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:

Section 1. Subsection (h) of section 603 of the financial services law, as added by section 26 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

(h) "Surprise bill" means 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

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

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

(4) an insured for services rendered by a non-participating provider when the insured reasonably relied upon a statement that the non-participating provider was a participating provider made by the non-participating provider, or agent or representative of the non-participating provider, or as specified on the non-participating provider's website; or

(5) 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 of the public health law.

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

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

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

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

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

(b) "Emergency services" means ambulance services as defined in subdivision two of section three thousand one of the public health law and, with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to

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

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

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

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

(3) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's **or ambulance provider's** fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's **or ambulance provider's** fee, that a settlement between the health care plan and non-participating physician **or ambulance provider** is reasonably likely, or that both the health care plan's payment and the non-participating physician's **or ambulance provider's** fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating physician **or ambulance provider** may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty day period for dispute resolution.

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

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

(3) A patient that is not an insured shall not be required to pay the physician's **or ambulance provider's** fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

(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

network; and (B) provide the insured or enrollee the option of assigning the payment of any benefits due under such contract or policy directly to the health care provider. Whenever, in any health insurance claims form, an insured or enrollee specifically authorizes the payment of benefits directly to a health care provider, the health care provider shall submit claims for benefits to the health care plan and the health care plan shall make payment for any benefits to the health care provider.

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

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

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

§ 7. This act shall take effect immediately.