

# Guide to New York's out-of-network consumer protection law

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New York's groundbreaking Out-of-Network Consumer Protection Law, which took effect Mar. 31, 2015, protects New Yorkers from financial exposure from surprise bills and emergency services. It requires hospitals, clinics and other practitioners to post information relating to plan participation and fees, and it mandates that managed care organizations and other network plans disclose details of their networks and out-of-network payment policies.

The law applies to all New York state-regulated insurance products, including health maintenance organizations, preferred provider organizations, exclusive provider organizations, municipal health benefit plans, student health plans and Medicaid managed care plans. The law does not apply to Medicaid fee-for-service, Employee Retirement Income Security Act preempted, Medicare Advantage, Medicare fee-for-service and self-insured health plans.

## Highlights:

- extends access to an out-of-network provider when one is not available in-network;
- holds patients harmless for emergency services and “surprise bills” (protects them from “balance bills”);
- requires disclosures be made to patients by hospitals, health plans, physicians and healthcare professionals;
- has a dispute resolution process for surprise bills and emergency services;
- extends network adequacy requirements to all comprehensive health plans;
- contains out-of-network coverage requirements;
- defines usual and customary cost as the 80th percentile of all charges for a particular specialty provided in the same geographic area, according to FAIR Health, an independent database;
- establishes an appeals process for out-of-network referral denials; and
- expands patient appeal rights.

## Emergency services:

- consumers with New York state-regulated insurance coverage are held harmless by their health plan for out-of-network emergency services bills – this means consumers are only responsible for the in-network copayment, coinsurance or deductible and are not responsible for any balance bills; and
- uninsured consumers and those with employer or union self-insured coverage may file a dispute for an emergency services bill from a physician.

## **Independent dispute resolution process for those with NYS-regulated insurance coverage:**

1. The consumer signs an assignment of benefit form to permit the physician to seek payment from the health plan.
2. The plan pays the physician the billed amount or negotiates a reimbursement amount.
3. If negotiation is unsuccessful, the plan must pay an amount it determines is reasonable.
4. At that point, if a disagreement remains, either the plan or the physician can submit the dispute to the independent dispute resolution entity, which makes a determination within 30 days.
5. The IDRE will select either the plan's payment or the physician fee, or direct both parties to attempt a good faith negotiation.

## **Independent dispute resolution process for uninsured consumers, insured consumers who did not assign benefits for a surprise bill and consumers with employer or union self-insured coverage:**

1. The consumer can submit the surprise bill to the IDRE.
2. The consumer is not required to pay the physician's fee to submit the bill for review.
3. The IDRE will determine a reasonable fee for services.
4. The physician pays the cost of the dispute resolution when the IDRE determines that the doctor's fee is not reasonable.
5. The consumer pays the cost of the dispute resolution when the IDRE determines that the physician's fee is reasonable, unless it would pose a hardship to the consumer. "Hardship" means a household income below 250% of the Federal Poverty Level.

## **Disclosure requirements for hospitals:**

- standard charges for items and services, including Diagnosis-Related Groups;
- a list of participating health plans;
- notification that physician services are separate from hospital charges and that physicians may not be in-network; and
- information regarding physician plan participation and appropriate contact information.

## **For non-emergency hospital services, the hospital must:**

- advise the patient to check with the arranging physician to determine the network status of any physicians who will be reasonably anticipated for the planned services; and
- provide patients with information on how to determine physician plan participation.