New York ACEP strongly supports the intent of this legislation to ensure that patients receive clear, concise and timely bills. However, we are very concerned about the implications of the provisions in this legislation that would prohibit a physician or other provider with any financial or contractual relationship with the hospital from separately billing the patient.

Given that the professional services provided by a contracted physician are likely only to be a small component of the overall hospital services received by a patient, we are extremely concerned that prohibiting a private physician group from separately billing a patient for services provided at a hospital puts the physician group at a distinct financial disadvantage, will increase health care costs, and ultimately reduce patient quality of care.

There is a high likelihood that a hospital will not pay a physician group on a timely basis, thereby undermining the financial stability of independent practices and harming their ability to continue to provide necessary patient care. Moreover, there are numerous complicating circumstances that this bill as written fails to address. These include further billing for applicable patient cost-sharing as required by their insurance policy (co-pay, coinsurance, deductible, etc.) after a claim has been paid by the insurance company, and how partial payments will be allocated between the multiple health care parties whose services are being billed by the hospital.

In addition, prohibiting private physician groups from billing patients will put even greater pressure on groups to sell their practices to large hospital systems, forcing physicians to become employees and undermining the independence of the patient-physician treatment relationship. This pressure already exists in every part of the State, and indeed across the country.

This bill will for all intents and purposes, force physician practices to become employees of hospitals in order to receive timely and adequate payments, at a time when many physicians are already being forced into employment arrangements in order to continue delivering care due to the very difficult practice environment.

The current trend of hospital acquisition of physician practices drives up health care costs and can reduce patient quality of care.1 According to a February 2019 report, nationwide hospital purchases of physician practices grew from 35,700 in July 2012 to 80,000 in January 2018. This 128% growth represents more than double the number of hospital-owned practices.

The report also found that costs rise for services performed in a hospital outpatient setting as opposed to a private physician’s office. **Those costs are increasingly borne by government payers as well as higher out-of-pocket costs for patients.**

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1 PAI. Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018, February 2019
Another recent study found that “consolidation has a negative impact on quality measures used to monitor care quality as well as patient satisfaction.” “Increased market concentration was strongly associated with reduced quality across all 10 patient satisfaction measures.” The study concluded that “patient satisfaction fell as market concentration increased,” and “overall clinical quality of care could suffer.”

New York ACEP strongly supports greater transparency and timeliness of billing for patients. We are committed to working with the sponsors of this legislation to achieve these goals and to preserve the independent physician practice model and high-quality patient care.

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2 Rice University, Baker’s Institute for Public Policy, February 14, 2019
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STATE OF NEW YORK

6757
2019-2020 Regular Sessions

IN SENATE

September 30, 2019

Introduced by Sens. RIVERA, KRUEGER, BRESLIN -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

AN ACT to amend the public health law, in relation to standardized consolidated itemized general hospital bills (Part A); to amend the public health law, in relation to regulation of the billing of facility fees (Part B); to amend the public health law, in relation to standardized patient financial liability forms (Part C); to amend the public health law, in relation to an all payer database (Part D); to amend the public health law, in relation to the general hospital indigent care pool; and to repeal certain provisions of such law relating thereto (Part E); to amend the civil practice law and rules, in relation to the commencement of medical debt actions (Part F); to amend the public health law, in relation to hospital statements of rights and responsibilities of patients; to amend the financial services law, in relation to dispute resolution for emergency services; and to amend the financial services law and the insurance law, in relation to health insurance benefits (Part G)

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short title. This act shall be known and may be cited as the "patient medical debt protection act".

§ 2. This act enacts into law major components of legislation which relate to patient medical debt protection. Each component is wholly contained within a Part identified as Parts A through G. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [...] is old law to be omitted.

LBD13193-05-9
corresponding section of the Part in which it is found. Section four of
this act sets forth the general effective date of this act.

PART A

Section 1. The public health law is amended by adding a new section
2827 to read as follows:
§ 2827. Standardized consolidated itemized general hospital bills. 1.
After a patient's discharge or release from a general hospital licensed
under this article, the facility shall provide to the patient or to the
patient's survivor or legal guardian, as appropriate, a consolidated
itemized statement or a bill detailing in plain language, comprehensible
to an ordinary layperson, the specific nature of charges or expenses
incurred by the patient. The consolidated itemized statement, developed
by the commissioner in consultation with the superintendent of financial
services, shall detail all services provided to the patient during the
hospitalization, including all professional services administered. A
provider with any financial or contractual relationship with the facility
may not separately bill the patient or the patient's survivor or
legal guardian. The initial statement or bill shall be provided no more
than seven days after the patient's discharge or release, or after a
request for such statement or bill, whichever is earlier. The initial
statement or bill shall contain a statement of specific services
received and expenses incurred by date and provider for such items of
service, enumerating in detail the constituent components of the
services received within each department of the facility and including
unit price data on rates charged by the facility. The statement or bill
shall identify each item as paid, assigned to a third party payer, or
expected payment by the patient, and shall include the amount due, if
applicable. If an amount is due from the patient, a due date for such
amount shall be included.

2. Any subsequent statement or bill provided to a patient or to the
patient's survivor or legal guardian, as appropriate, relating to the
episode of care must include all of the information required by subdivi-
sion one of this section, with any clearly delineated revisions.

3. Each consolidated itemized statement or bill provided pursuant to
this section shall:
(a) include the services provided by hospital-based physicians and
other health care providers who may not bill separately.
(b) not include any generalized category of expenses such as "other"
or "miscellaneous" or similar categories.
(c) list drugs by brand or generic name and not refer to drug code
numbers when referring to any drugs.
(d) specifically identify physical, rehabilitative, occupational, or
speech therapy treatment by date, type, and length of treatment when
such treatment is a part of the statement or bill. Providers of such
services shall not produce separate bills.
(e) prominently display the telephone number of the facility's patient
liaison responsible for expediting the resolution of any billing dispute
between the patient, or the patient's survivor or legal guardian, and
the billing department.

4. Each facility shall establish policies and procedures for reviewing
and responding to questions from patients concerning such patient's
consolidated itemized statement or bill. Such response shall be provided
no more than seven business days after the date a question is received.
If the patient is not satisfied with the response, the facility shall
provide the patient with the contact information of the agency to which
the issue shall be sent for review.

§ 2. This act shall take effect on the one hundred eightieth day after
it shall have become a law.

PART B

Section 1. The public health law is amended by adding a new section
2827-a to read as follows:

§ 2827-a. Regulation of the billing of facility fees. 1. For purposes
of this section “facility fee” means any fee charged or billed by a
hospital under this article other than a residential health care facili-
ty, or by a health care professional authorized under title eight of the
education law that is: (a) intended to compensate the facility, or
health care professional for the operational expenses; and (b) separate
and distinct from a professional fee.

2. No hospital licensed under this article other than a residential
health care facility or health care professional authorized under title
eight of the education law shall bill or seek payment from a patient for
a facility fee related to the provision of preventive care service as
defined by the United States Preventive Services Task Force.

3. No hospital licensed under this article other than a residential
health care facility or health care professional authorized under title
eight of the education law shall bill or seek payment from a patient for
a facility fee that is not covered by the patient’s health insurance
carrier.

§ 2. This act shall take effect immediately.

PART C

Section 1. The public health law is amended by adding a new section
2827-b to read as follows:

§ 2827-b. Standardized patient financial liability forms. 1. All
hospitals licensed under this article and health care professionals
authorized under title eight of the education law shall be required to
use the uniform patient financial liability form developed by the
commissioner, in consultation with the commissioner of education. The
standardized form shall disclose to the patient whether their care is
in-network or out-of-network, whether the care is a covered benefit
under the patient insurance contract, the exact nature and amount of the
patient’s projected financial liability and shall specifically indicate
the exact amount of personal financial liability to be undertaken by the
patient. In no event shall a patient be financially liable for undis-
closed bills or any bills related to services provided by a provider who
failed to ascertain that he or she was in the patient’s health plan
network. The commissioner shall develop the uniform financial liability
form within six months of the effective date of a chapter of the laws of
two thousand nineteen that added this section, and it shall be adopted
by all hospitals and health care professionals within thirty days of the
issuance of such form by the commissioner.

§ 2. This act shall take effect immediately. Effective immediately,
the addition, amendment and/or repeal of any rule or regulation neces-
sary for the implementation of this act on its effective date are
authorized to be made and completed on or before such effective date.

PART D
S. 6757

1. Section 1. Subdivision 18-a of section 206 of the public health law is amended by adding a new paragraph (e) to read as follows:

   (e)(i) The commissioner shall ensure that the New York state all payer database shall serve the interests of New York's health care consumers.
   (ii) All hospitals licensed under article twenty-eight of this chapter and health care professionals authorized under title eight of the education law shall be required to participate in the all payer database through their insurance carrier contracts, which in no event shall be deemed proprietary information for the purposes of submitting data to the all payer database.

§ 2. This act shall take effect immediately.

PART E

Section 1. Subdivisions 9 and 9-a of section 2807-k of the public health law, subdivision 9 as amended by section 17 of part B of chapter 60 of the laws of 2014, subdivision 9-a as added by section 39-a of part A of chapter 57 of the laws of 2006 and paragraph (k) of subdivision 9-a as added by section 43 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must only implement minimum collection policies and procedures [approved] provided by the commissioner.

9-a. (a) As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand [seven, establish] twenty-one, adopt and implement the uniform financial aid policies and procedures, in accordance with the provisions of this subdivision, assistance form policy, to be developed and issued by the commissioner no later than one hundred eighty days after the effective date of a chapter of the laws of two thousand nineteen that amended this subdivision. No later than thirty days of the issuance of the uniform financial assistance form and policy, general hospitals shall implement such form and policy, for reducing hospital charges and charges for physicians who work in the hospital otherwise applicable to low-income individuals without health insurance, or who have [exhausted their] health insurance [benefits] that does not cover or limits coverage of the service, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts. Immigration status shall not be an eligibility criterion. General hospitals shall use the New York state health marketplace eligibility determination page to establish the patient's household income and residency in lieu of the financial application form provided they have secured the consent of the patient. A general hospital shall not require a patient to apply for coverage through the New York state health marketplace in order to receive care or financial assistance.

(b) Such reductions from charges for uninsured patients with incomes below at least [three] four hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed [the greater of] the amount that would have been paid for the same services [by the “highest volume payor” for such general hospital as defined in
subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services] provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

(i) For patients with incomes at or below at least [one] two hundred percent of the federal poverty level, the hospital shall collect no more than a nominal payment amount, consistent with guidelines established by the commissioner;

(ii) For patients with incomes between at least [one] two hundred one percent and [one] four hundred [fifty] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases from the nominal amount described in subparagraph (i) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the greater of the amount that would have been paid for the same services [by the "highest volume payer" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services] provided pursuant to title XIX of the federal social security act (medicaid);

(iii) [For patients with incomes between at least one hundred fifty-one percent and two hundred fifty percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the twenty percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of the greater of the amount that would have been paid for the same services by the "highest volume payer" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid); and

(iv) [For patients with incomes [between at least two hundred fifty-one percent and three hundred] above four hundred one percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services [by the "highest volume payer" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services] provided pursuant to title XIX of the federal social security act (medicaid][.]; and

(v) For the purposes of this paragraph, "highest volume payer" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payer, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.

(vi) A hospital may implement policies and procedures to permit, but not require, consideration on a case-by-case basis of exceptions to the requirements described in subparagraphs (i) and (ii) of this paragraph
based upon the existence of significant assets owned by the patient that
should be taken into account in determining the appropriate payment
amount for that patient's care, provided, however, that such proposed
policies and procedures shall be subject to the prior review and
approval of the commissioner and, if approved, shall be included in the
hospital's financial assistance policy established pursuant to this
section, and provided further that, if such approval is granted, the
maximum amount that may be collected shall not exceed the greater of the
amount that would have been paid for the same services by the "highest
volume payer" for such general hospital as defined in subparagraph (v)
of this paragraph, or for services provided pursuant to title XVIII of
the federal social security act (medicare), or for services provided
pursuant to title XIX of the federal social security act (medicaid). In
the event that a general hospital reviews a patient's assets in deter-
mining payment adjustments such policies and procedures shall not
consider as assets a patient's primary residence, assets held in a tax-
defered or comparable retirement savings account, college savings
accounts, or cars used regularly by a patient or immediate family
members.

(vii) Nothing in this paragraph shall be construed to limit a
hospital's ability to establish patient eligibility for payment
discounts at income levels higher than those specified herein and/or to
provide greater payment discounts for eligible patients than those
required by this paragraph.

(c) [Such policies and procedures shall be clear, understandable, in
writing and publicly available in summary form and—each hospital part-
icipating in the pool shall ensure that every patient is
made aware of the existence of such policies and procedures, uniform
financial assistance form and policy and is provided, in a timely
manner, with a copy of such policies and procedures, form and
policy upon request. [Any summary provided to patients shall, at a mini-
imum, include specific information as to income levels used to determine
eligibility for assistance, a description of the primary service area of
the hospital and the means of applying for assistance. For general]
General hospitals with twenty-four hour emergency departments, [such
policies and procedures] shall require the notification of patients
during the intake and registration process, through the conspicuous
posting of language-appropriate information in the general hospital, and
information on bills and statements sent to patients, that financial
[aid] assistance may be available to qualified patients and how to
obtain further information. For specialty hospitals without twenty-four
hour emergency departments, such notification shall take place through
written materials provided to patients during the intake and registra-
tion process prior to the provision of any health care services or
procedures, and through information on bills and statements sent to
patients, that financial [aid] assistance may be available to qualified
patients and how to obtain further information. [Application materials
shall include a notice to patients that upon submission of a completed
application, including any information or documentation needed to deter-
mine the patient's eligibility pursuant to the hospital's financial
assistance policy, the patient may disregard any bills until the hospi-
tal has rendered a decision on the application in accordance with this
paragraph] General hospitals shall post the uniform financial assistance
application form and policy in a conspicuous location on the general
hospital's website. The commissioner shall likewise post the uniform
financial assistance form and policy on the department's hospital
profile page related to the general hospital's or any successor website.
(d) The commissioner shall provide application materials to general
hospitals, including the uniform financial assistance application form
and policy. These application materials shall include a notice to
patients that upon submission of a completed application form, the
patient may disregard any bills until the general hospital has rendered
a decision on the application in accordance with this paragraph. The
application materials shall include specific information as the income
levels used to determine eligibility for financial assistance, a
description of the primary service area of the hospital and the means to
apply for assistance. Such policies and procedures shall include clear,
objective criteria for determining a patient's ability to pay and for
providing such adjustments to payment requirements as are necessary. In
addition to adjustment mechanisms such as sliding fee schedules and
discounts to fixed standards, such policies and procedures shall also
provide for the use of installment plans for the payment of outstanding
balances by patients pursuant to the provisions of the hospital's financial
assistance policy. The monthly payment under such a plan shall not
exceed [ten] five percent of the gross monthly income of the patient;[,
provided, however, that if patient assets are considered under such a
policy, then patient assets which are not excluded assets pursuant to
subparagraph (vi) of paragraph (b) of this subdivision may be considered
in addition to the limit on monthly payments.] The rate of interest
charged to the patient on the unpaid balance, if any, shall not exceed
the [rate for a ninety-day security] federal funds rate issued by the
United States Department of Treasury[, plus .5 percent] and no plan
shall include an accelerator or similar clause under which a higher rate
of interest is triggered upon a missed payment. [If such policies and
procedures] The policy shall not include a requirement of a deposit
prior to non-emergent, medically-necessary care[, such deposit must be
included as part of any financial aid consideration]. Such policies and
procedures shall be applied consistently to all eligible patients.
(e) Such policies and procedures shall permit patients to apply for
assistance within at least [ninety] two hundred forty days of the date
of discharge or date of service and provide at least [twenty] sixty days
for patients to submit a completed application. Such policies and proce-
dures may require that patients seeking payment adjustments provide
[appropriate] the following financial information and documentation in
support of their application[, provided, however, that such application
process shall not be unduly burdensome or complex] that are used by the
New York state of health marketplace: pay checks or pay stubs; rent
receipts; a letter from the patient's employer attesting to the
patient's gross income; or, if none of the aforementioned information
and documentation are available, a written self-attestation of the
patient's income. General hospitals shall, upon request, assist patients
in understanding the hospital's policies and procedures and in applying
for payment adjustments. [Application forms shall be printed] The
commissioner shall translate the financial assistance application form
and policy into the "primary languages" of each general hospital. Each
general hospital shall print and post these materials to its website in
the "primary languages" of patients served by the general hospital. For
the purposes of this paragraph, "primary languages" shall include any
language that is either (i) used to communicate, during at least five
percent of patient visits in a year, by patients who cannot speak, read,
write or understand the English language at the level of proficiency
necessary for effective communication with health care providers, or
(ii) spoken by non-English speaking individuals comprising more than one
percent of the primary hospital service area population, as calculated
using demographic information available from the United States Bureau of
the Census, supplemented by data from school systems. Decisions regard-
ing such applications shall be made within thirty days of receipt of a
completed application. Such policies and procedures shall require that
the hospital issue any denial/approval of such application in writing
with information on how to appeal the denial and shall require the
hospital to establish an appeals process under which it will evaluate
the denial of an application. [Nothing in this subdivision shall be
interpreted as prohibiting a hospital from making the availability of
financial assistance contingent upon the patient first applying for
coverage under title XIX of the social security act (medicaid) or anoth-
er insurance program if, in the judgment of the hospital, the patient
may be eligible for medicaid or another insurance program, and upon the
patient's cooperation in following the hospital's financial assistance
application requirements, including the provision of information needed
to make a determination on the patient's application in accordance with
the hospital's financial assistance policy.]

(f) Such policies and procedures shall provide that patients with
incomes below [three] four hundred percent of the federal poverty level
are deemed presumptively eligible for payment adjustments and shall
conform to the requirements set forth in paragraph (b) of this subdivi-
sion, provided, however, that nothing in this subdivision shall be
interpreted as precluding hospitals from extending such payment adjust-
ments to other patients, either generally or on a case-by-case basis.
Such [policies and procedures] policy shall provide financial [aid]
assistance for emergency hospital services, including emergency trans-
fers pursuant to the federal emergency medical treatment and active
labor act (42 USC 1395dd), to patients who reside in New York state and
for medically necessary hospital services for patients who reside in the
hospital's primary service area as determined according to criteria
established by the commissioner. In developing such criteria, the
commissioner shall consult with representatives of the hospital indus-
try, health care consumer advocates and local public health officials.
Such criteria shall be made available to the public no less than thirty
days prior to the date of implementation and shall, at a minimum:

(i) prohibit a hospital from developing or altering its primary
service area in a manner designed to avoid medically underserved commu-
nities or communities with high percentages of uninsured residents;
(ii) ensure that every geographic area of the state is included in at
least one general hospital's primary service area so that eligible
patients may access care and financial assistance; and
(iii) require the hospital to notify the commissioner upon making any
change to its primary service area, and to include a description of its
primary service area in the hospital's annual implementation report
filed pursuant to subdivision three of section twenty-eight hundred
three-l of this article.

(g) Nothing in this subdivision shall be interpreted as precluding
hospitals from extending payment adjustments for medically necessary
non-emergency hospital services to patients outside of the hospital's
primary service area. For patients determined to be eligible for finan-
cial [aid] assistance under the terms of [a hospital's] the uniform
financial [aid] assistance policy, such [policies and procedures] policy
shall prohibit any limitations on financial [aid] assistance for
services based on the medical condition of the applicant, other than
typical limitations or exclusions based on medical necessity or the
clinical or therapeutic benefit of a procedure or treatment.
(h) Such policies and procedures shall not permit the securing of a
lien or forced sale or foreclosure of a patient's primary residence in
order to collect an outstanding medical bill and shall require the
hospital to refrain from sending an account to collection if the patient
has submitted a completed application for financial [aid, including any
required supporting documentation] assistance, while the hospital deter-
mines the patient's eligibility for such [aid] assistance. Such [poli-
cies and procedures] policy shall provide for written notification,
which shall include notification on a patient bill, to a patient not
less than thirty days prior to the referral of debts for collection and
shall require that the collection agency obtain the hospital's written
consent prior to commencing a legal action. Such [policies and proce-
dures] policy shall require all general hospital staff who interact with
patients or have responsibility for billing and collections to be
trained in such [policies and procedures] policy, and require the imple-
mentation of a mechanism for the general hospital to measure its compli-
ance with [such policies and procedures] the policy. Such [policies and
procedures] policy shall require that any collection agency under
contract with a general hospital for the collection of debts follow the
[hospital's] uniform financial assistance policy, including providing
information to patients on how to apply for financial assistance where
appropriate. Such [policies and procedures] policy shall prohibit
collections from a patient who is determined to be eligible for medical
assistance pursuant to title XIX of the federal social security act at
the time services were rendered and for which services medicaid payment
is available.
(i) Reports required to be submitted to the department by each general
hospital as a condition for participation in the pools, and which
contain, in accordance with applicable regulations, a certification from
an independent certified public accountant or independent licensed
public accountant or an attestation from a senior official of the hospi-
tal that the hospital is in compliance with conditions of participation
in the pools, shall also contain, for reporting periods on and after
January first, two thousand seven:
(i) a report on hospital costs incurred and uncollected amounts in
providing services to [eligible] patients [without insurance] found
eligible for financial assistance, including the amount of care provided
for a nominal payment amount, during the period covered by the report;
(ii) hospital costs incurred and uncollected amounts for deductibles
and coinsurance for eligible patients with insurance or other third-par-
ty payor coverage;
(iii) the number of patients, organized according to United States
postal service zip code, who applied for financial assistance pursuant
to the [hospital's] uniform financial assistance policy, and the number,
organized according to United States postal service zip code, whose
applications were approved and whose applications were denied;
(iv) the reimbursement received for indigent care from the pool estab-
lished pursuant to this section;
(v) the amount of funds that have been expended on [charity-care]
financial assistance from charitable bequests made or trusts established
for the purpose of providing financial assistance to patients who are
eligible in accordance with the terms of such bequests or trusts;
(vi) for hospitals located in social services districts in which the
district allows hospitals to assist patients with such applications, the
number of applications for eligibility under title XIX of the social
security act (medicaid) that the hospital assisted patients in complet-
ing and the number denied and approved;
(vii) the hospital's financial losses resulting from services provided
under medicaid; and
(viii) the number of referrals to collection agents or outside vendor
court cases and liens placed on [the primary] any residences of patients
through the collection process used by a hospital.
(j) [Within ninety days of the effective date of this subdivision each
hospital shall submit to the commissioner a written report on its poli-
cies and procedures for financial assistance to patients which are used
by the hospital on the effective date of this subdivision. Such report
shall include copies of its policies and procedures, including material
which is distributed to patients, and a description of the hospital's
financial aid policies and procedures. Such description shall include
the income levels of patients on which eligibility is based, the finan-
cial aid eligible patients receive and the means of calculating such
aid, and the service area, if any, used by the hospital to determine
eligibility] The commissioner shall include the data collected under
paragraph (i) of this subdivision in regular audits of the annual gener-
al hospital institutional cost report.
(k) In the event it is determined by the commissioner that the state
will be unable to secure all necessary federal approvals to include, as
part of the state's approved state plan under title nineteen of the
federal social security act, a requirement[. as set forth in paragraph
one of this subdivision. ] that compliance with this subdivision is a
condition of participation in pool distributions authorized pursuant to
this section and section twenty-eight hundred seven-w of this article,
then such condition of participation shall be deemed null and void and,
notwithstanding section twelve of this chapter, failure to comply with
the provisions of this subdivision by a hospital on and after the date
of such determination shall make such hospital liable for a civil penal-
ity not to exceed ten thousand dollars for each such violation. The impos-
tion of such civil penalties shall be subject to the provisions of
section twelve-a of this chapter.
§ 2. Subdivision 14 of section 2807-k of the public health law is
REPEALED and subdivisions 15, 16 and 17 are renumbered subdivisions 14,
15 and 16.
§ 3. This act shall take effect immediately.

PART F

Section 1. The civil practice law and rules is amended by adding a new
section 213-d to read as follows:
§ 213-d. Actions to be commenced within two years; medical debt. An
action on a medical debt by a hospital licensed under article twenty-
eight of the public health law or a health care professional authorized
under title eight of the education law shall be commenced within two
years of treatment and no determination of a debt or award of debt may
be based upon a service having occurred more than two years before the
action is commenced.
§ 2. Section 5004 of the civil practice law and rules, as amended by
chapter 258 of the laws of 1981, is amended to read as follows:
§ 5004. Rate of interest. Interest shall be at the rate of nine per
centum per annum, except where otherwise provided by statute, provided
that in medical debt actions by a hospital licensed under article twenty-eight of the public health law or a health care professional author-
ized under title eight of the education law the interest rate shall be
three per centum per annum.
§ 3. This act shall take effect immediately.

PART G

Section 1. Subsection (h) of section 603 of the financial services
law, as added by section 26 of part H of chapter 60 of the laws of 2014,
is amended to read as follows:
(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) an insured for services rendered by a non-participating provider
when the insured reasonably relied upon an oral or written statement
that the non-participating provider was a participating provider made by
a health care plan, or agent or representative of a health care plan, or
as specified in the health care plan provider listing or directory, or
provider information on the health plan’s website;
(4) an insured for services rendered by a non-participating provider
when the insured reasonably relied upon a statement that the non-parti-
cipating provider was a participating provider made by the non-partici-
pating provider, or agent or representative of the non-participating
provider, or as specified on the non-participating provider’s website; or
(5) 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.
§ 2. Paragraph (k) of subdivision 1 of section 2803 of the public
health law, as added by chapter 241 of the laws of 2016, is amended to
read as follows:
(k) The statement regarding patient rights and responsibilities,
required pursuant to paragraph (g) of this subdivision, shall include
provisions informing the patient of his or her right to [choose] be held
harmless from certain bills for emergency services and surprise bills,
and to submit surprise bills or bills for emergency services to the
independent dispute process established in article six of the financial
services law, and informing the patient of his or her right to view a
list of the hospital's standard charges and the health plans the hospital participates with consistent with section twenty-four of this chapter.

§ 3. Paragraph 1 of subsection (a) of section 605 and sections 606 and 608 of the financial services law, as added by section 26 of part H of chapter 60 of the laws of 2014, are amended to read as follows:

(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. If an insured assigns benefits to a non-participating physician or ambulance provider, such payment shall be made directly to the assignee.

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

§ 606. Payment for independent dispute resolution entity. (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 or hospital'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 or hospital's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician or hospital.

§ 6. Subsection (c) of section 3241 of the insurance law, as added by section 6 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

(c) When an insured or enrollee under a contract or policy that provides coverage for emergency services receives the services from a health care provider that does not participate in the provider network
of an insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, 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 this chapter ("health care plan"), the health care plan shall ensure that the insured or enrollee shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the health care plan's provider network.

For the purpose of this section, "emergency services" shall have the meaning set forth in [subparagraph (D) of paragraph nine of subsection (i) of section three thousand two hundred sixteen of this article, subparagraph (D) of paragraph four of subsection (k) of section three thousand two hundred twenty-one of this article, and subparagraph (D) of paragraph two of subsection (a) of section four thousand three hundred three of this chapter] subsection (b) of section six hundred three of the financial services law.

§ 7. This act shall take effect immediately.

§ 3. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 4. This act shall take effect immediately provided, however, that the applicable effective date of Parts A through G of this act shall be as specifically set forth in the last section of such Parts.
NEW YORK STATE SENATE
INTRODUCER'S MEMORANDUM IN SUPPORT
submitted in accordance with Senate Rule VI. Sec 1

BILL NUMBER: S6757

SPONSOR: RIVERA

TITLE OF BILL: An act to amend the public health law, in relation to
standardized consolidated itemized general hospital bills (Part A); to
amend the public health law, in relation to regulation of the billing of
facility fees (Part B); to amend the public health law, in relation to
standardized patient financial liability forms (Part C); to amend the
public health law, in relation to an all payer database (Part D); to
amend the public health law, in relation to the general hospital indi-
gent care pool; and to repeal certain provisions of such law relating
thereto (Part E); to amend the civil practice law and rules, in relation
to the commencement of medical debt actions (Part F); and to amend the
financial services law, in relation to services rendered by a non-parti-
cipating provider; to amend the public health law, in relation to hospi-
tal statements of rights and responsibilities of patients; to amend the
financial services law, in relation to dispute resolution for emergency
services; and to amend the financial services law and the insurance law,
in relation to health insurance benefits (Part G)

PURPOSE:

To protect patients from medical debt by simplifying hospital billing;
standardizing hospital financial assistance, shortening the statute of
limitations for medical debt and adding network misinformation and
balance billing protections to the 2014 Surprise Bill Laws.

SUMMARY OF PROVISIONS:

Part A would amend Public Health Law § 2827 to require that general
hospitals provide plain language bills to patients who have received
hospital services, or their legal guardian or survivor. All charges for
one hospital visit would be consolidated into one bill that details
services, date, and provider, received within seven days of discharge.
Charges would be labelled as paid, assigned to an insurer or owed by the
patient. Providers not employed by the general hospital would not bill
separately. Bills would include contact information to settle disputes.

Part B would add a new Public Health Law § 2827-a to define "facility
fees" and ban hospitals and professional practices from charging
patients for facility fees for either preventive care or if their insur-
ance will not cover the fee.

Part C would add a new Public Health Law § 2827-b to standardize patient
financial liability forms to be used by all hospitals and health care
professionals.

Part D would amend Public Health Law § 206 to require all hospitals and
health care professionals to participate in the state all-payer data-
based. Part E would amend Public Health Law § 2807-k to standardize
policies, applications, and appeal procedures related to hospital finan-
cial assistance. It would improve public reporting of hospital financial
assistance data, and increase the income limit for assistance.

Part F would add a new Civil Practice Law §§ 213-d and 5004 to shorten the statute of limitations on medical debt held by consumers to two years from the current six years, and reduce the percentage rate on medical debt judgements to 3%.

Part G sections 1-6 would amend Insurance Law § 603; Public Health Law § 2803; Financial Services Law § 605, 606 and 608; and Insurance Law § 3241; making various conforming amendments to hold consumers harmless from surprise out-of-network bills, or plan and provider misinformation about their network participation, to require plans to honor assignment of benefits, and prohibit "balancebilling" for charges other than applicable co-payments.

**JUSTIFICATION:**

This legislation offers to clarify and simplify medical billing, protect patients from medical debt, and update New York's landmark surprise billing law to provide additional consumer protections for out of network charges.

Hospital visits produce bills that keep coming for years, use administrative codes that are unique to individual facilities, and do not track what charges have already been paid. It is common for patients to receive multiple bills for the same service long after they or their insurer has already paid for that service. Florida has enacted a number of provisions to protect consumers by ensuring that hospital bills are clear, follow standard formats, and are provided in a timely manner. Patients in New York should receive those same protections.

Facility fees are charged separately from payments for medical services to subsidize hospital and clinic operations. This bill would allow insurers to negotiate with provider and pay facility fees through their contracts, but would not allow providers to charge individual patients. It would also ban facility fees altogether for preventive care to make sure that there is no financial disincentive for patients to receive care that is proven to improve their health.

It is increasingly common for providers to present patients with liability forms to sign before providing care that ask patients to take on financial liability for services that they cannot foreseeably budget for. These forms can mislead patients into believing they must pay bills even when they are protected against those bills under New York State Law, for example in the event of a surprise bill. A standard form would ensure patient-friendly language that complies with existing New York laws protecting patients from unfair financial liability for medical care.

The All-Payer Database (APD) is meant to become an important regulatory tool and a tool that will help consumers plan ahead for expensive medical care. The State cannot adequately know billing practices if it does not have accurate information, yet some providers are asking health plans to exclude their data from APD submissions. Additionally, the public has yet to see the benefits of New York's investment in the All-Payer Database. This section would affirm that the All-Payer Database should be developed to meet the needs of consumers.

The lack of standardization in how hospitals implement the Hospital Financial Assistance Law results in patients who should receive assistance going without. The state's audits have repeatedly found that hospitals are not complying with the law, as have audits conducted by consumer advocates. A proven income eligibility verification process already exists in The New York State of Health exchange insurance program which
can also be used to determine eligibility for hospital financial assistance.

The amount of time medical providers have to sue patients for unpaid bills should be shortened from six years to two. Sixteen other states and the District of Columbia have shorter statute of limitations for medical debt actions than New York—including Arkansas which provides eighteen months to two years. Currently, hospitals must submit their medical claims to insurers within two years or forfeit their ability to secure payments on the outstanding claim. This provision would ensure that patients are afforded similar statute of limitations protections as the insurance industry.

The bill would amend New York’s 2014 surprise bill law to ensure that consumers are protected from two forms of surprise medical bills that are not currently covered:

*The first improvement would protect patients from surprise bills when a patient relies on incorrect information provided by a provider or health plan that the provider or facility is in-network, when in fact, it is not. Under current law, the patient is still responsible for the cost of care when such postings are incorrect. It is estimated that 35 percent of surprise billing disputes fall into this category.
*The second improvement is to ensure that patients are not “balance billed” for charges that are subject to the dispute resolution process for which patients are held harmless. While the 2015 law held patients harmless from costs associated with surprise bills, it did not prohibit health care providers from continuing to bill patients. As a result, many patients receive bills that they do not owe, and often end up paying bills that they are not responsible for.

**LEGISLATIVE HISTORY:**

New bill.

**FISCAL:**

None to state

**EFFECTIVE DATE:**
Part A takes effect 180 days after becoming law, Parts B, C, D, E, F and G take effect immediately.

2 Florida Title XXIX Public Health § 395.301