STATE OF NEW YORK

6757

2019-2020 Regular Sessions

IN SENATE

September 30, 2019

Introduced by Sens. RIVERA, KRUEGER, BRESLIN -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

AN ACT to amend the public health law, in relation to standardized consolidated itemized general hospital bills (Part A); to amend the public health law, in relation to regulation of the billing of facility fees (Part B); to amend the public health law, in relation to standardized patient financial liability forms (Part C); to amend the public health law, in relation to an all payer database (Part D); to amend the public health law, in relation to the general hospital indigent care pool; and to repeal certain provisions of such law relating thereto (Part E); to amend the civil practice law and rules, in relation to the commencement of medical debt actions (Part F); and 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 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 health insurance benefits (Part G)

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

Section 1. Short title. This act shall be known and may be cited as the "patient medical debt protection act".

§ 2. This act enacts into law major components of legislation which relate to patient medical debt protection. Each component is wholly contained within a Part identified as Parts A through G. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the

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

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corresponding section of the Part in which it is found. Section four of this act sets forth the general effective date of this act.

PART A

Section 1. The public health law is amended by adding a new section 2827 to read as follows:

§ 2827. Standardized consolidated itemized general hospital bills. 1. After a patient's discharge or release from a general hospital licensed under this article, the facility shall provide to the patient or to the patient's survivor or legal guardian, as appropriate, a consolidated itemized statement or a bill detailing in plain language, comprehensible to an ordinary layperson, the specific nature of charges or expenses incurred by the patient. The consolidated itemized statement, developed by the commissioner in consultation with the superintendent of financial services, shall detail all services provided to the patient during the hospitalization, including all professional services administered. A provider with any financial or contractual relationship with the facility may not separately bill the patient or the patient's survivor or legal guardian. The initial statement or bill shall be provided no more than seven days after the patient's discharge or release, or after a request for such statement or bill, whichever is earlier. The initial statement or bill shall contain a statement of specific services received and expenses incurred by date and provider for such items of service, enumerating in detail the constituent components of the services received within each department of the facility and including unit price data on rates charged by the facility. The statement or bill shall identify each item as paid, assigned to a third party payer, or expected payment by the patient, and shall include the amount due, if applicable. If an amount is due from the patient, a due date for such amount shall be included.

2. Any subsequent statement or bill provided to a patient or to the patient's survivor or legal guardian, as appropriate, relating to the episode of care must include all of the information required by subdivision one of this section, with any clearly delineated revisions.

3. Each consolidated itemized statement or bill provided pursuant to this section shall:

(a) include the services provided by hospital-based physicians and other health care providers who may not bill separately.

(b) not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

(c) list drugs by brand or generic name and not refer to drug code numbers when referring to any drugs.

(d) specifically identify physical, rehabilitative, occupational, or speech therapy treatment by date, type, and length of treatment when such treatment is a part of the statement or bill. Providers of such services shall not produce separate bills.

(e) prominently display the telephone number of the facility's patient liaison responsible for expediting the resolution of any billing dispute between the patient, or the patient's survivor or legal guardian, and the billing department.

4. Each facility shall establish policies and procedures for reviewing and responding to questions from patients concerning such patient's consolidated itemized statement or bill. Such response shall be provided no more than seven business days after the date a question is received. If the patient is not satisfied with the response, the facility shall

provide the patient with the contact information of the agency to which the issue shall be sent for review.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law.

PART B

Section 1. The public health law is amended by adding a new section 2827-a to read as follows:

§ 2827-a. Regulation of the billing of facility fees. 1. For purposes of this section "facility fee" means any fee charged or billed by a hospital under this article other than a residential health care facility, or by a health care professional authorized under title eight of the education law that is: (a) intended to compensate the facility, or health care professional for the operational expenses; and (b) separate and distinct from a professional fee.

2. No hospital licensed under this article other than a residential health care facility or health care professional authorized under title eight of the education law shall bill or seek payment from a patient for a facility fee related to the provision of preventive care service as defined by the United States Preventive Services Task Force.

3. No hospital licensed under this article other than a residential health care facility or health care professional authorized under title eight of the education law shall bill or seek payment from a patient for a facility fee that is not covered by the patient's health insurance carrier.

§ 2. This act shall take effect immediately.

PART C

Section 1. The public health law is amended by adding a new section 2827-b to read as follows:

§ 2827-b. Standardized patient financial liability forms. 1. All hospitals licensed under this article and health care professionals authorized under title eight of the education law shall be required to use the uniform patient financial liability form developed by the commissioner, in consultation with the commissioner of education. The standardized form shall disclose to the patient whether their care is in-network or out-of-network, whether the care is a covered benefit under the patient insurance contract, the exact nature and amount of the patient's projected financial liability and shall specifically indicate the exact amount of personal financial liability to be undertaken by the patient. In no event shall a patient be financially liable for undisclosed bills or any bills related to services provided by a provider who failed to ascertain that he or she was in the patient's health plan network. The commissioner shall develop the uniform financial liability form within six months of the effective date of a chapter of the laws of two thousand nineteen that added this section, and it shall be adopted by all hospitals and health care professionals within thirty days of the issuance of such form by the commissioner.

§ 2. This act shall take effect immediately. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART D

Section 1. Subdivision 18-a of section 206 of the public health law is amended by adding a new paragraph (e) to read as follows:

(e)(i) The commissioner shall ensure that the New York state all payer database shall serve the interests of New York's health care consumers.

(ii) All hospitals licensed under article twenty-eight of this chapter and health care professionals authorized under title eight of the education law shall be required to participate in the all payer database through their insurance carrier contracts, which in no event shall be deemed proprietary information for the purposes of submitting data to the all payer database.

§ 2. This act shall take effect immediately.

PART E

Section 1. Subdivisions 9 and 9-a of section 2807-k of the public health law, subdivision 9 as amended by section 17 of part B of chapter 60 of the laws of 2014, subdivision 9-a as added by section 39-a of part A of chapter 57 of the laws of 2006 and paragraph (k) of subdivision 9-a as added by section 43 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must **only** implement minimum collection policies and procedures [~~**approved**~~] **provided** by the commissioner.

9-a. (a) As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand [~~**seven, establish**~~] **twenty-one, adopt and implement the uniform** financial [~~**aid policies and procedures, in accordance with the provisions of this subdivision**~~] **assistance form policy, to be developed and issued by the commissioner no later than one hundred eighty days after the effective date of a chapter of the laws of two thousand nineteen that amended this subdivision. No later than thirty days of the issuance of the uniform financial assistance form and policy, general hospitals shall implement such form and policy**, for reducing **hospital** charges **and charges for physicians who work in the hospital** otherwise applicable to low-income individuals without health insurance, or who have [~~**exhausted their**~~] health insurance [~~**benefits**~~] **that does not cover or limits coverage of the service**, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts. **Immigration status shall not be an eligibility criterion. General hospitals shall use the New York state of health marketplace eligibility determination page to establish the patient's household income and residency in lieu of the financial application form, provided they have secured the consent of the patient. A general hospital shall not require a patient to apply for coverage through the New York state of health marketplace in order to receive care or financial assistance.**

(b) Such reductions from charges for uninsured patients with incomes below at least [~~**three**~~] **four** hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed [~~**the greater of**~~] the amount that would have been paid for the same services [~~**by the "highest volume payor" for such general hospital as defined in**~~

~~subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services~~] provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

(i) For patients with incomes at or below at least [~~one~~] **two** hundred percent of the federal poverty level, the hospital shall collect no more than a nominal payment amount, consistent with guidelines established by the commissioner;

(ii) For patients with incomes between at least [~~one~~] **two** hundred one percent and [~~one~~] **four** hundred [~~fifty~~] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases from the nominal amount described in subparagraph (i) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the greater of the amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services~~] provided pursuant to title XIX of the federal social security act (medicaid);

(iii) [~~For patients with incomes between at least one hundred fifty-one percent and two hundred fifty percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the twenty percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid); and~~

~~(iv)~~] For patients with incomes [~~between at least two hundred fifty-one percent and three hundred~~] **above four hundred one** percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services~~] provided pursuant to title XIX of the federal social security act (medicaid)[~~.~~]**; and**

[~~(v) For the purposes of this paragraph, "highest volume payor" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.~~

~~(vi) A hospital may implement policies and procedures to permit, but not require, consideration on a case-by-case basis of exceptions to the requirements described in subparagraphs (i) and (ii) of this paragraph~~

~~based upon the existence of significant assets owned by the patient that should be taken into account in determining the appropriate payment amount for that patient's care, provided, however, that such proposed policies and procedures shall be subject to the prior review and approval of the commissioner and, if approved, shall be included in the hospital's financial assistance policy established pursuant to this section, and provided further that, if such approval is granted, the maximum amount that may be collected shall not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid). In the event that a general hospital reviews a patient's assets in determining payment adjustments such policies and procedures shall not consider as assets a patient's primary residence, assets held in a tax-deferred or comparable retirement savings account, college savings accounts, or cars used regularly by a patient or immediate family members.~~

~~(vii)~~] **(iv)** Nothing in this paragraph shall be construed to limit a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified herein and/or to provide greater payment discounts for eligible patients than those required by this paragraph.

(c) [~~Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each~~] **Each** general hospital participating in the pool shall ensure that every patient is made aware of the existence of such [~~policies and procedures~~] **uniform financial assistance form and policy** and is provided, in a timely manner, with a [~~summary~~] **copy** of such [~~policies and procedures~~] **form and policy** upon request. [~~Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general~~] **General** hospitals with twenty-four hour emergency departments, [~~such policies and procedures~~] shall require the notification of patients during the intake and registration process, through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial [~~aid~~] **assistance** may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and through information on bills and statements sent to patients, that financial [~~aid~~] **assistance** may be available to qualified patients and how to obtain further information. [~~Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph~~] **General hospitals shall post the uniform financial assistance application form and policy in a conspicuous location on the general hospital's website. The commissioner shall likewise post the uniform**

financial assistance form and policy on the department's hospital profile page related to the general hospital's or any successor website.

(d) The commissioner shall provide application materials to general hospitals, including the uniform financial assistance application form and policy. These application materials shall include a notice to patients that upon submission of a completed application form, the patient may disregard any bills until the general hospital has rendered a decision on the application in accordance with this paragraph. The application materials shall include specific information as the income levels used to determine eligibility for financial assistance, a description of the primary service area of the hospital and the means to apply for assistance. Such policies and procedures shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the hospital's financial assistance policy. The monthly payment under such a plan shall not exceed [~~ten~~] five percent of the gross monthly income of the patient[~~, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments.~~] The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed the [~~rate for a ninety-day security~~] federal funds rate issued by the United States Department of Treasury[~~, plus .5 percent~~] and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. [~~If such policies and procedures~~] The policy shall not include a requirement of a deposit prior to non-emergent, medically-necessary care[~~, such deposit must be included as part of any financial aid consideration~~]. Such policies and procedures shall be applied consistently to all eligible patients.

(e) Such policies and procedures shall permit patients to apply for assistance within at least [~~ninety~~] two hundred forty days of the date of discharge or date of service and provide at least [~~twenty~~] sixty days for patients to submit a completed application. Such policies and procedures may require that patients seeking payment adjustments provide [~~appropriate~~] the following financial information and documentation in support of their application[~~, provided, however, that such application process shall not be unduly burdensome or complex~~] that are used by the New York state of health marketplace: pay checks or pay stubs; rent receipts; a letter from the patient's employer attesting to the patient's gross income; or, if none of the aforementioned information and documentation are available, a written self-attestation of the patient's income. General hospitals shall, upon request, assist patients in understanding the hospital's policies and procedures and in applying for payment adjustments. [~~Application forms shall be printed~~] The commissioner shall translate the financial assistance application form and policy into the "primary languages" of each general hospital. Each general hospital shall print and post these materials to its website in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency

necessary for effective communication with health care providers, or (ii) spoken by non-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. Such policies and procedures shall require that the hospital issue any denial/approval of such application in writing with information on how to appeal the denial and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. [~~Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first applying for coverage under title XIX of the social security act (medicaid) or another insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another insurance program, and upon the patient's cooperation in following the hospital's financial assistance application requirements, including the provision of information needed to make a determination on the patient's application in accordance with the hospital's financial assistance policy.~~]

(f) Such policies and procedures shall provide that patients with incomes below [~~three~~] **four** hundred percent of the federal poverty level are deemed presumptively eligible for payment adjustments and shall conform to the requirements set forth in paragraph (b) of this subdivision, provided, however, that nothing in this subdivision shall be interpreted as precluding hospitals from extending such payment adjustments to other patients, either generally or on a case-by-case basis. Such [~~policies and procedures~~] **policy** shall provide financial [~~aid~~] **assistance** for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (42 USC 1395dd), to patients who reside in New York state and for medically necessary hospital services for patients who reside in the hospital's primary service area as determined according to criteria established by the commissioner. In developing such criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. Such criteria shall be made available to the public no less than thirty days prior to the date of implementation and shall, at a minimum:

(i) prohibit a hospital from developing or altering its primary service area in a manner designed to avoid medically underserved communities or communities with high percentages of uninsured residents;

(ii) ensure that every geographic area of the state is included in at least one general hospital's primary service area so that eligible patients may access care and financial assistance; and

(iii) require the hospital to notify the commissioner upon making any change to its primary service area, and to include a description of its primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-l of this article.

(g) Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's primary service area. For patients determined to be eligible for financial [~~aid~~] **assistance** under the terms of [~~a hospital's~~] **the uniform** financial [~~aid~~] **assistance** policy, such [~~policies and procedures~~] **policy** shall prohibit any limitations on financial [~~aid~~] **assistance** for

services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

(h) Such policies and procedures shall not permit the **securance of a lien or** forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall require the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial [~~aid, including any required supporting documentation~~] **assistance**, while the hospital determines the patient's eligibility for such [~~aid~~] **assistance**. Such [~~policies and procedures~~] **policy** shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection agency obtain the hospital's written consent prior to commencing a legal action. Such [~~policies and procedures~~] **policy** shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in such [~~policies and procedures~~] **policy**, and require the implementation of a mechanism for the general hospital to measure its compliance with [~~such policies and procedures~~] **the policy**. Such [~~policies and procedures~~] **policy** shall require that any collection agency under contract with a general hospital for the collection of debts follow the [~~hospital's~~] **uniform** financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. Such [~~policies and procedures~~] **policy** shall prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services medicaid payment is available.

(i) Reports required to be submitted to the department by each general hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

(i) a report on hospital costs incurred and uncollected amounts in providing services to [~~eligible~~] patients [~~without insurance~~] **found eligible for financial assistance**, including the amount of care provided for a nominal payment amount, during the period covered by the report;

(ii) hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;

(iii) the number of patients, organized according to United States postal service zip code, who applied for financial assistance pursuant to the [~~hospital's~~] **uniform** financial assistance policy, and the number, organized according to United States postal service zip code, whose applications were approved and whose applications were denied;

(iv) the reimbursement received for indigent care from the pool established pursuant to this section;

(v) the amount of funds that have been expended on [~~charity care~~] **financial assistance** from charitable bequests made or trusts established for the purpose of providing financial assistance to patients who are eligible in accordance with the terms of such bequests or trusts;

(vi) for hospitals located in social services districts in which the district allows hospitals to assist patients with such applications, the number of applications for eligibility under title XIX of the social security act (medicaid) that the hospital assisted patients in completing and the number denied and approved;

(vii) the hospital's financial losses resulting from services provided under medicaid; and

(viii) the number of **referrals to collection agents or outside vendor court cases and** liens placed on [~~the primary~~] **any** residences of patients through the collection process used by a hospital.

(j) [~~Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material which is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility~~] **The commissioner shall include the data collected under paragraph (i) of this subdivision in regular audits of the annual general hospital institutional cost report**.

(k) In the event it is determined by the commissioner that the state will be unable to secure all necessary federal approvals to include, as part of the state's approved state plan under title nineteen of the federal social security act, a requirement[~~, as set forth in paragraph one of this subdivision,~~] that compliance with this subdivision is a condition of participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article, then such condition of participation shall be deemed null and void and, notwithstanding section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for a civil penalty not to exceed ten thousand dollars for each such violation. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

§ 2. Subdivision 14 of section 2807-k of the public health law is REPEALED and subdivisions 15, 16 and 17 are renumbered subdivisions 14, 15 and 16.

§ 3. This act shall take effect immediately.

PART F

Section 1. The civil practice law and rules is amended by adding a new section 213-d to read as follows:

§ 213-d. Actions to be commenced within two years; medical debt. An action on a medical debt by a hospital licensed under article twenty-eight of the public health law or a health care professional authorized under title eight of the education law shall be commenced within two years of treatment and no determination of a debt or award of debt may be based upon a service having occurred more than two years before the action is commenced.

§ 2. Section 5004 of the civil practice law and rules, as amended by chapter 258 of the laws of 1981, is amended to read as follows:

§ 5004. Rate of interest. Interest shall be at the rate of nine per centum per annum, except where otherwise provided by statute**, provided that in medical debt actions by a hospital licensed under article twenty-eight of the public health law or a health care professional authorized under title eight of the education law the interest rate shall be three per centum per annum**.

§ 3. This act shall take effect immediately.

PART G

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 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. Paragraph 1 of subsection (a) of section 605 and sections 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:

(1) When a health care plan receives a bill for emergency services from a non-participating physician, the health care plan shall pay an amount that it determines is reasonable for the emergency services rendered by the non-participating physician, 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.**

§ 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 hospital** that knows the insured is insured under a health care plan, the non-participating physician **or hospital** shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician **or hospital**.

§ 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. When the independent dispute resolution entity determines the non-participating physician'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, the health care plan and the non-participating physician 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 hospital'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 hospital's** fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician **or hospital**.

§ 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) 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 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.

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.

§ 3. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 4. This act shall take effect immediately provided, however, that the applicable effective date of Parts A through G of this act shall be as specifically set forth in the last section of such Parts.