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

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2009-2010 Regular Sessions

I N A S S E M B L Y

February 5, 2009

Introduced by M. of A. MORELLE, LANCMAN, CYMBROWITZ, PERRY, KOON, ALESSI, GALEF, STIRPE, SCHIMEL, CHRISTENSEN, MAISEL, DelMONTE, EDDINGTON, GREENE, CUSICK, SEMINERIO, LUPARDO, GABRYSZAK, TITONE, PHEFFER -- Multi-Sponsored by -- M. of A. BENJAMIN, BING, MAGNARELLI, WEISENBERG -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to premium rates for health insurance; to amend the insurance law and the public health law, in relation to coverage of services of participating providers; and to amend the insurance law, in relation to the fair and equitable settlement of claims for health care and payments for health services

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

Section 1. This act shall be known and may be cited as the "health insurance premium integrity act".

S 2. Subsection (e) of section 3231 of the insurance law, as added by chapter 501 of the laws of 1992, is amended to read as follows:

(e) (1) DEFINITIONS. FOR PURPOSES OF THIS SUBSECTION: (A) "POLICY FORM" SHALL MEAN A POLICY OR POLICIES AND ASSOCIATED RIDERS WHOSE EXPERIENCE HAS BEEN POOLED IN ORDER TO DETERMINE RATES FOR EACH POLICY AND EACH RIDER;

(B) "LOSS RATIO" SHALL MEAN THE RATIO OF DIRECT CLAIMS INCURRED FOR THE REPORTING CALENDAR YEAR TO DIRECT PREMIUMS EARNED FOR THE SAME REPORTING CALENDAR YEAR, EXPRESSED AS A PERCENTAGE;

(C) "DIRECT CLAIMS INCURRED" SHALL MEAN CLAIMS PAID DURING THE REPORTING CALENDAR YEAR PLUS THE UNPAID CLAIMS RESERVE AT THE END OF THE REPORTING CALENDAR YEAR AND CALCULATED CONSISTENT WITH SUBPARAGRAPH (C) OF PARAGRAPH THREE OF THIS SUBSECTION;

(D) "DIRECT PREMIUMS EARNED" SHALL MEAN PREMIUMS WRITTEN DURING THE REPORTING CALENDAR YEAR PLUS THE UNEARNED PREMIUMS AT THE BEGINNING OF THE YEAR LESS THE UNEARNED PREMIUMS AT THE END OF THE YEAR, EXCLUSIVE OF REINSURANCE ASSUMED OR CEDED; AND

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

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(E) "SMALL GROUP" SHALL MEAN A GROUP POLICY THAT IS SUBJECT TO THE REQUIREMENTS OF THIS SECTION.

(2) An insurer desiring to increase or decrease premiums after April first, nineteen hundred ninety-three for any policy form subject to this section shall submit a rate filing or application to the superintendent. The superintendent shall determine whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved.

[(2)] (3) (A) Beginning October first, nineteen hundred ninety-four, as an alternate procedure to the requirements of paragraph [one] TWO of this subsection, an insurer desiring to increase or decrease premiums for any policy form subject to this section may instead submit a rate filing or application to the superintendent and such application or filing shall be deemed approved, provided that (i) the anticipated minimum loss ratio [for a policy form] shall not be less than seventy-five percent of the premium FOR AN INDIVIDUAL HEALTH INSURANCE POLICY AND NOT LESS THAN EIGHTY PERCENT OF THE PREMIUM FOR A SMALL GROUP HEALTH INSURANCE POLICY, and (ii) the insurer submits, as part of such filing, a certification by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that the insurer is in compliance with the provisions of this paragraph, based upon that person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the insurer in establishing premium rates for policy forms subject to this section. SUCH CERTIFICATION SHALL AFFIRM THAT THE RATE FILING OR APPLICATION SUBMITTED TO THE SUPERINTENDENT PURSUANT TO THIS SUBSECTION WAS PREPARED IN ACCORDANCE WITH GENERALLY ACCEPTED ACTUARIAL PRINCIPLES AND THIS SECTION. THE INSURER SHALL, AT THE REQUEST OF THE SUPERINTENDENT, PROVIDE ADDITIONAL UNDERLYING ACTUARIAL DOCUMENTATION TO SUPPORT THE RATE FILING OR APPLICATION. PROVIDED, HOWEVER, THE REQUEST FOR SUCH INFORMATION SHALL NOT PRECLUDE THE NEW PREMIUM RATE FROM GOING INTO EFFECT.

(B) Each calendar year, an insurer shall return, in the form of aggregate benefits for each policy form filed pursuant to the alternate procedure set forth in this paragraph at least seventy-five percent of the aggregate premiums collected for the INDIVIDUAL HEALTH INSURANCE policy form during that calendar year, OR EIGHTY PERCENT OF THE AGGREGATE PREMIUMS COLLECTED FOR A SMALL GROUP HEALTH INSURANCE POLICY FORM DURING THAT CALENDAR YEAR. IF AN INSURER HAS POOLED THE EXPERIENCE OF POLICIES AND/OR RIDERS TO DETERMINE THE PREMIUM RATES, IN ACCORDANCE WITH APPLICABLE LAW, THE INSURER SHALL CALCULATE THE LOSS RATIOS IN ACCORDANCE WITH THE MANNER IN WHICH IT ESTABLISHED THE PREMIUM RATES. Insurers shall annually report, no later than [May] AUGUST first of each year, the loss ratio calculated pursuant to this paragraph for each such policy form for the previous calendar year. In each case where the loss ratio for a policy form fails to comply with the seventy-five percent loss ratio requirement FOR AN INDIVIDUAL HEALTH INSURANCE POLICY, OR THE EIGHTY PERCENT MINIMUM LOSS RATIO REQUIREMENT FOR A SMALL GROUP HEALTH INSURANCE POLICY, AS SET FORTH IN THIS PARAGRAPH, the insurer shall issue a dividend or credit against future premiums for all policy holders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal seventy-five percent of the aggregate premiums collected for [the] AN INDIVIDUAL HEALTH INSURANCE policy form AND EIGHTY PERCENT OF THE AGGREGATE PREMIUM COLLECTED FOR A SMALL GROUP HEALTH INSURANCE POLICY FORM in the previous calendar year. The

dividend or credit shall be issued to each policy which was in effect as of December thirty-first of the applicable year [and remains in effect as of the date the dividend or credit is issued]. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. AN INSURER SHALL MAKE A REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF THOSE POLICY HOLDERS WHO ARE NO LONGER POLICY HOLDERS WHEN THE DIVIDEND OR CREDIT IS ISSUED. The annual report required by this paragraph shall include an insurer's calculation of the dividends and credits, as well as an explanation of the insurer's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policy holder.

(C) DIRECT CLAIMS INCURRED FOR USE IN TESTING LOSS RATIO COMPLIANCE UNDER THIS PARAGRAPH SHALL BE CALCULATED AS FOLLOWS: (I) THE CLAIMS PAID DURING THE REPORTING CALENDAR YEAR; PLUS (II) CAPITATION PAYMENTS PAID FOR SERVICES TO BE RENDERED DURING THE REPORTING CALENDAR YEAR; PLUS (III) THE UNPAID CLAIM RESERVE AT THE END OF THE REPORTING CALENDAR YEAR WHICH SHALL BE CALCULATED AS THE SUM OF CLAIMS PAID FROM JANUARY FIRST THROUGH JUNE FIRST OF THE YEAR FOLLOWING THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED IN THE REPORTING CALENDAR YEAR OR PRIOR YEARS, PLUS THE UNPAID CLAIMS RESERVE AS OF JUNE FIRST OF THE YEAR FOLLOWING THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED IN THE REPORTING CALENDAR YEAR OR PRIOR YEARS DETERMINED FROM CLAIMS PAYMENTS THROUGH JUNE FIRST OF THE YEAR FOLLOWING THE REPORTING CALENDAR YEAR; MINUS (IV) THE UNPAID CLAIM RESERVE AT THE BEGINNING OF THE REPORTING CALENDAR YEAR WHICH SHALL BE CALCULATED AS THE SUM OF THE CLAIMS PAID FROM JANUARY FIRST THROUGH JUNE FIRST OF THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED PRIOR TO THE REPORTING CALENDAR YEAR, PLUS THE UNPAID CLAIMS RESERVE AS OF JUNE FIRST OF THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED PRIOR TO THE REPORTING CALENDAR YEAR DETERMINED FROM CLAIM PAYMENTS THROUGH JUNE FIRST OF THE REPORTING YEAR; PLUS OR MINUS (V) THE EFFECTS FOR THE REPORTING YEAR OF THE MARKET STABILIZATION POOLS; MINUS (VI) THE EFFECTS FOR THE REPORTING YEAR OF THE STOP-LOSS POOLS. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT THE SUPERINTENDENT FROM REVIEWING CLAIMS DATA BEYOND JUNE FIRST.

(D) (I) ANY INSURER THAT VIOLATES THE PROVISIONS OF THIS SECTION INCLUDING, BUT NOT LIMITED TO, ANY FAILURE TO PROVIDE A DIVIDEND OR CREDIT TO SUBSCRIBERS AS REQUIRED BY SUBPARAGRAPH (B) OF THIS PARAGRAPH, SHALL BE SUBJECT TO THE MAXIMUM PENALTIES PROVIDED IN THIS CHAPTER.

(II) IN ADDITION TO THE PENALTIES OTHERWISE IMPOSED PURSUANT TO THIS CHAPTER, WHERE AN INSURER ELECTING TO ADJUST PREMIUMS PURSUANT TO THE ALTERNATE PROCEDURE SET FORTH IN SUBPARAGRAPH (A) OF THIS PARAGRAPH, IS DETERMINED BY THE SUPERINTENDENT TO HAVE, IN A MANNER IN VIOLATION OF THE PROVISIONS OF THIS SECTION, MATERIALLY MISREPRESENTED THE LOSS RATIOS REQUIRED BY SUBPARAGRAPHS (A) AND (B) OF THIS PARAGRAPH IN TWO CONSECUTIVE FILINGS, AND IF, AT ANY TIME DURING A THREE YEAR PERIOD IN WHICH SUCH MATERIAL VIOLATIONS OCCURRED, THE INSURER FAILED TO PROVIDE A DIVIDEND OR CREDIT AS REQUIRED BY SUBPARAGRAPH (B) OF THIS PARAGRAPH, SUCH INSURER SHALL BE PRESUMED TO BE SUBSTANTIALLY NONCOMPLIANT WITH THE REQUIREMENTS OF THIS PARAGRAPH AND THE SUPERINTENDENT SHALL, AFTER A NOTICE AND A HEARING, HAVE THE AUTHORITY TO PROHIBIT SAID INSURER FROM ADJUSTING PREMIUMS PURSUANT TO THE ALTERNATE PROCEDURE FOR THE AFFECTED POLICY FORMS FOR A PERIOD OF UP TO THREE YEARS, COMMENCING WITH THE

SUPERINTENDENT'S NOTICE OF SUCH DETERMINATION. THIS PROHIBITION SHALL BE IN ADDITION TO ANY OTHER PENALTIES THAT THE SUPERINTENDENT MAY IMPOSE PURSUANT TO THIS CHAPTER.

(E) THE ALTERNATE PROCEDURE SET FORTH IN THIS PARAGRAPH SHALL NOT BE AVAILABLE TO ADJUST NEWLY-APPROVED PREMIUM RATES OR RATES RECENTLY ADJUSTED THROUGH THE PRIOR APPROVAL PROCESS UNTIL THE EARLIER OF (I) THE DEVELOPMENT OF SUFFICIENT ACTUAL CLAIMS EXPERIENCE TO JUSTIFY THE REQUESTED ADJUSTMENT, AS CERTIFIED BY A MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES OR OTHER INDIVIDUAL ACCEPTABLE TO THE SUPERINTENDENT, OR (II) TWELVE MONTHS FROM THE PRIOR APPROVAL. PROVIDED HOWEVER, NOTHING IN THIS SUBPARAGRAPH SHALL BE CONSTRUED TO PROHIBIT AN INSURER FROM UTILIZING THE ALTERNATE PROCEDURE TO ADJUST RATES ON A POLICY WHERE THE RATES FOR A RIDER TO THAT POLICY HAVE NOT BEEN IN EFFECT FOR TWELVE MONTHS.

S 3. Subsections (a), (b), (c), (d), (e), (f), (g), (h), (i) and (j) of section 4308 of the insurance law are relettered subsections (b), (c), (d), (e), (f), (g), (h), (i), (j) and (k) and a new subsection (a) is added to read as follows:

(A) DEFINITIONS. FOR PURPOSES OF THIS SECTION:

(1) "CONTRACT FORM" SHALL MEAN A CONTRACT OR CONTRACTS AND ASSOCIATED RIDERS WHOSE EXPERIENCE HAS BEEN POOLED IN ORDER TO DETERMINE RATES FOR EACH CONTRACT AND EACH RIDER;

(2) "LOSS RATIO" SHALL MEAN THE RATIO OF DIRECT CLAIMS INCURRED FOR THE REPORTING CALENDAR YEAR TO DIRECT PREMIUMS EARNED FOR THE SAME REPORTING CALENDAR YEAR, EXPRESSED AS A PERCENTAGE;

(3) "DIRECT CLAIMS INCURRED" SHALL MEAN CLAIMS PAID DURING THE REPORTING CALENDAR YEAR PLUS THE UNPAID CLAIMS RESERVE AT THE END OF THE REPORTING CALENDAR YEAR AND CALCULATED CONSISTENT WITH PARAGRAPH FOUR OF SUBSECTION (I) OF THIS SECTION;

(4) "DIRECT PREMIUMS EARNED" SHALL MEAN PREMIUMS WRITTEN DURING THE REPORTING CALENDAR YEAR PLUS THE UNEARNED PREMIUMS AT THE BEGINNING OF THE YEAR LESS THE UNEARNED PREMIUMS AT THE END OF THE YEAR, EXCLUSIVE OF REINSURANCE ASSUMED OR CEDED; AND

(5) "SMALL GROUP" SHALL MEAN A GROUP CONTRACT THAT IS SUBJECT TO THE REQUIREMENTS OF SECTION FOUR THOUSAND THREE HUNDRED SEVENTEEN OF THIS ARTICLE.

S 4. Paragraph 1 of subsection (h) of section 4308 of the insurance law, as added by chapter 504 of the laws of 1995 and such subsection as relettered by section three of this act, is amended to read as follows:

(1) Beginning January first, nineteen hundred ninety-six, as an alternate procedure to the requirements of subsection [(c)] (D) of this section, a corporation subject to the provisions of this article desiring to increase or decrease premiums for any contract subject to this section may instead submit a rate filing or application to the superintendent and such application or filing shall be deemed approved, provided that (A) the anticipated incurred loss ratio for a contract form shall not be less than eighty-five percent for individual direct payment contracts or [seventy-five] EIGHTY percent for small group and small group remittance contracts, nor, except in the case of individual direct payment contracts with a loss ratio of greater than one hundred five percent during nineteen hundred ninety-four, shall the loss ratio for any direct payment, group or group remittance contract be more than one hundred five percent of the anticipated earned premium, and (B) the corporation submits, as part of such filing, a certification by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that [that] THE corporation is in compliance with the provisions of this subsection, based upon that person's examination,

including a review of the appropriate records and of the actuarial assumptions and methods used by the corporation in establishing premium rates for contracts subject to this section. [For purposes of this section, a small group is any group whose contract is subject to the requirements of section forty-three hundred seventeen of this article.] SUCH CERTIFICATION SHALL AFFIRM THAT THE RATE FILING OR APPLICATION SUBMITTED TO THE SUPERINTENDENT PURSUANT TO THIS SUBSECTION WAS PREPARED IN ACCORDANCE WITH GENERALLY ACCEPTED ACTUARIAL PRINCIPLES AND THIS SECTION. THE INSURER SHALL, AT THE REQUEST OF THE SUPERINTENDENT, PROVIDE ADDITIONAL UNDERLYING ACTUARIAL DOCUMENTATION TO SUPPORT THE RATE FILING OR APPLICATION PROVIDED, HOWEVER, THE REQUEST FOR SUCH INFORMATION SHALL NOT PRECLUDE THE PREMIUM RATE FROM GOING INTO EFFECT.

S 5. Subsection (i) of section 4308 of the insurance law, as added by chapter 504 of the laws of 1995 and as relettered by section three of this act, is amended to read as follows:

(i) (1) Each calendar year, a corporation subject to the provisions of this article shall return, in the form of aggregate benefits incurred for each contract form filed pursuant to the alternate procedure set forth in subsection [(g)] (H) of this section, at least eighty-five percent for individual direct payment contracts or [seventy-five] EIGHTY percent for small group and small group remittance contracts, but, except in the case of individual direct payment contracts with a loss ratio of greater than one hundred five percent in nineteen hundred ninety-four, for any direct payment, group or group remittance contract, not in excess of one hundred five percent of the aggregate premiums earned for the contract form during that calendar year. IF A CORPORATION HAS POOLED THE EXPERIENCE OF CONTRACTS AND/OR RIDERS TO DETERMINE THE PREMIUM RATES IN ACCORDANCE WITH APPLICABLE LAW, THE CORPORATION SHALL CALCULATE THE LOSS RATIOS IN ACCORDANCE WITH THE MANNER IN WHICH IT ESTABLISHED THE PREMIUM RATES. Corporations subject to the provisions of this article shall annually report, no later than [May] AUGUST first of each year, the loss ratio calculated pursuant to this subsection for each such contract form for the previous calendar year.

(2) In each case where the loss ratio for a contract form fails to comply with the eighty-five percent minimum loss ratio requirement for individual direct payment contracts, or the [seventy-five] EIGHTY percent minimum loss ratio requirement for small group and small group remittance contracts, as set forth in paragraph one of this subsection, the corporation shall issue a dividend or credit against future premiums for all contract holders with that contract form in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year plus the amount of the dividends and credits shall equal no less than eighty-five percent for individual direct payment contracts, or [seventy-five] EIGHTY percent for small group and small group remittance contracts, of the aggregate premiums earned for the contract form in the previous calendar year. The dividend or credit shall be issued to each contract that was in effect as of December thirty-first of the applicable year [and remains in effect as of the date the dividend or credit is issued]. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. A CORPORATION SHALL MAKE A REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF THOSE CONTRACT HOLDERS WHO ARE NO LONGER CONTRACT HOLDERS WHEN THE DIVIDEND OR CREDIT IS ISSUED. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the dividends and credits, as well as an explanation of the corporation's plan to

issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a contract holder or subscriber.

(3) In each case where the loss ratio for a contract form fails to comply with the one hundred five percent maximum loss ratio requirement of paragraph one of this subsection, the corporation shall institute a premium rate increase in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year shall equal no more than one hundred five percent of the sum of the aggregate premiums earned for the contract form in the previous calendar year and the aggregate premium rate increase. The rate increase shall be applied to each contract that was in effect as of December thirty-first of the applicable year and remains in effect as of the date the rate increase is imposed. All rate increases must be imposed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the premium rate increase, as well as an explanation of the corporation's plan to implement the rate increase. The instructions and format for calculating and reporting loss ratios and implementing rate increases shall be specified by the superintendent by regulation.

(4) DIRECT CLAIMS INCURRED FOR USE IN TESTING LOSS RATIO COMPLIANCE UNDER THIS SUBSECTION SHALL BE CALCULATED AS FOLLOWS: (I) THE CLAIMS PAID DURING THE REPORTING CALENDAR YEAR; PLUS (II) CAPITATION PAYMENTS PAID FOR SERVICES TO BE RENDERED DURING THE REPORTING CALENDAR YEAR; PLUS (III) THE UNPAID CLAIM RESERVE AT THE END OF THE REPORTING CALENDAR YEAR WHICH SHALL BE CALCULATED AS THE SUM OF CLAIMS PAID FROM JANUARY FIRST THROUGH JUNE FIRST OF THE YEAR FOLLOWING THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED IN THE REPORTING CALENDAR YEAR OR PRIOR YEARS, PLUS THE UNPAID CLAIMS RESERVE AS OF JUNE FIRST OF THE YEAR FOLLOWING THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED IN THE REPORTING CALENDAR YEAR OR PRIOR YEARS DETERMINED FROM CLAIMS PAYMENTS THROUGH JUNE FIRST OF THE YEAR FOLLOWING THE REPORTING CALENDAR YEAR; MINUS (IV) THE UNPAID CLAIM RESERVE AT THE BEGINNING OF THE REPORTING CALENDAR YEAR WHICH SHALL BE CALCULATED AS THE SUM OF THE CLAIMS PAID FROM JANUARY FIRST THROUGH JUNE FIRST OF THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED PRIOR TO THE REPORTING CALENDAR YEAR, PLUS THE UNPAID CLAIMS RESERVE AS OF JUNE FIRST OF THE REPORTING CALENDAR YEAR ON CLAIMS INCURRED PRIOR TO THE REPORTING CALENDAR YEAR DETERMINED FROM CLAIM PAYMENTS THROUGH JUNE FIRST OF THE REPORTING YEAR; PLUS OR MINUS (V) THE EFFECTS FOR THE REPORTING YEAR OF THE MARKET STABILIZATION POOLS; MINUS (VI) THE EFFECTS FOR THE REPORTING YEAR OF THE STOP-LOSS POOLS. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT THE SUPERINTENDENT FROM REVIEWING CLAIMS DATA BEYOND JUNE FIRST.

S 6. Section 4308 of the insurance law is amended by adding two new subsections (l) and (m) to read as follows:

(1) (I) ANY INSURER THAT VIOLATES THE PROVISIONS OF THIS SECTION INCLUDING, BUT NOT LIMITED TO, ANY FAILURE TO PROVIDE A DIVIDEND OR CREDIT TO SUBSCRIBERS AS REQUIRED BY SUBSECTION (I) OF THIS SECTION, SHALL BE SUBJECT TO THE MAXIMUM PENALTIES PROVIDED IN THIS CHAPTER.

(II) IN ADDITION TO THE PENALTIES OTHERWISE IMPOSED PURSUANT TO THIS CHAPTER, WHERE AN INSURER ELECTING TO ADJUST PREMIUMS PURSUANT TO THE ALTERNATE PROCEDURE SET FORTH IN SUBSECTION (H) OF THIS SECTION, IS DETERMINED BY THE SUPERINTENDENT TO HAVE, IN A MANNER IN VIOLATION OF

THE PROVISIONS OF THIS SECTION, MATERIALLY MISREPRESENTED THE LOSS RATIOS REQUIRED BY SUBSECTIONS (H) AND (I) OF THIS SECTION IN TWO CONSECUTIVE FILINGS, AND IF, AT ANY TIME DURING A THREE YEAR PERIOD IN WHICH SUCH MATERIAL VIOLATIONS OCCURRED, THE INSURER FAILED TO PROVIDE A DIVIDEND OR CREDIT AS REQUIRED BY SUBSECTION (I) OF THIS SECTION, SUCH INSURER SHALL BE PRESUMED TO BE SUBSTANTIALLY NONCOMPLIANT WITH THE REQUIREMENTS OF THIS PARAGRAPH AND THE SUPERINTENDENT SHALL, AFTER A NOTICE AND A HEARING, HAVE THE AUTHORITY TO PROHIBIT SAID INSURER FROM ADJUSTING PREMIUMS PURSUANT TO THE ALTERNATE PROCEDURE FOR THE AFFECTED POLICY FORMS FOR A PERIOD OF UP TO THREE YEARS, COMMENCING WITH THE SUPERINTENDENT'S NOTICE OF SUCH DETERMINATION. THIS PROHIBITION SHALL BE IN ADDITION TO ANY OTHER PENALTIES THAT THE SUPERINTENDENT MAY IMPOSE PURSUANT TO THIS CHAPTER.

(M) THE ALTERNATE PROCEDURE SET FORTH IN SUBSECTION (H) OF THIS SECTION SHALL NOT BE AVAILABLE TO ADJUST NEWLY-APPROVED PREMIUM RATES OR RATES RECENTLY ADJUSTED THROUGH THE PRIOR APPROVAL PROCESS UNTIL THE EARLIER OF (I) THE DEVELOPMENT OF SUFFICIENT ACTUAL CLAIMS EXPERIENCE TO JUSTIFY THE REQUESTED ADJUSTMENT, AS CERTIFIED BY A MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES OR OTHER INDIVIDUAL ACCEPTABLE TO THE SUPERINTENDENT, OR (II) TWELVE MONTHS FROM THE PRIOR APPROVAL. PROVIDED HOWEVER, NOTHING IN THIS SUBSECTION SHALL BE CONSTRUED TO PROHIBIT AN INSURER FROM UTILIZING THE ALTERNATE PROCEDURE TO ADJUST RATES ON A POLICY WHERE THE RATES FOR A RIDER TO THAT POLICY HAVE NOT BEEN IN EFFECT FOR TWELVE MONTHS.

S 7. Subsection (g) of section 4308 of the insurance law, as added by chapter 501 of the laws of 1992 and as relettered by section three of this act, is amended to read as follows:

(g) The results of any audit conducted pursuant to subsections [(d)] (E) and [(e)] (F) of this section shall be provided to the corporation and each member of its board of directors. The superintendent shall have the authority to direct the corporation in writing to implement any recommendations resulting from the audit that the superintendent finds to be necessary and reasonable; provided, however, that the superintendent shall first consider any written response submitted by the corporation or the board of directors prior to making such finding. Upon any application for a rate adjustment by the corporation, the superintendent shall review the corporation's compliance with the directions and recommendations made previously by the superintendent, as a result of the most recently completed management or financial audit and shall include such findings in any written decision concerning such application.

S 8. Paragraph 1 of subsection (i) and subsections (j) and (k) of section 4308 of the insurance law, as added by chapter 504 of the laws of 1995 and such subsections as relettered by section three of this act, are amended to read as follows:

(1) Each calendar year, a corporation subject to the provisions of this article shall return, in the form of aggregate benefits incurred for each contract form filed pursuant to the alternate procedure set forth in subsection [(g)] (H) of this section, at least eighty-five percent for individual direct payment contracts or [seventy-five] EIGHTY percent for small group and small group remittance contracts, but, except in the case of individual direct payment contracts with a loss ratio of greater than one hundred five percent in nineteen hundred ninety-four, for any direct payment, group or group remittance contract, not in excess of one hundred five percent of the aggregate premiums earned for the contract form during that calendar year. IF A CORPORATION HAS POOLED THE EXPERIENCE OF CONTRACTS AND/OR RIDERS TO DETERMINE THE PREMI-

UM RATES IN ACCORDANCE WITH APPLICABLE LAW, THE CORPORATION SHALL CALCULATE THE LOSS RATIOS IN ACCORDANCE WITH THE MANNER IN WHICH IT ESTABLISHED THE PREMIUM RATES. Corporations subject to the provisions of this article shall annually report, no later than [May] AUGUST first of each year, the loss ratio calculated pursuant to this subsection for each such contract form for the previous calendar year.

(j) The alternate procedure described in subsections [(g) and] (h) AND (I) of this section shall apply to individual direct payment contracts issued pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of this article on and after January first, nineteen hundred ninety-seven.

(k) The eighty-five percent minimum loss ratio for individual direct payment contracts described in subsections [(g) and] (h) AND (I) of this section shall be reduced to eighty-two and one-half percent as of January first, nineteen hundred ninety-seven and shall be further reduced to eighty percent as of January first, nineteen hundred ninety-eight and thereafter. The refund or credit requirements for failure to meet minimum loss ratios will continue, but at these reduced percentages.

S 9. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 26 to read as follows:

(26)(A) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE ADMITTING PHYSICIAN OR TREATING PHYSICIAN IS NOT A PARTICIPATING PROVIDER.

(B) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A PARTICIPATING PHYSICIAN WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

(C) FOR PURPOSES OF THIS PARAGRAPH, A "MANAGED CARE HEALTH INSURANCE POLICY" IS A POLICY THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVIDER PARTICIPATING IN THE INSURER'S NETWORK IN ORDER FOR THE INSURED TO RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE POLICY.

S 10. Subsection (k) of section 3221 of the insurance law is amended by adding a new paragraph 15 to read as follows:

(15)(A) NO GROUP OR BLANKET MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE ADMITTING PHYSICIAN OR TREATING PHYSICIAN IS NOT A PARTICIPATING PROVIDER.

(B) NO GROUP OR BLANKET MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A PARTICIPATING PHYSICIAN WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

(C) FOR PURPOSES OF THIS PARAGRAPH, A "MANAGED CARE HEALTH INSURANCE POLICY" IS A POLICY THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVIDER PARTICIPATING IN THE INSURER'S NETWORK IN ORDER FOR THE INSURED TO RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE POLICY.

S 11. Section 4303 of the insurance law is amended by adding a new subsection (ff) to read as follows:

(FF) (1) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPORATION, HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPORATION THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED

AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE ADMITTING PHYSICIAN OR TREATING PHYSICIAN IS NOT A PARTICIPATING PROVIDER.

(2) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPORATION, HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPORATION THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A PARTICIPATING PHYSICIAN WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

(3) FOR PURPOSES OF THIS SUBSECTION, A "MANAGED CARE CONTRACT" IS A CONTRACT THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVIDER PARTICIPATING IN THE CORPORATION'S NETWORK IN ORDER FOR THE SUBSCRIBER TO RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE CONTRACT.

S 12. Subdivisions 3 and 4 of section 4406 of the public health law, subdivision 3 as renumbered by chapter 538 of the laws of 1993, are renumbered subdivisions 4 and 5 and a new subdivision 3 is added to read as follows:

3. (A) NO CONTRACT ISSUED PURSUANT TO THIS SECTION SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE ADMITTING PHYSICIAN OR TREATING PHYSICIAN IS NOT A PARTICIPATING PROVIDER.

(B) NO CONTRACT ISSUED PURSUANT TO THIS SECTION SHALL PROVIDE THAT SERVICES OF A PARTICIPATING PHYSICIAN WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

S 13. Subsection (a) of section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, is amended to read as follows:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider WITHIN TWENTY-ONE DAYS OF RECEIPT OF A CLAIM OR BILL FOR SERVICES RENDERED THAT IS SUBMITTED BY ELECTRONIC MEANS AND within forty-five days of receipt of a claim or bill for services rendered THAT IS SUBMITTED OTHER THAN BY ELECTRONIC MEANS, SUCH AS BY PAPER OR FACSIMILE.

S 14. The opening paragraph of subsection (b) of section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, is amended to read as follows:

In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing WITHIN FOURTEEN CALENDAR DAYS OF RECEIPT OF A

CLAIM SUBMITTED BY ELECTRONIC MEANS AND within thirty calendar days of receipt of [the] A claim THAT IS SUBMITTED BY OTHER THAN ELECTRONIC MEANS, SUCH AS BY PAPER OR FACSIMILE:

S 15. This act shall take effect immediately; provided, however, that:

(a) sections one through eight of this act shall take effect January 1, 2010 and shall apply to premium rate changes effective on and after that date and to loss ratio reports required to be filed beginning in 2011;

(b) sections nine through twelve of this act shall take effect January 1, 2010 and shall apply to policies and contracts issued, renewed, modified, altered and amended on and after such effective date, provided, further, that any policies and contracts to which sections nine through twelve of this act apply and that were approved by the superintendent of insurance shall be deemed to comply with all applicable laws and regulations until January 1, 2010; and

(c) sections thirteen and fourteen of this act shall take effect January 1, 2010 and shall apply to claims transmitted and received on and after such date.