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

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Cal. No. 63

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I N A S S E M B L Y

(PREFILED)

January 7, 2009

Introduced by M. of A. GOTTFRIED, CANESTRARI, DINOWITZ, JACOBS, JOHN, PAULIN, KAVANAGH, SCARBOROUGH -- Multi-Sponsored by -- M. of A. ABBATE, AUBRY, BING, BRENNAN, CLARK, COLTON, COOK, CUSICK, CYMBROWITZ, ENGLEBRIGHT, GALEF, GLICK, HEASTIE, HOOPER, KELLNER, LIFTON, MAYER-SOHN, McENENY, MILLMAN, ORTIZ, PEOPLES-STOKES, PERRY, PHEFFER, J. RIVERA, ROBINSON, SWEENEY, TOWNS, WEISENBERG -- read once and referred to the Committee on Health -- reported from committee, advanced to a third reading, amended and ordered reprinted, retaining its place on the order of third reading

AN ACT to amend the public health law and the insurance law, in relation to notification of an enrollee's designee and the enrollee's health care provider of the initiation of an external appeal and the appeal determination; and to repeal certain provisions of the public health law and the insurance law allowing a health care plan to charge an insured a fee for an appeal

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

Section 1. Subdivision 3 of section 4910 of the public health law is REPEALED.

S 2. Paragraphs (a) and (b) of subdivision 2 of section 4914 of the public health law, paragraph (a) as added by chapter 586 of the laws of 1998 and paragraph (b) as amended by chapter 237 of the laws of 2009, are amended to read as follows:

(a) The enrollee shall have forty-five days to initiate an external appeal after the enrollee [receives], THE ENROLLEE'S DESIGNEE, IF ANY, AND THE ENROLLEE'S HEALTH CARE PROVIDER, RECEIVE 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. Such request shall be in writing in accordance with the instructions and in such form

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

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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 such forty-five-day period; 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.

(b) The external appeal agent shall make a determination with respect to the appeal within thirty days of the receipt of the 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, THE ENROLLEE'S DESIGNEE, IF ANY, the enrollee's health care provider where appropriate, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

S 3. Subsection (c) of section 4910 of the insurance law is REPEALED.

S 4. Paragraphs 1 and 2 of subsection (b) of section 4914 of the insurance law, paragraph 1 as added by chapter 586 of the laws of 1998 and paragraph 2 as amended by chapter 237 of the laws of 2009, are amended to read as follows:

(1) The insured shall have forty-five days to initiate an external appeal after the insured [receives], THE INSURED'S DESIGNEE, IF ANY, AND THE INSURED'S HEALTH CARE PROVIDER, RECEIVE 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. 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 such forty-five-day period; 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.

(2) The external appeal agent shall make a determination with regard to the appeal within thirty days of the receipt of the 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, THE INSURED'S DESIGNEE, IF ANY, the insured's health care provider where appropriate, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

S 5. This act shall take effect on the one hundred eightieth day after it shall become a law.

REPEAL NOTE.--Subdivision 3 of section 4910 of the public health law repealed by section one of this act and subsection (c) of section 4910 of the insurance law repealed by section three of this act, allows the health care plan to charge an insured a fee of up to fifty dollars per external appeal.