[N.Y. Fin. Serv. Law §§ 601 through 608.]

§ 601. Dispute resolution process established: Emergency Medical Services and Surprise Bills

The superintendent shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The superintendent shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The superintendent shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process of this article. To the extent practicable, the physician shall be licensed in this state.

§ 602. Applicability: Emergency Medical Services and Surprise Bills

(a) This article shall not apply to health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including the workers' compensation law and article fifty-one of the insurance law, and shall not preempt any such law.

(b)(1) With regard to emergency services billed under American medical association current procedural terminology (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, the dispute resolution process established in this article shall not apply when:

(A) the amount billed for any such CPT code meets the requirements set forth in paragraph three of this subsection, after any applicable co-insurance, co-payment and deductible; and

(B) the amount billed for any such CPT code does not exceed one hundred twenty percent of the usual and customary cost for such CPT code.

(2) The health care plan shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a CPT code as set forth in this subsection than the insured would have incurred if such emergency services were provided by a participating physician.

(3) Beginning January first, two thousand fifteen and each January first thereafter, the superintendent shall publish on a website maintained by the department of financial services, and provide in writing to each health care plan, a dollar amount for which bills for the procedure codes identified in this subsection shall be exempt from the dispute resolution process established in this article. Such amount shall equal the amount from the prior year, beginning with six hundred dollars in two thousand fourteen, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the consumer price index. In no event shall an amount exceeding one thousand two hundred dollars for a specific CPT code billed be exempt from the dispute resolution process established in this article.

§ 603. Definitions: Emergency Medical Services and Surprise Bills

For the purposes of this article:

(a) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in : (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; (4) serious disfigurement of such person; or (5) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the social security act 42 U.S.C. § 1395dd

(b) "Emergency services" means, with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the social security act, 42 U.S.C. § 1395dd, to stabilize the patient.

(c) "Health care plan" means an insurer licensed to write accident and health insurance pursuant to article thirty-two of the insurance law; a corporation organized pursuant to article forty-three of the insurance law; a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law; a health maintenance organization certified pursuant to article forty-four of the public health law; or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law.

(d) "Insured" means a patient covered under a health care plan's policy or contract.

(e) "Non-participating" means not having a contract with a health care plan to provide health care services to an insured.

(f) "Participating" means having a contract with a health care plan to provide health care services to an insured.

(g) "Patient" means a person who receives health care services, including emergency services, in this state.

(h) "Surprise bill" means a bill for health care services, other than 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 health care 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 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.

(i) "Usual and customary cost" means the eightieth 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. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law.

§ 604. Criteria for determining a reasonable fee: Emergency Medical Services and Surprise Bills

In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(a) whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(1) fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating, and

(2) in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan;

(b) the level of training, education and experience of the physician;

(c) the physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating;

(d) the circumstances and complexity of the particular case, including time and place of the service;

(e) individual patient characteristics; and

(f) the usual and customary cost of the service.

§ 605. Dispute resolution for emergency services: Emergency Medical Services and Surprise Bills

(a) Emergency services for an insured. (1) When a health care plan receives a bill for emergency services from a non-participating physician, the health care plan shall pay an amount that it determines is reasonable for the emergency services rendered by the non-participating physician, in accordance with section three thousand two hundred twenty-four-a of the insurance law, except for the insured's co-payment, coinsurance or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician pursuant to subsection (c) of section three thousand two hundred forty-one of the insurance law.

(2) A non-participating physician or a health care plan may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity.

(3) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's fee, that a settlement between the health care plan and non-participating physician is reasonably likely, or that both the health care plan's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating physician may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty day period for dispute resolution.

(b) Emergency services for a patient that is not an insured. (1) A patient that is not an insured or the patient's physician may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the superintendent.

(2) An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in section six hundred four of this article.

(3) A patient that is not an insured shall not be required to pay the physician's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

(c) The determination of an independent dispute resolution entity shall be binding on the health care plan, physician and patient, and shall be admissible in any court proceeding between the health care plan, physician or patient, or in any administrative proceeding between this state and the physician.

§ 606. Hold harmless and assignment of benefits for surprise bills for insured: Emergency Medical Services and Surprise Bills

Hold harmless and assignment of benefits for surprise bills for insureds. When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, the non-participating physician shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

§ 607. Dispute resolution for surprise bills: Emergency Medical Services and Surprise Bills

(a) Surprise bill received by an insured who assigns benefits. (1) If an insured assigns benefits to a non-participating physician, the health care plan shall pay the non-participating physician in accordance with paragraphs two and three of this subsection.

(2) The non-participating physician may bill the health care plan for the health care services rendered, and the health care plan shall pay the non-participating physician the billed amount or attempt to negotiate reimbursement with the non-participating physician.

(3) If the health care plan's attempts to negotiate reimbursement for health care services provided by a non-participating physician does not result in a resolution of the payment dispute between the non-participating physician and the health care plan, the health care plan shall pay the non-participating physician an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's copayment, coinsurance or deductible, in accordance with section three thousand two hundred twenty-four-a of the insurance law.

(4) Either the health care plan or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity, provided however, the health care plan may not submit the dispute unless it has complied with the requirements of paragraphs one, two and three of this subsection.

(5) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

(6) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's fee, that a settlement between the health care plan and non-participating physician is reasonably likely, or that both the health care plan's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating physician may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty day period for dispute resolution.

(b) Surprise bill received by an insured who does not assign benefits or by a patient who is not an insured. (1) An insured who does not assign benefits in accordance with subsection (a) of this section or a patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

(2) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in section six hundred four of this article.

(3) A patient or insured who does not assign benefits in accordance with subsection (a) of this section shall not be required to pay the physician's fee to be eligible to submit the dispute for review to the independent dispute entity.

(c) The determination of an independent dispute resolution entity shall be binding on the patient, physician and health care plan, and shall be admissible in any court proceeding between the patient or insured, physician or health care plan, or in any administrative proceeding between this state and the physician.

§ 608. Payment for independent dispute resolution entity: Emergency Medical Services and Surprise Bills

(a) For disputes involving an insured, when the independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician. When the independent dispute resolution entity determines the non-participating physician's fee is reasonable, payment for the dispute resolution process shall be the

responsibility of the health care plan. When a good faith negotiation directed by the independent dispute resolution entity pursuant to paragraph four of subsection (a) of section six hundred five of this article, or paragraph six of subsection (a) of section six hundred seven of this article results in a settlement between the health care plan and non-participating physician, the health care plan and the non-participating physician shall evenly divide and share the prorated cost for dispute resolution.

(b) For disputes involving a patient that is not an insured, when the independent dispute resolution entity determines the physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The superintendent shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship. When the independent dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician.