Using Health Insurance Consumer Protections to Increase Reimbursements for Providers and Decrease Out-of-Pocket Costs for Consumers

By Alexandra Berke

A key goal of the Affordable Care Act ("ACA") was the creation of health insurance marketplaces (the "Marketplace") to make insurance available to individuals for direct purchase. As Marketplaces have been implemented, the national rate of uninsured Americans dropped to under 9% for the first time.[1] More health care consumers means more people who need to understand their rights to access care. Understanding consumer health rights can help individuals decrease out-of-pocket costs while increasing reimbursements for their doctors. A few critical statutes, outlined in this article, can help consumers get the care they need, get it paid for by their insurance company, and decrease stress for all parties to keep focus on access to health care instead of dealing with insurance challenges.

It is important to acknowledge that access to health insurance is just the first step in gaining access to health care. To obtain needed medical visits, tests, and treatments, consumers must follow their insurance plan's rules to see in-network providers; get treatments the insurer deems "medically necessary"; and take medications covered by the plan's formulary, or risk loss of benefits. Consumers are often unaware of their insurers' rules, and it can feel like insurers are working to keep it that way.

Too often, consumers first learn they have not been following the rules after treatment, when there is a financial consequence. Not surprisingly, patient advocacy is a growing industry, with individuals and families hiring professional advocates to help manage their medical care, finding the right doctors, working with insurers to cover claims, and contesting medical bills.[2]

The consumer protections outlined in this article can help individuals have care paid for by their insurer, avoiding large unreimbursed provider bills. Demystifying these legal rights can save insureds and their advocates time, money, and frustration, allowing them to focus on their health, instead of the cost of health care.

This article provides a snapshot of New Yorkers' health insurance coverage, and outlines in four parts key consumer protections in New York State law that can be used to help patients, providers, and their advocates navigate the health care system to get the care they need while using their insurance benefits: (1) Part A examines transitional care laws, *i.e.*, maintaining the right to continue seeing a provider even after that provider or individual leaves the insurance network; (2) Part B outlines the right to appeal, who it applies to, and how to prepare a successful appeal; (3) Part C outlines the network adequacy requirements, including what can be done if your insurer is not meeting those requirements, and, finally, (4) Part D provides a brief explanation of the 2015 "Surprise Bill" law.

Snapshot of New Yorkers' Health Insurance Coverage

The Kaiser Family Foundation took a snapshot of where all 19.75 million New Yorkers get their coverage in 2014, the first year New Yorkers could enroll in insurance on the ACA-created Marketplace, known as the "New York State of Health Marketplace."[3] In 2014, 49% of New Yorkers were enrolled in insurance through an employer, 25% were enrolled in Medicaid, 13% in Medicare, and 6% were in non-group plans, including private insurance on the Marketplace.[4] Since the first New York Marketplace open enrollment in 2014, the number of people enrolled in insurance through the Marketplace has increased almost three-fold, from 960,762 to 2.8 million, or 15% of New Yorkers, and the percentage of uninsured New Yorkers has dropped by nearly 850,000 people from ten percent to five percent.[5]

All covered New Yorkers have consumer protection rights linked to the insurance plan the consumer is enrolled with. Each insurance program, including Medicaid, Medicare or employer-based insurance, follows its own, slightly different consumer protection rules, creating numerous potential traps for the unwary consumer.

Consumer Protections Available to the Insureds

(1) Part A: Using Transitional Care Laws to Access Out-of-Network Providers

The cost of seeing an out-of-network provider is borne entirely by the insured if their insurance does not reimburse them for routine out-of-network care, and many do not. Even plans that offer out-of-network reimbursements provide lower amounts than consumers regard as customary. Health insurance enrollment and eligibility is linked to employment, family size and income. When someone changes jobs, gets married or becomes pregnant during the insurance year, they may be enrolled in a different insurance plan. Even if a consumer

does not change the insurance plan they are enrolled in during a coverage year, the insurer may make changes to the network during the plan year or between plan years.[6] The insured may incur costs without realizing a provider is no longer in the network, leaving the provider unpaid and the insured with bills they did not expect and may be unable to pay fully. But, if the insured fits any of the below categories, bills for out-of-network care may be paid by the insurer.

a. Staying Covered When a Provider Leaves the Network

When a provider leaves an insurer's network for reasons unrelated to fraud or losing its license, the insured can continue to see that provider for a statutory period of time as though they are in-network. If the insured is engaged in an ongoing course of treatment when they receive notice that a provider is no longer in-network, they are entitled to 90 days of transitional care. Pregnant women have special protections; if they are in their second trimester of pregnancy at the time the provider left the network, their transitional care lasts through birth and includes post-partum care related to the delivery, even if more than 90 days, as though the provider is in-network.[7]

Without this protection, the pregnant woman would have two options for obtaining coverage under her plan: (1) pay out-of-pocket for all visits, sonograms and lab tests, with no hope of reimbursement, or (2) find a new provider, such as an OB/GYN, who is in-network. Both of these options can be highly disruptive for a pregnant patient who has developed a relationship with her doctor and cannot afford to pay for the full cost of care. Plus, finding a new provider can be challenging because of inaccuracies in provider directories[8] and the fact that doctors often refuse to accept new patients late in their pregnancy.

b. Continuing to See a Provider When the Consumer Switches Insurance Plans

Transitional care may be available when an individual switches insurance to a plan that is regulated by New York State law. To receive transitional care rights when the insured switches insurance plans—not the provider—the individual must either have a disease or condition that is life-threatening, degenerative or debilitating, or be in at least the second trimester of pregnancy.[9] The individual must be joining a plan that is subject to this law, not a self-insured or grandfathered plan that is governed by ERISA and not additionally subject to New York State law. The best way to learn whether a plan is self-insured or grandfathered is to call the plan, or ask the Human Resources office of the company that provides the plan.

If the individual has transitional rights because of a degenerative or disabling condition, they can continue to see their out-of-network provider for up 60 days from the date of enrollment in the new plan, as though still in-network. If the transitional rights stem from the insured's being in the second trimester of pregnancy when she enrolls in her new plan, she can continue to receive care from her now out-of-network provider through post-partum care related to the delivery.

For example, when insurer Health Republic abruptly went out of business in November 2015, numerous enrollees were receiving treatment for cancer from Memorial Sloan Kettering. However, none of the other insurance plans sold through the Marketplace, where the individuals had purchased their Health Republic plan, had coverage for Memorial Sloan Kettering available in-network. Unless the Health Republic insureds could get access to another insurance plan that had Memorial Sloan Kettering in-network, they could use transitional care rights to continue receiving care from their doctors without paying entirely out of pocket.

c. Mechanics of Receiving Transitional Care

No matter why an insured is eligible for transitional care, getting the insurer to pay the out-of-network provider is not self-executing, and requires the enrollee to take action. Plus, the law requires the insurer to cover the out-of-network provider during the transitional period, but the provider is not required to participate.[10] Participation requires the provider to act like an in-network provider with the insurer during the transitional period. This means accepting the insurer's in-network reimbursement rates as payment in full, and adhering to the insurer's policies and procedures, including quality assurance requirements and obtaining pre-authorization or other procedural requirements.[11]

Another hurdle to be met is that each insurer has its own method for authorizing transitional care, so the affected individuals should start coordinating the transitional care as soon as they realize that they need to do so. The process starts with a call to the insurer to get an explanation of its procedure to request transitional care to have the provider bill the insurer.[12] Complaints against insurers who stall or do not follow the law can be directed to the Department of Financial Services ("DFS") through its website for commercial plans,[13] or to the Department of Managed Care for Medicaid plans.[14] Filing a complaint is simple and triggers a process wherein DFS may reach out to the insurer about the complaint.[15]

(2) Part B: Appealing Insurance Denials

When a private insurer denies a claim for any reason, the enrollee has the right to appeal that decision. Both the

reason for denying the claim, and the type of insurance at issue, shape where to direct an appeal and how to frame a winning argument.[16]

Based on a DFS annual report tracking success rates of insurance appeals, appealing an insurer's denial is a worthwhile strategy for the insureds and their providers. There are two types of appeal: (1) internal appeals decided internally by an insurance company representative, and (2) external appeals to DFS, which are decided by a neutral third party. According to DFS records, in 52% of all internal appeals, which are submitted to the insurer itself and can be filed on the basis of any type of denial, the insurer overturned the previous decision.[17] Approximately 40% of the 1,786 external appeals submitted in 2014 were at least partially overturned in favor of the insured.[18] These numbers imply that individuals who receive denials from their insurer could benefit from filing an appeal.

Claim denials fall into two broad categories: (1) the insurer disagrees with the necessity or efficacy of the treatment, claiming that it is not medically necessary, that it is experimental or investigational; or (2) the insurer has a procedural argument against coverage, because the service was received from an out-of-network provider, it is not a covered service, or the service required preauthorization which the insured failed to obtain.

Generally, if the denial falls into the first category, the individual has internal and external appeal rights.[19] Internal appeals are reviewed by the insurer directly and external appeals are accepted by DFS before being randomly assigned to an external review agent.[20] If the denial is primarily procedural, it can be reviewed externally only if there is a medical reason for seeing an out-of-network doctor, such as the out-of-network health service being materially different from the recommended in-network service,[21] or the insurer claims that it has an in-network provider with the appropriate training and experience to meet the health needs of the insured, making out-of-network care unnecessary.[22]

Appeals can be submitted before or after care is received, depending on whether the denial is for a preauthorization or the denial comes after the service has been provided. If the consumer successfully gets the insurer's decision overturned, the insurer must pay for the care that was provided as though it had never been denied, according to the reimbursement rates under the plan.

Medical necessity denials may be appealed externally. Each appeal is extremely fact specific and must link the details of the individuals' medical history with the relevant medical necessity standard. Each insurance plan maintains its own standards for medical necessity, which is the only standard the plan needs to consider when making a decision. Third-party reviewers, who are doctors and nurses contracted by DFS, can use other information to decide if the insurer's treatment denial was in the best interest of the patient, including the attending physician's recommendation, and generally accepted practice guidelines from the federal government, medical societies or boards and associations.[23]

(3) Part C: Network Adequacy Requirements and How to Get Care Out of the Network

Insurance plans must follow network adequacy requirements that control if the plan has a provider who can provide the right care within a reasonable time, without the individual traveling too far from home. Networks are certified by DFS before a plan can be sold in New York State, and are adequate if they can "… meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract."[24]

The standards for network adequacy are set broadly in the New York State Public Health Law and Insurance Law, with some details outlined more specifically within insurance contracts. For example, enrollees must be able to select from at least three primary care providers within the time and distance travel standards.[25] Time and distance requirements for Medicaid plans are found in the Managed Care model contract[26] and private plans sold through the Marketplace can be found in the standards for plans to participate.[27] The number of providers in each area of specialty practice must be sufficient to meet the needs of the enrollment population and there is no exclusion of any appropriately licensed type of provider as a class.[28]

Complaints about a plan network should be directed to DFS.[29] Although insurance plans are required to update their provider listings within fifteen (15) days of a change in physician network or hospital affiliations,[30] many provider listings contain so many mistakes that individuals may not be able to accurately assess whether their network is adequate. If individuals cannot get access to an in-network provider because the network is inadequate, they can use the external appeal system as described in Part B to get their insurance to pay for an out-of-network provider as though they were in-network.

a. Rights to Begin Seeing an Out-of-Network Provider

When first shopping for a plan, consumers should check to confirm that their current providers are in-network. But they may develop a need to see a specific provider after they have enrolled in a plan, and will be unable to switch during the plan year, creating yet another hurdle for access to care.

Enrollees in HMOs, PPOs and EPOs have the right to go out-of-network if they cannot find an in-network provider who meets the network adequacy requirements discussed above. The member handbook or subscriber contract or certificate should explain the procedure for enrollees to demonstrate that they need go out-of-network. If the internal procedure does not work, enrollees can access the DFS external appeals process mentioned above to appeal the denial of their coverage. As part of the process, patients must enlist their physician to certify that the in-network provider does not have the appropriate training and years of experience treating the patients' condition, or number of procedures performed, to meet the particular health needs of the patients.[31]

These network adequacy protections can be laborious for the individual making the appeal, but using these protections, and complaining to DFS when they do not work, will help improve these processes in the future.

(4) Part D: Protections Against "Surprise Bills"

In 2015, New York enacted a law to protect consumers from "surprise bills." Individuals insured in HMOs had already been protected by surprise bills incurred when they went out-of-network during the course of an emergency, but this law expands those protections to people in non-HMO insurance, covering surprises that occur outside of an emergency. Since many medical bills come as a surprise to the person receiving them, the law carefully defines surprise.

To determine if a bill is a surprise, the first question is whether or not the individual is insured. If the answer is "yes" and the plan is not self-insured, the process moves forward. The next question is whether the service that led to the bill took place in an in-network facility or after a referral to an out-of-network facility.

If an insured individual received services in an in-network hospital or Ambulatory Surgical Center, from an out-of-network doctor, the bill is a surprise if: (1) an in-network doctor was not available; or (2) an out-of-network provider was used without the insured's knowledge; or (3) unforeseen medical circumstances arose at the time that services were being provided. It is not a surprise bill if the insured chose to see an out-of-network provider.[32]

If the insured is referred to an out-of-network provider by an in-network doctor, the bill is a surprise if the patient did not sign a written consent acknowledging that the services would be out-of-network and the costs would not be covered by their insurer. This referral can occur if: (1) a patient is being seen by an in-network doctor, and an out-of-network provider also treats the patient, or (2) an in-network doctor sends a specimen to an out-of-network lab or pathologist, or (3) if the insurer requires a referral for any service.[33]

If the medical bill is a "surprise" under the law, individuals can remove themselves from the dispute over the bill. The individuals assign their benefits to the physician, allowing the physician and the health insurer to negotiate, in front of a third party arbitrator assigned by DFS, as necessary.[34]

This law also attempts to prevent surprise bills by requiring providers to disclose what health care plans they participate with, and which hospitals they are affiliated with at the time an appointment is scheduled. As such, doctors in private practice are required to provide information about the insurance networks of any other providers they are working with on the patient's care.[35] Hospitals are required to update their website to include which insurance plans they participate in, the physician groups they contract with, and which physicians are employed by the hospital. Hospitals also need to provide patients with instructions before they receive non-emergency services to help the patients determine which networks their providers are in, including an explanation that a doctor working at an in-network facility is not necessarily an in-network doctor.

To date, DFS has not released clear data on how this law is working for patients who experience a non-emergency out-of-network referral, but the NYS Department of Health is conducting a statewide audit of 50 to 60 hospitals to determine if they are meeting the notice standards.[36]

Conclusion

Our health insurance system is deeply complex, but within the maze there are rules that help individuals and providers get correctly reimbursed by the insurer. Heightened awareness of the rules by all players in the health insurance market can help patients and families to focus on managing their health, not their health insurance.

Endnotes

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14. Complaints and Appeals, Department of Health, https://www.health.ny.gov/health_care/managed_care/complaints/.
15. DFS logs complaints to identify trends affecting consumers in the insurance process.
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