LEGAL PROTECTIONS AGAINST SURPRISE MEDICAL BILLS IN NEW YORK

I. Surprise Medical Bills and Emergency Services: Protections under the No Surprises Act (Federal) and the Surprise Bill Law (NYS)

The No Surprises Act (NSA) went into effect nationwide on January 1, 2022, to protect patients from receiving **unexpected medical bills for emergency services or surprise bills from out-of-network providers**. It supplements New York's protections that were already in effect under the Surprise Bill Law. Generally, New Yorkers who are fully insured under a NYS-regulated health plan will continue to be governed by NY's Surprise Bill Law (with some modifications and exceptions.) If you are not in that category, possibly because you have 'self-funded 'insurance or are not insured, you will have protections under the NSA.

What is Balance Billing?

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, **if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30**. Many surprise bills were the result of balance billing by out-of-network providers. The NSA law and NY's Surprise Bill law prohibit or limit the use of balance billing by out-of-network providers.

Patients in New York are protected from surprise bills when they:

- are treated by an out-of-network provider at a participating hospital or ambulatory surgical center (ASC) in their health plan's network;
- have health insurance coverage provided by an insurer or HMO and a participating doctor refers them to a non-participating provider;
- receive emergency services in hospitals, including inpatient care following emergency room treatment.

What you need to know about these important protections if:

1. You have full health insurance coverage with an HMO or insurer that is regulated by New York law,
2. Your employer or union provides self-funded (or 'self-paying) coverage that is not subject to New York law, or
3. You are uninsured.

Which of the following options would apply to you will depend on the type of health insurance you have and the start date of the plan that was in effect when you received the service. There are also options if you are uninsured.

II. Surprise Bills – Legal Protections:

1. If you have full health insurance under NY law

[Your health insurance ID card may say 'fully insured']

Surprise bills happen when an out-of-network provider treats you at an in-network hospital or ambulatory surgical center OR you are referred by an in-network doctor to an out-of-network provider. (In-network means in your health plan's network.)

Result: You only have to pay your in-network cost-sharing for a surprise bill.

What is a 'surprise bill'?

(a) It is a surprise bill at an in-network hospital or ambulatory surgical center (ASC) if an out-of-network provider treats you and:

- An in-network provider was not available, OR
- An out-of-network provider provided services without your knowledge, OR
- Unforeseen medical services were provided when you received health care services.

It is NOT a surprise bill if you chose to receive services from an out-of-network provider instead of from an available in-network provider before you got to the hospital or ASC.

Under NY's Surprise Bills Act, since January 1, 2022, the following services are usually considered a surprise bill when provided by an out-of-network provider in a hospital or ASC:

- emergency medicine,
- anesthesia,
- pathology,
- radiology,
- laboratory,
- neonatology,
- assistant surgeon,
- hospitalist, or
- critical care services.

If your health care services were provided before January 1, 2022, you are only protected from a surprise bill if you were treated at an in-network hospital or ambulatory surgical center by an out-of-network physician. Other types of health care providers were not covered by the law at that time.

(b) It is a surprise bill when your in-network doctor refers you to an out-of-network provider if:

- You did not sign a written consent that you knew the services were out-of-network and would not be covered by your health plan; AND
- During a visit with your participating doctor, a non-participating provider treats you; OR
- Your in-network doctor takes a specimen from you in the office (for example, blood) and sends it to an out-of-network laboratory or pathologist; OR
- For any other health care services when referrals are required under your plan.

(c) If you get a surprise bill because an out-of-network provider treats you at an in-network hospital or ambulatory surgical center - OR your doctor refers you to an out-of-network provider:

- You only have to pay your in-network cost-sharing.
- If an out-of-network provider bills you for any amount over your in-network cost-sharing (copayment, coinsurance, or deductible) this is called **balance-billing**.
- If your doctor referred you to an out-of-network provider, you MUST send a Surprise Bill Certification Form to your health plan and your provider to make sure that they know you received a Surprise Bill and that you must be protected from balance billing.
- If an out-of-network provider treats you at an in-network hospital or ambulatory surgical facility, you MUST send a Surprise Bill Certification Form to your health plan and your provider if you received the health care services before January 1, 2022 to make sure that they know you received a Surprise Bill and that you must be protected from balance billing. The form is not required for services provided after January 1, 2022 at an in-network hospital or ambulatory surgical facility, but it is recommended.
- You may also file a complaint with DFS.

2. If you have 'self-paying' coverage through your employer or union

[Your health insurance ID card says 'self-funded' or does not say 'fully insured']

(a) If your employer or union self-funds your coverage for plans issued or renewed on and after January 1, 2022, the federal No Surprises Act (NSA) protections against surprise bills from an out-of-network provider in an in-network hospital or ambulatory surgical center (ASC), will apply.

Result: You are only responsible for paying your in-network cost-sharing (copayment, coinsurance, or deductible) for a surprise bill.

For more information about the Federal consumer protections, visit the CMS No Surprises Act website.

(b) For plans issued or renewed before January 1, 2022, you may qualify for an **independent dispute resolution (IDR)** process through New York State by submitting an IDR application to dispute the bill. To be eligible:

- services must have been provided by a doctor at a hospital or ASC; and
- you were not given all the required information about your care.

See Information Your Doctor and Other Health Care Professionals Must Give You and Information Your Hospital Must Give You for a list of the information that must be provided to you.

To apply for IDR: Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

3. If you are uninsured

['Good Faith Estimate' for Uninsured or Self-Pay Patients]

(a) If you are uninsured, or you are insured but you don't plan to file a claim with your health plan, health care providers must give you a **good faith estimate** of what their expected charges will be before you get health care services.

Providers must give you the good faith estimate:

- For services scheduled at least 3 business days ahead of time, within 1 business day of scheduling the service; or
- For services scheduled at least 10 business days ahead of time, within 3 business days of scheduling the service; or
- When you ask for the good faith estimate, within 3 business days of you asking for the estimate.

The good faith estimate will include:

- A description of the service you will be getting;
- A list of other services that are reasonably expected to be provided with the service you are getting;
- The diagnosis and expected service codes; and
- The expected charges for the services.

For more information about good faith estimates, visit the CMS No Surprises Act website.

The Dispute Resolution Process for 'Good Faith Estimates'

[There are two types of dispute process: 'Patient-Provider' and 'Independent']

(1) Patient-Provider Dispute Resolution Process

- If you are billed for an amount that is **at least $400** more than the amount on the good faith estimate you got from your health care provider, you (or your authorized representative) may dispute the charges in the patient-provider dispute resolution process. There is a **$25 fee**.
- You must ask for the review **within 120 days** of getting the bill.
- An independent reviewer will look at the good faith estimate, the bill, and information from the provider to decide the amount, if any, that you have to pay for each service.

For more information about the patient-provider dispute resolution process, visit the CMS No Surprises Act website.

(2) Independent Dispute Resolution (IDR)

If your provider does not give you a good faith estimate and you feel the charge is unreasonable, you may qualify for an independent dispute resolution (IDR) through New York State by submitting an IDR application to dispute the bill.

The federal NSA law and NY's Surprise Bill law both cover IDR billing disputes for (1) emergency services (and certain in-patient visits following an emergency doctor visit) and (2) surprise bills from all out-of-network health care providers.

To be eligible for IDR:

- services must be provided by a health care provider at a participating hospital or ambulatory surgical center, and/or
- you were not given all the required information about your care.

See Information Your Doctor and Other Health Care Professionals Must Give You and Information Your Hospital Must Give You for a list of the information that must be provided to you.

To apply for IDR: Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

III. Emergency Services – Legal Protections

1. If you have full health insurance under NY law

[Your health insurance ID card says 'fully insured']

The NY Surprise Bill Law does not permit balance billing for emergency services, and patients cannot waive (voluntarily give up) their balance billing protections. (The NSA does allow patients to waive those rights in certain situations.)

- Your provider may only bill you for your in-network cost-sharing (copayment, coinsurance, or deductible) for emergency services, including inpatient services if you are admitted to the hospital after your emergency room visit.
- This includes bills from all medical providers and the hospital(s) that treat you. (For emergency services provided before January 2022, only physicians and hospitals were covered by the law.)
- Let your health plan know if you receive a bill from an out-of-network provider for emergency services.
- You may also file a complaint with DFS.

Result: You only have to pay your in-network cost-sharing (copayment, coinsurance, and deductible) for bills for out-of-network emergency services in a hospital.

2. If you have self-paying coverage through your employer or union

[Your health insurance ID card says 'self-funded' or does not say 'fully insured']

(a) If your employer or union self-funds your coverage for plans issued or renewed on and after January 1, 2022, the federal NSA protections for out-of-network emergency services will apply. This includes inpatient care following emergency room treatment (post-stabilization services).

Result: You are only responsible for paying your in-network cost-sharing (copayment, coinsurance, or deductible) for emergency services.

However, self-funded patients receiving stabilization services after a medical emergency can agree to another option. They are permitted, under the NSA, to waive (voluntarily give up) their balance billing protections under certain conditions, which includes a 'Notice and Consent' procedure.

For more information about the Federal consumer protections, visit the CMS No Surprises Act website.

(b) For plans issued or renewed before January 1, 2022, you may qualify for an **independent dispute resolution (IDR)** process through New York State by submitting an IDR application to dispute the bill.

Important:

- If you win your case against the provider, the provider must pay the cost of the IDR process;
- If the provider wins the case and their bill is upheld, you must pay the fee for the IDR (**up to $395**), unless your household income is below 250% of the Federal Poverty Level.

To apply for IDR: Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

3. If you are uninsured

If you are uninsured, you may file a dispute through the New York State independent dispute resolution (IDR) process if you receive a bill for emergency services in New York that you believe is excessive.

Important:

- If you win your case against the provider, the provider must pay the cost of the IDR process;
- If the provider wins the case and their bill is upheld, you must pay the fee for the IDR (**up to $395**), unless your household income is below 250% of the Federal Poverty Level.

To apply for IDR: Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

Who Pays for Independent Dispute Resolution (IDR)?

(1) Disputes Between a Provider and a Health Plan, Involving an Insured Patient.

- Provider pays the cost of the dispute resolution when the IDRE determines that the health plan's payment is reasonable.
- Health plan pays the cost of the dispute resolution when the IDRE determines that the provider's fee is reasonable.
- Provider and the health plan share the prorated cost when there is a settlement.
- There may be a minimal fee to the provider or health plan submitting the dispute if the dispute is found ineligible or incomplete.

(2) Disputes involving an Uninsured or Self-Paying Patient.

- The provider pays the cost of the dispute resolution when the IDRE determines that the provider's fee is not reasonable.
- The patient pays the cost of the dispute resolution when the IDRE determines that provider's fee is reasonable, unless it would pose a hardship to the patient. "Hardship" means a household income below 250% of the Federal Poverty Level.

NYS Department of Financial Services

https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills