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New York's Surprise Medical Bill Law: three things health care providers need to know before March 31

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As summarized in a prior client alert, New York's Emergency Services and Surprise Bills law (the "Surprise Medical Bill Law"), set to go into effect on March 31, 2015, is largely intended to provide consumer protections from medical bills received from out-of-network physicians for services rendered in a hospital emergency room. The law also applies to medical bills received from out-of-network physicians and other health care providers for services rendered outside an emergency room in those cases where, for example, a patient has been referred to an out-of-network provider by an in-network physician, absent required disclosures and consents. The Department of Financial Services issued proposed regulations on December 31, 2014,[1] which primarily focus on the qualifications and processes of the Independent Dispute Resolution Entity (the "IDRE") that will handle disputes among health plans, providers and patients regarding reimbursement for "surprise bills" and bills for emergency room services submitted by out-of-network physicians. Additionally, the proposed regulations clarify that the law, in certain circumstances, applies to services rendered by non-physician health care providers like physical therapists and laboratories and defines essential terms of the law that were previously unclear, such as what constitutes a referral to a non-participating referred health care provider.

The Surprise Medical Bill Law is complex and every health care provider should take the time to consider how it will impact their specific practice and policies (especially for health care providers that do not participate in many, or any, health insurance plans). The three key aspects of the law are summarized below:

- **Patients are only responsible for in-network cost-sharing responsibilities in the emergency room.** After March 31, insured patients will only be financially responsible for their in-network cost-sharing responsibilities (i.e., copayments and deductibles) for services rendered in the emergency room, regardless of whether those services were provided by in-network or out-of-network physicians. Physicians must submit their bills directly to the

[1] The new section of proposed regulation is 23 NYCRR 200. Full text of the proposed regulations can be found here.

patient's health plan and negotiate reimbursement. Disputes regarding reimbursement may be submitted to the IDRE.

- **Patient disclosures and increased transparency.** Once in effect, the law requires health care providers to disclose information to patients such as: which health plans a provider participates with, the provider's hospital affiliations, anticipated charges, and the names and contact information of any other professionals that may be involved in the patient's care and from whom the patient may receive a bill for services (such as anesthesiologists or pathologists) so that the patient may learn of those providers' network status. Hospitals must also post information for patients, such as a list of charges and the health plans that the hospital and its physician-employees participate in. Under the proposed regulations, health plans must also disclose information to its insureds on "surprise bills" and the independent dispute resolution process.
- **Failure to provide required patient disclosures and obtain consents will result in "Surprise Bills" and limitations on charges to patient.** Outside the emergency room setting, insured patients must receive disclosures as to a health care provider's participation status with the patients' health plan and must explicitly consent to referrals to out-of-network providers. The proposed regulations clarify that, in this context, "providers" include non-physician professionals and entities such as physical therapists, laboratories and home care agencies. The proposed regulations also clarify that for these purposes "referrals" include 1) services performed by non-participating providers in the participating physician's office or practice during the course of the same visit, 2) a specimen that is taken from a patient in the participating physician's office and sent to a non-participating laboratory or pathologist, or 3) any services performed by a non-participating health care provider when referrals are required under the insured's contract. Failure to provide such disclosures and obtain such consents will result in a bill presented by such providers to constitute a "surprise bill" and in turn the patient will only be responsible for the in-network cost-sharing responsibility. Such providers will be required to negotiate payment directly with the patient's health plan and any disputes will be subject to the IDRE process.

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