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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 Jersey Appeals Court Rejects Appeal Challenging Horizon OMNIA Plan Approval: In a published decision, Capital Health System, Inc. v. New Jersey Dept. of Banking and Insurance, No. A-1211-15T3, slip op. (N.J. App. Div. June 7, 2016), the Superior Court of New Jersey, Appellate Division, affirmed the September 18, 2015 final decision of the New Jersey Department of Banking and Insurance ("DOBI") approving Horizon Blue Cross Blue Shield of New Jersey's ("Horizon's) application to establish the OMNIA Health Alliance network ("OMNIA"). A group of ten New Jersey hospitals appealed, challenging DOBI's final decision in approving Horizon's plan as arbitrary and capricious. The hospitals claimed the OMNIA network does not comply with the statutory and regulatory geographic access and availability standards for network adequacy for time and distance, is contrary to the public interest, that DOBI failed to conduct a meaningful analysis of the network, and that the approval was not supported by substantial evidence. The Court held that the applicable statutory and regulatory framework permitted a carrier such as Horizon to set up a tiered benefit network. The Court noted that a government agency such as DOBI is vested with substantial authority to interpret the statutes and regulations which fall within its regulatory scope, and that the courts must, in general, defer to an agency's expertise in analyzing its decisions. The Court held that, despite the hospitals' challenges, DOBI had acted within the scope of its authority in rendering its decision. According to press reports, the hospitals have not decided how they will proceed in light of the Appellate Division's ruling. The next step in the process, should the hospitals decide to pursue it, would be to request the New Jersey Supreme Court to hear the case. There is no appeal as of right to the Supreme Court in this case, so that Court would have to agree to hear the case. However, this case presents an issue of public importance and is of the type the Supreme Court would generally agree to hear.

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