STATE OF NEW YORK

8590

2025-2026 Regular Sessions

IN SENATE

November 26, 2025

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

AN ACT to amend the insurance law, in relation to establishing time-frames for the payment of claims to hospitals

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

Section 1. Subsection (a) of section 3224-a of the insurance law is amended by adding 7 new paragraphs 1, 2, 3, 4, 5, 6 and 7 to read as follows:

(1) 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 pay the claim to the hospital, as defined in article twenty-eight of the public health law, at the contracted rate for the services and site of service as billed within the timeframes set forth in this subsection. Such payment shall be made regardless of any such payor's medical necessity, payment or administrative policies, including, but not limited to, those policies regarding preauthorization, concurrent and retrospective medical necessity review, timely filing, and documentation requirements.

(2) Subsequent to and contingent upon paying the claim as billed, the payor may, within ninety days, request that the hospital submit the specific clinical documentation available to the treating physician at the time the determination was made that hospital care was clinically appropriate to a joint committee composed of equal numbers of medical directors and/or delegated clinicians from the payor and the hospital (the "joint committee") for a post payment review. The payor may only request submission of such documentation when there is a good faith, reasonable basis supported by specific information available for review by the joint committee that the service rendered by the hospital was not clinically appropriate. The payor shall not request documentation for more than ten percent of the claims paid since the last meeting of the

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

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joint committee. If the joint committee finds that over fifty percent of the cases for which documentation was requested were billed inappropriately, the payor may prospectively increase the maximum percentage of paid claims for which documentation can be requested to fifteen percent.

(3) Within sixty business days of receiving a request for specific clinical documentation available to the treating physician at the time the determination was made that inpatient hospital care was clinically appropriate, the hospital shall provide the clinical documentation to the joint committee for a post payment review. The joint committee shall meet not less than quarterly to conduct such reviews. The payor shall not reduce, adjust, amend or change the billed claims except as set forth in paragraph five of this subsection.

(4) Failure by the hospital to provide the clinical documentation necessary to confirm the medical necessity of the hospital services to the joint committee within the sixty business days of request by the payor, as required by paragraph three of this subsection, shall result in an automatic appeal to the independent third-party review agent described in paragraph five of this subsection. Nothing herein shall require the joint committee to be registered as a utilization review agent under article forty-nine of the public health law or article forty-nine of this chapter.

(5) Upon receipt of the documentation requested pursuant to paragraph two of this subsection, but no later than the next regularly scheduled joint committee meeting, the joint committee shall review the documentation and make a joint determination, in accordance with policies and standards mutually agreed upon by the hospital and the payor, as to whether the hospital services were medically necessary based on the clinical information available to the treating provider at the time a patient was seen and/or admitted. The payor and hospital may agree to meet more frequently than quarterly so long as such frequency does not require the joint committee to meet more frequently than every thirty days. In the event a joint determination cannot be agreed upon by the end of the first joint committee meeting immediately following receipt of documentation requested pursuant to paragraph two of this subsection, the payor shall, in conjunction with the hospital, jointly forward the clinical documentation and any other information either party deems to be relevant and chooses to provide with regard to the determination of medical necessity to a mutually agreed upon independent third-party review agent for a determination, which shall be binding. If the independent review agent determines that the services provided were not medically necessary based on the clinical information available to the treating provider at the time a patient was seen and/or admitted, in accordance with those same standards considered by the joint committee, in whole or in part, the hospital shall refund the payor the amount determined to be not medically necessary within thirty days. If the joint committee or independent third-party review determines that the services were not medically necessary, in whole or in part, the hospital shall not bill the insured, except for any applicable copayment, coinsurance or deductible that would be owed for the services.

(6) Nothing in this subsection shall preclude a payor and a health care provider from agreeing to other dispute resolution mechanisms provided that the payor remains responsible to pay the claim as billed by the hospital prior to reviewing such claim for medical necessity. Furthermore, when a hospital and payor are parties to a participating provider agreement applicable to the hospital services being reviewed by

the joint committee, the definition of medical necessity set forth in such participating provider agreement shall apply for purposes of joint committee and independent third party review; however, such definition of medical necessity shall not simply reference back to a payor's policies, nor shall it include site of service or cost.

(7) Nothing in this subsection shall be construed as limiting or abridging in any way a health care provider's rights under paragraph nine of subsection (i) of section thirty-two hundred sixteen or paragraph eight of subsection (a) of section forty-nine hundred two of this chapter with respect to insurance coverage for services to treat an emergency condition.

§ 2. This act shall take effect January 1, 2026. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.