

STATE OF NEW YORK

1793--A

2019-2020 Regular Sessions

IN SENATE

January 16, 2019

Introduced by Sen. RIVERA -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the financial services law, in relation to services rendered by a non-participating provider; to amend the public health law, in relation to hospital statements of rights and responsibilities of patients; to amend the general municipal law, in relation to insurance coverage of ambulance and emergency medical services; to amend the financial services law, in relation to dispute resolution for emergency services; and to amend the financial services law and the insurance law, in relation to assignment of health insurance benefits

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Subsection (h) of section 603 of the financial services
2 law, as added by section 26 of part H of chapter 60 of the laws of 2014,
3 is amended to read as follows:
4 (h) "Surprise bill" means a bill for health care services, other than
5 emergency services, received by:
6 (1) an insured for services rendered by a non-participating physician
7 at a participating hospital or ambulatory surgical center, where a
8 participating physician is unavailable or a non-participating physician
9 renders services without the insured's knowledge, or unforeseen medical
10 services arise at the time the health care services are rendered;
11 provided, however, that a surprise bill shall not mean a bill received
12 for health care services when a participating physician is available and
13 the insured has elected to obtain services from a non-participating
14 physician;
15 (2) an insured for services rendered by a non-participating provider,
16 where the services were referred by a participating physician to a non-
17 participating provider without explicit written consent of the insured

EXPLANATION--Matter in italics (underscored) is new; matter in brackets
[-] is old law to be omitted.

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1 acknowledging that the participating physician is referring the insured
2 to a non-participating provider and that the referral may result in
3 costs not covered by the health care plan; ~~[or]~~

4 (3) an insured for services rendered by a non-participating provider
5 when the insured reasonably relied upon an oral or written statement
6 that the non-participating provider was a participating provider made by
7 a health care plan, or agent or representative of a health care plan, or
8 as specified in the health care plan provider listing or directory, or
9 provider information on the health plan's website;

10 (4) an insured for services rendered by a non-participating provider
11 when the insured reasonably relied upon a statement that the non-parti-
12 cipating provider was a participating provider made by the non-partici-
13 pating provider, or agent or representative of the non-participating
14 provider, or as specified on the non-participating provider's website;
15 or

16 (5) a patient who is not an insured for services rendered by a physi-
17 cian at a hospital or ambulatory surgical center, where the patient has
18 not timely received all of the disclosures required pursuant to section
19 twenty-four of the public health law.

20 § 2. Paragraph (k) of subdivision 1 of section 2803 of the public
21 health law, as added by chapter 241 of the laws of 2016, is amended to
22 read as follows:

23 (k) The statement regarding patient rights and responsibilities,
24 required pursuant to paragraph (g) of this subdivision, shall include
25 provisions informing the patient of his or her right to ~~[choose]~~ be held
26 harmless from certain bills for emergency services and surprise bills,
27 and to submit surprise bills or bills for emergency services to the
28 independent dispute process established in article six of the financial
29 services law, and informing the patient of his or her right to view a
30 list of the hospital's standard charges and the health plans the hospi-
31 tal participates with consistent with section twenty-four of this chap-
32 ter.

33 § 3. Subdivision 2 of section 122-b of the general municipal law, as
34 amended by chapter 303 of the laws of 1980, is amended to read as
35 follows:

36 2. Such municipality shall formulate rules and regulations relating to
37 the use of such apparatus and equipment in the provision of emergency
38 medical services or ambulance service and may fix a schedule of fees or
39 charges to be paid by persons requesting the use of such facilities.
40 Such rules and regulations shall ensure that insured individuals incur
41 no out-of-pocket costs for use of such services and/or facilities,
42 except any applicable co-payment, coinsurance or deductible. Such muni-
43 cipalities may provide for the collection of such fees and charges or
44 may formulate rules and regulations for the collection thereof by the
45 individuals, municipal corporations, associations, or other organiza-
46 tions furnishing service under contract as provided in paragraph (c) of
47 subdivision one of this section.

48 § 4. Subsection (b) of section 603 of the financial services law, as
49 added by section 26 of part H of chapter 60 of the laws of 2014, is
50 amended to read as follows:

51 (b) "Emergency services" means ambulance services as defined in subdi-
52 vision two of section three thousand one of the public health law and,
53 with respect to an emergency condition: (1) a medical screening exam-
54 ination as required under section 1867 of the social security act, 42
55 U.S.C. § 1395dd, which is within the capability of the emergency depart-
56 ment of a hospital, including ancillary services routinely available to

1 the emergency department to evaluate such emergency medical condition;
2 and (2) within the capabilities of the staff and facilities available at
3 the hospital, such further medical examination and treatment as are
4 required under section 1867 of the social security act, 42 U.S.C. §
5 1395dd, to stabilize the patient.

6 § 5. Sections 605, 606 and 608 of the financial services law, as added
7 by section 26 of part H of chapter 60 of the laws of 2014, are amended
8 to read as follows:

9 § 605. Dispute resolution for emergency services. (a) Emergency
10 services for an insured. (1) When a health care plan receives a bill for
11 emergency services from a non-participating physician or ambulance
12 provider, the health care plan shall pay an amount that it determines is
13 reasonable for the emergency services rendered by the non-participating
14 physician or ambulance provider, in accordance with section three thou-
15 sand two hundred twenty-four-a of the insurance law, except for the
16 insured's co-payment, coinsurance or deductible, if any, and shall
17 ensure that the insured shall incur no greater out-of-pocket costs for
18 the emergency services than the insured would have incurred with a
19 participating physician pursuant to subsection (c) of section three
20 thousand two hundred forty-one of the insurance law. If an insured
21 assigns benefits to a non-participating physician or ambulance provider,
22 such payment shall be made directly to the assignee.

23 (2) A non-participating physician or ambulance provider, or a health
24 care plan may submit a dispute regarding a fee or payment for emergency
25 services for review to an independent dispute resolution entity.

26 (3) The independent dispute resolution entity shall make a determi-
27 nation within thirty days of receipt of the dispute for review.

28 (4) In determining a reasonable fee for the services rendered, an
29 independent dispute resolution entity shall select either the health
30 care plan's payment or the non-participating physician's or ambulance
31 provider's fee. The independent dispute resolution entity shall deter-
32 mine which amount to select based upon the conditions and factors set
33 forth in section six hundred four of this article. If an independent
34 dispute resolution entity determines, based on the health care plan's
35 payment and the non-participating physician's or ambulance provider's
36 fee, that a settlement between the health care plan and non-participat-
37 ing physician or ambulance provider is reasonably likely, or that both
38 the health care plan's payment and the non-participating physician's or
39 ambulance provider's fee represent unreasonable extremes, then the inde-
40 pendent dispute resolution entity may direct both parties to attempt a
41 good faith negotiation for settlement. The health care plan and non-par-
42 ticipating physician or ambulance provider may be granted up to ten
43 business days for this negotiation, which shall run concurrently with
44 the thirty day period for dispute resolution.

45 (b) Emergency services for a patient that is not an insured. (1) A
46 patient that is not an insured or the patient's physician or ambulance
47 provider may submit a dispute regarding a fee for emergency services for
48 review to an independent dispute resolution entity upon approval of the
49 superintendent.

50 (2) An independent dispute resolution entity shall determine a reason-
51 able fee for the services based upon the same conditions and factors set
52 forth in section six hundred four of this article.

53 (3) A patient that is not an insured shall not be required to pay the
54 physician's or ambulance provider's fee in order to be eligible to
55 submit the dispute for review to an independent dispute resolution enti-
56 ty.

(c) The determination of an independent dispute resolution entity shall be binding on the health care plan, physician or ambulance provider and patient, and shall be admissible in any court proceeding between the health care plan, physician, ambulance provider or patient, or in any administrative proceeding between this state and the physician or ambulance provider.

§ 606. Hold harmless and assignment of benefits for emergency services and surprise bills for insureds. When an insured assigns benefits for an emergency service or a surprise bill in writing to a non-participating physician or ambulance provider that knows the insured is insured under a health care plan, the non-participating physician or ambulance provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

§ 608. Payment for independent dispute resolution entity. (a) For disputes involving an insured, when the independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician or ambulance provider. When the independent dispute resolution entity determines the non-participating physician's or ambulance provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan. When a good faith negotiation directed by the independent dispute resolution entity pursuant to paragraph four of subsection (a) of section six hundred five of this article, or paragraph six of subsection (a) of section six hundred seven of this article results in a settlement between the health care plan and non-participating physician or ambulance provider, the health care plan and the non-participating physician or ambulance provider shall evenly divide and share the prorated cost for dispute resolution.

(b) For disputes involving a patient that is not an insured, when the independent dispute resolution entity determines the physician's or ambulance provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The superintendent shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship. When the independent dispute resolution entity determines the physician's or ambulance provider's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician.

§ 6. Subsection (c) of section 3241 of the insurance law, as added by section 6 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

(c) (1) When an insured or enrollee under a contract or policy that provides coverage for emergency services receives the services from a health care provider that does not participate in the provider network of an insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter ("health care plan"), the health care plan shall: (A) ensure that the insured or enrollee shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the health care plan's provider

1 network; and (B) provide the insured or enrollee the option of assigning
2 the payment of any benefits due under such contract or policy directly
3 to the health care provider. Whenever, in any health insurance claims
4 form, an insured or enrollee specifically authorizes the payment of
5 benefits directly to a health care provider, the health care provider
6 shall submit claims for benefits to the health care plan and the health
7 care plan shall make payment for any benefits to the health care provid-
8 er.

9 (2) Whenever an insured or enrollee specifically authorizes the
10 payment of benefits directly to a health care provider, the health care
11 provider shall not bill the insured or enrollee for payment of any
12 amount other than any applicable copayment, coinsurance and/or deduct-
13 ible unless the health plan fails to honor an assignment of benefits.

14 (3) The health care provider shall not further bill the insured or
15 enrollee for any remaining balance once the health care plan has made
16 its initial payment for which the insured or enrollee must be held harm-
17 less by the health plan, but shall, with notice to the insured or enrol-
18 lee of the existing balance, resubmit the balance to the health plan. In
19 the event an insured or enrollee mistakenly reimburses a health care
20 provider for emergency services for which the insured or enrollee has
21 assigned payment of benefits pursuant to paragraph one of this
22 subsection, the health care provider shall promptly refund such payment,
23 less any applicable copayment, coinsurance and/or deductible, to the
24 insured or enrollee.

25 For the purpose of this section, "emergency services" shall have the
26 meaning set forth in [~~subparagraph (D) of paragraph nine of subsection~~
27 ~~(i) of section three thousand two hundred sixteen of this article,~~
28 ~~subparagraph (D) of paragraph four of subsection (k) of section three~~
29 ~~thousand two hundred twenty-one of this article, and subparagraph (D) of~~
30 ~~paragraph two of subsection (a) of section four thousand three hundred~~
31 ~~three of this chapter]~~ subsection (b) of section six hundred three of
32 the financial services law.

33 § 7. This act shall take effect immediately.