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I N A S S E M B L Y

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Introduced by M. of A. MORELLE, BRADLEY, GOTTFRIED, HOYT, FIELDS,
JAFEE, SPANO, MILLMAN, PERRY, BARRON, ESPAILLAT, COOK, KOON, MAISEL
-- Multi-Sponsored by -- M. of A. GALEF, JOHN, MAGEE, MARKEY, MAYER-
SOHN, MCENENY, MENG, WEISENBERG -- (at request of the Governor) --
read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation
to providing enhanced consumer and provider protections; in relation
to referrals to specialists and grievance procedures; in relation to
credits or dividends; in relation to provider contracts and provider
credentialing; in relation to overpayment recovery; in relation to
external appeals; in relation to prompt payment of claims; in relation
to participation status of health care providers; in relation to
provider networks; and in relation to utilization review timeframes

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

1 Section 1. The insurance law is amended by adding a new section 316
2 to read as follows:
3 S 316. ELECTRONIC FILINGS. NOTWITHSTANDING SUBDIVISION ONE OF SECTION
4 THREE HUNDRED FIVE OF THE STATE TECHNOLOGY LAW, THE SUPERINTENDENT MAY
5 PROMULGATE REGULATIONS TO REQUIRE AN INSURER OR OTHER PERSON OR ENTITY
6 MAKING A FILING OR SUBMISSION WITH THE SUPERINTENDENT PURSUANT TO THIS
7 CHAPTER TO SUBMIT THE FILING OR SUBMISSION TO THE SUPERINTENDENT BY
8 ELECTRONIC MEANS. SHOULD THE SUPERINTENDENT REQUIRE THAT A FILING OR
9 SUBMISSION BE MADE BY ELECTRONIC MEANS, AN INSURER OR OTHER PERSON OR
10 ENTITY AFFECTED THEREBY MAY SUBMIT A REQUEST TO THE SUPERINTENDENT FOR
11 AN EXEMPTION FROM THE ELECTRONIC FILING REQUIREMENT UPON A DEMONSTRATION
12 OF UNDUE HARDSHIP, IMPRACTICABILITY, OR GOOD CAUSE, SUBJECT TO THE
13 APPROVAL OF THE SUPERINTENDENT.
14 S 2. Subsections (g) and (h) of section 3217-b of the insurance law,
15 subsection (g) as relettered by chapter 586 of the laws of 1998, are

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

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1 relettered subsections (h) and (i) and a new subsection (g) is added to
2 read as follows:

3 (G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A
4 CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY
5 THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE
6 INSURER GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE INSURER HAS
7 DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT
8 CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE
9 CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE
10 SUBJECT OF THE NOTICE BY THE INSURER, THE HEALTH CARE PROFESSIONAL MAY,
11 WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE
12 INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON
13 THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE
14 PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE"
15 SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE
16 THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A HEALTH CARE
17 PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A
18 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
19 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY
20 THIS SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE
21 REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS
22 REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHOD-
23 OLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (B)
24 SUCH CHANGE IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY
25 THE INCLUSION OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE,
26 REIMBURSEMENT METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

27 (2) NOTHING IN THIS SUBSECTION SHALL CREATE A PRIVATE RIGHT OF ACTION
28 ON BEHALF OF A HEALTH CARE PROFESSIONAL AGAINST AN INSURER FOR
29 VIOLATIONS OF THIS SUBSECTION.

30 S 3. The insurance law is amended by adding a new section 3217-d to
31 read as follows:

32 S 3217-D. GRIEVANCE PROCEDURE AND ACCESS TO SPECIALTY CARE. (A) AN
33 INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF
34 PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED
35 IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS
36 CHAPTER SHALL ESTABLISH AND MAINTAIN A GRIEVANCE PROCEDURE CONSISTENT
37 WITH THE REQUIREMENTS OF SECTION FOUR THOUSAND EIGHT HUNDRED TWO OF THIS
38 CHAPTER.

39 (B) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES AN
40 EXCLUSIVE NETWORK OF PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS
41 NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION
42 (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER SHALL
43 PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIRE-
44 MENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR,
45 SUBSECTION (G-6) OF SECTION FOUR THOUSAND NINE HUNDRED, SUBSECTION (A-1)
46 OF SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF
47 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH
48 FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF
49 THIS CHAPTER.

50 (C) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A
51 NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT
52 AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE
53 OF THIS CHAPTER AND REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO
54 A REFERRAL FROM A PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH
55 SPECIALTY CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C)
56 AND (D) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER;

1 PROVIDED HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED TO REQUIRE THAT
2 AN INSURER, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE INSURER, MAKE A
3 REFERRAL TO A PROVIDER THAT IS NOT IN THE INSURER'S NETWORK.

4 (D) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A
5 NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT
6 AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE
7 OF THIS CHAPTER SHALL PROVIDE ACCESS TO TRANSITIONAL CARE CONSISTENT
8 WITH THE REQUIREMENTS OF SUBSECTIONS (E) AND (F) OF SECTION FOUR THOU-
9 SAND EIGHT HUNDRED FOUR OF THIS CHAPTER.

10 S 4. The opening paragraph and subsections (a) and (b) of section
11 3224-a of the insurance law, as amended by chapter 666 of the laws of
12 1997, are amended to read as follows:

13 In the processing of all health care claims submitted under contracts
14 or agreements issued or entered into pursuant to THIS ARTICLE AND arti-
15 cles [thirty-two,] forty-two [and], forty-three AND FORTY-SEVEN of this
16 chapter and article forty-four of the public health law and all bills
17 for health care services rendered by health care providers pursuant to
18 such contracts or agreements, any insurer or organization or corporation
19 licensed or certified pursuant to article forty-three OR FORTY-SEVEN of
20 this chapter or article forty-four of the public health law shall adhere
21 to the following standards:

22 (a) Except in a case where the obligation of an insurer or an organ-
23 ization or corporation licensed or certified pursuant to article forty-
24 three OR FORTY-SEVEN of this chapter or article forty-four of the public
25 health law to pay a claim submitted by a policyholder or person covered
26 under such policy ("COVERED PERSON") or make a payment to a health care
27 provider is not reasonably clear, or when there is a reasonable basis
28 supported by specific information available for review by the super-
29 intendent that such claim or bill for health care services rendered was
30 submitted fraudulently, such insurer or organization or corporation
31 shall pay the claim to a policyholder or covered person or make a
32 payment to a health care provider within [forty-five] FIFTEEN days of
33 receipt of a claim or bill for services rendered THAT IS TRANSMITTED VIA
34 THE INTERNET OR ELECTRONIC MAIL, OR FORTY-FIVE DAYS OF RECEIPT OF A
35 CLAIM OR BILL FOR SERVICES RENDERED THAT IS SUBMITTED BY OTHER MEANS,
36 SUCH AS PAPER OR FACSIMILE. THE INSURER, ORGANIZATION, OR CORPORATION
37 SHALL NOT DENY PAYMENT FOR A CLAIM FOR MEDICALLY NECESSARY COVERED
38 SERVICES ON THE BASIS OF: A FAILURE TO OBTAIN A REFERRAL; UNTIMELY
39 FILING OF THE CLAIM; LATE NOTIFICATION OF A HOSPITAL ADMISSION OR THE
40 PROVISION OF SERVICES THAT THE INSURER, ORGANIZATION OR CORPORATION MAY
41 REQUIRE; A FAILURE TO PROVIDE NOTIFICATION OF A HOSPITAL ADMISSION OR
42 PROVISION OF SERVICES THAT THE INSURER, ORGANIZATION OR CORPORATION MAY
43 REQUIRE; A FAILURE TO PROVIDE PROPER REGISTRATION OF A HOSPITAL ADMIS-
44 SION OR PROVISION OF SERVICES THAT THE INSURER, ORGANIZATION OR CORPO-
45 RATION MAY REQUIRE; OR ANY OTHER ADMINISTRATIVE OR TECHNICAL DEFECT AS
46 THE SUPERINTENDENT MAY SPECIFY IN A REGULATION AFTER CONSULTATION WITH
47 THE COMMISSIONER OF HEALTH. THE INSURER, ORGANIZATION OR CORPORATION AND
48 HEALTH CARE PROVIDER MAY AGREE, PURSUANT TO A WRITTEN CONTRACT, TO MODI-
49 FIED PAYMENT TERMS FOR CLAIMS SUBMITTED WITH AN ADMINISTRATIVE OR TECH-
50 NICAL DEFECT; PROVIDED, HOWEVER, THAT THE ALTERNATE PAYMENT TERMS SHALL
51 NOT DIFFER SUBSTANTIALLY FROM THE PAYMENT TERMS APPLICABLE TO CLAIMS
52 SUBMITTED WITHOUT AN ADMINISTRATIVE OR TECHNICAL DEFECT. THE SUPER-
53 INTENDENT MAY APPROVE MODIFIED PAYMENT TERMS IN A CONTRACT OR AGREEMENT
54 ISSUED OR ENTERED INTO PURSUANT TO THIS ARTICLE AND ARTICLES FORTY-THREE
55 AND FORTY-SEVEN OF THIS CHAPTER AND ARTICLE FORTY-FOUR OF THE PUBLIC
56 HEALTH LAW FOR CLAIMS SUBMITTED WITH AN ADMINISTRATIVE OR TECHNICAL

1 DEFECT; PROVIDED, HOWEVER, THAT THE ALTERNATE PAYMENT TERMS SHALL NOT
2 DIFFER SUBSTANTIALLY FROM THE PAYMENT TERMS APPLICABLE TO CLAIMS SUBMIT-
3 TED WITHOUT AN ADMINISTRATIVE OR TECHNICAL DEFECT.

4 (b) In a case where the obligation of an insurer or an organization or
5 corporation licensed or certified pursuant to article forty-three of
6 this chapter or article forty-four OR FORTY-SEVEN of the public health
7 law to pay a claim or make a payment for health care services rendered
8 is not reasonably clear due to a good faith dispute regarding the eligi-
9 bility of a person for coverage, the liability of another insurer or
10 corporation or organization for all or part of the claim, the amount of
11 the claim, the benefits covered under a contract or agreement, or the
12 manner in which services were accessed or provided, an insurer or organ-
13 ization or corporation shall pay any undisputed portion of the claim in
14 accordance with this subsection and notify the policyholder, covered
15 person or health care provider in writing within FIFTEEN CALENDAR DAYS
16 OF THE RECEIPT OF THE CLAIM SUBMITTED VIA THE INTERNET OR ELECTRONIC
17 MAIL, OR thirty calendar days of the receipt of the claim SUBMITTED BY
18 OTHER MEANS, SUCH AS PAPER OR FACSIMILE:

19 (1) that it is not obligated to pay the claim or make the medical
20 payment, stating the specific reasons why it is not liable; or

21 (2) to request all additional information needed to determine liabil-
22 ity to pay the claim or make the health care payment; PROVIDED HOWEVER,
23 THE INSURER, ORGANIZATION OR CORPORATION SHALL NOT SEND OUT A QUESTION-
24 NAIRE TO DETERMINE WHETHER THE POLICYHOLDER OR COVERED PERSON IS COVERED
25 FOR ALL OR PART OF THE CLAIM BY ANOTHER INSURER, CORPORATION OR ORGAN-
26 IZATION UNLESS IT HAS NOT SENT OUT A QUESTIONNAIRE IN THE PREVIOUS
27 TWELVE MONTHS OR IT HAS A BASIS TO BELIEVE THAT THE POLICYHOLDER OR
28 COVERED PERSON HAS OTHER COVERAGE.

29 Upon receipt of the information requested in paragraph two of this
30 subsection or an appeal of a claim or bill for health care services
31 denied pursuant to paragraph one of this subsection, an insurer or
32 organization or corporation licensed OR CERTIFIED pursuant to article
33 forty-three OR FORTY-SEVEN of this chapter or article forty-four of the
34 public health law shall comply with subsection (a) of this section.

35 S 5. Subsection (b) of section 3224-b of the insurance law, as added
36 by chapter 551 of the laws of 2006, is amended to read as follows:

37 (b) Overpayments to [physicians] HEALTH CARE PROVIDERS. (1) Other
38 than recovery for duplicate payments, a health plan shall provide thirty
39 days written notice to [physicians] HEALTH CARE PROVIDERS before engag-
40 ing in additional overpayment recovery efforts seeking recovery of the
41 overpayment of claims to such [physicians] HEALTH CARE PROVIDERS. Such
42 notice shall state the patient name, service date, payment amount,
43 proposed adjustment, and a reasonably specific explanation of the
44 proposed adjustment.

45 (2) A HEALTH PLAN SHALL PROVIDE A HEALTH CARE PROVIDER WITH THE OPPOR-
46 TUNITY TO CHALLENGE AN OVERPAYMENT RECOVERY AND SHALL ESTABLISH WRITTEN
47 POLICIES AND PROCEDURES FOR HEALTH CARE PROVIDERS TO FOLLOW TO CHALLENGE
48 AN OVERPAYMENT RECOVERY. THESE WRITTEN POLICIES AND PROCEDURES SHALL
49 INCLUDE A PROVISION STATING THAT A CHALLENGE TO AN OVERPAYMENT RECOVERY
50 SHALL BE MADE BY A HEALTH CARE PROVIDER IN WRITING WITHIN THIRTY DAYS OF
51 RECEIPT OF THE OVERPAYMENT RECOVERY REQUEST. ANY CHALLENGE TO AN OVER-
52 PAYMENT RECOVERY THAT CANNOT BE RESOLVED BETWEEN THE HEALTH PLAN AND THE
53 HEALTH CARE PROVIDER WITHIN THIRTY DAYS FROM THE HEALTH PLAN'S RECEIPT
54 OF THE CHALLENGE SHALL BE RESOLVED ACCORDING TO DISPUTE RESOLUTION
55 PROCEDURES ESTABLISHED BY THE PARTIES IN THEIR CONTRACTUAL AGREEMENT OR,

1 IF NO SUCH PROCEDURES ARE SET FORTH IN SUCH AGREEMENT, SHALL BE SUBMIT-
2 TED TO A THIRD-PARTY ARBITRATOR FOR A DETERMINATION.

3 (3) A health plan shall not initiate overpayment recovery efforts more
4 than twenty-four months after the original payment was received by a
5 [physician] HEALTH CARE PROVIDER. [Provided, however, that] HOWEVER, no
6 such time limit shall apply to overpayment recovery efforts [which] THAT
7 are: (i) based on a reasonable belief of fraud or other intentional
8 misconduct, [or abusive billing,] (ii) required by, or initiated at the
9 request of, a self-insured plan, or (iii) required by a state or federal
10 government program. Notwithstanding the aforementioned time limitations,
11 in the event that a [physician] HEALTH CARE PROVIDER asserts that a
12 health plan has underpaid a claim or claims, the health plan may defend
13 or set off such assertion of underpayment based on overpayments going
14 back in time as far as the claimed underpayment. [For purposes of this
15 paragraph, "abusive billing" shall be defined as a billing practice
16 which results in the submission of claims that are not consistent with
17 sound fiscal, business, or medical practices and at such frequency and
18 for such a period of time as to reflect a consistent course of conduct.]

19 (4) A HEALTH PLAN SHALL NOT OFFSET PAYMENT TO A HEALTH CARE PROVIDER
20 PURSUANT TO AN OVERPAYMENT RECOVERY EFFORT UNLESS: THE HEALTH CARE
21 PROVIDER AGREES TO THE REDUCTION IN WRITING; THE HEALTH CARE PROVIDER
22 FAILS TO OBJECT TO THE HEALTH PLAN'S OVERPAYMENT RECOVERY WITHIN THIRTY
23 DAYS OF RECEIPT OF THE REQUEST FOR RECOUPMENT; THE OVERPAYMENT RECOVERY
24 HAS BEEN UPHOLD ACCORDING TO PROCEDURES ESTABLISHED BY THE PARTIES IN
25 THEIR CONTRACTUAL AGREEMENT; OR A THIRD-PARTY ARBITRATOR UPHOLD THE
26 OVERPAYMENT RECOVERY.

27 (5) A HEALTH PLAN SHALL NOT PURSUE OVERPAYMENT RECOVERY EFFORTS
28 AGAINST AN INSURED IF THE HEALTH PLAN IS PRECLUDED FROM PURSUING OVER-
29 PAYMENT RECOVERY EFFORTS AGAINST A HEALTH CARE PROVIDER PURSUANT TO
30 PARAGRAPH THREE OF THIS SUBSECTION.

31 (6) FOR THE PURPOSES OF THIS SUBSECTION THE TERM "HEALTH CARE PROVID-
32 ER" SHALL MEAN AN ENTITY LICENSED OR CERTIFIED PURSUANT TO ARTICLE TWEN-
33 TY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC HEALTH LAW, A FACILITY
34 LICENSED PURSUANT TO ARTICLE NINETEEN, THIRTY-ONE OR THIRTY-TWO OF THE
35 MENTAL HYGIENE LAW, OR A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED
36 OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

37 [(3)] (7) Nothing in this section shall be deemed to limit [an insur-
38 er's] A HEALTH PLAN'S right to pursue recovery of overpayments that
39 occurred prior to the effective date of this section where the [insurer]
40 HEALTH PLAN has provided the [physician] HEALTH CARE PROVIDER with
41 notice of such recovery efforts prior to the effective date of this
42 section.

43 S 6. Subparagraph (B) of paragraph 2 of subsection (e) of section 3231
44 of the insurance law, as added by chapter 501 of the laws of 1992, is
45 amended to read as follows:

46 (B) Each calendar year, an insurer shall return, in the form of aggre-
47 gate benefits for each policy form filed pursuant to the alternate
48 procedure set forth in this paragraph at least seventy-five percent of
49 the aggregate premiums collected for the policy form during that calen-
50 dar year. Insurers shall annually report, no later than May first of
51 each year, the loss ratio calculated pursuant to this paragraph for each
52 such policy form for the previous calendar year. In each case where the
53 loss ratio for a policy form fails to comply with the seventy-five
54 percent loss ratio requirement, the insurer shall issue a dividend or
55 credit against future premiums for all policy holders with that policy
56 form in an amount sufficient to assure that the aggregate benefits paid

1 in the previous calendar year plus the amount of the dividends and cred-
2 its shall equal seventy-five percent of the aggregate premiums collected
3 for the policy form in the previous calendar year. The dividend or cred-
4 it shall be issued to each policy HOLDER WHO HAD A POLICY which was in
5 effect [as of December thirty-first of] AT ANY TIME DURING the applica-
6 ble year [and remains in effect as of the date the dividend or credit is
7 issued]. THE DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT
8 PREMIUMS EARNED FOR THE APPLICABLE YEAR AMONG ALL POLICY HOLDERS ELIGI-
9 BLE TO RECEIVE SUCH DIVIDEND OR CREDIT. AN INSURER SHALL MAKE A REASON-
10 ABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVIDENDS OR
11 CREDITS TO, FORMER POLICY HOLDERS ENTITLED TO THE DIVIDEND OR CREDIT.
12 All dividends and credits must be distributed by September thirtieth of
13 the year following the calendar year in which the loss ratio require-
14 ments were not satisfied. The annual report required by this paragraph
15 shall include an insurer's calculation of the dividends and credits, as
16 well as an explanation of the insurer's plan to issue dividends or cred-
17 its. The instructions and format for calculating and reporting loss
18 ratios and issuing dividends or credits shall be specified by the super-
19 intendent by regulation. Such regulations shall include provisions for
20 the distribution of a dividend or credit in the event of cancellation or
21 termination by a policy holder.

22 S 7. The insurance law is amended by adding a new section 3240 to read
23 as follows:

24 S 3240. COVERAGE OF SERVICES OF PARTICIPATING PROVIDERS. AN INSURER
25 THAT ISSUES A HEALTH INSURANCE CONTRACT PURSUANT TO THIS ARTICLE OR A
26 PLAN OR CONTRACT PURSUANT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS
27 CHAPTER WITH A NETWORK OF HEALTH CARE PROVIDERS, OR A HEALTH MAINTENANCE
28 ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC
29 HEALTH LAW (COLLECTIVELY "HEALTH PLAN") THAT UTILIZES A NETWORK OF
30 PARTICIPATING PROVIDERS SHALL NOT TREAT A PROVIDER THAT PARTICIPATES
31 WITHIN ITS NETWORK AS A NON-PARTICIPATING PROVIDER SOLELY BECAUSE ONE OR
32 MORE OTHER PROVIDERS RENDERING SERVICES TO THE INSURED FOR THE SAME OR
33 RELATED MEDICAL CONDITION, ILLNESS OR INJURY DOES NOT PARTICIPATE WITHIN
34 THE HEALTH PLAN'S PROVIDER NETWORK. A HEALTH PLAN SHALL MAKE A DETERMI-
35 NATION AS TO THE AMOUNT OF REIMBURSEMENT TO THE PARTICIPATING PROVIDER
36 IN ACCORDANCE WITH THE TERMS OF THE CONTRACT BETWEEN THE PARTICIPATING
37 PROVIDER AND THE HEALTH PLAN. THE INSURED SHALL BE RESPONSIBLE ONLY FOR
38 THE IN-NETWORK COST SHARING PROVISIONS OF THE POLICY OR CERTIFICATE.

39 S 8. The insurance law is amended by adding a new section 3241 to read
40 as follows:

41 S 3241. NETWORK ADEQUACY. AN INSURER THAT ISSUES A HEALTH INSURANCE
42 CONTRACT PURSUANT TO THIS ARTICLE OR A PLAN OR CONTRACT PURSUANT TO
43 ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER, WITH A NETWORK OF
44 HEALTH CARE PROVIDERS, SHALL ENSURE THAT THE NETWORK IS ADEQUATE TO MEET
45 THE HEALTH NEEDS OF ITS INSURED AND PROVIDE AN APPROPRIATE CHOICE OF
46 PROVIDERS SUFFICIENT TO RENDER THE SERVICES COVERED UNDER THE PLAN OR
47 CONTRACT. THE SUPERINTENDENT SHALL REVIEW THE NETWORK OF HEALTH CARE
48 PROVIDERS FOR ADEQUACY AT THE TIME OF THE SUPERINTENDENT'S INITIAL
49 APPROVAL OF A HEALTH INSURANCE PLAN OR CONTRACT THAT USES A NETWORK OF
50 PROVIDERS AND IS ISSUED PURSUANT TO THIS ARTICLE OR ARTICLE FORTY-THREE
51 OR FORTY-SEVEN OF THIS CHAPTER, AT LEAST EVERY THREE YEARS THEREAFTER
52 AND UPON APPLICATION BY THE INSURER FOR EXPANSION OF ANY SERVICE AREA
53 ASSOCIATED WITH THE PLAN OR CONTRACT.

54 S 9. The insurance law is amended by adding a new section 4306-c to
55 read as follows:

1 S 4306-C. GRIEVANCE PROCEDURE AND ACCESS TO SPECIALTY CARE. (A) A
2 CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS PLAN
3 CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A
4 COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A
5 MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF
6 SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER SHALL ESTABLISH
7 AND MAINTAIN A GRIEVANCE PROCEDURE CONSISTENT WITH THE REQUIREMENTS OF
8 SECTION FOUR THOUSAND EIGHT HUNDRED TWO OF THIS CHAPTER.

9 (B) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS
10 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT
11 ISSUES A COMPREHENSIVE CONTRACT THAT UTILIZES AN EXCLUSIVE NETWORK OF
12 PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS NOT A MANAGED CARE
13 HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR
14 THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO
15 OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION
16 (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR, SUBSECTION (G-6) OF
17 SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTION (A-1) OF
18 SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF SUBSECTION
19 (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH FOUR OF
20 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS
21 CHAPTER.

22 (C) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS
23 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT
24 ISSUES A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS AND
25 IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION
26 (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER AND
27 REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO A REFERRAL FROM A
28 PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH SPECIALTY CARE
29 CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C) AND (D) OF
30 SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER; PROVIDED
31 HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED TO REQUIRE THAT A CORPO-
32 RATION, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE CORPORATION, MAKE A
33 REFERRAL TO A PROVIDER THAT IS NOT IN THE CORPORATION'S NETWORK.

34 (D) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS
35 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT
36 ISSUES A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS AND
37 IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION
38 (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER SHALL
39 PROVIDE ACCESS TO TRANSITIONAL CARE CONSISTENT WITH THE REQUIREMENTS OF
40 SUBSECTIONS (E) AND (F) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF
41 THIS CHAPTER.

42 S 10. Paragraph 2 of subsection (h) of section 4308 of the insurance
43 law, as added by chapter 504 of the laws of 1995, is amended to read as
44 follows:

45 (2) In each case where the loss ratio for a contract form fails to
46 comply with the eighty-five percent minimum loss ratio requirement for
47 individual direct payment contracts, or the seventy-five percent minimum
48 loss ratio requirement for small group and small group remittance
49 contracts, as set forth in paragraph one of this subsection, the corpo-
50 ration shall issue a dividend or credit against future premiums for all
51 contract holders with that contract form in an amount sufficient to
52 assure that the aggregate benefits incurred in the previous calendar
53 year plus the amount of the dividends and credits shall equal no less
54 than eighty-five percent for individual direct payment contracts, or
55 seventy-five percent for small group and small group remittance
56 contracts, of the aggregate premiums earned for the contract form in the

1 previous calendar year. The dividend or credit shall be issued to each
2 contract HOLDER OR SUBSCRIBER WHO HAD A CONTRACT that was in effect [as
3 of December thirty-first of] AT ANY TIME DURING the applicable year [and
4 remains in effect as of the date the dividend or credit is issued]. THE
5 DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT PREMIUMS EARNED
6 FOR THE APPLICABLE YEAR AMONG ALL CONTRACT HOLDERS OR SUBSCRIBERS ELIGI-
7 BLE TO RECEIVE SUCH DIVIDEND OR CREDIT. A CORPORATION SHALL MAKE A
8 REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVI-
9 DENDS OR CREDITS TO, FORMER CONTRACT HOLDERS OR SUBSCRIBERS ENTITLED TO
10 THE DIVIDEND OR CREDIT. All dividends and credits must be distributed by
11 September thirtieth of the year following the calendar year in which the
12 loss ratio requirements were not satisfied. The annual report required
13 by paragraph one of this subsection shall include a corporation's calcu-
14 lation of the dividends and credits, as well as an explanation of the
15 corporation's plan to issue dividends or credits. The instructions and
16 format for calculating and reporting loss ratios and issuing dividends
17 or credits shall be specified by the superintendent by regulation. Such
18 regulations shall include provisions for the distribution of a dividend
19 or credit in the event of cancellation or termination by a contract
20 holder or subscriber.

21 S 11. Subsections (g) and (h) of section 4325 of the insurance law,
22 subsection (g) as relettered by chapter 586 of the laws of 1998, are
23 relettered subsections (h) and (i) and a new subsection (g) is added to
24 read as follows:

25 (G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A
26 CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY
27 THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE
28 INSURER GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE INSURER HAS
29 DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT
30 CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE
31 CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE
32 SUBJECT OF THE NOTICE BY THE INSURER, THE HEALTH CARE PROFESSIONAL MAY,
33 WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE
34 INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON
35 THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE
36 PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE"
37 SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE
38 THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A HEALTH CARE
39 PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A
40 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
41 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS
42 SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE REQUIRED
43 BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS
44 A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR
45 PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (B) SUCH CHANGE
46 IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLU-
47 SION OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT
48 METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

49 (2) NOTHING IN THIS SUBSECTION SHALL CREATE A PRIVATE RIGHT OF ACTION
50 ON BEHALF OF A HEALTH CARE PROFESSIONAL AGAINST AN INSURER FOR
51 VIOLATIONS OF THIS SUBSECTION.

52 S 12. Subsection (a) of section 4803 of the insurance law, as amended
53 by chapter 551 of the laws of 2006, is amended to read as follows:

54 (a) (1) An insurer which offers a managed care product shall, upon
55 request, make available and disclose to health care professionals writ-
56 ten application procedures and minimum qualification requirements which

1 a health care professional must meet in order to be considered by the
2 insurer for participation in the in-network benefits portion of the
3 insurer's network for the managed care product. The insurer shall
4 consult with appropriately qualified health care professionals in devel-
5 oping its qualification requirements for participation in the in-network
6 benefits portion of the insurer's network for the managed care product.
7 An insurer shall complete review of the health care professional's
8 application to participate in the in-network portion of the insurer's
9 network and, within ninety days of receiving a health care profes-
10 sional's completed application to participate in the insurer's network,
11 will notify the health care professional as to [(i)]: (A) whether he or
12 she is credentialed; or [(ii)] (B) whether additional time is necessary
13 to make a determination in spite of THE insurer's best efforts or
14 because of a failure of a third party to provide necessary documenta-
15 tion, or non-routine or unusual circumstances require additional time
16 for review. In such instances where additional time is necessary
17 because of a lack of necessary documentation, an insurer shall make
18 every effort to obtain such information as soon as possible.

19 (2) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE
20 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO
21 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS
22 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF
23 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK, IS
24 NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH
25 ONE OF THIS SUBSECTION, SUCH HEALTH CARE PROFESSIONAL SHALL BE DEEMED
26 "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NETWORK
27 PORTION OF AN INSURER'S NETWORK; PROVIDED, HOWEVER, THAT A PROVISIONALLY
28 CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN INSURED'S PRIMARY
29 CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDEN-
30 TIALED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY CREDENTIALLED
31 HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH
32 DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE
33 FINAL CREDENTIALING DETERMINATION IS MADE BY THE INSURER. A HEALTH CARE
34 PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE
35 GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTIFIES THE INSURER IN
36 WRITING THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE HEALTH
37 CARE PROFESSIONAL OR THE GROUP PRACTICE: (A) SHALL REFUND ANY PAYMENTS
38 MADE BY THE INSURER FOR IN-NETWORK SERVICES PROVIDED BY THE PROVI-
39 SIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL THAT EXCEED ANY
40 OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE INSURED'S CONTRACT WITH THE
41 INSURER; AND (B) SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED, EXCEPT
42 TO COLLECT THE COPAYMENT OR COINSURANCE THAT OTHERWISE WOULD HAVE BEEN
43 PAYABLE HAD THE INSURED RECEIVED SERVICES FROM A HEALTH CARE PROFES-
44 SIONAL PARTICIPATING IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK.
45 INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED
46 TWENTY-FOUR-A OF THIS CHAPTER SHALL NOT BE ASSESSED BASED ON THE DENIAL
47 OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL
48 WAS PROVISIONALLY CREDENTIALLED; PROVIDED, HOWEVER, THAT NOTHING HEREIN
49 SHALL PREVENT AN INSURER FROM PAYING A CLAIM FROM A HEALTH CARE PROFES-
50 SIONAL WHO IS PROVISIONALLY CREDENTIALLED UPON SUBMISSION OF SUCH CLAIM.
51 AN INSURER SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED
52 BY A PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE
53 GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

54 S 13. Section 4900 of the insurance law is amended by adding a new
55 subsection (g-7) to read as follows:

(G-7) "RARE DISEASE TREATMENT" MEANS A TREATMENT OR SERVICE FOR A HEALTH CONDITION WITH A RELATIVELY LIMITED INCIDENCE, AS SPECIFIED OR DEFINED IN A REGULATION AS SHALL BE PROMULGATED BY THE SUPERINTENDENT.

S 14. Subsections (c) and (g) of section 4903 of the insurance law, subsection (c) as added by chapter 705 of the laws of 1996, and subsection (g) as added by chapter 586 of the laws of 1998, are amended to read as follows:

(c) A utilization review agent shall make a determination involving continued or extended health care services, [or] additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, OR HEALTH CARE SERVICES NECESSARY TO ENSURE A SAFE DISCHARGE FOLLOWING AN INPATIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information. Notification of continued or extended OR POST-HOSPITAL services shall include the number of extended OR POST-HOSPITAL services approved, the new total of approved services, the date of onset of services and the next review date.

(g) Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be [an adverse determination subject to appeal pursuant to section four thousand nine hundred four of this title] AN APPROVAL.

S 15. 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 AGREE TO AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM TO RESOLVE DISPUTES OTHERWISE SUBJECT TO THIS ARTICLE.

S 16. 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 17. Subparagraphs (B) and (C) of paragraph 2 of subsection (b) of section 4910 of the insurance law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

(B) the insured's attending physician has certified that the insured has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial OR RARE DISEASE TREATMENT, and

(C) the insured's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of

section four thousand nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the insured than any covered standard health service or procedure; or (b) a clinical trial OR RARE DISEASE TREATMENT for which the insured is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

S 18. 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, 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.

(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, THE INSURED'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

S 19. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of subsection (b) of section 4914 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(a) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, upon review of the applicable medical and scientific evidence (or upon confirmation that the recommended treatment is a clinical trial OR RARE DISEASE TREATMENT), the insured's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article is likely to be more beneficial than any standard treatment or treatments for the insured's life-threatening or disabling condition or disease (or, in the case of a clinical trial OR RARE DISEASE TREATMENT, is likely to benefit the insured in the treatment of the insured's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

S 20. 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

1 care plan shall be obligated to pay such amount together with interest
2 thereon calculated at a rate which is the greater of the rate set by the
3 commissioner of taxation and finance for corporate taxes pursuant to
4 paragraph one of subsection (e) of section one thousand ninety-six of
5 the tax law or twelve percent per annum, to be computed from the date
6 the bill was required to be paid, in the event that payment is not made
7 within such forty-five days.

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

14 (3) IF AN INSURED'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL
15 OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT
16 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE
17 EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND
18 THE INSURED'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL AND
19 SHALL BE MADE BY THE HEALTH CARE PLAN AND THE INSURED'S HEALTH CARE
20 PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS
21 SET FORTH IN PARAGRAPH ONE OF THIS SUBSECTION; PROVIDED, HOWEVER, THAT
22 THE SUPERINTENDENT MAY, UPON A DETERMINATION THAT HEALTH CARE PLANS OR
23 HEALTH CARE PROVIDERS ARE EXPERIENCING A SUBSTANTIAL HARDSHIP AS A
24 RESULT OF PAYMENT FOR THE EXTERNAL APPEAL WHEN THE EXTERNAL APPEAL AGENT
25 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, IN CONSULTATION
26 WITH THE COMMISSIONER OF HEALTH, PROMULGATE REGULATIONS TO LIMIT SUCH
27 HARDSHIP.

28 (4) IF AN INSURED'S HEALTH CARE PROVIDER WAS ACTING AS THE INSURED'S
29 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH
30 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED
31 ON A STANDARD FORM DEVELOPED BY THE SUPERINTENDENT IN CONSULTATION WITH
32 THE COMMISSIONER OF HEALTH PURSUANT TO SUBSECTION (E) OF THIS SECTION.
33 THE SUPERINTENDENT SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL
34 APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECES-
35 SARY, IN WHICH CASE THE SUPERINTENDENT SHALL MAKE AT LEAST TWO WRITTEN
36 REQUESTS TO THE INSURED TO CONFIRM THE DESIGNATION. THE INSURED SHALL
37 HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE INSURED FAILS TO
38 RESPOND TO THE SUPERINTENDENT WITHIN THE SPECIFIED TIMEFRAME, THE SUPER-
39 INTENDENT SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO
40 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE
41 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE
42 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT'S REQUESTS
43 WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL REJECT THE
44 APPEAL.

45 S 21. The insurance law is amended by adding a new section 4917 to
46 read as follows:

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

53 S 22. Subdivision 5-c of section 4406-c of the public health law is
54 relettered subdivision 5-d and a new subdivision 5-c is added to read as
55 follows:

1 5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT
2 CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE
3 PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE
4 CHANGE, THE HEALTH CARE PLAN GIVES THE HEALTH CARE PROFESSIONAL WITH
5 WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY
6 THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF
7 THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE
8 CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE
9 HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE
10 NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR
11 HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION
12 DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS
13 SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A
14 PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF
15 MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A HEALTH CARE PROFESSIONAL,
16 AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A HEALTH CARE PROFES-
17 SIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE
18 EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS SUBDIVISION SHALL
19 NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGU-
20 LATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF
21 CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES
22 ESTABLISHED BY A GOVERNMENT AGENCY; OR (II) SUCH CHANGE IS EXPRESSLY
23 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR
24 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY
25 OR PAYMENT POLICY INDEXING MECHANISM.

26 (B) NOTHING IN THIS SUBDIVISION SHALL CREATE A PRIVATE RIGHT OF ACTION
27 ON BEHALF OF A HEALTH CARE PROFESSIONAL AGAINST AN INSURER FOR
28 VIOLATIONS OF THIS SUBDIVISION.

29 S 23. Subdivision 1 of section 4406-d of the public health law, as
30 amended by chapter 551 of the laws of 2006, is amended to read as
31 follows:

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

50 (B) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE
51 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO
52 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS
53 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF
54 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S
55 NETWORK, IS NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO
56 PARAGRAPH (A) OF THIS SUBDIVISION, THE HEALTH CARE PROFESSIONAL SHALL BE

1 DEEMED "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NET-
2 WORK PORTION OF THE HEALTH CARE PLAN'S NETWORK; PROVIDED, HOWEVER, THAT
3 A PROVISIONALLY CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN
4 ENROLLEE'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS
5 BEEN FULLY CREDENTIALLED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY
6 CREDENTIALLED HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING
7 THE NINETIETH DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST
8 UNTIL THE FINAL CREDENTIALING DETERMINATION IS MADE BY THE HEALTH CARE
9 PLAN. A HEALTH CARE PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL
10 CREDENTIALING IF THE GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTI-
11 FIES THE HEALTH CARE PLAN IN WRITING THAT, SHOULD THE APPLICATION ULTI-
12 MATELY BE DENIED, THE HEALTH CARE PROFESSIONAL OR THE GROUP PRACTICE:
13 (I) SHALL REFUND ANY PAYMENTS MADE BY THE HEALTH CARE PLAN FOR IN-NET-
14 WORK SERVICES PROVIDED BY THE PROVISIONALLY CREDENTIALLED HEALTH CARE
15 PROFESSIONAL THAT EXCEED ANY OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE
16 ENROLLEE'S CONTRACT WITH THE HEALTH CARE PLAN; AND (II) SHALL NOT PURSUE
17 REIMBURSEMENT FROM THE ENROLLEE, EXCEPT TO COLLECT THE COPAYMENT THAT
18 OTHERWISE WOULD HAVE BEEN PAYABLE HAD THE ENROLLEE RECEIVED SERVICES
19 FROM A HEALTH CARE PROFESSIONAL PARTICIPATING IN THE IN-NETWORK PORTION
20 OF A HEALTH CARE PLAN'S NETWORK. INTEREST AND PENALTIES PURSUANT TO
21 SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW
22 SHALL NOT BE ASSESSED BASED ON THE DENIAL OF A CLAIM SUBMITTED DURING
23 THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL WAS PROVISIONALLY CREDEN-
24 TIALED; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT A HEALTH
25 CARE PLAN FROM PAYING A CLAIM FROM A HEALTH CARE PROFESSIONAL WHO IS
26 PROVISIONALLY CREDENTIALLED UPON SUBMISSION OF SUCH CLAIM. A HEALTH CARE
27 PLAN SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED BY A
28 PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE GROUND
29 THAT THE CLAIM WAS NOT TIMELY FILED.

30 S 24. Section 4900 of the public health law is amended by adding a new
31 subdivision 7-g to read as follows:

32 7-G. "RARE DISEASE TREATMENT" MEANS A TREATMENT OR SERVICE FOR A
33 HEALTH CONDITION WITH A RELATIVELY LIMITED INCIDENCE, AS SPECIFIED OR
34 DEFINED IN A REGULATION AS SHALL BE PROMULGATED BY THE COMMISSIONER.

35 S 25. Subdivisions 3 and 7 of section 4903 of the public health law,
36 subdivision 3 as added by chapter 705 of the laws of 1996 and subdivi-
37 sion 7 as added by chapter 586 of the laws of 1998, are amended to read
38 as follows:

39 3. A utilization review agent shall make a determination involving
40 continued or extended health care services, [or] additional services for
41 an enrollee undergoing a course of continued treatment prescribed by a
42 health care provider, OR HEALTH CARE SERVICES NECESSARY TO ENSURE A SAFE
43 DISCHARGE FOLLOWING AN INPATIENT HOSPITAL ADMISSION, and SHALL provide
44 notice of such determination to the enrollee or the enrollee's designee,
45 which may be satisfied by notice to the enrollee's health care provider,
46 by telephone and in writing within one business day of receipt of the
47 necessary information. Notification of continued or extended OR
48 POST-HOSPITAL services shall include the number of extended OR POST-HOS-
49 PITAL services approved, the new total of approved services, the date of
50 onset of services and the next review date.

51 7. Failure by the utilization review agent to make a determination
52 within the time periods prescribed in this section shall be deemed to be
53 [an adverse determination subject to appeal pursuant to section forty
54 nine hundred four of this title] AN APPROVAL.

55 S 26. Section 4906 of the public health law, as amended by chapter 586
56 of the laws of 1998, is amended to read as follows:

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

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

10 S 27. The opening paragraph of subdivision 2 of section 4910 of the
11 public health law, as added by chapter 586 of the laws of 1998, is
12 amended to read as follows:

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

16 S 28. Subparagraphs (ii) and (iii) of paragraph (b) of subdivision 2
17 of section 4910 of the public health law, as added by chapter 586 of the
18 laws of 1998, are amended to read as follows:

19 (ii) the enrollee's attending physician has certified that the enrol-
20 lee has a life-threatening or disabling condition or disease (a) for
21 which standard health services or procedures have been ineffective or
22 would be medically inappropriate, or (b) for which there does not exist
23 a more beneficial standard health service or procedure covered by the
24 health care plan, or (c) for which there exists a clinical trial OR RARE
25 DISEASE TREATMENT, and

26 (iii) the enrollee's attending physician, who must be a licensed,
27 board-certified or board-eligible physician qualified to practice in the
28 area of practice appropriate to treat the enrollee's life threatening or
29 disabling condition or disease, must have recommended either (a) a
30 health service or procedure (including a pharmaceutical product within
31 the meaning of subparagraph (B) of paragraph [b] (B) of subdivision five
32 of section forty-nine hundred of this article) that, based on two docu-
33 ments from the available medical and scientific evidence, is likely to
34 be more beneficial to the enrollee than any covered standard health
35 service or procedure; or (b) a clinical trial OR RARE DISEASE TREATMENT
36 for which the enrollee is eligible. Any physician certification
37 provided under this section shall include a statement of the evidence
38 relied upon by the physician in certifying his or her recommendation,
39 and

40 S 29. Paragraphs (b) and (c) of subdivision 2 of section 4914 of the
41 public health law, as added by chapter 586 of the laws of 1998, are
42 amended to read as follows:

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

55 (c) Notwithstanding the provisions of paragraphs (a) and (b) of this
56 subdivision, if the enrollee's attending physician states that a delay

1 in providing the health care service would pose an imminent or serious
2 threat to the health of the enrollee, the external appeal shall be
3 completed within three days of the request therefor and the external
4 appeal agent shall make every reasonable attempt to immediately notify
5 the enrollee, THE ENROLLEE'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and
6 the health plan of its determination by telephone or facsimile, followed
7 immediately by written notification of such determination.

8 S 30. Item 1 of clause (ii) of subparagraph (B) of paragraph (d) of
9 subdivision 2 of section 4914 of the public health law, as added by
10 chapter 586 of the laws of 1998, is amended to read as follows:

11 (1) that the patient costs of the proposed health service or procedure
12 shall be covered by the health care plan either: when a majority of the
13 panel of reviewers determines, upon review of the applicable medical and
14 scientific evidence (or upon confirmation that the recommended treatment
15 is a clinical trial OR RARE DISEASE TREATMENT), the enrollee's medical
16 record, and any other pertinent information, that the proposed health
17 service or treatment (including a pharmaceutical product within the
18 meaning of subparagraph (B) of paragraph (b) of subdivision five of
19 section forty-nine hundred of this article) is likely to be more benefi-
20 cial than any standard treatment or treatments for the enrollee's life-
21 threatening or disabling condition or disease (or, in the case of a
22 clinical trial OR RARE DISEASE TREATMENT, is likely to benefit the
23 enrollee in the treatment of the enrollee's condition or disease); or
24 when a reviewing panel is evenly divided as to a determination concern-
25 ing coverage of the health service or procedure, or

26 S 31. Subdivision 4 of section 4914 of the public health law, as added
27 by chapter 586 of the laws of 1998, is amended to read as follows:

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

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

46 (C) IF AN ENROLLEE'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL
47 OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT
48 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE
49 EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND
50 THE ENROLLEE'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL
51 AND SHALL BE MADE BY THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE
52 PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS
53 SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION; PROVIDED, HOWEVER, THAT
54 THE COMMISSIONER MAY, UPON A DETERMINATION BY THE SUPERINTENDENT OF
55 INSURANCE THAT HEALTH CARE PLANS OR HEALTH CARE PROVIDERS ARE EXPERIENC-
56 ING A SUBSTANTIAL HARDSHIP AS A RESULT OF PAYMENT FOR THE EXTERNAL

1 APPEAL WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S
2 DETERMINATION IN PART, IN CONSULTATION WITH THE SUPERINTENDENT, PROMUL-
3 GATE REGULATIONS TO LIMIT SUCH HARDSHIP.

4 (D) IF AN ENROLLEE'S HEALTH CARE PROVIDER WAS ACTING AS THE ENROLLEE'S
5 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH
6 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED
7 ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER IN CONSULTATION WITH
8 THE SUPERINTENDENT OF INSURANCE PURSUANT TO SUBDIVISION FIVE OF THIS
9 SECTION. THE SUPERINTENDENT OF INSURANCE SHALL HAVE THE AUTHORITY UPON
10 RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST
11 OTHER INFORMATION AS NECESSARY, IN WHICH CASE THE SUPERINTENDENT OF
12 INSURANCE SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE ENROLLEE TO
13 CONFIRM THE DESIGNATION. THE ENROLLEE SHALL HAVE TWO WEEKS TO RESPOND TO
14 EACH SUCH REQUEST. IF THE ENROLLEE FAILS TO RESPOND TO THE SUPERINTEN-
15 DENT OF INSURANCE WITHIN THE SPECIFIED TIME FRAME, THE SUPERINTENDENT OF
16 INSURANCE SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO
17 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE
18 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE
19 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT OF INSURANCE
20 REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF INSURANCE
21 SHALL REJECT THE APPEAL.

22 S 32. The public health law is amended by adding a new section 4917 to
23 read as follows:

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

30 S 33. This act shall take effect January 1, 2010; provided, however,
31 that:

32 1. sections twelve and twenty-three of this act shall take effect
33 October 1, 2009, and shall apply to applications submitted after that
34 date, and shall not apply to applications submitted prior to such date
35 if such application is resubmitted in substantially similar form on or
36 after October 1, 2009;

37 2. provided, further, that the amendments to subsection (i) of section
38 3217-b of the insurance law made by section two of this act shall not
39 affect the repeal of such subsection and shall be deemed repealed there-
40 with;

41 3. provided, further, that the amendments to subsection (i) of section
42 4325 of the insurance law made by section eleven of this act shall not
43 affect the repeal of such subsection and shall be deemed repealed there-
44 with; and

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