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Late breaking news on medical-legal developments affecting physicians and health care professionals

Emergency Room Physicians Sue the Department of Health & Human Services ("HHS") over Out-of-Network Payments: The American College of Emergency Physicians ("ACEP") recently filed a federal lawsuit against the HHS, claiming a provision of the Affordable Care Act ("ACA") allows insurers to underpay for out-of-network emergency medical services. Under the ACA, insurers must pay the greatest of three costs: the insurers' in-network amount, the Medicare amount or the "usual, customary and reasonable" amount. The usual, customary and reasonable ("UCR") amount is typically the amount physicians charge for care as it is often the greatest of the three payment models. Insurers previously have been accused of manipulating UCR figures to lower their obligation, leaving patients with a greater amount to pay out-of-pocket. Further complicating matters for physicians, some states also require the ER physician to accept the insurers' payment, even if it is far below the doctor's set fee. The lawsuit is seeking to have the federal government overturn and amend this controversial provision. One of the driving forces for this lawsuit is the lack of transparency by insurers. The suit asks that insurers be transparent on the data they're using to pay for services rendered by an out-of-network hospital. Out-of-network reimbursement is a key issue in emergency medicine as emergency room physicians are more likely to treat out-of-network patients because the Emergency Medical Treatment and Labor Act requires them to care for anyone who walks into an emergency room regardless of their ability to pay. Emergency room physicians are worried they have no protection in states that prevent unexpected out-of-network bills, such as New York, which requires insurers and providers that disagree on out-of-network payment to go through an independent dispute-resolution process.

CMS Warns ACA Insurers: No Waiting Periods Can Be Imposed: Health insurers that sell plans with mandated benefits under the Affordable Care Act cannot require plan participants to wait a certain amount of time before they can use those benefits. The ACA prohibits health plans from denying coverage to people based on their age, pre-existing conditions or potential use of medical care. In 2014, the CMS voiced concerns about insurers that imposed waiting periods for specific benefits, saying the practice could "discourage enrollment of or discriminate against individuals with significant health needs" or against people who might need a lot of care in the future. In addition, the CMS further revised the policy to include pediatric dental benefits. Previously, plans sold to individuals could impose a waiting period for children who needed certain dental care but under the revised rule that waiting period is no longer permissible. However, because many insurers have already submitted rates and plan designs to state insurance departments for their 2017 plans, the policy related to pediatric orthodontia won't go into effect into Jan. 1, 2018.

New York Exchange Plan Insurers Request Large Rate Hikes: New York insurers asked for large premium increases as a way to counteract rising costs, and in the case of some insurers, massive losses. Insurers selling plans to individuals requested a 17.3% average increase and those selling small-group plans asked for an average 12% rate hike. New York State of Health is thought to be more stable than other markets nationally, but insurers in NY are still seeing increases in health care spending and costs of providing health insurance. UnitedHealthcare, which has pulled out of insurance marketplaces in many other states after suffering considerable losses, asked for a 45.6% increase to premiums. Though UnitedHealthcare is the largest U.S. insurer, it only signed up 2% of individuals who purchased insurance through New York State of Health last year. Insurers believe there are three main reasons for higher premiums: medical costs have gone up, government programs that helped cover their costs are ending and plan members needed more care than was previously expected. New York's Department of Financial Services can review the rates and force insurers to lower them. Last year, insurers in the state requested a 10.4% increase for individual policies on average, and were allowed to boost rates by about 7.1%. The Department of Financial Service's decision on the current rate hikes is being monitored closely by the insurance industry as the agency was blamed, in part, for the collapse of Health Republic Insurance of New York last year.

For more information on the above items, contact Kern Augustine Conroy & Schoppmann, P.C. at 1-800-445-0954 or via email at info@DrLaw.com.