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

793

2009-2010 Regular Sessions

I N A S S E M B L Y

(PREFILED)

January 7, 2009

Introduced by M. of A. GOTTFRIED, JACOBS, GALEF, JOHN, DINOWITZ, PAULIN, COOK, STIRPE, TITONE, LANCMAN -- Multi-Sponsored by -- M. of A. BRADLEY, BRENNAN, BROOK-KRASNY, CAHILL, DelMONTE, FARRELL, GABRYSZAK, GLICK, KELLNER, KOON, LAVINE, LUPARDO, MAGEE, MAISEL, McENENY, MILLMAN, PHEFFER, SWEENEY -- read once and referred to the Committee on Health

AN ACT to amend the public health law, the social services law and the insurance law, in relation to prompt payment of health care claims, dispute resolution relating to conflicts between a third party payor and a health care provider

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

Section 1. Section 206 of the public health law is amended by adding a new subdivision 26 to read as follows:

26. (A) THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE, SHALL ADOPT RULES AND REGULATIONS ESTABLISHING AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM TO MAKE DETERMINATIONS REGARDING DISAGREEMENTS BETWEEN HEALTH CARE PROVIDERS AND THIRD PARTY PAYERS CONCERNING PAYMENTS RELATED TO HEALTH CARE SERVICES RENDERED BY HEALTH CARE PROVIDERS, AND SHALL ADOPT SUCH RULES AND REGULATIONS AS ARE NECESSARY TO PROMOTE UNIFORMITY IN THE INTERPRETATION OF APPLICABLE LAWS, REGULATIONS, AND CONTRACTUAL PROVISIONS.

(B) DEFINITIONS. A "HEALTH CARE PROVIDER" SHALL MEAN AN ENTITY LICENSED OR CERTIFIED PURSUANT TO THIS ARTICLE, ARTICLE THIRTY-SIX OR FORTY OF THIS CHAPTER, A FACILITY LICENSED PURSUANT TO ARTICLE NINETEEN, FORMER ARTICLE TWENTY-THREE OR ARTICLE THIRTY-ONE OF THE MENTAL HYGIENE LAW, OR A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW, OR A REPRESENTATIVE DESIGNATED BY SUCH ENTITY OR PERSON. A "THIRD PARTY PAYER" SHALL INCLUDE AN ENTITY DEFINED IN SUBDIVISION ONE-A OF SECTION TWENTY-EIGHT HUNDRED

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

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SEVEN-J OF THIS CHAPTER, WITH THE EXCEPTION OF GOVERNMENTAL AGENCIES, BUT SHALL INCLUDE THIRD PARTY PAYERS THAT ENROLL PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW, OR A REPRESENTATIVE DESIGNATED BY SUCH ENTITY.

(C) ADMINISTRATION OF ALTERNATIVE DISPUTE RESOLUTION SYSTEM. THE COMMISSIONER SHALL SELECT AND APPROVE STATEWIDE OR REGIONAL ALTERNATIVE DISPUTE RESOLUTION AGENTS TO CONDUCT AND DETERMINE ALTERNATIVE DISPUTE RESOLUTION REVIEWS. THE COMMISSIONER SHALL ESTABLISH CRITERIA FOR THE SELECTION OF SUCH AGENTS, INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

I. EMPLOYMENT OR CONTROL THROUGH OTHER ARRANGEMENTS OF A SUFFICIENT NUMBER OF PERSONNEL QUALIFIED TO REVIEW DISPUTES, INCLUDING SUFFICIENT PHYSICIAN AND OTHER CLINICAL SPECIALISTS WHERE APPROPRIATE;

II. DEMONSTRATION OF AN ABILITY TO REVIEW AND RENDER DECISIONS REGARDING DISPUTES IN A TIMELY MANNER;

III. ABILITY TO MAKE AVAILABLE FOR INSPECTION BY THE COMMISSIONER AND SUPERINTENDENT OF INSURANCE RECORDS AND INFORMATION RELATED TO ITS REVIEW ACTIVITIES;

IV. LACK OF CONFLICT OF INTEREST BASED ON PAYER, PROVIDER, OR PROFESSIONAL AFFILIATION, INCLUDING PROCEDURES TO ENSURE THAT CASES SUBMITTED FOR REVIEW THAT HAVE BEEN PREVIOUSLY REVIEWED BY THE AGENT IN A SEPARATE CAPACITY ARE IDENTIFIED FOR REASSIGNMENT TO OTHER AGENTS;

V. FAMILIARITY WITH BILLING, CODING, AND CLAIMS PAYMENT PRACTICES OF HEALTH CARE PAYERS AND PROVIDERS IN NEW YORK STATE;

VI. FAMILIARITY WITH THE NATURE OF CONTRACTUAL RELATIONSHIPS BETWEEN PAYERS AND PROVIDERS;

VII. FAMILIARITY WITH RELEVANT PROVISIONS OF THIS ARTICLE AND THE INSURANCE LAW AND RELATED RULES AND REGULATIONS CONCERNING THE DELIVERY AND REVIEW OF, AND BILLING AND PAYMENT FOR, HEALTH CARE SERVICES;

VIII. ABILITY TO ENSURE CONFIDENTIALITY OF PATIENT INFORMATION;

IX. ABILITY TO PROMOTE UNIFORMITY IN THE INTERPRETATION OF APPLICABLE LAWS, REGULATIONS, AND CONTRACTUAL PROVISIONS AS DEFINED BY THE COMMISSIONER AND SUPERINTENDENT OF INSURANCE; AND

X. ABILITY TO ESTABLISH POLICIES AND PROCEDURES AND TO CARRY OUT THE PROVISIONS OF THIS SECTION.

(D) MINIMUM AMOUNT IN DISPUTE. I. NO DISPUTE SHALL BE ACCEPTED FOR REVIEW BY THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM UNLESS THE CLAIMED VALUE OF THE DISPUTED ITEM OR SERVICE IS FIVE HUNDRED DOLLARS OR MORE, PROVIDED, HOWEVER, THAT A DISPUTED ITEM OR SERVICE MAY INCLUDE MULTIPLE ITEMS WHOSE AGGREGATE VALUE MEETS THE MINIMUM REQUIREMENT WHEN THE DISPUTE IS ALLEGED TO ARISE FROM THE SAME PATTERN OR PRACTICE APPLIED TO SUCH MULTIPLE ITEMS.

II. EXCEPT FOR DISPUTES WHICH MAY BE CONSIDERED AND RESOLVED UNDER TITLE TWO OF ARTICLE FORTY-NINE OF THIS CHAPTER OR TITLE TWO OF ARTICLE FORTY-NINE OF THE INSURANCE LAW AS IMPLEMENTED THROUGH THE SUPERINTENDENT OF INSURANCE OR THE COMMISSIONER'S ADMINISTRATIVE PRACTICES OR THROUGH REGULATION, THE DISPUTE RESOLUTION SYSTEM ESTABLISHED BY THIS SUBDIVISION SHALL REVIEW DISAGREEMENTS RELATED TO THE PROVISIONS OF SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW; THE PROVISIONS OF STATE OR FEDERAL LAW OR REGULATION; THE PROCESS AND PROCEDURES UTILIZED BY THIRD PARTY PAYERS FOR THE SUBMISSION, REVIEW, AND APPEAL OF CLAIMS; CONTRACTUAL PROVISIONS RELATED TO PAYMENT AND MEDICAL REVIEW; AND OTHER DISPUTES RELATED TO PAYMENT AMOUNTS AND BILLING AND CLAIMS ADJUDICATION PRACTICES. DISPUTES SUBJECT TO REVIEW SHALL INCLUDE, BUT NOT BE LIMITED TO:

A. DISPUTES REGARDING PAYMENT RESULTING FROM THE REVIEW OF A HEALTH CARE PROCEDURE, SERVICE, OR SERVICES CONDUCTED PURSUANT TO ARTICLE

FORTY-NINE OF THIS CHAPTER OR ARTICLE FORTY-NINE OF THE INSURANCE LAW, REGARDLESS OF WHEN THE REVIEW WAS BEGUN OR COMPLETED; PROVIDED, HOWEVER, THAT IF THE PERSON RECEIVING THE HEALTH CARE PROCEDURE OR SERVICE THAT GAVE RISE TO THE PAYMENT DISPUTE IS FINANCIALLY LIABLE FOR PART OR ALL OF THE DISPUTED PAYMENT, SUCH PERSON HAS GIVEN HIS OR HER CONSENT IN WRITING TO PERMIT THE PROVIDER OR PAYER TO PURSUE THE DISPUTE, WHICH CONSENT MAY BE PROVIDED IN ADVANCE OF THE PROVISION OF THE PROCEDURE OR SERVICE AND WHICH SHALL BE INCLUDED IN THE MATERIALS SUBMITTED TO THE REVIEW AGENT IN SUPPORT OF THE REVIEW;

B. DISPUTES REGARDING PAYMENT RELATED TO THE PRIOR AUTHORIZATION OF A SERVICE;

C. DISPUTES REGARDING PROVISIONS OF STATE OR FEDERAL LAW OR REGULATION RELATED TO THE APPROPRIATENESS, BILLING, OR PAYMENT FOR HEALTH CARE SERVICES BY THIRD PARTY PAYERS;

D. DISPUTES RELATED TO CODING OR DETERMINATION OF DIAGNOSES;

E. DISPUTES RELATED TO PAYMENT ASSOCIATED WITH THE APPROPRIATENESS OF THE LEVEL OR SETTING FOR THE DELIVERY OF THE HEALTH CARE SERVICE; AND

F. DISPUTES REGARDING PAYMENT RELATED TO THE APPROPRIATENESS OF SERVICES RENDERED THROUGH THE EMERGENCY DEPARTMENT.

(E) TIMEFRAMES. THE ALTERNATIVE DISPUTE RESOLUTION AGENT SHALL REVIEW AND RENDER A DECISION ON A DISPUTE WITHIN THIRTY DAYS OF THE RECEIPT OF ALL REQUESTED INFORMATION. THE DECISION WILL BE BASED UPON A REVIEW OF THE MATERIALS SUBMITTED BY THE PARTIES AND APPLICABLE LAWS AND REGULATIONS, IF ANY, AND SHALL BE IN WRITING. ANY PAYMENT DETERMINED TO BE OWED BY A HEALTH CARE PROVIDER OR THIRD PARTY PAYER PURSUANT TO SUCH DECISION SHALL BE MADE WITHIN THIRTY DAYS OF THE RECEIPT OF THE ALTERNATIVE DISPUTE RESOLUTION AGENT'S DECISION.

(F) INTEREST. WHENEVER THE AMOUNT OF PAYMENT MADE BY A THIRD PARTY PAYER TO A HEALTH CARE PROVIDER DIFFERS FROM THE AMOUNT OF PAYMENT DETERMINED IN ACCORDANCE WITH THIS SECTION, INTEREST SHALL BE DUE ON ANY EXCESS OWED TO THE HEALTH CARE PROVIDER OR THE THIRD PARTY PAYER AT THE GREATER OF THE RATE EQUAL TO 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 THAT IS THIRTY DAYS AFTER RECEIPT BY THE PROVIDER OR PAYER OF THE ALTERNATIVE DISPUTE RESOLUTION AGENT'S DECISION. WHEN THE AMOUNT OF INTEREST DUE ON SUCH A CLAIM IS LESS THAN TWO DOLLARS, A THIRD PARTY PAYER OR HEALTH CARE PROVIDER SHALL NOT BE REQUIRED TO PAY INTEREST ON SUCH CLAIM.

(G) FEES. THE COMMISSIONER SHALL ESTABLISH A FEE SCHEDULE NECESSARY TO SUPPORT THE OPERATION OF THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM. FEES CHARGED SHALL BE BORNE BY THE PARTY THAT DOES NOT PREVAIL OR PROPORTIONALLY DISTRIBUTED BY DOLLAR VALUE IN CASES OF A MIXED DETERMINATION.

(H) PROHIBITIONS. NO HEALTH CARE PROVIDER OR THIRD PARTY PAYER SHALL BY CONTRACT, WRITTEN POLICY, OR WRITTEN PROCEDURE PROHIBIT OR RESTRICT THE USE OF THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM ESTABLISHED HEREIN, NOR SHALL USE OF THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM BE A PRIOR REQUIREMENT TO SEEKING ANY OTHER REMEDIES OTHERWISE PERMITTED BY LAW OR CONTRACT.

(I) THE DECISION OF THE ALTERNATIVE DISPUTE RESOLUTION AGENT SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING.

(J) THE ALTERNATIVE DISPUTE RESOLUTION AGENT SHALL NOTIFY THE COMMISSIONER AND THE SUPERINTENDENT OF INSURANCE WHEN IT BELIEVES THAT DISPUTES ADJUDICATED BY IT MAY CONSTITUTE A VIOLATION OF APPLICABLE STATE OR FEDERAL LAW OR REGULATION OR FAIR BUSINESS PRACTICES. THE

COMMISSIONER AND SUPERINTENDENT OF INSURANCE SHALL INVESTIGATE SUCH CASES AND SEEK APPROPRIATE REMEDIES.

(K) A THIRD PARTY PAYER SHALL INCLUDE IN ANY QUARTERLY AND ANNUAL FILINGS MADE TO THE COMMISSIONER AND THE SUPERINTENDENT OF INSURANCE INFORMATION RELATED TO THE ALTERNATIVE DISPUTE RESOLUTION PROCESS, INCLUDING THE NUMBER OF DISPUTES BROUGHT BY IT IN THE TIME PERIOD COVERED BY THE FILING; THE NUMBER OF DISPUTES BROUGHT AGAINST IT IN THE TIME PERIOD COVERED BY THE FILING; AND THE DISPOSITION OF SUCH DISPUTES WITH A STATEMENT OF WHETHER IT PREVAILED OR DID NOT PREVAIL IN WHOLE OR IN PART.

(1) FOR CLAIM PAYMENT AMOUNTS OR OTHER DISPUTES ELIGIBLE FOR DISPUTE RESOLUTION PURSUANT TO THIS SECTION, NO INSURED PERSON SHALL HAVE ANY FINANCIAL LIABILITY FOR ANY PORTION OF THE HEALTH CARE PROVIDER'S BILL, AND NO HEALTH CARE PROVIDER SHALL BILL AN INSURED OR PURSUE COLLECTION EFFORTS AGAINST SUCH INSURED FOR THE DIFFERENCE BETWEEN THE HEALTH CARE PROVIDER'S BILL AND THE THIRD PARTY PAYER'S PAYMENT MADE ON SUCH BILL EXCEPT FOR DEDUCTIBLES, COINSURANCE BASED ON THE UNDISPUTED PORTION OF THE BILL, AND FOR UNCOVERED SERVICES; PROVIDED THAT THE DEFINITION OF UNCOVERED SERVICES SHALL NOT INCLUDE ANY SERVICES OR CLAIMS WHICH ARE IN DISPUTE BETWEEN THE THIRD PARTY PAYER AND THE PROVIDER. THE PROHIBITION ON BILLING AND COLLECTION EFFORTS PRESCRIBED BY THIS PARAGRAPH SHALL REMAIN IN EFFECT UNTIL THE DISPUTE RESOLUTION AGENT RENDERS A DECISION.

S 2. Section 2805-a of the public health law is amended by adding a new subdivision 5 to read as follows:

5. EVERY GENERAL HOSPITAL SHALL ALSO SUBMIT A QUARTERLY REPORT ON BILLING PROCEDURES FOR THIRD-PARTY PAYORS AND PAYMENTS. SUCH REPORT SHALL INCLUDE BUT NOT BE LIMITED TO, A LISTING OF THE NUMBER OF DAYS FROM THE DATE SERVICES WERE RENDERED UNTIL A CLAIM WAS SUBMITTED TO A THIRD-PARTY PAYOR FOR SUCH SERVICES, THE NUMBER OF DAYS FROM THE DATE THAT A CLAIM WAS SUBMITTED UNTIL PAYMENT WAS RECEIVED, THE NUMBER OF DAYS FROM THE DATE THAT PAYMENT WAS RECEIVED UNTIL THE DATE THAT SUCH PAYMENT WAS POSTED, AND SUCH OTHER INFORMATION AS THE COMMISSIONER DEEMS APPROPRIATE.

S 3. Paragraph (g) of subdivision 4 of section 2807-e of the public health law, as amended by chapter 255 of the laws of 1994, is amended to read as follows:

(g) The commissioner, in consultation with the superintendent [and the commissioner of social services] OF INSURANCE, shall establish procedures for requiring third-party payors to accept the electronic submission of claims information for inpatient or ambulatory care services made pursuant to the provision of this section. A THIRD-PARTY PAYOR VIOLATES THIS SUBDIVISION IN EACH INSTANCE THAT THE PAYOR FAILS TO ACCEPT ELECTRONICALLY A CLAIM THAT A HEALTH CARE PROVIDER ATTEMPTS TO SUBMIT ELECTRONICALLY. ANY THIRD-PARTY PAYOR VIOLATING THIS SECTION AFTER JANUARY FIRST, TWO THOUSAND NINE, MUST PAY TWO PERCENT OF THE FINAL CLAIM AMOUNT TO THE HEALTH CARE PROVIDER AS A PENALTY FOR EACH VIOLATION. HOWEVER, THE COMMISSIONER SHALL PROMULGATE A SCHEDULE FOR GRADUAL COMPLIANCE WITH THE PROVISIONS OF THIS PARAGRAPH BY THIRD-PARTY PAYORS THAT CONTRACT WITH THE DEPARTMENT UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW AND ARE CONTROLLED BY, SPONSORED BY, OR OTHERWISE AFFILIATED THROUGH A COMMON GOVERNANCE OR THROUGH A PARENT CORPORATION WITH ONE OR MORE PRIVATE, NOT-FOR-PROFIT OR PUBLIC GENERAL HOSPITALS OR DIAGNOSTIC AND TREATMENT CENTERS LICENSED PURSUANT TO THIS ARTICLE. SUCH SCHEDULE SHALL BE BASED ON THE MANAGEMENT INFORMATION SYSTEMS CAPACITY AND ENROLLMENT OF SUCH PAYORS AND SHALL REQUIRE

COMPLIANCE WITH THIS PARAGRAPH BY NO LATER THAN JULY FIRST, TWO THOUSAND TEN.

S 4. Subdivision 21 of section 364-j of the social services law is amended by adding a new paragraph (g) to read as follows:

(G) THE DEPARTMENT OF HEALTH SHALL, BY MARCH FIRST, TWO THOUSAND TEN AND ANNUALLY BY DECEMBER FIRST THEREAFTER, ANNOUNCE THE PREMIUM RATES EFFECTIVE FOR THE NEXT RATE YEAR. THE DEPARTMENT OF HEALTH SHALL FURTHER COMMENCE PAYMENT OF THE NEW RATES ON APRIL FIRST, TWO THOUSAND TEN AND ANNUALLY ON JANUARY FIRST THEREAFTER. NOTWITHSTANDING ANY LAW, RULE OR REGULATION TO THE CONTRARY, IN THE EVENT THAT THE DEPARTMENT OF HEALTH FAILS TO COMMENCE PAYMENT OF THE NEW RATES BY APRIL FIRST, TWO THOUSAND TEN OR BY JANUARY FIRST THEREAFTER, THE DEPARTMENT OF HEALTH SHALL PAY INTEREST ON ANY INCREASE IN THE RATES OVER THE PRIOR YEAR'S RATES AT THE INTEREST RATE SPECIFIED IN SECTION ONE HUNDRED SEVENTY-NINE-G OF THE STATE FINANCE LAW.

S 5. The opening paragraph of subparagraph (i) of paragraph (a) of subdivision 5 of section 4900 of the public health law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

AN INDIVIDUAL health care [procedures, treatments or services] PROCEDURE, TREATMENT OR UNIT OF SERVICE FOR WHICH A UTILIZATION REVIEW AGENT CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS OF WHETHER THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS PART OF A COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREATMENTS OR UNITS OF SERVICE

S 6. Subparagraph (A) of paragraph (b) of subdivision 5 of section 4900 of the public health law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

(A) [services] AN INDIVIDUAL HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE provided within a clinical trial FOR WHICH A UTILIZATION REVIEW AGENT CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS OF WHETHER THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS PART OF A COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREATMENTS, OR UNITS OF SERVICE, and

S 7. Subparagraph (A) of paragraph 1 of subsection (e) of section 4900 of the insurance law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

(A) AN INDIVIDUAL health care [procedures, treatments or services] PROCEDURE, TREATMENT OR UNIT OF SERVICE FOR WHICH A UTILIZATION REVIEW AGENT CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS OF WHETHER THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS PART OF A COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREATMENTS OR UNITS OF SERVICE

S 8. Subparagraph (A) of paragraph 2 of subsection (e) of section 4900 of the insurance law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

(A) [services] AN INDIVIDUAL HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE provided within a clinical trial FOR WHICH A UTILIZATION REVIEW AGENT CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS OF WHETHER THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS PART OF A COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREATMENTS, OR UNITS OF SERVICE, and

S 9. Section 4900 of the public health law is amended by adding a new subdivision 7-g to read as follows:

7-G. "RETROSPECTIVE ADVERSE DETERMINATION" MEANS AN ADVERSE DETERMINATION THAT AN ENROLLEE, AN ENROLLEE'S DESIGNEE, OR AN ENROLLEE'S HEALTH CARE PROVIDER RECEIVES FROM A UTILIZATION REVIEW AGENT AFTER THE ENROL-

LEE HAS RECEIVED A HEALTH CARE SERVICE, REGARDLESS OF WHEN THE UTILIZATION REVIEW AGENT BEGAN ITS REVIEW OF THE SERVICE.

S 10. Section 4900 of the insurance law is amended by adding a new subsection (g-7) to read as follows:

(G-7) "RETROSPECTIVE ADVERSE DETERMINATION" MEANS AN ADVERSE DETERMINATION THAT AN ENROLLEE, AN ENROLLEE'S DESIGNEE, OR AN ENROLLEE'S HEALTH CARE PROVIDER RECEIVES FROM A UTILIZATION REVIEW AGENT AFTER THE ENROLLEE HAS RECEIVED A HEALTH CARE SERVICE, REGARDLESS OF WHEN THE UTILIZATION REVIEW AGENT BEGAN ITS REVIEW OF THE SERVICE.

S 11. Paragraph (b) of subdivision 1 of section 4902 of the public health law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

(b) Development of written policies and procedures that govern all aspects of the utilization review process and a requirement that a utilization review agent shall maintain and make available to enrollees and health care providers a written description of such procedures including procedures to appeal an adverse determination together with a description, jointly promulgated by the commissioner and the superintendent of insurance as required pursuant to subdivision five of section forty-nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such appeals. THE UTILIZATION REVIEW AGENT SHALL NOTIFY PROVIDERS AND ENROLLEES AT LEAST TWENTY BUSINESS DAYS BEFORE IT CHANGES ITS POLICIES AND PROCEDURES;

S 12. Paragraph 2 of subsection (a) of section 4902 of the insurance law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

(2) Development of written policies and procedures that govern all aspects of the utilization review process and a requirement that a utilization review agent shall maintain and make available to insureds and health care providers a written description of such procedures including procedures to appeal an adverse determination together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such appeals. THE UTILIZATION REVIEW AGENT SHALL NOTIFY PROVIDERS AND ENROLLEES AT LEAST TWENTY BUSINESS DAYS BEFORE IT CHANGES ITS POLICIES AND PROCEDURES;

S 13. Paragraph (c) of subdivision 1 of section 4902 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(c) Utilization of written clinical review criteria developed pursuant to a utilization review plan CONSISTENT WITH THE REQUIREMENTS OF SECTION FORTY-NINE HUNDRED TEN OF THIS ARTICLE; MADE AVAILABLE TO ENROLLEES AND HEALTH CARE PROVIDERS, UPON REQUEST, IN SUFFICIENT SPECIFICITY TO APPRISE THE PROVIDER OF EVERY CASE-SPECIFIC CLINICAL REVIEW CRITERION AND STANDARD USED IN THE REVIEW PROCESS; WITH ADVANCE NOTICE OF AT LEAST TWENTY BUSINESS DAYS TO CONTRACTED PROVIDERS OF CHANGES TO SUCH CRITERIA AND STANDARDS;

S 14. Paragraph 3 of subsection (a) of section 4902 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(3) Utilization of written clinical review criteria developed pursuant to a utilization review plan CONSISTENT WITH THE REQUIREMENTS OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS ARTICLE; MADE AVAILABLE, UPON

REQUEST, TO ENROLLEES AND HEALTH CARE PROVIDERS IN SUFFICIENT SPECIFICITY TO APPRISE THE PROVIDER OF EVERY CASE-SPECIFIC CLINICAL REVIEW CRITERION AND STANDARD USED IN THE REVIEW PROCESS; WITH ADVANCE NOTICE OF AT LEAST TWENTY BUSINESS DAYS TO CONTRACTED PROVIDERS OF CHANGES TO SUCH CRITERIA AND STANDARDS;

S 15. Paragraph (h) of subdivision 1 of section 4902 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(h) Establishment of a requirement that emergency services rendered to an enrollee shall not be subject to prior authorization OR NOTICE REQUIREMENTS OF FEWER THAN FIVE DAYS FOLLOWING RECEIPT OF THESE SERVICES, UNLESS OTHERWISE AGREED TO BY A HEALTH CARE PLAN AND A HEALTH CARE PROVIDER, nor shall reimbursement for such services be denied [on retrospective review; provided, however,] FOR ANY REASON EXCEPT that such services [are] WERE NOT medically necessary to stabilize or treat an emergency condition.

S 16. Paragraph 8 of subsection (a) of section 4902 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(8) Establishment of a requirement that emergency services rendered to an insured shall not be subject to prior authorization OR NOTICE REQUIREMENTS OF FEWER THAN FIVE DAYS FOLLOWING RECEIPT OF THESE SERVICES, UNLESS OTHERWISE AGREED TO BY A HEALTH CARE PLAN AND A HEALTH CARE PROVIDER, nor shall reimbursement for such services be denied [on retrospective review; provided, however,] FOR ANY REASON EXCEPT that such services [are] WERE NOT medically necessary to stabilize or treat an emergency condition.

S 17. 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 NOT REQUIRE AN ENROLLEE, AN ENROLLEE'S DESIGNEE OR AN ENROLLEE'S HEALTH CARE PROVIDER TO REQUEST PRE-AUTHORIZATION FOR HEALTH CARE SERVICES MORE THAN SEVEN BUSINESS DAYS IN ADVANCE OF THE DATE ON WHICH THE SERVICES ARE PROPOSED TO BE PROVIDED. A utilization review agent shall make a utilization review determination involving [health care] SUCH services [which require preauthorization] and provide notice of [a] ITS 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.

S 18. Subdivision 7 of section 4905 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

7. When making prospective, concurrent and retrospective determinations, utilization review agents shall collect only such information as is necessary to make such determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification or routinely request copies of medical records of all patients reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to such review are medically necessary. In such cases, only the necessary or relevant sections of the medical record shall be required. A utilization review agent may request copies of partial or complete medical records retrospectively. [This subdivision shall not apply to health maintenance organizations licensed pursuant to article forty-three of the insurance law or certified pursuant to article forty-four of this chapter.]

S 19. Section 4905 of the public health law is amended by adding a new subdivision 16 to read as follows:

16. A PRE-AUTHORIZATION APPROVAL GRANTED BY A UTILIZATION REVIEW AGENT IS A BINDING COMMITMENT TO MAKE PAYMENT FOR SPECIFIC SERVICES PERFORMED AND PRE-AUTHORIZED, EXCEPT IN CASES WHERE THE SERVICES WERE RENDERED TO AN INDIVIDUAL NOT ENROLLED IN A PLAN AT THE TIME SERVICES WERE RENDERED, OR WHEN THERE IS A REASONABLE BASIS SUPPORTED BY SPECIFIC INFORMATION AVAILABLE FOR REVIEW BY THE SUPERINTENDENT OF INSURANCE THAT SUCH APPROVAL WAS OBTAINED FRAUDULENTLY. IN THE EVENT THAT MORE THAN ONE PAYOR IS RESPONSIBLE FOR PAYMENT FOR HEALTH CARE SERVICES RENDERED, PRE-AUTHORIZATION SHALL NOT PRECLUDE ANY CLAIM BY THE PAYOR FOR INDEMNIFICATION OR CONTRIBUTION FROM OTHER PAYORS RESPONSIBLE FOR PAYMENT. SPECIFIC SERVICES MAY INCLUDE SPECIFIC PROCEDURES, SITE OF SERVICE, INPATIENT ADMISSION OR A TREATMENT PLAN FOR A CHRONIC PATIENT.

S 20. The public health law is amended by adding a new section 4908-a to read as follows:

S 4908-A. ENFORCEMENT. IN ADDITION TO ANY OTHER POWERS CONFERRED ON THE COMMISSIONER TO ENFORCE THIS CHAPTER, THE COMMISSIONER MAY TAKE THE FOLLOWING ACTIONS WHEN ENTITIES SUBJECT TO THIS TITLE FAIL TO COMPLY WITH THE PROVISIONS OF THIS TITLE.

1. THE COMMISSIONER MAY REQUIRE AN ENTITY TO SUBMIT A CORRECTIVE ACTION PLAN AND PERIODIC UPDATES UNTIL THE COMMISSIONER IS SATISFIED THAT THE ENTITY IS IN COMPLIANCE AND HAS ADOPTED THE NECESSARY PROCEDURES TO ENSURE FUTURE COMPLIANCES.

2. THE COMMISSIONER MAY IMPOSE A FINE OF UP TO ONE THOUSAND DOLLARS FOR EACH VIOLATION OF THIS TITLE.

3. THE COMMISSIONER MAY RENEW WITH RESTRICTIONS OR REFUSE TO RENEW THE REGISTRATION OF A UTILIZATION REVIEW AGENT.

4. THE COMMISSIONER MAY REVOKE THE REGISTRATION OF A UTILIZATION REVIEW AGENT.

5. THE COMMISSIONER MAY RESTRICT THE REGISTRATION OF A UTILIZATION REVIEW AGENT TO PERFORM PARTICULAR TYPES OF UTILIZATION REVIEW UNTIL THE AGENT COMPLIES WITH THIS TITLE.

S 21. 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 NOT REQUIRE AN ENROLLEE, AN ENROLLEE'S DESIGNEE OR AN ENROLLEE'S HEALTH CARE PROVIDER TO REQUEST PRE-AUTHORIZATION FOR HEALTH CARE SERVICES MORE THAN SEVEN BUSINESS DAYS IN ADVANCE OF THE DATE ON WHICH THE SERVICES ARE PROPOSED TO BE PROVIDED. A utilization review agent shall make a utilization review determination involving [health care] SUCH services [which require pre-authorization] and provide notice of [a] ITS 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.

S 22. Section 4905 of the insurance law is amended by adding a new subsection (p) to read as follows:

(P) A PRE-AUTHORIZATION APPROVAL GRANTED BY A UTILIZATION REVIEW AGENT IS A BINDING COMMITMENT TO MAKE PAYMENT FOR SPECIFIC SERVICES PERFORMED AND PRE-AUTHORIZED, EXCEPT IN CASES WHERE THE SERVICES WERE RENDERED TO AN INDIVIDUAL NOT ENROLLED IN A PLAN AT THE TIME SERVICES WERE DELIVERED, OR WHEN THERE IS A REASONABLE BASIS SUPPORTED BY SPECIFIC INFORMATION AVAILABLE FOR REVIEW BY THE SUPERINTENDENT THAT SUCH APPROVAL WAS OBTAINED FRAUDULENTLY. IN THE EVENT THAT MORE THAN ONE PAYOR IS RESPONSIBLE FOR PAYMENT FOR HEALTH CARE SERVICES RENDERED, PRE-AUTHORIZATION SHALL NOT PRECLUDE ANY CLAIM BY THE PAYOR FOR INDEMNIFICATION OR

CONTRIBUTION FROM OTHER PAYORS RESPONSIBLE FOR PAYMENT. SPECIFIC SERVICES MAY INCLUDE SPECIFIC PROCEDURES, SITE OF SERVICE, INPATIENT ADMISSION OR A TREATMENT PLAN FOR A CHRONIC PATIENT.

S 23. The insurance law is amended by adding a new section 4908-a to read as follows:

S 4908-A. ENFORCEMENT. IN ADDITION TO ANY OTHER POWERS CONFERRED ON THE SUPERINTENDENT TO ENFORCE THIS CHAPTER, THE SUPERINTENDENT MAY TAKE THE FOLLOWING ACTIONS WHEN ENTITIES SUBJECT TO THIS TITLE FAIL TO COMPLY WITH THE PROVISIONS OF THIS TITLE.

(A) THE SUPERINTENDENT MAY REQUIRE AN ENTITY TO SUBMIT A CORRECTIVE ACTION PLAN AND PERIODIC UPDATES UNTIL THE SUPERINTENDENT IS SATISFIED THAT THE ENTITY COMPLIES.

(B) THE SUPERINTENDENT MAY IMPOSE A FINE OF UP TO ONE THOUSAND DOLLARS FOR EACH VIOLATION OF THIS TITLE.

(C) THE SUPERINTENDENT MAY RENEW WITH RESTRICTIONS OR REFUSE TO RENEW THE REGISTRATION OF A UTILIZATION REVIEW AGENT.

(D) THE SUPERINTENDENT MAY REVOKE THE REGISTRATION OF A UTILIZATION REVIEW AGENT.

(E) THE SUPERINTENDENT MAY RESTRICT THE REGISTRATION OF A UTILIZATION REVIEW AGENT TO PERFORM PARTICULAR TYPES OF UTILIZATION REVIEW UNTIL THE AGENT COMPLIES WITH THIS TITLE.

S 24. Section 2601 of the insurance law, paragraphs 4 and 5 of subsection (a) as amended by chapter 547 of the laws of 1997 and paragraph 6 of subsection (a) as amended by chapter 388 of the laws of 2008, is amended to read as follows:

S 2601. Unfair claim settlement practices; penalties. (a) No insurer, CORPORATION, OR ORGANIZATION LICENSED, ORGANIZED, OR CERTIFIED PURSUANT TO THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by [an insurer] SUCH ENTITIES, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:

(1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;

(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear, except where there is a reasonable basis supported by specific information available for review by the department that the claimant has caused the loss to occur by arson. After receiving a properly executed proof of loss, the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days;

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; [or]

(6) failing to promptly disclose coverage pursuant to subsection (d) or subparagraph (A) of paragraph two of subsection (f) of section three thousand four hundred twenty of this chapter;

(7) FAILING TO COMPLY WITH SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THIS CHAPTER;

(8) FAILING TO ABIDE BY THE TERMS OF A CONTRACT WITH A HEALTH CARE PROVIDER, INCLUDING FAILURE TO MAKE PAYMENT AT THE CONTRACTED RATES, OR STATE OR FEDERAL LAWS OR REGULATIONS;

(9) REQUESTING MEDICAL RECORDS FROM HEALTH CARE PROVIDERS TO EVALUATE CLAIMS AT A RATE OR WITH SUCH FREQUENCY WHICH, UPON INVESTIGATION BY THE SUPERINTENDENT, IS FOUND NOT TO BE JUSTIFIED; OR

(10) DENYING PAYMENT TO HEALTH CARE PROVIDERS, IN WHOLE OR IN PART, WHEN, UPON INVESTIGATION BY THE SUPERINTENDENT, MORE THAN FIFTY PER CENTUM OF THE CLAIMS DENIALS ARE OVERTURNED ON APPEAL PURSUANT TO ARTICLE FORTY-NINE OF THE PUBLIC HEALTH LAW, ARTICLE FORTY-NINE OF THIS CHAPTER OR SECTION TWO HUNDRED SIX OF THE PUBLIC HEALTH LAW, OR IN A JUDICIAL PROCEEDING OR ARBITRATION.

(b) Evidence as to numbers and types of complaints to the department against [an insurer] SUCH ENTITIES and as to the department's complaint experience with other [insurers] ENTITIES writing similar lines of insurance shall be admissible in evidence in any administrative or judicial proceeding under this section or article twenty-four or seventy-four of this chapter, but, EXCEPT FOR PARAGRAPHS SEVEN, EIGHT, NINE AND TEN OF SUBSECTION (A) OF THIS SECTION, no [insurer] ENTITY shall be deemed in violation of this section solely by reason of the numbers and types of such complaints.

(c) (1) If it is found, after notice and an opportunity to be heard, that an insurer has violated this section, each instance of noncompliance with subsection (a) [hereof] OF THIS SECTION may be treated as a separate violation of this section for purposes of ordering a monetary penalty pursuant to subsection (b) of section one hundred nine of this chapter. A violation of this section shall not be a misdemeanor.

(2) IF IT IS FOUND, AFTER NOTICE AND AN OPPORTUNITY TO BE HEARD, THAT 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 IS IN VIOLATION OF PARAGRAPHS SEVEN, EIGHT, NINE OR TEN OF SUBSECTION (A) OF THIS SECTION WITH RESPECT TO A PARTICULAR HEALTH CARE PROVIDER, THE SUPERINTENDENT SHALL REQUIRE THE INSURER, ORGANIZATION, OR CORPORATION TO ESTABLISH AN INTERIM PAYMENT SYSTEM THAT MAKES PAYMENT TO THE AFFECTED PROVIDER FOR HEALTH CARE SERVICES.

(A) SUCH INTERIM PAYMENT SYSTEM SHALL CONSIST OF UNIFORM PAYMENT AMOUNTS MADE ON A WEEKLY BASIS TO THE PROVIDER OF SERVICES BASED ON THE MOST RECENTLY AVAILABLE INFORMATION ON THE ACTUAL AVERAGE WEEKLY PAYMENT AMOUNTS TO THE HEALTH CARE PROVIDER, CALCULATED OVER A SIX MONTH PERIOD, INCREASED BY AN APPROPRIATE TREND FACTOR. PAYMENT AMOUNTS SHALL BE RETROACTIVELY ADJUSTED TO REFLECT ACTUAL AMOUNTS OWED PURSUANT TO A CLAIM RECONCILIATION PROCESS. RETROSPECTIVE ADJUSTMENTS FOR OVERPAYMENT TO PROVIDERS SHALL BE MADE OVER THE SAME NUMBER OF PAYMENTS AS WERE UTILIZED IN THE RECONCILIATION CALCULATION. RETROSPECTIVE ADJUSTMENTS FOR UNDERPAYMENT TO PROVIDERS SHALL BE MADE IN THE NEXT PAYMENT.

(B) THE SUPERINTENDENT SHALL REQUIRE AN INTERIM PAYMENT SYSTEM ONLY FOR AN ENTITY LICENSED OR CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC HEALTH LAW, A FACILITY LICENSED PURSUANT TO ARTICLE NINETEEN OR THIRTY-ONE OF THE MENTAL HYGIENE LAW, A DISPENSER OR PROVIDER OF PHARMACEUTICAL PRODUCTS, SERVICES OR DURABLE MEDICAL EQUIPMENT OR AN INDEPENDENT PRACTICE ASSOCIATION WHICH IS AUTHORIZED TO FURNISH HEALTH CARE SERVICES UNDER A CONTRACT WITH AN INSURER, CORPORATION OR ORGANIZATION. THE INTERIM PAYMENT SYSTEM SHALL BE MAINTAINED FOR SUCH TIME AS SPECIFIED BY THE SUPERINTENDENT AND AT LEAST UNTIL SUCH TIME THAT THE INSURER, ORGANIZATION, OR CORPORATION DEMONSTRATES TO THE SATISFACTION OF THE SUPERINTENDENT THAT IT HAS IN

PLACE SYSTEMS THAT WILL ENSURE THAT IT NO LONGER WILL CONSISTENTLY VIOLATE THE PROVISIONS OF THIS SECTION OR THE TERMS OF A CONTRACT WITH A HEALTH CARE PROVIDER RELATED TO PAYMENT AND MEDICAL REVIEW.

S 25. Section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, is amended to read as follows:

S 3224-a. Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to articles thirty-two, forty-two and forty-three of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law shall adhere to the following standards:

(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 [forty-five days of receipt of a claim or bill for services rendered.]:

(1) FIFTEEN BUSINESS DAYS OF RECEIPT OF A CLAIM OR BILL FOR SERVICES RENDERED WHICH IS TRANSMITTED ELECTRONICALLY WITHIN THIRTY DAYS OF THE DATE THE SERVICES WERE RENDERED, OR IN THE CASE OF INPATIENT CARE, THE DATE OF DISCHARGE, IN THE CORRECT AMOUNT PROVIDED FOR UNDER THE CONTRACT, IF A CONTRACT APPLIES; OR

(2) THIRTY DAYS OF RECEIPT OF A CLAIM OR BILL FOR SERVICES RENDERED WHICH IS SUBMITTED IN WRITING OR AN ELECTRONIC TRANSMISSION WHICH DOES NOT COMPLY WITH PARAGRAPH ONE OF THIS SUBSECTION.

(b) (1) 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] AND health care provider in writing within thirty calendar days of the receipt of the claim:

[(1)] (A) that it is not obligated to pay the claim or make the medical payment, IN WHOLE OR IN PART, stating the specific reasons why it is not liable; or

[(2)] (B) to request all additional information needed to determine liability to pay the claim or make the health care payment, IN WHOLE OR IN PART, AND

(C) THE AMOUNT THAT IS TO BE PAID BY THE INSURER OR ORGANIZATION OR CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OF

THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND THE AMOUNTS FOR WHICH PAYMENT IS DENIED OR IN DISPUTE, SHOWING THE CALCULATIONS FOR PAYMENT, BY SERVICE PROVIDED, INCLUDING CO-PAYMENTS, DEDUCTIBLES, SURCHARGES AND FEE-SCHEDULES.

(2) Upon receipt of the information requested in [paragraph two] SUBPARAGRAPH (B) OF PARAGRAPH ONE of this subsection or an appeal of a claim or bill for health care services denied pursuant to SUBPARAGRAPH (A) OF paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall [comply with subsection (a) of this section] MAKE PAYMENT OR NOTIFY THE POLICYHOLDER, COVERED PERSON AND HEALTH CARE PROVIDER OF A FINAL DETERMINATION TO DENY PAYMENT STATING THE SPECIFIC REASONS WHY IT IS NOT LIABLE WITHIN FIFTEEN CALENDAR DAYS OF THE RECEIPT OF THE INFORMATION REQUESTED.

(c) [Each] AT LEAST ANNUALLY, THE SUPERINTENDENT SHALL COLLECT AND PUBLISH THE POSTAL AND ELECTRONIC ADDRESSES TO WHICH POLICYHOLDERS, COVERED PERSONS AND HEALTH CARE PROVIDERS MAY SUBMIT CLAIMS, ADDITIONAL INFORMATION AND APPEALS TO EACH INSURER, CORPORATION AND ORGANIZATION. THIS INFORMATION SHALL INCLUDE ADDRESSES FOR ANY ELECTRONIC TRANSACTIONS VENDOR OR ANY SUBCONTRACTORS THAT PROCESS CLAIMS ON BEHALF OF THE INSURER, CORPORATION, OR ORGANIZATION AND INSTRUCTIONS ON WHICH CLAIMS, INFORMATION OR APPEALS SHOULD BE SUBMITTED TO WHICH ADDRESS.

(D) (1) UNLESS OTHERWISE AGREED TO IN A CONTRACT BETWEEN AN INSURER, CORPORATION OR ORGANIZATION AND A HEALTH CARE PROVIDER, AN INSURER, CORPORATION OR ORGANIZATION SHALL ALLOW A HEALTH CARE PROVIDER DESIGNATED IN SUBPARAGRAPH (B) OF PARAGRAPH TWO OF SUBSECTION (C) OF SECTION TWO THOUSAND SIX HUNDRED ONE OF THIS CHAPTER AT LEAST ONE HUNDRED TWENTY DAYS, AND ANY OTHER HEALTH CARE PROVIDER AT LEAST SIX MONTHS, TO SUBMIT A CLAIM AFTER THE PROVIDER LEARNS THAT THE INSURER, CORPORATION OR ORGANIZATION HAD, AT THE TIME SERVICES WERE DELIVERED, A CONTRACT AND AN OBLIGATION TO REIMBURSE THE CLAIMS FOR HEALTH SERVICES THAT WERE RECEIVED BY A POLICYHOLDER OR COVERED PERSON OR AFTER THE PROVIDER HAS RECEIVED A DENIAL, IN WHOLE OR IN PART, FROM ANOTHER ENTITY BELIEVED TO HAVE AN OBLIGATION TO PAY CLAIMS FOR HEALTH SERVICES RECEIVED BY THE POLICYHOLDER OR COVERED PERSON. AN INSURER, CORPORATION OR ORGANIZATION SHALL ALLOW A POLICYHOLDER OR COVERED PERSON AT LEAST SIX MONTHS TO SUBMIT A CLAIM AFTER A HEALTH CARE SERVICE WAS PROVIDED OR AFTER THE POLICYHOLDER OR COVERED PERSON RECEIVED A DENIAL FROM ANOTHER ENTITY THAT PROVIDES HEALTH BENEFITS TO HIM OR HER.

(2) AN INSURER, CORPORATION OR ORGANIZATION SHALL ALLOW POLICYHOLDERS, COVERED PERSONS, AND HEALTH CARE PROVIDERS AT LEAST THIRTY CALENDAR DAYS TO SUBMIT ANY ADDITIONAL INFORMATION IT REQUESTED PURSUANT TO SUBPARAGRAPH (B) OF PARAGRAPH ONE OF SUBSECTION (B) OF THIS SECTION OR THAT IT REQUESTED TO RESPOND TO AN APPEAL FILED BY A POLICYHOLDER, COVERED PERSON, OR HEALTH CARE PROVIDER PURSUANT TO THIS SUBSECTION.

(3) PURSUANT TO THIS SUBSECTION, AN INSURER, CORPORATION OR ORGANIZATION SHALL ALLOW A POLICYHOLDER, COVERED PERSON OR HEALTH CARE PROVIDER AT LEAST FORTY-FIVE DAYS TO APPEAL, AFTER RECEIPT OF A DENIAL OF A CLAIM OR A BILL PURSUANT TO SUBPARAGRAPH (A) OF PARAGRAPH ONE OF SUBSECTION (B) OF THIS SECTION.

(4) THE DATE OF RECEIPT OF A CLAIM OR ADDITIONAL INFORMATION SHALL BE, WITH RESPECT TO CLAIMS OR INFORMATION DELIVERED BY THE UNITED STATES POSTAL SERVICE OR OTHER DELIVERY SERVICE, THE DATE OF DELIVERY AT THE SITE SPECIFIED BY THE INSURER, CORPORATION OR ORGANIZATION WITH THE SUPERINTENDENT PURSUANT TO SUBSECTION (C) OF THIS SECTION; OR SHALL BE, WITH RESPECT TO CLAIMS OR INFORMATION DELIVERED ELECTRONICALLY, THE DATE

OF ELECTRONIC ACKNOWLEDGMENT FROM THE INSURER, CORPORATION OR ORGANIZATION OR ITS ELECTRONIC TRANSACTIONS VENDOR. AN INSURER, CORPORATION, ORGANIZATION OR ANY AGENT ACTING ON BEHALF OF SUCH ENTITY WHO ACCEPTS AND RECEIVES CLAIMS IN ELECTRONIC FORMAT SHALL, WITHIN FORTY-EIGHT HOURS AFTER THE RECEIPT OF SUCH A CLAIM, TRANSMIT ELECTRONICALLY AN ACKNOWLEDGMENT OF THE RECEIPT OF SUCH A CLAIM TO THE HEALTH CARE PROVIDER OR ENTITY WHICH SUBMITTED THE CLAIM.

(5) NO INSURER, CORPORATION OR ORGANIZATION SHALL SEEK TO RECOVER FROM A HEALTH CARE PROVIDER, OR REDUCE PAYMENT TO A HEALTH CARE PROVIDER, ANY PORTION OF A PAYMENT BEYOND THE DATE WHICH IS ONE YEAR AFTER THE DATE OF PAYMENT, EXCEPT WHEN THERE IS A REASONABLE BASIS SUPPORTED BY SPECIFIC INFORMATION AVAILABLE FOR REVIEW BY THE SUPERINTENDENT THAT SUCH PAYMENT WAS OBTAINED FRAUDULENTLY.

(E)(1) EXCEPT AS PROVIDED IN PARAGRAPH FOUR OF THIS SUBSECTION, EACH claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to 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 claim or health care payment was required to be made. When the amount of interest due on such a claim is less [then] THAN two dollars, [and] AN insurer or organization or corporation shall not be required to pay interest on such claim.

[(d)] (2) EXCEPT AS PROVIDED IN PARAGRAPH FOUR OF THIS SUBSECTION, IN A CASE WHERE AN INSURER, ORGANIZATION OR CORPORATION FAILS TO PAY THE INTEREST AMOUNT SPECIFIED IN THIS SUBSECTION WITH THE AMOUNT OF THE CLAIM OR HEALTH CARE PAYMENT, THE SUPERINTENDENT SHALL IMPOSE THE MAXIMUM PENALTY PROVIDED IN THIS CHAPTER.

(3) PURSUANT TO PARAGRAPH (G) OF SUBDIVISION FOUR OF SECTION TWENTY-EIGHT HUNDRED SEVEN-E OF THE PUBLIC HEALTH LAW, FOR EACH CLAIM OR BILL FOR HEALTH CARE SERVICES FOR WHICH AN INSURER, ORGANIZATION OR CORPORATION CANNOT ACCEPT ELECTRONIC TRANSMISSION FROM A HEALTH CARE PROVIDER, THE INSURER, ORGANIZATION OR CORPORATION SHALL BE OBLIGATED TO PAY AN ADDITIONAL AMOUNT OF INTEREST EQUAL TO TWO PERCENT OF THE AMOUNT OF THE CLAIM.

(4) IF, AFTER INVESTIGATION, THE SUPERINTENDENT FINDS THAT AN INSURER, ORGANIZATION, OR CORPORATION HAS PROCESSED NINETY-EIGHT PER CENTUM OF CLAIMS RECEIVED IN A GIVEN TIME PERIOD IN COMPLIANCE WITH THIS SECTION, THEN ANY REMAINING CLAIMS NOT PROCESSED IN COMPLIANCE WITH THIS SECTION BUT WHICH WERE PAID WITHIN SIXTY DAYS OF SUBMISSION AND WITH THE APPROPRIATE INTEREST PAYMENT FOR LATE CLAIMS SHALL NOT CONSTITUTE VIOLATIONS OF THIS SECTION, SO LONG AS SUCH CLAIMS OWED TO AN INDIVIDUAL HEALTH CARE PROVIDER, IN THE AGGREGATE, DO NOT EXCEED FIVE PERCENT OF THE ACCOUNTS RECEIVABLE OWED BY THAT INSURER, ORGANIZATION OR CORPORATION TO THAT HEALTH CARE PROVIDER FOR SUCH PERIOD.

(F) For the purposes of this section:

(1) "policyholder" shall mean a person covered under such policy or a representative designated by such person; and

(2) "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public

health law, a facility licensed pursuant to article nineteen, FORMER ARTICLE twenty-three or ARTICLE thirty-one of the mental hygiene law, a health care professional licensed, registered or certified pursuant to title eight of the education law, a dispenser or provider of pharmaceutical products, services or durable medical equipment, or a representative designated by such entity or person.

[(e)] (G) IN A CASE WHERE (A) MORE THAN FIVE PERCENT OF THE ACCOUNTS RECEIVABLE BALANCE DUE TO A HEALTH CARE PROVIDER FROM AN INSURER, ORGANIZATION OR CORPORATION IS WITHHELD BECAUSE THE OBLIGATION TO PAY IS NOT REASONABLY CLEAR PURSUANT TO SUBSECTION (B) OF THIS SECTION, OR (B) AN INSURER, ORGANIZATION OR CORPORATION REQUESTS A PATIENT'S MEDICAL RECORDS PURSUANT TO PARAGRAPH TWO OF SUBSECTION (B) OF THIS SECTION FOR MORE THAN FIVE PERCENT OF CLAIMS SUBMITTED BY A HEALTH CARE PROVIDER, THERE SHALL BE A PRESUMPTION THAT PAYMENT HAS NOT BEEN WITHHELD BECAUSE OF A GOOD FAITH DISPUTE AND THE SUPERINTENDENT SHALL INVESTIGATE THE PAYMENT PRACTICES OF THE INSURER, ORGANIZATION OR CORPORATION. IN ADDITION, THE SUPERINTENDENT SHALL INVESTIGATE THE PAYMENT PRACTICES OF THE INSURER, ORGANIZATION OR CORPORATION IN ANY INSTANCE WHERE HE OR SHE HAS REASON TO BELIEVE THAT THE INSURER, ORGANIZATION OR CORPORATION HAS NOT COMPLIED WITH THE PROVISIONS OF THIS SECTION. IN DETERMINING WHETHER MORE THAN FIVE PERCENT OF THE ACCOUNTS RECEIVABLE BALANCE DUE TO A HEALTH CARE PROVIDER FROM AN INSURER, ORGANIZATION OR CORPORATION IS WITHHELD OR WHETHER MEDICAL RECORDS ARE REQUESTED FOR MORE THAN FIVE PERCENT OF THE CLAIMS SUBMITTED BY A HEALTH CARE PROVIDER, THE SUPERINTENDENT SHALL DISREGARD CLAIMS FOR REIMBURSEMENT OF EMERGENCY CARE RENDERED BY A HEALTH CARE PROVIDER THAT DOES NOT PARTICIPATE IN THE NETWORK OF THE INSURER, ORGANIZATION OR CORPORATION RECEIVING THE CLAIM.

(H) Nothing in this section shall in any way be deemed to impair any right available to the state to adjust the timing of its payments for medical assistance pursuant to title eleven of article five of the social services law, or for child health insurance plan benefits pursuant to title [one-a] ONE-A of article twenty-five of the public health law or otherwise be deemed to require adjustment of payments by the state for such medical assistance or child health insurance.

[(f)] (I) In any action brought by the superintendent pursuant to this section or article twenty-four of this chapter relating to this section regarding payments for medical assistance pursuant to title eleven of article five of the social services law, child health insurance plan benefits pursuant to title [one-a] ONE-A of article twenty-five of the public health law, benefits under the voucher insurance program pursuant to section one thousand one hundred twenty-one of this chapter, and benefits under the New York state small business health insurance partnership program pursuant to article nine-A of the public health law, it shall be a mitigating factor that the insurer, corporation or organization is owed any premium amounts, premium adjustments, stop-loss recoveries or other payments from the state or one of its fiscal intermediaries under any such program.

S 26. This act shall take effect immediately, except that sections one through ten and sections fifteen through twenty-five of this act shall take effect on the first of January next succeeding the date on which it shall have become a law and sections eleven, twelve, thirteen and fourteen of this act shall take effect on the sixtieth day after it shall have become a law; provided, however, that the amendments to section 364-j of the social services law made by section four of this act shall not affect the repeal of such section and shall be deemed repealed therewith; provided, further, that if section 7 of chapter 388 of the laws

of 2008 shall not have taken effect on or before the first of January next succeeding the date on which this act shall have become a law, the amendments to paragraph 6 of subsection (a) of section 2601 of the insurance law made by section twenty-four of this act shall take effect on the same date and in the same manner as such chapter of the laws of 2008 takes effect. Effective immediately, the addition, amendment and/or repeal of any rule or regulation or other administrative action necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.