NEW YORK'S SURPRISE OUT-OF-NETWORK PROTECTION LAW

Report on the Independent Dispute Resolution Process

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New York State Department of Financial Services
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EXECUTIVE SUMMARY

New York's Out-of-Network Law ("OON Law"), the first of its kind in the nation, takes a comprehensive approach to addressing bills for emergency services and surprise bills from out-of-network (OON) doctors and other health care providers, and ensures that consumers are protected.[1] In 2009, then Attorney General Cuomo fought for groundbreaking settlements with health plans over their improper calculation of the promised usual and customary rate (UCR) for OON benefits by using defective data that, among other things, was old, mixed in-network costs for an OON benefit, and was collected by a subsidiary of a health plan that had a conflict of interest. Building on that success, the Department of Financial Services (DFS) under Governor Cuomo issued a 2012 report entitled "*An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers*" after receiving numerous complaints from consumers who received unexpected and sometimes excessive medical bills from OON providers.

DFS worked with various stakeholders – including consumers, providers, and health plans – to pass and implement the groundbreaking OON Law in 2014. From its implementation in March of 2015 through the end of 2018, the OON Law has saved consumers over $400,000,000. The OON Law reduced OON billing in New York by 34% and lowered in-network emergency physician payments by 9%.[2]

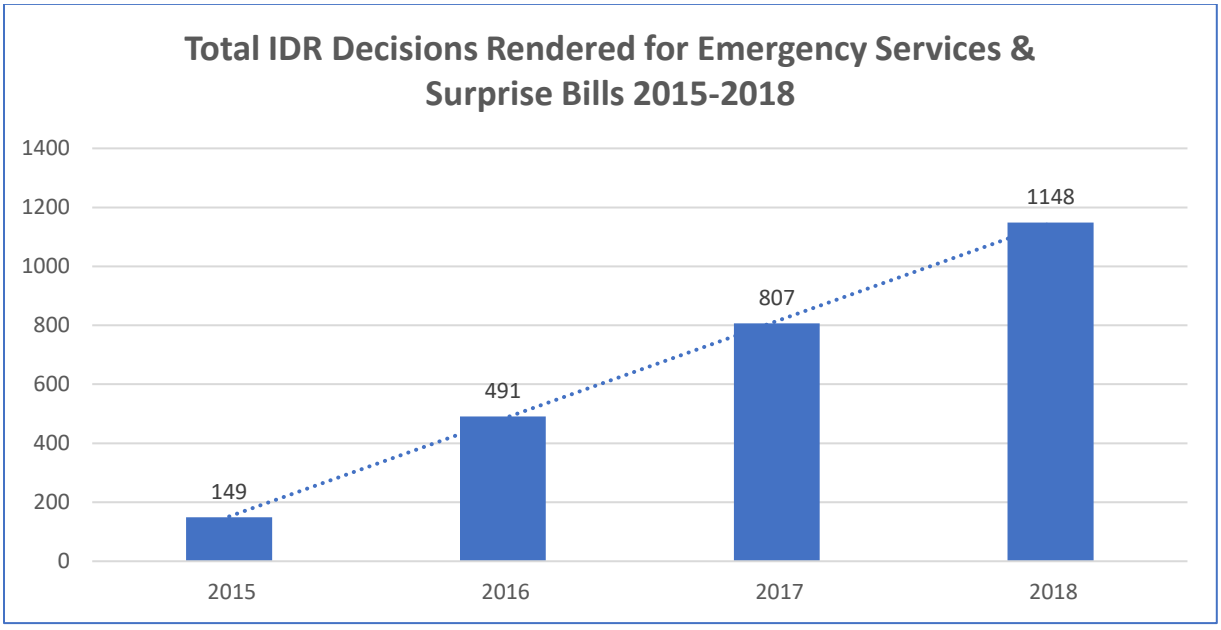
The OON Law contains extensive consumer protections, including requirements that health plans hold consumers harmless from emergency and surprise OON bills, improved

[1] Part H of Chapter 60 of the Laws of 2014.
[2] https://www.nber.org/papers/w23623.

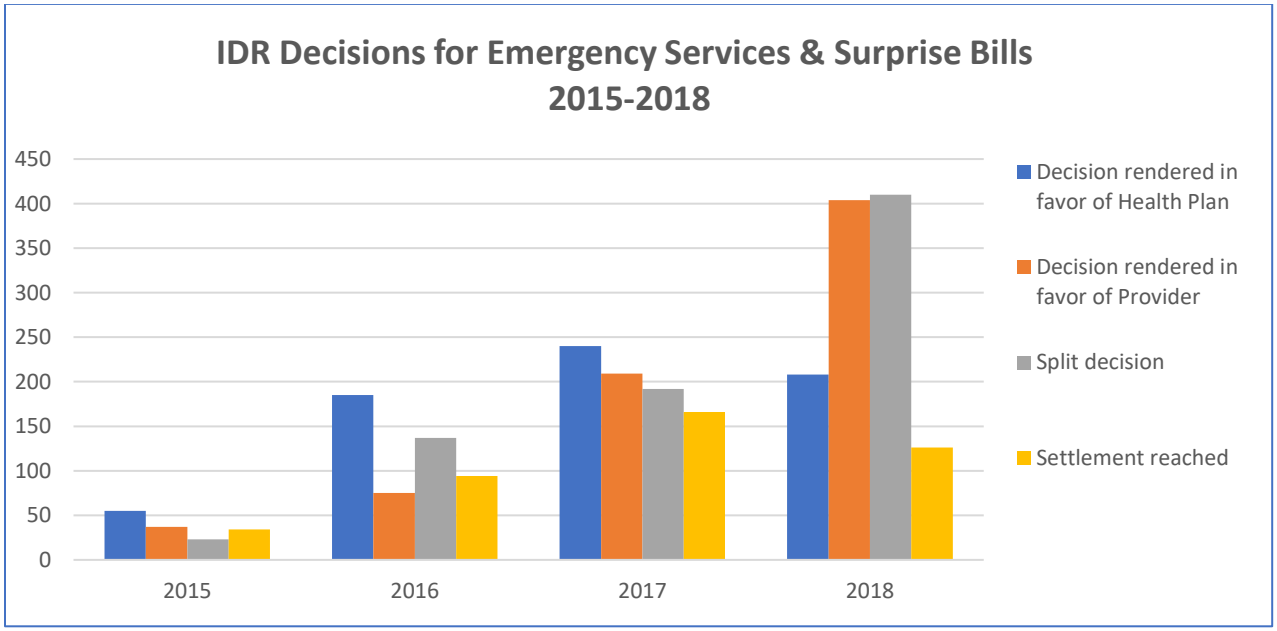
disclosure, extended network adequacy requirements, minimum OON coverage to be made available to consumers, expanded external appeal rights, and easier claims submission.

The OON Law's fundamental reform is that the consumer is protected from OON emergency and surprise bills, and billing is between the provider and the health plan. To resolve any billing disputes between the provider and the health plan, the OON Law establishes an Independent Dispute Resolution (IDR) process for OON emergency physician services in a hospital, and surprise bills in hospitals and other outpatient settings. Providers, health plans, and consumers may submit a dispute to an IDR entity (IDRE) through a portal on the DFS website. The IDRE makes a determination as to whether the provider's fee or the health plan's payment is more reasonable, based upon the last best offer of each party. This Report focuses on the progress of the IDR process to date.

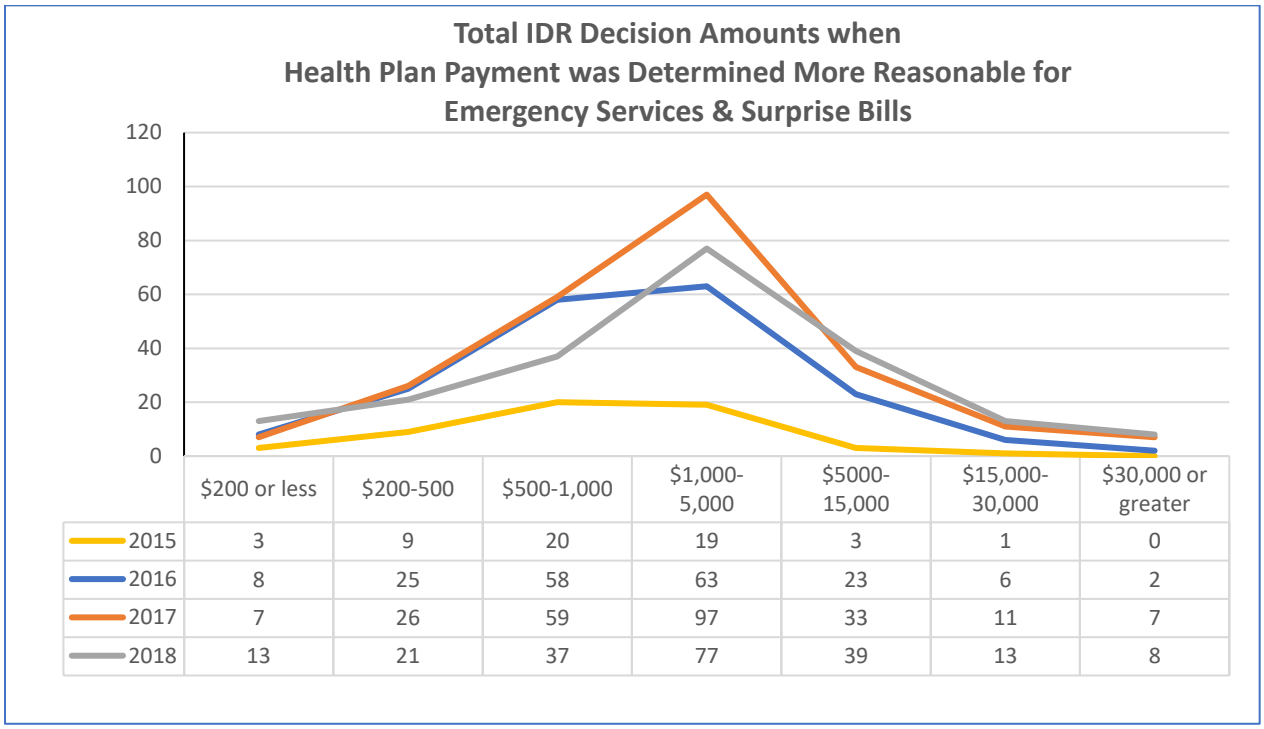
The IDR process was implemented on March 31, 2015, and 2,595 decisions were rendered between 2015-2018. The number of IDR requests and decisions has been steadily increasing each year as evidenced in the chart below.



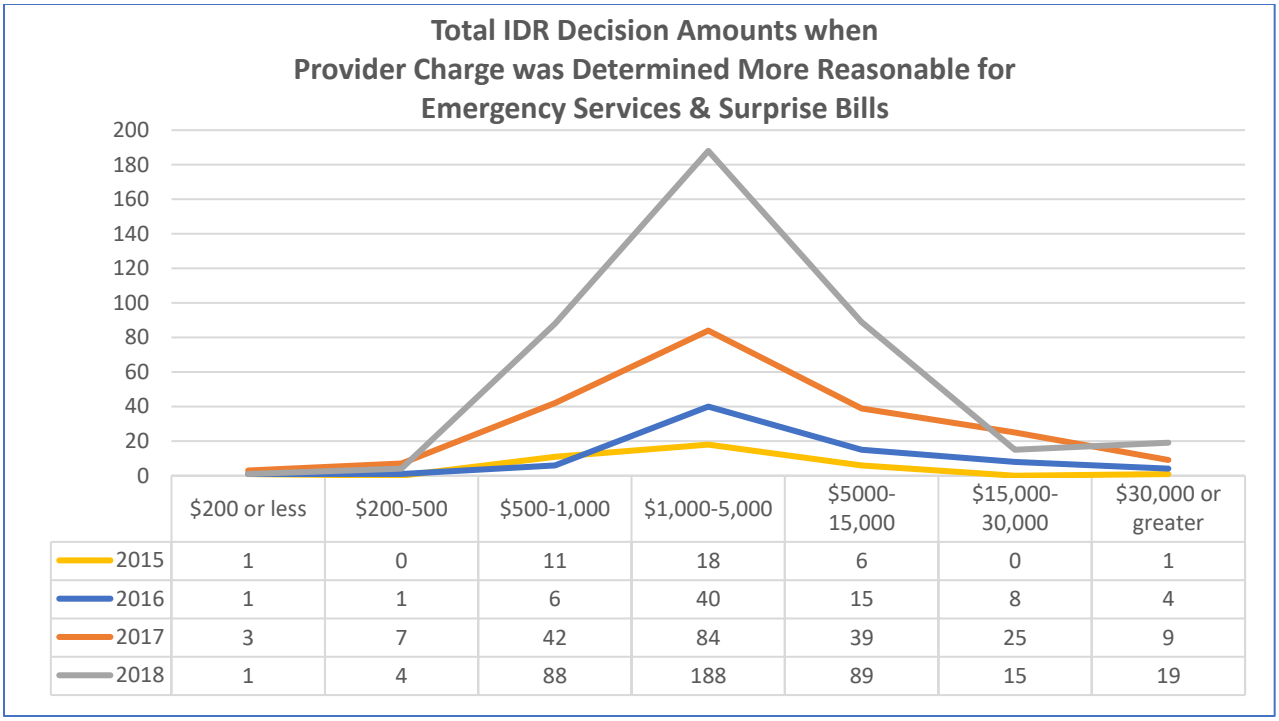
Providers have been prevailing more often than health plans when the emergency services and surprise bill results are combined for 2015-2018. However, that is not the case when the results are considered based on decision type for 2015-2018. With respect to emergency services, 43% of decisions were in favor of the health plan, 24% were in favor of the provider, and 33% were split between the health plan and provider, which occurred when more than one current procedural terminology (CPT) code was submitted for the patient's services and the IDRE found in favor of the health plan for some codes and the provider for others. However, beginning in 2018, providers prevailed more often than health plans for disputes involving emergency services. With respect to surprise bill decisions for 2015-2018, 13% were in favor of the health plan, 48% were in favor of the provider, and 39% were split between the health plan and provider. One unexpected finding DFS encountered is that several services may be provided during one date of service, and a significant number of both emergency and surprise bill decisions have found in favor of the health plan's payment for some services and the provider's charge for other services in these situations as evidenced in the chart below.



DFS also monitors the dollar amounts determined to be the most reasonable in the IDR decisions. The dollar amounts of IDR decisions are most frequently in the $1,000 to $5,000 range, regardless of whether the health plan or the provider prevails.



	$200 or less	$200-500	$500-1,000	$1,000-5,000	$5000-15,000	$15,000-30,000	$30,000 or greater
2015	3	9	20	19	3	1	0
2016	8	25	58	63	23	6	2
2017	7	26	59	97	33	11	7
2018	13	21	37	77	39	13	8



	$200 or less	$200-500	$500-1,000	$1,000-5,000	$5000-15,000	$15,000-30,000	$30,000 or greater
2015	1	0	11	18	6	0	1
2016	1	1	6	40	15	8	4
2017	3	7	42	84	39	25	9
2018	1	4	88	188	89	15	19

DFS sampled IDR decisions to determine how the prevailing party's payment or charge compares to UCR. Overall, when the health plan's payment was determined to be more reasonable, that payment was most frequently 20% to 100% lower than UCR. For IDR decisions where the provider's charge was determined to be more reasonable, the provider's charge was most frequently 0% to 50% higher than UCR.

This Report provides a summary of New York's groundbreaking OON Law, the IDR process, and the IDR results.

BACKGROUND

Before 2009, health plans typically used a database supplied by Ingenix, a subsidiary of UnitedHealth Group, to determine reimbursement rates for OON 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.[3] The report found that the Ingenix database systematically understated the market rates for health care services. The data used in the database was outdated and it mixed in-network bills with OON bills. The report further found that the Ingenix database was tainted by a conflict of interest because it was compiled by a self-interested health plan. The Attorney General entered into settlement agreements with health plans 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 OON reimbursements based on UCR.

Today, health plans typically base OON reimbursements on one of three sources: the FAIR Health database, the Medicare fee schedule, or a set fee established by the health plan. However, there are instances when the reimbursement amount is less than what the provider charges.

DFS received complaints from consumers who did everything reasonably possible to use in-network hospitals and doctors, but nonetheless received a bill from a specialist or other provider who the consumer did not know was OON. Related complaints of undisclosed and excessive charges were particularly pronounced in the emergency care setting. Surprise, involuntary medical bills from OON providers contributed to the growing problem of consumer medical debt, which has been a significant cause of personal bankruptcy. Simply put, surprise medical bills are causing some consumers to go broke.

Under the OON Law, consumers are taken out of disputes over OON emergency and surprise bills, and health plans and providers can use the IDR process to resolve such billing disputes. The OON Law includes extensive consumer protections including hold harmless

[3]See: https://ag.ny.gov/press-release/attorney-general-cuomo-announces-historic-nationwide-reform-consumer-reimbursement.

requirements, protection from surprise bills, improved disclosure, extended network adequacy requirements, minimum OON coverage to be made available to consumers, expanded external appeal rights, and easier claims submission. The OON Law also established an OON Workgroup appointed by the Governor with recommendations by the Legislature. The OON Workgroup Report, issued at the beginning of 2017, found the OON Law to be highly effective in expanding the availability of OON coverage in the small group market and in establishing consumer protections relating to hold harmless, independent dispute resolution, disclosure, network adequacy, and improved claims submission.

In fact, the OON Law has saved consumers over $400,000,000 from the time it was implemented in March of 2015 through the end of 2018 with respect to emergency services alone. This savings has been realized in part through a reduction in costs associated with emergency services and an increased incentive for network participation. Consumers in need of emergency services are typically unable to choose the physician that provides the services. In addition, even when the consumer receives emergency services at an in-network hospital, the physician may not necessarily be in-network. Prior to the OON Law, there were no protections from excessive emergency charges; consumers or health plans would just pay the amount billed, and physicians providing emergency services did not have an incentive to participate in health plan networks. By establishing an independent dispute resolution process for OON emergency services, the OON Law reduced OON billing by 34% and lowered in-network emergency physician payments by 9%.[4]

New York was the first state to address the surprise bill issue with a comprehensive legislative approach. Other states are now using the New York OON Law as a model, and

[4] https://www.nber.org/papers/w23623.

federal legislation is being considered based at least in part on the New York model. This Report focuses on the performance of the IDR process, which is an integral part of the OON Law.

OVERVIEW OF IDR PROCESS

New York's IDR is a streamlined process whereby a paper review is conducted, and timely decisions are rendered, on disputes involving bills for emergency physician services or surprise bills.[5] IDR requests are submitted to DFS and assigned to IDREs for review.

IDREs Certified to Review Disputes

IDREs are certified by DFS and these entities must demonstrate that they can meet all New York IDR standards and requirements. IDREs are required to use reviewers experienced in medical billing and UCR, in consultation with licensed physicians in active practice in the same or similar specialty as the physician providing the service subject to the IDR, when reviewing disputes. DFS has certified three IDREs to conduct IDR in New York.

Timeframes and Process for Submitting an IDR

Within three business days of receiving an application for IDR, the IDRE must screen the application for a conflict of interest. If a conflict exists, the application is returned to DFS for reassignment. If no conflict exists, the IDRE reviews the application for eligibility. If information is needed to determine eligibility, the IDRE contacts the submitting party and provides three business days to submit the information, with a reminder given at the end of that

[5] See Financial Services Law Article 6 and 23 NYCRR 400.

timeframe, and one additional business day provided. If the information is not submitted, the IDRE rejects the application.

If the application is eligible, the IDRE sends notification of the assignment of the dispute to the involved parties within three business days. The IDRE requests information from the parties, including: the fees charged and fees paid for the service that is the subject of the dispute; the fees paid by the health plan to reimburse similarly qualified providers for the same services in the same region; the provider's usual charge for comparable services rendered to other patients in health plans in which the provider is not participating; the provider's level of training, education, and experience; the circumstances and complexity of the case; individual patient characteristics; the UCR for the service; and any other information the parties deem relevant. The information must be submitted within five business days of the notification, and if a partial response or no response is received, the dispute will be decided based on the available information. The IDRE cannot reconsider a dispute for which a determination has been made based upon additional information received after the determination.

The IDRE has 30 days from the submission of a dispute to make a determination and, with respect to disputes between providers and health plans, must choose either the OON provider charge or the health plan payment. If an IDRE determines that a settlement is reasonably likely, or that the health plan's payment and the provider's fee represent unreasonable extremes, the IDRE may direct the parties to attempt a good faith negotiation for settlement. The parties may be granted up to 10 business days for this negotiation, which runs concurrently with the 30-day timeframe for an IDR decision.

Standards for IDRE Decisions

In making its decision, the IDRE must consider: whether there is a gross disparity between the fee charged by the provider and (1) fees paid to the provider for the same services rendered by that provider to other patients; and (2) fees paid by the health plan to reimburse other similarly qualified providers who don't participate with the health plan for the same services. The IDRE must also consider the provider's training, education, experience, and usual charge; the circumstances and complexity of the case; patient characteristics; and UCR.[6]

Patients who do not have fully insured coverage, either because their employer self-funded the coverage or because they are uninsured, may also submit a dispute regarding emergency services or a surprise bill for review to an IDRE.[7] In such cases, the IDRE must determine a reasonable fee for the services, which may not be the provider's charge or the plan's payment, and consider the same factors that are considered when the dispute is between a provider and a health plan.

IDRE Costs

The party that does not prevail pays the cost of the IDR or, if a settlement is reached, the health plan and the provider evenly divide the prorated cost. In IDRs submitted by patients who are uninsured or have self-funded coverage, if the IDRE determines that the provider's fee is unreasonable, the provider is responsible for paying the cost of the IDR. If the IDRE determines that the provider's fee is reasonable, the patient is responsible for the cost of the IDR, unless

[6] UCR is defined as the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the Superintendent (FAIR Health).

[7] Consumers with group coverage that is self-funded under the Employee Retirement Income Security Act of 1974 are eligible for IDR. Providers are bound by the decision, but the self-funded plan is not. Self-funded plans are not subject to New York jurisdiction, and providers may not submit disputes involving self-funded plan payments through the New York IDR process.

DFS determines that payment would pose a hardship to the patient, in which case payment may be waived.

IDRE Decisions

The IDRE must forward copies of its determination regarding each dispute to the parties of the dispute and to DFS within two business days of rendering the determination. The IDR determination is binding and admissible in court.

IDR RESULTS FOR EMERGENCY SERVICES

Under the OON Law, disputes involving bills for emergency physician services in New York hospitals are eligible for IDR unless the physician fees are subject to schedules or other monetary limitations in law including Workers Compensation, no-fault, managed long-term care, Medicare, and Medicaid.[8] In addition, the OON Law exempts eighteen CPT codes for emergency services from the IDR process if the amount billed does not exceed 120% of UCR and is $683.22 (2019 amount, which is adjusted annually for inflation rates) or less.[9] Regardless of whether the dispute is submitted to IDR, the OON Law still requires health plans to hold

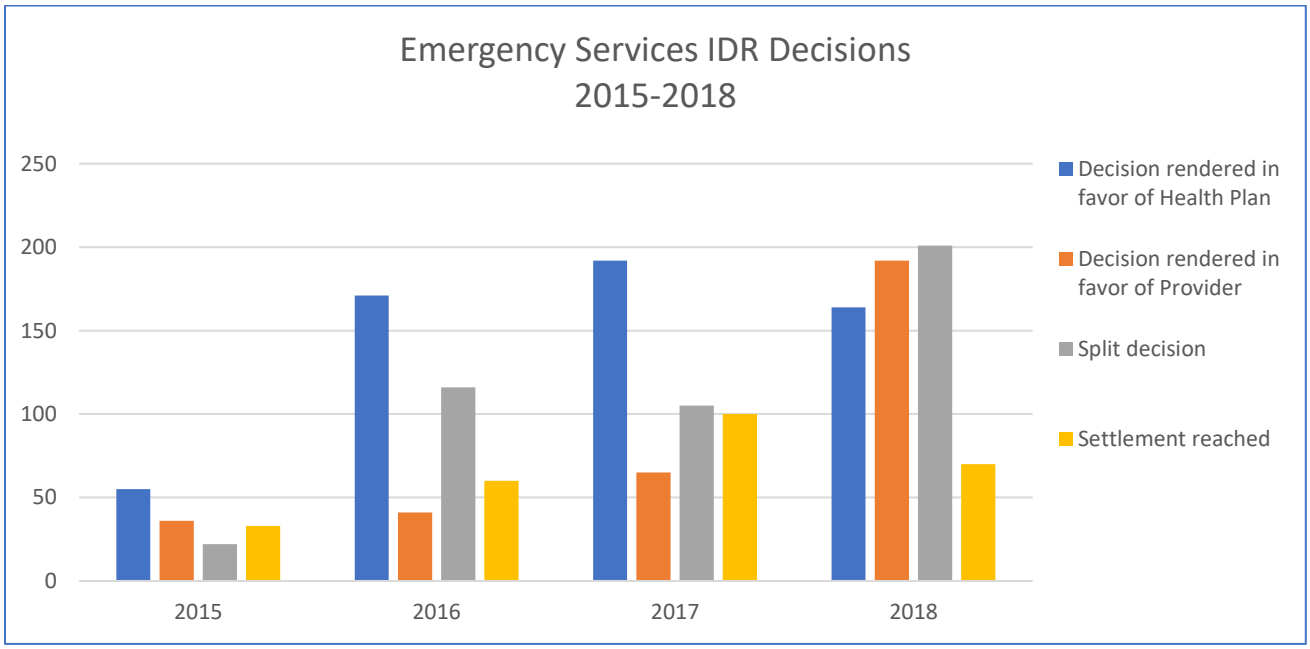
[8] Emergency services means, with respect to an emergency condition: (1) a medical screening examination as required under 42 U.S.C. § 1395dd that is within the capability for the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) with the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. § 1395dd to stabilize the patient.

[9] CPT codes 99281–99285, 99288, 99291–99292, 99217–99220, 99224–99226, and 99234–99236.

insureds harmless for emergency services for any amount that exceeds the in-network deductible, copayments, or coinsurance.[10]

Findings 2015-2018

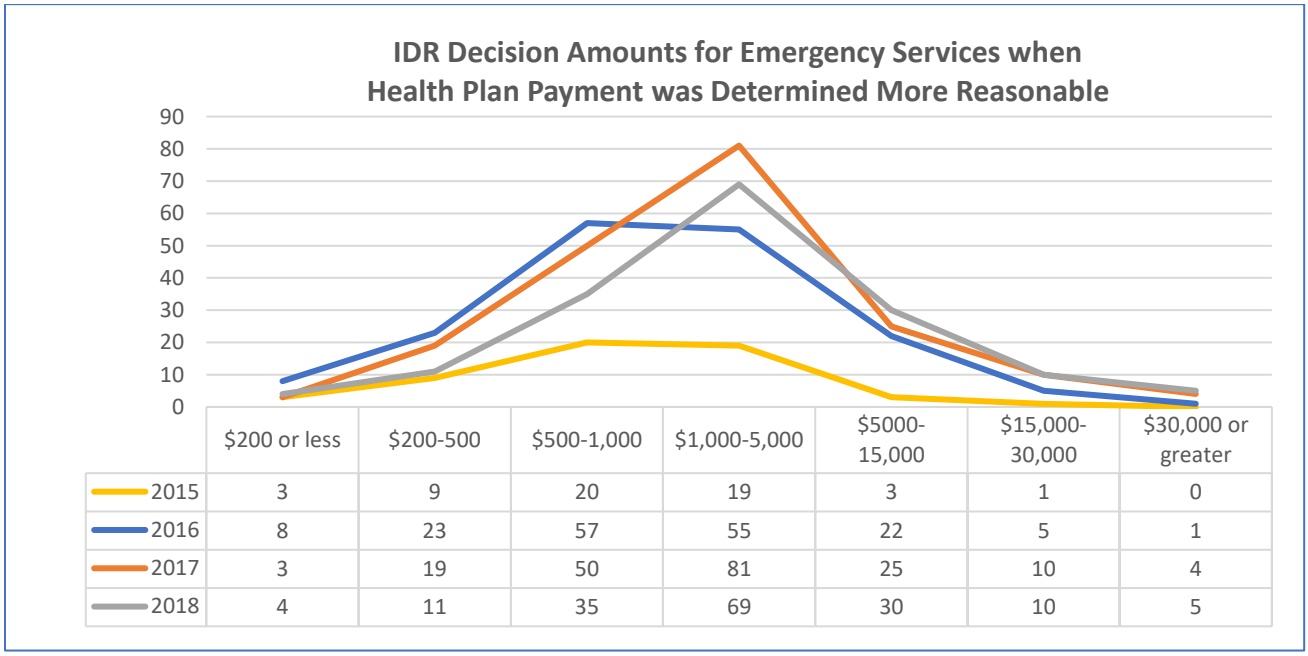
In 2015-2018, 2,250 IDR disputes involving bills for emergency services were submitted to DFS. Of those, 1,360 IDR decisions were rendered. Health plans prevailed in 43% of the cases, while providers prevailed in 24% of cases. Although, beginning in 2018, providers prevailed more often than health plans did. There were split decisions in 33% of the cases, meaning that more than one CPT code was submitted for the date of service, and the IDRE found in favor of the health plan for some codes and the provider for others.



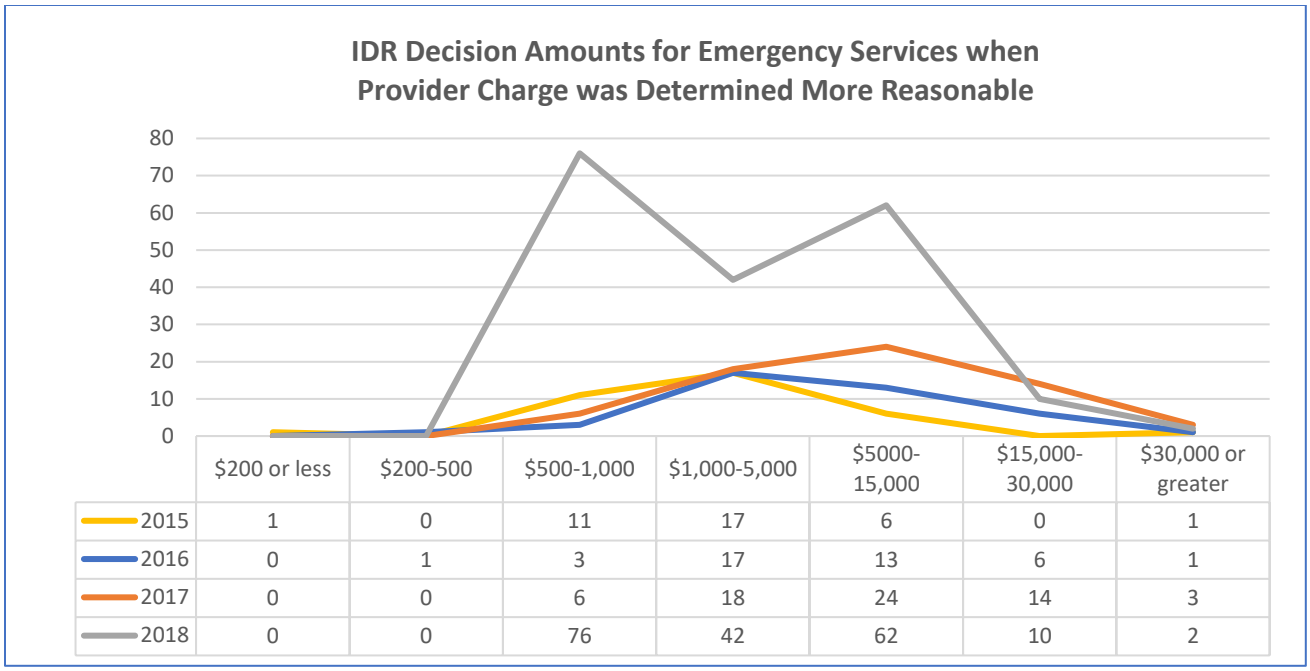
[10] The hold harmless requirements for OON emergency services apply to both physician services and hospital charges; however only the physician charges are eligible for IDR.

Dollar Amounts

In the 582 disputes decided in favor of health plans from 2015-2018, the most prevalent dollar amount paid by health plans was in the $1,000 to $5,000 range. In the 334 disputes decided in favor of providers, the most prevalent dollar amount awarded to providers was in the $5,000 to $15,000 range. The following charts compare the decisions and the dollar amounts awarded based upon the prevailing party.



	$200 or less	$200-500	$500-1,000	$1,000-5,000	$5000-15,000	$15,000-30,000	$30,000 or greater
2015	3	9	20	19	3	1	0
2016	8	23	57	55	22	5	1
2017	3	19	50	81	25	10	4
2018	4	11	35	69	30	10	5



	$200 or less	$200-500	$500-1,000	$1,000-5,000	$5000-15,000	$15,000-30,000	$30,000 or greater
2015	1	0	11	17	6	0	1
2016	0	1	3	17	13	6	1
2017	0	0	6	18	24	14	3
2018	0	0	76	42	62	10	2

Provider Specialty

DFS also tracks IDR disputes involving emergency services by provider specialty. The most common specialty for disputes involving emergency services in 2015 to 2018 was plastic surgery, followed by emergency medicine and orthopedic surgery. Less common provider specialties included cardiology, neurology, radiology, dental surgery, anesthesiology, assistant surgery, psychiatry, gastroenterology, OB/GYN, urology, and pediatrics, which each accounted for less than 1% of all disputes reviewed through December 31, 2018. The following chart identifies the provider specialties involved in 1% or more of the IDR disputes for emergency services.

2015-2018 Provider Specialty for Emergency Services	2015-2018 Percentage of IDR Disputes Submitted for Emergency Services
Plastic Surgery	40%
Emergency Medicine	22%
Orthopedic Surgery	19%
General Surgery	10%
Internal Medicine	2%
Neurosurgery	2%
Laboratory	1%

Settlements

Of the 2,250 disputes involving bills for emergency services that were submitted to DFS for IDR during 2015-2018, there were 263 cases that settled, amounting to 12%. The OON Law provides that the IDRE may direct the health plan and the physician to negotiate if the IDRE determines that settlement is reasonably likely, or if both the health plan's payment and the physician's bill represent unreasonable extremes.

Determined Ineligible

In 2015-2018, 26% of the disputes submitted involving bills for emergency services (577 in all) were determined ineligible. Of those, the primary reason for rejection was because the coverage was self-funded, followed by withdrawal of the application; rejection because the dispute did not involve emergency services; the application was not received; or the consumer had health insurance coverage that was issued outside New York and not subject to New York's jurisdiction. Less common rejection reasons accounting for less than 1% of rejections included the following: the bill was for facility charges rather than physician charges; the request listed an incorrect date of service; the services were rendered by a participating provider; the claim was paid and the balance was the patient's responsibility; the services were covered by the New York

State Essential Plan; and the claim was not an OON claim. The following chart identifies the rejection reasons that accounted for 1% or more of emergency services disputes that were rejected.

2015-2018 Reason for Rejection for Emergency Services	2015-2018 Percentage Rejected for Emergency Services
Self-funded Coverage	18%
Application Withdrawn	17%
Dispute Did Not Involve Emergency Services	14%
Application Not Received	12%
Coverage Issued Out-of-State	10%
Wrong Health Plan Identified	6%
Settlement Reached Before IDR Filed	4%
Federal Employee Coverage	3%
Out-of-State Hospital	3%
Law Not in Effect at Time of Service	2%
Services Covered by Medicaid	2%
Services Not Rendered by a Physician	2%
Duplicate Submission	1%
Exempt Emergency Services CPT Codes	1%
No Response to Eligibility Inquiry	1%
Services Covered by Medicare	1%

Observations of the Emergency Services IDR Requests

The number of IDR requests involving emergency services submitted to DFS has been exponentially increasing each year as 207 were submitted in 2015, and 848 were submitted in 2018. The number of disputes involving emergency services found ineligible remained consistent during 2016 to 2018, at about 170 to 175 each year. With respect to the determinations, in 2015-2017, the health plan's payment was found to be more reasonable than the provider's charge in a majority of the disputes, but in 2018, the provider's charge was found to be more reasonable than the health plan's payment in the majority of disputes. The number of cases, 33% in all, where the IDRE found in favor of the health plan for some CPT codes and the

provider for others was also significant, and such split decisions had not been anticipated when the law was implemented.

IDR RESULTS FOR SURPRISE BILLS

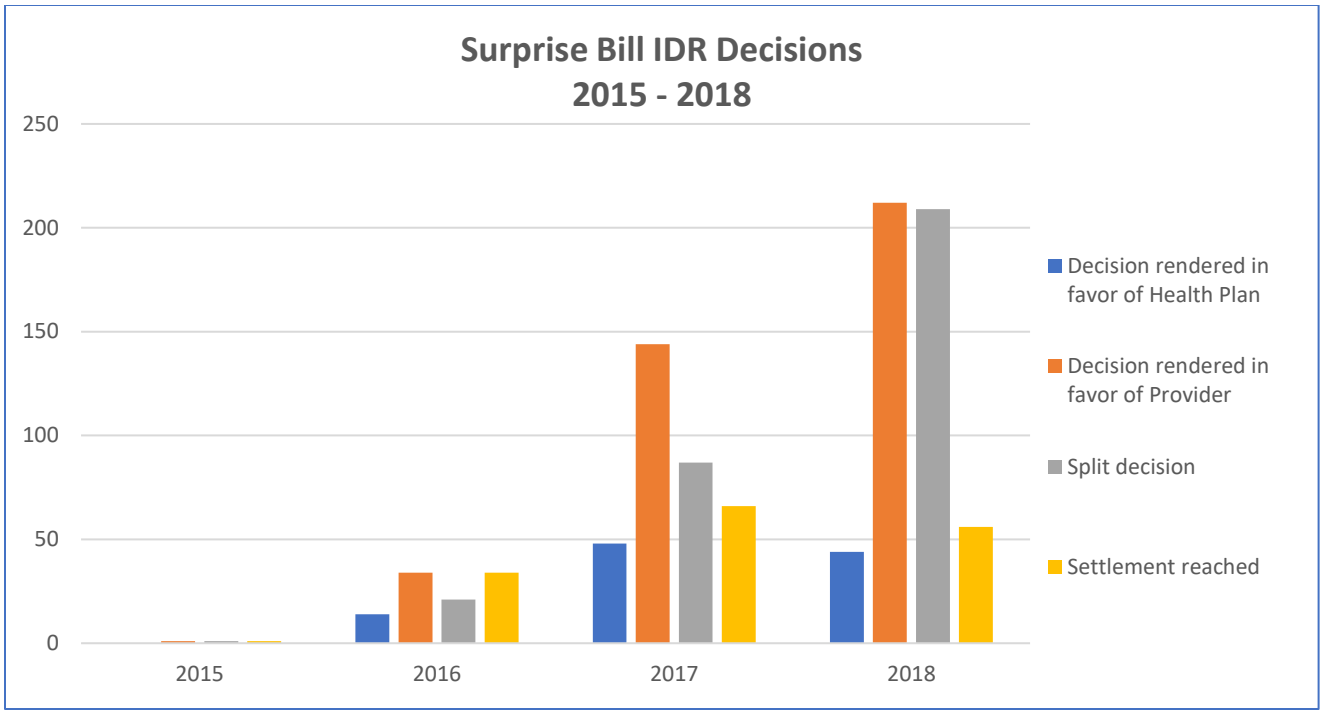
Disputes regarding surprise bills are also eligible for IDR. A surprise bill occurs when a patient receives services from a non-participating physician at a participating hospital or ambulatory surgical center and: (1) a participating physician was not available; or (2) a non-participating physician provided services without the patient's knowledge; or (3) unforeseen medical circumstances arose at the time the health care services were provided. A surprise bill also occurs when a patient is referred by a participating physician to a non-participating provider and the patient did not sign a written consent stating that the patient knew the services would be OON and would result in costs not covered by his or her health plan. A referral to a non-participating provider occurs when: (1) during the course of a visit with a participating physician, a non-participating provider treats the patient; or (2) the participating physician takes a specimen from a patient in the office (for example, blood) and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under the patient's plan. Finally, a surprise bill occurs when a patient who is uninsured or has self-funded coverage receives services from a physician at a hospital or ambulatory surgical center when the patient has not timely received all the required disclosures. A surprise bill does not occur if the patient chooses to receive services from a non-participating physician instead of from an available participating physician.

Once an insured assigns benefits for a surprise bill to a non-participating physician, the physician cannot bill the insured except for any applicable copayment, coinsurance, or deductible that would have been owed if the insured had gone to a participating physician. Health plans are also required to ensure that the insured incurs no greater out-of-pocket costs for the services than the insured would have incurred with a participating provider, as long as the insured has assigned benefits to the non-participating provider.

A surprise bill is exempt from the IDR process when physician fees are subject to schedules or other monetary limitations under any other law, including Workers Compensation, no-fault, managed long-term care, Medicare, and Medicaid fee-for-service.

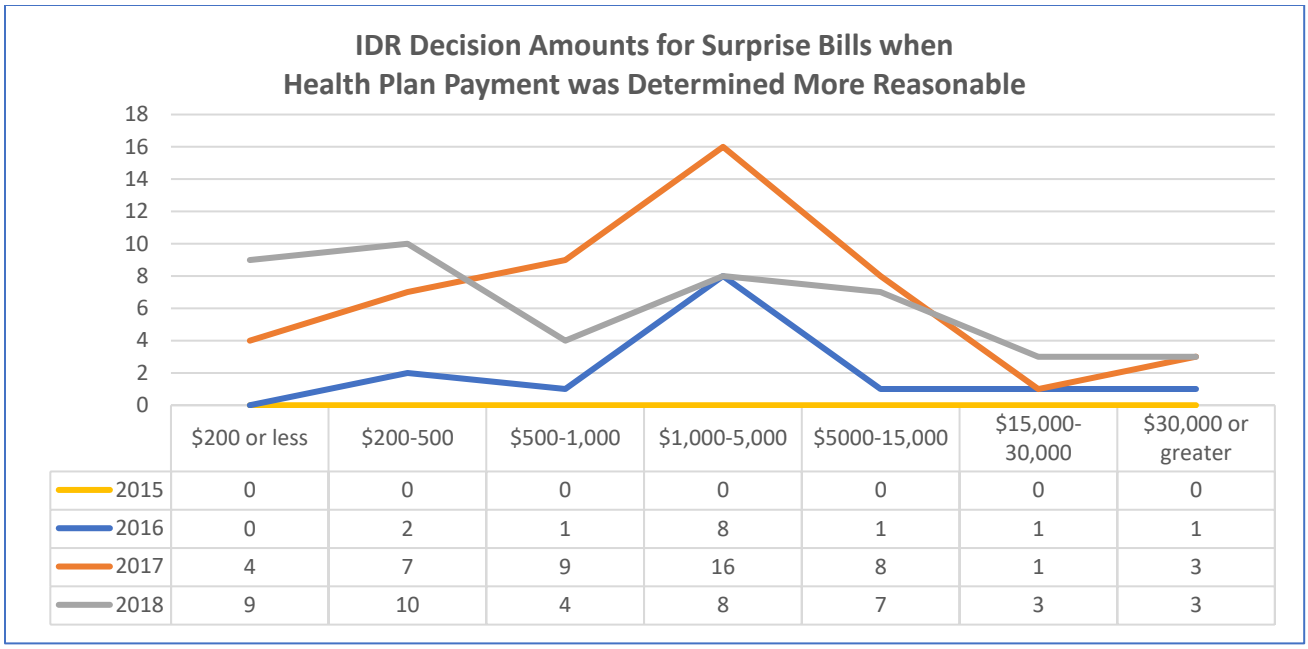
Findings 2015-2018

In 2015-2018, 1,486 disputes involving surprise bills were submitted to IDR. Of those, 815 IDR decisions were rendered. Health plans prevailed in 13% of the cases, while providers prevailed in 48% of the cases. There were split decisions in 39% of the cases, meaning that more than one CPT code was submitted for that date of service, and the IDRE found in favor of the health plan for some codes and the provider for others.

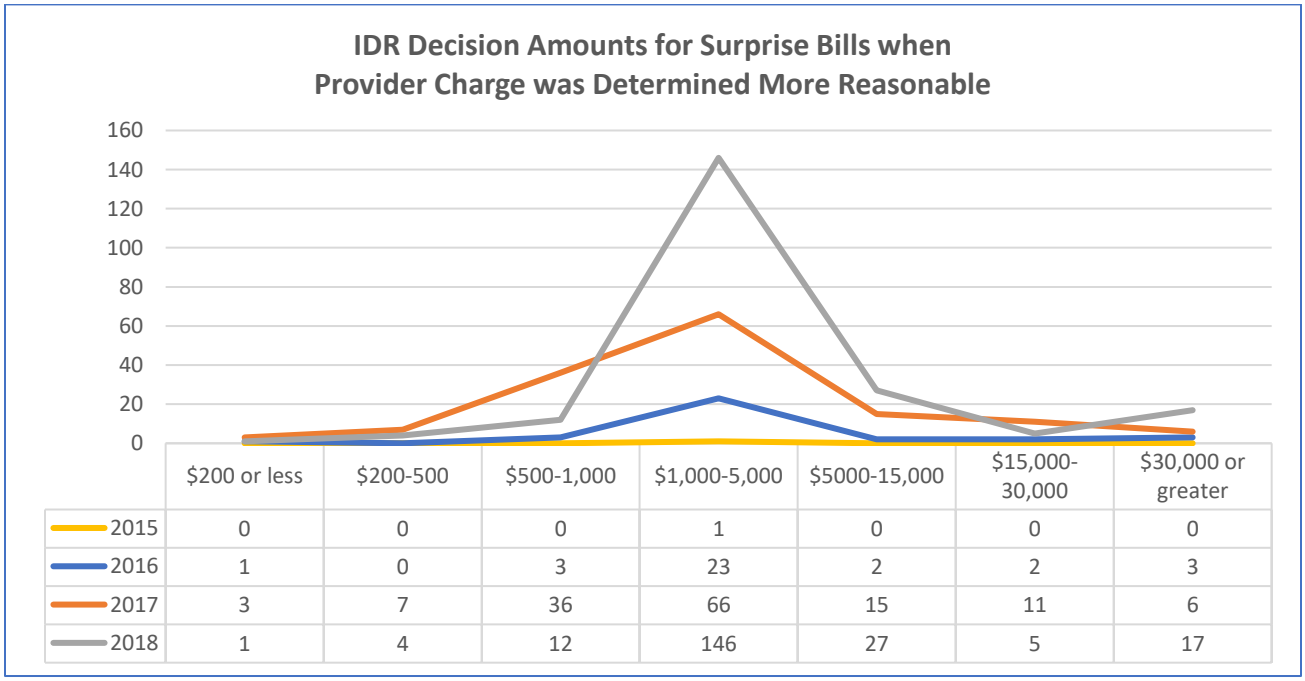


Dollar Amounts

In the 106 disputes decided in favor of health plans, the most prevalent dollar amount paid by health plans was in the $1,000 to $5,000 range. In the 391 disputes decided in favor of providers, the most prevalent dollar amount awarded to providers was also in the $1,000 to $5,000 range. The following charts compare the decisions and the dollar amounts awarded based upon the prevailing party.



	$200 or less	$200-500	$500-1,000	$1,000-5,000	$5000-15,000	$15,000-30,000	$30,000 or greater
2015	0	0	0	0	0	0	0
2016	0	2	1	8	1	1	1
2017	4	7	9	16	8	1	3
2018	9	10	4	8	7	3	3



	$200 or less	$200-500	$500-1,000	$1,000-5,000	$5000-15,000	$15,000-30,000	$30,000 or greater
2015	0	0	0	1	0	0	0
2016	1	0	3	23	2	2	3
2017	3	7	36	66	15	11	6
2018	1	4	12	146	27	5	17

Provider Specialty

DFS also tracks IDR disputes for surprise bills by provider specialty. The most common specialty for disputes involving surprise bills in 2015-2018 was neurosurgery, followed by

anesthesiology; plastic surgery; neurology; and general surgery. Less common provider specialties that accounted for less than 1% of all disputes reviewed through December 31, 2018 included pediatrics; radiology; assistant surgery; gastroenterology; laboratory; neonatology; and OB/GYN. The following chart identifies the provider specialties involved in 1% or more of the IDR disputes for surprise bills.

2015-2018 Provider Specialty for Surprise Bills	**2015-2018 Percentage of IDR Disputes Submitted for Surprise Bills**
Neurosurgery	31%
Anesthesiology	25%
Plastic Surgery	15%
Neurology	12%
General Surgery	3%
Cardiology	2%
Emergency Medicine	2%
Infectious Disease	2%
Internal Medicine	2%
Orthopedic Surgery	1%

Settlements

Of the 1,486 disputes involving surprise bills that were submitted to DFS for IDR during 2015-2018, there were 157 cases that settled, amounting to 11%. The OON Law provides that the IDRE may direct the health plan and the provider to negotiate if the IDRE determines that settlement is reasonably likely, or if both the health plan's payment and the physician's bill represent unreasonable extremes.

Determined Ineligible

In 2015 to 2018, 31% of the disputes submitted involving surprise bills (457 in all) were found ineligible. Of those, the primary reason for rejection was because there was not a surprise bill, followed by a failure to sign the assignment of benefits; an application was not received; the

application was withdrawn; the assignment of benefits was not submitted to the health plan; and the coverage was self-funded. Less common rejection reasons accounting for less than 1% of rejections included because the services were received outside New York; the bill was for facility charges; the submission was a duplicate; the services were covered by Medicaid; the services were not rendered by a physician; the services were rendered by a participating provider; and the claim was paid and the balance was the patient's responsibility. The following chart identifies the rejection reasons that accounted for 1% or more of surprise bill disputes that were rejected.

2015-2018 Reason for Rejection for Surprise Bills	**2015-2018 Percentage Rejected for Surprise Bills**
Dispute Did Not Involve Surprise Bill	17%
Assignment of Benefits Not Signed	14%
Application Not Received	13%
Application Withdrawn	12%
Assignment of Benefits Not Submitted to Health Plan	10%
Self-funded Coverage	8%
Coverage Issued Out-of-State	4%
Settlement Reached Before IDR Filed	4%
Wrong Health Plan Identified	4%
Law Not in Effect at Time of Service	3%
Federal Employee Coverage	2%
No Response to Eligibility Inquiry	1%
Out-of-State Facility	1%
Services Covered by Medicare	1%

Observations of the Surprise Bill IDR Requests

Similar to emergency services, the number of IDR requests involving surprise bills submitted to DFS has been exponentially increasing each year; 36 were submitted in 2015 and 723 were submitted in 2018. The number of disputes involving surprise bills found ineligible has remained consistent for 2016-2018 at about 131 to 148 each year. With respect to determinations, in 2015-2018, the provider's charge was found to be more reasonable than the

health plan's payment in a majority of the disputes. Similar to emergency services, the number of cases, 39% in all, where the IDRE found in favor of the health plan for some CPT codes and the provider for others was also significant, and such split decisions had not been anticipated when the law was implemented.

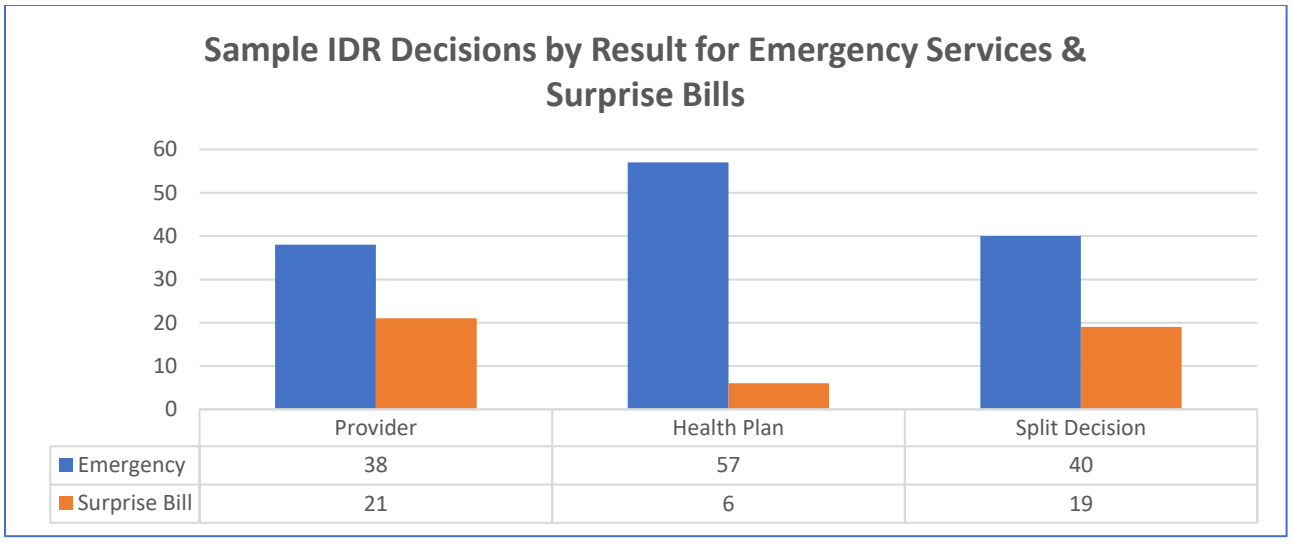
IDR DECISIONS IN RELATION TO UCR

The OON Law requires the IDRE to consider UCR along with other factors when making its determination. DFS sampled IDR decisions for emergency services and surprise bills to determine how the prevailing fee in each decision relates to UCR for the service that was the subject of the dispute.

Methodology

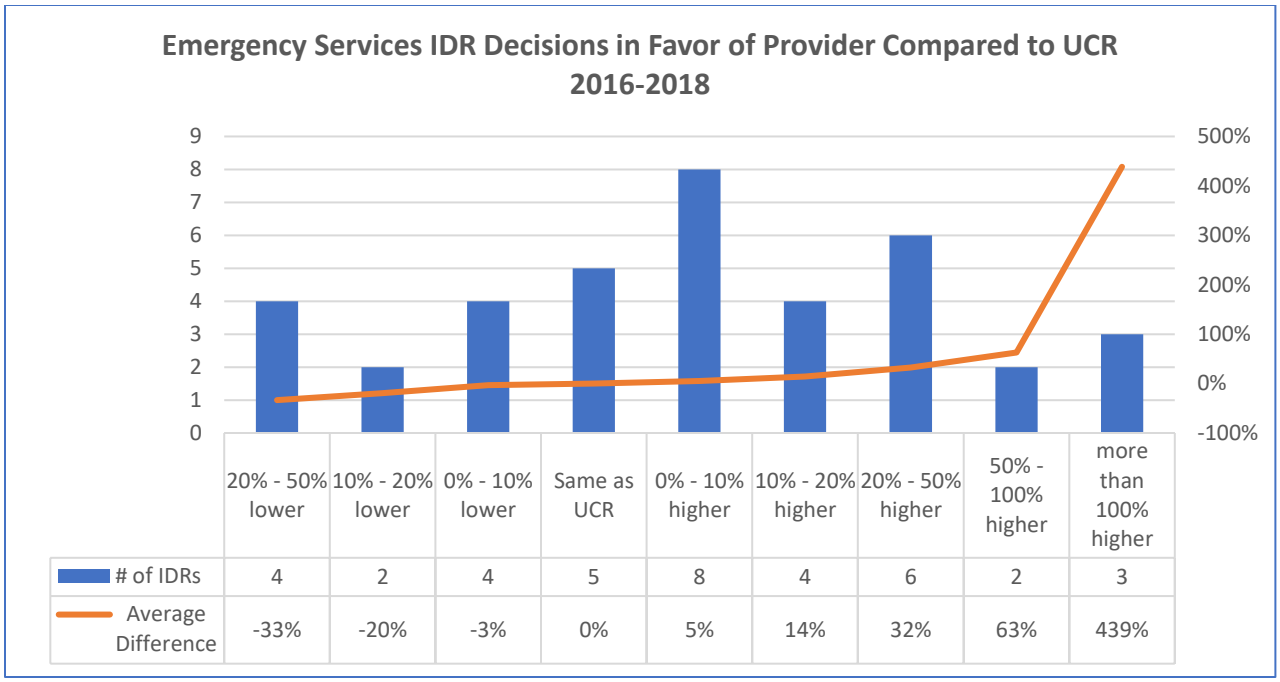
A total of 2,446 IDR decisions were rendered between 2016 and 2018.[11] The computer software program ACL was used to select a random sample size at the 95% confidence level, for each of these years. A statistically valid sample size was determined to be at least 180 decisions for calendar years 2016 to 2018. Accordingly, a sample size of 181 was used to conduct the analysis. The chart below details the distribution of the sample between IDRs for emergency services and surprise bills, broken down by results.

[11] Results from 2015 were excluded from the sampling due to the small size of the data, in part because it reflected only a partial year.

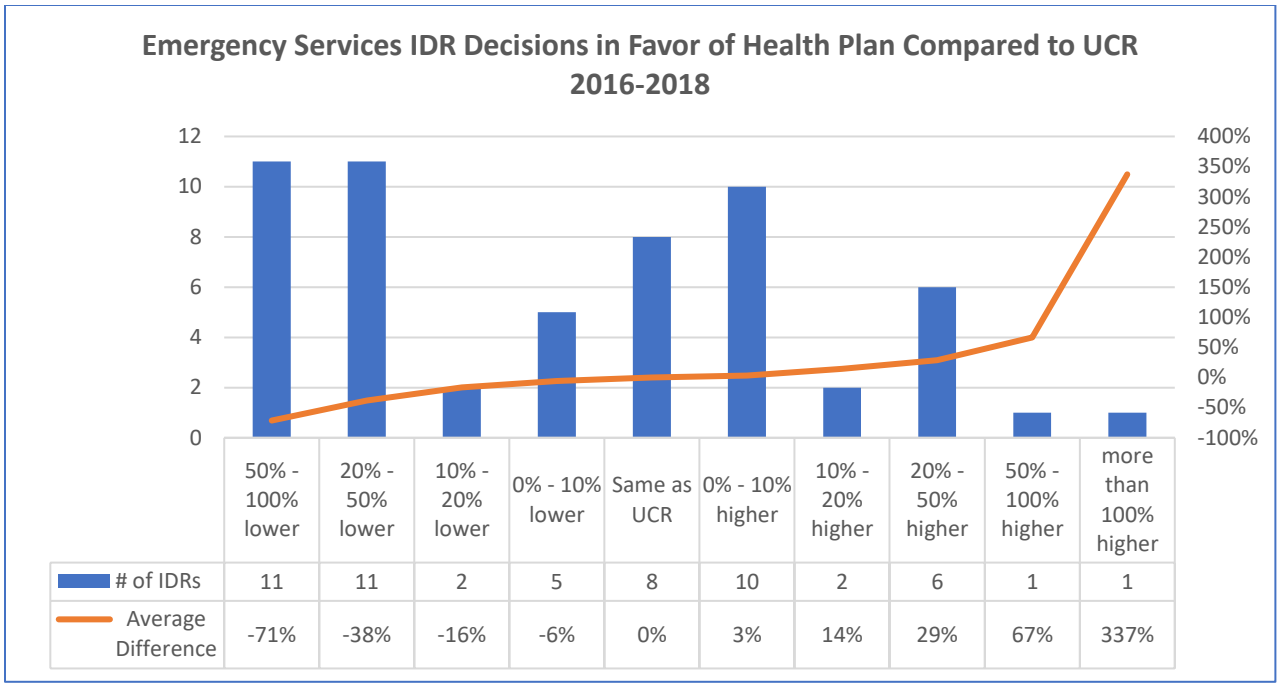


Emergency Services IDRs Compared to UCR

In the sample decisions for IDRs involving emergency services in which the provider's charge was found to be more reasonable than the health plan's payment, the greatest number of decisions were 0% to 10% higher than UCR, with an average difference of 5%. The next greatest number of decisions were 20% to 50% higher than UCR, with an average difference of 32%, followed by those that were the same as UCR. The fewest number of decisions were either 50% to 100% more than UCR or 10% to 20% lower than UCR. The chart below details the number of emergency services decisions rendered in favor of providers relative to how close the dollar amounts were to UCR.

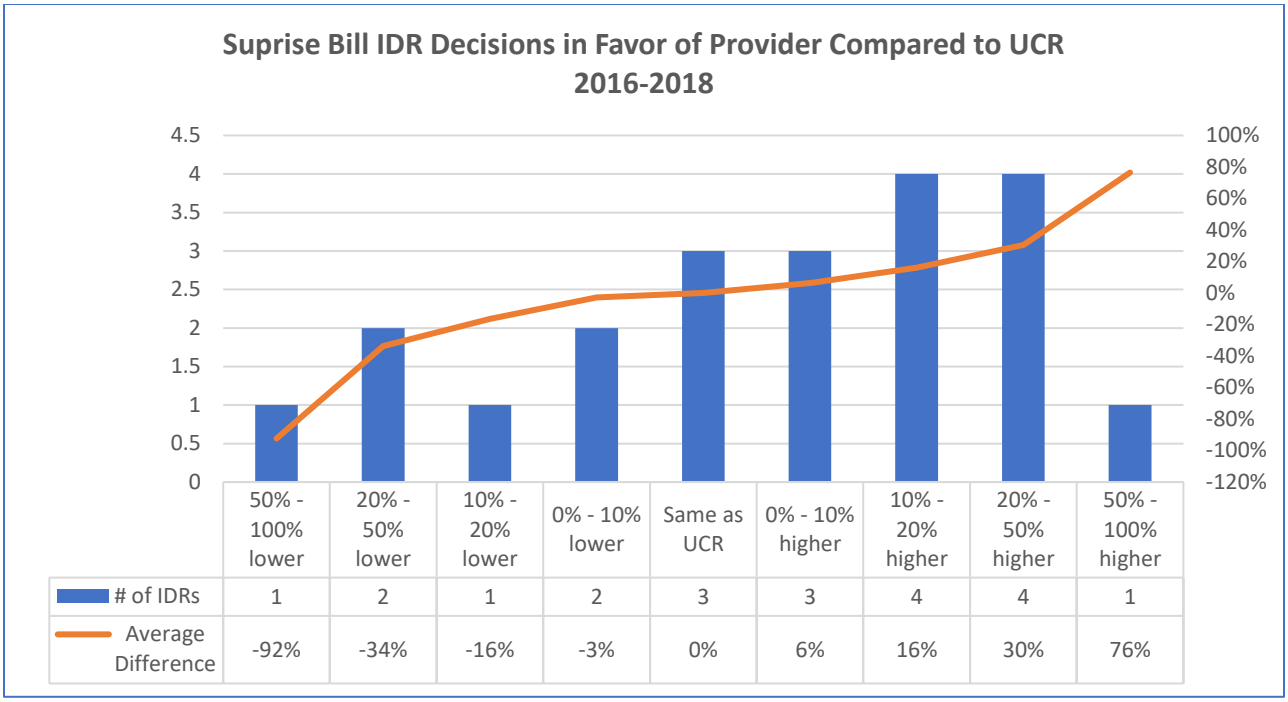


In the sample decisions for IDRs involving emergency services in which the health plan's payment was found to be more reasonable than the provider's charge, those that were 50% to 100% lower than UCR, with an average difference of 71%, and those that were 20% to 50% lower than UCR, with an average difference of 38%, were most prevalent, followed by those that were 0% to 10% higher than UCR, with an average difference of 3%, and those that were the same as UCR. The fewest number of decisions were either 50% to 100% more than UCR or more than 100% higher than UCR. The chart below details the number of emergency services decisions rendered in favor of health plans relative to how close the dollar amounts were to UCR.

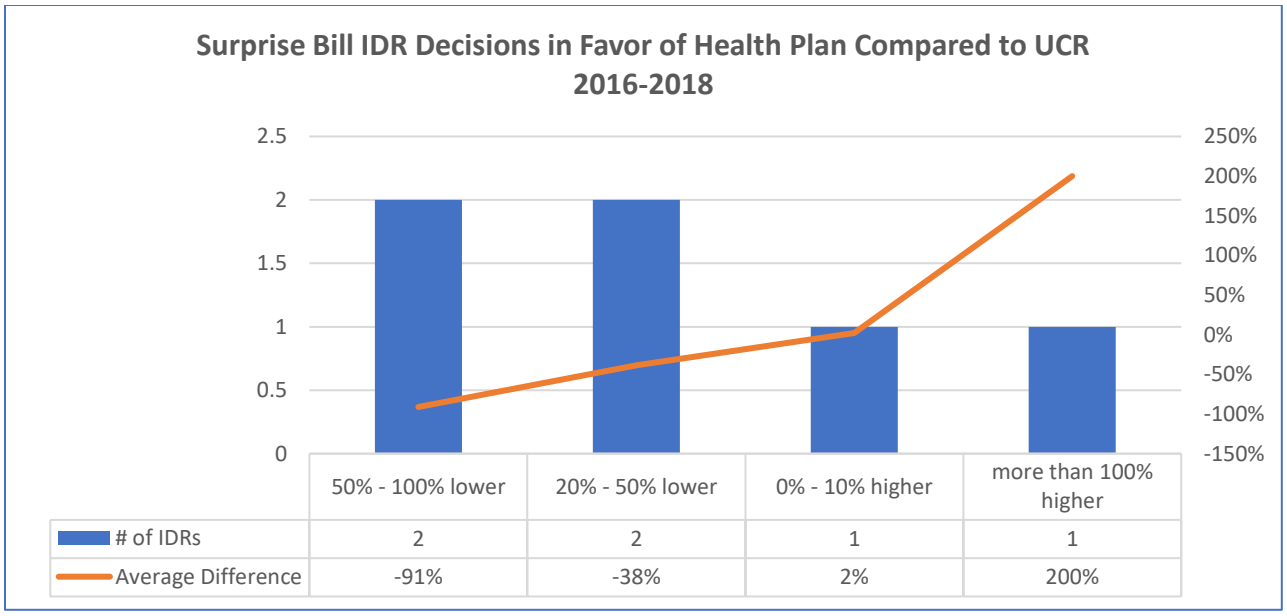


Surprise Bill IDRs Compared to UCR

In the sample decisions for IDRs involving surprise bills in which the provider's charge was found to be more reasonable than the health plan's payment, those that were 10% to 20% higher than UCR, with an average difference of 16%, and those that were 20% to 50% higher than UCR, with an average difference of 30%, were most prevalent, followed by those that were 0% to 10% higher than UCR, with an average difference of 6%, and those that were the same as UCR. The fewest number of decisions were 50% to 100% lower than UCR, 10% to 20% lower than UCR, and 50% to 100% higher than UCR. The chart below details the number of surprise bill decisions rendered in favor of providers relative to how close the dollar amounts were to UCR.



In the sample decisions for IDRs involving surprise bills in which the health plan's payment was found to be more reasonable than the provider's charge, more decisions were 50% to 100% lower than UCR and 20% to 50% lower than UCR than those that were 0% to 10% higher than UCR and those that were more than 100% higher than UCR. The chart below details the number of surprise bill decisions rendered in favor of health plans relative to how close the dollar amounts were to UCR.



NEXT STEPS

DFS convened a workgroup in 2016 to make recommendations on the OON Law. The workgroup found the OON Law to be highly effective in establishing the IDR process and providing consumer protections in relation to IDR for emergency physician services and surprise bills. One of the recommendations discussed by the workgroup was expanding the OON Law to include hospital charges for emergency services in the IDR process. DFS is actively considering this recommendation as a potential enhancement to New York's IDR process.

CONCLUSION

New York's landmark OON Law takes a comprehensive approach to addressing bills for emergency services and surprise bills, and ensures that consumers are held harmless. The OON Law established an IDR process to resolve disputes involving OON emergency physician

services in a hospital, and surprise bills in hospitals and other outpatient settings. Consumers are held harmless for these bills, and providers, health plans, and consumers may submit a dispute to an IDRE. Decisions are rendered in 30 days and they are binding on the parties. Since implementation of the OON Law in 2015, DFS has seen a steady increase in the number of IDRs submitted. As awareness continues to increase around this issue, DFS expects the number of IDRs to continue to increase. New York's OON Law has been a true success in bringing stakeholders together to solve the problem of excessive charges for emergency services and surprise bills.