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New York's surprise medical bill law

By Rebecca Simone and Bryan R. Denberg

New York's "Emergency Medical Services and Surprise Bills" law, new legislation included in the 2014–2015 state budget (the "Surprise Bill Law"), is a response to consumer complaints about receiving inadequate reimbursement from their insurers for medical services that they received outside of a provider network.¹ More specifically, it is an act to, among other things, "amend the insurance law, the public health law and the financial services law, in relation to establishing protection to prevent surprise medical bills including network adequacy requirements, claim submission requirements, access to out-of-network care and prohibition of excessive emergency charges." The requirements of the Surprise Bill Law go into effect March 31, 2015 (with limited exceptions).

First and foremost, the Surprise Bill Law provides new protections for consumers from "surprise" bills for emergency medical services. For example, consumers who receive emergency services will not have to pay more than their usual in-network cost sharing and/or copayments, regardless of the network status of the providers. Additionally, consumers who receive other out-of-network medical services when there were no in-network providers available or when they did not receive the disclosures required by this new law can assign their claims to the out-of-network providers and pay only their usual in-network cost-sharing. In both of these situations, the medical bill is negotiated by and between the provider and the health plan.

Disputes between providers and health plans over the fee charged for medical services will go through an independent review process. There is, however, an exemption from the resolution process for emergency services resulting in bills less than \$600 (indexed for inflation for years after 2014).

The Surprise Bill Law also imposes new "network adequacy rules." Health plans that are based on comprehensive provider networks (including preferred provider organizations (PPOs) and exclusive provider organization plans (EPOs)) are required to be certified as having provider networks that can meet the health needs of their members without having to rely on more expensive out-of-network services. Prior to the Surprise Bill Law, these network adequacy rules

¹ The Surprise Bill Law can be found in Part H of Chapter 60 of the Laws of New York (2014).

only applied to health maintenance organizations (HMOs) and other “managed care” plans. Also, if a plan’s network does not have a geographically accessible provider with appropriate expertise to treat a patient’s medical problem, patients in all plans can seek services from out-of-network providers without incurring an additional out-of-network expense. Additionally, consumers with life-threatening or seriously disabling or degenerative conditions in all health plans will have the right (where medically appropriate) to have specialists serve as their primary care doctors. If consumers and health plans disagree on whether there is “inadequate” provider expertise to meet a patient’s medical needs within the existing provider network, they can take the dispute to New York State’s external review system.

Another notable provision of the Surprise Bill Law is that the state of New York has the option to require group insurers that have not offered out-of-network coverage to offer it in regions where it has not previously been available.

Furthermore, health plans now face new disclosure requirements relating to out-of-pocket expenses. Some examples of the new disclosures required include:

- When authorization is sought for particular services, insurance companies must tell their members whether those providers are in-network, how much they will reimburse, and how that compares to the usual, customary, and reasonable (“UCR”) fee.
- If a health insurance company allows its patients to access out-of-network services, those companies must give the patient examples of how much they will pay for common medical procedures out-of-network and how those amounts compare to typical charges.

Providers also face new disclosure requirements, including:

- Prior to providing non-emergency services, providers must disclose to patients their right to know what will be billed for the procedure and, if the patient requests, they must disclose the anticipated cost, warning patients that costs could go up if unanticipated complications occur.
- Providers must provide patients with their network and hospital affiliations in writing or online.
- When patients make appointments, providers must indicate whether they participate in a patient’s network.
- If other professionals will be involved in a patient’s care, the patient must be advised of who it might include and how to learn how much the network will cover for those doctors.

Moreover, hospitals must provide additional information to patients as well. For example, hospitals must:

- publicly post a schedule of charges for various services on their website;
- list the health plans in which they participate;
- warn patients that physician services may not be covered by hospital bills and tell them how to check with physicians regarding their network affiliations;
- post the names of practice groups for such services as radiology, anesthesiology, and pathology with which the hospital has a contract, along with information on how

- consumers can determine the network affiliations of those groups; and
- post information, including network affiliations, of doctors who are hospital employees (and give this information directly to patients when they register or are admitted for care).

Lastly, the Surprise Bill Law sets up an “out-of-network reimbursement rate working group” that is appointed by the governor and will include health plan, physician, and consumer members. The working group is charged with the responsibility of studying and making recommendations for changes in the rules regarding the availability of out-of-network coverage and the level of reimbursement for out-of-network services. This workgroup will issue a report by January 1, 2016.

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