S T A T E O F N E W Y O R K

5834

2013-2014 Regular Sessions

I N S E N A T E

June 17, 2013

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

AN ACT to amend the public health law and the insurance law, in relation to approvals by a utilization review agent

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

Section 1. Subdivision 2 of section 4903 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

2. 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 enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information. TO THE EXTENT PRACTICABLE, SUCH WRITTEN NOTIFICATION TO THE ENROLLEE'S HEALTH CARE PROVIDER SHALL BE TRANSMITTED ELECTRONICALLY, IN A MANNER AND IN A FORM AGREED UPON BY THE PARTIES.

S 2. Paragraph (a) of subdivision 2 of section 4914 of the public health law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(a) The enrollee shall have four months to initiate an external appeal after the enrollee receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal, or after the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the enrollee's health care provider shall have [forty-five] SIXTY days to initiate an external appeal after the enrollee or the enrollee's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after

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

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both the plan and the enrollee have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subdivision five of this section. The enrollee, and the enrollee's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 3. Subsection (b) of section 4903 of the insurance law, as added by 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. TO THE EXTENT PRACTICABLE, SUCH WRITTEN NOTIFICATION TO THE ENROLLEE'S HEALTH CARE PROVIDER SHALL BE TRANSMITTED ELECTRONICALLY, IN A MANNER AND IN A FORM AGREED UPON BY THE PARTIES.

S 4. Paragraph 1 of subsection (b) of section 4914 of the insurance law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(1) The insured shall have four months to initiate an external appeal after the insured receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial, or after both the plan and the insured have jointly agreed to waive any internal appeal, or after the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the insured's health care provider shall have [forty-five] SIXTY days to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subsection (e) of this section. The insured, and the insured's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 5. This act shall take effect July 1, 2014.