

7745

I N S E N A T E

June 17, 2012

Introduced by Sen. HANNON -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

AN ACT to amend the insurance law, the public health law and the financial services law, in relation to establishing protections to prevent surprise medical bills including network adequacy requirements, claim submission requirements, adequacy of and access to out-of-network care and prohibition of excessive emergency charges; and providing for the repeal of certain provisions upon expiration thereof

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 Section 1. Paragraphs 11, 12, 13, 14, 16 and 17 of subsection (a) of
2 section 3217-a of the insurance law, as added by chapter 705 of the laws
3 of 1996, are amended and three new paragraphs 16-a, 18 and 19 are added
4 to read as follows:
5 (11) where applicable, notice that an insured enrolled in a managed
6 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF
7 PROVIDERS offered by the insurer may obtain a referral to a health care
8 provider outside of the insurer's network or panel when the insurer does
9 not have a health care provider with appropriate training and experience
10 in the network or panel to meet the particular health care needs of the
11 insured and the procedure by which the insured can obtain such referral;
12 (12) where applicable, notice that an insured enrolled in a managed
13 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF
14 PROVIDERS offered by the insurer with a condition which requires ongoing
15 care from a specialist may request a standing referral to such a
16 specialist and the procedure for requesting and obtaining such a stand-
17 ing referral;
18 (13) where applicable, notice that an insured enrolled in a managed
19 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF
20 PROVIDERS offered by the insurer with (i) a life-threatening condition
21 or disease, or (ii) a degenerative and disabling condition or disease,
22 either of which requires specialized medical care over a prolonged peri-
23 od of time may request a specialist responsible for providing or coordi-

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

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1 nating the insured's medical care and the procedure for requesting and
2 obtaining such a specialist;

3 (14) where applicable, notice that an insured enrolled in a managed
4 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF
5 PROVIDERS offered by the insurer with (i) a life-threatening condition
6 or disease, or (ii) a degenerative and disabling condition or disease,
7 either of which requires specialized medical care over a prolonged peri-
8 od of time, may request access to a specialty care center and the proce-
9 dure by which such access may be obtained;

10 (16) notice of all appropriate mailing addresses and telephone numbers
11 to be utilized by insureds seeking information or authorization; [and]

12 (16-A) WHERE APPLICABLE, NOTICE THAT AN INSURED SHALL HAVE DIRECT
13 ACCESS TO PRIMARY AND PREVENTIVE OBSTETRIC AND GYNECOLOGIC SERVICES
14 INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINA-
15 TIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, FROM A QUALIFIED
16 PROVIDER OF SUCH SERVICES OF HER CHOICE FROM WITHIN THE PLAN OR FOR ANY
17 CARE RELATED TO A PREGNANCY;

18 (17) where applicable, a listing by specialty, which may be in a sepa-
19 rate document that is updated annually, of the name, address, and tele-
20 phone number of all participating providers, including facilities, and
21 in addition, in the case of physicians, board certification[.],
22 LANGUAGES SPOKEN AND AFFILIATION WITH PARTICIPATING HOSPITALS. THE LIST-
23 ING SHALL ALSO BE POSTED ON THE INSURER'S WEBSITE AND THE INSURER SHALL
24 UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF
25 A PROVIDER FROM THE INSURER'S NETWORK OR A CHANGE IN A PHYSICIAN'S
26 HOSPITAL AFFILIATION;

27 (18) A DESCRIPTION OF THE METHOD BY WHICH AN INSURED MAY SUBMIT A
28 CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELEC-
29 TRONIC MAIL OR BY FACSIMILE; AND

30 (19) WHERE APPLICABLE, WHEN A POLICY OFFERS OUT-OF-NETWORK COVERAGE
31 PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THIRTY-TWO HUNDRED FORTY
32 OF THIS ARTICLE:

33 (A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE INSURER TO
34 DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

35 (B) A DESCRIPTION OF THE AMOUNT THAT THE INSURER WILL REIMBURSE UNDER
36 THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A
37 PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH
38 CARE SERVICES; AND

39 (C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED
40 OUT-OF-NETWORK HEALTH CARE SERVICES.

41 S 2. Paragraphs 11 and 12 of subsection (b) of section 3217-a of the
42 insurance law, as added by chapter 705 of the laws of 1996, are amended
43 and three new paragraphs 13, 14 and 15 are added to read as follows:

44 (11) where applicable, provide the written application procedures and
45 minimum qualification requirements for health care providers to be
46 considered by the insurer for participation in the insurer's network for
47 a managed care product; [and]

48 (12) disclose such other information as required by the superinten-
49 dent, provided that such requirements are promulgated pursuant to the
50 state administrative procedure act[.];

51 (13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A
52 HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

53 (14) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE,
54 DISCLOSE THE DOLLAR AMOUNT THAT THE INSURER WILL PAY FOR A SPECIFIC
55 OUT-OF-NETWORK HEALTH CARE SERVICE; AND

(15) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS AN INSURED OR PROSPECTIVE INSURED TO DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE INSURER WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 3. Section 3217-a of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN 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 THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 4. Section 3217-d of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 5. Section 3224-a of the insurance law is amended by adding a new subsection (i) to read as follows:

(I) AN INSURER OR AN ORGANIZATION OR CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL ACCEPT CLAIMS SUBMITTED BY A POLICYHOLDER OR COVERED PERSON THROUGH THE INTERNET, ELECTRONIC MAIL OR BY FACSIMILE.

S 6. The insurance law is amended by adding a new section 3240 to read as follows:

S 3240. NETWORK COVERAGE. (A) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, OR A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER THAT ISSUES A HEALTH INSURANCE POLICY OR CONTRACT WITH A NETWORK OF HEALTH CARE PROVIDERS SHALL ENSURE THAT THE NETWORK IS ADEQUATE TO MEET THE HEALTH NEEDS OF INSURED AND PROVIDE AN APPROPRIATE CHOICE OF PROVIDERS SUFFICIENT TO RENDER THE SERVICES COVERED UNDER THE POLICY OR CONTRACT. THE SUPERINTENDENT SHALL REVIEW THE NETWORK OF HEALTH CARE PROVIDERS FOR ADEQUACY AT THE TIME OF THE SUPERINTENDENT'S INITIAL APPROVAL OF A HEALTH INSURANCE POLICY OR CONTRACT; AT LEAST EVERY THREE YEARS THEREAFTER; AND UPON APPLICATION FOR EXPANSION OF ANY SERVICE AREA ASSOCIATED WITH THE POLICY OR CONTRACT. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED BY THE COMMISSIONER OF HEALTH TO MEET THE STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND

1 FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE
2 DEEMED ADEQUATE BY THE SUPERINTENDENT.

3 (B) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE
4 FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN
5 CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH
6 MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE
7 PUBLIC HEALTH LAW, THAT PROVIDES COVERAGE FOR OUT-OF-NETWORK SERVICES
8 SHALL PROVIDE SIGNIFICANT COVERAGE OF THE USUAL AND CUSTOMARY COSTS OF
9 OUT-OF-NETWORK HEALTH CARE SERVICES.

10 (C) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE
11 FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN
12 CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH
13 MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE
14 PUBLIC HEALTH LAW, THAT PROVIDES COVERAGE FOR OUT-OF-NETWORK SERVICES
15 SHALL OFFER AT LEAST ONE POLICY OR CONTRACT OPTION IN EACH GEOGRAPHICAL
16 REGION COVERED THAT PROVIDES COVERAGE FOR AT LEAST EIGHTY PERCENT OF THE
17 USUAL AND CUSTOMARY COST OF OUT-OF-NETWORK HEALTH CARE SERVICES AFTER
18 IMPOSITION OF A DEDUCTIBLE.

19 (D) FOR THE PURPOSES OF THIS SECTION "USUAL AND CUSTOMARY COST" SHALL
20 MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH
21 CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY
22 AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING
23 DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPER-
24 INTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN
25 INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THIS ARTICLE, A
26 MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE
27 FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTI-
28 FIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

29 S 7. Section 4306-c of the insurance law is amended by adding a new
30 subsection (d) to read as follows:

31 (D) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFIT
32 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT
33 ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND
34 IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION
35 (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL
36 PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIRE-
37 MENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF
38 THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE
39 HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR
40 THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF
41 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAP-
42 TER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B)
43 OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

44 S 8. Paragraphs 11, 12, 13, 14, 16-a, 17, and 18 of subsection (a) of
45 section 4324 of the insurance law, as added by chapter 705 of the laws
46 of 1996, paragraph 16-a as added by chapter 554 of the laws of 2002, are
47 amended and two new paragraphs 19 and 20 are added to read as follows:

48 (11) where applicable, notice that a subscriber enrolled in a managed
49 care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF
50 PROVIDERS offered by the corporation may obtain a referral to a health
51 care provider outside of the corporation's network or panel when the
52 corporation does not have a health care provider with appropriate train-
53 ing and experience in the network or panel to meet the particular health
54 care needs of the subscriber and the procedure by which the subscriber
55 can obtain such referral;

(12) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the subscriber's medical care and the procedure for requesting and obtaining such a specialist;

(14) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

(16-a) where applicable, notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [for no fewer than two examinations annually for such services] or [to] FOR any care related to A pregnancy [and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition];

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification[; and], LANGUAGES SPOKEN AND AFFILIATION WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON THE CORPORATION'S WEBSITE AND THE CORPORATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE CORPORATION'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

(18) a description of the mechanisms by which subscribers may participate in the development of the policies of the corporation[.];

(19) A DESCRIPTION OF THE METHOD BY WHICH A SUBSCRIBER MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELECTRONIC MAIL OR BY FACSIMILE; AND

(20) WHERE APPLICABLE, WHEN A CONTRACT OFFERS OUT-OF-NETWORK COVERAGE PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THIRTY-TWO HUNDRED FORTY OF THIS CHAPTER:

(A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE CORPORATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(B) A DESCRIPTION OF THE AMOUNT THAT THE CORPORATION WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES.

1 S 9. Paragraphs 11 and 12 of subsection (b) of section 4324 of the
2 insurance law, as added by chapter 705 of the laws of 1996, are amended
3 and three new paragraphs 13, 14 and 15 are added to read as follows:

4 (11) where applicable, provide the written application procedures and
5 minimum qualification requirements for health care providers to be
6 considered by the corporation for participation in the corporation's
7 network for a managed care product; [and]

8 (12) disclose such other information as required by the superinten-
9 dent, provided that such requirements are promulgated pursuant to the
10 state administrative procedure act[.];

11 (13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A
12 HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

13 (14) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE,
14 DISCLOSE THE DOLLAR AMOUNT THAT THE CORPORATION WILL PAY FOR A SPECIFIC
15 OUT-OF-NETWORK HEALTH CARE SERVICE; AND

16 (15) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE
17 THAT REASONABLY PERMITS A SUBSCRIBER OR PROSPECTIVE SUBSCRIBER TO DETER-
18 MINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE
19 SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE
20 BETWEEN WHAT THE CORPORATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH
21 CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH
22 CARE SERVICES.

23 S 10. Section 4324 of the insurance law is amended by adding a new
24 subsection (f) to read as follows:

25 (F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL
26 MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH
27 CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY
28 AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING
29 DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPER-
30 INTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN
31 INSURER, A CORPORATION SUBJECT TO THIS ARTICLE, A MUNICIPAL COOPERATIVE
32 HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS
33 CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO
34 ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

35 S 11. Subsection (g-7) of section 4900 of the insurance law is redes-
36 igned subsection (g-8) and a new subsection (g-7) is added to read as
37 follows:

38 (G-7) "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL UNDER A MANAGED
39 CARE PRODUCT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT
40 HUNDRED ONE OF THIS CHAPTER OF A REQUEST FOR AN AUTHORIZATION OR REFER-
41 RAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS THAT THE HEALTH CARE PLAN
42 HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS
43 NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR
44 HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE
45 REQUESTED HEALTH SERVICE. THE NOTICE OF A DENIAL OF AN OUT-OF-NETWORK
46 REFERRAL PROVIDED TO AN INSURED SHALL INCLUDE INFORMATION EXPLAINING
47 WHAT INFORMATION THE INSURED MUST SUBMIT IN ORDER TO APPEAL THE DENIAL
48 OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBSECTION (A-2) OF SECTION
49 FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A DENIAL OF AN OUT-OF-
50 NETWORK REFERRAL UNDER THIS SUBSECTION DOES NOT CONSTITUTE AN ADVERSE
51 DETERMINATION AS DEFINED IN THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK
52 REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS
53 DEFINED IN SUBSECTION (G-6) OF THIS SECTION.

54 S 12. Subsection (b) of section 4903 of the insurance law, as added by
55 chapter 705 of the laws of 1996, is amended to read as follows:

(b) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. THE NOTIFICATION SHALL IDENTIFY WHETHER THE SERVICES ARE CONSIDERED IN-NETWORK OR OUT-OF-NETWORK.

S 13. Section 4904 of the insurance law is amended by adding a new subsection (a-2) to read as follows:

(A-2) AN INSURED OR THE INSURED'S DESIGNEE MAY APPEAL A DENIAL OF AN OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN STATEMENT FROM THE INSURED'S ATTENDING PHYSICIAN, WHO MUST BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT THAT: (1) THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED FOR THE HEALTH SERVICE; AND (2) RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 14. Subsection (b) of section 4910 of the insurance law is amended by adding a new paragraph 4 to read as follows:

(4)(A) THE INSURED HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(B) THE INSURED'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 15. Paragraph 4 of subsection (b) of section 4914 of the insurance law is amended by adding a new subparagraph (D) to read as follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE RELATING TO AN OUT-OF-NETWORK REFERRAL, THE EXTERNAL APPEAL AGENT SHALL REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND, IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

(I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS;

(II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

(I) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE

1 INSURED, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE INSURED'S MEDICAL
2 RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES
3 NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET
4 THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED WHO IS ABLE TO PROVIDE
5 THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS
6 THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH
7 CARE NEEDS OF AN INSURED, IS ABLE TO PROVIDE THE REQUESTED HEALTH
8 SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME;
9 OR

10 (II) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE;

11 (III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO
12 BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN;

13 (IV) BE BINDING ON THE PLAN AND THE INSURED; AND

14 (V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

15 S 16. The public health law is amended by adding a new section 23 to
16 read as follows:

17 S 23. CLAIM FORMS. A PHYSICIAN SHALL INCLUDE A CLAIM FORM FOR A
18 THIRD-PARTY PAYOR WITH A PATIENT BILL FOR HEALTH CARE SERVICES, OTHER
19 THAN A BILL FOR THE PATIENT'S CO-PAYMENT, COINSURANCE OR DEDUCTIBLE.

20 S 17. The public health law is amended by adding a new section 24 to
21 read as follows:

22 S 24. DISCLOSURE. 1. A HEALTH CARE PROFESSIONAL SHALL DISCLOSE TO
23 PATIENTS OR PROSPECTIVE PATIENTS IN WRITING OR THROUGH AN INTERNET
24 WEBSITE THE HEALTH CARE PLANS IN WHICH THE HEALTH CARE PROFESSIONAL IS A
25 PARTICIPATING PROVIDER AND THE HOSPITALS WITH WHICH THE HEALTH CARE
26 PROFESSIONAL IS AFFILIATED.

27 2. IF A HEALTH CARE PROFESSIONAL DOES NOT PARTICIPATE IN THE NETWORK
28 OF A PATIENT'S OR PROSPECTIVE PATIENT'S HEALTH CARE PLAN, THE HEALTH
29 CARE PROFESSIONAL SHALL, UPON RECEIPT OF A REQUEST FROM A PATIENT OR
30 PROSPECTIVE PATIENT, DISCLOSE TO THE PATIENT OR PROSPECTIVE PATIENT IN
31 WRITING THE AMOUNT OR ESTIMATED AMOUNT THE HEALTH CARE PROFESSIONAL WILL
32 BILL THE PATIENT OR PROSPECTIVE PATIENT FOR HEALTH CARE SERVICES
33 PROVIDED OR ANTICIPATED TO BE PROVIDED TO THE PATIENT OR PROSPECTIVE
34 PATIENT.

35 3. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL PROVIDE A
36 PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, MAILING
37 ADDRESS, AND TELEPHONE NUMBER OF ANY HEALTH CARE PROVIDER OF ANESTHE-
38 SIOLOGY, LABORATORY, PATHOLOGY, RADIOLOGY OR ASSISTANT SURGEON SERVICES
39 PERFORMED IN THE PHYSICIAN'S OFFICE OR COORDINATED OR REFERRED BY THE
40 PHYSICIAN.

41 4. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL, FOR A
42 PATIENT'S SCHEDULED HOSPITAL ADMISSION OR SCHEDULED OUTPATIENT HOSPITAL
43 SERVICES, PROVIDE A PATIENT AND THE HOSPITAL WITH THE NAME, PRACTICE
44 NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY OTHER PHYSICIAN WHOSE
45 SERVICES WILL BE ARRANGED BY THE PHYSICIAN AND ARE SCHEDULED AT THE TIME
46 OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION.

47 5. A HOSPITAL SHALL ESTABLISH, UPDATE, MAKE PUBLIC AND POST ON THE
48 HOSPITAL'S WEBSITE, A LIST OF THE HOSPITAL'S STANDARD CHARGES FOR ITEMS
49 AND SERVICES PROVIDED BY THE HOSPITAL, INCLUDING FOR DIAGNOSIS-RELATED
50 GROUPS ESTABLISHED UNDER SECTION 1886(D)(4) OF THE FEDERAL SOCIAL SECU-
51 RITY ACT.

52 6. A HOSPITAL SHALL POST ON THE HOSPITAL'S WEBSITE: (A) THE HEALTH
53 CARE PLANS IN WHICH THE HOSPITAL IS A PARTICIPATING PROVIDER; AND (B)
54 THE NAME, PRACTICE NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF ANY
55 HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN AND WHOSE SERVICES WILL BE

1 PROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL
2 CHARGES.

3 7. A HOSPITAL SHALL, AT THE EARLIER OF EITHER PRE-ADMISSION TESTING,
4 OUTPATIENT REGISTRATION, OR A NON-EMERGENCY HOSPITAL ADMISSION: (A)
5 PROVIDE A PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME,
6 MAILING ADDRESS AND TELEPHONE NUMBER OF ANY HEALTH CARE PROFESSIONAL WHO
7 IS A PHYSICIAN AND WHOSE SERVICES ARE REASONABLY ANTICIPATED AT THE TIME
8 OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION AND WILL BE
9 PROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL
10 CHARGES, AS REPORTED BY THE PATIENT'S PHYSICIAN; AND (B) DISCLOSE WHETH-
11 ER THE SERVICES OF HEALTH CARE PROFESSIONALS WHO ARE PHYSICIANS AND
12 TYPICALLY PROVIDE HOSPITAL SERVICES SUCH AS, BUT NOT LIMITED TO, ANESTH-
13 ESIOLOGY, PATHOLOGY OR RADIOLOGY ARE BILLED AS PART OF THE HOSPITAL
14 CHARGES.

15 8. FOR PURPOSES OF THIS SUBDIVISION:

16 (A) "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER
17 LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIR-
18 TY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE
19 FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT
20 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A
21 HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR
22 OF THIS CHAPTER; OR A SELF-FUNDED EMPLOYEE WELFARE BENEFIT PLAN.

23 (B) "HEALTH CARE PROFESSIONAL" MEANS AN APPROPRIATELY LICENSED, REGIS-
24 TERED OR CERTIFIED HEALTH CARE PROFESSIONAL PURSUANT TO TITLE EIGHT OF
25 THE EDUCATION LAW.

26 S 18. Paragraphs (p-1), (q) and (r) of subdivision 1 of section 4408
27 of the public health law, paragraph (p-1) as added by chapter 554 of the
28 laws of 2002, and paragraphs (q) and (r) as added by chapter 705 of the
29 laws of 1996, are amended and two new paragraphs (s) and (t) are added
30 to read as follows:

31 (p-1) notice that an enrollee shall have direct access to primary and
32 preventive obstetric and gynecologic services INCLUDING ANNUAL EXAMINA-
33 TIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF
34 ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services
35 of her choice from within the plan [for no fewer than two examinations
36 annually for such services] or [to] FOR any care related to A pregnancy
37 [and that additionally, the enrollee shall have direct access to primary
38 and preventive obstetric and gynecologic services required as a result
39 of such annual examinations or as a result of an acute gynecologic
40 condition];

41 (q) notice of all appropriate mailing addresses and telephone numbers
42 to be utilized by enrollees seeking information or authorization; [and]

43 (r) a listing by specialty, which may be in a separate document that
44 is updated annually, of the name, address and telephone number of all
45 participating providers, including facilities, and, in addition, in the
46 case of physicians, board certification[.], LANGUAGES SPOKEN AND AFFIL-
47 IATION WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON
48 THE HEALTH MAINTENANCE ORGANIZATION'S WEBSITE AND THE HEALTH MAINTENANCE
49 ORGANIZATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDI-
50 TION OR TERMINATION OF A PROVIDER FROM THE HEALTH MAINTENANCE ORGANIZA-
51 TION'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

52 (S) WHERE APPLICABLE, A DESCRIPTION OF THE METHOD BY WHICH AN ENROLLEE
53 MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE
54 INTERNET, ELECTRONIC MAIL OR BY FACSIMILE; AND

1 (T) WHERE APPLICABLE, WHEN A CONTRACT OFFERS OUT-OF-NETWORK COVERAGE
2 PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THIRTY-TWO HUNDRED FORTY
3 OF THE INSURANCE LAW:

4 (I) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE HEALTH MAINTENANCE ORGANIZATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

5 (II) A DESCRIPTION OF THE AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES; AND

6 (III) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES.

7 S 19. Paragraphs (k) and (l) of subdivision 2 of section 4408 of the public health law, as added by chapter 705 of the laws of 1996, are amended and three new paragraphs (m), (n) and (o) are added to read as follows:

8 (k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization; [and]

9 (l) disclose other information as required by the commissioner, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

10 (M) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

11 (N) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND

12 (O) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS AN ENROLLEE OR PROSPECTIVE ENROLLEE TO DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

13 S 20. Section 4408 of the public health law is amended by adding a new subdivision 7 to read as follows:

14 7. FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN 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 OF FINANCIAL SERVICES. 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 THIS ARTICLE.

15 S 21. Subdivision 7-g of section 4900 of the public health law is renumbered subdivision 7-h and a new subdivision 7-g is added to read as follows:

16 7-G. "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL OF A REQUEST FOR AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. THE NOTICE OF A DENIAL OF AN OUT-OF-NETWORK REFERRAL PROVIDED TO AN ENROLLEE SHALL INCLUDE INFORMA-

1 TION EXPLAINING WHAT INFORMATION THE ENROLLEE MUST SUBMIT IN ORDER TO
2 APPEAL THE DENIAL OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBDIVISION
3 ONE-B OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A
4 DENIAL OF AN OUT-OF-NETWORK REFERRAL UNDER THIS SUBDIVISION DOES NOT
5 CONSTITUTE AN ADVERSE DETERMINATION AS DEFINED IN THIS ARTICLE. A DENIAL
6 OF AN OUT-OF-NETWORK REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-
7 OF-NETWORK DENIAL AS DEFINED IN SUBDIVISION SEVEN-F OF THIS SECTION.

8 S 22. Subdivision 2 of section 4903 of the public health law, as added
9 by chapter 705 of the laws of 1996, is amended to read as follows:

10 2. A utilization review agent shall make a utilization review determi-
11 nation involving health care services which require pre-authorization
12 and provide notice of a determination to the enrollee or enrollee's
13 designee and the enrollee's health care provider by telephone and in
14 writing within three business days of receipt of the necessary informa-
15 tion. THE NOTIFICATION SHALL IDENTIFY WHETHER THE SERVICES ARE CONSID-
16 ERED IN-NETWORK OR OUT-OF-NETWORK.

17 S 23. Section 4904 of the public health law is amended by adding a new
18 subdivision 1-b to read as follows:

19 1-B. AN ENROLLEE OR THE ENROLLEE'S DESIGNEE MAY APPEAL A DENIAL OF AN
20 OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN
21 STATEMENT FROM THE ENROLLEE'S ATTENDING PHYSICIAN, WHO MUST BE A
22 LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRAC-
23 TICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE
24 FOR THE HEALTH SERVICE SOUGHT THAT: (A) THE IN-NETWORK HEALTH CARE
25 PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE
26 THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH
27 CARE NEEDS OF THE ENROLLEE FOR THE HEALTH SERVICE; AND (B) RECOMMENDS AN
28 OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO
29 MEET THE PARTICULAR HEALTH CARE NEEDS OF THE ENROLLEE, AND WHO IS ABLE
30 TO PROVIDE THE REQUESTED HEALTH SERVICE.

31 S 24. Subdivision 2 of section 4910 of the public health law is
32 amended by adding a new paragraph (d) to read as follows:

33 (D)(I) THE ENROLLEE HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE
34 GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE
35 IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND
36 EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND
37 WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

38 (II) THE ENROLLEE'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED,
39 BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE
40 SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE FOR THE
41 HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVID-
42 ER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE
43 APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE
44 NEEDS OF AN ENROLLEE, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE
45 APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE
46 NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH
47 SERVICE.

48 S 25. Paragraph (d) of subdivision 2 of section 4914 of the public
49 health law is amended by adding a new subparagraph (D) to read as
50 follows:

51 (D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH (D) OF SUBDI-
52 VISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE
53 RELATING TO AN OUT-OF-NETWORK REFERRAL, THE EXTERNAL APPEAL AGENT SHALL
54 REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND,
55 IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMI-

NATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

(I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS;

(II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

(1) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE ENROLLEE, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE ENROLLEE'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME; OR

(2) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE;

(III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN;

(IV) BE BINDING ON THE PLAN AND THE ENROLLEE; AND

(V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

S 26. The financial services law is amended by adding a new article 7 to read as follows:

ARTICLE 7

EMERGENCY MEDICAL SERVICES

SECTION 701. DEFINITIONS.

702. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES.

703. DISPUTE RESOLUTION.

704. CRITERIA FOR DETERMINING EXCESSIVE CHARGES.

S 701. DEFINITIONS. 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.

(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. S 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. S 1395DD, TO STABILIZE THE PATIENT.

(C) "EXCESSIVE FEE" MEANS A FEE THAT IS IN EXCESS OF AN AMOUNT DETERMINED IN ACCORDANCE WITH SECTION SEVEN HUNDRED FOUR OF THIS ARTICLE.

(D) "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT 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 SELF-FUNDED EMPLOYEE WELFARE BENEFIT PLAN.

(E) "INSURED" MEANS A PATIENT COVERED UNDER A POLICY OR CONTRACT WITH A HEALTH CARE PLAN.

(F) "PATIENT" MEANS A PERSON WHO RECEIVES EMERGENCY SERVICES IN THIS STATE.

(G) "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.

S 702. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES. (A) A PHYSICIAN WHO PROVIDES HEALTH CARE SERVICES IN THIS STATE SHALL NOT CHARGE AN EXCESSIVE FEE BASED ON THE CRITERIA FOR PROVIDING EMERGENCY SERVICES IN SECTION SEVEN HUNDRED THREE OF THIS ARTICLE.

(B) THIS ARTICLE DOES NOT APPLY TO EMERGENCY SERVICES WHERE PROVIDER 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.

S 703. DISPUTE RESOLUTION. (A) A HEALTH CARE PLAN OR A PATIENT ALLEGING THAT A PHYSICIAN HAS CHARGED AN EXCESSIVE FEE FOR PROVIDING EMERGENCY SERVICES MAY SUBMIT THE DISPUTE FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY, IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE SUPERINTENDENT, IF THE PHYSICIAN'S CHARGE EXCEEDS THE USUAL AND CUSTOMARY COST OF THE HEALTH CARE SERVICES.

(B) A PATIENT SHALL NOT BE REQUIRED TO PAY THE PHYSICIAN'S FEE IN ORDER TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO THE INDEPENDENT DISPUTE RESOLUTION ENTITY.

S 704. CRITERIA FOR DETERMINING EXCESSIVE CHARGES. (A)(1) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DECIDE WHETHER THE FEE CHARGED BY THE PHYSICIAN FOR THE SERVICES RENDERED IS EXCESSIVE. IN MAKING SUCH A DETERMINATION THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL CONSIDER ALL RELEVANT FACTORS INCLUDING:

(I) WHETHER THERE IS A GROSS DISPARITY BETWEEN THE FEE CHARGED BY THE PHYSICIAN FOR SERVICES RENDERED AS COMPARED TO: (A) FEES PAID BY THE HEALTH CARE PLAN TO REIMBURSE SIMILARLY QUALIFIED PHYSICIANS FOR THE SAME SERVICES IN THE SAME REGION WHO DO NOT PARTICIPATE WITH THE HEALTH CARE PLAN; AND (B) FEES PAID TO THE INVOLVED PHYSICIAN FOR THE SAME SERVICES RENDERED BY THE PHYSICIAN TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN DOES NOT PARTICIPATE;

(II) THE LEVEL OF TRAINING, EDUCATION AND EXPERIENCE OF THE PHYSICIAN;

1 (III) THE PHYSICIAN'S USUAL CHARGE FOR COMPARABLE SERVICES WITH REGARD
2 TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN DOES NOT PARTIC-
3 IPATE;

4 (IV) THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUD-
5 ING TIME AND PLACE OF THE SERVICE;

6 (V) INDIVIDUAL PATIENT CHARACTERISTICS; AND

7 (VI) THE USUAL AND CUSTOMARY COST OF THE SERVICE.

8 (2) IF THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THAT THE
9 FEE CHARGED IS EXCESSIVE, THEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY
10 SHALL DETERMINE A REASONABLE FEE FOR THE SERVICES BASED UPON THE SAME
11 CONDITIONS AND FACTORS SET FORTH IN THIS SUBDIVISION, WHICH FEE SHALL
12 NOT BE LESS THAN THE USUAL AND CUSTOMARY COST FOR SUCH SERVICES. THE
13 PHYSICIAN SHALL RETURN TO THE HEALTH CARE PLAN ANY PORTION OF THE FEE
14 PAID BY THE HEALTH CARE PLAN IN EXCESS OF THE AMOUNT DETERMINED TO BE
15 REASONABLE BY THE INDEPENDENT DISPUTE RESOLUTION ENTITY.

16 (B) THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY
17 SHALL BE BINDING ON THE HEALTH CARE PLAN, PHYSICIAN AND PATIENT, AND
18 SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE HEALTH CARE
19 PLAN, PHYSICIAN OR PATIENT, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN
20 THIS STATE AND THE PHYSICIAN.

21 (C) THE SUPERINTENDENT SHALL PROMULGATE REGULATIONS TO ESTABLISH STAN-
22 DARDS FOR THE DISPUTE RESOLUTION PROCESS INCLUDING STANDARDS FOR ESTAB-
23 LISHING WHICH PARTY SHALL BE RESPONSIBLE FOR PAYMENT OF THE DISPUTE
24 RESOLUTION PROCESS.

25 S 27. This act shall take effect January 1, 2013, provided, however,
26 that:

27 1. for policies renewed on and after such date this act shall take
28 effect on the renewal date;

29 2. sections twelve, sixteen, seventeen, twenty-two and twenty-six of
30 this act shall apply to health care services provided on and after such
31 date and section twenty-six of this act shall expire and be deemed
32 repealed January 1, 2015; and

33 3. sections eleven, thirteen, fourteen, fifteen, twenty-one, twenty-
34 three, twenty-four and twenty-five of this act shall apply to denials
35 issued on and after such date.