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Considering Going Out of Network in New York? Food For Thought

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As insurance companies continue efforts to reduce reimbursement rates and increase administrative burdens on their participating providers, more and more physicians are considering terminating their in-network contracts with private insurance payors and going out-of-network. If you or your practice are contemplating doing so, here are some issues you may want to consider when making that decision.

As an out-of-network physician, you are not limited in the fees that you can charge by either in-network negotiated rates (although you continue to be subject to the Medicare fee schedule for Medicare patients should you continue to accept Medicare); you are free to charge any rate that you believe is commensurate with your expertise and the quality of services you provide, subject to the regulations of the New York State. Generally, absent a contractual agreement, a physician should charge a reasonable and customary fee for your specialty and geographic area. Keeping in mind, private payors are increasingly attempting to challenge the fees charged by out-of-network physicians. Some insurance companies are notorious for suing physicians, alleging "excessive" billing/"unconscionable" fees.

One of the most common issues that arise in connection with an out-of-network practice is the extent to which an out-of-network physician is required to collect co-payments, co-insurance and deductibles. When dealing with Medicare and Medicaid - a routine waiver of such payments can constitute a violation of the Anti-Kickback Act or the False Claims Act. Although those statutes do not generally apply to patients with private insurance, New York has both criminal and civil statutes prohibiting an outright waiver of a co-payment, co-insurance or deductible payment. That said, a physician/practice may occasionally waive a co-payment or deductible following a determination of financial hardship, but this must be done on a case by case basis. A physician, who, as a general business practice, waives co-insurance, co-payments, or deductibles, may be accused of insurance fraud[1].

An exception to the requirement to balance-bill patients arises when services are rendered by an out-of-network provider to an insured patient seeking emergency treatment at an in-network hospital or facility. The New York's Financial Services Law protects patients from being responsible for "surprise bills". The recent law, limits the patient's responsibility to no greater than their in-network co-payments, co-insurance or deductible obligation, as long as, they went to an in-network hospital or ambulatory surgical center, regardless if the emergency services were rendered by an out-of-network provider.

It may also be inappropriate to balance bill a patient in various non-emergent situations where the bill would be classified as a "surprise bill". Financial Services Law § 603(h) defines a "surprise bill" as a bill for health care services, other than emergency services, received by:

(1) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory

surgical center, where a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician;

(2) an insured for services rendered by a non-participating provider, where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan; or

(3) a patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center, where the patient has not timely received all of the disclosures required pursuant to section twenty-four (24) of the public health law.

Another very common questions that arises is when physicians are considering going out-of-network, is whether some, not all of the physician, at the practice go out-of-network. In that case, there are various additional elements to consider. For starters, the practice needs to review its contracts with insurance companies, as some may require that all physicians at the practice be participating providers. In addition, where some practitioners are out-of-network while others are in-network, treatment of any patient by the out-of-network physician may be considered an out-of-network referral by the group, which would be subject to any limitations or prohibitions in the participation agreement, including notice of the out-of-network status and advice regarding the availability of in-network providers.

Finally, where not all physicians in the group have the same participation status, they generally need to bill for their in-network and out-of-network services under separate billing/tax identification numbers. Depending on the proportions in each category, this may run the risk of the group ceasing to qualify as a "group practice" within the meaning of the Federal Stark law, the Federal Anti-kickback safe harbors, and the New York "mini-Stark" law[2], resulting in practices and transactions which are legal only when conducted within a single group practice. Thereby suddenly becoming subject to rules governing transactions between or among separate group practices. Therefore, it is critical that a thorough legal analysis be conducted before any decision is made to include both in-network and out-of-network providers within a single group.

The decision to go out-of-network is not an easy decision. The anticipated resistance from the insurance industry and recently enacted legislature in New York make the future viability of such a decision all the more difficult to predict. However, with careful planning, legal and financial guidance, it is still possible under the right circumstances for physicians to successfully transition to out-of-network status.

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[1] N.Y. Penal Law § 176.05(2) and N.Y. Ins. Law § 403(c), [2] NYS Public Health Law §238-a.

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