Protections for New York Consumers: Understanding Your Out-of-Pocket Costs

As of April 2015, state law gives New York consumers extra protections when shopping for health insurance. As a part of the law, insurers need to explain what out-of-network services they cover and how they decide what they will pay for out-of-network care, using the same standard so that you can easily compare different plans. You have access to more information about exactly who is in your network. You also are protected from unexpected "surprise" bills for planned care and for bills for emergency services that are out-of-network.

By law, consumers living in New York State have certain protections when shopping for and using their health insurance. Your insurer must provide up-to-date information about who is in your network. They must explain what they will reimburse for care outside of their network of doctors, hospitals and other providers. They are required to give examples of their reimbursement calculations for common out-of-network services. In these examples, all insurers must use the same standard of "usual and customary cost," which is FAIR Health's 80th percentile benchmark charge for a service, so that consumers can easily estimate their out-of-pocket costs for different plans. Check plan documents to see examples and compare one plan to another.

The law also provides protections for high out-of-network bills for emergency services. If you are insured, you are protected from high bills for out-of-network emergency care for health problems that threaten life or in other ways call for immediate attention. (But, if you have a high deductible plan, there can be bills for in-network services that you are likely to consider "high.") If you are uninsured, you may submit disputes about bills for emergency services to a dispute resolution process established by state law.

Under New York law, you also are protected from unexpected "surprise" bills for planned care if you inquire in advance to find out if all your providers will be in your plan's network. A surprise bill typically happens when you get care from an out-of-network doctor working at an in-network facility. In New York State, if you get a surprise bill for planned care from an out-of-network doctor or facility when you tried beforehand to stay in your plan's network, you have to pay only the amount you would have owed for in-network care.

Suppose you have a life-threatening or degenerative condition, and you need a doctor with a rare specialty, or a hospital that provides special treatment. Your plan's network may not include that provider. In such cases, the law requires plans to let you access necessary providers and pay for those special services on the same basis that you would pay a network provider. For such services, check with your plan to get permission ahead of time.

Here is how the bill protects consumers:

When You Shop for Health Insurance

When you shop for a plan, insurers need to explain their out-of-network rules and give examples of how they calculate reimbursement payments for common out-of-network medical procedures and services. To help you compare costs across plans, the prices in these examples will be comparable to the 80th percentile charge (80th percentile) for each service. The "80th percentile" is a standard that many plans use to decide their "allowable amount." Generally, it means that approximately 80% of charges for a particular procedure in a specific geographic area are equal to that amount or less. FAIR Health's 80th percentile has been recognized as meeting the requirements of the 80th percentile referenced in the new law and may be used to establish these examples.

When insurers use the same charge in their comparative examples, it helps you understand the difference between what you might pay in plans that use the 80th percentile benchmark and those that use a different percentile, or a different standard such as a percentage of Medicare rates. It also will give you an idea of how much you will pay for in-network care versus out-of-network care. If you expect to get care outside your plan's network, you should ask your doctor or hospital how much they will charge. Then, you can use your insurer's example to estimate how much you will need to pay out-of-pocket.

It is important to understand that the 80th percentile charge in these examples is used only to help you compare the financial terms of the plans. By comparing the way, the plan calculates reimbursements with the example of a reimbursement based on the 80th percentile, you measure the differences between plans and between in- and out-of-network care. Plans can determine the maximum price that they will accept, as well as the portion of that price that they will reimburse. Each plan can decide the maximum price they will accept from an out-of-network provider, and how much of that price they will pay. But, if an insurer offers an out-of-network benefit, and that benefit is not based on the 80th percentile, you may request a plan option that covers out-of-network services based on 80% of the 80th percentile. The premium, deductibles and copays for a plan based on the 80th percentile may be higher than the premiums for plans that insurers regularly offer. Insurers are required to offer these 80th percentile plans, if requested, unless they get an exemption from New York State's Superintendent of Insurance. Keep in mind that there are many other costs to consider in a plan, like premiums, copays and deductibles. You will want to think about all of these costs when you are choosing a plan, not just the allowed amount.

When You Get a "Surprise Bill" for Planned Care or a Bill for Emergency Care

Under the law, if you get a "surprise bill" for planned care or a bill for emergency services from an out-of-network doctor, hospital or other facility, you only have to pay the amount you would have owed if the services had been in-network. Your out-of-network provider and insurer must negotiate the rest of the charge with each other. If they cannot agree, either of them can submit the bill to a new dispute resolution process that will determine a reasonable fee.

Surprise Bills for Planned, Non-Emergency Services

For you to be protected by this rule, a "surprise bill" for services planned in advance must be a genuine surprise. This means that before you got care, you checked with your plan and all your providers—including your doctor, hospital and any other facilities, like labs or imaging centers, to make sure they were in your plan's network. You also are protected if a network doctor refers you to an out-of-network doctor without your agreement in writing, or if you are treated by an out-of-network doctor at a hospital but were not told that she or he was outside your network.

Remember, even if you plan carefully and arrange for only in-network doctors and facilities, you still may receive “surprise” bills.

Bills for Emergency Services

To be protected by this rule, you must have been treated for a true medical or behavioral health (mental health) emergency. Treatments that are covered include services for conditions that, without immediate attention, would seriously risk your health (or another person’s health for behavioral health treatment, or your baby’s health if you are pregnant), risk serious damage to your bodily functions, or cause serious disability or disfigurement. If you are uninsured, the law still provides some protection. If your emergency room bills seem too high, you or your doctor may submit them to the state’s new dispute resolution program, and they will decide on a reasonable fee for you to pay.

Planning Medical Care: When You Need to Know Who is in Your Network

What you need to do:

Generally, using providers who are in-network costs you less than using out-of-network providers. Sometimes, even when you would like to use an in-network physician or facility, you may discover that your only option is out-of-network. Under the law, consumers who are careful in planning their healthcare services or have unusual medical conditions (as well as those who need emergency treatment), can have their out-of-pocket costs limited to the amounts they would have paid if the treatment were in-network.

The best way to protect yourself from surprise bills is to plan in advance. Before you get care, check with your plans, your physicians and any medical facilities involved in your care to find out who is in your network. Keep a written record of any phone calls and information that you get from websites.

What your plan and providers need to do:

Under the law, each year plans must provide a list of all the doctors, hospitals and other facilities that belong to their networks. And they must post these lists on their websites. The lists must include doctors’ board certifications, the languages they speak, and the network hospitals where they practice. Any changes to the network must be posted within 15 days of the change.

The law also requires both doctors and hospitals to let you know the networks to which they belong and post the information on their websites. Providers who do not belong to your network must tell you they are out-of-network before they treat you. If you ask, they must give you an estimate of how much they will charge. If you need hospital care, your doctor must tell you about any other physicians, especially anesthesiologists, pathologists and radiologists, who will be involved so that you can find out if they are in your network. Hospitals also must post a list on their websites of all the networks they work with, the hospital physicians who do not participate in those networks, and the standard prices they charge for items and services.

When You Need a Specialist

Plan networks need to include an adequate number of providers in all the specialties that their members will generally need, like cardiology or anesthesiology. But sometimes, you may face a medical condition that is complex, life-threatening or degenerative, like Parkinson’s disease or multiple sclerosis. These conditions may need a doctor with a rare specialty or expertise, or a hospital that provides special treatment. In some cases, your plan’s network may not have a specialist or hospital that provides the care you need or may not have one near you.

In these cases, the new law requires plans to give you the information you need to find these special services and access care the same way you would from a network provider. If possible, you should get your plan's approval before you visit the out-of-network specialist or facility. Generally, you will need your regular doctor's support to have your plan cover these specialized out-of-network services.

There is a process for you to appeal if your request for an out-of-network specialist is denied. You also are able to make an external appeal, outside the insurance company.
Remember: the law protects you if you have checked to make sure that all of your providers—including doctors, hospitals and any other facilities (like labs or imaging centers) were in your plan's network. Don't be afraid to ask questions and get the information you need. You are your own best advocate!