New York State Attorney General Letitia James

Dear New Yorkers:

When you are purchasing or selecting a health plan for yourself, your family or your business, be sure to pay attention to out-of-network benefits. Most private health plans utilize a network of providers who agree to set prices for medical services. However, many of these private health plans also permit members to go outside of the plan's network of providers to seek medical care, at higher out-of-pocket costs to the patient.

Be careful! Read and understand how your insurance covers out-of-network providers; check your provider directory carefully to determine if your provider is in or out of network; and, whenever possible, ask your providers questions to make sure that each medical professional involved with your procedure is in-network.

Making sure you understand how a health plan reimburses out-of-network services BEFORE you purchase or select a health plan can help prevent problems down the road.

Sincerely,

Letitia James

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Resources

Office of the Attorney General
Health Care Bureau
800-428-9071
www.ag.ny.gov

U.S. Department of Health
and Human Services
www.healthcare.gov
Website provides variety of information on health insurance and the health care law.

New York State
Department of Financial Services
dfs.ny.gov
Consumer Hotline: 800-342-3736
Provides information about affordable health insurance and other insurance topics.

FAIR Health
www.fairhealthconsumer.org
A national, independent not-for-profit corporation providing unbiased data and services to health care consumers.

Health Plan Networks:
Avoid Surprise if Caught Outside

NEW YORK STATE OFFICE
of the
ATTORNEY GENERAL
Health Care Bureau

Out-of-Network Charges : Buyer Beware

A health plan contracts with a wide range of providers— including doctors, physical therapists, imaging centers and labs — who agree to accept the plan's "contracted rate" as full payment. These providers are considered to be "in-network."

The contracted rate can include both the insurer's cost as well as the patient's. The patient's cost can come in the form of a co-payment, a deductible or co-insurance.

Out-of-network providers have not agreed to the health plan's rate, and their charges may be higher. The patient is usually responsible for the difference between the provider's fee and the insurance company's reimbursement.

Before you purchase or sign up for a health plan, be sure you understand what your financial responsibility for services will be — in and out of your plan's network.

How Insurance Providers Calculate Your Out-of-Network Reimbursement

How your insurance provider calculates your out-of-network reimbursement is extremely important because it affects your out-of-pocket expenses. Insurance companies generally reimburse claims according to one of the following reimbursement methods:

- Usual and Customary Rate (UCR), is a typical rate for a service in your area.
- Percentage of Medicare is a rate based on the Medicare Fee Schedule. Since Medicare generally pays a lower rate than private plans, insurers often set the reimbursement rate higher than the Medicare rate (for example, 140% of the Medicare Rate).

Usually the reimbursement is greater when your plan uses the UCR method — even when more than 100% of the Medicare rate is used! Here is an example, based on a new patient office visit in New York City.

Estimated Out-of-Pocket Costs: A Comparison

Provider Charge	UCR-Based Reimbursement	Your Cost
$450.00	$315.00	$135.00
Provider Charge	**140% of Medicare**	**Your Cost**
$450.00	$137.31	$312.69

This example was developed using the FH Consumer Cost Lookup website (www.fairhealthconsumer.org). This website can be a valuable tool for estimating reimbursement rates where you live. With just a few clicks, you can compare the out-of-pocket costs for a long list of procedures for both UCR and Percentage of Medicare-based reimbursements.

Avoid Surprise or "Balance" Bills

The best way to save money is to stay in your network for all your health care. Unfortunately, consumers are often surprised by a "balance bill" from a provider they assumed was part of their plan. This frequently happens in emergency care. Providers may have admitting rights at a hospital, but are not employees. Even though the hospital is in-network, not all the providers in the facility are and you may get a bill from a doctor who is out-of-network.

While it is often difficult to avoid charges like these in an emergency, here are some tips for staying in-network for planned treatment:

- When referred to a specialist, check to be sure that provider is in your network; ask your primary care physician for assistance in finding a participating specialist.
- Ask that lab work be sent to an in-network facility.
- If you receive treatment that requires multiple providers, ask the facility for a list of those treating you, and compare this list with your in-network provider list. If possible, request that out-of-network providers be substituted with in-network providers.
- Contact your insurer and ask for assistance in obtaining in-network providers.

Insurance: Participate vs. Accept

When health care providers *participate* in your health insurance, they agree to accept the insurance company's payment, along with your copay. If they *accept* your insurance, it may mean they will interact with the insurance company, but you may be responsible for the difference between what the provider charges and the insurance company pays. Avoid a surprise bill by verifying with both your provider and your insurance company that the provider participates in the network.

Received a Surprise Bill?

Especially when medical care is administered in the emergency room, it can be hard to avoid unexpected balance bills. However, there are a few options to avoid, or at least minimize, some of the costs.

- Contact the provider to find out if you can negotiate a discounted rate.
- Inform the hospital or facility of the provider's charge. In many instances, the hospital administration is not aware of the fees charged by the providers in the emergency room, and may intervene on your behalf to try to get a reduction in a provider's bill.
- Ask your insurance company to reimburse at a higher rate, given the emergency circumstances.

Choosing an Out-of-Network Provider

If your only or best choice is using an out-of-network provider, you can still be informed about the out-of-pocket costs you may face.

- Call your insurance provider to find out how much it will reimburse you for the treatment.
- Use the FH Consumer Cost Lookup website at www.fairhealthconsumer.org to determine common fees for your area and to estimate how much your insurer will reimburse for the service.
- If the provider participates in a different insurance plan, ask if those rates could apply to you. If the out-of-pocket costs seem like more than you can afford, talk to your doctor. Although health care providers are not obligated to agree to lower rates, you may be able to negotiate.

Improper Bill or Denied Coverage?

The Health Care Bureau's toll-free Helpline, 1-800-428-9071, provides information and assistance to thousands of New Yorkers. If you feel that you have been improperly billed, or that your insurance company is improperly denying you coverage, call and let the Health Care Bureau fight for you.