) coverage. Further, when a plan does not include a provider who is qualified to meet an individual's need for care – for example, someone with a unique cancer – the individual can be authorized to go out-of-network to get this specialty, often life-saving care. These requirements will mean that fewer New Yorkers need to go out-of-network for care and, ultimately, that more New Yorkers get the health care they need.

Transparency and Streamlined Claims

HCFANY also supports provisions in the legislation that would increase transparency and streamline the claims process. Consumers who prudently try to manage their health care expenses face daunting obstacles. The legislation would ease this burden for consumers by requiring insurers to disclose key information about out-of-network coverage, so that consumers can understand: (1) which providers are in-network and which are out-of-network; (2) how much out-of-network providers expect to charge for a variety of services; and (3) how much the insurer expects to reimburse for out-of-network services. Additionally, the legislation would ease the claims process for consumers, by allowing individuals to submit e-claims for out-of-network services.

Below are the stories of seven real New Yorkers. All had good health insurance. But all faced surprise medical bills, one of more than $150,000, due to events entirely beyond their control. Excessive surprise bills are one of the factors in medical debt, which in turn is the leading contributor to personal bankruptcy. The proposed legislation could protect New Yorkers in situations similar to those described below from medically related financial ruin. HCFANY therefore urges the legislature to adopt these provisions of the Executive Budget.

Thank you for your consideration.

Appendix: Real Stories of How Current Law Fails to Protect New York Patients[1]

Story 1 – Jonathon

Jonathon is a Long Island resident insured by an EPO plan. When he complained to his doctor of losing feeling in his hands, his doctor sent him to the emergency room immediately. He went to an in-network hospital and had an MRI, after which the treatment team decided he needed immediate back surgery. They took out three disks and put in a metal plate. An in-network surgeon performed the procedure, but requested assistance from a provider of inter-operative neuro-physiological monitoring, which reduces risk of damage to the nervous system during surgery by providing guidance to the surgeon and anesthesiologist. This provider was out-of-network. Jonathon's EPO does not include out-of-network coverage, so it paid no part of the $8,000 bill. Current law does not protect Jonathon from liability for the $8,000 bill, even though he went to an in-network hospital and an in-network surgeon provided his necessary emergency surgery.

Story 2 – Marcia

Marcia is a 49 year-old cancer survivor with multiple sclerosis. She is insured by the Empire Plan, a PPO which covers most New York State employees and retirees. Marcia was hospitalized at an in-network hospital for a month with a serious C-diff. infection. She was visited on four consecutive days by an internist whom she did not request. In fact, she had specifically requested to be seen by her long-standing neurologist, who also practiced at that hospital. The internist was out-of-network and billed Marcia $12,500 for the four visits. Her PPO plan has out-of-network coverage, but it only reimbursed $1,777. Current law does not protect Marcia from liability for the balance of more than $10,000 owed to the out-of-network internist, even though she specifically requested that a different doctor treat her.

Story 3 – Connor

Connor is a 68-year-old Westchester resident with heart problems, insured in a PPO. He had a stent put in, and when he was experiencing extreme shortness of breath he rushed to his local in-network hospital. The heart problem was too severe to be treated there, so he was transferred to a major academic medical center nearby, also in-network. After observation and testing, his treatment team decided that he needed emergency open heart surgery to implant a special pump. Though he was at an in-network hospital, neither the surgeon nor his assistant was in-network. The surgeon billed $71,000, out of which his insurer's out-of-network benefit paid $29,000. The assistant billed $35,000, out of which his insurer paid $6,737. In total, Connor was left owing more than $70,000 for his surgery, even though he had "good insurance" and went to in-network facilities for his emergency treatment.

Story 4 – Juan

Juan is a corrections officer from Long Island, employed by a county government and insured through a PPO. After his thumb was cut in half in a table-saw accident, he went to an in-

[1] Stories adjusted to protect anonymity of patients.

network emergency room. The on-call plastic surgeon, though, was not in-network. After the surgery Juan's insurance only paid about $7,000 out of the $17,000 bill. Current law does not protect Juan liability for the $10,000 balance on the bill, even though he was insured and sought emergency care at an in-network hospital.

Story 5 – Giuseppe

After Giuseppe fell and injured himself, his wife made sure that the ambulance took him to an in-network hospital near their Westchester County home. Giuseppe had the Empire Plan, a PPO that covers many New York State workers, retirees, and their dependents. He was treated at the hospital for five days, and they thought the insurance would take care of everything. But they were surprised to get a bill for $700 from a plastic surgeon who was called in for a consultation during Giuseppe's stay. Giuseppe does not remember seeing the doctor and certainly had no idea he was being seen by an out-of-network specialists. His PPO has out-of-network coverage, but it only covered $360. Current law does not protect Giuseppe from owing the $340 balance on this bill. Giuseppe's wife wants to make a sign to hang around her husband's neck next time he is in the hospital requesting that he not be seen by out-of-network doctors.

Story 6 – Melissa

Melissa is a 59-year-old breast cancer survivor living on Long Island. She works as a billing assistant in a doctor's office and is covered by an EPO offered at her job. She received a double mastectomy and the first stage of her reconstruction in March of 2011. Her plan's network included only one plastic surgeon within 30 miles of her home, and this doctor was not yet board certified in plastic surgery at the time. New York law did not protect Melissa's right to have access to an out-of-network plastic surgeon to perform the procedure. She went to an out-of-network surgeon and was stuck with a financially-crippling bill far larger than she expected. In January of 2012 Melissa needed a revision to the reconstruction to remove temporary tissue expanders. By this time her insurer's one network plastic surgeon had attained board certification, but Melissa felt more comfortable maintaining continuity with the surgeon who performed the first operation. New York law does not protect Melissa's right to see an out-of-network surgeon, or even to have a neutral medical expert determine the gravity of her continuity of care issue. New York law also did not require Melissa's doctor to discuss his fees with her before providing the surgery.

Story 7 - David

David of Long Island fell from the roof a three-story building and was rushed to the nearest emergency room, which happened to be out-of-network. He was insured through a PPO plan, which provides out-of-network coverage but did not pay his bills in full. The lead surgeon, who performed extensive life-saving procedures, sent David a bill for $169,000, out of which his insurer paid only $15,000. New York law does not protect David from liability for the balance bill of $154,000.