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

5296

2009-2010 Regular Sessions

I N A S S E M B L Y

February 11, 2009

Introduced by M. of A. MORELLE -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to prohibiting certain adverse reimbursement change to a contract with a physician; and in relation to grievance procedures and providing access to specialty care

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

Section 1. Subsections (g) and (h) of section 3217-b of the insurance law, subsection (g) as relettered by chapter 586 of the laws of 1998, are relettered subsections (h) and (i) and a new subsection (g) is added to read as follows:

(G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A CONTRACT WITH A PHYSICIAN THAT IS OTHERWISE PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE INSURER GIVES THE PHYSICIAN WITH WHOM THE INSURER HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE CONTRACTING PHYSICIAN OBJECTS TO THE CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE INSURER, THE PHYSICIAN MAY, WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A PHYSICIAN. THE NOTICE PROVISIONS REQUIRED BY THIS SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (B) SUCH CHANGE IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR REFERENCE TO

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

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A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

(2) NOTHING IN THIS SUBSECTION SHALL CREATE A PRIVATE RIGHT OF ACTION ON BEHALF OF A PHYSICIAN AGAINST AN INSURER FOR VIOLATIONS OF THIS SUBSECTION.

S 2. The insurance law is amended by adding a new section 3217-d to read as follows:

S 3217-D. GRIEVANCE PROCEDURE AND ACCESS TO SPECIALTY CARE. (A) 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 ESTABLISH AND MAINTAIN A GRIEVANCE PROCEDURE CONSISTENT WITH THE REQUIREMENTS OF SECTION FOUR THOUSAND EIGHT HUNDRED TWO OF THIS CHAPTER.

(B) 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 AND REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO A REFERRAL FROM A PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH SPECIALTY CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C) AND (D) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER; PROVIDED HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED TO REQUIRE THAT AN INSURER, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE INSURER, MAKE A REFERRAL TO A PROVIDER THAT IS NOT IN THE INSURER'S NETWORK.

(C) 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 TRANSITIONAL CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (E) AND (F) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER.

S 3. Paragraph (B) of paragraph 2 of 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:

(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 policy form during that calendar year. Insurers shall annually report, no later than May 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, 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 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]. 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. 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. 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.

S 4. The insurance law is amended by adding a new section 4306-c to read as follows:

S 4306-C. GRIEVANCE PROCEDURE AND ACCESS TO SPECIALTY CARE. (A) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE CONTRACT 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 ESTABLISH AND MAINTAIN A GRIEVANCE PROCEDURE CONSISTENT WITH THE REQUIREMENTS OF SECTION FOUR THOUSAND EIGHT HUNDRED TWO OF THIS CHAPTER.

(B) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE CONTRACT 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 AND REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO A REFERRAL FROM A PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH SPECIALTY CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C) AND (D) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER; PROVIDED HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED TO REQUIRE THAT A CORPORATION, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE CORPORATION, MAKE A REFERRAL TO A PROVIDER THAT IS NOT IN THE CORPORATION'S NETWORK.

(C) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE CONTRACT 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 TRANSITIONAL CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (E) AND (F) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER.

S 5. Paragraph 2 of subsection (h) of section 4308 of the insurance law, as added by chapter 504 of the laws of 1995, is amended to read as follows:

(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 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 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]. A CORPORATION SHALL MAKE A REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF THOSE CONTRACT HOLDERS OR SUBSCRIBERS WHO ARE NO

LONGER CONTRACT HOLDERS OR SUBSCRIBERS WHEN 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. 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.

S 6. Subsections (g) and (h) of section 4325 of the insurance law, subsection (g) as relettered by chapter 586 of the laws of 1998, are relettered subsections (h) and (i) and a new subsection (g) is added to read as follows:

(G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A CONTRACT WITH A PHYSICIAN THAT IS OTHERWISE PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE INSURER GIVES THE PHYSICIAN WITH WHOM THE INSURER HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE CONTRACTING PHYSICIAN OBJECTS TO THE CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE INSURER, THE PHYSICIAN MAY, WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A PHYSICIAN. THE NOTICE PROVISIONS REQUIRED BY THIS SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (B) SUCH CHANGE IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

(2) NOTHING IN THIS SUBSECTION SHALL CREATE A PRIVATE RIGHT OF ACTION ON BEHALF OF A PHYSICIAN AGAINST AN INSURER FOR VIOLATIONS OF THIS SUBSECTION.

S 7. Subsection (a) of section 4803 of the insurance law, as amended by chapter 551 of the laws of 2006, is amended to read as follows:

(a) (1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's network and, within ninety days of receiving a health care professional's completed application to participate in the insurer's network, will notify the health care professional as to [(i)]: (A) whether he or

she is credentialed; or [(ii)] (B) whether additional time is necessary to make a determination in spite of THE insurer's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible.

(2) IF THE COMPLETE APPLICATION OF A NEWLY-LICENSED PHYSICIAN OR A PHYSICIAN THAT HAS RECENTLY RELOCATED TO THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS STATE, WHO JOINS A GROUP PRACTICE OF PHYSICIANS EACH OF WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK, IS NOT APPROVED OR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH ONE OF THIS SUBSECTION, SUCH PHYSICIAN SHALL BE DEEMED "PROVISIONALLY CREDENTIALED" AND MAY PARTICIPATE IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK; PROVIDED, HOWEVER, THAT SUCH PHYSICIAN MAY NOT BE DESIGNATED AS AN INSURED'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDENTIALED. THE NETWORK PARTICIPATION FOR THE PROVISIONALLY CREDENTIALED PHYSICIAN SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE FINAL CREDENTIALING DETERMINATION IS MADE BY THE INSURER. A PHYSICIAN SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE GROUP PRACTICE OF PHYSICIANS AGREES THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE PHYSICIAN OR THE GROUP PRACTICE: (A) SHALL REFUND ANY PAYMENTS MADE BY THE INSURER FOR IN-NETWORK SERVICES PROVIDED BY THE PROVISIONALLY CREDENTIALED PHYSICIAN THAT EXCEED ANY OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE INSURED'S CONTRACT WITH THE INSURER; AND (B) SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED, EXCEPT TO COLLECT THE COPAYMENT OR COINSURANCE THAT OTHERWISE WOULD HAVE BEEN PAYABLE HAD THE INSURED RECEIVED SERVICES FROM A PHYSICIAN PARTICIPATING IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK. INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THIS CHAPTER SHALL NOT BE ASSESSED BASED ON THE DENIAL OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE PHYSICIAN WAS PROVISIONALLY CREDENTIALED; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT AN INSURER FROM PAYING A CLAIM FROM A PHYSICIAN WHO IS PROVISIONALLY CREDENTIALED UPON SUBMISSION OF SUCH CLAIM. AN INSURER SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED BY A PROVISIONALLY CREDENTIALED PHYSICIAN SOLELY ON THE GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

S 8. Section 4906 of the insurance law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

S 4906. Waiver. (A) Any agreement which purports to waive, limit, disclaim, or in any way diminish the rights set forth in this article, except as provided pursuant to section four thousand nine hundred ten of this article shall be void as contrary to public policy.

(B) NOTWITHSTANDING SUBSECTION (A) OF THIS SECTION, IN LIEU OF THE EXTERNAL APPEAL PROCESS AS SET FORTH IN THIS ARTICLE, A HEALTH CARE PLAN AND A FACILITY LICENSED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW MAY MUTUALLY AGREE TO AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM TO RESOLVE DISPUTES OTHERWISE SUBJECT TO THIS ARTICLE.

S 9. The opening paragraph of subsection (b) of section 4910 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

An insured, the insured's designee and, in connection with CONCURRENT AND retrospective adverse determinations, an insured's health care provider, shall have the right to request an external appeal when:

S 10. Paragraphs 2 and 3 of subsection (b) of section 4914 of the insurance law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

(2) The external appeal agent shall make a determination with regard to the appeal within thirty days of the receipt of the [insured's] request therefor, submitted in accordance with the superintendent's instructions. The external appeal agent shall have the opportunity to request additional information from the insured, the insured's health care provider and the insured's health care plan within such thirty-day period, in which case the agent shall have up to five additional business days if necessary to make such determination. The external appeal agent shall notify the insured, WHERE APPROPRIATE THE INSURED'S HEALTH CARE PROVIDER, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

(3) Notwithstanding the provisions of paragraphs one and two of this subsection, if the insured's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the insured, the external appeal shall be completed within three days of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the insured, WHERE APPROPRIATE, THE INSURED'S HEALTH CARE PROVIDER, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

S 11. Subsection (d) of section 4914 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(d) [Payment] (1) EXCEPT AS PROVIDED IN PARAGRAPHS TWO AND THREE OF THIS SUBSECTION, PAYMENT for an external appeal shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days, from the date the appeal determination is received by the health care plan, and the health care plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

(2) IF AN INSURED'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN WHOLE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS SET FORTH IN PARAGRAPH ONE OF THIS SUBSECTION.

(3) IF AN INSURED'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE EVENLY SPLIT BETWEEN THE HEALTH CARE PLAN AND THE INSURED'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL AND SHALL BE MADE BY THE HEALTH CARE PLAN AND THE INSURED'S HEALTH CARE PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS SET FORTH IN PARAGRAPH ONE OF THIS SUBSECTION FOR ONE YEAR FROM THE EFFECTIVE DATE OF THIS SUBSECTION. AFTER ONE YEAR FROM THE EFFECTIVE DATE OF THIS SUBSECTION, THE SUPERINTENDENT SHALL EVALUATE WHETHER HEALTH CARE PLANS OR HEALTH CARE PROVIDERS ARE EXPERIENCING A SUBSTANTIAL HARDSHIP AS A RESULT OF PAYMENT FOR THE EXTERNAL APPEAL WHEN THE

EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART. THE SUPERINTENDENT, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, MAY PROMULGATE A REGULATION TO SPECIFY PAYMENT RESPONSIBILITIES OF PROVIDERS AND HEALTH CARE PLANS WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART WHICH SHALL SUPERSEDE THE REQUIREMENTS OF THIS PARAGRAPH.

(4) IF AN INSURED'S HEALTH CARE PROVIDER WAS ACTING AS THE INSURED'S DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED ON A STANDARD FORM DEVELOPED BY THE SUPERINTENDENT IN CONSULTATION WITH THE COMMISSIONER OF HEALTH PURSUANT TO SUBSECTION (E) OF THIS SECTION. THE SUPERINTENDENT SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECESSARY. THE SUPERINTENDENT SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE INSURED TO CONFIRM THE DESIGNATION. THE INSURED SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE INSURED FAILS TO RESPOND TO THE SUPERINTENDENT WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL PEND THE EXTERNAL APPEAL AND MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT'S REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL REJECT THE APPEAL.

S 12. The insurance law is amended by adding a new section 4917 to read as follows:

S 4917. HOLD HARMLESS. A HEALTH CARE PROVIDER REQUESTING AN EXTERNAL APPEAL OF A CONCURRENT ADVERSE DETERMINATION, INCLUDING WHEN THE HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL AS THE INSURED'S DESIGNEE, SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED EXCEPT TO COLLECT A COPAYMENT, COINSURANCE OR DEDUCTIBLE FOR SERVICES DETERMINED NOT MEDICALLY NECESSARY BY THE EXTERNAL APPEAL AGENT.

S 13. Subdivision 5-c of section 4406-c of the public health law is relettered subdivision 5-d and a new subdivision 5-c is added to read as follows:

5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A CONTRACT WITH A PHYSICIAN THAT IS OTHERWISE PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE HEALTH CARE PLAN GIVES THE PHYSICIAN WITH WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE CONTRACTING PHYSICIAN OBJECTS TO THE CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE PHYSICIAN MAY, WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A PHYSICIAN. THE NOTICE PROVISIONS REQUIRED BY THIS SUBDIVISION SHALL NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (II) SUCH CHANGE IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

(B) NOTHING IN THIS SUBDIVISION SHALL CREATE A PRIVATE RIGHT OF ACTION ON BEHALF OF A PHYSICIAN AGAINST AN INSURER FOR VIOLATIONS OF THIS SUBDIVISION.

S 14. Subdivision 1 of section 4406-d of the public health law, as amended by chapter 551 of the laws of 2006, is amended to read as follows:

1. (A) A health care plan shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the health care plan. The plan shall consult with appropriately qualified health care professionals in developing its qualification requirements. A health care plan shall complete review of the health care professional's application to participate in the in-network portion of the health care plan's network and shall, within ninety days of receiving a health care professional's completed application to participate in the health care plan's network, notify the health care professional as to [(a)]: (I) whether he or she is credentialed; or [(b)] (II) whether additional time is necessary to make a determination in spite of the health care plan's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible.

(B) IF THE COMPLETE APPLICATION OF A NEWLY-LICENSED PHYSICIAN OR A PHYSICIAN THAT HAS RECENTLY RELOCATED TO THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS STATE, WHO JOINS A GROUP PRACTICE OF PHYSICIANS EACH OF WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S NETWORK, IS NOT APPROVED OR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, THE PHYSICIAN SHALL BE DEEMED "PROVISIONALLY CREDENTIALED" AND MAY PARTICIPATE IN THE IN-NETWORK PORTION OF THE HEALTH CARE PLAN'S NETWORK; PROVIDED, HOWEVER, THAT SUCH PHYSICIAN MAY NOT BE DESIGNATED AS AN ENROLLEE'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDENTIALED. THE NETWORK PARTICIPATION FOR THE PROVISIONALLY CREDENTIALED PHYSICIAN SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE FINAL CREDENTIALING DETERMINATION IS MADE BY THE HEALTH CARE PLAN. A PHYSICIAN SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE GROUP PRACTICE OF PHYSICIANS AGREES THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE PHYSICIAN OR THE GROUP PRACTICE: (I) SHALL REFUND ANY PAYMENTS MADE BY THE HEALTH CARE PLAN FOR IN-NETWORK SERVICES PROVIDED BY THE PROVISIONALLY CREDENTIALED PHYSICIAN THAT EXCEED ANY OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE ENROLLEE'S CONTRACT WITH THE HEALTH CARE PLAN; AND (II) SHALL NOT PURSUE REIMBURSEMENT FROM THE ENROLLEE, EXCEPT TO COLLECT THE COPAYMENT THAT OTHERWISE WOULD HAVE BEEN PAYABLE HAD THE ENROLLEE RECEIVED SERVICES FROM A PHYSICIAN PARTICIPATING IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S NETWORK. INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW SHALL NOT BE ASSESSED BASED ON THE DENIAL OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE PHYSICIAN WAS PROVISIONALLY CREDENTIALED; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT A HEALTH CARE PLAN FROM PAYING A CLAIM FROM A PHYSICIAN WHO IS PROVISIONALLY CREDENTIALED UPON SUBMISSION OF SUCH CLAIM. A HEALTH CARE PLAN SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED BY A PROVISIONALLY CREDENTIALED PHYSICIAN SOLELY ON THE GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

S 15. Section 4906 of the public health law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

S 4906. Waiver. 1. Any agreement which purports to waive, limit, disclaim, or in any way diminish the rights set forth in this article, except as provided pursuant to section four thousand nine hundred ten of this article shall be void as contrary to public policy.

2. NOTWITHSTANDING SUBDIVISION ONE OF THIS SECTION, IN LIEU OF THE EXTERNAL APPEAL PROCESS AS SET FORTH IN THIS ARTICLE, A HEALTH CARE PLAN AND A FACILITY LICENSED PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER MAY MUTUALLY AGREE TO AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM TO RESOLVE DISPUTES OTHERWISE SUBJECT TO THIS ARTICLE.

S 16. The opening paragraph of subdivision 2 of section 4910 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

An enrollee, the enrollee's designee and, in connection with CONCURRENT AND retrospective adverse determinations, an enrollee's health care provider, shall have the right to request an external appeal when:

S 17. Paragraphs (b) and (c) of subdivision 2 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

(b) The external appeal agent shall make a determination with respect to the appeal within thirty days of the receipt of the [enrollee's] request therefor, submitted in accordance with the commissioner's instructions. The external appeal agent shall have the opportunity to request additional information from the enrollee, the enrollee's health care provider and the enrollee's health care plan within such thirty-day period, in which case the agent shall have up to five additional business days if necessary to make such determination. The external appeal agent shall notify the enrollee, WHERE APPROPRIATE, THE ENROLLEE'S HEALTH CARE PROVIDER, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

(c) Notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, if the enrollee's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the enrollee, the external appeal shall be completed within three days of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the enrollee, WHERE APPROPRIATE, THE ENROLLEE'S HEALTH CARE PROVIDER, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

S 18. Subdivision 4 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

4. [Payment] (A) EXCEPT AS PROVIDED IN PARAGRAPHS (B) AND (C) OF THIS SUBDIVISION, PAYMENT for an external appeal shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days from the date the appeal determination is received by the health care plan, and the health care plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

(B) IF AN ENROLLEE'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN WHOLE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION.

(C) IF AN ENROLLEE'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE EVENLY SPLIT BETWEEN THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL AND SHALL BE MADE BY THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION. AFTER ONE YEAR FROM THE EFFECTIVE DATE OF THIS SUBDIVISION, THE SUPERINTENDENT OF INSURANCE SHALL EVALUATE WHETHER HEALTH CARE PLANS OR HEALTH CARE PROVIDERS ARE EXPERIENCING A SUBSTANTIAL HARDSHIP AS A RESULT OF PAYMENT FOR THE EXTERNAL APPEAL WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART. THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE, MAY PROMULGATE A REGULATION TO SPECIFY PAYMENT RESPONSIBILITIES OF PROVIDERS AND HEALTH CARE PLANS WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART WHICH SHALL SUPERSEDE THE REQUIREMENTS OF THIS PARAGRAPH.

(D) IF AN ENROLLEE'S HEALTH CARE PROVIDER WAS ACTING AS THE ENROLLEE'S DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE PURSUANT TO SUBDIVISION FIVE OF THIS SECTION. THE SUPERINTENDENT OF INSURANCE SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECESSARY. THE SUPERINTENDENT OF INSURANCE SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE ENROLLEE TO CONFIRM THE DESIGNATION. THE ENROLLEE SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE ENROLLEE FAILS TO RESPOND TO THE SUPERINTENDENT OF INSURANCE WITHIN THE SPECIFIED TIME FRAME, THE SUPERINTENDENT OF INSURANCE SHALL PEND THE EXTERNAL APPEAL AND MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT OF INSURANCE REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF INSURANCE SHALL REJECT THE APPEAL.

S 19. The public health law is amended by adding a new section 4917 to read as follows:

S 4917. HOLD HARMLESS. A HEALTH CARE PROVIDER REQUESTING AN EXTERNAL APPEAL OF A CONCURRENT ADVERSE DETERMINATION, INCLUDING WHEN THE HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL AS THE ENROLLEE'S DESIGNEE, SHALL NOT PURSUE REIMBURSEMENT FROM THE ENROLLEE EXCEPT TO COLLECT A COPAYMENT FOR SERVICES DETERMINED NOT MEDICALLY NECESSARY BY THE EXTERNAL APPEAL AGENT.

S 20. This act shall take effect January 1, 2010; provided, however, that:

1. sections seven and fourteen of this act shall take effect October 1, 2009, and shall apply to applications submitted after that date, and shall not apply to applications submitted prior to such date if such application is resubmitted in substantially similar form on or after October 1, 2009;

2. the amendments to subsection (a) of section 3217-d of the insurance law made by section two of this act and subsection (a) of section 4306-c of the insurance law made by section four of this act shall take effect January 1, 2010 or the date uniform standards for a grievance procedure are adopted to be consistent with federal requirements, whichever is later;

3. provided, further, that the amendments to subsection (i) of section 3217-b of the insurance law made by section one of this act shall not affect the repeal of such subsection and shall be deemed repealed therewith;

4. provided, further, that the amendments to subsection (i) of section 4325 of the insurance law made by section six of this act shall not affect the repeal of such subsection and shall be deemed repealed therewith; and

5. provided, further, that the amendments made to subdivision 5-d of section 4406-c of the public health law made by section thirteen of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith.