

## New York's "Emergency Medical Services and Surprise Bills" Law

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Earlier this year, the New York Legislature enacted, and Governor Cuomo signed, legislation<sup>1</sup> that will impact billing and reimbursement for some out-of-network health care services, require new disclosures from providers regarding their plan participation status, and add new rules for health plans regarding networks and reimbursement for out-of-network services. Given that the implementation date for this law is April 1, 2015, it is critical for providers and health plans to create an action plan to ensure compliance with the requirements of this law.

Some of the key features and responsibilities of the respective stakeholders per the new law are summarized below.

### A. DISCLOSURE REQUIREMENTS

#### 1. For Professionals, Group Practices, Diagnostic and Treatment Centers, and Health Centers

Pursuant to the law, the following information must be disclosed by professionals, group practices, diagnostic and treatment centers, and health centers<sup>2</sup> to patients or prospective patients:

- The names of the health plans with which such provider participates (this information must be disclosed either in writing or via the provider's website);

<sup>1</sup> The legislation, entitled the "Emergency Medical Services and Surprise Bills" law, amends the New York Insurance Law, Public Health Law, and Financial Services Law, and is available at [http://assembly.state.ny.us/leg/?default\\_fld=&bn=A09205&Summary=Y&Text=Y](http://assembly.state.ny.us/leg/?default_fld=&bn=A09205&Summary=Y&Text=Y).

<sup>2</sup> "Health center" is defined under 42 U.S.C. Section 254(b) and includes federally qualified health centers.

- The names of the hospitals with which such provider is affiliated (this information must be disclosed either in writing or via the provider's website and verbally when an appointment is made);
- That the amount or estimated amount for the service is available upon request (this information must be disclosed before the provision of non-emergency services); and
- Upon receipt of a request, the amount or estimated amount that will be billed—or the fee schedule if a health center—absent unforeseen medical circumstances (this information must be disclosed in writing).

The following information must also be disclosed by *physicians*:

- To patients or prospective patients—the name, practice name, address, and phone number of any provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.
- To both patients scheduled for hospital admission or outpatient hospital service and the hospital—the name, practice name, address, and phone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration, or admission at the time that the non-emergency services are scheduled, and information as to how to determine the plans in which the physician participates.

## 2. For Hospitals

The law requires that a hospital post on its *website*:

- A list of the hospital's standard charges for items and services provided by the hospital, including diagnosis-related groups ("DRGs"); and
- The health care plans with which the hospital is a participating provider, and it must specifically state the following:
  - that the physician services provided in the hospital may not be included in the hospital's charges;
  - that physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital;
  - that the prospective patient should check with the physician arranging for the hospital service to determine the health care plans with which the physician participates;

- as applicable, the names, mailing address, and phone numbers of practice groups that the hospital has contracted with, including radiology, anesthesiology, and pathology services, and information on how to determine the health care plans in which they participate; and
- as applicable, the names, mailing address, and phone numbers of physicians employed by the hospital and whose services may be provided at the hospital, and the health care plans in which they participate.

Hospitals will also need to include in *registration or admission materials* in advance of non-emergency services:

- Advice that the patient should check with his or her physician arranging such hospital service to determine the (1) name, practice name, address, and phone number of any physicians whose services will be arranged by such physician; and (2) whether the services of physicians employed or contracted by the hospital to provide anesthesiology, pathology, and/or radiology are reasonably anticipated to be provided to patient; and
- Information as to how to timely determine the health care plans participated in by all such physicians, as determined by the physician arranging the hospital service.

### 3. For HMOs and Insurers

The new law requires health maintenance organizations (“HMOs”) and insurers to make certain disclosures relating to out-of-network reimbursement, where applicable. Some examples of these required disclosures include:

- Putting information on their *website* that reasonably allows an insured to determine the anticipated out-of-pocket cost for an out-of-network health care service based on the difference between the amount that they will reimburse for the out-of-network health care service and the “usual and customary cost”<sup>3</sup> for such out-of-network health care service; and
- *Upon request* of an insured or prospective insured, disclosing the approximate dollar amount that the insurer will pay for an out-of-network service and that such approximation is not binding and may change.

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<sup>3</sup> “Usual and customary cost” is defined as the 80<sup>th</sup> percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of the Department of Financial Services.

HMOs and insurers must also update network *directories* on their website within 15 days of an addition or termination of a provider or a change in a physician's hospital affiliation.

## **B. BILLING AND REIMBURSEMENT FOR OUT-OF-NETWORK SERVICES**

Although traditionally HMOs<sup>4</sup> in New York State have been required by law to offer adequate networks and to hold their members harmless for certain out-of-network services, most preferred provider organizations (“PPOs”) and exclusive provider organizations (“EPOs”) have not had to comply with similar requirements. This law changes that by adding comparable standards and protections for members in PPOs and EPOs.<sup>5</sup> The law also attempts to stem the recent tide of decreasing reimbursement for out-of-network coverage by requiring HMOs and insurers to make, for those products that offer out-of-network coverage, at least one option available for out-of-network coverage at 80 percent of its usual and customary cost, as defined in the law,<sup>6</sup> which is typically a higher reimbursement amount than many products offered today. In addition, the law adds new rules protecting patients from surprise bills related to non-emergency services and includes protections for certain emergency services.

### **1. Surprise Bills for Non-Emergency Services**

Under this law, providers and health plans have new rules regarding billing and reimbursement for out-of-network services if such billing constitutes a “surprise bill.”<sup>7</sup> “Surprise bills” do not include emergency services and can be summarized into the following three categories:<sup>8</sup>

<sup>4</sup> These include commercial and Medicaid but not Medicare Advantage.

<sup>5</sup> See, e.g., Section 3241 of the Insurance Law. Note the new law will not impact services provided to members in self-insured plans.

<sup>6</sup> See footnote 3 for the definition “usual and customary cost.” Note that the superintendent may also require HMOs and insurers to make such an out-of-network option available for products that do not offer out-of-network coverage.

<sup>7</sup> In its March 7, 2012, report entitled “An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers,” which studied the issues related to surprise bills, the New York State Department of Financial Services noted that it “recognizes that there are competing interests in crafting solutions to [problems associated with surprise billing]. New rules aimed at addressing these issues should recognize the right of providers to remain out-of-network, and should avoid placing undue burdens that could interfere with patient care or deter specialists from providing emergency care or other needed services. Nonetheless, there is room for improvement. . . .”

<sup>8</sup> A “surprise bill” under the new law is defined as:

a bill for health care services, other than an 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 healthcare 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

<b><i>A bill for non-emergency services is a “surprise bill” if:</i></b>			
<b><i>The service is provided by a ...</i></b>	<b><i>To:</i></b>	<b><i>Where:</i></b>	<b><i>And:</i></b>
A non-participating physician	An insured patient	At an in-network hospital or ambulatory surgery center	1. The participating physician is unavailable; or 2. The service was rendered without the patient’s knowledge; or 3. Unforeseen medical services arose at the time that the health care services were rendered
A non-participating provider <sup>9</sup>	An insured patient	Anywhere	The patient was referred by a participating physician without the patient’s explicit written consent that the referral was to a non-participating provider and that it may result in costs not being covered by the patient’s plan
A physician	An uninsured patient	At any hospital or ambulatory surgery center	The patient has not timely received all disclosures required from providers under Section 24 of the Public Health Law

The new rules on billing and reimbursement for all surprise bills can be summarized as follows:

- Physicians that accept an assignment of benefits from a patient and knows that the patient is insured may not bill that patient for more than the amount that the patient would have paid if the service was provided in-network (e.g., copay or coinsurance and applicable deductible).

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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) 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.

Section 603(h) of the New York Financial Services Law.

<sup>9</sup> The law uses the word “provider” for this category (see preceding footnote), but it is unclear from other references in the law whether this was intended to mean only “physician.” For purposes of the analysis in this Client Alert, the assumption is that “physician” was intended.

- Physicians may bill an insured patient if no assignment of benefits was made, but the patient may take the bill to binding dispute resolution before owing any amount.
- Physicians may bill an uninsured patient, but the patient may take the bill to binding dispute resolution before owing any amount.

The dispute resolution process for surprise bills works as follows:

- i. For out-of-network physician services that include an assignment of benefits from an insured, the health plan must pay the physician the billed amount or attempt to negotiate a different amount. If the latter fails to resolve any payment dispute, the plan must pay an amount that the plan determines is reasonable and either party may submit the dispute to an independent dispute resolution entity (provided, however, that, if the plan wants to submit the dispute, it must first pay pursuant to the prior sentence).
- ii. For out-of-network physician services provided to an insured that do not include an assignment of benefits, or provided to an uninsured patient, such patient may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity (and the patient does not need to pay the bill before disputing).
- iii. The independent dispute resolution entity will make a binding decision within 30 days and:
  - in the first scenario above, select either the plan's payment or the physician's fee (taking certain factors into account); and
  - in the second scenario above, determine a reasonable fee (taking certain factors into account).

## 2. Emergency Services

There are also new rules on billing and reimbursement for certain emergency services provided by *physicians* who are non-participating providers with a particular health plan. Specifically:

- For emergency services provided to an insured by a non-participating physician who bills the health plan, the plan must pay a reasonable amount and ensure that the insured will incur no greater out-of-pocket costs for the services than he or she would have incurred if the physician were participating. The physician or plan may submit a dispute to an independent dispute resolution entity, which must then make a binding determination within 30 days and select either the plan's payment or the physician's fee; and

- For emergency services that are provided to an uninsured by a physician, such uninsured person may submit a dispute regarding a fee to an independent dispute resolution entity upon approval of the superintendent of the Department of Financial Services. The patient need not pay the physician's fee in order to be eligible to submit the dispute for such review. The independent dispute resolution entity will then make a binding determination of a reasonable fee for the service.

### 3. Miscellaneous Billing Issues

When billing for out-of-network services (other than for copay, coinsurance, or deductible), all physicians must provide patients with claim forms for patients to use with third-party payers.

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*This Client Alert was authored by **Jackie Selby**. For additional information about the New York law governing emergency medical services and surprise bills, or for assistance in ensuring that your organization is in compliance with this law, please contact the author or the Epstein Becker Green attorney who regularly handles your legal matters.*

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