

5472

2009-2010 Regular Sessions

I N S E N A T E

May 8, 2009

Introduced by Sens. BRESLIN, DUANE, ESPADA, HASSELL-THOMPSON, ONORATO, SAMPSON, STAVISKY -- (at request of the Governor) -- read twice and ordered printed, and when printed to be committed 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 ASSEMBLY, 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
16 relettered subsections (h) and (i) and a new subsection (g) is added to
17 read as follows:

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

LBD12014-08-9

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

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

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

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

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

48 (C) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A
49 NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT
50 AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE
51 OF THIS CHAPTER AND REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO
52 A REFERRAL FROM A PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH
53 SPECIALTY CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C)
54 AND (D) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER;
55 PROVIDED HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED TO REQUIRE THAT

1 AN INSURER, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE INSURER, MAKE A
2 REFERRAL TO A PROVIDER THAT IS NOT IN THE INSURER'S NETWORK.

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

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

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

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

1 DIFFER SUBSTANTIALLY FROM THE PAYMENT TERMS APPLICABLE TO CLAIMS SUBMIT-
2 TED WITHOUT AN ADMINISTRATIVE OR TECHNICAL DEFECT.

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

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

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

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

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

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

44 (2) A HEALTH PLAN SHALL PROVIDE A HEALTH CARE PROVIDER WITH THE OPPOR-
45 TUNITY TO CHALLENGE AN OVERPAYMENT RECOVERY AND SHALL ESTABLISH WRITTEN
46 POLICIES AND PROCEDURES FOR HEALTH CARE PROVIDERS TO FOLLOW TO CHALLENGE
47 AN OVERPAYMENT RECOVERY. THESE WRITTEN POLICIES AND PROCEDURES SHALL
48 INCLUDE A PROVISION STATING THAT A CHALLENGE TO AN OVERPAYMENT RECOVERY
49 SHALL BE MADE BY A HEALTH CARE PROVIDER IN WRITING WITHIN THIRTY DAYS OF
50 RECEIPT OF THE OVERPAYMENT RECOVERY REQUEST. ANY CHALLENGE TO AN OVER-
51 PAYMENT RECOVERY THAT CANNOT BE RESOLVED BETWEEN THE HEALTH PLAN AND THE
52 HEALTH CARE PROVIDER WITHIN THIRTY DAYS FROM THE HEALTH PLAN'S RECEIPT
53 OF THE CHALLENGE SHALL BE RESOLVED ACCORDING TO DISPUTE RESOLUTION
54 PROCEDURES ESTABLISHED BY THE PARTIES IN THEIR CONTRACTUAL AGREEMENT OR,
55 IF NO SUCH PROCEDURES ARE SET FORTH IN SUCH AGREEMENT, SHALL BE SUBMIT-
56 TED TO A THIRD-PARTY ARBITRATOR FOR A DETERMINATION.

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

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

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

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

35 [(3)] (7) Nothing in this section shall be deemed to limit [an insur-
36 er's] A HEALTH PLAN'S right to pursue recovery of overpayments that
37 occurred prior to the effective date of this section where the [insurer]
38 HEALTH PLAN has provided the [physician] HEALTH CARE PROVIDER with
39 notice of such recovery efforts prior to the effective date of this
40 section.

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

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

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

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

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

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

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

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

54 S 4306-C. GRIEVANCE PROCEDURE AND ACCESS TO SPECIALTY CARE. (A) A
55 CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS PLAN
56 CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A

1 COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A
2 MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF
3 SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER SHALL ESTABLISH
4 AND MAINTAIN A GRIEVANCE PROCEDURE CONSISTENT WITH THE REQUIREMENTS OF
5 SECTION FOUR THOUSAND EIGHT HUNDRED TWO OF THIS CHAPTER.

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

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

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

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

42 (2) In each case where the loss ratio for a contract form fails to
43 comply with the eighty-five percent minimum loss ratio requirement for
44 individual direct payment contracts, or the seventy-five percent minimum
45 loss ratio requirement for small group and small group remittance
46 contracts, as set forth in paragraph one of this subsection, the corpo-
47 ration shall issue a dividend or credit against future premiums for all
48 contract holders with that contract form in an amount sufficient to
49 assure that the aggregate benefits incurred in the previous calendar
50 year plus the amount of the dividends and credits shall equal no less
51 than eighty-five percent for individual direct payment contracts, or
52 seventy-five percent for small group and small group remittance
53 contracts, of the aggregate premiums earned for the contract form in the
54 previous calendar year. The dividend or credit shall be issued to each
55 contract HOLDER OR SUBSCRIBER WHO HAD A CONTRACT that was in effect [as
56 of December thirty-first of] AT ANY TIME DURING the applicable year [and

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

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

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

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

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

51 (a) (1) An insurer which offers a managed care product shall, upon
52 request, make available and disclose to health care professionals writ-
53 ten application procedures and minimum qualification requirements which
54 a health care professional must meet in order to be considered by the
55 insurer for participation in the in-network benefits portion of the
56 insurer's network for the managed care product. The insurer shall

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

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

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

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

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

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

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

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

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

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

32 S 16. The opening paragraph of subsection (b) of section 4910 of the
33 insurance law, as added by chapter 586 of the laws of 1998, is amended
34 to read as follows:

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

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

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

48 (C) the insured's attending physician, who must be a licensed, board-
49 certified or board-eligible physician qualified to practice in the area
50 of practice appropriate to treat the insured's life-threatening or disa-
51 bling condition or disease, must have recommended either (a) a health
52 service or procedure (including a pharmaceutical product within the
53 meaning of subparagraph (B) of paragraph two of subsection (e) of
54 section four thousand nine hundred of this article) that, based on two
55 documents from the available medical and scientific evidence, is likely
56 to be more beneficial to the insured than any covered standard health

1 service or procedure; or (b) a clinical trial OR RARE DISEASE TREATMENT
2 for which the insured is eligible. Any physician certification provided
3 under this section shall include a statement of the evidence relied upon
4 by the physician in certifying his or her recommendation, and

5 S 18. Paragraphs 2 and 3 of subsection (b) of section 4914 of the
6 insurance law, as added by chapter 586 of the laws of 1998, are amended
7 to read as follows:

8 (2) The external appeal agent shall make a determination with regard
9 to the appeal within thirty days of the receipt of the [insured's]
10 request therefor, submitted in accordance with the superintendent's
11 instructions. The external appeal agent shall have the opportunity to
12 request additional information from the insured, the insured's health
13 care provider and the insured's health care plan within such thirty-day
14 period, in which case the agent shall have up to five additional busi-
15 ness days if necessary to make such determination. The external appeal
16 agent shall notify the insured, THE INSURED'S HEALTH CARE PROVIDER WHERE
17 APPROPRIATE, and the health care plan, in writing, of the appeal deter-
18 mination within two business days of the rendering of such determi-
19 nation.

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

29 S 19. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of
30 subsection (b) of section 4914 of the insurance law, as added by chapter
31 586 of the laws of 1998, is amended to read as follows:

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

47 S 20. Subsection (d) of section 4914 of the insurance law, as added by
48 chapter 586 of the laws of 1998, is amended to read as follows:

49 (d) [Payment] (1) EXCEPT AS PROVIDED IN PARAGRAPHS TWO AND THREE OF
50 THIS SUBSECTION, PAYMENT for an external appeal shall be the responsi-
51 bility of the health care plan. The health care plan shall make payment
52 to the external appeal agent within forty-five days, from the date the
53 appeal determination is received by the health care plan, and the health
54 care plan shall be obligated to pay such amount together with interest
55 thereon calculated at a rate which is the greater of the rate set by the
56 commissioner of taxation and finance for corporate taxes pursuant to

1 paragraph one of subsection (e) of section one thousand ninety-six of
2 the tax law or twelve percent per annum, to be computed from the date
3 the bill was required to be paid, in the event that payment is not made
4 within such forty-five days.

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

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

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

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

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

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

53 5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT
54 CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE
55 PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE
56 CHANGE, THE HEALTH CARE PLAN GIVES THE HEALTH CARE PROFESSIONAL WITH

1 WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY
2 THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF
3 THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE
4 CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE
5 HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE
6 NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR
7 HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION
8 DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS
9 SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A
10 PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF
11 MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A HEALTH CARE PROFESSIONAL,
12 AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A HEALTH CARE PROFES-
13 SIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE
14 EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS SUBDIVISION SHALL
15 NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGU-
16 LATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF
17 CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES
18 ESTABLISHED BY A GOVERNMENT AGENCY; OR (II) SUCH CHANGE IS EXPRESSLY
19 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR
20 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY
21 OR PAYMENT POLICY INDEXING MECHANISM.

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

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

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

46 (B) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE
47 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO
48 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS
49 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF
50 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S
51 NETWORK, IS NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO
52 PARAGRAPH (A) OF THIS SUBDIVISION, THE HEALTH CARE PROFESSIONAL SHALL BE
53 DEEMED "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NET-
54 WORK PORTION OF THE HEALTH CARE PLAN'S NETWORK; PROVIDED, HOWEVER, THAT
55 A PROVISIONALLY CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN
56 ENROLLEE'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS

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

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

28 7-G. "RARE DISEASE TREATMENT" MEANS A TREATMENT OR SERVICE FOR A
29 HEALTH CONDITION WITH A RELATIVELY LIMITED INCIDENCE, AS SPECIFIED OR
30 DEFINED IN A REGULATION AS SHALL BE PROMULGATED BY THE COMMISSIONER.

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

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

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

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

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

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

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

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

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

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

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

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

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

51 (c) Notwithstanding the provisions of paragraphs (a) and (b) of this
52 subdivision, if the enrollee's attending physician states that a delay
53 in providing the health care service would pose an imminent or serious
54 threat to the health of the enrollee, the external appeal shall be
55 completed within three days of the request therefor and the external
56 appeal agent shall make every reasonable attempt to immediately notify

1 the enrollee, THE ENROLLEE'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and
2 the health plan of its determination by telephone or facsimile, followed
3 immediately by written notification of such determination.

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

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

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

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

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

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

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

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

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

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

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

34 2. provided, further, that the amendments to subsection (i) of section
35 3217-b of the insurance law made by section two of this act shall not
36 affect the repeal of such subsection and shall be deemed repealed there-
37 with;

38 3. provided, further, that the amendments to subsection (i) of section
39 4325 of the insurance law made by section eleven of this act shall not
40 affect the repeal of such subsection and shall be deemed repealed there-
41 with; and

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