Regulatory Impact Statement for the Proposed First Amendment to 23 NYCRR 400

1. Statutory authority: The authority of the Superintendent of Financial Services ("Superintendent") to promulgate the First Amendment to 23 NYCRR 400 derives from Financial Services Law sections 202, 301, 302 and Article 6 and Insurance Law section 301.

   Financial Services Law section 202 establishes the office of the Superintendent of Financial Services ("Superintendent").

   Financial Services Law Section 301 authorizes the Superintendent to take such action as the Superintendent deems necessary to protect and educate users of financial products and services.

   Financial Services Law section 302 and Insurance Law section 301, in pertinent part, authorize the Superintendent to prescribe regulations interpreting the Insurance Law and to effectuate any power granted to the Superintendent in the Insurance Law, Financial Services Law, or any other law.

   Financial Services Law Article 6 establishes an independent dispute resolution ("IDR") process through which a dispute involving a bill for emergency services or a surprise bill may be resolved. This law grants the Superintendent the power to certify entities performing the IDR and authorizes the Superintendent to promulgate regulations establishing standards for the IDR process.

2. Legislative objectives: Chapter 60 of the Laws of 2014 added a new Article 6 to the Financial Services Law to address the issue of consumers receiving unexpected medical bills from out-of-network providers. Article 6 provides that consumers must be held harmless for out-of-network emergency bills and surprise bills and directs the provider and health maintenance organizations or insurers authorized to do business in New York State (collectively, “health care plans”) to work out payment for these bills. Article 6 establishes an IDR process by which a dispute involving a bill for emergency services or a surprise bill may be resolved.
3. Needs and benefits: Financial Services Law Article 6 established an IDR process by which a dispute for a bill for emergency services or a surprise bill may be resolved, and the Department promulgated 23 NYCRR 400 to provide additional rules on IDR. This IDR process has protected several thousands of consumers from bills for emergency services or surprise bills.

While Article 6 and Part 400 have protected many insureds, in certain circumstances, insureds may not be aware that they may seek protection from a surprise bill. Insureds, following the advice of their physicians, may believe that a service is an emergency service, but then end up stuck with a surprise bill when the health care plan later determines that the services were not emergency services and therefore denies the claim because the health care plan determined that the services did not need to be performed on an emergency basis. In fact, a recent case in the news highlighted the potential for such an occurrence.

This rule will ensure that a health care plan notifies an insured when it denies a claim for services that are believed by the insured to have been emergency services, but that the health care plan determined did not need to be performed on an emergency basis, so that the insured may seek protection from surprise bills under Financial Services Law Article 6. This rule also requires a health care plan to provide: (1) information about surprise bills; (2) a copy of the assignment of benefits form with the denial; (3) the health care plan’s designated electronic and mailing address where the assignment of benefits form can be submitted; and (4) a statement that the insured should not delay filing an internal appeal or external appeal even if the insured believes the medical necessity denial should be processed as a surprise bill.

If a health care plan receives an assignment of benefits form and determines that the bill is not a surprise bill, the health care plan must provide a written notification that includes the procedures for filing a grievance under Insurance Law section 4802 or Public Health Law section 4408-a and information on how to file a complaint with the Superintendent. A health care plan must provide the notice of an initial denial within the time frames established in 29 C.F.R. § 2560.503-1. Those time frames require a health care plan to make an
initial determination and provide written notice within 30 days of receipt of the claim, or in this case, receipt of
the assignment of benefits form, if the health care plan does not need additional information. If the health care
plan needs additional information, it must notify the insured or the insured’s designee within 30 days of receipt
of the assignment of benefits form and provide 45 days for a response. The health care plan must make a
determination and provide notice to the insured or the insured’s designee in writing within 15 days of the earlier
of the receipt of the information or the end of the 45-day period if the health care plan determines that it is not a
surprise bill.

The health care plan must provide the foregoing information in a grievance determination under Insurance
Law section 4802 or Public Health Law section 4408-a related to the assignment of benefits form for a surprise
bill.

Besides requiring additional notifications from health care plans, this rule also requires non-participating
physicians who bill for emergency services or a surprise bill to provide the insured with information regarding
the IDR process in a form prescribed by the Superintendent, along with the claim form and assignment of
benefits form, which are currently only required to be provided with surprise bills.

4. Costs: Health care plans and physicians may incur additional costs to comply with the rule. The
additional costs for physicians may include costs to provide consumer disclosure information with bills for out-
of-network emergency services and surprise bills. However, any additional costs should be minimal because
the current law already requires physicians to provide a claim form and an assignment of benefits form to an
insured who receives a surprise bill. The additional costs for a health care plan may include costs to provide
insureds with additional notifications regarding surprise bills in the initial and final adverse determinations and
additional notifications upon receipt of an assignment of benefits form if the health care plan determines that a
bill is not a surprise bill. However, the additional costs should be minimal because health care plans are
currently required by Insurance Law and Public Health Law sections 4903 and 4904 to provide initial and final
adverse determinations to insureds and the additional information required to be distributed to insureds by this rule may be contained within the existing notifications to mitigate costs. Similarly, Insurance Law section 4802 and Public Health Law section 4408-a currently require health care plans to provide grievance and grievance appeal determinations to insureds, and additional information may be added to existing notifications.

The Department of Financial Services will not incur any costs to implement this rule.

The rule will not impose compliance costs on any local governments.

5. Local government mandates: The rule does not impose any program, service, duty or responsibility on any county, city, town, village, school district, fire district or other special district.

6. Paperwork: Health care plans and physicians will incur additional paperwork to comply with this rule because they will need to provide insureds with additional notices.

7. Duplication: This rule does not duplicate, overlap, or conflict with any existing state or federal rules or other legal requirements.

8. Alternatives: The Department considered not modifying the rule to provide these additional notices when a health care plan determines that services were not emergency services and therefore denies the claim because the health care plan determines that the services did not need to be performed on an emergency basis. However, without the notices, the insured may not be aware that, if the insured receives a bill for the denied services, the bill could be a surprise bill and the insured has additional protections under the law. Additionally, without the modification to the process for a health care plan determination that a bill is not a surprise bill, insureds may not be receiving written determinations that include information regarding their rights to appeal the determination or submit a complaint to the Superintendent.

9. Federal standards: The rule does not exceed any minimum standards of the federal government for the same or similar subject areas.
10. Compliance schedule: The rule will take effect 30 days after publication of the Notice of Adoption in the State Register.
Regulatory Flexibility Analysis for Small Businesses and Local Governments for the Proposed First Amendment to 23 NYCRR 400

1. Effect of the rule: This rule affects all health maintenance organizations and insurers authorized to do business in New York State (collectively, “health care plans”). Based upon information that health care plans have provided in their annual statements and filed with the Department of Financial Services (“Department”), they are not “small businesses” as defined in State Administrative Procedure Act (“SAPA”) Section 102(8) because they are not independently owned and operated and do not employ 100 or fewer employees.

However, this rule affects physicians, some of whom may be small businesses under SAPA. The Department does not maintain records of the number of physicians licensed in this state who are small businesses.

This rule does not affect local governments.

2. Compliance requirements: No local government will have to undertake any reporting, recordkeeping, or other affirmative acts to comply with this rule because the rule does not apply to any local government.

A physician who is a small business will be subject to reporting, recordkeeping, or other compliance requirements as the physician will need to include consumer disclosure information in bills for out-of-network emergency services and surprise bills.

3. Professional services: No local government will need professional services to comply with this rule because the rule does not apply to any local government. No physician that is a small business affected by this rule should need to retain professional services, such as lawyers or auditors, to comply with this rule.

4. Compliance costs: No local government will incur any costs to comply with this amendment because the amendment does not apply to any local government. Physicians who are small businesses may incur additional costs to comply with the rule. Those additional costs may include costs to provide consumer
disclosure information with bills for out-of-network emergency services and surprise bills. However, any additional costs should be minimal because the current law already requires physicians who are small businesses to provide a claim form and an assignment of benefits form to an insured who receives a surprise bill.

5. Economic and technological feasibility: This rule does not apply to any local government; therefore, no local government should experience any economic or technological impact as a result of the rule. Physicians who are small businesses should not incur any economic or technological impact as a result of the rule.

6. Minimizing adverse impact: There will not be an adverse impact on any local government because the rule does not apply to any local government. This rule should not have an adverse impact on a physician who is a small business because it only requires a non-participating physician to provide an insured with consumer disclosure information for surprise bills. For bills for emergency services, it requires a non-participating physician to send the same disclosures that are already required to be sent for surprise bills, plus the additional consumer disclosure information the rule adds for surprise bills. The Department will provide the form for the new consumer disclosure information to non-participating physicians who are small businesses.

7. Small business and local government participation: The Department will comply with SAPA Section 202-b(6) by publishing the proposed amendment in the State Register and posting the proposed amendment on its website.
1. Types and estimated numbers of rural areas: Insurers and health maintenance organizations (collectively, “health care plans”) and physicians affected by this amendment operate in every county in this state, including rural areas as defined by State Administrative Procedure Act section 102(10).

2. Reporting, recordkeeping and other compliance requirements; and professional services: A health care plan, including a health care plan in a rural area, may be subject to additional reporting, recordkeeping, or other compliance requirements. Health care plans may need to amend notifications sent to insureds when they determine that services of a non-participating physician or a non-participating health care provider at a participating hospital are not emergency services and make an adverse determination pursuant to Insurance Law or Public Health Law Article 49 or when a health care plan receives an assignment of benefits form but determines that the bill is not a surprise bill. Non-participating physicians, including non-participating physicians in rural areas, will also need to provide consumer disclosure information regarding the independent dispute resolution (“IDR”) process in a format prescribed by the Superintendent of Financial Services (“Superintendent”). With regard to surprise bills, this rule does not create new notice requirements, but rather requires additional disclosure information to be included in current notices health care plans and non-participating physicians are already obligated to provide to insureds.

Health care plans and physicians, including health care plans and physicians in a rural area, should not need to retain professional services, such as lawyers or auditors, to comply with this amendment.

3. Costs: Health care plans and physicians may incur additional costs to comply with the rule. The additional costs for physicians may include costs to provide consumer disclosure information with bills for out-of-network emergency services and surprise bills. However, any additional costs should be minimal because the current law already requires physicians to provide a claim form and an assignment of benefits form to an insured who receives a surprise bill. The additional costs for a health care plan may include costs to provide
insureds with additional notifications regarding surprise bills in the initial and final adverse determinations and additional information upon receipt of an assignment of benefits form if the health care plan determines that a bill is not a surprise bill. However, the additional costs should be minimal because health care plans are currently required by Insurance Law and Public Health Law sections 4903 and 4904 to provide initial and final adverse determinations to insureds and the additional information required to be distributed to insureds by this rule may be contained within the existing notifications to mitigate costs. Similarly, Insurance Law section 4802 and Public Health Law section 4408-a currently require health care plans to provide grievance and grievance appeal determinations to insureds, and additional information may be added to existing notifications.

4. Minimizing adverse impact: This amendment uniformly affects health care plans and physicians that are located in both rural and non-rural areas of New York State. The amendment should not have an adverse impact on rural areas.

5. Rural area participation: Health care plans and physicians, including health care plans and physicians in rural areas, will have an opportunity to participate in the rule-making process when the proposed amendment is published in the State Register and on the Department of Financial Services’ website.
Statement Setting Forth the Basis for the Finding that the Proposed First Amendment to 23 NYCRR 400 Will Not Have a Substantial Adverse Impact on Jobs and Employment Opportunities

The Department of Financial Services ("Department") finds that this amendment should have no substantial adverse impact on jobs or employment opportunities in New York because the amendment merely requires health maintenance organizations, insurers authorized to do business in New York State, and physicians to provide certain notices and consumer disclosure information related to surprise bills and bills for emergency services to insureds.